

Male Injecting Drug Users and the Impact of Imprisonment

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The candidate confirms that the work submitted is her own and that appropriate credit has been given where reference has been made to the work of others.

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Abstract

To reflect concerns associated with the over representation of drug users in prison, policy regarding the control and treatment of drug users in prison in England and Wales has developed significantly over recent years, particularly since increased prison drug risk taking, such as injecting has been identified. Yet, there is little up to date, in-depth research considering what happens to injecting behaviour in prison. This study therefore used qualitative research to explore the impact of imprisonment on men's injecting drug use and provide a current perspective on how and why the prison environment influenced their drug using behaviour, considering how this differed to their community behaviours. Thirty men with a history of injecting drug use and imprisonment were sampled from community services in an English city. They were interviewed in-depth about their drug use before, during and after release from prison. A grounded theory approach underpinned the study and informed the analysis. Prison was identified as a time when participants found relief from hectic and intense drug using community lifestyles as they exercised more choice and control over their drug use. Yet time in prison was not necessarily drug free as participants took illicit drugs to prison with them to use. This advanced preparation and the reasons for it are new findings, enabled through the exploratory research approach. Men's illicit drug using behaviours in prison differed to their pre prison practices as different drugs were used, in different ways to injecting and at reduced levels to before imprisonment. The misuse of buprenorphine medication by snorting in prison was also identified as a new trend, taking over from heroin. To categorise the different types of men's prison drug using behaviours and to help explain the nature these when compared to before prison, the study developed and presents models of illicit drug use and routes of drug administration.

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List of Abbreviations

ABH	Actual bodily harm
BBV	Blood-borne virus
BOSS	Body Orifice Scanner System
BPS	British Psychological Society
CINAHL	Cumulative Index to Nursing and Allied Health Literature
CARAT	Counselling, Assessment, Referral, Advice and Throughcare
CDT	Community Drug Treatment Service
CJS	Criminal Justice System
DISC	Developing Initiatives Supporting Communities
DIP	Drug Intervention Programme
DRR	Drug Rehabilitation Requirement
DTTO	Drug Treatment and Testing Order
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
GBH	Grievous bodily harm
HMP	Her Majesty's Prison
HMPS	Her Majesty's Prison Service
HIV	Human immunodeficiency virus
IDU	Injecting drug user
IDTS	Integrated Drug Treatment System
MDT	Mandatory Drug Testing
NDTMS	National Drug Treatment Monitoring System
NHS	National Health Service
NTA	National Treatment Agency
NOMS	National Offender Management Service
PCT	Primary Care Trust
RCT	Randomised controlled trial
REC	Research Ethics Committee
SRP	Supply Reduction Programme
SD	Standard deviation
SPCR	Surveying Prisoner Crime Reduction
TWOC	Taking cars without owner's consent
UK	United Kingdom
UKDPC	United Kingdom Drug Policy Commission
VTU	Voluntary Testing Unit
YOI	Young Offenders' Institution

Chapter 1 - Introduction

This thesis presents the findings from empirical qualitative research which explored how imprisonment impacted on prison and community illicit drug use behaviours, specifically on the practice of injecting drug use. The study used in-depth interviews with men in England who had previously served in prison but who had since been released. This chapter briefly provides the background, rationale and focus of the research, outlining its aim and objectives, the questions which it sought to answer and the methodological approach adopted.

Background

There has been an enormous growth in the global illicit drug trade over recent decades, resulting in contemporary western societies witnessing an increase in the number of people using drugs (Pates, McBride & Arnold, 2005), particularly psychoactive drugs such as heroin, ecstasy, cocaine and amphetamine. The situation in the United Kingdom (UK) is no exception and studies consistently show that the UK has among the highest rates of recorded illegal drug use in the western world¹. In 2005/2006 when this research started, there were an estimated 332,000 opiate and/ or crack cocaine users in England, extending to nearly 400,000 within the UK (Hay et al., 2007). Within this, males are estimated to be three times more likely than females to be problem drug users. The current Health Profile of England shows that there has been little progress reducing the rate of drug dependence over the last five years, describing the situation as 'stable' (Department of Health, 2007).

Intravenous injection is one of the most common ways illicit drugs are administered as it gives an instant pleasurable 'hit' or 'rush' seconds after administration as liquefied drugs quickly travel in the bloodstream to the brain (Neale, 2002). Injecting has spread quickly in

¹ The UK Misuse of Drugs Act 1971 groups illegal drugs into three classes (A, B and C) depending on the degree of harm deemed attributable to each drug. Opiates, such as heroin, are among the strongest type of drug and are categorized as Class A as they are considered to cause the greatest harm to those who use them. Stimulant drugs, such as cocaine and ecstasy, affect the body in a different way to the sedative effects of opiates as they elevate the central nervous system and temporarily increase alertness and are also in Class A. A further stimulant, amphetamine is in Class B, although any Class B drug in injectable form is treated as Class A. Those controlled drugs deemed to be least harmful are in Class C, such tranquillisers such as benzodiazepines. Cannabis was downgraded from Class B to Class C in January 2004 but it was later re-classified to Class B in 2009 (HM Government, 2008).

Western countries since the 1970s and 1980s (European Monitoring Centre for Drugs and Drug Addiction, 2001; Pates, McBride & Arnold, 2005). However, the practice of injecting drugs is linked to deleterious health and social consequences for individuals engaging in it and the wider society, particularly as use becomes more routine (Berridge & Robinson, 2003). Firstly, injecting is thought to be the main cause of health damage related to illicit drug use in contemporary Europe (European Monitoring Centre for Drugs and Drug Addiction, 2001; Towl, 2006), encompassing physical and mental morbidity and an increased risk of mortality through the early onset of diseases, including blood-borne viruses, or fatal drug overdose. Negative social consequences include debt, unemployment, family relationship breakdown, social disharmony and antisocial behaviour. Whilst the relationship between drug use and crime is complex, increased criminal activity is also a common consequence of drug use as some addicted users commit acquisitive crimes in order to obtain money to pay for drugs (Bennett, 2000; Bennett & Holloway, 2007; Coid et al., 2000; Edmunds, Hough & Turnbull, 1999) or commit criminal activities whilst under their influence.

Drug users often come into contact with criminal justice systems on account of their involvement in criminal activities alongside illegal drug use. Being given a custodial prison sentence is legally considered to be the most severe penalty for criminal behaviour, characterised by removal from the general population, loss of liberty and enforced rules regarding accepted behaviour and strict regimes (Jewkes & Johnston, 2006). Prison populations throughout the world contain an over representation of substance users (Singleton, Farrell & Meltzer, 2003), including injecting drug users (World Health Organization, 2003; World Health Organization, 2005) and those addicted to opiates (Shewan, Stover & Dolan, 2005) and a significant proportion of them will also have co-existing mental health and psychiatric problems (Singleton et al., 1999).

There are 138 prison establishments (128 public, 10 private) in England and Wales, with a throughput of almost 140,000 offenders per year (Crighton & Towl, 2008). There are an estimated 40,000 drug users in prison in England and Wales at any one time (Lee & George, 2005), representing roughly half of all serving prisoners and the drugs economy in prison has been highlighted as a current controversy affecting prisons and shaping penal policy (Jewkes & Johnston, 2006). Whilst identifying trends of highly compromised and forbidden behaviours makes establishing accurate figures of the numbers of drug users in prison difficult, research can more readily identify the numbers of drug users entering prison, providing an idea of how many drug users there are in prison. For example, almost three quarters (73%) of those entering prison in England and Wales had used drugs in the previous year, of whom nearly half reported using heroin, crack or powder cocaine (Ramsay,

2003). Of the 73%, half reported that their offences were connected to their drug use, highlighting the link between crime and drug use (Ramsay, 2003). A later large longitudinal general purpose national survey with a cohort design had similar findings. Indeed, Surveying Prisoner Crime Reduction identified that the majority of newly sentenced adult prisoners self-reported to have used at least one illegal drug during the year before custody, a third having used heroin and crack cocaine (Stewart, 2008). Other surveys have identified the widespread use of drug use prior to custody (Ramsay, Bullock & Niven, 2005). Yet despite these estimates of the numbers of drug users in prison, they do not indicate anything precise about what happens to these drugs users' practices when in prison (Jewkes & Johnston, 2006) and offer explanations for this.

In relation to injecting, in 2005 64% of injecting drug users (IDUs) participating in the United Kingdom's Unlinked Anonymous Prevalence Monitoring Programme agency survey had been in prison or a young offenders' institution and 42% of this group had been in prison at least five times (Health Protection Agency et al., 2006). This reflects figures stating that over a third of people received into British prisons each year are treated for opiate dependence, 40% of whom report injecting drug use during the 28 days preceding imprisonment (Department of Health (England) and the devolved administrations, 2007).

Policy and Research Context

Her Majesty's Prison Service (HMPS) manages English and Welsh prisons and is part of the National Offender Management Service (NOMS), which is accountable to the Government. The key focus of prison establishments is to contain and control their populations securely and humanely in order to protect the wider public, whilst benefiting those living and working in prisons (Lee & George, 2005). As drugs can represent a threat to the security, containment and control of the prison population, strategic policy and practice in relation to prison drug use in England and Wales has developed rapidly over the years (HM Government, 1995; HM Government, 1998; HM Prison Service, 1998; HM Prison Service, 2000; Home Office, 2004; National Treatment Agency, 2002; National Treatment Agency, 2005). Historically, prison policies focussed on preventing and disrupting the supply of illicit drugs in prison and reducing the level of drug use in prison and associated high risk practices, particularly injection (HM Government, 1995). Whilst more recent policies are still concerned with disrupting the supply of, and demand for illicit drugs in prison, there has been increased focus on the health needs of prisoners, including identifying prisoners who have misused drugs and providing them with effective health advice, treatment and support of appropriate intensity (HM Government, 2002; HM Prison Service, 1998; HM Prison

Service, 2002a; Ramsay, Bullock & Niven, 2005). Most recently, this includes a more organised and systematic approach to clinical management and developing a range of clinical services encompassing risk management, care planning and the provision of adequate substitute medication and psychosocial support for prisoners with drug dependence, as demonstrated in the former Labour Government's ten year Drug Strategy (2008 – 2018) (Department of Health, 2006; HM Government, 2002; HM Government, 2008; HM Prison Service, 2002). This has been largely driven by the desire to improve prisoners' health and reduce re-offending and levels of crime committed (Department of Health, 2006; National Offender Management Service, 2005).

Research has shown that whilst illicit drugs are available in prison environments (Blakey, 2008; Hughes, 2003b; Penfold, Turnbull & Webster, 2005), being in prison may often result in changes in a person's drug using behaviour and practices, often a reduction in overall use (Bullock, 2003; Singleton et al., 2005). A comprehensive systematic review of the published peer reviewed literature on the experiences of male injecting drug users in prison in England and Wales since 1995 was conducted and is provided in Chapter 2. To summarise the review briefly, it highlighted that a limited amount of peer reviewed research published in the academic literature has been conducted in England and Wales with male injecting drug users who had been in prison about their experiences of drug use in prison since 1995, particularly regarding their prison drug using decisions (Hughes, 1999b; Hughes, 2000c; Hughes 2000d; Hughes, 2001; Hughes, 2004; Tompkins et al., 2007a). The review identified that most of the published peer reviewed research was qualitative in nature, which largely focussed on the increased health and blood-borne virus transmission risk practices of using drugs in prison (Hughes, 1999b; Hughes, 2001; Hughes, 2004; Wright, Tompkins & Jones, 2005) or the receipt of prison drug treatment (Broderick & Kouimtsidis, 2007; Hughes, 2000b; Sheard et al., 2009; Smith & Ferguson, 2005; Squirrell, 2007; Tompkins et al., 2007a).

Research Focus and Approach

The increasing number of people with a history of injecting drug use in prison, the developing prison policy and practice in the area of controlling and treating drug use and the limited amount of up to date and relevant peer reviewed in-depth research were factors which led to the design of the current research. The study aimed to examine the impact of imprisonment on men's injecting drug use, seeking to identify and explain the variation between different men's accounts regarding drug use during imprisonment and their prison drug using choices and behaviours in the current climate, taking social, psychological,

medical and environmental situations into account as less research has been done into these areas (Wilson et al., 2007). Given the relative dearth of recent scientific information on the topic, it sought to provide a detailed, contemporary perspective on *how* and *why* the prison environment was perceived to influence the behaviour of men who were intravenously injecting illicit drugs at the time of imprisonment. In so doing it sought to inform the debate regarding initiatives and interventions aimed at prisoners with injecting drug use histories and ascertain any risks of prison drug using behaviours, for prisoners engaged in its practice, the prison itself and the wider society. This aimed to lead to consider how any such risks could be reduced in the future in the interests of personal and public health. This research was considered both timely and important given the continued high numbers of drug users in prison in England and Wales despite the changing policies and practices, from the punitive and preventative agendas of the 1980s and 1990s to the more recent recovery and harm reduction agendas, influenced by overarching Governmental plans to reduce drug use and drug related offending (see Chapter 2). Furthermore, this relevant and up to date information is required in the hope that it can be considered so that emerging related policy and practice can be as tailored and targeted as possible and as reflective of the current situation informing it.

I considered that qualitative research was the most suitable methodological approach to explore the impact of imprisonment on injecting drug use. This approach places the importance on understanding the social world through the perceptions, attitudes and experiences of individuals (Bryman, 2001) and has increasingly been used with hard to reach groups such as injecting drug users (Neale, Allen & Coombes, 2005; Rhodes et al., 2005) and offenders (Hucklesby & Wincup, 2010; Noaks & Wincup, 2004). Furthermore, qualitative research attempts to uncover the meanings that inform and structure the participants' experiences through obtaining and interpreting 'thick' and detailed accounts and descriptions from which detailed analysis and understandings are made possible (Denzin, 2001; Seale, 1999). The study concentrated on former male prisoners, who were injecting illicit drugs at the time of being sent to prison. Only men were included in the study as they commit more offences than their female counterparts (Harrower, 1998) and the English and Welsh prison population is predominantly male. Indeed, the population in prison at 27th May 2011 was 84,529 of which 80,357 were male (in comparison to 4,172 females) (Ministry of Justice, 2011). Furthermore, men are over-represented as drug users and in their uptake of community drug services when compared to their female counterparts (Department of Health, 2001a), potentially reflecting their greater use of illicit drugs.

Research Aims and Objectives

The aim of the research was to explore the impact of imprisonment on injecting drug use amongst men who were injecting Class A drugs prior to being imprisoned. Linked to this, the research had a number of specific overarching objectives guiding it. As detailed below, these were to:

- Explore the issues that influence and contribute to men's drug use behaviour whilst in prison, examining the changes in behaviour and any reasons for behaviour change
- Reveal the prison drug using experiences and specific practices of drug use amongst men in prison (who were injecting drugs when sentenced to prison). Use this to try to identify markers of behaviour amongst male prisoners with a history of drug use.
- Examine the differences between men who stopped using illicit drugs in prison with those who continued to use (either by smoking or injecting) and what appeared to influence these differences within and between individuals.
- Explore male injecting drug users' thoughts and feelings of drug use in prison focussing on their overall risk perception regarding drug use and drug taking practices. Explore risk as a generic notion, covering all areas.
- Explore how time in prison affected how men contemplated their drug use and how it influenced their drug using behaviour, patterns and drug using choices and behaviours on release.
- Consider the theoretical and practical implications of the findings to help inform evidence based policy and practice.

Stemming from these overarching objectives were a number of specific questions which directed the research and which it sought to answer. These are detailed below:

- How did imprisonment initially impact on men, their drug use behaviour, their state of mind, their relationships and subsequently during their prison sentence(s)?
- How do men's drug use and related behaviour and practices change when in prison? And why?
- How do men articulate their experiences, thoughts and feelings of drug use in prison?
- How do men who stopped using drugs whilst in prison and those who used illicit drugs in prison differ?
- Why are there differences between men's prison drug using behaviours? To what extent do factors such as personal circumstances, biological and psychological addiction, family history, social support and relationships, peer pressure and others influence a man's behaviour?

- What were the specific drug using practices of men who continued to use illicit drugs in prison?
- What do men perceive as the risks associated with drugs and drug use in prison?
- To what extent has current policy and practice in relation to the treatment of drug users in prison appeared to influence male drug users' behaviour and choices?
- What is the impact of imprisonment on drug use post prison release, especially amongst men who stopped using drugs whilst in prison?
- What influenced men who stopped using drugs whilst in prison to stay off drugs when in the community? How easy/difficult was this perceived to be?
- What influenced men who stopped using drugs whilst in prison to re-start drug use on release from prison?
- How might this research help contribute to informing future policy and practice in the relevant areas and what recommendations for policy and practice arise from it?

Research Methods

For this study, I used in-depth interviews to give men with direct experiences of injecting drug use and imprisonment a voice and to collect data about how imprisonment impacted on injecting drug use behaviour. Interviews have been described as 'conversations with a purpose' (Burgess, 1984) and are seen as the 'gold standard' of qualitative research (Silverman, 2000). In-depth interviews were selected to allow examination of *why* and *how* men reported that imprisonment affected injecting drug use by ascertaining their reported drug using behaviours before, during and after imprisonment. The study took a broad qualitative view of risk, to encompass the generic risks associated with drug use and the prison environment, rather than focussing on the health risks linked to injecting drugs in prison like the majority of earlier qualitative studies. The notion of risk therefore included the risks of having drugs in prison, the risks of continued drug use in prison by any route of administration and the risks associated with a reduction in, or cessation of drug use whilst in prison. To obtain a clearer understanding and enhance subsequent theoretical developments, I allowed drug users to identify personally and articulate what they construct and view as the potential risks associated with drugs in prison in the interviews, which would ultimately be guided by their own thoughts, opinions and direct experiences.

I used a grounded theory approach to analysis as this is particularly suited to researching areas about which little is known (Glaser & Strauss, 1967; Strauss & Corbin, 1990). Grounded theory provided a rigorous approach to developing and explaining conceptual

interpretations and understanding from an inductive, bottom up analytical approach of what participants described in the interviews about what had happened to their drug use in prison (Bryman & Burgess, 1999, Creswell, 1998, Glaser & Strauss, 1967; Strauss & Corbin, 1990). Whilst there are different interpretations of grounded theory (Dey, 2007; Madill, in press), the grounded theory approach which mainly informed the current study is that of Strauss and Corbin (1990). Using grounded theory to guide the conduct of the research allowed me to contextualise the men's accounts and experiences by identifying and comparing participants' thoughts and feelings and drug use before prison and upon release from prison, alongside their thoughts, feelings and use whilst imprisoned. This was important to identify how the setting of a prison environment might or might not shape an individual and affect a man's thoughts and feelings, shape his drug use and choices and how it might subsequently affect any change in thinking and behaviour.

Personal Interest and Influences

On completing my undergraduate degree in Sociology and Social Policy at Durham University I was appointed as a Research Assistant (and later as a Research Fellow) in the National Health Service (NHS). During this employment, I mainly used in-depth interviews with homeless people and drug users (primarily injectors) about aspects of their lifestyles, health and drug use. When I started the current research in 2005, I had four years' worth of experience of designing and conducting qualitative research with injecting drug users. This prior work led to the topic of this thesis. In early qualitative studies I conducted, homeless people and injecting drug users expressed differing and interesting views about their time spent in prison in terms of what it meant to them, how they felt about it and how it had affected them. However these topics were only discussed if they were specifically relevant to the research being conducted. For example, a study into hepatitis C amongst homeless drug users conducted in 2001 highlighted needle smuggling on prison visits and excessive needle reuse in prisons (Wright, Tompkins & Jones, 2005). Study participants touched on how needles were a currency in prison, which were often traded for tobacco and discussed how needle scarcity led them to be used, and subsequently sharpened, many times (Wright, Tompkins & Jones, 2005). A later study, for which I conducted and analysed interviews with injecting drug using women identified more positive findings associated with prison as they often expressed a desire to be sent to prison on purpose in order to receive immediate medical assistance for drug dependence (Tompkins, Sheard & Neale, 2008). This finding was later reiterated in a larger study for which I interviewed injecting drug users about the barriers they faced in accessing treatment (Tompkins et al., 2007a).

These studies encouraged me to think more broadly about what imprisonment meant for injecting drug users, particularly in relation to their drug using practices. It struck me that injecting drug users had varied experiences of imprisonment, some claiming that they had wanted to use drugs during imprisonment and reported having obtained the necessary equipment to do so. I also found it intriguing that people reported having intentionally committed crime in order to receive a custodial sentence in the hope or expectation that medical assistance for drug dependence would be more easily obtained in prison than in the community. This led to the investigation of existing literature and the development of the current research and the associated questions.

This research was influenced by my harm reductionist epistemological perspective (Riley et al., 1999). I took this pragmatic public health approach as it acknowledges that people engage in illegal behaviours that carry risks, not least that people use drugs, a behaviour which may continue in prison (Newcombe, 1992; World Health Organization, 2005). Over recent decades this approach has emerged as a dominant and guiding principle in the delivery and treatment of community drug services although it has been less prominent in the prison policy pertaining to illicit drug use (Hughes, 2003a). In recognising and acknowledging that people engage in behaviours that carry risks, harm reduction approaches attempt to reduce the associated potential dangers or risks. In so doing, harm reduction is less concerned with stopping illegal drug use, but instead focuses on decreasing the adverse consequences of such use for those who engage in its practice (Newcombe, 1992; Riley et al., 1999; World Health Organization, 2005). The benefits of a harm reduction approach to injecting drug use is that if individuals continue to engage in illegal and therefore potentially risky drug using behaviours that they may do so as safely as possible, with the least possible effect on their health and welfare. My harm reduction belief and standpoint has inevitably affected the way in which the research has been carried out, such as how I engaged and questioned participants and how I interpreted the interview data. The influence of my harm reduction perspective is considered where relevant throughout the thesis.

Organisation and Structure of Thesis

This chapter has briefly introduced the current study, reasons why it has been conducted, the background to it and the methodological approach which guided it. The subsequent chapters further describe the conduct and findings of the research discussing the theoretical and practical implications of these. The thesis is structured in such a way so it reports the main findings from the interviews regarding prison and prison drug use to mirror the chronological order in which they were discussed and in which they had occurred. A chapter

outlining the behaviour and practices on the participants' last prison sentences is also included. This is included at the end of the thesis in Chapter 9 as this chapter is subject to a higher level of analytical interpretation than the more descriptive findings chapters which are presented earlier in the thesis. More specifically, detail on what is included in the following chapters is provided below.

Chapter 2 – Policy and Literature Review

This chapter starts with a brief overview of recent English and Welsh prison drug policy. The main focus of the chapter is a synthesis of the published research literature on the drug using experiences of adult male injecting drug users in prison in England and Wales since 1995.

Chapter 3 – Methods

In this chapter I firstly describe the overall qualitative research design and then outline the practical application of the qualitative methods used for the study. The chapter highlights the issues which had to be considered in order to commence the research and when employing the chosen methods. Personal reflections linked to using these methods during the practical and analytical stages of the study are provided throughout the chapter, in an attempt to recognise how my role as a researcher influenced the generation of data. The chapter also outlines the strengths and weaknesses of the current research.

Chapter 4 - Description of Participants

This chapter provides a descriptive overview of the study participants in terms of their demographic characteristics, childhoods, social circumstances, criminal activity and significant life behaviours which was collected from pre interview information slips and from the interview discussions.

Chapters 5, 6 and 7 - Findings: Drug Use Before, During and After Imprisonment

These chapters provide a description of participants' personal experiences of drug use, before imprisonment, whilst in prison and after release based on initial analysis of the interview data. I have presented these findings in a chronological way to reflect the interview process and to assist the reader to engage with participants through their accounts. As the focus of this empirical research was specifically on how time in prison influenced drug use behaviours, Chapter 6 which mainly discusses this is somewhat longer than Chapters 5 and 7 which describe the behaviours before and after imprisonment. To some extent, Chapter 4 also provides information about participants before and after their last prison sentence as it describes the participants circumstances at the time of interview, which was after their last

prison sentence and also outlines information prior to their imprisonment, such as their general drug use histories.

Chapter 8 - Consideration of Findings

This chapter presents findings from a detailed grounded theory analysis of the interview data which follows from the more descriptive level of analysis of the previous findings chapters. The higher level and more conceptual analysis that was carried out for Chapter 8 identified six important overarching themes which permeated the interview discussions and which transcended participants' community and prison experiences. These themes describe and help to explain the participants' lifestyles, behaviour and drug use, both within and outside of prison. The six identified themes are Age and Stage of Life, Deny Responsibility, Desire for Excitement, Living on the Edge, Resourceful and Adaptable and Complex Social Networks.

Chapter 9 – Models of Illicit Drug Use and Administration in Prison

Unlike Chapter 6 which relates to any previous prison sentences which the participants had served, this chapter focuses solely on participants last prison sentences. In it, this chapter describes and illustrates two models of participants' use of illicit drugs in prison which were developed from the grounded theory analysis of the interview data. The first model focuses on the type of illicit drugs used when last in prison and the second on the route of drug administration used.

Chapter 10 – Concluding Discussion

This chapter concludes the thesis and brings together a summary of the key findings. The chapter also discusses the implications of the study and makes suggestions for future research arising from it.

Chapter 2 – Policy and Literature Review

The previous chapter briefly outlined that prison policy and practice has developed over recent years, changing from focussing solely on disrupting the supply and use of illicit drugs to considering the health and social needs of drug dependent prisoners. This chapter outlines the features of the main drug and prison policies in England and Wales. This policy review is important to contextualise the review of the published peer reviewed literature on the drug using experiences of drug users in prison which follows in this chapter.

Overview of Prison Illicit Drugs Policy Since 1995

Peer reviewed research reports published in the early to mid 1990s revealed high levels of drug use, including drug injecting across British prisons (Bird et al., 1992; Bird et al., 1995; Carvel & Hart, 1990; Covell et al., 1993; Dolan, Donoghoe, & Stimson, 1990; Dye & Isaacs, 1991; Gore et al., 1995; Kennedy et al., 1991; Shewan, Gemmell & Davies, 1994; Taylor et al., 1995; Turnbull, Dolan & Stimson, 1991). Subsequently, policies were developed to address the presence and use of drugs in prison.

In England and Wales in 1995 the then Conservative Government's White Paper, *Tackling Drugs Together* aimed to reduce drug misuse in prison to ensure that drug problems were not exacerbated (HM Government, 1995). The 1995 Prison Service Drug Strategy detailed how this would be achieved (HM Prison Service, 1995). Contrary to the principles of harm reduction, the strategy took a tough approach to the Government's perceived stance of tackling problem drugs in prison, focussing on enforcement, control and punishment (Duke, 2000). Ensuring prison did not exacerbate drug problems was to be achieved by reducing prison drug supply through control methods such as enhanced perimeter fencing and visitor searching. To a lesser extent, providing treatment, counselling and support for drug users aimed to reduce prison drug demand. One way of identifying drug use and reducing prisoners' demand was through the introduction of random urine mandatory drug testing (MDT) which was extended to all English and Welsh prisons by March 1996 (Gore & Bird, 1996). The MDT target was to test 10% of the prison population every month with the aim of identifying prisoners in need of treatment and deal with those using drugs or refusing testing (HM Prison Service, 1995). Soon after the 1995 policy was launched, reports still identified high levels of drug use in British prisons (Bellis et al., 1997; Gore et al., 1997; Turnbull, Power & Stimson, 1996). However care has to be taken when interpreting the extent of

these findings. For example, the study by Bellis et al. (1997) was conducted in early 1996, not long after the introduction of the 1995 policy and so it is debateable whether the policy will have had any influence by that time. Furthermore, as it was only carried out in one English prison the results cannot be generalised more widely (Bellis et al., 1997).

Despite proposals to treat drug using prisoners, the lack of financial resources complementing the strategy hindered treatment service provision. Furthermore, the introduction of MDT was criticised for numerous reasons (Bird, 2005; Gore & Bird, 1995; Gore & Bird, 1998; Gore, Bird & Cassidy, 1999; Hughes, 2000a), not least that their effectiveness in controlling and reducing drug use was unknown (Gore & Bird, 1996). MDTs were also criticised for inadvertently impacting on decisions regarding health care provision as they underestimated opiate use and subsequently underestimated the need for treatment for opiate use (Gore & Bird, 1998). Mandatory testing was also argued to encourage prisoners to use heroin instead of cannabis (and arguably take more risks when using heroin) on account of the reduced length of time that it remains detectable in the body (Crosby 2005; Edgar & O' Donnell, 1998; Gore & Bird, 1995; Gore & Bird, 1998; Gore, Bird & Cassidy, 1999; Gore, Bird & Ross, 1996; Hughes, 2000a). Furthermore, prisoners caught using heroin were subject to harsher punishments, losing 21 days of remission (compared to 14 for cannabis). Keeping prisoners longer on account of positive drug tests had increased cost implications and criticism (Bird, 2005; Trace, 1998) as resources were diverted from drug rehabilitation programmes (Gore & Bird, 1996). The strategy's emphasis on reducing drug use and controlling supply was perceived to be prioritised over providing rehabilitative medical help to prisoners with drug problems (Duke, 2000; Hucklesby & Wilkinson, 2001; Hughes, 2000a; Hughes, 2003a; Seddon, 1996). Whilst service providers could use the introduction of MDT to argue for expanding drug treatment, provision remained '*ad hoc, underdeveloped and uncoordinated*' (Duke, 2000:401).

In 1998, the strategy was revised (HM Prison Service, 1998). '*Tackling Drugs in Prison*' was a continuation of the previous policy (Duke, 2006) as part of the incoming Labour Government's ten year National Drugs Strategy, '*Tackling Drugs to Build a Better Britain*' (HM Government, 1998) which intensified the role of the criminal justice system in dealing with drugs. The strategy's main commitment was to reduce illegal drug use in custody and reduce drug-related re-offending (HM Prison Service, 1998) by using time in prison to help achieve abstinence (Hughes, 2003a). Tackling the supply and demand for drugs in prisons through security and control remained a focus (Duke, 2006) but there was more emphasis on the Prison Service providing support for drug users. Prior to this time prisoners had had limited drug treatment opportunities (Hucklesby & Wilkinson, 2001), so improving the

availability and quality of clinical drug treatment programmes (Duke, 2000) and increasing the number of prisoners in treatment was encouraged. The strategy encouraged the Prison Service to collaborate with community agencies to introduce effective prison drug services (HM Government, 1998) and bridge care and support on prison release through the development of the Counselling, Assessment, Referral Advice and Throughcare (CARAT) service (HM Prison Service, 2002b). This non-clinical service aimed to provide specialized treatment such as assessment, care planning, groupwork, counselling, harm minimisation and relapse prevention advice for drug users in prison and on release. The strategy continued mandatory drug testing but also introduced targeted and voluntary testing units (VTUs) in drug free wings to help encourage abstinence. Attempts to focus on harder more dangerous drugs and strategies for short-term prisoners and unconvicted prisoners on remand were also components of the 1998 Strategy.

The Prison Service Drug Strategy was updated in 2002 (HM Prison Service, 2002a) in line with the National Updated Drugs Strategy (HM Government, 2002). Two key elements of the strategy continued to focus on reducing drug supply and demand in prison (Lee & George, 2005). A special Supply Reduction Programme (SRP), aiming to restrict the availability of drugs in prisons was launched by the Prison Service Drug Strategy Unit in 2003. Continuing the provision of support for drug users in prison, the third element of the strategy emphasised providing drug using prisoners with effective advice, treatment and support and effective throughcare arrangements with community providers (Lee & George, 2005). CARATs were central to this delivery and drug strategy spending priorities changed to reflect the shifting priorities towards providing prison drug treatment over controlling drug supply and testing (Ramsay, Bullock & Niven, 2005). At this time available prison treatment varied by prison but across the estate included a range of interventions such as clinical services, drug rehabilitation programmes, therapeutic communities and short duration drug treatment programmes (Lee & George, 2005). However, the quality and adequacy of the clinical treatment provided and the reach of prescribing policy has been criticised from a harm reduction standpoint for being inconsistent and unethical due to the continued perceived over emphasis of policies on the control and punishment of prison drug users up until this point (Hughes, 2003a; Kerr et al., 2004). This harm reduction perspective is arguably inconsistent with more historical beliefs that prison is a place of punishment and should be characterised by principles of reduced eligibility and provision as harm reduction prioritises measures which reduce the negative and adverse health, social and economic consequences arising from drug use over the elimination of drugs and their use (Hughes, 2003a; Kerr et al., 2004).

The National Offender Management Service (NOMS) was introduced in 2004 with the aim to better manage offenders in prison and probation services. Their 2005 Drug Strategy (National Offender Management Service, 2005) was part of their review of strategies to improve the health of drug using prisoners and reduce re-offending. Building on and subsuming earlier Prison Service strategies, it arguably adopted a more balanced approach than the preceding strategies by involving treatment and restrictive controls and emphasised the role of agencies in managing offenders (Paylor, Hucklesby & Wilson, 2010; National Offender Management Service, 2005). This may be because of international developments that were taking place at this time. For example, the link between prison and public health was acknowledged (Department of Health, 2006; Gatherer, Moller & Hayton, 2005). Reflecting this, prisoner health in England and Wales became a health and Prison Service priority (Sparrow, 2006). Whilst initially recommended by the Chief Inspector of Prisons in 1996 (Her Majesty's Chief Inspector of Prisons, 1996), by April 2006 responsibility for prison healthcare in England and Wales transferred from the Home Office to the National Health Service (NHS) local Primary Care Trusts (PCTs) (Cinamon & Bradshaw, 2005; Condon, Hek & Harris, 2006; Hayton & Boyington, 2006; Hek, 2006) although funding was to be allocated to the PCTs through the Ministry of Justice. This required modernising and expanding prison health services and for drug treatment to be consistent with community provision (Department of Health and HM Prison Service, 2002; Sparrow, 2006). The equivalence of prisoner and community patient needs meant that not providing clinical support and treatment to drug dependent prisoners was felt to extend their punishment and enforce marginalisation by denying the basic human right to health care, particularly given the developing evidence base about the benefits of providing such treatment within prison (Stover & Michels, 2010). Akin to community practice the prescription of opiate maintenance medications to drug dependent prisoners to control the need for drug use, reduce drug use and drug injecting and reduce the associated harms of drug use such as mortality, self harm and the transmission of blood-borne viruses received increased attention and was expanded (National Offender Management Service, 2005), reflecting international developments (Kerr et al., 2004). This was assisted through the Integrated Drug Treatment System (IDTS) which provided significant funding for clinical and psychosocial prison drug treatment², including the continuation of community clinical treatments in prison and continued to emphasised the importance of throughcare arrangements on release and end to end management. Also, for the first time national clinical guidelines for treating drug users in prison were issued (Department of Health, 2006).

² For example, the Government budget for prison drug treatment services was £25.4 million in 2008/2009 (Paylor, Hucklesby & Wilson, 2010).

Such drug treatment changes described above were reflected in the Labour Government's 2008 ten year Drug Strategy, which committed all prisons to provide community equivalent drug treatment by 2011 (HM Government, 2008). The 2008 Strategy highlights how providing prisoners with access to a minimum standard of clinical drug treatment, raising the quality of prison interventions and prioritising treatment and throughcare arrangements on release should help to maximise the effectiveness of prison in reducing drug misuse and its related harms (Dolan et al., 2003). In the same year, a review of prison drug treatment was conducted which involved reviewing documentary and research evidence, national and regional stakeholder interviews and focus group discussions and local and high security prison visits and focus groups with former prisoners (PricewaterhouseCoopers, 2008). The review raised criticisms and concerns regarding the situation. For example, the lack of a clear and inter-departmental strategy, fragmented organisational arrangements for funding, commissioning and performance managing and delivering services, the lack of a clear evidence base for some services offered, process inefficiencies and gaps in service provision were identified. The review therefore made recommendations as to how the delivery of drug services to drug users in prisons could be improved, including the establishment of a drug strategy group (PricewaterhouseCoopers, 2008). This independent expert Prison Drug Strategy Review Group was later formed. This Group subsequently conducted its own review of drug treatment and interventions in prisons for adult prisoners over the age of 18 (Prison Drug Treatment Strategy Review Group, 2010) and submitted recommendations as a response to the 2010 Drug Strategy consultation.

The change in political administration to a coalition Government between the Conservatives and the Liberal Democrats in 2010 led to a new Drug Strategy was published (HM Government, 2010). The latest strategy, *'Reducing Demand, Restricting Supply and Building Recovery,'* maintains the existing commitment to creating drug free prison environments through increasing the number of drug-free wings, where increased security prevents access to drugs (HM Government, 2010). Furthermore, like earlier strategies, the strategy aims to disrupt drugs entering prisons and prison drug dealing but aims to do so by strengthening intelligence capability in prisons and using new technologies (HM Government, 2010), building on developments in these areas. The use of opiate substitution was acknowledged to form part of an individual's recovery and achieving abstinence from drug use. Consequently, using opiate substitution in prisons was not dismissed as some harm reductionists feared. However the Strategy introduced a further change in the arrangements for funding of substance misuse services for prisoners in England and Wales through transferring the overall responsibility for this from the Ministry of Justice to the Department of

Health from April 2011 (HM Government, 2010). Given the newness of the latest Drug Strategy at the time of writing, the reach of the policy is very much unknown.

Since 1995 prison drug treatment has received renewed focus, including a more systematic approach to managing drug using prisoners through a broader range of clinical responses, risk management, joint management and care planning, alongside the integration of psychosocial support (Lee & George, 2005). Measures in prison to control the drug using prisoner population, reduce prison drug supply and identify and reprimand drug using prisoners such as through mandatory and voluntary drug testing remain. However these are still subject to criticisms linked to the rigid testing schedules which allow prisoners to plan their drug use around these and the switch to harder drugs which do not stay detectable in the body for as long as others such as cannabis (Bird, 2005; Djemil, 2008; Dyer, 2008). However, the shift in policy emphasis to encompass a health focus to expand prison drug treatment in order to reduce vulnerability to suicide and self harm whilst in prison and possible drug overdose and death on release is evident. This is particularly so given the renewed emphasis of joined up policies, that is, policies that focus on the continuity of care of drug users from the community and into prisons, between prisons and on release from prison, not just policies that are solely focussed on the time spent within prison. Bearing this policy context in mind, the chapter now considers the drug using experiences of men in prison, as ascertained from the peer reviewed literature.

Literature Review Rationale

Systematic reviewing has developed as a method of identifying and synthesising all the available primary research evidence on a specific subject (Victor, 2008). Systematic reviews are very popular in informing policy and decision making about the organisation and delivery of health and social care (NHS Centre for Reviews and Dissemination, 2001) as they collate and share the key findings of large bodies of literature on a topic (Victor, 2008). Reviews highlight similarities and differences between studies and explore reasons for any variations (NHS Centre for Reviews and Dissemination, 2001). The collation and synthesis of relevant evidence in a review is particularly beneficial to people who may not have time to read the individual studies themselves and/ or be able to consider carefully the validity and reliability of them.

A main benefit of systematic reviews is their validity and reliability. This is due to certain features and processes which are integral to the approach when preparing literature reviews, such as comprehensive searching, paying attention to the quality of the evidence, pre-

defining strict inclusion and exclusion criteria by which the relevance of studies are assessed and adopting clear, rigorous and replicable approaches to synthesising the resulting data (Victor, 2008). The transparency of searching for studies and reporting their findings is also beneficial as others can easily scrutinise the process used and judge the quality of the review from this (Victor, 2008).

However, systematic research reviews are also subject to certain criticisms. For example, questions are sometimes raised about the comprehensiveness and quality of evidence and about the transparency and reliability of the review process (Victor, 2008). A further criticism is that bias can be introduced in a number of ways, such as if the review only includes certain types of evidence and ignores others like grey literature and theses (Victor, 2008). Another potential source of bias and human error may be introduced if the review is conducted by one reviewer rather than two or more who may operate as a cross check and a marker of quality. Furthermore, traditional systematic reviews often rely on quality of evidence and studies using randomised controlled trial (RCT) design are viewed as the highest quality, although these may be practically and ethically difficult to conduct in the social sciences and so may be missing from more social science orientated research reviews. In addition, there can be a danger of losing clarity of the purpose and focus of tightly defined systematic reviews if more 'extended' reviews are undertaken which draw upon more diverse evidence bases and studies involving varied methodologies (Victor, 2008). Furthermore, as identified by Petticrew (2003), systematic reviews are time consuming as sifting thousands of titles and abstracts for their relevance to the review question is laborious and the yield of relevant studies to include in the review is often disappointingly low. There is also suspicion that relevant papers may be rejected for not meeting sometimes 'unreasonably rigorous' methodological or study criteria (Petticrew, 2003). Despite the systematic and prescribed techniques for searching databases for available evidence relevant to a review, concerns are raised about the adequacy of database indexing and search tools which vary across different databases. Further concerns relate to the potential for the searches to miss relevant work, especially grey literature and unpublished work which may not be thoroughly indexed in the databases (Dixon-Woods, Fitzpatrick & Roberts, 2001).

Furthermore, reviews of limited evidence have been found unhelpful, confusing and frustrating if there is no clear take home message and have been criticised for being unable to provide specific guidance on effective or ineffective interventions (Petticrew, 2003). Rather they often conclude that few primary studies of sufficient quality exist to answer the review question despite them trying to seek and collate the best evidence (Petticrew, 2003). A

further concern regarding systematic reviews is that qualitative research may be marginalised from them as techniques for including and synthesising qualitative evidence have been under developed in comparison to quantitative work (Dixon-Woods, Fitzpatrick & Roberts, 2001).

Despite the potential shortcomings of systematic research reviews, a systematic approach to the current review was chosen as it was felt that the advantages of the approach outweighed any potential disadvantages. However, reflection is provided where relevant in order to consider the potential limitations and implications of adopting this approach for the current review.

Planning the Literature Review - Aim and Scope

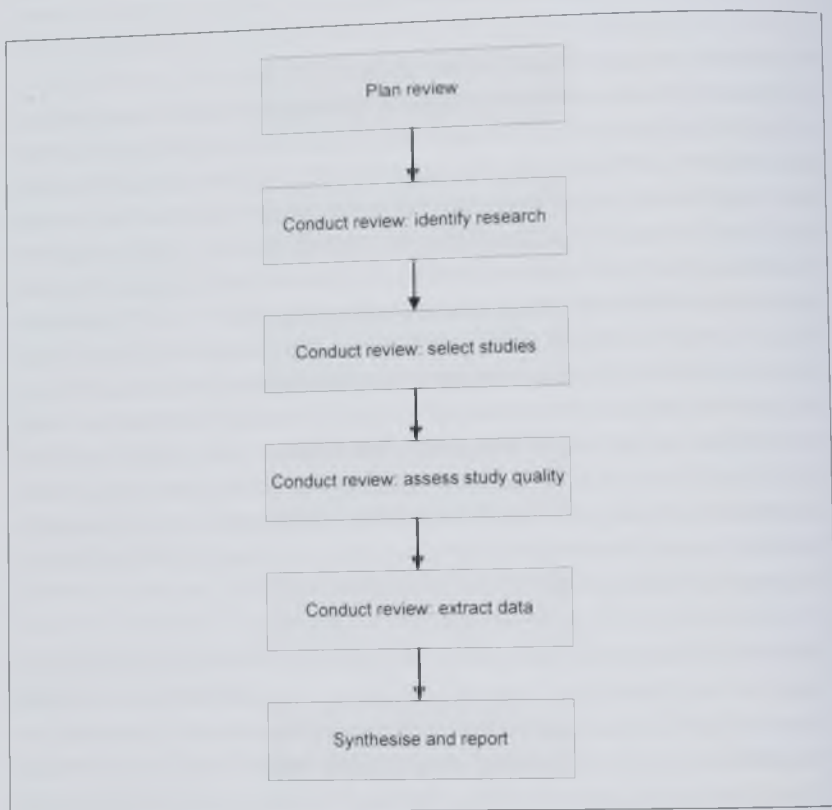
A systematic literature review was conducted to gather and synthesise relevant empirical evidence published in the peer reviewed academic literature regarding the drug using experiences of adult male injecting drug users in prison in England and Wales³ since the 1995 Prison Service Drug Strategy. Whilst the current research focuses on men released from prison in England and Wales since the National Updated Drugs Strategy (HM Government, 2002), the review focuses on original data from empirical studies conducted and published in the academic peer reviewed literature since 1995 in order to capture any relevant prisoner experiences in the context of the policy developments outlined above. Whilst there is some debate within the field of qualitative research and particularly amongst Grounded Theorists as to when it is best to conduct a literature review and how much reading should be done prior to data collection and analysis (Charmaz, 2006), the current formal literature review was not conducted until 2010, after the interviews had taken place. Before this time, reading in the area had been conducted, but not so much as to potentially colour or bias my own thoughts and judgements and subsequent thinking, analysis interpretations (Charmaz, 2006).

The review focussed on the peer reviewed literature in order to identify empirical research which, by virtue of having been externally peer reviewed, was considered to be of scientific rigour and quality and guard against the possible inclusion of research of a lesser quality and the possible implications of comparing non-peer reviewed studies alongside peer reviewed studies. The specific question which the review seeks to answer is, 'what does the academic published peer reviewed research literature report about the nature of drug using

³ The review did not include Scotland as this is administratively separate from England and Wales.

experiences of adult male injecting drug users in prison in England and Wales since 1995? This recognises that experiences are **subjective** in nature and are dynamic as they may change over time as **circumstances change**, such as policy developments or changing personal circumstances or **beliefs**. In line with systematic literature review best practice and guidance, the review was broadly divided into a number of stages, as shown in Figure 2.1 and described below (NHS Centre for Reviews and Dissemination, 2001; Victor, 2008). After defining the review aim and question, the next stage was to identify research.

Figure 2.1 – Overview of Systematic Review Stages



Conducting the Review – Identifying Research

The first part of identifying peer reviewed published academic research involved generating a search strategy. For this the literature review question was broken down into facets, firstly relating to drug use and secondly to being in prison and the review search parameters were built around these two areas. I initially intended to include the experience component of the literature review question as a third search parameter. However, I recognised that studies exclusively using qualitative or quantitative research approaches (or a mixture of these methods) could potentially contain relevant material regarding prison drug using experiences. I therefore decided that including key terms relating to the study methodology would not help to identify studies of experiences, but rather could be detrimental to producing a comprehensive search. Furthermore, whilst studies adopting more qualitative research approaches were likely to be more focussed on the experiences of drug users in prison, it was recognised that electronic databases often poorly index qualitative methodologies and it is often not practicable to construct strategies to capture the many ways qualitative research can be described (NHS Centre for Reviews and Dissemination, 2001; Shaw et al., 2004). This was a further reason for not including the experience component of the review question in the search or limiting the review to qualitative only studies to reduce the likelihood of missing relevant but inadequately indexed studies (Dixon-Woods, Fitzpatrick & Roberts, 2001; Dixon-Woods et al., 2006). I also discussed the issue with a literature search specialist from the Leeds University Library to check my decision regarding the exclusion of the potential third search parameter and her advice accorded with my conclusion based on the grounds listed above.

Identifying subject headings relating to drug use and/ or prison and key search terms to use was an iterative and staged process, done by examining various electronic databases, reading key articles, noting how they were indexed and in discussion with the University Librarian. The search strategy also developed iteratively and started on the PsycInfo database. Due to potential differences in the indexing of research papers, particularly between different databases, subject headings were kept broad to ensure that any relevant papers would be retrieved. For example, subject headings included terms for general drug use such as “drug abuse” and “drug addiction” (see Table 2.1 PsycInfo search lines 2 and 3) but also contained more specific injecting terms such as “intravenous drug usage” (see PsycInfo search line 1) and the names of injectable drugs. I ‘exploded’ rather than ‘focussed’ the subject headings in order to capture narrower terms so as to maximise the yield of potentially relevant literature. For example by exploding “drug abuse,” mapped narrower terms such as “heroin addiction” were automatically included in the search. To ensure as comprehensive and sensitive a search as possible, relevant keywords relating to drug use

such as "inject" and "drug abuse" appearing in an article title and/ or abstract were identified and added into the search using the ti,ab command. Keywords were truncated so that "inject\$" and "drug abus\$" (see PsycInfo search lines 10 and 12) would identify all articles containing any derivative of "inject" (such as "injecting", "injectors") and "drug abus" (such as "drug abuse", "drug abusing", "drug abusers") in their titles and/ or abstracts. After identifying the injecting drug use subject headings and keyword terms, they were combined together using Boolean logic 'OR' (see PsycInfo search line 23). Identifying subject headings, search terms and keywords for the prison component of the search followed the same process. Exploded subject headings such as "correctional institutions," "prisoners," "criminals," "incarceration" and "prisons" (see PsycInfo search lines 24, 25, 26, 27 and 29) were used to identify the population in prison or the state of being in prison. Truncated prison keywords appearing in an article's title or abstract included "prison\$", "inmate\$", "jail\$" and "custod\$" (see PsycInfo search lines 30, 31, 33 and 37). All prison terms and keywords were then combined using Boolean logic 'OR' (see PsycInfo search line 38).

The final stage of generating the search was to combine the injecting drug use and prison components, using Boolean logic 'AND', in order to identify articles relating to both injecting drug use and imprisonment (see PsycInfo search line 39). The search was then limited to articles published in the English language between 1995 and 2010 (see PsycInfo search lines 40 and 41). Whilst the review was only concerned with the experiences of men in prison, the search strategy was not limited to male only studies. This was due to concerns in consistency of indexing but also in recognition that potentially relevant information about men's experiences could be reported in studies which included both men and women. Table 2.1 below shows the final PsycInfo search strategy devised.

After identifying the PsycInfo search terms and keywords, the search was used as a basis to identify terms for subsequent databases. The number of databases chosen was limited to the four main electronic bibliographic medical databases which were felt to be the most relevant: Medline, Cumulative Index to Nursing and Allied Health Literature (CINAHL), Embase and PsycInfo. Each database has a slightly different focus and area of expertise.⁴

⁴ For example, Medline covers the international literature on biomedicine, including the allied health fields, the biological and physical sciences, humanities and information science as they relate to medicine and health care. CINAHL provides indexing for journals from the fields of nursing and allied health. Embase is a biomedical and pharmaceutical database indexing international journals in drug research, pharmacology, pharmaceuticals, toxicology, clinical and experimental human medicine, health policy and management, public health, occupational health, environmental health, drug dependence and abuse, psychiatry, forensic medicine and biomedical engineering/instrumentation. Finally, PsycInfo provides citations to the scholarly psychological, social, behavioural and health sciences literature.

For example, CINAHL was chosen to encompass nursing focussed literature whereas Medline would provide more clinically relevant articles.

Table 2.1 - PsycInfo Search Strategy

1. exp intravenous drug usage/
2. exp drug abuse/
3. exp drug addiction/
4. exp Crack Cocaine/
5. exp Heroin/
6. exp amphetamine/
7. drug addict\$.ti,ab.
8. drug depende\$.ti,ab.
9. intravenous drug\$.ti,ab.
10. inject\$ drug\$.ti,ab.
11. drug\$ inject\$.ti,ab.
12. drug abus\$.ti,ab.
13. drug misus\$.ti,ab.
14. drug us\$.ti,ab.
15. substance misus\$.ti,ab.
16. substance abus\$.ti,ab.
17. substance us\$.ti,ab.
18. amphetamine-related disorder\$.ti,ab.
19. cocaine-related disorder\$.ti,ab.
20. opioid-related disorder\$.ti,ab.
21. street drug\$.ti,ab.
22. heroin depend\$.ti,ab.
23. or/1-22
24. exp Correctional Institutions/
25. exp prisoners/
26. exp criminals/
27. exp incarceration/
28. exp Criminal Conviction/
29. exp prisons/
30. prison\$.ti,ab.
31. inmate\$.ti,ab.
32. offender\$.ti,ab.
33. jail\$.ti,ab.
34. gaol\$.ti,ab.
35. imprison\$.ti,ab.
36. incarcerat\$.ti,ab.
37. custod\$.ti,ab.
38. or/24-37
39. 23 and 38
40. limit 39 to yr="1995-2010"
41. limit 40 to english language

As indexing varies across different databases, developing the search strategies based on the PsycInfo search required performing pilot searches to ensure that the mapped searches were sensitive to each database's style of indexing. Consulting with the literature search specialist from the University Library about the different databases was particularly helpful in checking my devised searches and in clarifying different database workings. Most of the searching principles applied to PsycInfo were applicable to Medline and Embase as they were accessed through the same interface, although their indexing varied. Where the PsycInfo subject headings mapped to different Medline subject headings, the Medline specific headings were used for the Medline search. For example, the PsycInfo subject heading "intravenous drug usage" (see PsycInfo search line 1 in Table 2.1) was encompassed by the Medline heading "substance abuse, intravenous" (see Medline search line 4). In such cases, the PsycInfo heading was included in the Medline search as a keyword (see Medline search line 12 in Appendix 1) to ensure comprehensive searches and consistency between the database searches. This same process was applied to Embase but the search was translated for CINAHL as it used a different interface to OVID, although the searching principles largely remained the same. For all databases the injecting drug use subject headings and keywords and the prison subject headings and keywords were combined with 'OR' before the results of these were combined with 'AND'. Similarly the date and language limits described above were applied to all searches. Copies of the Medline, CINAHL, Embase and Medline database search strategies used in the searches can be seen in Appendix 1.

Final update searches of all four bibliographic databases were carried out during June 2011 in order to retrieve any published articles fit for inclusion which had been published since the review searches were first conducted in 2010. The update searches used exactly the same search strategies as the previous ones, but they were limited to year 2010-2011. Any duplicate references retrieved by both searches were identified and eliminated in EndNote. Table 2.2 below summarises the electronic databases searched and the combined retrieved results from both the initial and update searches.

It is acknowledged that empirical studies may have been conducted (or were being conducted at the time of searching) into the experiences of drug users in prison in England and Wales that had not been published in the academic peer reviewed literature. For example, this would include grey literature reports which may not have been identified by the electronic database searches. However, these studies are far less readily identified by traditional systematic review techniques (NHS Centre for Reviews and Dissemination, 2001). Whilst the focus of the review was on the peer reviewed literature, a brief section is included

at the end of the review which considers some of the relevant empirical research that has been conducted but which was not published in the academic peer reviewed literature to give a flavour of the findings. This literature was identified through knowledge of the area, through searching the internet and scanning the reference lists of included studies. Yet, the non-peer reviewed literature summarised does not claim to be all the non-peer reviewed published material available as this is impossible to know. Furthermore, as emphasised previously, the focus of the systematic review was on the peer reviewed literature published in the academic literature.

Table 2.2 - Electronic Databases Searched

Electronic database	Interface	Search 1 (1995 – June 2010) - References retrieved (pre de-duplication)	Search 2 (2010-16/06/2011) – References retrieved (pre de-duplication)	Total
CINAHL	EBSCO	1,410	192	1,602
Embase	OVID	3,048	501	3,549
Medline	OVID	2,463	322	2,785
PsycInfo	OVID	3,636	426	4,062
TOTAL		10,557	1,441	11,998

As the database search strategies were constructed in favour of sensitivity⁵, they had a low specificity⁶ (NHS Centre for Reviews and Dissemination, 2001). This meant that many references were identified from each database, 11,998 in total, as shown in Table 2.2⁷. The retrieved results were downloaded and saved into the EndNote Program X4 reference management software as a separate library. The references were de-duplicated in EndNote to eliminate any identical references captured by more than one database, after which 7,536 references remained.

⁵ Sensitivity relates to the power to identify all articles on a particular topic.

⁶ Specificity relates to the ability to exclude irrelevant articles from the results.

⁷ This includes 10,557 references from the initial searches and 1,441 references from the updated searches before duplicated references were removed.

Conducting the Review – Selecting Studies

To identify papers that help to answer the literature review question, I set inclusion and exclusion criteria against which the references could be independently reviewed. No inclusion or exclusion criteria were set according to study design as it was recognised that studies using various methodologies could yield relevant data. To be included in the review, papers had to meet the following criteria:

- Empirical research using quantitative, qualitative or mixed methods describing the nature of experiences or accounts of personal drug use in prison
- Published in the academic peer reviewed literature
- Data collection and participants imprisonment took place from 1995 onwards
- Participants in the studies had to fulfil the following criteria:
 - a history of illicit drug injection prior to imprisonment (either self-reported or assessed)
 - men over the age of 18 at the time of imprisonment
 - been remanded and/ or sentenced to serve in prison/s in England and/ or Wales at least once (that is, they could be in prison or could have been released and in the community at the time of the research)

To be excluded from the review, the papers had to meet at least one of the following criteria:

- Research not reporting empirical data
- Research not published in the academic peer reviewed literature
- Research not describing the experiences or accounts of drug use in prison, such as speculations about drug use in prison
- Data collection and participants' imprisonment took place before 1995
- Research relating to the use of non illicit substances, such as alcohol
- Opinion pieces /editorials
- Reviews
- Unpublished theses
- Book chapters
- Not written in English
- Participants in the studies were:
 - non injection drug users or had no history of injecting drug use
 - women only (although research of women and men could be included if it was possible to separate the experiences of the men from the women)
 - remanded and/ or sentenced to serve in prisons in countries other than in England and/ or Wales (although if the research included experiences of

prisoners from England and Wales it could be included if it was possible to separate them)

Screening the retrieved results to judge their relevance to the systematic review question was divided into manageable stages, as summarised in Figure 2.2 below. Firstly the titles and abstracts were quickly screened according to the inclusion and exclusion criteria. On account of the numbers of references retrieved, this assessment was unmasked and I was not blinded to the study author or publication details. On screening, the 7,536 references were electronically filed in the EndNote library into one of two broad categories, those to exclude and those where more information was required.

References to exclude (n=7,332)

These encompassed any references where it was obvious from reading the title and the abstract (where available) that the study met one or more of the exclusion criteria, such as book chapters and dissertations.

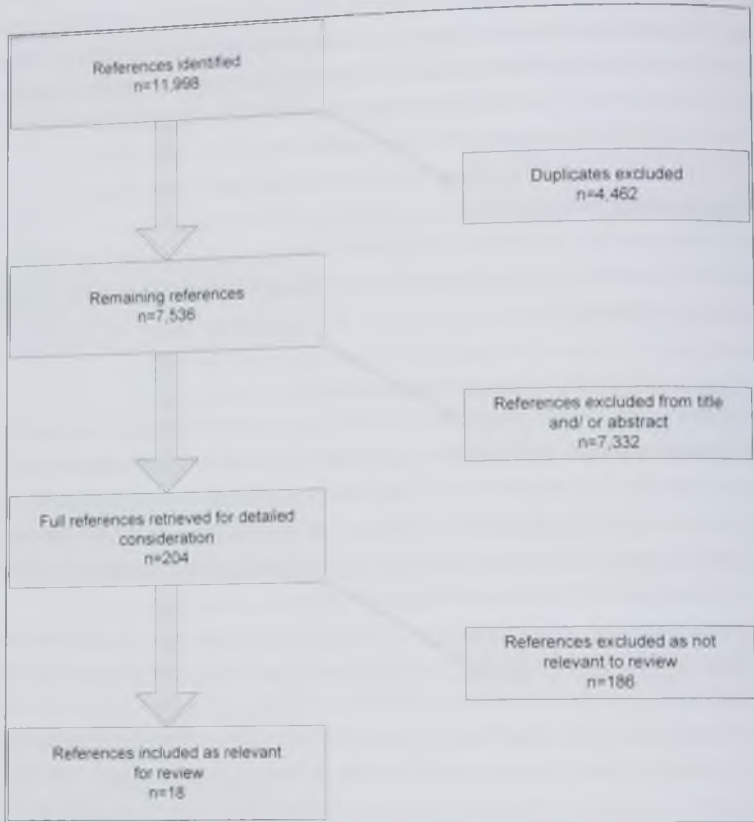
References where more information was required (n=204)

These references were those where it was unclear from an initial scanning of the title and abstract (where available) as to whether it was relevant to include or exclude and more information was needed to determine this. These references fell into three sub-categories:

- References to consider including (n=72). From reading the title and the abstract these appeared to be relevant to the review so required a careful consideration of the full paper against the inclusion and exclusion criteria.
- References with no abstract (n=81). Whilst many references did not have an abstract, they were not all filed as such as reading the title sometimes meant that the reference could be immediately excluded. For example, when the reference had no abstract but the title stated that the research had not been conducted in England and/ or Wales or it related to a non empirical piece of research, it was excluded. However, when a reference's relevance was unclear from the title alone, it was filed as 'no abstract', indicating that the abstract and/ or the full text needed to be obtained for further information.
- References which were unclear if either the research had been conducted in England and/ or Wales and/ or with men (currently or previously) in prison (n=51). These were references which I could not include or exclude after screening the title and abstract as there was not enough information but they were of sufficient interest to be

considered at the next stage of the review. They were therefore filed as requiring more information so that a later decision could be made.

Figure 2.2 – Overview of Study Selection Process



From the 7,536 references retrieved, 7,332 title and abstracts were screened. The full texts of 204 papers were obtained and fully read for more information to determine if they were to be included or excluded according to the criteria. On a full examination, the 132 references which had been filed as no abstract and those from which it was unclear if the research had been conducted in England and/ or Wales and/ or if the research participants had prison experience were all excluded on the grounds of relevance to the review. Similarly, the full

examination of the remaining 72 papers against the inclusion criteria identified that 54 were to be excluded, as summarised in Table 2.3. As shown by Table 2.3, most of these papers were excluded as they did not describe the experiences or accounts of drug use in prison. Similarly, a number of papers were excluded as they did not report empirical data or they were research reviews or despite being published since 1995, the data reported in the papers were collected before 1995.

Table 2.3 - Papers Excluded from the Review

Exclusion criteria	References	Number
Research not reporting empirical data	Bird, 2000; Davies, 2004; Hughes, 2000e; Hughes, 2003a; Lee & George, 2005; Malinowski, 2003; Stewart, 2007; Trace, 1998	8
Research not describing the experiences or accounts of drug use in prison	Brooke et al., 2000; Coomber, 2003; Gore & Bird, 1996; Gore, Bird & Ross, 1996; Gore, Bird, & Strang, 1999; Gore et al., 1999; Green et al., 2003a; Green et al., 2003b; Hardie et al., 1998; Harman & Paylor, 2004; Harman & Paylor, 2005; Howells, et al., 2002; Hughes, 2002; Khaw, Stobbart & Murtagh, 2007; Kipping, Scott, & Gray, 2011; Mason, Birmingham & Grubin, 1997; Mistral et al., 2008; Notarianni, Belk & Collins, 1995; Pearson & Hobbs, 2004; Roy, Fountain & Anitha, 2008; Small & Bennett, 2004; Weild et al., 2000	22
Data collection and/ or imprisonment took place before 1995	Bond, 1998; Boys et al., 2002; Brooke et al., 1998; Edwards, Curtis & Sherrard, 1999; Johnson & Farren, 1996; Keene, 1997a; Strang et al., 2006; Turnbull, Power & Stimson, 1996	8
Research reviews	Akeke, Mokgatle & Oguntibeju, 2007; Curtis, & Edwards, 1995; Fazel, Bains & Doll, 2006; Kothari, Marsden & Strang, 2002; Larney, 2010; Larney & Dolan, 2009; McMurrin, 2007; Stallwitz & Stover, 2007; Stover & Michels, 2010	9
Non injecting drug using participants	Turnbull & Webster, 1998	1
Participants were remanded and/ or sentenced to serve in prisons in countries other than England and/ or Wales	Gideon, 2010; Hennebel, Stover & Cassleman, 2005; Phillips, 2010; Stover, Casselman, & Hennebel, 2006	4
Combination of reasons	Brookes & Scott, 1997; Mitchell & McCarthy, 2001	2
Total		54

Eighteen out of 72 possible 'include' references met the inclusion criteria, as described and evaluated in Table 2.4. In Table 2.4 the papers are ordered alphabetically by author and aspects of the methodology such as sample size and participants are included in order to provide a context for discussing the findings and the reliability of them. The majority of these reported findings were from qualitative research interview studies, four used quantitative research methods (three surveys, one randomised controlled trial) and one was a case series using a mixed qualitative-quantitative approach. When reading the full texts against the inclusion and exclusion criteria it was sometimes difficult to identify the relevant information to determine whether or not they should be included. For example, it was sometimes hard to determine the former drug using status of prison participants or when the research was conducted. Consequently, where in doubt, the authors were contacted to seek clarification on specific issues. This was required for a number of references (Gore, Bird & Cassidy, 1999; Broderick & Kouimtsidis, 2007; George & Moreira, 2008; Lester, Hamilton-Kirkwood & Jones, 2003; Smith & Ferguson, 2005; Squirrell, 2007). Information regarding the nature of the varying queries is included in the review report and in Table 2.4 where relevant, along with the author responses when they were provided.

The database searches identified 11 references by the same author (Hughes, 1999b; Hughes, 2000b; Hughes, 2000c; Hughes, 2000d; Hughes, 2000e; Hughes, 2001; Hughes, 2002; Hughes, 2003a; Hughes, 2003b; Hughes, 2004; Hughes & Huby, 2000). These references do not report the findings of a number of different studies but report in detail the varying findings from Hughes's doctoral work which qualitatively explored how influences on drug injectors' risk behaviour operate inside and outside prison (Hughes, 1999a). As these were excluded from the review as non-peer reviewed publications, it was important that Hughes's peer reviewed publications were each considered for their relevance to the review, despite reporting findings from a single study. On consideration, not all Hughes's references were relevant and three were excluded (see Table 2.3). Whilst the eight included papers report different aspects of Hughes's doctorate, there was considerable overlap between them as six centre on reporting the experiences related to the access and use of drugs in prison, with a focus on risk behaviour and the strategies taken to reduce risks (Hughes, 1999b; Hughes, 2000c; Hughes, 2000d; Hughes, 2001; Hughes, 2003b; Hughes, 2004). There was also overlap with the other two included Hughes studies, one which largely reported the experiences of drug treatment inside prison (Hughes, 2000b) and the other which mainly reported on the wider aspects of drug injectors' lives within prison (Hughes & Huby, 2000) but contains relevant data on their experiences of accessing and using drugs in

prison when judged against the review inclusion criteria. This overlap between the papers is a significant limitation of including the papers from one single study in the current review.

Hughes's research itself has a number of limitations which must be considered when reporting and interpreting the findings of the eight papers included in this literature review which stemmed from the one single study⁸. Primarily, the main limitation of Hughes's study is linked to the methodological approach taken. That is, the study collected data regarding constructions of risk perception produced through asking participants how they considered characters in a written vignette would respond to particular situations regarding injecting risk behaviour (Hughes, 1999a). This approach to gathering views and data was complemented by the author (who was also the interviewer) encouraging participants to expand on their answers by asking them to discuss and reflect on observations from their personal experiences where appropriate (Hughes, 1998). Whilst the vignette approach might encourage participants to talk about sometimes difficult issues and practices, the limitation of it is that data about behaviours generated from it may not concur with real life behaviours as participants may feel detached from the vignette scenario or may provide socially desirable responses particularly as the vignette was read aloud to them by the author (Hughes, 1998; Hughes, 1999b; Hughes, 2000d; Hughes & Huby, 2002). Questions about the generalisability and transferability of the findings gathered by this approach must also be asked. Furthermore, the data collected by Hughes may be an artefact of the vignette approach and may deviate from the actual experiences of the research participants. Alternatively, it could be speculated that the data collected and interpreted may be an artefact of Hughes's analysis of this unique data collection approach as only he was involved in the analysis and his methodology has not been replicated by other researchers.

There were other methodological limitations linked to the conduct of Hughes's research which must be remembered when reading this review. Notably, Hughes used in-depth interviews and focus groups to collect his data, although he provides no acknowledgement about the differences in the data gathered by these approaches and he attends to the data in the same way, grouping it together for the purpose of his analysis. It would be expected that the data gathered in the individual interviews would be richer in nature and more context specific, whereas the group data would be less rich but broader across a number of people's experiences (Mason, 2002). It is also possible that the focus group discussions may have implicitly or explicitly led to participants to feel pressurised into converging with the dominant opinions offered by others in the group. Furthermore, it was also not certain from the reading

⁸ These limitations are presented and discussed here as they are important to consider. As such, they are only briefly summarised in Table 2.4.

of the various papers whether or not the vignette scenario and topic guide used in the interviews were used in the three focus groups or not.

Furthermore, there are discrepancies in some of Hughes's papers included regarding the number of participants involved in the study and whose experiences are reported in the specific papers. Hughes's doctorate was based on the conduct of qualitative research with 24 individuals (Hughes, 1999) through in-depth interviews and focus group discussions. Whilst some of the resultant publications concur in that the findings reported are from these 24 participants (Hughes, 2000b; Hughes 2001; Hughes 2003b; Hughes & Huby, 2000), other papers do not report the findings from the full sample of the wider study but relate to a sample of 14 participants (out of 17 participants) who were interviewed and the vignette was used⁹ (Hughes, 2000c; Hughes, 2000d) although no information about why this is the case is offered in the papers. The other two included Hughes papers also use different sample sizes, one suggesting that all 17 interview participants and ten focus group participants were included as the total sample was 27 participants (Hughes, 1999b) and the other stated that the sample was 25 participants (Hughes, 2004). Regardless of the sample used for the individual publications, whilst all participants had been in prison, there was no contextual information provided about when they had last been in prison or how long ago they had been released. This type of information would have been particularly helpful in the context of the current review as it might be that participants in Hughes's many papers included in this review are reports linked to some time before 1997 when the data was collected.

As a result of some of these limitations, I had to exercise caution in interpreting the papers and these caveats should be remembered in reading the review. I tried to only include material in the review that related to the actual reported actions of participants in Hughes's papers when they had been in prison rather than their perceptions of how individuals in the vignette scenarios might act in that situation. However in reality this was complex as it was sometimes hard to distinguish between prison and community injecting risk practices presented in Hughes's findings and between reports of actual practices and perceived practices from those linked to how participants thought that the characters in the vignettes may have behaved. Differences in how the papers presented the data obtained from the larger study also confused this as some papers only presented findings pertaining to prison behaviours (Hughes, 2000b; 2003b), some used section headings and signposting to

⁹ After consulting Hughes's doctorate (1999a) it was apparent that he conducted 17 interviews in total, two which were pilot interviews where he tested and developed the topic guide and the vignette scenario and one which was conducted without the vignette. It is unclear why he did not present the findings from all 17 interviews in some resulting publications but did in others.

separate the findings between community and prison behaviours (Hughes, 2000d; Hughes, 2001) whereas others combined community and prison behaviours in the articles but did not distinguish between them (Hughes, 2000c; Hughes 2004).

These limitations highlighted raise some questions about the quality of Hughes's research or at least the accuracy of the formal reporting of it. Furthermore, the generalisability of Hughes's research findings to drug injectors in prison based on the issues reported above but mainly linked to the unique nature of the research design is limited. Yet, despite these shortcomings it was considered important to include the articles authored by Hughes due to the rich and relevant data reported in them, although it is with these caveats that the data reported from Hughes in this review must be contextualised. The other research publications included in the review also had a number of limitations. However, given that these were not as significant as they did not all stem from one study which resulted in a number of relevant papers for inclusion the review, these are presented in Table 2.4 and in the review narrative where appropriate rather than in advance as in the case of Hughes.

Table 2.4 – Summary of Papers Included in the Review

Author & Date	Aim	Setting	Study period	Participants	Approach	Data collection methods	Limitations
Broderick & Kouimtsidis, 2007	Investigate prisoners' perceptions of treatment and treatment choices offered	HMP Wandsworth, England	Not specified. Emailed lead author confirmed it was conducted in 2004	n=8 male poly substance users in prison in receipt of detox or recently completed	Qualitative	Semi structured interviews	<ul style="list-style-type: none"> -Uncertain when conducted -Only fluent English speakers -Researcher managed detoxification unit and had had clinical involvement with participants -Small sample size
George & Moreira, 2008	Give insight into reasons for and experiences of snorting Subutex	Community drug service in Birmingham, England	Not specified. Email to lead author confirmed was conducted in 2007	n=6 heroin dependent patients (5 men) with prior prison history (who had snorted Subutex)	Case series	Semi structured questionnaires with qualitative component	<ul style="list-style-type: none"> -Small sample size -Preliminary data -No ethical approval -Convenient sample -Basic thematic qualitative data presentation and no information on analysis conduct
Gore, Bird & Cassidy, 1999	Elicit prisoners' views on the drug problem in prisons	Two (unnamed) prisons in England	August 1997 and October 1997	n=299 male drug users (confirmed by email to lead author)	Quantitative	Self completion questionnaire	<ul style="list-style-type: none"> -Self completion questionnaire (?literacy) -Participants had to comment on drugs, not consistently asked and collected -Non response figures not reported
Hughes, 1999b	Explore drug injectors' perceptions of clean and dirty in relation to HIV risk behaviour in and out of prison	Community services in 2 North East England cities	1997 (not specified but was part of larger study)	n=27 current or former IDUs with prior prison experience	Qualitative	17 in-depth interviews with vignette and 3 small group discussions	<ul style="list-style-type: none"> -Possible discrepancy in number of participants -No data on gender -Vignette -Generalisability concerns

Hughes, 2000b	Explore drug injectors' views of prison substitute prescribing	Community services in 2 North East England cities	1997	n=24 (18 men) current or former IDUs with prior prison experience	Qualitative	17 in-depth interviews and 3 small group discussions	-No mention of vignette -Generalisability concerns -Mainly current injectors so may explain why view prior prison experiences as having failed them -No prison specific information (e.g. how many prisons had served in or if experiences linked to one prison) or when prison experiences relate to
Hughes, 2000c	Identify drug injectors' understanding of cleaning needles and syringes in and out of prison	Community services in 2 North East England cities	1997	n=14 (9 men) current or former IDUs with prior prison experience	Qualitative	14 in-depth interviews with vignette	-Vignette -Generalisability concerns -Small sample size (subset) -Hard to distinguish between prison and community experiences
Hughes, 2000d	Explore influence of social distance on HIV risk behaviour and drug injecting behaviour in prison	Community services in 2 North East England cities	1997	n=14 (9 men) current or former IDUs with prior prison experience	Qualitative	14 in-depth interviews with vignette	-Vignette -Generalisability concerns -Small sample size (subset)
Hughes, 2001	Explore drug injectors' perceptions of HIV risk with regards to needing an injection and experiencing drug withdrawal in and out of prison	Community services in 2 North East England cities	1997 (not specified but was part of larger study)	n=24 (18 men) current or former IDUs with prior prison experience	Qualitative	14 in-depth interviews with vignette and 3 small group discussions	-Vignette -Generalisability concerns
Hughes, 2003b	Identify how drugs and equipment enter prison, how supplies maintained and their availability and quality	Community services in 2 North East England cities	1997 (not specified but was part of larger study)	n=24 (18 men) current or former IDUs with prior prison experience	Qualitative	17 in-depth interviews with vignette and 3 small group discussions	-Vignette -Generalisability concerns -No prison specific information (e.g. security category of prison(s) served in) or when prison experiences relate to

Hughes, 2004	Explore drug injectors' constructions of drug injecting HIV risk in and out of prison	Community services in 2 North East England (not specified but was part of larger study)	1997 (not specified but was part of larger study)	n=25 (19 men) current or former IDUs with prior prison experience	Qualitative	17 in-depth interviews with vignette and 3 small group discussions	<ul style="list-style-type: none"> -Possible discrepancy in number of participants -Vignette -Generalisability concerns
Hughes & Huby, 2000	Explore drug injectors' lives in prison	Community services in 2 North East England cities	1997 (not specified but was part of larger study)	n=24 (18 men) current or former IDUs with prior prison experience	Qualitative	17 in-depth interviews with vignette and 3 small group discussions	<ul style="list-style-type: none"> -Mainly current injectors so may explain why view prior prison experiences negatively -Report men's and women's experiences together, no distinctions made -Vignette -Generalisability concerns
Lester, Hamilton-Kirkwood & Jones, 2003	Collect information on health determinants directly from prisoners	HMP Cardiff, Wales	Not specified. Email to lead author confirmed was conducted in 2001	n = 133 male prisoners (of whom 91 used illegal drugs before prison)	Quantitative	Self completion multiple choice anonymous questionnaire	<ul style="list-style-type: none"> -Low response rate (44%) -All prisoners, not just drug users -Self completion, multiple choice questionnaire -Non random allocation of questionnaires (alternate cells) -Non representative sample
Sheard et. al., 2009	Compare dihydrocodeine and buprenorphine for prison opiate detoxification	HMP Leeds, England	July 2004 - July 2005	n=90 male opiate users in prison for 28 days or more	Quantitative	Randomised controlled trial (clinician and patient blind to randomisation)	<ul style="list-style-type: none"> -Patient preference affected willingness to be randomised -Possibly underpowered to determine effect of interventions on longer term abstinence -Intention to treat (ITT) analysis assumes missing urines were opiate positive -No data on

							randomisation refusals -High loss to follow up data for community releases at 6 months
Singleton, Farrell & Meltzer, 2003	Analysis of psychiatric morbidity survey, including information on substance misuse	Prisons in England and Wales	1997	Male and female prisoners. No more specific details	Quantitative	Survey	-Data gathered as part of larger psychiatric morbidity survey -No data on sample size or participants -No information on how survey was conducted -Presents figures of extent of use but no further explanation around these
Smith & Ferguson, 2005	Explore and describe the social and psychological processes that prisoners in treatment use to negotiate and manage their addiction and/ or recovery	A prison drug rehabilitation programme	Not specified. Emailed lead author to confirm ¹⁰	n=11 male prisoners with histories of substance abuse	Qualitative using grounded theory	In-depth semi structured interviews at 2 time points	-Uncertain when conducted -Unsure if all IDUs or former IDUs -Small sample -Interviews at 2 time points only conducted with 6/11 participants
Squirrell, 2007	Explore substance using offenders' views and experiences of treatment within UK criminal justice system (CJS)	Community treatment and prison	May - September 2005	n=33 (30 men) current and former substance using offenders with experience of criminal justice system (CJS)	Qualitative	Interviews	-No explanation of analysis -No information on interviews (e.g. focus, where conducted, length) -Encompasses drugs and alcohol so sometimes hard to separate views -Limited data on participant characteristics and demographics -Limited detailed interpretation of findings

¹⁰ However no response was received but the paper was included on the assumption that all participants were on prison drug rehabilitation programme and this is unlikely to have been offered in prison pre 1995, as the earlier policy review highlighted.

							<ul style="list-style-type: none"> -CJS in general so sometimes hard to separate prison experiences -No data when served in prison or when prison experiences relate to -Generalisability concerns
Tompkins et al., 2007a	Explore drug injectors' experiences of drug related care and treatment in prison	3 community locations in West Yorkshire	January - April 2006	n=51 current IDUs (42 men) with prior history of imprisonment	Qualitative	In-depth interviews	<ul style="list-style-type: none"> -All current IDUs so may explain why view prior prison experiences as having failed them -Focus on negative opposed to positive aspects -No data when last served in prison or when prison experiences relate to
Wright, Tompkins & Jones, 2005	Explore injecting behaviour, practices and experiences and how these were affected by a positive hepatitis C diagnosis	Primary care health centre for homeless people in the north of England	Not specified (but know that was conducted in 2003 as part of linked study)	n=17 (15 men) homeless IDUs with a positive hepatitis C diagnosis	Qualitative	In-depth interviews	<ul style="list-style-type: none"> -Not all former prisoners -No data on prior prison experiences (e.g. length of sentence or when served) or when prison experiences relate to -Generalisability concerns

Conducting the Review - Assessing Study Quality

It is usual in systematic reviews (particularly in reviews of effectiveness) to assess the quality of the studies in terms of their design, conduct and analysis and how they have minimised biases or errors in order to consider these when interpreting study findings and when comparing them to similar studies (NHS Centre for Reviews and Dissemination, 2001). However, there are varied views about whether and how this should be done when considering primary qualitative research studies and their inclusion in systematic reviews as this process may be contrary to the nature of qualitative enquiry (Dixon-Woods et al., 2006; Lucas et al., 2007; NHS Centre for Reviews and Dissemination, 2001). The need to judge and assess the quality and credibility of qualitative research is undisputed and various frameworks have been suggested which overlap in their appraisal criteria (NHS Centre for Reviews and Dissemination, 2001). However, it is acknowledged that rigidly applying a hierarchy or checklist approach to critical appraisal of qualitative research can bring problems, particularly in relation to transparency in assessing interpretative work (Lucas et al., 2007; NHS Centre for Reviews and Dissemination, 2001). As the majority of papers that were considered relevant to include in the review were of a qualitative research design, akin to other reviews of qualitative research, no set criteria were applied to assess the study quality if they met the review inclusion criteria as applying rigid quality criteria might risk excluding relevant papers that did not follow a particular reporting regime (Lucas et al., 2007). Rather, all papers meeting the inclusion criteria were included and a framework for quality appraisal was used at the formal data synthesis stage where I considered the quality of the research described in the papers according to principles of conducting ethical and rigorous qualitative research to contribute to the strength of the evidence (Spencer et al., 2003).

Conducting the Review - Data Extraction

In order to gather consistent information from papers, I designed a data extraction sheet containing the data items to be extracted when reading each (a copy of which can be seen in Appendix 2). The sheet was structured in a logical order to assist when entering data and covered general information about the study, such as the author and year of publication before ascertaining more specific information regarding the study's aims, methods and findings. As part of assessing study quality, the data extraction sheet also had a section to note study limitations and any concerns regarding the study method, data collected or conclusions drawn. This

meant that I could consider these and the bearing that they may have on the study findings when reporting and interpreting them.

Synthesis and Reporting

As most of the included papers report qualitative research, a narrative review was conducted. This was a process of synthesising and collating the study's findings and descriptively (rather than statistically) exploring heterogeneity and homogeneity across them (Petticrew, 2003). As very few papers report relevant quantitative findings from intervention studies, no quantitative synthesis or meta-analysis was performed. Rather, the qualitative and quantitative findings from the studies are discussed where relevant in the narrative and act to triangulate findings throughout the comparison of data collected from different perspectives. The synthesised findings from the included papers are discussed below and quotations from the qualitative studies illustrate key points. Reflections on the quality of the research conducted and any limitations are included where relevant throughout the review alongside the discussion of the main findings. As the included papers largely distinguished either drug users' experiences of accessing and using drugs in prison or their experiences of prison drug treatment, the review is divided and structured accordingly.

Drug Users' Experiences of Accessing and Using Drugs in Prison

Twelve articles mainly describe the use of drugs in prison, although as outlined earlier, six of these are from Hughes's doctoral study and so report findings from the same data set (George & Moreira, 2008; Gore, Bird & Cassidy, 1999; Hughes, 2000c; Hughes, 2000d; Hughes, 2001; Hughes, 2003b; Hughes, 2004; Hughes & Huby, 2000; Lester, Hamilton-Kirkwood & Jones, 2003; Singleton, Farrell & Meltzer, 2003; Tompkins et al., 2007a; Wright, Tompkins & Jones, 2005). The majority of these papers report findings from retrospective qualitative research studies of current or former drug users in the community about their prior prison experiences. Whilst the focus of a further paper is mainly on drug treatment, (Hughes, 2000b), it also reports relevant findings relating to prisoner experiences of accessing and using drugs, so is included in both sections of the review. Six common areas were identified across the qualitative papers which had a bearing on the use of drugs in prison. These were varied drug and equipment availability and supply, motivations and changing patterns of use, changing drugs of choice, centrality of prisoner

relationships, widespread risk behaviour and ineffective risk reduction strategies. The review's findings pertaining to these areas are reported and synthesised below. Sometimes the information reported in one area overlaps with that related to another, recognising that individuals' drug using experiences are influenced by a variety of different situations and circumstances. In these cases this is signposted in the review for clarity.

Varied Drug and Equipment Availability and Supply

The policy review earlier identified that a focus of early prison drug policy was on controlling the supply of drugs to prison. Papers reviewed here reported that the availability of drugs fluctuated in prison (Hughes, 2003b; Tompkins et al., 2007a), although unlike Hughes's paper, the availability of drugs in prison was not the focus of Tompkins et al.'s paper. This finding appeared to be consistent across the studies, despite the fact that the data for these studies was collected during different policy climates, Hughes's in 1997 during the time of the 1995 Drug Strategy and Tompkins et al.'s in 2006 in the era of the 2002 Updated Drug Strategy and after the introduction of NOMS.

There were periods obviously when there was a drought when you couldn't get anything. (Tompkins et al., 2007a:192)

Furthermore, Hughes's (2003b) paper reporting the experiences of 24 drug users (18 of whom were men), acknowledged that the size in terms of the quantity of prison drug deals was small although the paper does not state anything about the nature or the security category of the prison(s) to which the men referred. The only other published peer reviewed research study which contained information about the availability of drugs in prison was a small study by George & Moreira (2008) in which participants reported that buprenorphine was easier to obtain than heroin and crack cocaine¹¹. However, this study did not include any information on the type of prison(s) or the security category of the prison(s) either. Fluctuating drug availability influenced levels of prison drug consumption and was reported to make it difficult for users to keep a habit when imprisoned. This would also inevitably affect drug users' drug using experiences when in prison.

¹¹ Although a non-peer reviewed survey was conducted into buprenorphine misuse and published by the Ministry of Justice in 2007 (Ministry of Justice, 2007).

There's no keeping a habit in gaol because you don't know when it's going to come. (Hughes, 2003b:58)

Hughes (2003b) describes two main supply routes of drugs and the equipment required to use them into prisons which enabled the former prisoners involved in his research to use drugs and supply others. Firstly, drugs and equipment were concealed in the body and taken in by prisoners to ensure a ready supply. Supplies were also maintained by community visitors whereby prisoners arranged for them to bring and pass drugs and/ or equipment during a social visit (Hughes, 2003b). Whilst former prisoners described receiving drugs from visitors as unnerving, the threat of punishment had not deterred them (Hughes, 2003b). However, it could be speculated that this has something to do with methodological issues linked to Hughes's research. For example, those who participated in the research might have been those who were not deterred by punishments, so it is hard to know if drug users who did not take part shared the same experiences or if they were different. It may be that those who didn't take part might have been deterred by the threat of punishment when in prison, and possibly by the perceived possibility of reporting this in the research, thus also deterring them from participating in it. Nevertheless, Hughes reports that some had regularly received drugs and equipment this way, whereas others were more sporadic as it depended on contacting community suppliers (Hughes, 2003b). In prison, drug and equipment supplies were reported to be maintained by trading them with other prisoners although care was taken to keep knowledge of supplies quiet to avoid them being stolen by other prisoners (Hughes, 2003b). Drugs and equipment ('works') were often traded for tangible assets so both parties benefitted from the transaction (Wright, Tompkins & Jones, 2005).

You've got the gear, I've got the works. I've got no gear right. I'll lend you my works if you give me a wash out of your gear. Like both ways. You need what I've got, I need what you've got. (Hughes, 2003b:55)

Hughes also found that the relational dynamic underpinned prison drug availability as they were easier to procure between the socially close, overlapping with the Centrality of Prisoner Relationships later discussed in the review. The socially close included those already known to one another, cell mates and those serving longer sentences as there was more time for relationships to develop between them (Hughes, 2003b). Furthermore, whilst drugs were rarely given freely, it was more common among the socially close (Hughes, 2003b). Accruing drug debt was

highlighted as a problem of obtaining drugs without paying for them and could result in violent sanctions (Hughes, 2003b). These considerations may therefore be expected to have a bearing on the nature and extent of men's drug using experiences when in prison.

Motivations and Changing Patterns of Use

The policies reviewed earlier acknowledge that people use drugs when in prison but goes no further to consider why this is the case. However, the qualitative papers included in the review suggest many reasons why people use drugs in prison and alongside these the inclusion of quantitative surveys offer data comparing pre-prison and within-prison drug use. Reasons for men using drugs in prison suggested by the papers include helping prisoners settle in, especially during their first few days (Hughes, 2003b), relieving drug withdrawal (Hughes, 2003b; Tompkins et al., 2007a), breaking the monotony and boredom of prison life (Hughes, 2003b) and helping prisoners to sleep (Hughes & Huby, 2000).

Whatever drug you get in your cell, well apart from speed, it gets your head down, you know what I mean? Part of doing gaol is getting your head down.
(Hughes & Huby, 2000:468)

However, caution should be applied to interpreting these findings which suggest that drugs were used as a coping mechanism as most drug users involved in these retrospectively conducted studies were current drug users. Thus it might be speculated that the reasons they provided for using drugs in prison were linked to their continued drug using status (and possible failed attempts at stopping and perceived blaming of the prison service). This raises questions as to whether those not using drugs at the time of interview would reflect on their drug using status and practices in prison in the same way.

The papers report that drug use in prison and specific drug using behaviours can vary as it depends on a number of factors, largely the availability of drugs as described above and the influence of other prisoners, as later discussed. As acknowledged by Hughes (2001) and Tompkins et al. (2007a) the patterns of drug use in prison can, and do, change. This was confirmed by findings from three quantitative prisoner surveys (Gore, Bird & Cassidy, 1999; Lester, Hamilton-Kirkwood & Jones, 2003; Singleton, Farrell & Meltzer, 2003), two of which (Gore, Bird &

Cassidy, 1999; Singleton, Farrell & Meltzer, 2003) collected data in 1997¹². Most recently, a non representative self completion prisoner health survey in a single Welsh prison (Lester, Hamilton-Kirkwood & Jones, 2003) identified that 91/130 had used illegal drugs before prison, primarily heroin and cannabis and of them 44 (33%) continued using illegal drugs in prison, most commonly cannabis (29%) and heroin (13%), although no one reported injecting in prison. This might be due to some of the methodological limitations of the study. For example, the questionnaires were self completed by prisoners, they were not randomly distributed to prisoners and the survey achieved a low response rate of 44%. It could therefore be speculated that those with literacy problems, those with greater needs or those who were wary of reporting drug injecting in prison were some of the prisoners who were either not approached about the questionnaire or who did not respond to it. Whilst the study identifies continued use of some drugs in prison, it offers no insight into the reasons for the changes and reductions in their drug use (Lester, Hamilton-Kirkwood & Jones, 2003).

An earlier self completion questionnaire survey conducted to ascertain views on the prison drug problem in two English prisons¹³ also identified changing patterns of use (Gore, Bird & Cassidy, 1999) although the study did not ask this consistently of all participants but asked them to comment on this if they wished. Whilst non drug users were included in the sample, the paper is included in the review as it separates the views of drug users in prison (considered as those who had used drugs in the six months prior to sentence), (n=299) from non users (n=267). Out of 222 drug users who commented about the drug problem in prison, 117 (53%) mentioned mandatory drug testing (MDT) which, as earlier described in the policy review, had not long since been introduced at the time of the survey. Of these 111 (95%) viewed it negatively and 83 (just over 70%) referred to switching to, or increasing heroin/hard drug use from cannabis use as a result of MDT in order to evade detection. Fifty seven drug users believed that MDTs should be stopped altogether, and of those, 23 said that it should at least be stopped for cannabis. However a limitation of this study is that the prison security categories where the research took place was not reported and this could have an impact on the views of the prisoners involved. Finally, another

¹² It was unclear from the research by Lester, Hamilton-Kirkwood & Jones (2003) when their data were collected but email communication with the lead author confirmed that it was conducted in 2001.

¹³ The paper does not report the participants' gender, but email communication with the lead author confirmed that fieldwork was only undertaken in male prisons, although information on the security classification of the prisons is not provided.

prisoner survey conducted at the end of 1997 identified that 38% of male remand and 48% of male sentenced prisoners who had ever used drugs had used them during their current prison term but at a reduced frequency¹⁴ (Singleton, Farrell & Meltzer, 2003). Again drugs most frequently used in prison were cannabis and heroin, with far less mention of other drugs and reports of injecting on their current prison term were rare, at about 2% for the remand and 2% for the sentenced male prisoners (Singleton, Farrell & Meltzer, 2003).

Tompkins et al.'s study conducted in 2006, retrospectively gathered the views of community injectors who had previously served in prison. It found that alongside the availability of drugs, the provision of adequate medication to control opiate withdrawal largely influenced prisoners' drug using choices and behaviours (Tompkins et al., 2007a). However, there is little information on prison drug use behaviours presented (other than stating that some participants had stopped injecting drugs in prison whereas others had continued), as the remainder of the paper reports their experiences of drug treatment in prison, as later discussed (Tompkins et al., 2007a).

Changing Drugs of Choice

There is limited information in the included papers about the types of drugs used in prison. However, Tompkins et al.'s (2007a) study participants suggest that the prison environment was not conducive to stimulants and, accordingly heroin and cannabis were more commonly available and used. This was confirmed in the Welsh health survey which identified very little stimulant use in prison in comparison to the pre-prison reports (Lester, Hamilton-Kirkwood & Jones, 2003). Furthermore, as outlined in the section above, Gore, Bird & Cassidy's (1999) study identified increasing prison heroin/hard drug use from cannabis as a result of the introduction of MDT in order to evade detection, substantiating concerns raised when MDT was introduced as outlined in the earlier policy review.

A further paper reports the use of a different drug in prison, that of buprenorphine (also known by its trade name, Subutex), a medication sometimes prescribed for opiate dependence (George & Moreira, 2008). The authors conducted a closed semi

¹⁴ Whilst the survey was conducted at the end of 1997, it is assumed that a lot of the experiences which relate to the current prison term occurred since 1995, particularly for the remand prisoners as it is unlikely that they will have been on remand for as long as two years.

structured questionnaire with an open ended qualitative component with six heroin dependent community patients who had snorted buprenorphine. Table 2.4 identifies the study limitations which must be considered in terms of how transferable the results are as it was a very small scale case series with a self selected sample. Despite this, the paper reports relevant findings to this review particularly as the study was conducted in 2007, a time when buprenorphine prescription in prison was more widely available due to the introduction of IDTS from 2006. They found that all patients snorted buprenorphine in prison but had not done so before and most enjoyed doing so (George & Moreira, 2008). Overlapping with the Varied Drug and Equipment Availability and Supply and Motivations and Changing Patterns of Use themes previously discussed, participants (four of whom had previously used heroin in prison) suggested that buprenorphine was easy to obtain in prison, easier than cocaine and heroin, accounting for its use (George & Moreira, 2008). This perceived availability may possibly reflect the policy changes to improve and increase drug treatment for prison drug users as earlier outlined in the policy review which had been implemented by the time the study was conducted. Other reasons encouraging the snorting of buprenorphine in prison included the desire to obtain a high and only a small amount was needed. In addition, participants viewed snorting as a safer administration route than injecting (George & Moreira, 2008).

Centrality of Prisoner Relationships

Relationships with fellow prisoners appeared central to the prison drug use of former prisoners in Hughes's study. As suggested earlier in Varied Drug and Equipment Availability and Supply, establishing and maintaining friendships in prison were important for prisoners to locate drug and/ or equipment supplies (Hughes & Huby, 2000) as they were easier to procure amongst the socially close, such as cell mates or friends from the community (Hughes, 2003b). Furthermore, obtaining and using drugs in prison was influenced by the presence of others, especially if they were already friends from the community or if they had become friends in prison (Tompkins et al., 2007a). A further included qualitative study reported that other people involved in the prison drug subculture were also identified to make prisoners who had been through rehabilitation in prison vulnerable to relapse and encouraged them to maintain their drug habit (Smith & Ferguson, 2005).

A paper fully discussed later in the treatment section of the review highlights the role relationships played in drug using decision and motivations in prison¹⁵ (Squirrell, 2007). Despite a number of limitations identified in the paper (see Table 2.4), Squirrell (2007) reported how prisoners' efforts and attempts to abstain from drug use were in many cases reportedly jeopardised by the close proximity of other inmates who continued using drugs during imprisonment. Squirrell (2007) reported the presence of prisoners who were not committed to abstaining from drug use within supposedly drug-free environments, such as drug-free wings and rehabilitation programmes, generated discontent amongst those who wanted to try to abstain and they found it harder to avoid relapse. Prisoners on drug courses who said that they were more serious about stopping using drugs when in prison noted that this was hard when other prisoners on the courses were on them for pragmatic reasons (such as improving their chance of parole) rather than addressing drug use. In situations like this users committed to staying drug free tried to isolate themselves or mix with few prisoners to stay away from other drug users in order to reduce the potential temptation to use drugs (Squirrell, 2007). The presence of other drug users and the nature of prison drug users' relationships with one another thus consequently affected men's drug using experiences when in prison. This sometimes also led to implied resentment, such as linked to re-starting drug use.

I were clean when he come into that cell, we shared a cell and then when he came, by the time I got to see CARAT workers I had a habit again. (Tompkins et al., 2007a:193)

Obtaining and using drugs together thus facilitated the development of prison friendships and helped prisoners become closer, if only superficially (Hughes, 2000d). Indeed, participants in George & Moreira's study (2008) identified a social element to snorting buprenorphine in prison as it was portrayed as a group activity and participants had sometimes been influenced into snorting by other prisoners.

When you're using drugs you automatically become part of that group. And they automatically think you're doing something like brown (heroin) so they think, 'he must be all right, he must be in with the crowd sort of thing,' so they

¹⁵ Whilst the paper says that only four people were interviewed in prison, email correspondence with the author confirmed that all 33 participants had prior prison experience although the research focussed on the whole Criminal Justice System rather than solely on prison experiences.

don't usually give you any hassle. The only time you get any hassle is when you're not paying for what you're having. (Hughes & Huby, 2000:471)

Whilst drug users in prison were described in the papers written by Hughes to prioritise looking after themselves and their own needs, they considered the needs of their fellow inmates (Hughes, 2000d). Helping prisoners, particularly when in drug withdrawal further demonstrates how relationships between drug users in prison were a central aspect to maintaining drug use in that environment (Hughes, 2000d; Hughes, 2001). Socially close drug users in prison were described as sometimes feeling obliged to help one another, for instance by providing drugs, especially if they had helped them in the past (Hughes, 2000d). There were reciprocal benefits associated with helping one another so users sometimes helped one another in order that the recipient may repay the favour in the future (Hughes, 2003b).

Widespread Risk Behaviour

The studies reported a wide variety of risk behaviour linked to using drugs in prison, contributing to their experiences of prison drug use. These largely encompassed sharing injecting equipment amongst prisoners and efforts prisoners made to prolong the shelf life of previously used equipment. Hughes found that 'boring and demoralizing' prison regimes meant that drug users in prison generally did not think about or ignored risk when using (Hughes, 2004:359). For example, prisoners viewed the sharing of 'old and well used' needles and syringes and doctored and home (prison) made needles in prison as widespread and inevitable on account of the limited availability of sterile needles (Hughes, 2000b; Hughes, 2000c; Hughes, 2001) and the need to inject to overcome withdrawal. This concurs with findings from another qualitative retrospective study included in the review (Wright, Tompkins & Jones, 2005). Whilst the focus of Wright et al.'s study was not on drug using practices in prison, prison drug taking risk behaviours (including excessive needle sharing) were identified by hepatitis C positive homeless injecting drug users who had been in prison¹⁶ although a limitation of including this study in the current review is that it is unknown how many of the 17 participants included in it had previously been in prison. Furthermore, for drug users reflecting on their pre-1997 prison experiences¹⁷, the consequences of not receiving prescribed drugs or prescribed

¹⁶ Although whether or not participants had already contracted hepatitis C at the time of engaging in these previous prison risk behaviours is unknown.

¹⁷ A time when the provision of medication for drug dependence in prison was far from developed as described in the policy review at the start of the chapter.

drugs of a sufficient dose in prison to help their opiate addiction led to increased use and sharing injecting equipment amongst participants (Hughes, 2000b). The provision (or not) of drug treatment in prison and its effect on the drug using experiences of drug users in prison is considered more fully in the drug users' experiences of prison drug treatment section of the literature review.

Withdrawal was identified in the included papers as a time characterised by desperation. When in withdrawal in prison the likelihood of taking risks such as accepting used injecting equipment increased as the need for drugs to alleviate withdrawal was described by the author as overpowering (Hughes, 2001; Hughes, 2004). Indeed, Hughes identified that in these situations thoughts about the longer term consequences of risk behaviours, specifically contracting HIV, were unlikely to be fully considered as they were subsumed by the stronger influence of needing drugs (Hughes, 2004). This is not to say that they would not be thought about at a later time, either during the sentence or on release, but they were ignored or 'put to the back of their mind' in the immediacy of the situation (Hughes, 2004).

I was still rattling and all I wanted was a hit so I didn't really think about catching those diseases, it didn't even come into my mind. (Hughes, 2004:359)

Due to the scarcity of injecting equipment in prison, participants in Hughes's study reported having lent their used needles to other prisoners to use and having injected with others' used needles themselves, especially when experiencing withdrawal (Hughes, 2000b; Hughes, 2001; Hughes, 2003b).

There's only a few works on the landing you normally have to share because it is hard getting them in. (Hughes, 2003b:59)

Sharing and using used equipment was risky as there was no guarantee of cleanliness from possible infection from contaminated blood.

I've seen them in the same pad all waiting to use the same works and they've hardly ever cleaned them out properly. The blood in the works is still going to be warm. (Hughes, 2000c:27)

Hughes (2003b) therefore described that some users distinguished between equipment for their own use and for communal exchange (Hughes, 2003b). However, according to the included papers this was portrayed as a privileged and uncommon position to be in on account of the scarcity of equipment in prison.

Studies indicated that injecting equipment in prison represented capital as it was scarce and thus considered by participants to be an invaluable asset (Hughes, 2003b; Wright, Tompkins & Jones, 2005), despite these studies collecting their data six years apart from one another, Hughes (2003b) in 1997 and Wright, Tompkins & Jones (2005) in 2003. On account of this, a further risk linked to lending injecting equipment, particularly to those who were less well known was of it not being returned (Hughes, 2000d). Akin to accessing drugs in prison, the qualitative studies included in the review identified that prisoners had often traded items in exchange for using or purchasing injecting equipment (Hughes, 2003b; Wright, Tompkins & Jones, 2005). The limited availability of injecting equipment in prison resulted in prisoners using equipment for prolonged periods of time and a reluctance to dispose of it (Hughes, 2003b; Wright, Tompkins & Jones, 2005). Excessive re-use meant that available equipment was often of poor quality and studies describe how efforts to prolong its shelf life were taken (Hughes, 2003b; Wright, Tompkins & Jones, 2005). Broken or missing parts were substituted with replacement items where available.

People using, you know, the inside of a pen, you know, what the actual ink is in. Cleaning it out, sharpening it up and using that to inject. (Hughes, 2003b:60)

Furthermore, needles blunted by excessive use were reported to be sharpened on matchboxes, walls (Hughes, 2003b) or broken glass (Wright, Tompkins & Jones, 2005) to prolong their usability, but using them could be damaging, particularly to participants' health although as identified by Table 2.4 the papers by Hughes (2003b) and Wright, Tompkins & Jones (2005) do not provide any information about when the participants had been in prison or about when they were talking about. Therefore these practices described in the papers could date back a number of years, possibly even before 1995 when the review is focussed, particularly in the case of Hughes (2003b) which was conducted earlier, in 1997.

Other risky drug using behaviour which Hughes's participants described taking in prison was of changing to injecting rather than smoking drugs (Hughes, 2003b). The

reason for this was that there were reduced quantities of drugs in prison and a smaller amount could be injected in order to feel their effect when compared to smoking (Hughes, 2003b).

The bags in there were nothing like out here so you couldn't smoke it on foil, you had to inject to get enough. (Hughes, 2003b:58)

Ineffective Risk Reduction Strategies

Earlier we saw how Hughes reported that the need to alleviate withdrawal in prison was reported by participants in his study to take priority over considering the longer term risks associated with alleviating withdrawal (Hughes, 2004). On account of the perceived risks of injecting drugs in the pressurised nature of the prison environment, the included papers based on Hughes's larger study report how former prison injectors adopted varying drug and HIV risk minimisation strategies (Hughes, 2000b; Hughes, 2000c). However Hughes suggests that the majority of risk reduction strategies adopted can be understood as a means of enabling individuals to pursue and continue their drug use but in so doing involved risky HIV behaviour as the strategies they described adopting were arguably ineffective in reducing HIV risk (Hughes, 2004). Across the studies only a few people seemed to use the time afforded when in prison to consider their injecting risk behaviour in more effective harm reducing ways, such as stopping injecting or not sharing (Hughes, 2004; Tompkins et al., 2007a).

Drug users were reported to consider varying factors when assessing the risks of using drugs with others in prison. These risk considerations included assessing whether someone looked 'clean' or 'dirty' and evaluating what activities they engaged in (Hughes, 2000b). For example, for prisoners, using the prison gym symbolised healthiness and was therefore sometimes used as a marker of 'cleanliness' (Hughes, 2000b). How well known a prisoner was to the injector, or what an injector could find out about those who were less well known from more trusted peers were considered before embarking on potentially risky drug using behaviour (Hughes, 2000b). Again, the nature of prisoner relationships played a role here. That is, taking risks when using drugs in prison was considered more acceptable with people who were known and socially close than with those who were less well known or socially distant (Hughes, 2000b; Hughes, 2000d).

Me and my pad mate, we felt like that, we had a close, you know what I mean. I knew him, he knew me and we were like good mates and I knew him on the outside so I felt like we were relatively alright with each other. (Hughes, 2000d:1163)

Overlapping with the Centrality of Prisoner Relationships discussed earlier, the extent of social distance, that is how close prisoners perceived they were to one another, was found to sometimes help people decide on the legitimacy of other prisoners in some way and manage risks when considering sharing injecting equipment with strangers or people less well known in prison (Hughes, 2000d). However, the study also identified that sharing injecting equipment in prison was often unifying and encouraged prisoners to feel close to one another (Hughes, 2000b; Hughes, 2000d), possibly suggesting that once such decisions had been made, they were hard to reverse. Whilst drug users knew that the proximity of their relationships with other prisoners had no influence on the nature and extent of HIV infection risks, it was retrospectively reported to be used to rationalise and justify prison drug behaviours previously engaged in. This strategy alone was arguably largely ineffective in reducing risk but served to allow prisoners to consider that they had at least thought about some of the risks, or at least say that they had, before pursuing drug use (Hughes, 2004) or at least present to the researcher in a socially desirable way by pretending that they had.

One paper is devoted to reporting findings from Hughes's larger study about the risk reduction strategy of cleaning injecting equipment in prison (Hughes, 2000c). Unlike some of the other Hughes papers included in the review, this paper presents findings from the 14 in-depth interviews which were conducted with a vignette, however only nine of these were with men (Hughes, 2000c), which must be remembered in the current review when considering the transferability of the findings. As needles were reported to be commonly shared between prison drug users, they were frequently cleaned in an attempt to reduce potential HIV risk by those who used them after they had been used (Hughes, 2000c). However, materials to effectively clean needles and syringes such as bleach were not always available in prison, particularly in 1997 when the work was conducted (Hughes, 2000c). This arguably reflects how the prison policies at the time were more focussed on controlling drug supply, rather than minimising harm to users. Furthermore, former prisoners in the study had concerns about the potential damage that using such strong detergents may cause to the

equipment and had commonly used soap and water to clean used needles and syringes when in prison (Hughes, 2000c).

I cleaned the barrel out thoroughly, not with bleach, but I cleaned it out with soap and cold water and that. In prisons it tells you to do that, there's leaflets all over the place telling you if you're going to share clean and I did it that way and the guy who wanted me wash-out he just wasn't really bothered. I mean he used that same pin. (Hughes, 2000c:26)

Hughes reported that whilst many reported that they considered that these methods were adequate in preventing the transmission of infections, they felt that they were cleaned less thoroughly than they would be outside of prison due to the limited availability of cleaning materials in prison and the difficulty of inspecting cleaned needles (Hughes, 2000c).

In prison it's a couple of flushes of cold water and bang, you're at it. That's, do you know what I mean, that's just unblocking, that ain't cleaning. (Hughes, 2000c:27)

The urgency of using drugs in closely controlled prison environments was also suggested to contribute to the inability to thoroughly clean used equipment (Hughes, 2000c).

The first lad whacked it in, and the second lad, and it come to me, because we were rushing that much no one really cleaned it out. You know, they didn't flush it out several times 'cos we didn't have time for that it was just like get it together and it was in and that and I just didn't think about that because I was thinking if I get banged up I'm going to be poorly all night. I've got to get this, I've got to get me hit in so I can sleep and sit in my pad. (Hughes, 2000c:27)

This section of the review has considered men's drug using experiences in prison, largely gathered from retrospectively conducted qualitative studies and within that, mainly from a series of papers by Hughes which all report aspects of data collected for one larger study. A number of themes were identified across the studies as pertinent to their prison drug using experiences. A second area of the review focuses on the experiences of prison drug treatment. This was identified as important when considering prison drug using experiences, due to the link between assistance for

drug use and drug use itself. The review now reports the findings from the included papers relating to these treatment experiences.

Drug Users' Experiences of Prison Drug Treatment

It has been shown that the provision of adequate drug treatment helps people address their drug using behaviours and reduce the need to use drugs (Dolan et al., 2003). Thus access to prison drug treatment is important to consider when examining prison drug using practices as it may influence drug users' drug using experiences when in prison. Drug treatment in prison encompasses the clinical provision of substitute medications for dependence and also psycho-social interventions such as counselling. Six of the included papers described the provision of drug treatment in prison (Broderick & Kouimtsidis, 2007; Hughes, 2000b; Sheard et al., 2009; Smith & Ferguson, 2005; Squirrell, 2007; Tompkins et al., 2007a). Four papers used qualitative research to ascertain drug users' views of drug treatment in prison (Broderick & Kouimtsidis, 2007; Hughes, 2000b; Smith & Ferguson, 2005; Tompkins et al., 2007a), and one to ascertain views and experiences across the criminal justice system, within prison and the community (Squirrell, 2007). The sixth paper was a randomised controlled trial (RCT) of two opiate detoxification medications (Sheard et al., 2009) which was included on account of the quantitative evidence provided regarding men's prison detoxification experiences in a security category B English prison, which contributed to a broader perspective on the issue.

Of the papers which used qualitative research approaches, Broderick & Kouimtsidis (2007) and Smith and Ferguson (2005) prospectively ascertained male prisoners' views of treatment. These studies were small; Broderick & Kouimtsidis (2007) interviewed eight male prisoners who were receiving or had recently completed an opioid detoxification in HMP Wandsworth¹⁶ and Smith and Ferguson (2005) interviewed 11 male prisoners enrolled in a prison drug rehabilitation program. The studies by Hughes (2000b) and Tompkins et al. (2007a) were conducted retrospectively, involving current or former drug users in the community describing their prior prison drug treatment experiences. Squirrell (2007) included both retrospective and prospective data. Furthermore, Hughes (2000b), Squirrell (2007) and Tompkins et al. (2007a) included both men and women who had used drugs and been in prison. Whilst all papers were included in the review as the samples were

¹⁶ A large category B local prison in London.

primarily male¹⁹, care was taken to exclude any reported experiences that were specific to women only. Hughes's research was conducted in 1997 (2000b) and even though data for Broderick & Kouimtsidis (2007), Smith and Ferguson (2005), Squirrell (2007) and Tompkins et al. (2007a) was collected some years later (at least nine years in the case of Tompkins et al.) and in differing policy climates and they have various limitations (see Table 2.4), there were a number of parallels between the studies' findings regarding participants' prison drug treatment experiences. For the review, the findings from the qualitative studies have been categorised into eight themes, as synthesised and reported below. Relevant findings regarding men's detoxification experiences from Sheard et al. (2009) are interspersed where appropriate. Sometimes the information reported in one area overlaps with another so is signposted where applicable.

Inadequacy of Assessment and Access

Only Broderick & Kouimtsidis (2007) described the process of being assessed by the nursing team for substance misuse treatment in prison. They found that whilst prisoners' assessment experiences differed, they were unsure if the assessment had effectively identified their needs and prisoners could not always recall being assessed (Broderick & Kouimtsidis, 2007).

I remember her (substance misuse nurse) coming to see me because I was on C wing and she said I was going to see the doctor on E wing. She came and saw me. I can't really remember the assessment. (Broderick & Kouimtsidis, 2007:18)

Whilst accessing assistance in prison was felt to be easy at the start of a sentence and accounted for some to be sent to prison on purpose in recent years in order to receive help, users reported difficulties accessing the prison medical services for drug treatment during their sentence and after the first night (Tompkins et al., 2007a). Furthermore, Squirrell's study (2007) highlighted barriers to accessing care such as prison drug programmes, particularly for those on short sentences. Spending limited time in a particular prison coupled with the long waiting lists to access drug programmes, jeopardised the possibility of prisoners accessing treatment, limiting their treatment hopes (Squirrell, 2007), although a limitation of this paper is that it did

¹⁹ 18 men out of a sample of 24 in Hughes's study (2000b), 30 men out of a sample of 33 in Squirrell's study (2007) and 42 men out of a sample of 51 in Tompkins et al.'s study (2007a).

not include any information on the types of drugs used by participants, so it is uncertain what type of treatment they needed or were trying to access in prison.

Sentenced for six months, do three and move a couple of times, B cat to C cat and then it's too short to do a course. Saw Resettlement a couple of times; they said they'd get back to me. They're useless. The first couple of times it happened, they build up your hopes and you walk out of the door with nothing. You have to so a couple of years [to get help]. (Squirrell, 2007:67)

A further access issue suggested by Squirrell (2007) was the lack of space on drug-free wings and therapeutic units. Sometimes prisons reportedly used places on these wings for prisoners who were not seeking rehabilitation as there was insufficient space to house them elsewhere in the prison. This was criticised by participants for denying those who wanted assistance and exposing those on the wings for drug problems to the risks of relapse. This lack of space on drug free wings meant that prisoners who had been through intense prison drug treatment programmes were often released from the dedicated wing onto normal prison location afterwards without the necessary support, which could tempt them to use drugs (Squirrell, 2007).

Many participants in the studies interpreted their inability to access treatment as dependent on elements out of their personal control (Squirrell, 2007; Tompkins et al., 2007a), such as luck. Squirrell highlighted that prisoners experienced accessing treatment as "*a chance happening*" (2007:69) and a participant interviewed in Tompkins et al. suggested that treatment depended on "*landing lucky*" (2007a:194). A further aspect of accessing medication was the attitude of the prison prescribing doctor. Indeed, receiving treatment was seen to largely depend on the prison doctor (Hughes, 2000b; Tompkins et al., 2007a) as users reported that negative doctor attitudes had sometimes affected their previous experience of prison drug treatment, holding them responsible for being refused medication (Tompkins et al., 2007a). Attitudes towards prisoners is discussed further in Perceived Stigmatising Staff Attitudes.

Finally, there were similar reports of difficult to access non-clinical Counselling, Assessment, Referral, Advice and Throughcare (CARAT) services in prison from two of the quantitative surveys included in the review (Gore, Bird & Cassidy, 1999; Lester, Hamilton-Kirkwood & Jones, 2003). Gore, Bird and Cassidy's survey was

conducted in 1997 before the introduction of the CARAT service but it indicated that the provision of more counselling and rehabilitation courses received the most support from drug users (Gore, Bird & Cassidy, 1999). This arguably reflects what little counselling and rehabilitation was provided for drug users in prison when the study was conducted and their reduced access to what was available at the time. Later, 45/91 pre-prison drug users in a health survey of Welsh prisoners had used CARAT services in prison but 60% of these reported finding the service difficult to access (Lester, Hamilton-Kirkwood & Jones, 2003). Similar figures were reported regarding service accessibility for those who continued to use drugs in prison (Lester, Hamilton-Kirkwood & Jones, 2003).

Perceived Stigmatising Staff Attitudes

Drug users interviewed for three studies suggested that prison healthcare staff had negative attitudes towards them (Broderick & Kouimtsidis, 2007; Hughes, 2000b; Tompkins et al., 2007a) on account of their marginalised positions in society as injecting drug users and criminals (Tompkins et al., 2007a). Whilst users acknowledged that doctors varied between prisons (Hughes, 2000b), the more recent studies portrayed doctors as having stigmatising attitudes towards drug users in prison, characterised as unsympathetic, dismissive and aloof (Broderick & Kouimtsidis, 2007; Tompkins et al., 2007a). These reports of drug users' perceptions are not unusual considering that the overwhelming numbers of users involved in these papers were current drug users. It is interesting however that the participants in Broderick & Kouimtsidis's study (2007) reported these negative views as the researchers also had clinical responsibilities suggesting that this did not deter prisoners from reporting them. As outlined earlier, these attitudes were perceived to impact on a drug user's ability to access drug treatment in prison.

I saw the doctor in reception. He basically didn't listen to me, not at all, he didn't want to know. (Broderick & Kouimtsidis, 2007:19)

Participants in Tompkins et al.'s study (2007a) also suggested that they were judged by prison doctors on account of their engagement in their illicit drug using activities, reinforcing the perception that prison doctors had negative and stigmatising attitudes towards injectors. These views are not altogether surprising given that the focus of the research study from which the paper is based aimed to determine the barriers IDUs had faced in seeking treatment so encouraged this type of reporting.

He [doctor] said to me, 'self-inflicted, nowt but a good 20 press ups and a good wank won't cure.' (Tompkins et al., 2007a:195)

There were one doctor and he says, 'I ain't giving you nothing for your medication, for your withdrawal because you had enough drugs on out, I aren't giving you none in here.' So it depends really what doctor you get. (Tompkins et al., 2007a:194)

Medical staff were also not considered to listen to prisoners with drug use histories and be off hand in their dealings with them (Broderick & Kouimtsidis, 2007).

I want to say something to them, but anytime I've ever said anything they seemed to interrupt me or cut me off. (Broderick & Kouimtsidis, 2007:19)

As suggested by one study, views that prison staff had negative attitudes towards drug users extended to prison officers who were felt to stigmatise prisoners who had used drugs in their pasts even if they were seeking help in prison (Squirrell, 2007:68).

Prison officers' attitudes towards users are bad. You get a lot of stick off screws for doing something about it (drug problem). If you do something then you show up as a drug user, so they think they can take the piss out of you. Get a lot of attitude off prison officers, some help off them too. (Squirrell, 2007:68)

There were mixed views of officer's involvement in drug treatment programmes. In Squirrell's study (2007) prison officers' competence and motivation to deliver drug-related programmes was sometimes questioned by drug users. However, in contrast, prisoners enrolled in the drug rehabilitation programme which was the subject of Smith and Ferguson's research were complimentary of the prison officers involved in the it and recognised their support was essential in working towards abstinence (Smith & Ferguson, 2005).

They're a good bunch of lads in here (prison officers). You get the impression they really want it to work and they're willing to learn from us. You have to be in treatment. You can't do it on your own. You have to have some help or you're gonna use. (Smith & Ferguson, 2005:65)

Perhaps these differing views were held due to the different experiences and organisation of the programmes at the prisons or the type of prison where the studies were conducted (Smith & Ferguson, 2005; Squirrell, 2007). However, without any information on these areas in either paper, it is hard to know if this accounts for these view variations or not, or whether other factors were at play.

Lack of Treatment Consistency Within and Between Prisons and Prisoners

Across the studies, drug users' experiences of prison drug treatment were diverse and varied widely (Hughes, 2000b; Tompkins et al., 2007a). Indeed, previous prison drug treatment for opiate dependence reported in them included not receiving any medication, being prescribed mild painkillers only or being prescribed substitute medication (Hughes, 2000b; Tompkins et al., 2007a). This possibly reflects the different times when the studies were carried out and highlights their retrospective natures. When substitute medication had been prescribed it was largely criticised for being inadequate, quickly reduced and sometimes abruptly ended (Hughes, 2000b). This led to the overwhelming feeling that there were inconsistencies in prison drug prescribing within and between prisons and that every prison was different (Hughes, 2000b; Tompkins et al., 2007a). Participants noticed these differences changed between their prison experiences. It might be that the changes reflect some of the policy changes that occurred over the time period as earlier described.

When I was going to prison I thought methadone all right, I'll do a ten day detox. But when I got there it had been stopped a week because of money. (Hughes, 2000b:462)

A lack of consistent substitute prescribing policy across prisons appeared to contribute to inconsistencies within prison as prisoners saw these as affecting treatment (Tompkins et al., 2007a). This again highlights how different prisons adopted policy changes such as those described in the policy review at different times. There were also inconsistencies reported between the doctors working in the prisons and in individual doctor's practices, contributing to inconsistency and confusion amongst drug using prisoners in need of drug treatment.

Different doctors will give you different. See I could go in front of one doctor and he would give me five days. The same lad could go in front of the same doctor and get ten days, but why? If he's using the same amount as me I

should be getting the same as him and vice versa. (Tompkins et al., 2007a:194)

Contrary to this, prisoners in Broderick & Kouimtsidis's study (2007) contended that they were all prescribed the same substitute medication by the prison doctor but they did not see this as beneficial as it did not take their addiction severity into account or consider the appropriateness of the treatment for individuals (Broderick & Kouimtsidis, 2007). This is interesting as on the one hand participants in other studies criticised inconsistency yet in Broderick & Kouimtsidis's study (2007) they also criticised more consistent approaches across prisoners.

The first time when you come in through reception the doctor sits down with you and looks and says heroin addiction or cocaine addiction and methadone addiction and he just done the same, he's just done the same thing for everyone regardless of what your levels are. (Broderick & Kouimtsidis, 2007:19)

This difference might be accounted for by the fact that participants in Broderick & Kouimtsidis (2007) were all interviewed in the same prison about their current treatment experiences. Alternatively it might be that the researcher influenced the views that were expressed as they were also the lead clinician who had been clinically involved with the research participants (Broderick & Kouimtsidis, 2007), (unlike that in Hughes's (2000b)) paper and Tompkins et al.'s (2007a) study. Furthermore, as the data for Broderick & Kouimtsidis's study (2007) was collected prospectively from current prisoners who received drug treatment, it might be that participants thought or hoped that their involvement in the research and their reporting would result in the receipt of more and/ or different medications or assistance during the rest of their sentence in that prison, particularly due to the clinical involvement of the lead researcher. The participants in Hughes's study (2000b) and Tompkins et al.'s study (2007a) however retrospectively spoke about prior prison experiences served across England and Wales. Their experiences and accounts of what they perceived to be unfair and inequitable treatment are therefore likely to be more diverse on account of this. Similarly it might be that those with more positive experiences of prison treatment were not involved in the studies on account of the studies talking to current users and those most likely to be in need of treatment. A consequence of not prescribing substitute medication in prison was that users would be more tempted to use illicit drugs (Hughes, 2000b).

Limited Personal Involvement in Clinical Prescribing Decisions

Drug users in prison or with imprisonment experience commonly felt that they had had no influence or involvement in prescribing decisions about the nature and extent of their clinical drug treatment (Broderick & Kouimtsidis, 2007; Hughes, 2000b; Tompkins et al., 2007a). This was different to views reported by the 11 male prisoners in Smith & Ferguson's study (2005) where it was the participants' decision to enrol on the drug rehabilitation program. However it is inappropriate to compare and contrast users' experiences across these studies on account of the different types of treatment engaged in. That is, drug users in Broderick & Kouimtsidis (2007), Hughes (2000b) and Tompkins et al. (2007a) spoke about clinical prison prescribing, whereas those in Smith and Ferguson's (2005) grounded theory study were enrolled in a structured, therapeutic drug rehabilitation programme separate from the rest of the prison.

On account of being in prison, prisoners in Broderick & Kouimtsidis's study (2007) were reported to have felt an element of being coerced into treatment by their families or by the prison health professionals and did not feel listened to by prison medical staff. Drug users felt that their treatment decisions in prison were out of their personal control. Rather, obtaining treatment depended on their ability to 'blag' the medical officers (Hughes, 2000b), the attitude of the doctor (Hughes, 2000b; Tompkins et al., 2007a) and an element of luck (Tompkins et al., 2007a).

In Sheard et al.'s (2009) randomised controlled trial (RCT) both the drug using trial participants (prisoners at a security category B local prison, HMP Leeds) and the prison doctor were blind to the prescribed detoxification intervention until an envelope containing the name of the medication was opened by the doctor in front of the prisoner. Thus whilst prisoners in the RCT were also not involved in their treatment decision and were unable to state any medication preference, the influence of the prison doctor on their prescribing was negligible in comparison to the views reported by the qualitative study participants. Yet as identified as a limitation of the study in Table 2.4, the influence of patient preference played a part in the recruitment of trial participants as participants recognised that they might be randomly allocated to be prescribed dihydrocodeine when they would prefer to be prescribed buprenorphine (Sheard et al., 2009). It must therefore be considered that those drug users who consented to being randomised and took part were possibly those who had less medication preference, were less concerned about the possibility of experiencing

drug withdrawal in prison, were less knowledgeable regarding prison prescriptions for drug dependence, felt less able to refuse to take part in it or who were altruistic, recognising that being involved in the study was worth doing for the greater good. Alternatively it might be that those who refused to take part did so on the grounds of perceiving that taking part would reduce the extent of their personal involvement in prison clinical prescribing decisions, concurring with some of the qualitative findings reported above.

Inadequate Detoxification to Control Withdrawal

The experience of drug withdrawal in prison was commonly reported across the studies and drug users linked this to not being prescribed any or sufficient detoxification medication. Withdrawal was described as both physically painful and emotionally unpleasant (Tompkins et al., 2007a). Users reported that withdrawal had been most extreme at the start of a sentence, at times before prisons prescribed any substitute drug dependence medication or when they had only received sedatives, mild painkillers and anti-depressants (Hughes, 2000b; Tompkins et al., 2007a). The participant from Hughes's study (2000b) below reflects on his prison experiences before 1997 and highlights what it was like

When I went in the first time I was like on 2.5g a day habit. They started me off on one zimmervane and it was just like useless. It was like having half a sugar when you were used to three. I was going off the wall. (Hughes, 2000b:460)

Of course, caution must be applied in interpreting the findings from retrospective studies of prison experiences as participants in them were largely current users with prior prison experience so it would therefore be understandable if they perceived that their previous prison drug treatment had failed them on account of their current use (Hughes, 2000b; Tompkins et al., 2007a). Furthermore, those who were happy with the amount of medication they had received, those who had successfully completed treatment in prison and continued to be drug free on their release (and who consequently might portray more positive experiences of prison drug treatment) are unlikely to have been picked up by some of the studies included in the review as these largely focussed on current IDUs recruited from services for current users (Hughes, 2000b; Tompkins et al., 2007a).

Yet, withdrawal was not limited to earlier prison experiences as most users being detoxified or recently detoxified at HMP Wandsworth who were involved in the study which was conducted during 2004 reported suffering withdrawal symptoms during and after the detoxification (Broderick & Kouimtsidis, 2007). They were dissatisfied with their detoxification, the nature and quality of treatment provided and criticised their current treatment for not having controlled withdrawal (Broderick & Kouimtsidis, 2007). It may be speculated that they might have taken part in the research and reported this dissatisfaction to the researcher who was also the clinical manager in the hope that they would receive more medical assistance during the remainder of their prison sentence.

Across the studies, a wide variety of medications had been prescribed in prison for detoxification from illicit drugs, including dihydrocodeine, lofexidine, methadone and buprenorphine and injectors had had mixed experiences of these (Broderick & Kouimtsidis, 2007; Hughes, 2000b; Tompkins et al., 2007a). No detoxification medication choices were discussed in Smith and Ferguson's paper (2005), presumably because this was not a feature of the rehabilitation programme on which the prisoners were enrolled or in the study by Squirrell (2007), which focused more on treatment as a generic notion. Despite the medication variation, an overwhelming feeling of dissatisfaction with the level of medication prescribed and the length of time it was prescribed for permeated the studies (Broderick & Kouimtsidis, 2007; Hughes, 2000b; Tompkins et al., 2007a), although maybe those who were more satisfied with their treatment would not have participated in the research. For example, users criticised dihydrocodeine detoxification programmes as inadequate to combat withdrawal (Tompkins et al., 2007a) and in Hughes's study (2000b) reported more positive detoxification experiences with lofexidine rather than methadone although no more information why this was the case is offered. Methadone and buprenorphine were preferred as treatment options (Broderick & Kouimtsidis, 2007; Tompkins et al., 2007a). Regardless of the type of medication prescribed in prison, any medication was felt to be inadequate to control withdrawal if enough of it was not prescribed for a long enough period of time (Broderick & Kouimtsidis, 2007; Hughes, 2000b; Tompkins et al., 2007a).

The way people get reduced is too quick, because you are reducing every two days. (Broderick & Kouimtsidis, 2007:19)

Sheard et al.'s trial compared dihydrocodeine and buprenorphine for opiate detoxification amongst ninety male opiate users in prison (2009). The trial was conducted in 2004/2005 when the first line agent in prison was dihydrocodeine and buprenorphine was being introduced. The primary outcome was abstinence from illicit opiates five days after detoxification. By intention to treat analysis, a higher proportion of men allocated to buprenorphine provided opiate free urine (24/42) compared to dihydrocodeine (17/48) although a limitation of this study is that there was high loss to follow up data and so this analysis assumes that any missing urine results were positive for opiates. Despite this and other limitations as earlier identified, it is difficult to know to what extent these detoxification medications helped prisoners to manage their withdrawal symptoms as there is no information on this. The paper does indicate that 43% of prisoners who agreed to be included in the trial continued to acquire and use opiates through the first few days of imprisonment and detoxification. This raises questions regarding the suitability and adequacy of the detoxifications provided and demonstrates (as the authors recommend) how qualitative follow up research could strengthen the findings and help understand participants' experiences (Sheard et al., 2009). Exploring and understanding the perspectives of the prison doctors and prison officers might also be useful to identify their views on what the prisoners had reported.

Inconsistency with Community Medications

A common source of dissatisfaction within the included studies describing treatment was the lack of consistency of community drug dependence medications prescribed in prison. This reflects the fact that they were all conducted prior to this practice being nationally recommended under IDTS in 2006 (Department of Health, 2006). Dissatisfaction related to the lack of continuity of community prescriptions in prison and to the medication levels prescribed compared to the community despite the different time periods when the research was undertaken (Hughes, 2000b; Tompkins et al., 2007a). Drug users believed that community medications should not be interrupted and that prescriptions should be consistent in and out of prison (Hughes, 2000b; Tompkins et al., 2007a).

You can't just go into prison and get taken away from your medication. I think if you're a methadone user and have been for a long time, I think there should be a clinic where you go every morning in prison and get your methadone.
(Hughes, 2000b:462)

The impact of going to prison on the continuity of treatment was highlighted in Singleton, Farrell & Meltzer's quantitative survey (2003) resonating with users' views collected qualitatively. The survey, conducted in 1997, found that less than a third of those who reported receiving methadone in the month before coming to prison received it in the month immediately after imprisonment. In a later study conducted closer to the time when the continuation of community drug dependence prescriptions were more advanced, a further experience was that the continuation of community maintenance prescriptions had sometimes been delayed when they went to prison (Tompkins et al., 2007a). This was not discussed by Hughes (2000b) other than with the recognition that very few prisoners stayed maintained on community prescriptions. This arguably reflects the changing prison prescribing policies and practices over the years as Hughes's study (2000b) was conducted before arrangements for the continuation of community prescriptions for drug dependence were as developed as when the Tompkins et al. (2007a) study was carried out.

Changes Noticed and Things Improved

Perhaps reflective of the prison policy and practice changes in providing clinical assistance, users retrospectively identified how things had gradually improved in prison for drug users over the years (Hughes, 2000b; Tompkins et al., 2007a).

Last year I got remanded and it has changed quite a bit inside now actually. They seem to have got their act together because what they do now is you get a minimum of 14 day detox. (Tompkins et al., 2007a:198)

However, things were not perfect, as it was felt that there was still some way to go. For example, dihydrocodeine detoxifications were reported to have been replaced with what users considered to be more suitable medications in methadone and buprenorphine, but as alluded to earlier, medication satisfaction was not only linked to the medication prescribed, but the level and length of time it was prescribed for (Tompkins et al., 2007a).

Prison Treatment can Provide Opportunities for Future

More positively, prison was seen as offering a valuable respite and time away from using drugs if prisoners wanted to, even if they intended to reinstate use on release (Broderick & Kouimtsidis, 2007; Smith & Ferguson, 2005; Tompkins et al., 2007a).

I don't think anyone comes to prison to get off drugs but while you are in prison you have got to use it. You have got so much time and you have got to use that time to your advantage. (Broderick & Kouimtsidis, 2007:20)

The provision of adequate substitute detoxification medication (Broderick & Kouimtsidis, 2007; Tompkins et al., 2007a) and rehabilitation programmes (Smith & Ferguson, 2005; Squirrell, 2007) played a central role here. Furthermore, as we saw earlier, more recently, the reduced wait to access detoxification on arrival in prison was praised. Contrary to the previous quotation from Broderick & Kouimtsidis's study (2007), this reduced wait and access to medications on arrival may have encouraged some to be purposefully imprisoned to receive help for their drug use (Tompkins et al., 2007a) although accessing help after this time was reported as problematic. This difference in findings may be due to the fact that those interviewed in Broderick & Kouimtsidis's study (2007) were in prison at the time and were reluctant to say to the clinical researcher that they had purposefully gone to prison in order to receive medications for drug dependence in fear that their future care or future policies and procedures may change.

Users commented that their situation on prison release played a large part in whether any changes to their drug use made in prison were maintained on release. Having stable housing (Broderick & Kouimtsidis, 2007; Tompkins et al., 2007a) and the continuation of prison maintenance prescriptions in the community (Tompkins et al., 2007a) was influential here. Furthermore, whilst Squirrell (2007) identified some good experiences of prison treatment, she reported how prisoners were often faced with the inability to secure aftercare and support on release, which could impair their likelihood of abstaining from drugs and be at detriment to the work done in prison and the future potential to be drug free.

In a further study, prisoners enrolled in the drug rehabilitation programme wanted to use their current imprisonment to work towards achieving abstinence in prison which would extend to their release and their futures (Smith & Ferguson, 2005). Prisoners' motivation to engage in the rehabilitation programme stemmed from their reported desire to confront their addiction. Time in prison made them increasingly aware of the detrimental nature of their addiction which motivated them to pursue the program, although they recognised that achieving abstinence would be challenging (Smith & Ferguson, 2005). Yet despite their reservations and critical comments, they overwhelmingly saw their involvement in the programme (and other activities in

prison) as useful on their journey to recovery²⁰. Being on the programme stimulated them to consider strategies to get and stay clean from illicit drugs through recognising and understanding their relapse triggers and motivating factors (Smith & Ferguson, 2005). This again highlights how users portray that prison drug treatment provides an opportunity to consider their recovery and futures on release.

I want this programme to be a stepping stone to when I get out, to help me with this relationship I've got with this drug. The motivation's mine, but I need me family and this programme to give me the confidence to go and look for help outside. (Smith & Ferguson, 2005:68)

However, it is unclear from the paper what being on the rehabilitation programme actually entailed for prisoners (Smith & Ferguson, 2005). This omission makes it hard to say what it is about the programme per se (if anything other than being on the programme) that underpinned prisoners' views of using their time on it in a beneficial way to address their drug use and from which learning could be transferred to drug rehabilitation programmes in other prisons. It could be postulated therefore that the motivation of the individual prisoners with a history of drug misuse who choose to enrol on the programme is itself more central to them addressing their substance misuse in prison than the actual elements of the programme (Smith & Ferguson, 2005). Yet care must be taken in considering the wider resonance of these findings to other IDUs as the sample was small, only involving 11 men from one single prison drug rehabilitation programme and information on their injecting status or drug of choice is not presented (Smith & Ferguson, 2005).

Hughes (2000b) does not discuss the opportunity being in prison afforded to drug users and it can only be speculated why this is the case. The majority of those interviewed (n=17) were current injectors recruited from a variety of community (not solely drug) services (Hughes, 2000b). It could perhaps be that their current injecting status meant that they were more disgruntled about their prior prison drug treatment experiences, seeing it as having failed them in some way. Another possible explanation is that their views and experiences (gathered in 1997 but relating to imprisonments prior to this), reflect the dissatisfied prison experiences of drug users at the time or the perception of Hughes in analysing the accounts.

²⁰ Although it is not known when this study was conducted as attempts to find out through emails to the authors were unsuccessful.

Reports not Published in the Academic Peer Reviewed Literature

As outlined earlier, some research reports which had not been published in the academic peer reviewed literature but which were relevant to the current review were identified through non systematic searching. Whilst it was outside the review's scope to include these, a brief overview of the three main reports identified is provided here for context (Bullock, 2003; Penfold, Turnbull & Webster, 2005; Singleton et al., 2005). These reports were commissioned and carried out for the Home Office on behalf of the Government, highlighting that not all research in the area is necessarily published in the peer reviewed academic literature. This highlights the possible limitation of solely relying on certain electronic databases to identify all relevant material if the review had taken a broader focus²¹. Where relevant, more detailed consideration of their findings is provided in the discussion sections at the end of each chapter to compare with findings from the current research.

In 2000-2001 Bullock (2003) followed-up and interviewed 529 male prisoners who admitted to using drugs in the year prior to incarceration (a sub-sample (73%) from an earlier Criminality Survey (Liriano & Ramsay, 2003)) about their drug using behaviours to track their before, during and post prison drug using behaviours. Findings from Bullock's (2003) study would mainly fit within the Drug Users' Experiences of Accessing and Using Drugs in Prison section of the literature review. Penfold, Turnbull and Webster's (2005) study involved conducting qualitative interviews with 121 serving and recently released prisoners and 37 staff from six local English prisons and also analysed data from mandatory drug tests and security information reports to explore the drug supply and demand in these prisons. Findings from the study would be relevant to include in both the Drug Users' Experiences of Accessing and Using Drugs in Prison and the Drug Users' Experiences of Prison Drug Treatment sections of the literature review to complement the other findings. Finally, Singleton et al. (2005) conducted a self report survey between 2001 and 2002 to examine the impact and effectiveness of mandatory drug testing in prisons and gather information on episodes of drug use in prisons, including how these had been influenced by prison drug use prevention measures. The survey involved 2,720 prisoners aged 16 and over from a sample representative of all prisons in England and Wales, prison staff, analysis of data from a 1997 survey (Singleton et al., 1999) and analysis of MDT data. Information from the survey would be most relevant to

²¹ A cross check conducted at the end of the systematic review confirmed that Bullock (2003), Penfold, Turnbull & Webster (2005) and Singleton et al. (2005) were not identified by the four main electronic bibliographic database searches.

include in the Drug Users' Experiences of Accessing and Using Drugs in Prison section of the literature review. These findings would complement some of the more qualitative findings included as they identified levels of self reported prison drug use and changing drug use behaviours when in prison when compared to pre-prison (Singleton et al., 2005). Singleton et al.'s research (2005) also found limited referral into treatment for prisoners following a positive MDT test, which speaks to some of the findings reported in the Drug Users' Experiences of Prison Drug Treatment part of the review.

Chapter Summary and Discussion

This chapter has presented what the peer reviewed academic published research literature reports about the nature of drug using experiences of adult male injecting drug users in prison in England and Wales since 1995. A particular strength of the current review is in the employment of the systematic review methods in order to search for relevant peer reviewed papers and assess their relevance to the review question. A possible limitation is that the review did not extend to include a full appraisal of non peer reviewed academic empirical research, although this was outside the remit of the literature review.

The overview of the literature reviewed in the chapter leads to a number of general conclusions. Firstly, the literature concerning the experiences and practices of adult male injecting drug users in prison since 1995 is relatively sparse. Whilst many papers were identified by the comprehensive database searches as potentially relevant to the review, only 18 papers met the inclusion criteria. This might suggest that the nature of the inclusion criteria were too restrictive and/ or that there was limited research in the area of drug users' prison drug using experiences. Secondly, much of the relevant included research literature presented is based on single centre qualitative interview studies conducted in small geographic locations and which relied on participants volunteering to take part. This highlights the limited volume of quantitative research conducted in this area. Whilst prevalence studies regarding drug use in prison were identified by the search, these were excluded from the review if they did not report anything about the actual drug using experiences of injecting drug using men in prison. Thirdly, caution was necessary when reviewing the included papers, not least because eight of the included papers stemmed from one wider research study, but also due to the limitations inherent in them as a result of some of the methods employed when gathering their (largely retrospective) data.

Fourthly, due to the unique nature of the studies conducted and included in the review in terms of their samples and the methods used to collect the data, they had a number of limitations which had to be considered. Furthermore, the unique nature of the studies and their sample sometimes made it difficult to draw parallels between them and their findings. Nevertheless, the papers identified and included in the review covered two areas, the drug using experiences of accessing and using drugs in prison and secondly, the experiences of prison drug treatment. Within these areas dominant themes were identified as fully outlined and discussed within the review.

The scarcity of literature empirically investigating men's prison drug using experiences is intriguing. This scarcity arguably calls for further research in the area, particularly in light of the updated drug policies outlined in the policy review at the start of the chapter in order to consider their impact and inform future policy based on the most recent reported situation. The review therefore provides the context for the findings from the research reported later in this thesis. The review will therefore be relevant to those looking for an initial overview and understanding of some of the drug using experiences of men in prison since 1995 in England and Wales and the issues that influence these experiences. It is hoped that the findings from the current research bring further information, understanding and explanations regarding the different experiences of drug using men when in prison in England and Wales, and also contribute to the evolving policy and practice in this area. The chapter that follows outlines the methods used for the current study in order to try to achieve some of these overarching aims.

Chapter 3 - Methods

A qualitative approach was adopted for this study to answer the research question. This chapter describes in more detail the specific methods chosen and the application of them. It highlights the issues which had to be considered in order to commence the research and when employing the methods. Personal, practical and ethical reflections linked to using the methods are provided throughout the chapter where significant. Reflection is a normal and distinctive feature employed throughout the qualitative research process as it contributes to the development, integrity and rigour of a study (Banister et al., 1994; King, 1996; Mays & Pope, 1995).

Qualitative Research Methods

As briefly outlined in Research Focus and Approach in Chapter 1, qualitative research was chosen for this study. One reason for using qualitative research was the importance these methods place on exploring and understanding the lived experiences, situations, perceptions and meanings from the point of view of the individuals involved (Bryman, 2001), in this case male injecting drug users who had previously served in prison. The collection and analysis of naturally occurring data through qualitative methods such as observation or unstructured or semi structured interviews leads to the belief that such methods provide a 'deeper' understanding of social phenomena than that obtained from more structured quantitative research techniques (Silverman, 2000). Therefore a strength of qualitative research that was considered particularly relevant for the current research was that it was well suited to sensitive topics and/ or illegal activities about which relatively little is known or understood or with groups who are considered to be 'hidden' or 'hard to reach' (Neale, Allen & Coombes, 2005). Consequently, through its use, researchers are able to explore subjective understandings and produce dense descriptive narratives in order to try to explain the topic or what has been uncovered about it through the use of the particular qualitative methods. Providing this level of understanding and explanation was a goal of the current research as little is known and understood about injecting illicit drug users and their imprisonment experiences, particularly about the nature of their prison lives and drug using prison experiences. This resonates with researchers who have argued that qualitative addiction research seeks to both describe the social meanings that participants attach to drug use as well as the social processes by which meanings are created, reinforced and

reproduced (Neale, Allen & Coombes, 2005; Rhodes, 2000). The qualitative research technique of in depth interviews was therefore chosen in order to listen to injecting drug users' lived experiences from their perspectives and to understand and situate these experiences within the broader context of their lives (Neale, Allen & Coombes, 2005; Rhodes, 2000). Collecting such data directly from participants and analysing it inductively rather than testing a pre-determined hypothesis (Glaser & Strauss, 1967) also fit the study's exploratory nature, further rationalising the use of a qualitative research design.

Despite such strengths, there are also some weaknesses of qualitative research. The main criticisms of qualitative research centre on issues of reliability, validity and the generalisability, or transferability, of the findings (Silverman, 2000). Reliability concerns the extent to which judgements about the data are replicated consistently by the researcher and between other researchers (Silverman, 2000). The validity or accuracy of qualitative findings about the studied phenomena and the nature of the explanations offered are also sometimes subject to speculation and fears of anecdotal reporting can prevail (Silverman, 2000). In qualitative addiction research in particular, issues of validity have also concerned debating the integrity of drug using research participants and the accuracy of their reporting of events and experiences (Neale, Allen & Coombes, 2005) on account of their marginalised positions in society and involvement in illegal behaviours. Finally, a further critique of the approach is that the small sample sizes usually involved in qualitative studies mean that their findings cannot be widely generalised or portrayed as representative of drug users more generally (Neale, Allen & Coombes, 2005). Yet, this is resisted by many qualitative researchers who strive to produce explanations that are generalisable or which have a wider resonance in some way (Mason, 2002). All of these potential criticisms were areas which I considered throughout the conduct of the study. Further thoughts on the attempts that I made to limit the potential and extent of these criticisms are provided at varying places throughout this chapter, in particular in the later section on Study Strengths and Limitations.

Setting

The research was conducted in Leeds, a large cosmopolitan city in the north of England in the county of West Yorkshire. At the 2001 census, Leeds had a population of 715,402 (National Statistics website accessed 21/05/08). Leeds is not dissimilar to other large cities and urban populations in the country, particularly

northern cities such as Sheffield, Manchester, Liverpool and Newcastle, which are all less than 100 miles from Leeds. Since 1847 the city has been home to a large prison. Her Majesty's Prison (HMP) Leeds operates as a category B prison²², housing over one thousand adult²³ male unconvicted remand and sentenced prisoners from the local community and surrounding areas. There are a further three male only establishments in West Yorkshire. These include a maximum security prison (HMP Wakefield), a Young Offenders Institution²⁴ (HMYOI Wetherby) and, at the time of the research, a prison with a category C (closed) and category D (open) side within the same establishment (HMP Wealstun). The operational capacity of the adult male only prisons in West Yorkshire is almost three thousand prisoners (HM Prison Service website accessed 09/01/08). Within the Yorkshire and Humberside region there are an additional 13 prisons of varying security categories, two of which are for women.

Like many cities in the UK, over recent decades Leeds has witnessed many social and structural changes. One such change is the amount of people living in the city and the surrounding suburbs who use illicit drugs. This has been most noticeable with rising numbers of people who use Class A drugs such as heroin and crack cocaine. Data from 2004/2005, the time when this research started, estimates that the prevalence of problem drug (heroin and crack cocaine) users in the Leeds Drug Action Team area was 6,473 (95% confidence interval 6,050 – 7,154) (Hay et al., 2006). An estimated 5,024 (77.6%) of these were male. These figures are consistent, albeit slightly higher proportionally, than those reported by the Department of Health (England) and the devolved administrations (2007), although the reporting periods are slightly different. There has also been an increase in the intravenous injection of Class A drugs, rather than using alternative administration routes.

²² Adult male prisons in England and Wales range in levels of security and are categorised accordingly. Category A prisons have the highest security and are closed prisons. Category B and C prisons are also closed prisons but of medium security. Category D prisons have the lowest levels of security and are known as open prisons (Jewkes & Johnston, 2006; Matthews, 2009).

²³ In England and Wales the adult male prison estate holds offenders aged 21 years and over.

²⁴ Young prisoners are aged between 15 and 21 years, and are broken down into juveniles and young adults. Juveniles who are aged between 15 and 17 serve in Young Offender Institutions (YOI) (Jewkes & Johnston, 2006). Seventeen year olds who are on remand and who have been given a custodial sentence are also sent to a YOI. Young adults are those aged 18 to 20 years and those 21 year olds who were aged 20 or under at conviction who have not been reclassified as part of the adult population. Young adult offenders also usually serve in YOIs, although they may be transferred into adult prison prior to being 21 if deemed suitable and there have been previous reports of adult prisons housing young adult offenders (Smith, 2005).

As a result of the numbers of addicted drug users across the UK, there has been a growth in community service provision aiming to address their varying and complex health and social needs. In Leeds such services include health centres, day centres, support for people with housing problems and voluntary organisations and needle exchange programmes, which distribute sterile injecting equipment and provide advice to drug users. There has also been increasing service provision for drug users in contact with the criminal justice system, through community and custodial services.

Research Ethical Approval

It was necessary to obtain NHS research governance and ethical approval in order to conduct the research as some NHS services were involved in identifying potential drug using participants. I also adhered to current governance and ethical frameworks (Department of Health, 2001b; Department of Health, 2005). Bradford South and West Primary Care Trust (PCT) granted Research Governance approval in February 2006 (see Appendix 3 for a copy of the Research Governance approval letter). I applied to the NHS research ethics committee through the Central Office for Research Ethics Committees. The application was allocated to a meeting at the Leeds West Research Ethics Committee (REC) which I attended. Following minor revisions, such as changing the word incentive on participant information to 'reasonable expenses' and increasing the font size on participant information leaflets, the Committee approved the study in April 2006. (A copy of the final ethical approval letter can be found in Appendix 4). The research also complied with the British Psychological Society (BPS) ethical guidelines (British Psychological Society, 2006) and was retrospectively approved by the Institute of Psychological Sciences Ethics Committee at the University of Leeds in July 2007. (A copy of the approval email can be found in Appendix 5). On obtaining these approvals the research commenced, by identifying potential participants.

Identifying Participants

Recruiting Services

Over a few months, I arranged meetings with eight community drug and housing services which engaged with current and former injecting drug using former prisoners. The services were all based in Leeds city centre or in the nearby suburbs.

The services visited included two needle exchange programmes (one which operated an outreach mobile needle exchange), two probation hostels, a resettlement project, a General Practitioner service for homeless people with a high proportion of injecting drug using clients, a Community Drug Treatment Service (CDT) and the Developing Initiatives Supporting Communities (DISC) drug service. I approached this number and range of services to try to negotiate access to as wide and diverse a sample as possible, recognising that those who used services might do so sporadically. At the meetings I introduced the research to the service managers and workers to facilitate access to any eligible clients. I did not approach all eight services at once but staggered the selection and visits in order to avoid the services recruiting more participants than I could consider at the same time. Furthermore, staggering service recruitment was deliberate so that I could monitor the participants sampled and from that decide who to interview, as later discussed. I believe that my personal approach to services about the research had a positive impact on recruitment as identifying suitable men from them was relatively straightforward and all eight services responded favourably to the research.

Recruiting Potential Participants

Before starting to identify and recruit potential participants, I specified my sampling parameters and dimensions (Mason, 2002). To be eligible to take part in the research, potential participants needed to fulfil four criteria. That is, they needed to be male; they needed to have served a custodial sentence in adult prison in England or Wales; they needed to have been released from the custodial sentence after 2002 and they needed to have reported intravenously injecting drugs at the time that they were sent to prison. These criteria were chosen as people fulfilling these eligibility criteria were most considered to be the ones to provide relevant information about their experiences in order to explore and answer the research aim and questions and subsequently help to develop and test emerging theories and explanations (Mason, 2002).

Eligible participants were mainly recruited through the services. Either I, or service workers acting as gatekeepers, verbally introduced the study to eligible men. I recognised limitations of relying on service workers to recruit participants. These included only approaching those who they thought would be reliable enough to attend an interview or articulate enough to engage in one, which could potentially risk excluding eligible participants with relevant experiences. I therefore also adopted some other recruitment approaches to try to limit the likelihood and impact of these

potential limitations, including spending time in services, poster advertisements and 'snowball' sampling.

In order to encourage those who might not have been approached by service workers to take part, I also used complementary recruitment approaches. For example, I spent time in some of the services which operated 'drop in' services for their users, including six sessions on the mobile outreach needle exchange²⁵. I believe this aided recruitment as I personally met service users, approached potential participants and discussed the research with them. Spending time in the services also had the advantage of improving service workers' understanding of the research and meant that I could be introduced to potential participants through the workers acting as gatekeepers.

In addition, I designed posters and fliers to advertise the study, increase awareness and encourage participation amongst people who might not have been approached by service workers. The poster was formal, containing text about the study and was printed on A3 sized coloured paper in order to draw attention to it. (A copy of the poster can be found in Appendix 6). The poster and fliers were distributed to the services and were positioned in service waiting areas. In one needle exchange, the poster was also displayed on the back of the entrance door so that people could see it when leaving. After visiting services and seeing the wealth of colourful posters, I changed the poster to include less written information and more visual content to try to be more appealing, particularly to those with literacy difficulties. (A copy of the re-designed poster can be found in Appendix 7). Two men responded to the poster(s) and directly telephoned me.

Current injecting drug users who had spent time in prison were mainly recruited from the drug services, especially the needle exchange programmes. Men who had reduced or stopped using and injecting drugs were more commonly recruited from the probation hostels, the CDT and DISC. No men were recruited through the resettlement project despite re-contacting them to see if they had anyone suitable. I suspect that this was because people presenting to the resettlement project had, or were considered by the service worker acting as the gatekeeper to have more pressing issues to prioritise, namely their housing. Another possible explanation

²⁵ When attending the needle exchange services and outreach exchange I did not act in any capacity other than a researcher and did not adopt any 'cover' role to legitimise being there.

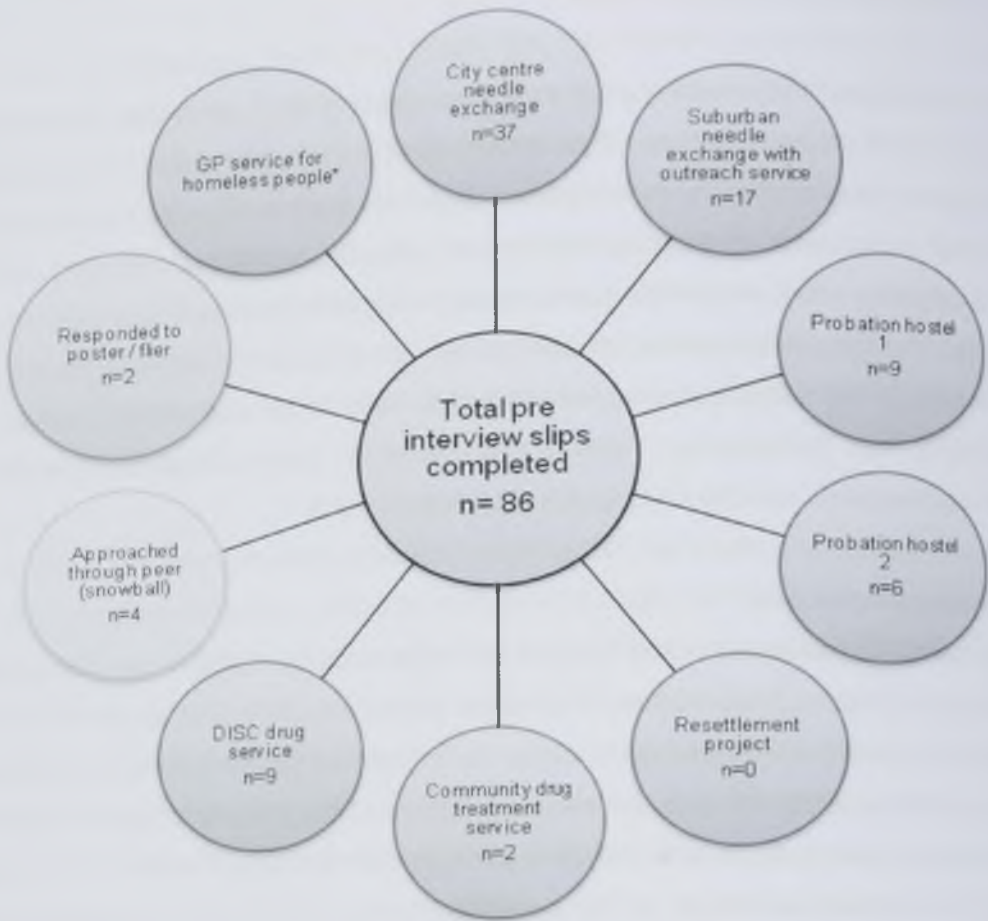
might be that there were less eligible people at the resettlement project or that the service worker did not approach potentially eligible service users to become involved as actively as other service workers.

I acknowledged that not all current or former injecting drug users who had been in prison would access services. Therefore, I used snowball sampling alongside the recruitment approaches to try to recruit eligible men who were less accessible or 'hidden' on account of their lack of service utilisation. Snowball sampling can be advantageous when researching vulnerable or highly stigmatised populations (Lee, 1993). This approach consisted of asking men who had been interviewed to mention the study to any suitable peers and encourage them to be involved and resulted in recruiting four participants. Table 3.1 on page 94 summarises the recruitment approaches taken and the participants recruited by each.

Gathering Information

After potential participants were introduced to the study by myself or service workers, they were given a pre-interview information slip to complete and return to me in a pre-paid envelope. The slip could either be completed by the potential participants themselves or with the help of service workers. This procedure was adopted to ensure that the research was inclusive to those with literacy difficulties. For the two men who responded directly to the poster(s), I provided details of the research and completed pre-interview information slips with them over the telephone. The pre-interview information slip requested the participant's demographic details, their contact details, current drug use, injecting drug use at time of imprisonment, length of last prison sentence, when and from where they were released and the amount of times they had served in adult prison in order to assess their eligibility to participate in the research against the four main eligibility criteria outlined earlier. (A copy of the pre-interview slip can be found in Appendix 8). As the slips were received, I entered the details into a Microsoft Excel spreadsheet and monitored this for the different sampling dimensions. A total of 86 pre-interview information slips were completed and received from men accessing the services or responding to the poster(s) or fliers or from snowball sampling, as shown in Figure 3.1. I considered that this was a sufficient number from which to sample men who would be able to provide full and meaningful accounts about how their time in prison impacted on their drug using behaviours, particularly their injecting. I therefore ceased recruitment at this time.

Figure 3.1 – Pre-Interview Information Slips Completed by Recruitment Approach



As shown in Figure 3.1, those recruited from the GP Service for Homeless People have been combined with those recruited from the city centre needle exchange. This was because these services are adjacent to one another and it was difficult to distinguish between users recruited from them.

I did not ask the services to collect information on how many men refused to be involved as I initially did not consider this necessary. However, on reflection, it would have been useful to know about the levels of refusals and reasons for not wanting to be involved. From my experiences of approaching men on the outreach needle exchange, they appeared interested and happy to be involved in the research. It might be questioned as to whether these initial reactions were fuelled by social desirability, presenting to me as willing in front of outreach workers. However as some men recruited this way were interviewed, it would appear that at least some of these reactions were genuine.

Despite the attempts to access a wide and diverse sample, I acknowledged that the approaches taken would inevitably result in a self selecting sample, largely made up of willing service users who either directly responded to a poster or to a request to take part from myself, a service worker or a peer. Later I recognise the limitations of this and consider the possible implications.

Sampling

Before sampling participants, I considered the pivotal variables, characteristics and experiences on which the research focussed and which I expected to have the greatest bearing on the findings and on the development of meaningful theory during the analysis (Mason, 2002). These variables included the nature of injecting drug use prior to imprisonment, length of last sentence, number of previous prison sentences and current drug use. I therefore chose these as the primary dimensions on which to sample participants. Having a range of characteristics and experiences across the sample would facilitate exploring their experiences from interview to interview and later testing and refining theoretical ideas. Age and ethnicity were determined as secondary sampling dimensions as whilst I considered that they could have a bearing on men's experiences and accounts they would be of less significance than the primary variable. Thus information on their age and ethnicity was also collected to monitor throughout sampling and recruitment.

The men were sampled for interview based on the information provided on the pre-interview information slips. Out of the 86 completed slips, six potential participants were unsuitable, five as they had been released from prison prior to 2002 and the other as he had smoked rather than injected illicit drugs prior to his last imprisonment. When sampling, I carefully examined the primary and secondary sampling variables of the 80 eligible participants. Participants were initially selected to ensure diversity across the primary variables and experiences. For example, I was keen to sample men who between them had injected a variety of different drugs and men who had a range of previous prison histories, in terms of the amount and length of sentences. Whilst trying to ensure diversity, I took care to not sample too many diverse experiences as this would result in a lot of data pertaining to a lot of different experiences which could result in not being able to make meaningful interpretations of the data. For example, most men injected both heroin and crack cocaine but just two had only injected amphetamine prior to last imprisonment so I only sampled one man who had injected amphetamine. No numbers or limits of who to interview

according to the primary and secondary sampling dimensions were prescribed in advance. Rather, a flexible sampling approach, akin to qualitative research was used as described below.

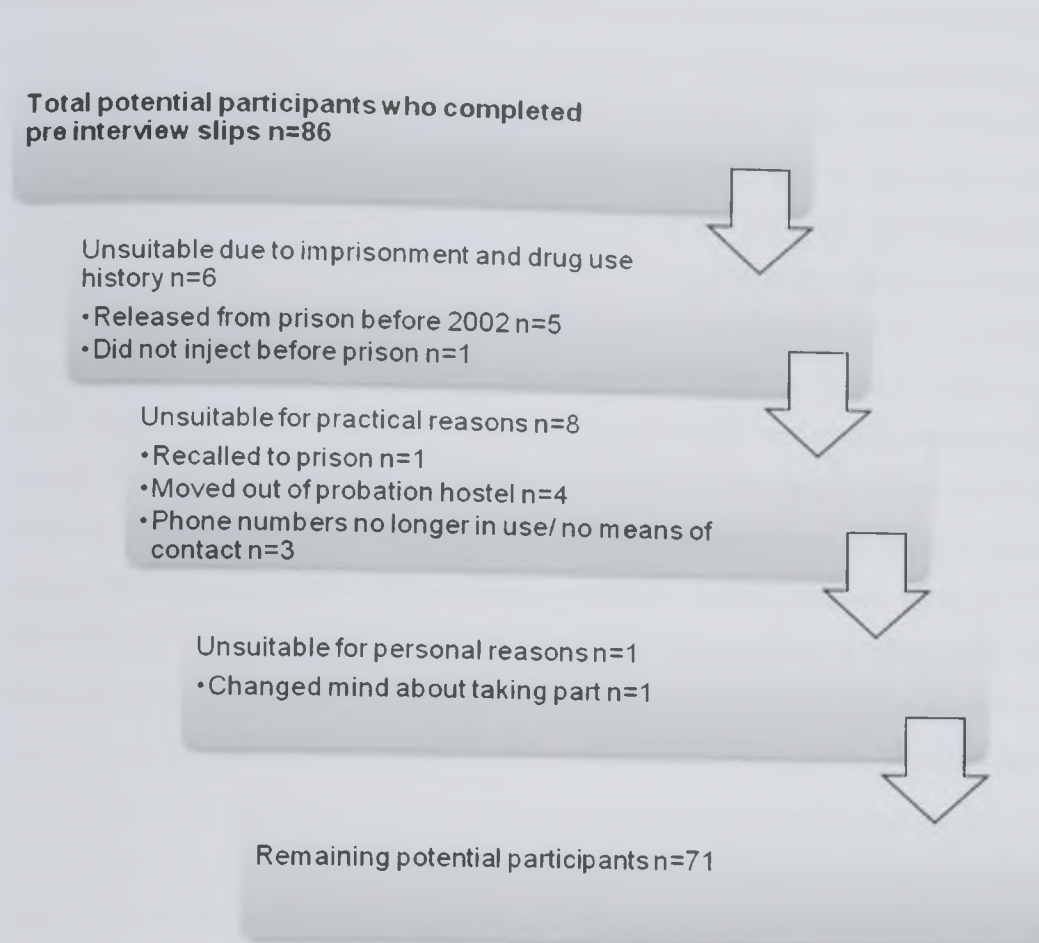
It was important for the analysis and for theory development that the sample of men with a history of injecting drug use and imprisonment contained a range of possible observations to make meaningful conceptual generalisations achievable and to maximise variability (Silverman, 1997). In line with inductive grounded theory practice, theoretical, data driven sampling, that is the selection of additional participants who were considered likely to provide data to fill in the gaps in the developing analysis was used (Glaser & Strauss, 1967). This was ensured by actively sampling new cases for their potential to generate new theory on account of their experiences. This required a theoretical sensitivity to consider experiences which would deepen and expand understandings and challenge or test evolving conceptualisations and theoretical developments (Glaser & Strauss, 1967; Pidgeon, 1996; Strauss & Corbin, 1990). Theoretical sampling was initially conducted from interview to interview by consulting where participants had been sampled from and the characteristics of those already interviewed when identifying who to interview next and which service to identify them from (Dey, 2007; Strauss & Corbin, 1990). This was done by considering who would be most beneficial to speak with to contribute to the study when actively identifying new participants from the varying services and also when considering what other services might be useful to introduce the work to and sample participants from. As interviewing progressed and as the analysis process started, theoretical sampling was done iteratively whereby the analysis guided the sampling and new participants were selected based on how they might be able to contribute, clarify and elucidate the emerging ideas. Monitoring each participant in terms of the primary and secondary variables during the sampling and recruitment and also after their interviews also played a key role throughout conducting the interviews to ensure sufficient range and diversity of experiences and characteristics.

Arranging Interviews

After selecting potential participants, I contacted them either by phone or through their worker. However I sometimes encountered problems doing this. For example, in three cases the men's phone numbers were no longer in use. For five participants, I was notified by the hostel where they lived when they completed the pre-interview information slip that they no longer lived there, some having been recalled to prison.

For those with whom I made contact, I confirmed their interest in being interviewed. Only one man changed his mind at this stage and did not want to be interviewed on account of him trying to forget about his past drug use and move on with his life. Figure 3.2 below summarises the numbers of unsuitable participants who completed the pre-interview information slips and why they were not considered suitable.

Figure 3.2 - Overview of Unsuitable Participants



For those selected, I arranged a convenient interview time and place to fit in with their routine and existing appointments, usually at a service the man visited in order to maximise the chance of attending. This approach may be argued to reinforce drug using behaviour. However, I believe that without emphasising this flexibility and understanding of the nature of drug dependence, I would not have recruited participants as successfully. Rather, adopting a strict demeanour and approach could have deterred drug users from attending and might have led to questions regarding the credibility and applicability of the research and concerns of sample bias,

convenience and representativeness. Participants were reminded of their interview appointment where possible by leaving a message with their service worker or telephoning them directly on the day of the interview. Where men had provided mobile phone numbers, I also sent text messages to remind them.

Despite reminders, four men out of 30 did not attend the interview appointments. This did not alarm me, as I had encountered this in previous studies with injecting drug users. If anything, I was surprised that this number was so low. Their non attendance might have been due to practical reasons such as forgetting about the interview or having a conflicting appointment. I also considered if non attendance might have been due to other reasons, such as a refusal to engage in the research. As drug users' lives are often centred on purchasing and using drugs to prevent physical withdrawal, some told me that it was unlikely that dependent users would attend for interview without having used drugs that day. I had to understand this when recruiting participants and scheduling the interviews, although three of those who did not attend had said that they were drug free when they were recruited. I believe that the low non attendance demonstrates the benefit of reminding participants of their appointments, the staged recruitment approach and the convenience of the interview venue chosen. Furthermore, it possibly highlights that those who were recruited were more stable, in terms of their drug use and their lives than those at the height of their drug use. I offered the four men a re-arranged interview and all attended. This suggests that practical reasons accounted for their initial non attendance, although I did not ask them to confirm this.

Table 3.1 - Summary of Recruitment Approaches and Participants Recruited

Recruitment approach	Details	Potential participants (total completed pre-interview slips)	Participants interviewed
Introduced through service	Needle exchanges & GP homeless service (n=3)	54	15
	Probation hostels (n=2)	15	7
	Drug services (n=2)	11	2
	Resettlement project (n=1)	0	0
Responded to advert	Poster/ flier	2	2
Approached by peer	Snowball	4	4
TOTAL		86	30

Before the Interviews

Personal Considerations

At the time of interviewing I was in my late twenties but as I am small in height and physique, people often think that I am younger. I considered this when dressing for the interviews. I was careful not to dress in a manner that might be considered by the men as off putting by being 'too official,' or sexually provocative. At the same time I did not wear anything scruffy or revealing as I wanted to give a professional yet relaxed appearance. I therefore wore casual trousers and T-shirts and/or jumpers for the interviews.

Prior to starting each interview, I quickly and discreetly assessed participants for obvious drug induced intoxication. I considered things such as their general behaviour, manner, pupil size and speech but no one appeared to be intoxicated at the start of the interview. As stated in the NHS ethical approval forms, if I had considered any of the men to have been heavily under the influence of drugs, I would have re-arranged the interview for an alternative time.

Ensuring Understanding and Gaining Consent

All participants were given an information sheet which they were encouraged to read although some had already read this at the recruitment stage. (A copy of the participant information sheet can be found in Appendix 9). I also provided a verbal explanation of the research and what the interview would largely cover. This was important as I suspected that based on prior experience and other research with drug users and prisoners some participants may have had poor literacy skills (Social Exclusion Unit, 2002). Furthermore at least one participant stated that he could not read and many had misspelt words on their pre-interview information slips. I also emphasised my independence from the services in order to allay any possible fears that participants might have had about me sharing the details of what they told me. Furthermore, I answered any questions that participants had prior to starting the interviews, such as what would happen with the findings and why I was conducting the research.

Given their involvement in illicit activities, it was important that the men felt comfortable and were able to be as honest as possible in disclosing their behaviours, thoughts and feelings. Confidentiality and the right to withdraw at any stage without affecting the medical, social or psychological care was explained to participants prior to starting the interviews. Their right to not answer any questions with which they were not comfortable was also explained to them. Participants were also assured that their responses would remain confidential and would be presented and reported anonymously. I believed that these measures and assurances provided a 'framework of trust,' (Lee, 1993) to aid disclosure and encourage participants to talk as openly and honestly as possible during the interviews, although I recognised that no measures could guarantee complete honesty. I also believed that these measures would reduce the likelihood of participants providing responses that they thought that I wanted to hear and subsequent social desirability bias or not giving sufficiently deep answers from which to develop and test theoretical ideas.

In line with the ethical guidelines guiding the research (British Psychological Society, 2006; Department of Health, 2001b; Department of Health, 2005) and guiding research with drug users (Day et al., 2002), participants were made fully aware that I was ethically and legally obliged to breach confidentiality if they disclosed serious crimes for which they had not been convicted, such as those against children. I verbally explained these caveats to confidentiality and disclosure reporting so that the men were clear about this before starting. Protecting confidentiality was also

particularly important for methodological rigour, as concerns regarding confidentiality could result in participants deliberately providing inaccurate, dishonest or misleading information. This in turn would result in data of uncertain reliability and validity, with potential consequences for the research credibility and its wider implications.

After discussing the participant information sheet and issues of confidentiality, written informed consent was obtained from each participant immediately prior to the interview commencing. I carefully went through the consent form to ensure that participants understood what involvement entailed and how their information would be used. (A copy of the consent form can be found in Appendix 10).

Establishing Rapport

It was important to establish rapport before the interview and recording formally started. Reading through the participant information sheet and obtaining consent, discussing the study and general conversation facilitated this. Rapport was established more quickly with men who I had previously met, such as those I recruited on the outreach needle exchange service. In these situations, it was important that they did not assume what they had already told me in pre-interview discussions. Rather, I stressed at the start of the interviews that they should accurately talk about everything that they could that was apposite to the research even if they had previously told me, as it needed to be discussed and formally recorded. I also explained why I needed this information – saying that descriptions of their actions, thoughts and feelings were important for my comprehension, subsequent interpretation and for theoretically and practically meaningful conclusions to be made. Finally, as I was born and brought up in Leeds, I have a noticeable yet mild northern accent. I believe this commonality aided rapport in some interviews, as most participants were from Leeds or the local area and spoke with Yorkshire accents.

Acknowledging the likely social differences between myself and my participants, I worried slightly about what they might assume of my middle class and educated upbringing. I feared that they might question my ability to engage with them to a level of understanding and considered how openly and honestly they would interact with me about their experiences and lifestyles. Linked to this was a concern that they might query my ability to question them on the topics of injecting drug use and imprisonment. I considered how to overcome and address these anxieties of how

participants might perceive me in order to generate meaningful interviews. One way I did this was by openly discussing my experience of interviewing drug injectors.

Before starting each interview I explained to participants that I had researched and interviewed injecting drug users for a number of years. Whilst I did not have direct lived experience of injecting or imprisonment, I was keen that participants did not see me as naïve and inexperienced, but as confident, able to discuss intricate issues and with a level of knowledge, understanding and genuine interest in the topics. I introduced this to try to ensure that the conversations would not be too basic to make interpretations difficult. Yet, by so doing I had to be careful that participants did not assume that I was an 'insider' who was so entrenched in the subject area that I knew what they might say, and by so being deter them from discussing their thoughts and experiences as this would result in data lacking in description and significance (Miller & Glassner, 2004). Furthermore, I did not want the participants to assume that I was an expert in the area as it might undermine their willingness to fully engage in the interviews and negatively affect the power relationships in them. Thus, whilst I told participants that I had interviewed drug users before, I emphasised my relatively little prison interview experience. This approach attempted to directly acknowledge them as more 'expert' in this area and empower and encourage them to contribute their perspectives (Hucklesby & Wincup, 2010; Miller & Glassner, 2004). I also did this so that I could use my lack of direct drug use and imprisonment experience and the social difference between myself and the participants to my advantage in the interviews (Hucklesby & Wincup, 2010). For example, I could ask participants to explain their thoughts and experiences further on account of the differences between us, again positioning them as the experts and using the social difference between us to facilitate explanations that might have been assumed of me or of someone who participants considered to have a greater understanding and/ or an 'insider' perspective (Miller & Glassner, 2004). Overall, I was confident that my prior interview experience and training stood me in good stead and I was keen for my experience to develop through conducting the interviews.

Interviewing Participants

Interview Procedure and Conduct

Interviewing started in August 2006 and finished in January 2008. Interviews lasted between 35 and 87 minutes and were conducted in private. The majority of

interviews (21) were carried out in rooms at the needle exchange services, seven were conducted in two probation hostels where the men were living and two were conducted in community drug services. Where possible, comfortable, quiet rooms were chosen to help the participants feel at ease and to reduce the level of background noise for the recording.

I carried out all the interviews which ensured consistency within and between them, and contributed to the grounded approach by allowing emerging and unexpected issues and concepts to be identified and explored in the course of the interviews (Mason, 2002). I have extensive experience of researching issues around injecting drug use (Hunt et al., 2007; Oldham et al., 2004; Sheard et al., 2007; Wright & Tompkins, 2004; Wright & Tompkins, 2006), particularly through qualitative research with injecting drug users (Neale, Sheard & Tompkins, 2007; Sheard & Tompkins, 2008; Tompkins et al., 2006; Tompkins et al., 2007b; Tompkins, Sheard & Neale, 2008; Tompkins, Wright & Jones, 2005; Wright, Tompkins & Jones, 2005; Wright, Tompkins & Sheard, 2007). This experience extends to interviewing injecting drug users who have been in prison (Tompkins, 2007; Tompkins et al., 2007a; Tompkins, Wright & Sheard, 2010) although interviewing specifically about prison was new territory for me to explore in the current research. Dealing with being knowledgeable regarding injecting drug use, but less so about imprisonment was a challenge with which sometimes I grappled during the interviews and the research more widely.

At the start of some interviews I noted participant's non-verbal behaviour, such as fiddling with paperwork, fidgeting or reduced eye contact. I interpreted from this that they were a little tense or wary, although I did not clarify this. In these cases I started the interview as quickly as possible so as not to draw out their possible anxiety or anticipation. I found that constructing simple open questions at the start of the interview helped the participants to relax, also helping me to relax.

I used a flexible approach to interviewing, in order to position the participants at the centre of the research and to be open and adaptable to their experiences and ideas in line with the research questions (Kvale, 1996; Mason, 2002). The interviews chiefly explored participants' injecting behaviour prior to imprisonment, drug use behaviour during prison sentences, (focussing specifically on a participant's first and last sentences and any differences on interim sentences) and their drug use on release from prison. The interviews also examined the emotional, practical, social and environmental issues associated with injecting drug use and imprisonment in order to

contextualise the accounts of drug use both in the community and in prison and provide rich and detailed qualitative data (Henwood, 2006; Mason, 2002; Miles & Huberman, 1994).

At places within this chapter and throughout the findings subsequently presented, italicised quotations from the interviews are provided to highlight pertinent issues and demonstrate the richness of the data collected. The quotations are verbatim to reflect accurately participants' language during the interviews. It was considered important to include slang terms and swear words to convey *what* participants said and *how* they said it alongside maintaining the integrity of their accounts. To assist readers who may not be familiar with terms used by participants relating to drug use or imprisonment, slang terms or dialect words are explained in brackets after they appear in the quotations. Some of the quotations include questions which I asked, as indicated in bold non-italicised font, preceded by my initials. In order to protect potential participant identification, pseudonyms rather than participants names are used. Names of people or places to whom they refer within the quotations have also been masked where appropriate and replaced with a suitable identifier to prevent participant's possible identification through them. Prison establishments mentioned within the quotations have been anonymised using numerical descriptors to prevent potential identification²⁶.

Topic Guide

A topic guide was used in the interviews. It was used in a flexible way, meaning that the areas on the guide were not always covered in as much depth with each participant, depending on individuals and their experiences (Banister et al., 1994). The topic guide was devised based on the research questions and covered the key themes to be explored (Mason, 2002; Taylor & Bogdan, 1998). (A copy of the initial topic guide can be seen in Appendix 11). The design of the initial guide grouped similar topics and ordered them under main headings. This grouping reflected how I expected the interviews to be structured, although as the interviews were responsive to individual participants and their accounts (Kvale, 1996), the topics of discussion sometimes varied in terms of how and when they were introduced and developed.

²⁶ Within the quotations, Prisons 1 and 5 refer to security category B prisons. Prison 2 refers to a security category B prison for young and adult male offenders. Prisons 3 and 4 refer to security category C prisons and Prison 6 refers to a category C prison with an open category D side.

The initial topic guide started informally. It sought general information, such as current lifestyle or drug use histories by asking factual and non-threatening questions to get the participant talking and put them at ease (Rubin & Rubin, 1995). General open questions, such as 'can you tell me a little bit about your history of drug use?' or 'can you describe your current situation?' helped to start the interviews and gain trust. These discussions helped to move on to talk about more important, yet potentially sensitive issues, including illegal drug use, criminal behaviour and being sent to prison. Questions such as, 'how did you feel knowing that you were going to prison without drugs?' and 'what were your thoughts when you were sentenced to prison?' formed the middle part of the topic guide and subsequent interviews. This section also concentrated on their time in prison and what happened to their drug use during imprisonment and often required significant probing as participants were not always forthcoming. Discussing why an individual had made a choice to use or to not use drugs was imperative here. Questions such as, 'how did you feel about your drug use whilst you were in prison?' and 'why do you think you decided to use/not use drugs when you were last in prison?' were asked to explore this. The deliberative nature of asking open questions was a way I could legitimately find out information and allowed men to discuss the most pertinent issues and express themselves in their own words, based on their own life experiences (May, 1997). At the same time, open questioning was intended to make them feel more at ease whilst eliciting their views and experiences.

The final part of the topic guide was concerned with returning the participant to talk about less directly sensitive issues in preparing them for the close of the interview. Topics included asking what could have made their time in prison easier or what they felt would help injecting drug users in prison. They were then asked if they had anything to add which had not been covered and discussed any hopes and plans they had for their futures. This brought the interviews to a close, helping to ensure that participants were hopefully left feeling calm and in a positive frame of mind (Rubin & Rubin, 1995). This approach has previously been used in other interview studies with injecting drug users and had been effective in my own earlier research (Tompkins, Sheard & Neale, 2008).

Using and Revising the Topic Guide

The topic guide was a working tool, which was revised after conducting the first few interviews. (A copy of the revised topic guide can be seen in Appendix 12). Revisions were mainly made to the content of the guide, although some were also made to the

structure. Revisions were necessary because it had sometimes been difficult to use the guide when interviewing participants with complex and extensive prison histories as the interviews often jumped around in terms of the issues discussed and this made it difficult to obtain full accounts and experiences. Furthermore, it became evident that some of the questions and prompts included in the initial guide sought heavily descriptive information, and it was necessary to focus on more emotional and psychological issues in order to gather and generate meaningful data. Prompts such as asking why participants had behaved, or not behaved in particular ways and what they thought had influenced these behaviours and choices were therefore included. Some of the more factual, descriptive sections of the guide were thus reduced or omitted in favour of more psychologically relevant questions. In revising, the ordering of the guide became more chronological. This started with discussing a person's drug use history and then their prison history, paying particular attention to the first and last sentences before discussing any sentences in-between. These 'warm up' topics (Mason, 2002) allowed consistent information to be obtained from each participant, without over standardising the interviews (Banister et al., 1994; Mason, 2002) and also made the interviews flow more logically. I favoured using this more chronological approach to interviewing after conducting some of the disjointed initial interviews.

The revised guide was used in subsequent interviews. Some issues and experiences participants raised during the interviews became important to respond to and follow up, particularly those which were not anticipated at the outset of the research (Banister et al., 1994; Mason, 2002). These were added to the topic guide to explore in subsequent interviews, allowing them to develop in an organic way (Mason, 2002). This reflects the iterative and inductive nature of the qualitative research design (Barbour & Kitzinger, 1999) and the fluid and flexible interview approach (Mason, 2002). For example, in the first interview conducted, Bryan discussed something ('plugging') which I did not fully understand. Although I had an idea what he was referring to by his reference to 'not being crude', I did not assume this so asked him to provide more detail, reassuring him that it was both interesting and relevant. I considered that in seeking such clarifications I might have appeared naïve and participants may question my ability to conduct the interviews, especially after having said that I had interviewed drug users before. As Bryan's initial response did not fully clarify what I wanted to know, I therefore interrupted him to probe about this. I asked for clarification using more direct questioning '*for the purpose of the recorder,*' to further legitimise my request and to hide my concerns regarding how he perceived me. This highlights that at times when probing participants I showed less of an

'insider' perspective but tried to turn the social distance between myself and the participants to my advantage to elicit explanations that participants might have assumed that I already knew (Miller & Glassner, 2004). This approach was important in order to not take for granted that I knew what participants were talking about and to ensure that my understanding was the same as their descriptions.

*I had four, **four** ten bags (of drugs) on me and I'm not being crude, **they** came out the next morning. I had them plugged and they came out next morning. So I just smoked one on the morning. And then I got moved from downstairs to upstairs, because you get moved in (Prison 1), you go in the overnight centre on a night and then you go upstairs next morning into proper prison and then I just used it all one day.*

CT: So can you tell me a little bit, because I think it will be interesting for the purpose of this study, like you said, not being crude, but about plugging? Can you give me a little bit more information about that?

Well what happened were I thought I had a warrant out the day before I actually went to prison and I went and handed myself in and I plugged four bags to go into (name of police station) and when I got there they said there wasn't a warrant out so I left them there anyway...

CT: (Interrupting) So when you say 'plugging,' can you explain for the purpose of the recorder exactly what you mean?

Yes. I've wrapped them (drugs) in durex (condom) and stuck them up me backside and pushed them up so they were right out the way. (Bryan)

Later participants also discussed how they had been 'prepared' and taken illicit drugs into prison with them. I therefore added this to the topic guide and explored it in future interviews – asking why they had done this and what they thought about this.

The most significant unanticipated area that emerged and was added into the revised guide was the prison misuse of buprenorphine, a prescribed medication for the treatment of drug dependence (Tompkins et al., 2009; Tompkins & Sheard, 2009). Questions regarding this were therefore woven into the guide and subsequent interviews to explore the practice within the context of prison drug using behaviours and choices. These aspects were new and exciting to me as a reasonably experienced interviewer into drug use and I probed and explored these issues in the interviews arguably in a more searching and in-depth manner than those which I considered less new and exciting in comparison. Further thoughts on this, including

the impact on analytical developments are presented when appropriate in the subsequent chapters.

Safety

To ensure my safety, manage risk, reduce interruptions and confidentiality concerns and in accordance with ethical and best practice recommendations (Day et al., 2002), no interviews were conducted in participants' homes, hostel bedrooms or cafes but rather they all were conducted in services. Only interview rooms at needle exchange services, probation hostels or community services were used. Only participants and I were present during the interviews, although service staff were aware that they were being conducted. I adhered to any onsite service safety measures, including carrying a personal alarm and escorting participants when in the services to manage risk (Hucklesby & Wincup, 2010). For each interview, I also told a colleague who I was interviewing, where it was taking place and contacted them afterwards to confirm that I was safe.

Apparatus

All interviews were audio recorded in their entirety using a small, unobtrusive Olympus DM-20 digital voice recorder with an external microphone to ensure optimal sound quality. The recorder was placed near the participant to keep any background noise on the recording to a minimum. The recorder was started whilst I explained the project to give participants time to adapt to its presence and turned off at the end of the interview.

Interruptions from either service workers entering the room or from mobile telephones ringing were limited and did not greatly impact on the interview flow. When there were interruptions, the recorder was paused until the interview could resume. Whilst I found this unsettling and annoying, generally such delays were of a minor nature and short duration.

Reflecting on the Interviews

Before, during and after the interviews I reflexively tried to consider my role in the process of data generation (Mason, 2002; Noaks & Wincup 2004). This was important as I acknowledged that my values and beliefs would have a bearing on the interview conduct and subsequent analysis and reporting (Noaks & Wincup, 2004; Wilkinson, 1988). Revealing how I considered that I had or may have influenced the

interviews relied on continuous, critical self awareness and examination. This was sometimes challenging, requiring a sophisticated level of reflection by trying to detach myself from the data and questioning how participants could have interpreted and responded to my demeanour and approach during the interviews. Reflecting on the interviews was assisted through noting my thoughts on paper in my fieldwork diary as they occurred to me during the interviewing stage, although what I noted was still subjective – based on my own judgement and beliefs. Examples of how my reflection impacted on my interviewing in fruitful ways are interspersed in the subsequent sections where appropriate.

Facilitating and Managing Disclosure

I dealt with being a reasonably experienced interviewer of injecting drug users, yet conducting new exploratory prison research as well as I could. Where it appeared that participants had not given full answers possibly as they thought that I would understand what they meant, I asked them to elaborate on points by probing their responses. I did this by listening to their answers and following them up, asking them to expand on their statements by saying, 'I know this might seem obvious to you, but can you explain what you mean by that?' By so doing I aimed to encourage and empower participants rather than demean them. I think that my local knowledge was sometimes beneficial if participants described where they lived, committed crime or used or bought drugs as showing participants that I was familiar with these areas aided the interview flow and understanding. In other situations however, I believe that emphasising the social distance between myself and participants in relation to our lives and experiences facilitated the gathering of rich and detailed descriptions that went beyond what they thought I already knew.

Men often quickly revealed intimate aspects of their lives in the interviews including their experiences of physical and sexual abuse, growing up in care, experiences of self harm, suicide attempts and bereavement. Sensitive disclosure was sometimes challenging as it was outside my research role to offer ongoing support. In my reflection, I questioned why participants disclosed such information and the credibility of some of their disclosures. Maybe these were things which they had not spoken of before but welcomed the opportunity to do so? Furthermore, I questioned whether they thought that I might be able to help them professionally. On the other hand, I considered that maybe they had spoken about sensitive issues many times previously to other professionals that their disclosure was not out of the ordinary. Either way, I felt that such disclosure was positive, highlighting that we had a good

rapport and that they trusted me with sensitive personal information. On hearing such things, I sometimes felt **confused** about how to feel and respond towards participants. I believe that some participants were (**knowingly** or not) trying to **portray** themselves in such a way to seek my sympathy. After reflecting on some of these situations, I adopted an empathic approach in the interviews to manage this on a personal level and to keep within the bounds of my academic research role.

As with any qualitative interviewing, I was aware that the discussions with participants would provide constructed or reconstructed accounts according to their versions of events and views of the social world (Mason, 2002; Miller & Glassner, 2004; Noaks & Wincup, 2004). As my position was to try to understand their experiences and situations to be able to explain and interpret them, I could not ignore how the individual interview interactions would contribute to the creation of participants' accounts and stories. For example, as part of obtaining accounts, I considered whether participants would tell me certain things with the desire to 'impress' me by providing embellished accounts as a facet of social desirability. On the surface, this was not always obvious in the interviews as participants appeared to speak frankly about their circumstances and experiences and seemed to provide full accounts. However, I was aware that this happened at a more subtle level. For example, how could I be sure that they did not omit detail or accounts which they did not want me to hear? Furthermore, trying to distinguish full accounts from embellished or exaggerated accounts was complex and subject to my own interpretation and judgement. This issue is further complicated by the fine line between an embellished account and the 'thick' description sought by in-depth interviewing (Rapley, 2004).

I tried to deal with the tensions of impression, exaggeration and embellishment in the interviews in a variety of ways. I was careful not to be over credulous of what participants said while at the same time trying to develop a mutually respectful stance within the interview. Sometimes I therefore asked questions of the same participant in different ways, to corroborate information provided. This included referring to individuals' completed pre-interview information slips and asking them to verify information, such as how many times they had been in prison. I took care when cross checking information as I did not want participants to interpret from this as undermining or that I disbelieved them as this would have been detrimental to the rapport between us.

CT: Can I ask a little bit then about which prisons you have been in because you have mentioned that you went to (Prison 1) for your two and a half year sentence but I know that you filled in on your form that you were released from (Prison 6)?

Yeah because like went to (Prison 1), that's an allocating jail so from (Prison 1) they shipped me out to (Prison 3) and from (Prison 3) to (Prison 6). (Jason)

The use of probing and seeking to delve more deeply into areas was also useful to try to elicit accurate accounts and challenge any possible desirable responses provided. This was particularly the case when a new idea or experience was raised that had not been discussed in earlier interviews. However I was also careful when probing and cross checking so I did not probe too deeply on issues which could compromise participant confidentiality or disrupt the social dynamic such as about their intention to commit planned future crimes.

Participants sometimes said things during the interviews to suggest that they were being honest, or were trying to present credibly. This is demonstrated in the quotations below and also in later quotations on fear on page 165.

I never lie about my past, everybody knows, even, in fact, everybody I know knows about what I've done in prison, and that I've been in prison. I've been there, I'm not going to lie about it, I've done it. (Chris)

I shouldn't be telling you this but I will do. I actually took a load (of drugs) in with me. (Gareth)

I noted in my reflection that even after assuring confidentiality at the start of the interview, participants sometimes appeared wary about answering certain questions:

CT: Have you ever managed to take any (drugs) in with you yourself?

Confidential this is, isn't it?

CT: Yes

Er yeah. (Jason)

CT: That is what I was saying at the start. It is extremely confidential because I understand what we are talking about is you know...

(Interrupting) I have yeah

CT: And can you tell me a little bit about that if that is alright?

This suggests that participants wanted to appear as speaking with integrity by telling the truth. It also highlights that there were sometimes possible elements of uneasiness associated with disclosing certain behaviours as participants were uncertain whether they could trust me and questioned what I might do with their information. My reflection about this helped the conduct of subsequent interviews as in interviews where I could sense potential uncertainty I ensured that I emphasised confidentiality when asking questions that I thought that they might be more wary of answering and encouraged their responses by saying things like, 'it is really helpful for the study' (Hucklesby & Wincup, 2010).

Participant Disposition

Even after conducting some interviews, reflecting on them and refining my questions, techniques and topic guide, not all the interviews went smoothly. For example, Gordon abruptly told me about the murder of three of his siblings within the first minute of the interview. It was not the disclosure per se that felt uncomfortable, but the timing of it and the matter of fact revelation. After the interviewing, during my reflection, I wondered if Gordon had done this deliberately, as a possible way to seek my sympathy or as a 'cry for help' or compassion which, knowingly or not, would mean that I was careful in dealing with him and issues from his past. Regardless, it did affect me as I thought it too invasive to ask anything too searching during the interview about the effect of this on his drug use as we had just started talking and I did not consider us to have built sufficient rapport. As a result the interview started strangely, with poor and stilted questioning. The interview continued but his short and to the point answers affected me, as I found it harder to ask open and relevant questions. I reflected on the interview in my fieldwork diary immediately afterwards.

Very strange interview. Me not feeling on top form and suffering with cold and participant very, very abrupt and difficult to understand due to accent.... Interview jumped around a lot. Found it very hard to focus and almost like he didn't want to be there for very long. His answers were so abrupt that made me feel very on edge and hurried into asking new questions. (Field note written after interview with Gordon).

I also found Jamie's interview hard to conduct because he spoke in a matter of fact way and provided short, literal and sometimes what I perceived during the interview as somewhat hostile answers. Furthermore, the way that he structured his responses

into questions made me feel that he thought that my questions were obvious. I wondered if he was trying to present as knowledgeable and superior, trying to undermine my perceived intelligence and control as the interviewer on account of my questions. Alternatively he might have thought that the questions posed were naïve for someone who openly said that they had interviewed injecting drug users before.

CT: Why wouldn't the needles be clean?

Because everybody else would've been using them wouldn't they?

CT: Right okay. If you'd got a clean one (needle) would you have done (inject)?

No

CT: No? What is your reason for saying no?

Because your tolerance goes down doesn't it? And you can OD (overdose) and I don't want to come out of jail in a body bag (dead) really do I? (Jamie)

There were generally few differences in the interviews held with current and former injectors although participants' drug using status sometimes affected the interview conduct. For example, I observed that Jack started to experience opiate withdrawal symptoms and when I checked if he was alright he said that he had not taken his substitute medication. Whilst he confirmed that he was happy for the interview to progress a little longer, his state of withdrawal required the interview to end reasonably abruptly so he could collect his medication.

Interviewee easy to engage and thought well and clearly about questions. However, partway through interview became obviously in withdrawal – nose started running, lots of heavy yawning and shifting around in chair. Said he needed to go to chemist. As a result interview ended sooner and last sections rushed a bit.... Didn't feel had enough time to close interview but wanted to end it to be fair on participant so could get to chemist. (Field note written after interview with Jack).

During the interview Jason became intoxicated from heroin which he had taken before it started. This resulted in his eyes closing, slurred speech and loss of concentration. I considered ending the interview and conducting it at another time but when I checked with him, he was determined to continue and became more alert during subsequent questioning.

Participant was gouching²⁷ (a sleepy drug induced state) during interview and eyes were frequently closed, so no eye contact...very distracting having eyes semi closed and speech sometimes a bit slurred. (Field note written after interview with Jason).

Compared to current injectors, participants who had abstained from using drugs appeared more alert and maintained good concentration throughout the interview. However, I found interviewing former injecting drug users more challenging. Professionally I was conscious that my prior interview experience did not extend to this group. Personally, I was concerned that interviewing former drug users about their previous crime and drug use might cause distress and embarrassment. This was due to the sensitive nature of these issues, especially for those who identified as 'having changed' and were less keen on talking about these prior activities.

Interviewing the amphetamine injector was at times challenging as he was very animated despite claiming that he had not taken any amphetamine that day. He spoke very quickly, often for a long period of time. This required patience, careful listening and questioning to sometimes steer the interview back to the topic. At times this was frustrating as I had to monitor closely what had or had not been discussed.

Issues of Personal Disclosure

During the interviews participants sometimes voiced assumptions about me, namely that I had never been to prison or injected drugs. Whilst I was keen not to spend interview time discussing my own situation, I felt that it was important to be honest and answer any direct question if it would benefit the research. However, as I was not asked outright about any such issues, I did not address their assumptions believing that it would detract from the interview focus. I did however sometimes turn these assumptions to my advantage, legitimising them and explaining that I needed clarification and exploration on certain points, feelings or reactions as I did not share their experiences.

In previous research where women have interviewed men, issues of participant resistance have been documented as being acted out in the form of sexual harassment towards female researchers (McKee & O'Brien, 1983). I was careful to consider how my gender and personal characteristics, combined with the positions of

²⁷ See the Language section later in this chapter.

researcher and researched, might affect the interview conduct and subsequent findings (Britten, 1995). As a young woman I was aware that some men being interviewed may feel uncomfortable with the potential associated changes in power balance, departing from traditional roles of men and women in patriarchal societies. Although no men evidenced such concerns during the interviews, I felt that it was present in some of them. For example, Keith occasionally spoke in a degrading way about women, referring to his wife as 'she' rather than by her name, referring to sex workers as 'whores' and referring to his female drug worker (who, he considered, did not listen to him and lacked life experience) as 'love' and 'woman.' Despite his personal and professional encounters with women in the past, I did not sense that he felt uncomfortable with being interviewed by me and he was not degrading during the interview.

Moral, Ethical and Distressing Issues

Participants seemed to open up well in the interviews and no information was disclosed that ethically required me to breach confidentiality and report to the police or other agencies. Some of the crimes that participants said they had committed were more challenging for me to deal with on a moral level, based on my own beliefs. However, I was pleased that participants discussed these often difficult experiences as I interpreted from this that they appeared to trust me with such information and my position as an interviewer was not to judge them based on their actions. Additionally, I was grateful from a research perspective as the reporting of morally and socially undesirable actions and behaviours raised my confidence in the responses. If I had felt that information was being withheld from me on a regular or consistent basis it would have significantly undermined my research. Whilst this did not happen, on reflection I suspect that I would have used my experience to ask probing questions or change tack if necessary to manage this in the immediacy of an interview.

The issue of 'interviewer distress' (Dickson-Swift et al., 2008; Rager, 2005) was a legitimate concern when listening to some men's narratives of their drug histories and imprisonment, especially if they revealed experiences of violence and/ or abuse against them. Particular discussions of troubled life events impacted on me and I can still recall times when participants discussed events which had occurred a number of years previously, often in fascinating detail. Seeing how these events had impacted on them was sometimes upsetting. I found interviews with men who were evidently emotionally vulnerable more difficult both emotionally and ethically. I did not want to contribute to the men dwelling on their past or feel guilty or responsible in case they

responded by engaging in destructive behaviours such as self harm or increased drug use. This was a **tension** with which I grappled as I also did not want to potentially compromise the research by not seeking the information that was needed for fear of being too sensitive to participants' vulnerabilities. I therefore proceeded with the interviews in a sensitive manner, whilst asking what I needed to ask.

Some discussions were less distressing for me than others, but appeared to cause participants concern. For example, one participant became tearful when discussing a relationship breakdown and at least two developed a stammer when talking. As this happened, their speech became more hesitant and stuttered and they sometimes appeared embarrassed. I monitored participants closely during the interviews and responded to any obvious distress as appropriate. An example of this is checking with participants if they would prefer not to discuss the issue. These situations required patience, careful listening and questioning to guide and focus the conversations. In line with good interview practice, I did not press participants to elaborate on uncomfortable or distressing experiences if I felt that it was inappropriate to do so because I believed that it might have been counterproductive. Furthermore, I considered that pressing participants may have upset the balance between myself and participants. Even though this may have led to a loss of data, this decision was taken in the interest of minimising their and my own possible embarrassment whilst maintaining rapport.

By researching men who had been found guilty of committing crime and who had served in prison I expected to discuss the nature of their crimes. Many injecting drug users who I had interviewed before had spoken about committing acquisitive crimes, particularly shoplifting. Yet in conducting the interviews for the current research, I found the extent of crimes in which the men had been involved went beyond what I had previously been told about. For example, interviews which were morally challenging for me to conduct included those with participants who openly disclosed violent forensic histories, involving assault and causing grievous and actual bodily harm to others as I could not condone these behaviours. I did not show this to participants as I believed that this was beyond my remit as an academic researcher. Furthermore, I feared that this might jeopardise the nature and flow of the interview and may prevent them from engaging in the rest of the interview, at possible detriment to the research. Rather, I dealt with such admissions in the immediacy of the interview situation by trying to separate the participant from their reported actions and not judging them on what they had done in their pasts. Whilst not condoning their

actions, this approach helped me to see the participants as people who were willing to discuss and confront their previous behaviours within the context of their often troubled lives. After such interviews it was important for me to debrief the content of the interview with a colleague or supervisor, whilst retaining participant confidentiality. More information on debriefing is provided on page 114.

The hardest interview for me to conduct was with Clive who had first been convicted and sent to prison for rape. Prior to Clive's disclosure, the interview had been going very well and there had been an instant rapport between us. Clive forewarned me that I might be shocked about his offence. I was unsure at the time if this meant that he did not want to talk about it but after checking with him, he disclosed the offence details. I strongly believe that the established rapport enabled this disclosure. I was admittedly initially taken aback by his admission as in my experience of interviewing drug users none had disclosed any sexual offence convictions. I did not display my surprise to Clive, as I believe this would have been unprofessional. I was also concerned that appearing shocked may have affected the power balances or may have jeopardised the rest of the interview, as he may have been wary about discussing other issues. On later reflection it is debatable whether concealing shock was beneficial or not as it may be that revealing and speaking about my shock might have contributed to rapport and further engender trust. In the subsequent discussion Clive revealed more about the offence. This was of direct relevance to the research as he attributed his initiation and use of drugs to coping with being labelled a 'rapist' when first serving a prison sentence.

The problem was me accepting it and being known as a rapist. Now there's rape and there's a rapist. Now I got taken to court for rape and I got found guilty of rape and it obviously doesn't make me a rapist. But in one's own body and mind, I think it's probably one of the few things that any man would not be able to cope with. One of the worst things I've always said for a woman is to be raped. The second thing is to be accused of it. So in myself, in my own mind I wasn't coping very well. And there is a stigma and it stays with you a long time. So then somebody mentioned to me, you know, come and have a smoke of this heroin, and it'll make you feel better and so forth. And the drug made me feel a lot better. (Clive)

It would have been difficult for me to understand and interpret Clive's views on his drug using behaviour and choices when first in prison (and subsequently) without him

having disclosed the details, (or at least his justified version of them) of his offence and drug use.

Language

Sometimes participants used colloquial and street or slang terms for drugs. For example, they commonly referred to heroin as 'smack,' 'brown,' 'brandy' or 'gear' and crack cocaine as 'white,' 'whiskey' or 'rock.' They also used street vocabulary to describe states of drug intoxication, such as 'gouching' or drug withdrawal such as 'rattling.' Their use of slang extended to prison, which was colloquially referred to as 'the nick,' and imprisonment which was referred to as being 'locked up,' 'banged up' or 'sent down.' I was already familiar with these terms and understood what they meant from my drug use interview experience. This highlights how I was positioned in the interviews to some extent as an insider and believe that participants largely trusted that I would understand them (Hucklesby & Wincup, 2010; Miller & Glassner, 2004). I did not need to ask for language clarifications as frequently as a more novice or outsider interviewer would have done (Miller & Glassner, 2004) but it was necessary when participants used esoteric words or phrases that I did not know.

Like six quid for a prison chat, a prison chat, er how can I put it?

CT: What do you call it? A prison what?

A prison chat.

CT: Chat?

Chat, a prison chat.

CT: Chat. Ok. I've never heard that. And that means like a bag in prison?

Yeah. 'Have you got any chats?' That's what you say. (Jason)

I believe that my prior knowledge and understanding facilitated the interview flow and meant participants could talk freely. The extract below, from the very start of Kyle's interview, highlights some of the slang language sometimes used.

I was just bang on gear for years, until like about 27 year old or something. And then I thought I'd had enough of gear. But I were doing loads of snowballs and I used to do Big Issue in town and used to earn 30 quid, go up Chappy, get 15 of whiskey and 15 of brown and I used to bang them both together. (Kyle)

This quotation is now reproduced, with explanations in brackets to explain what Kyle meant by the slang terms:

I was just bang on gear (using heroin heavily) for years until like about 27 year old or something. And then I thought I'd had enough of gear (heroin). But I were doing loads of snowballs (injecting heroin and crack cocaine simultaneously) and I used to do Big Issue (a magazine sold by homeless people) in town and used to earn 30 quid (pounds), go up Chappy (Chapelton, a renowned drug dealing area in Leeds), get 15 of whiskey (crack cocaine) and 15 of brown (heroin) and I used to bang (inject) them both together. (Kyle)

During the interviewing I wondered if participants, consciously or not, tried to 'test' my authenticity, knowledge and understanding by using more street language than they might otherwise have done. However, on reflection, I think that this is unlikely and it is more probable that how they spoke in the interviews reflected their usual parlance and this resonates with other interviews that I have conducted with IDUs. In fact, I contend that they were so used to talking like this that they would not think that others would not understand them, particularly as they knew that I had interviewed drug users previously.

After the Interviews

Debriefing

After each interview, before participants left, I engaged them in a short conversation. This was to debrief participants and to steer them away from the interview, in an attempt to ensure that they did not leave feeling troubled as a result of it. Topics of conversation included how they had found the interview, asking if they had anything extra to add and reiterating what would be done with the research findings. I felt that steering them away from the main interview topics was especially important after interviews where participants had disclosed upsetting or intimate personal histories or where they seemed slightly disengaged. At this time I also reiterated the confidential nature of the research and of their responses.

No participants appeared to leave the interview in a troubled or anxious state. In some cases, they openly said that they had enjoyed the interview and found

participating beneficial. For example, those who were trying to refrain from injecting drug use said that attending the interview had kept them occupied and given them a meaningful way to spend their time. This reassured me that they did not feel troubled as a result and concurs with other researchers who have reported similar experiences from interview participants (Gilbert, 2001; Rager, 2005).

CT: I think that's covered everything that I wanted to cover. I suppose the only thing that I'd say really is really if there's anything extra to add that I haven't asked you?

No, no it's fine. It's been quite interesting actually compared to what I would've expected it to be. I just sort of expected normal question here, question there rather than an explanation into stuff. It's been completely different to what I expected.

CT: Oh so it has been all right?

Yes I quite enjoyed it actually. (Chris)

After the interviews, I debriefed with colleagues and my University supervisors. When they had been upsetting or distressing, debriefing occurred immediately afterwards. General debriefing took the form of providing supervisors with a verbal overview of who I had interviewed and what the discussions had included. More detailed debriefing sessions were also scheduled whereby on four separate occasions I sent both supervisors an interview transcript to read. We then met face to face to discuss the interview, their thoughts about it (such as areas which surprised them or which should be covered in future interviews) and my interview technique. These meetings were most frequent at the start of the interviewing stage, when I met with each supervisor twice to discuss the individual interviews. I found these meetings useful in order that I could apply learning and develop my skills and questioning in future interviews. For example, one supervisor noted that I sometimes asked more than one question within a question, so I tried to limit this as interviewing continued.

Reimbursement

As approved by the Research Ethics Committees, a £15 payment to cover 'reasonable expenses' was given to each participant on completion of the interview. This amount was carefully determined to cover travel and compensate for participants' time. The nature of the payment was carefully considered, as undue inducement could make participation and informed consent questionable (Fry et al., 2005; Ritter, Fry & Swan, 2003). Participants interviewed in services which permitted

cash payments were given the choice between cash and voucher payments, although no-one, regardless of their drug using status, opted for a voucher. Those interviewed in the probation hostels had the choice of a supermarket voucher or the money being paid directly towards their rent and all chose the voucher.

No participant refused the payment or expressed dissatisfaction with the level of remuneration, although many said that they had forgotten about receiving it. Sometimes remarks were made regarding the payment. For example, some expressed surprise that cash reimbursement was allowed, whereas others felt a little disgruntled if the service had dictated a voucher payment. I managed this by explaining to participants that I followed the services' wishes, rather than it being my choice to issue vouchers. I also tried to highlight the variety of things which could be purchased using the vouchers, and the likelihood of receiving change in cash if they did not spend the total amount. I found it interesting that men often openly stated what they would purchase with the voucher, a couple mentioning that they intended to purchase something for their child with it. Suggesting this might have been a way in which they tried to impress me and/or demonstrate that they were caring and responsible, particularly after disclosing some of their less virtuous pursuits. No current drug users interviewed said that they would use the money to buy drugs. I suspect that this was because they knew that this would have put us both in a compromised legal, moral and ethical position. Furthermore, it may be because they did not want to say things that they thought that I would not want to hear. Issues of social desirability reporting cannot therefore be eliminated altogether.

Field Notes

Immediately following the interviews, once participants had left, I wrote observation 'field notes' (Banister et al., 1994). This ensured that thoughts and ideas were recorded to complement the audio recording. Writing these notes also helped me debrief from the interview and recall individuals and their interviews in the future. The field notes formed a fieldwork diary that provided context to the interviews and could be revisited at any time. The notes were largely made up of descriptions, analytic ideas and personal impressions and feelings (Lofland, 2004).

Descriptions included participants' physical appearance and observations or experiences relating to the conduct and flow of the interview, such as interruptions. Notes were also made about how the participants engaged, acted and responded, including descriptions of any non verbal behaviour.

Participant became slightly tearful at times when discussing recent separation with partner and lack of **access** to his **children**. Was conscious not to pursue as did not want to **upset**..... Participant said had enjoyed interview and was better **than he expected** it to be which was nice to hear and glad it hadn't **been** too distressing or upsetting for him. (Field note written after interview with Chris).

Analytic ideas written in the field notes included perceptions of emerging thoughts and ideas and questions that **might** be relevant to cover in the future interviews and analysis. For example, after the **first** three interviews I noted in my fieldwork diary to explore an idea that **seemed** to be emerging about how participants plugged drugs to take with them if they **expected** to be sent to prison. These notes sometimes led to changes in the topic guide as **earlier** discussed. Further discussion regarding how they were **scrutinised** and considered to inform the analysis is provided where relevant in the **thesis**. Field notes relating to my personal impressions and feelings included **how** I **generally felt** the interviews had gone and thoughts about the personal and emotional impact of conducting the interviews and the research more generally (Wincup, 2001). I believe that having an awareness of my emotions **benefitted** the research process (Gilbert, 2001) as these helped me to hone my interviewing skills further and develop my thoughts and analysis as the research process continued.

Managing the Interview Data

Transcription

After each interview, the audio file was transferred from the digital recorder and saved as a Windows Media Audio File on a computer. The interview audio files were electronically sent (via a password protected server) to a professional transcriber with previous experience of transcribing interviews with injecting drug users who was paid to transcribe the interviews after signing a confidentiality agreement. A pre-arranged standard format was used for the transcription, whereby interviewer speech appeared in bold font and participant speech appeared in normal font. No set transcription conventions as such were followed, but displays of emotions such as laughter or interruptions were included on the transcript in single brackets if they were present on the recording. Numbers in parentheses were used to indicate

pauses in speech, and the amount of elapsed time in silence was recorded by tenth of seconds. Names of people and places discussed in the interview appeared on the transcript in order to provide context during analysis. On transcription, the transcripts (Microsoft Word documents) were returned electronically to me. The audio files and transcripts were labelled by a number rather than the participant's name to preserve confidentiality. When the transcriber returned the transcripts she sometimes commented on a participant or participants in the main, demonstrating how she was also sometimes affected by the content of the interviews.

Data Security

Once I confirmed receipt of the transcription, the interview audio file and transcription was deleted from the transcriber's computer. I also erased the audio file from the recorder, although a copy was kept on a password protected computer server. All transcripts were read and checked thoroughly whilst listening to the interview recording for accuracy (Rapley, 2004) which took roughly four hours per interview. This included making any amendments to the initial transcription or filling in sections or words which the transcriber had not fully heard or understood. This familiarisation formed an important part of the analysis approach. The checked and corrected transcripts were printed out with continuous line numbering. (A section from a transcript can be seen in Appendix 13). To ensure confidentiality and in accordance with the Data Protection Act 1998, the interview transcripts were stored securely, in a locked fireproof cabinet, which only I could access. The transcripts were labelled numerically rather than by participant names.

Analytical Process

Considering the Sample

As outlined in Chapter 1, I used a grounded theory approach to analysis (Glaser & Strauss, 1967; Strauss & Corbin, 1990; Strauss & Corbin, 1998). The analysis of the interviews using a grounded theory approach was an ongoing, iterative process throughout the research, particularly when moving in and out of the 'field' between sampling and conducting interviews with participants (Henwood, 2006). As the data analysis itself was not a distinct phase in its own right (Bryman & Burgess, 1994), I could be sensitive to personal and contextual accounts and attend to issues within and between interviews with participants as and when they emerged. This was of central importance to deepening my understanding and to developing and testing

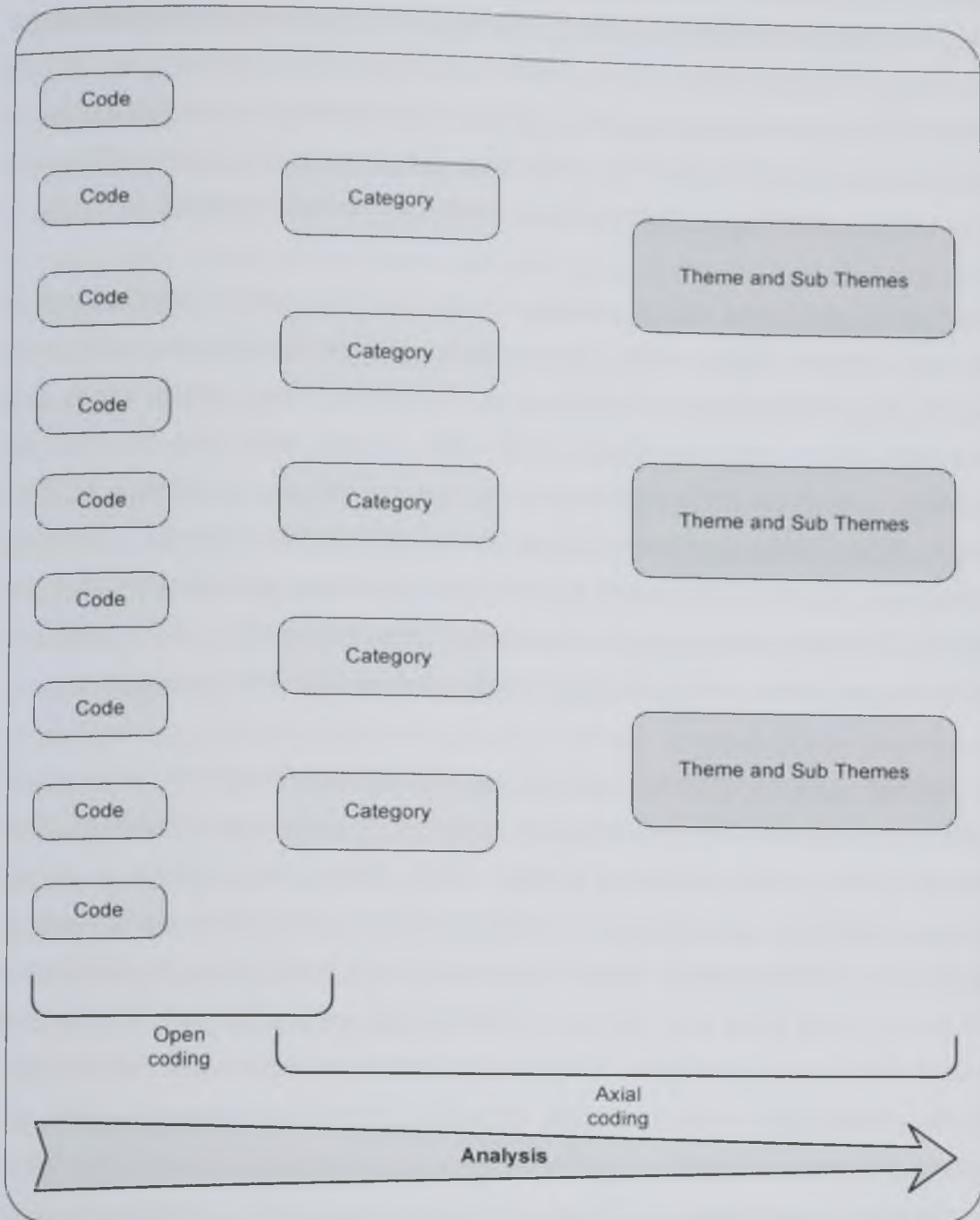
theoretical ideas in future interviews. It also informed my decisions regarding who to target and sample for subsequent interviews: that is, theoretical sampling. This process allowed ideas to develop organically to inform more formalised analysis, in line with the iterative practice of grounded theory (Henwood, 2006).

Whilst I had conducted small scale grounded theory analysis before, I felt daunted by the task, knowing that the dataset for this research was much larger. Also, I considered that the data were much more complex and intricate than I had previously worked with, and it was critical that the interpretive analysis of the men's subjective meanings accurately reflected this complexity and considered the nuances inherent in the interview accounts. Furthermore, I also considered how my own experience as a drug use researcher could affect the analysis which I conducted. The formalised analytical process was loosely divided into stages each with a number of phases, as discussed below and as summarised diagrammatically in Figure 3.3 (Strauss & Corbin, 1990; Strauss & Corbin, 1998). Where appropriate I include personal reflections on how I found the analysis generally and more specifically, which areas were more challenging. Below, I outline and fully describe the analysis procedures and practices undertaken throughout the analysis and specifically at the different analytical stages. In so doing, I aim to demonstrate the transparency of these processes and subsequently highlight the analytical integrity and interpretive validity that arises from this meaningful interpretation of the data (Henwood, 2006).

Open Coding

The first phase of open coding was familiarising myself with the data whilst still conducting fieldwork. Working through the data and immersion in it was facilitated by listening to recordings, reading transcripts and re-visiting the observational 'field' notes and memos about my ideas around the data made after and between interviews (Henwood, 2006). Systematic reading of interview transcripts started the process of open ended indexing (Glaser & Strauss, 1967), whereby I explored and noted recurring issues and ideas present in the interviews. This took up to a day per transcript because each transcript spanned up to 30 pages of A4 and these were all read line by line, passage by passage whilst notes were made. After this first reading, I re-read some or all of the interview again to obtain a clearer and more contextualised understanding of the discussion.

Figure 3.3 – Overview of Grounded Theory Analytical Process



On reading the transcripts it became apparent that the participants sometimes appeared to have an excellent ability to present plausible accounts and a self-effacing self-presentation. This had not been as immediately obvious to me when in the field and it was only during the analysis when I had more distance that I considered this more deeply. It was during this reading that I was also more able to consider what participants may have neglected to tell me in the interviews and why this may have been the case. How they told me certain things also had to be

analytically questioned, as there were obvious differences in the telling of some accounts. For example some appeared to be more 'rehearsed' or matter of fact, possibly as a result of having told them a number of times whereas others appeared to be more nonchalant or blasé. I also noted these things in my fieldwork diary during the coding in order that they could be re-visited as the analysis progressed as I found the contradiction between what they sometimes portrayed as their complex lives but their sometimes simplified or matter of fact renditions of them interesting.

Familiarisation and open ended indexing facilitated the iterative development of codes and tentative labels which represented areas of significance which were discussed and re-occurred in the interviews. During the open coding stage, data were broken down and examined. From this, codes were derived from the participants' narratives and descriptions to encapsulate the meanings in them accurately. Many codes were identified and these were labelled, revised, condensed and developed as more information pertaining to the areas was identified from the transcripts. This was assisted by the constant comparison method of checking and adjusting derived codes and labels against the interview data where necessary.

More detailed coding followed, whereby each interview transcript was worked through systematically, line by line and passage by passage (Charmaz, 2006; Strauss & Corbin, 1997; Strauss & Corbin, 1998). During open coding, a concise summary of each line or passage was written and was attributed to the appropriate code, or into a 'miscellaneous' code if it was initially not clear where the information should go or where there was not yet a suitable code where the data fit. This was conducted electronically, whereby the transcript summaries were typed into Microsoft Word documents, with one document for each code. Any response from any participant that was relevant to a particular area was labelled and succinctly coded on the same document together. The participant interview number and the transcript line reference number were included next to the summary to provide a clear audit trail as to where the summarised information was discussed in the interview and to facilitate revisiting the transcript should this be required. Sometimes during this process a quotation which highlighted the code well was identified from the transcript. In these cases, this was highlighted and electronically added to a Microsoft Word document which was developed for the particular code. Overall, this coding process culminated in one document covering all summarised responses from all participants per identified code and a further document of quotations associated with each code.

Whilst the use of computer software packages such as MAXqda, NVivo and Nud*ist has become more popular over recent years to assist with the analysis of qualitative data (Seale, 2000), none were used for the current study. This was a conscious decision which I made and was based on a number of overlapping factors. Whilst I had previously used some of these packages, I was concerned that the structure of the types of software programmes may limit the nature of the Grounded Theory analysis or may potentially force me (unknowingly) to analyse the interview data in a particular way. Furthermore, from a practical perspective, I considered that the main benefit of these qualitative computer software packages was that they would assist with the ordering and structuring of the collected data, rather than performing any of the actual analysis and producing outputs akin to quantitative research software (Neale, Allen & Coombes, 2005). Yet, I was already familiar and confident with using Microsoft Word for assisting with sorting and structuring interview data and for conducting complex and voluminous qualitative data analysis and I did not perceive the benefits of sorting and structuring in a software package to outweigh performing this using Microsoft Word. Moreover, from my experience of using some of these software packages in the past, I felt that I better engaged with my data when I could read a printed out transcript and jot down notes by hand rather than reading a transcript on a screen and noting early thoughts or electronically writing memos. Whilst I did not use a formal qualitative computer software package, I used some of the functions available within Microsoft Word to assist with the analysis process, such as the identification and retrieval of specific words, phrases or participants through the search facility and copy and pasting saved time when entering data that pertained to more than one theme.

Open coding was a flexible process which allowed all data to be coded and for it not to be forced into the codes. During open coding, care was taken that the summaries 'fitted' the data and provided a recognizable description of what was said (Pidgeon & Henwood, 1996). Particular care was given to data which seemed to contradict the direction of coding so that the analysis did not oversimplify the participants' meanings. Ensuring that the summaries 'fitted' the data was achieved by reading sections of the interview to understand the context in which the issue was being discussed. Thus whilst the codes developed were my interpretation of the data, they are grounded in it. Furthermore, care was taken to keep the summaries as close to the transcript data as possible, such as by using the language, terminology and descriptions used by participants in the interviews. As an example, a section from the code 'fear' (which encompassed the fear of going to prison, fear when in prison and

fear linked to using drugs when in prison) and how the data were carefully and succinctly summarised and linked to the participant and to the relevant part of their transcript can be seen in Appendix 14.

During coding, the codes and labels were checked against successive transcript passages, reflecting the flexible nature of the process. After initially analysing and coding each transcript the content of each was scrutinised to check that it accurately described the interview data attributed to the code. This allowed for codes to be revised and renamed if necessary to better reflect them if more information gleaned from the interview transcripts allowed as the open coding continued and developed. For example, 'plugging' (referring to participants anally storing drugs to smuggle into prison with them) was identified as an early code and passages whereby participants spoke about anal storage of drugs to take into prison were coded under this. However, as initial coding continued it became apparent on reading more transcripts that anally storing drugs was not the only way participants had smuggled drugs into prison, either concealed in their body or otherwise. The code was re-named, 'taking drugs in: preparation, planning and plugging' in order to reflect this and the transcripts were coded accordingly. This name change was felt to be important as the new name also encompassed a more psychological element to the taking of drugs into prison, covering their reasons and thoughts behind such planned and deliberate action, and this information was therefore also coded within it.

Many of the open codes identified overlapped and are inter-connected. This highlights the complexity of the data, the issues inherent in them and the level of coding that was applied. Similarly, a section of a transcript could be coded with more than one code. Where there was overlap between codes, a note was made under the entry on the Microsoft Word document and a link was made to the relevant other code(s). An entry was also made on the linked code, and was shown by writing the name of the linked code next to the summarised entry in capital letters. For example, when participant 9 spoke about his fear of 'rattling' (withdrawing) from drugs in prison (see Appendix 14 entry 9 line 607), summaries were entered on the 'fear' and the 'rattle and withdrawal' code documents. Participants' drug use accounts often spanned many transcript pages or ran recurrently throughout large sections of the interviews. As such, care was taken during analysis to tease out participants' prison drug use behaviours. 'Deviant' cases or experiences, that is those reports or instances that did not easily fit with the majority of others or with my own ideas about the data, were noted during the coding (Mason, 2002; Silverman, 2006). What

participants reported and how they discussed it was also included in the relevant coding documents. I noted my analytical thoughts and questions about the differences in individuals and/ or their experiences in my fieldwork diary as they occurred to me in order that I would be able to consider them during the later stages of the analysis such as when developing explanations. The findings from the categories identified from the open coding are presented in Chapter 5.

After coding, the coded data were further inspected. This was assisted by the Microsoft Word documents which organised and brought together all aspects of the data pertaining to a particular area. Inspections of the coded data entered onto these documents therefore took place and the data within and between these documents were compared. This inspection led to the codes which pertained to similar phenomena, events and experiences being clustered together, grouping and organising like with like. This clustering of conceptually similar codes formed categories, which mainly related to prison drug use and time spent in prison. Categorisation was aided by the overlapping nature and complexity of some of the codes identified. For example, codes such as 'being young and having fun', 'the influence of others', 'pleasurable effects', 'drug naivety' and 'the dawning of addiction' were clustered under a category of 'initiation and continuation of drug use in the community'.

When conducting the early analysis, I sometimes felt overwhelmed by the volume and complexity of the collected data. Having the staged approach to analysis and regular meetings with my supervisors helped to manage these feelings. In addition, I also sometimes felt frustrated, for example if I read a transcript or section of a transcript where I had not followed up the interview responses with suitable probes or prompts to seek further information and/ or clarification on certain issues. I could do little about these things other than have them as learning points for future interviews.

At times I also felt so close to the data and to some of the issues surrounding injecting drug users and the accounts provided that I was almost unable to disentangle what was analytically and theoretically important to decipher from what I already knew and thought about injecting drug use. In these cases I had to take a step back from the interview data, to ensure that I looked at it in a more detached fashion. This was important in order that my previous experience of conducting drug use research did not colour my understanding and interpretation of some of the issues. For example, when doing this, I had to try to make what over the years had

become almost normal and ordinary for me to hear from injecting drug users as not normal and extraordinary. I did this by considering things such as what participants had said, how they said certain things and the language they used. I also speculated on the context in which the interview interactions occurred and tried to consider my role in the production of the interviews and how these things could have a bearing on the construction of information provided by participants and how I used and interpreted this information (Miller & Glassner, 2004). In trying to disentangle issues within the analysis, I also found discussions with my supervisors helpful as they offered different and beneficial analytical ideas on account of their reduced familiarity with researching drug use. As I initially found taking an objective step back to a more outside position from the interviews quite challenging, I considered it important to note any preconceptions to the research and debate my own influence on the data and on its interpretation in this thesis. I believe that in doing this and in continually considering and questioning my different perspectives throughout the analytical process, it strengthened my understanding and subsequent ideas and interpretation.

Axial Coding

The analysis conducted for Chapters 5, 6 and 7 (from codes to categories) was developed as the process of analysis continued. The latter stages of the analysis involved axial coding, whereby thematically similar codes and categories were integrated and clustered together at a higher level of abstraction as a theme (from categories to themes). Through this axial coding process six super-ordinate themes were identified and linkages between them were established at a conceptual level (Strauss & Corbin, 1990). These themes all implicitly permeated the data and represented attributes of injecting drug users and the contexts of their lives which impinged and impacted on their drug use. Establishing these linkages was assisted through comparing data and writing memos of my conceptual thoughts and ideas while immersed in the data (Glaser, 1978) during the later coding and categorising. For example codes such as pleasurable effects, relieving boredom, escalation of crime and snorting buprenorphine described in Chapters 5, 6, and 7 and categories such as drug effects were clustered into the broad theme 'desire for excitement' as this captured their similarity and content at a more abstract level of meaning (Strauss & Corbin, 1990). Furthermore, codes such as the dawning of addiction, the cycle of drugs and crime, inevitability and relief and being caught and categories such as criminal activity and behaviour clustered into the broad theme 'living on the edge'. Each of the six themes identified had at least two sub themes attached to it. I found this higher order categorisation of the data less daunting and complex as other areas

of the analysis. This might be due to the familiarity which I had with the data by then from conducting the interviews, re-listening to them and the open coding stage. I also consider that this was facilitated by coding summaries of the interview data onto the Microsoft Word documents as these were easier to re-visit to check ideas than returning to the interview transcripts.

Towards Theory Development

The final stage of the analysis builds on that reported in Chapters 5, 6, 7 and 8 and is presented in Chapter 9. In Chapter 9 two models associated with drug use in prison which were derived from the staged approach to the interpretive and rigorous analysis of the interviews are introduced and described. In developing the models more selective working through individual interview accounts was initially conducted, in order to consider how individual participant experiences compared to those of others and identify similarities and differences amongst them. The analysis undertaken for the development of the models is described within that chapter.

Study Strengths and Limitations

The main strength of this in-depth study is that it gave men with a history of injecting drug use and imprisonment a voice to facilitate the disclosure of information regarding their drug use behaviour in prison. In so doing it provides an updated qualitative psychological perspective about men's illicit drug using practices within prison since the Updated Drug Strategy in 2002, one of the first studies to explore this for a number of years, particularly from this perspective. Furthermore, the choice of the grounded theory analytical technique for the study allowed the constant comparison and approach to sampling that gave rise to the findings and to the models described. Indeed, as a result it has some practical implications for those working with injecting drug users in prison and in the community.

A further strength of the current study relates to the rigour with which I believe that the research was conducted. Reliability in qualitative research focuses on identifying and documenting recurrent, accurate and consistent themes and patterns as they are found and develop from the data. In the current grounded theory research, this was facilitated by meticulous record keeping, the writing of memos and having comprehensive, computerised analysis documents that act as a transparent audit trail of analysis and analytical developments which can be revisited by other researchers.

However, while qualitative research does not attempt to generalise in the same way that quantitative research does, the research has some limitations. These are important to outline as they may impact on the transferability of the findings. Most significantly, it is a relatively small scale exploratory study conducted in one county in England. As such, the findings cannot represent every experience of men who had injected drugs and been in prison and they may not be extrapolated to the wider English former male drug using prison population, less so to the wider international scene. In line with rigorous qualitative research practice, every attempt was made to access a range of eligible men who had been in prison by using a two-staged approach to sampling and recruitment, by recruiting participants through services and peer referral, and by recording and monitoring the criteria of those sampled. Yet, the main limitation is of the self selecting nature of the sample, accessed largely from community services. To some extent, this criticism is a feature of qualitative interview studies which, like all research, rely on the voluntary participation and collaboration of willing participants.

Further limitations relate to the generalisability of the findings. As the study focussed on adult men, it is unable to say anything about how transferrable the findings are to women injecting drug users who have been in prison or about young offenders in relation to their prison drug using experiences and this must be borne in mind when reading the findings that follow. Although most participants were interviewed within six months of their last prison release and 23 were interviewed within a year of their last prison release, recall bias and/ or social desirability reporting might affect their reflective accounts of their previous imprisonments, especially those released more than six months previously. This is an inevitable consequence of retrospective research and a limitation of the study. Furthermore, the research did not always consider the different security categories of the prisons in which the men had served and talks about the general experience of imprisonment, rather than making distinctions between the experiences of drug users within prisons of different security categories which may influence prisoners' drug using experiences in a variety of different ways. However, within these limitations, the study highlights how the social and criminal background of prisoners combined within the environment of the prison setting to contribute to the nature of drug use in prison and of the impact of imprisonment on injecting drug use and male injecting drug users.

Chapter Summary and Discussion

This chapter has focussed on the practical application of the methods chosen for the study. Whilst it is possible to conduct qualitative and/ or quantitative research with drug users in prison and many studies have done this (as identified in Chapter 2), it was felt that the ethical challenges linked to identifying, recruiting and interviewing men in prison with a history of injecting drug use and talking to them about their prison drug use were too great to address for this study. It was not the scale of these challenges, but the implications of them that I questioned. For example, identifying prisoners to interview in prison would raise issues of confidentiality (Mitchell & McCarthy, 2001) and I had concerns over the accuracy and quality of the data which might have been reported about illicit prison drug using practices if the study had been conducted in prison (Boys et al., 2002; Hucklesby & Wincup, 2010). This was because prisoners may have been more reluctant to share this information with a researcher who they did not know or trust for fear of their responses being used against them, such as being reported to the prison authorities. Like many qualitative studies, interviews were therefore conducted retrospectively to minimise the potential risks linked to taking place in prison. As such, reports about men's lives, experiences of substance use, involvement in criminal activities, imprisonment histories and personal circumstances were recounted years after the events. As in all interview studies, the reliability of participants' recollection of events and the issue of socially desirable reporting must therefore be deliberated, despite shortening the period of recall by stipulating that to be eligible to take part, they had to have been released from prison since 2002. Issues of social desirability reporting and the accuracy of recollection and self-report have been considered when reporting and interpreting participants accounts in the chapters that follow.

Despite having sampled and interviewed injecting drug users for research prior to the current study, the interviews were at times challenging to conduct and tested my skills and experience as I had not interviewed about prison before. Furthermore, interviewing some former injecting drug users about their drug use at times required subtle changes in my interview approach and tested my techniques. Whilst every effort was made to access a diverse range of participants through a variety of methods and a range of services, the self selecting nature of the sample cannot be ignored. This will be considered in the analysis and in the discussion of the findings. The following chapters report the study findings as identified through the analysis described in this chapter.

Chapter 4 - Description of Participants

As discussed in Chapter 3, the sampling strategy was chosen to ensure that a range of men who had both history of drug injecting and imprisonment were included. The purpose of the current chapter is to provide a brief descriptive overview of the study participants in terms of their demographic characteristics and personal and social circumstances such as substance use, criminal activity and housing which they reported in the interviews. Obtaining specific information on these areas was not a central part of the research so no structured instrument was used to collect this and ensure consistency. Rather, this information was collected from the pre-interview information slips and from the self-report interview discussions which employed checks to confirm and validate the information where possible. Presenting this provides important contextual information for the reader, which will be later drawn upon in the analysis and the discussion of the findings.

Demographic Characteristics

Age and Ethnicity

Thirty men were interviewed for the study. They ranged from 20 to 50 years of age with a mean age of 34 years (SD 6.99). Most of the men were White British (24), two (Bobby and Andy) were Asian British, two (Gordon and Al) were White Other, one (Benji) was Black British and one (Adam) was Black Caribbean. Participants demographic information as taken from the completed pre-interview information slips is shown in Table 4.1 and brief summaries of each participant in terms of their demographics and life situations are provided in Appendix 15.

Table 4.1 - Participant Age and Ethnicity

Pseudonym	Age (years)	Ethnicity
Bryan	34	White British
Jason	33	White British
Paul	41	White British
Benji	38	Black British
Rob	34	White British
Derek	31	White British
Jack	20	White British
Chris	38	White British
Pete	24	White British
Matty	26	White British
Ian	29	White British
Gareth	29	White British
Jeff	33	White British
Tony	38	White British
Eddy	36	White British
Kev	42	White British
Wayne	34	White British
Adam	42	Black Caribbean
Sean	32	White British
Steve	35	White British
Barry	46	White British
Jamie	29	White British
Clive	50	White British
Justin	32	White British
Keith	39	White British
Gordon	46	White Other
Bobby	26	Asian British
Kyle	28	White British
Al	32	White Other
Andy	26	Asian British

Childhood and Early Life Experiences

Participants' childhood and early life experiences generally included their reported experiences of care, their siblings and information about their education and schooling.

Experience of Care

Six men (Matty, Pete, Gareth, Eddy, Bobby and Al) reported in the interviews having been brought up for some or all of their childhoods in the care of the Local Authority

Social Services, including children's homes and foster homes. Gareth, Bobby and Al reported having experienced some form of abuse whilst living in care, resulting in Bobby running away. Gareth said that he had been in care since he was aged three.

I've been in children's homes all my life, foster care, I was, even from the age of three year old. I think I've been in about six or seven times in foster care. Some of the families that I were with tried abusing me. I got abused by a baby sitter as well when I was a kid and then I think I just went my own way. When I were 13 year old me older sister became my legal guardian. (Gareth)

A further man, Jeff, told me that he had been sexually abused when he was younger by a babysitter.

Siblings

Participants sometimes talked about their relationships with their siblings. Gareth and Kev had been brought up and cared for by their older sisters. Siblings were also said to have sometimes provided participants support, money and accommodation, such as on release from prison and when fleeing violence. Men drew similarities between themselves and their siblings in the interviews. Five men said that their siblings were current or ex drug users (Matty, Ian, Kev, Keith and Andy). Ian had committed crime with his brother. Two men (Chris and Ian) had been in prison at the same time as their brothers and Matty at the same time as his cousin. Eddy had a brother who had also been in prison. Gordon claimed that his three brothers had been murdered and Chris had two alcoholic brothers.

Some participants such as Pete and Kev were keen to identify how their siblings were different from them in some ways. In these cases, participants believed that they themselves had made the 'wrong' choice by using drugs and committing crime.

I were a crook before I started doing heroin and stuff like that. It's, it's just something in you. I mean my dad never committed a crime, my mum never committed a crime, my two brothers and me sisters have never committed a crime. It's just I chose, I had two paths to go down and went down wrong path. (Kev)

Education and Schooling

Discussions regarding education rarely featured in the interviews. Rather, the brief discussions around school focussed on the trouble that the men had got into when they were at school. Other discussions focussed on how the men had not always attended school when they were younger. Instead they reported missing school and occupying themselves with what they considered as more enjoyable (often illegal or antisocial) activities with their friends and peers. This was often linked to experimenting with alcohol and drugs. Bobby, an Asian British man mentioned that he and his sister had been bullied at school due to the colour of their skin. Leaving school or college at a young age with few or no qualifications was commonly mentioned. Only Al spoke about having attended university, although it was unclear if he completed the course as this was when his drug use escalated.

Substance Use

Participants' alcohol and illicit drug use was discussed at length in the interviews. The findings relating to drinking alcohol are presented here, but as those pertaining to their use of illicit drugs are the focus of the current study, they are only briefly mentioned as they are fully presented in subsequent chapters. For example, their experiences of starting to use drugs are described in detail in Drug Initiation and Continuation in the following chapter and their prison drug initiation experiences are fully described at the start of Chapter 6.

Alcohol

Three men (Paul, Jeff and Kev) described how they used to be alcoholics, having started drinking at a young age (from 11 years old). For them, their illicit drug use started some years later. Chris and Tony described heavy alcohol use in their pasts, although their drinking stopped when they experienced problematic health consequences. Chris and Jeff stated that their fathers were alcoholics. Four other men (Benji, Adam, Jamie and Kyle) said that they used alcohol occasionally when they were not using, or trying to stop using illicit drugs, although some expressed concern that they may swap one addiction for another if their drinking became heavy. Others said that they did not drink as they did not always have friends who they could do this with.

Illicit Drug Use

The men retrospectively described long and complex histories of using illicit drugs. Overall, their illicit Class A drug use histories ranged from four to 26 years. In general, they described that their illicit drug use started with the recreational use of Class B and C drugs including cannabis, solvents and hallucinogens (such as magic mushrooms and LSD), and later stimulants ('uppers') (such as amphetamine and ecstasy) early in their teenage years, when socializing with friends. In general, this was described as a time when they experimented with stimulant drugs as recreationally using them helped them have a good time and stay awake longer and cemented their friendships. Staying up late through using stimulants often led participants to experiment with depressants ('downers') and using heroin later in their teenage years in order to help them to overcome ('come down from') the stimulation. Whilst amphetamine had been popular and a drug that they had used in their younger years, many had stopped using this drug as their use of other drugs developed. Only one man at the time of interview was an amphetamine injector.

Use of the stimulant crack cocaine use was said to have largely started some months or years after men had started using heroin, often after they had been given it to try for free by drug dealers. For all men, their illicit drug use was said to become less recreational but more entrenched and the focus of their lives as their illicit use progressed. Polydrug use, the use of more than one illicit drug at the same time, such as using heroin and crack cocaine together, was also common and men explained how it was often hard in recent years to be able to purchase heroin and crack cocaine separately from drug dealers. At the time of interview, most men were currently using heroin, mainly by intravenously injecting although two men said that they were smoking it. Some participants were also using crack cocaine, either by injection alongside the heroin or by smoking. In addition, twenty seven out of the thirty participants were in receipt of daily opiate substitute medication at the time of interview, either the prescription of methadone or the medication, buprenorphine, either as detoxification or maintenance prescriptions. Whilst information on participants medication dosing was not collected systematically from them, they sometimes spoke about their current doses in the interviews. These ranged from 25ml to 125ml of methadone a day. A number of the men who were on prescribed medication said that they were not using illicit drugs in addition to their prescription at the time of their interview, although at least half of them were still using heroin on occasion, with at least five men reporting to be using heroin every day alongside their prescribed substitute medication.

The participants continued use of Class A drugs is discussed in much further detail in Chapters 5, 6, 7 and 8, including the consequences which they attributed to their drug use and their feelings towards it. More information regarding each individual in terms of their drug use is also provided in the participant summaries in Appendix 15.

Criminal Activity and Behaviour

Committing Crime

Men revealed long and complex histories of antisocial and criminal behaviour. For most, their criminal activities were linked with their use of illegal drugs as they needed money to purchase drugs and crime proved a quick and easy way of obtaining this. The men spoke of having committed many different crimes, most commonly, theft through shoplifting and selling drugs. Some participants said that they had been involved in serious, organised crime, often operating on behalf of members of the criminal fraternity and large scale drug users. The consequences of this were not limited to being in trouble with the law but sometimes extended to being 'wanted' by other criminals seeking retribution, including receiving death threats from them. Begging, residential or commercial burglary, armed robbery (with a knife or gun) and fraud were also discussed as ways men had obtained money to spend on illicit drugs. Other crimes which the men said that they had committed and been charged with included violent offences such as assault causing actual and grievous bodily harm (ABH/ GBH) to their victims. At least two participants reported hospitalising their victims through their use of violence. Driving offences, covering theft from vehicles, driving with no insurance or no license and taking cars without the owner's consent (TWOC) were also mentioned. Whilst most crimes were drug related in some way, more direct drug crimes included drug dealing for themselves or for drug dealers either through portioning drugs into different sized deals, selling the drugs or collecting money for drugs. More detail regarding the nature and extent of their criminal activities is provided in later chapters.

Imprisonment Histories

Being sent to prison when the men were young was a common experience, having been sent to detention centre, borstal or young offender institutions, usually at the age of 15, 16 or 17. These men also later served in adult prison establishments when

they were older. Some men had not spent time in a young offenders' institution when they were younger, but went straight to adult prison.

Between them, participants reported having served in over 35 different adult and young offender prison establishments throughout England. Their sentences ranged from a few weeks to ten years, reflecting the seriousness of the crimes committed. This is reflected in the self-reported length of their last sentence, which ranged from two weeks to seven years with a mean of 21 months (SD 22.83). In total, the men said that they had served a number of custodial sentences, ranging from one to 60 with a mean of ten times in prison (SD 12.66). It was not possible to verify the number of custodial sentences participants claimed to have received or the length of previous sentences. Accordingly, I was sometimes sceptical of their reports, particularly Steve who said that he had been in prison at least 60 times by the age of 35 and Eddy who reported 42 prior prison sentences by the age of 36. Those who spoke of being in prison many times said that they had usually received a number of relatively short sentences, typically up to a maximum of 12 months' duration for what the courts considered as less serious crime. After release from a sentence, they were often caught committing further minor offences and were sent back to prison.

Table 4.2 below summarises participants' reported prison histories. Information on the length of last sentence and the year of release was identified from the completed pre-interview information slips. The offence for which they were last sentenced was gleaned from participants' interviews. The offence is presented according to how they described it, not according to formal offence categories used by the police and the courts. For example, Jamie said that he was last sent to prison for 'stabbing someone' rather than saying how it had been formally categorised. There is missing information regarding Eddy's last offence sentenced for, as this was not disclosed.

Table 4.2 - Participant Prison Histories and Last Prison Sentence

Pseudonym	Times in prison	Year last released	Length last sentence (months) ²⁸	Nature offence last sentenced for
Bryan	18	2006	2	Arrested for manslaughter and supply
Jason	10	2006	30	Burglary
Paul	4	2006	6	Shoplifting
Benji	5	2006	3	Violence
Rob	20	2006	0.75	Shoplifting (deliberate)
Derek	1	2004	0.5	Shoplifting
Jack	1	2006	36	Robbery
Chris	8	2005	24	Assault
Pete	2	2003	4	Shoplifting
Matty	6	2006	16	Breach DTTO ²⁹
Ian	3	2006	84	Burglary
Gareth	7	2007	24	Shoplifting, assault and carrying offensive weapon
Jeff	1	2006	60	GBH with intent
Tony	7	2006	3	Possession with intent to supply
Eddy	42	2006	8	Unknown as not discussed
Kev	20+	2007	18	Allowing house to be used for sale of drugs
Wayne	9	2007	1.5	Shoplifting
Adam	4	2007	3	Shoplifting and driving with no insurance
Sean	7	2007	24	Assault
Steve	60-70	2005	10	Violence
Barry	5	2004	48	Drug dealing heroin
Jamie	8	2007	54	Stabbing someone
Clive	2	2007	60	Demanding money and false imprisonment
Justin	3	2003	6	Shoplifting
Keith	18	2007	45	Robbery with a knife
Gordon	5+	2007	5	Shoplifting
Bobby	7	2007	4.375	Shoplifting
Kyle	10-11	2007	5	Shoplifting, assault, fail to appear and breach of bail
Al	1	2005	48	Possession with intent to supply
Andy	15	2007	5	Assault

²⁸ The length of the prison sentence given, not the length of time served.

²⁹ Drug Treatment and Testing Orders (DTTOs) were introduced in 1998 as intensive community sentences lasting between six months and three years for drug misusing offenders. Under DTTO sentences offenders were required to be regularly drug tested, attend intensive treatment and rehabilitation programmes and have their progress regularly reviewed at court. DTTOs were replaced with Drug Rehabilitation Requirements (DRRs) in 2005.

Personal Circumstances

Participants described that their lifestyles, largely the pursuit of drugs and crime, frequently affected their physical and mental health, relationships with family and friends, domestic situations and their employment circumstances.

Physical and Mental Health

The feeling that illicit drug use caused both mental and physical health problems was frequently expressed in the interviews. The men spoke of long histories of mental ill health, such as depression and schizophrenia and many had been prescribed medication and received counselling for this. A few (including Jeff, Tony and Kev) said that they had experienced psychosis linked to the use of stimulants, such as amphetamines or crack cocaine. Some men, including Chris, Gareth and Justin described previous self harm or suicide attempts.

I have tried once before, killing myself. (Chris)

Physical ill health and general wellbeing was also linked to drug use. General poor health was evidenced through bacterial and viral infections and drug injecting related complications such as deep vein thrombosis, cellulitis, blood poisoning, ulcers, blood clots and blood-borne virus infections such as hepatitis C.

When I started injecting in me groin I got a lot of problems. I got a clot on me lung twice, I got cellulitis, blood poisoning twice, so that's why I am off it now, just 'cos of all the health problems. I was basically going to lose a leg, or both legs or I was going to die. So I'm quite lucky to be here. (Derek)

Participants described suppressed appetites and reduced food intake while using drugs. This inevitably resulted in significant weight loss, and some described weighing as little as seven or eight stone (or 51 kilograms) at the height of their drug use. Drug use was also described as affecting participants' appearance and levels of cleanliness, as their preoccupation with acquiring and using drugs superseded the maintenance of their personal appearance and hygiene.

Your personal hygiene just drops, you end up stinking, looking mucky, you never get changed, you never go in bath, you never eat. (Kev)

It was apparent that men saw their time in prison as having a more positive effect on their physical health, as they were able to eat properly by having three meals a day in contrast to their lifestyles in the community. This helped them to put on weight. Further, they engaged in physical activity such as going to the gym which they would not normally do whilst in the community, again contributing to improved physical health. They also described sleeping more in prison than they did in the community. For these reasons, Bryan and Jason referred to prison as a *'health farm'* as they looked and felt healthier when they left compared to when they were sentenced. However, prison was not necessarily viewed as beneficial for the men's mental health, with an overwhelming feeling that the monotonous and tense nature of the prison environment could contribute to, and compound, depression and anxiety.

Relationships with Family and Partners

Men described their relationships with their families if it was of significance within the interview. Discussions often centred around how much trouble they had caused for their families when they were younger. These tensions were said to have been exacerbated with increased contact with the police and criminal justice system because of their antisocial and/ or criminal behaviour, fragmenting some relationships, particularly when they had been sent to prison for the first time. In some cases, participants said that their illegal behaviour and imprisonment had strained their relationships so much that their families had disowned them. Benji and Barry described how they were estranged from their families, having not seen their mothers for a long time. Some men, including Paul, Chris, Jamie and Gareth had tried to keep their drug use or substitute opiate prescription secret from their families for fear of how it would affect the relationships.

Half the time I used to lie to them (father and sisters) and say that I wasn't on gear (heroin). I used to say that I was on amphetamine, taking speed and pills all time. But I wasn't obviously, I was on the crack and the heroin. And once they found out they just disowned me. They just didn't want to know. (Gareth)

Other participants spoke of still being in contact with their families, although the relationships were difficult. This was often because the participant's families had told them that they could not forgive them for things that they had done whilst using drugs. Examples include lying to their families and stealing from them as these actions had caused family tensions, hurt and upset.

I lost everything through heroin, I lost all my family, you know what I mean? I was in their house, I was nicking (stealing) their rings, their gold chains, it was just terribly wrong. But as I mentioned the only, when it happened, right obviously all you're interested in is heroin, but after you get arrested and you're locked up you're off of the heroin and you lie in the jail and you think fucking, that was out of order, I've done this and I done that, and I done that and I done this. And then you get out and it all happens all over again. You just goes round in a circle. It's madness. (Keith)

Some men said that they were particularly distressed about this and had only realised how their behaviours had caused problems for their families since their drug use had reduced or stopped. At times, they seemed quite remorseful in the interviews about this. Whilst it appeared that they wanted to make up for their previous behaviour and their family relationships had improved, they acknowledged that they had caused too much hurt and upset for their families to fully forgive them and for the relationships to fully recover.

I'm just glad we (him and mother) are talking. I'm just glad we are getting on. I'd love it to be back how it was but it will never get like it was again. I can't see it ever being like it was again because so much has happened you know. I've hurt her so much. (Pete)

In other cases, the men's post hoc reflections revealed that they felt that their families were responsible for their drug use and criminal behaviour. Being left by their parents and growing up in care had led to participants including Kev and Matty feeling neglected and the actual experience of physical and sexual abuse (Gareth, Bobby and Al). In Chris and Jeff's circumstances of having an alcoholic father, or, in Tony's case, feeling that his parents were unable to talk to him and did not want to know him, were said to have also affected family relationships. In such cases participants drew a link between these experiences and their drug use.

I went into care at six year old. None of me family wants to know me and that. So I just started using, I started using from then on. I thought well, you know what I mean, if nobody cares why should I care about myself? (Matty)

A few men described having family support which they felt was especially important when trying to stop using drugs. This support was mainly practical, such as providing

them somewhere to live. Families had also provided emotional support, in the form of encouragement not to use drugs or writing to the men when they were in prison. Financial support was also mentioned by participants as something sometimes provided through their families in order that the men could buy drugs rather than commit crime for the money. Family provision of financial assistance also extended to when the men were in prison to allow them to buy provisions.

Some participants stressed the love and emotional support they provided to their families. For example, Steve was living with, and caring for his dying father and Andy wanted to care for his ill mother in the future. In analysing the interview accounts I questioned why participants told me such things. I considered that participants revealed a more compassionate and caring side to their natures, possibly as a result of having reflected on some of their previous behaviours when in prison. In so doing, they identified that whilst they had engaged in illegal pursuits they were capable of having, or at least wanting, more 'normal' lifestyles in their futures. I consider that I had no reason to not believe these claims, particularly when they were made by men who claimed that they had stopped or reduced their drug use.

Whilst participant sexuality was not formally ascertained, the men presented heterosexually. The majority of participants were single. At the time of interview only Bryan reported being in a stable relationship, living with his girlfriend. Kyle and Andy said that they lived with their partners but described the relationships as unstable and expected them to end soon. At least four had been married, although the relationships had since broken down, some after many years. Splitting up with a long term wife or a partner was described as particularly upsetting. These feelings were intensified if the couple had children and the relationship had ended as the men were often unable to see or spend time with the children.

She (ex) proper screwed me head up like do you know what I mean? Proper. And she wouldn't let me see my kids. (Tony)

Spending time in prison was said to compound the situation as men were unable to care for partners and families. Men described how they often dealt with an upsetting break up by using or starting to use drugs again.

Fatherhood

Nearly half of the participants said that they had children, aged between 18 months and 23 years of age and at least one man had a grandchild. Only Bryan, Jason and Andy lived with their children – Bryan and Andy with the child/children and their partner (who was also the child/children's mother). Jason lived alone with his son following the mother's recent suicide. Most other participants discussed how they were either estranged from their (ex) partner and children or how they had sporadic and limited contact with them. This was linked to not having anywhere stable to live where their children could stay, not wanting their children to see them whilst they were using drugs, the children having been 'taken away' by the mother or not having formal arrangements to see them.

I don't see my kids because of my drug use, do you know what I mean? It's not a nice environment for them to be around. (Tony)

Rectifying this situation and having contact with their children and grandchild was discussed as a major factor motivating the men to stop or reduce their drug use.

Death of Family and Close Friends

The experience of bereavement was frequently discussed by the men. Bobby had been bereaved by both parents during his early teens. Gareth, Kev and Justin said that they had also lost a parent, Kev, at a young age. Gareth had also been bereaved by his girlfriend at the same time and Kev had also experienced the death of his son. At the time of interview, Steve and Andy each had a dying parent. Gordon described the murder of three brothers. Bereavement of close family members was often reported to have affected a man's drug use, as using drugs was described as helping them to cope with bereavement.

You tend to take heroin or drugs to hide your emotions, because I'm going through like bereavement counselling and I haven't sorted my problems out. The only way I've done it is by using drugs and I've just hid them over the years, because like when I first started my Mum passed away, that's why I started. My Mum and Dad passed away so I started using at an early age, about 15, 16. (Bobby)

Jason had recently been bereaved when his ex partner, the mother of their teenage son, committed suicide. Paul and Jeff linked the death of their grandmothers when they were younger with their drug and alcohol use. Jeff said:

It was the deaths of both me nana and my grandma dying relatively close together, like four weeks to the day apart because really me nana and my grandma looked after me most of the time when I were younger, when I were like a baby. And up to about the age of about five or six or seven I'd stay with them, you know alternately, while me mother and father went to work so they more or less brought me, you know looked after me a quite a lot when I were young. So I were really close to them and I don't think I handled it very well and I turned to drugs. (Jeff)

The death of close drug using friends was discussed by six men.

Most of them (friends who have died) overdosing, some of them like through losing like bad livers and kidneys and things like that. Some of them have gone to jail for like life imprisonment you know what I mean, some of them have gone to jail for 15 years and things like that. Some of them have been stabbed and killed. Some of them have been shot and I've lost a lot of friends. (Rob)

Tony and Justin spoke about how they had discovered their friends' dead bodies – one hanging and one in a pool of blood in the participant's house.

Employment

Some participants had previously been employed, largely in poorly paid, unskilled, manual work such as mechanics, gardening or retail. However, as their drug use increased, they often left or were dismissed, stating that their physical need and desire for drugs meant that being at work for prolonged periods of time was impossible without having used drugs.

I were in full time employment and everything. I used to work for (name of large supermarket chain) as a supervisor. But I lost all that when I got onto heroin. Because obviously when hadn't had gear, I couldn't go into work, I were poorly. I'd try and get money for gear, so I used to ring up sick. I mean they only take so much of it. And then I just got sacked. (Wayne)

For participants making money through other, often illegitimate means was sometimes more attractive, as this was not bound by the same rules of **conduct** or hours of attendance, although there were other parallels between legitimate and illegitimate work, such as a **focus** and sense of purpose and associated rewards. Other forms of 'work' that participants had been involved with were less formal such as 'working' for themselves or drug dealers, either selling or delivering drugs or sharing drugs out into deals and making money from so doing.

Before I got sentenced I used to bag up (share quantities of drugs into deals) for a dealer so I was actually splitting the ounces of gear (heroin) into £10 bags and I used to get so much for doing this. (Bryan)

Some participants had also been employed when in prison in cleaning, tailoring and kitchen work. Working in prison was seen as beneficial as it provided money and **combated** the boredom participants associated with being in prison, although some of the work the participants did there was described as monotonous.

At the time of interview Wayne spoke about being in current part time paid employment and at least one man was attending college. Having formal paid employment was something that the men commonly claimed that they wanted in their futures as they believed this would help them stay away from crime and help them live a 'normal' life. Some already had ideas of what they wanted to do in their future employment, including using their own experience to help others in a professional drug counselling role. Others, including Gareth, Jamie and Andy wanted to use existing or newly acquired skills in manual work such as building and labouring. Jeff and Gordon wanted to receive further education and training to be able to seek work in the future whereas Chris was more sceptical about finding future employment on account of his criminal record, despite having culinary skills and qualifications.

Accommodation, Housing and Homelessness

Participants had complex and unstable housing histories, often dating back to their childhoods. Their current accommodation and prior experiences of homelessness were particularly prominent in the interview discussions and was often linked to their use of illicit drugs.

Current Accommodation

At the time of interview, seven participants were living in approved premises (bail hostels), six lived in hostel accommodation, three lived at their parents' house, two lived in a bedsit, one lived in a shared house, one was staying temporarily with friends and one was in other temporary accommodation. Only two had their own tenancies. The housing circumstances of the remaining participants were not discussed in the interviews and are therefore unknown. Only Gordon expressed that he was happy in the hostel where he was staying. In general, participants said that they were unhappy with their current accommodation. This was often linked to the nature of communal living such as in hostels and what they described as the evident presence of drugs at the hostels. There was an overwhelming feeling amongst these men that their life was on hold due to where they were living and they couldn't look towards the future without more permanent housing. Steve and Barry were in the process of bidding for council housing and others were soon to start bidding.

Whilst participants spoke about wanting their own housing, Kev and Clive amongst others emphasised that they needed supported housing, as their life skills were insufficient to manage on their own. Kev believed that he was 'institutionalised' and never wanted to leave prison or the hostel environment. He feared that he could not manage without a high level of support and was concerned how reduced support would negatively impact on his drug use.

Homelessness

Men's drug use and spending time in prison was said to affect their later housing experiences. Being 'kicked out' of home was reported to have contributed to housing problems from an earlier age. At least ten had experienced homelessness at some point in their lives, resulting in having nowhere to stay so they said that they had slept rough, outdoors. At times of homelessness men had also stayed with other drug using friends or associates, in night shelters, hostels, bed and breakfast and hostel accommodation. The experience of homelessness was said to have affected participants' drug use as at this time use increased. This was because drugs provided some comfort to help them 'forget' about their worries and helped participants keep warm, especially when sleeping outside.

I was homeless on the streets of Brighton for two and a half years after that, and that's where my use went from regular but lightish, to, you know,

absolutely habitual daily chase really, which is, you know, what every heroin addict is on to eventually. And that's when I started using crack as well. (Al)

Some men said that they had lost their housing or had been evicted from hostels due to using drugs. Living in specialist or supported housing was also mentioned, such as housing for people with mental health problems. At least six men had nowhere to live on release from their last prison sentence, with a number stating that the housing support on prison release was inadequate. Whilst men claimed that they had sought housing advice and been put on the housing list when in prison, often they described being released with no accommodation and they encountered problems accessing community housing services. Positive experiences of engaging with community housing services were limited.

You don't get the support you need when you come out of prison, regardless of what anyone says, I haven't had no support since I've been out of jail. I still haven't even had me own accommodation. I've got a DIP (Drug Intervention Programme) worker, I've got a key worker, I've got a, I've got someone who is supposed to get me accommodation today, I've got an interview with her and this has been going on for months. I'm just going round in circles. I went to Leeds Housing in Leeds, told them I were homeless and all that, just got out of prison and they turned round to me basically and said they didn't believe me. (Ian)

Chapter Summary and Discussion

Information presented in this chapter was obtained from participants completed pre-interview slips and the in-depth interviews. Consistent information on what were considered the most important dimensions (such as age and number of prior prison experiences) was obtained for all participants. However, information presented such as on participants' schooling, siblings and their last offence details, was obtained less consistently as this was ascertained from the interviews. As these topics were less important to obtain consistent participant information on, they were not always all covered or relevant to discuss so less complete data about these was collected. As qualitative research is more concerned with uncovering, situating and obtaining participant's individual experiences in order to understand and explain their experiences, attitudes and beliefs than adopting a standardised approach to participants as in quantitative research (Silverman, 2000), the lack of consistently

collected data on these areas is neither uncommon for the method nor problematic for the study. This was because obtaining information regarding the prison drug use focus by mining and probing participants' answers for depth, detail and thick descriptions was prioritised in the interviews. However in retrospect I consider that it would have been useful to have collected more consistent information from all participants on some of the seemingly less relevant areas as during the analysis their significance in determining and shaping behaviours became even more apparent and provided important context for taking the analysis forward.

Consistent with other research conducted with drug using prisoners, including quantitative surveys, the data collected for the current study were based on self-report (Boys et al., 2002; Stewart, 2009). None of the self-reported information provided before or during the interviews was formally checked or validated, such as against prison or police records or with biological measures to confirm current drug using status as I considered doing so to be outside the study scope and it may have undermined participants. Additionally, formally checking this information would have been unethical as I did not seek approval from participants or the research ethics committees to check their reported information. As discussed in Chapter 3, I employed techniques during interviewing to corroborate reports where possible, such as asking for clarification and probing answers. However, it must be acknowledged these techniques cannot overcome the fact that the interview encounters by their very interactionist nature produced participants' co-constructed accounts and versions of their actions, experiences, feelings and thoughts (Miller & Glassner, 2004; Noaks & Wincup, 2004; Rapley, 2004). Whilst this does not necessarily mean that they are any less real, I acknowledge that the conversations are constructions which are intimately tied to interactional context in which they took place and the broader social and cultural context in which they were embedded.

It would have been impossible for the current study to seek to verify the drug using accounts of participants when they were within prison given the retrospective nature of it. Yet, some previous research with injecting drug users has tested the accuracy of self-report and has shown good reliability of information. For example, studies have identified that self-reported substance use is generally reliable and valid (Darke, 1998; Kokkevi et al., 1997), although of course care has to be taken in interpreting that this means that all other studies conducted with drug users and drug using prisoners are 'true.' Not formally validating the information participants' provided, such as their prior history of imprisonment or length of previous sentences through

the use of existing data, prison records or through other methods may be criticised for not verifying at least **some** of the claims to have a sense as to how close to the truth they were. Yet this was **not considered** to be important in the current study as the focus was on **their reported** prison and community drug using behaviours within **the broader social and cultural** contexts, not solely their other characteristics.

From examining the characteristics of those involved, I consider that study participants reflect the wider group of men with drug use and prison histories from which they were drawn in **terms of** their demographic characteristics. This is no accident as their **characteristics** were monitored during sampling. Whilst the adult prison estate **houses men** aged over 21 years, men aged between 20 and 50 years, many of whom **presented** through support services, who had an average age of 34 years, **participated in** the study. Whilst not all of the services the men presented through were drug **services**, the average age of participants largely reflects the age profile of injecting **drug** users accessing treatment in England. Indeed, according to the National Drug Treatment Monitoring System figures, a quarter of IDUs accessing treatment in 2009-2010 were aged between 30 and 34 years (National Treatment Agency, 2010). No men over 50 years old were interviewed. This might reflect that as users increase in age there is more time for them to have stopped injecting illicit **drugs due to** successfully seeking treatment or through poor health or fatal consequences, suggesting that there are less older injecting drug users, a suggestion which would concur with recent NTA statistics (National Treatment Agency, 2010).

Injecting drug use among minority ethnic groups (particularly Asians) is generally reported to be less prevalent than among white drug users (Beddoes et al., 2010). Furthermore, whilst the prevalence of injecting is hard to ascertain, determining the prevalence amongst minority ethnic groups is complicated by their under representation at drug services and reluctance to disclose use due to cultural beliefs (National Treatment Agency, 2003). Routinely collected national information shows that for the nearly 80,000 people starting drug treatment in England in 2008/09 whose injecting status was known, half (50%) had ever injected and almost a quarter (24%) were current injectors. However, only 7% of people from Asian and Black ethnic backgrounds were current injectors compared to 26% of White people (United Kingdom Drug Policy Commission (UKDPC, 2010). The sample obtained for the current research reflects this ethnic diversity as most of the participants with drug injecting history (24/30) were White British. Furthermore this reflects the ethnic profile

of prisoners as a national cross sectional survey of all prisons in England and Wales found that 80% (n=2,515) were white (Boys et al., 2002). This also resonates with more recent data as over 25% of the prison population (and 20% of British national prisoners) whose ethnicity was recorded at the end of June 2009 were from a minority ethnic group (Berman, 2010). There are also parallels between the sample for the current study and routinely collected CARAT service data on prisoners accessing the service between 2002 and 2005 whereby in 2004/05, where ethnicity was known, 86% of prisoners assessed by CARAT services were white (May, 2005).

Participants' accounts of their early life experiences presented in this chapter reflect many of the factors that have been linked to increased risk of delinquency in childhood. For example, they talked about being from deprived areas, feeling neglected or rejected by their parents, growing up in care, spending time with antisocial peers, having incomplete and disrupted schooling and few educational attainments. Such factors contributed to them experiencing homelessness, abuse and strained family relationships, which can all combine and contribute to increased criminality and increased propensities to use drugs (Frischer et al., 2005) which in themselves contribute to and reinforce their exclusion and marginalisation further. Participants also had varied engagement in criminal behaviours, largely linked to committing acquisitive crimes such as burglaries, robberies, theft and handling to fund their drug use. This concurs with quantitative surveys that have shown a link between drug use and acquisitive crime (Bennett, 2000). For example, the Criminology Survey³⁰ conducted in 2000 identified that almost half (48%) of those using a prohibited drug daily were convicted of burglary, theft or handling and over half (55%) of those who had taken drugs in the 12 months before prison said that their offences were connected to their use (Liriano & Ramsay, 2003). Furthermore, from analysis of routinely collected CARAT data of prisoners accessing CARAT services in all prisons in England and Wales, the most common offences of those accessing prison CARAT services from April 2002 to March 2005 was theft/ handling (24%) and burglary (17%) (May, 2005). As also identified by the analysis of routinely collected CARAT data (May, 2005), some participants in the current study had also committed violent and threatening crimes. These participants also linked their crimes to their drug use through the need to obtain drugs or through the effect that the consumed drugs had had on their judgement at the time of committing the offence/s.

³⁰ The Criminology Survey is a representative sample of male prisoners sentenced during February and March 2000 in England and Wales (Liriano & Ramsay, 2003).

Reflecting their criminal involvement, most men had been in prison numerous times, often from a young age. This concurs with research which found that 61% of men who have been in prison were reconvicted within two years (HM Government, 2005). Participants re-imprisonment also resonates with drug user reconviction rates from the Prisoner Crime Reduction Survey which identified that 71% of polydrug users before imprisonment in England and Wales were reconvicted (Ministry of Justice, 2010a). For the current study, the involvement of typically older participants with extensive drug use and criminal histories might be linked to the self selecting nature of the sample, suggesting that these men felt most comfortable to discuss their experiences and therefore volunteered to be interviewed. Alternatively, it might reflect the fact that participants were mainly recruited through community services and those with fewer prison experiences may be less engaged with services, either out of choice or perceived reduced necessity.

Next, Chapter 5 provides more information regarding participants reported pre-prison drug using practices and experiences.

Chapter 5 - Drug Use Before Imprisonment

This chapter provides a description of participants' personal experiences of drug use before imprisonment. This is necessary in order to provide the context from which the changes in their reported drug using behaviour when in prison can be described and interpreted. The findings reported here are based on the analysis from the coding and clustering of codes into categories (as described in Analytical Process in Chapter 3). In obtaining participants' accounts, structure was imposed on the interviews through the chronological topic guide. Consequently, the findings in this chapter and subsequent chapters are presented broadly according to the chronological framework. The aim is to assist the reader to engage with participants through their accounts and to comprehend the flow and content of the interviews. A detailed presentation of the main categories identified from the initial analysis relating to participants drug use before their imprisonment is provided below in order to provide important context for the prison drug use findings that follow later in the thesis. Careful attention is paid to the similarities and differences between the participants and their experiences.

Drug Initiation and Continuation

Chapter 4 described briefly the men's reported histories of using drugs. When developing the analysis, five areas appeared to be central to participants' drug initiation and continuation of use. These were 'being young and having fun', the 'influence of others', 'pleasurable effects', 'drug naivety' and the 'dawning of addiction'.

Being Young and Having Fun

Some participants said that they initiated drug use at a very young age, before they were teenagers, with the use of cannabis, solvents and hallucinogens (such as magic mushrooms and LSD (Lysergic Acid Diethylamide)) (Jeff, Tony, Steve and Andy). Others reported starting to use cannabis, solvents and hallucinogens soon into their teenage years (Kev, Justin and Kyle). Using stimulants ('uppers') such as amphetamine and ecstasy was also reported to start largely during teenage years. This coincided with participants spending time socializing with friends (Pete, Jeff and Kev), often against advice from their parents about avoiding perceived bad company.

In general, men expressed that they were 'bored' and found that the more they went out socializing and having fun, the more they experimented with and used drugs.

We (he and friends) were just getting up and going out and doing it (taking drugs) just for something to do really. Do you know what I mean 'cos we were bored, we were really, we had nowt (nothing) to do and we were bored. (Pete)

They described how using drugs helped them have a good time and stay awake longer, prolonging their time having fun whilst overcoming boredom. Going out and staying up late through having fun and using stimulant drugs was said often to lead participants to experiment with depressants ('downers'). Using heroin helped them to overcome the stimulation.

I started using heroin when I started going clubbing I were using it to come down off Es (ecstasy) because I were working and that is how I got into heroin. I was just using it on a weekend and recreationally and then ended up using it more and more. (Bryan)

While most participants said that they started using heroin as teenagers, Andy claimed that he started using it earlier. Claims like this were impossible to verify and must be viewed with some level of suspicion, particularly as Andy was not definite about the age at which his heroin use started.

I've been using drugs for pretty much most of my life. I started smoking cannabis at a very young age and I progressed to using heroin round about the age of 11. (Andy)

Starting to use drugs later, when men were in their twenties or thirties was reported, although less commonly (Jason, Paul and Clive). Like those who started using drugs when they were young, they inferred a social element associated with starting to use drugs, such as using with their friends or family members.

Influence of Others

The reported influence of other people on participants to experiment with drugs cannot be underestimated and this permeated their accounts of starting to use. Participants described many occasions of initiating drug use whilst spending time with friends and peers.

My friend, he were like, 'oh have a little bit of this it'll take your mind off things'. (Steve)

Some described being introduced to heroin by family members, friends and girlfriends who were already using although, in some cases, participants said that friends had also tried to discourage them from trying it. Others said that they were introduced following involvement with antisocial peers (*'the wrong crowd'*). The combination of feeling under pressure from peers and their desire for excitement suggests that participants found it hard to resist or refuse experimenting with illicit drugs.

It was the boyfriend of a family member. He was on it (heroin). And I didn't really know what it was, do you know what I mean, because I was young, young and naïve. And one day, I used to smoke cannabis with him and drink now and again with him, and one day he said, 'do you want to come with me somewhere?' I went with him and he was buying heroin and he asked me if I wanted to try a bit, but not to tell this family member, do you know what I mean? And I tried it and I've pretty much been on it ever since. (Andy)

Not all men had first tried using drugs in the community as six said they started using heroin whilst in prison. This was the case for Benji, Gareth, Kev, Barry, Jamie and Clive. The influence of other people was also significant here, as later discussed in Drug Use During Imprisonment.

I ended up on heroin at 15 through going to jail when I was at a young age, mixing and involving with the wrong people in prison. (Gareth)

Men appeared to reinforce and rationalise their initial use of drugs in the interviews by saying that they were not the only ones doing so. Regardless of their relationship with whoever it was, the influence of knowing other drug users made them feel that they were not alone in their initial drug use as 'everyone was doing it.'

Everyone were on it. It was like somebody had dropped a bomb on Leeds and it were all smack (heroin), you know what I mean, were everywhere. So everybody were injecting and you saw what they were like after having a dig (injection) so I thought, yes, I'll try that, which I did. (Justin)

Pleasurable Effects

Participants described that their initial physical experiences of using heroin were not always pleasant as it made them feel sick. Nevertheless they continued using it recreationally because they felt that the psychologically beneficial effects of using it outweighed the initial unpleasant physical consequences. They explained a sense of enjoyment from using heroin, linked to the relaxing and comforting feeling it provided. These feelings often lasted a number of hours and were said to help them forget about their problems and provided them with confidence.

It made me throw up at first, but like once I had thrown up and I were just laid down gouching (under the effect of heroin) it like, I didn't have a care in world, and nowt (nothing) would bother me, do you know what I mean? And it were great. I loved it. I know it's a bad thing to say, I loved taking smack (heroin) but I did when I first took it, I really did enjoy taking it. (Pete)

Keith described the comforting effects of heroin.

If you get any hassles, it just takes away everything. What I think of it, it actually wraps you up. (Keith)

Gordon infers that using drugs helped him to escape from the reality of bereavement.

It was sort of escapism from what had happened, you know what I mean? When you're drugged out of your head you don't really think about your situation. There was a lot of people killed and I was on a death threat too so it was an escape from that. (Gordon)

The previous experience and use of amphetamine was common, having been used to help participants stay awake. This led them to use heroin because of its depressant effects, helping them to 'come down' from the effects of stimulant drugs.

Most participants described first trying heroin by smoking it, although Jack injected as he said that the people he was with at the time were injecting. For all other participants, the main route of heroin and crack cocaine administration changed as their use progressed from smoking to intravenously injecting. Reasons they gave for starting injecting included the influence of other people, knowing that less drugs were

used when injecting in comparison to smoking making it a more economical choice, the quicker effect of the drug into the bloodstream and having the equipment required for injecting.

I started smoking it at first and then we started injecting it. Like I say, better buzz. That is what it was, it was a better buzz and cheaper. (Pete)

The majority of participants reported that crack cocaine use largely started some months or years after starting to use heroin. The use of crack cocaine was described as euphoric – producing a ‘high’ that lasted a few minutes. Whilst participants described using heroin and crack cocaine separately, the practice of injecting them together (which they referred to as ‘snowballing’ or ‘speedballing’) became popular as their use continued. Using these two drugs together was said to complement each other as the crack cocaine first produced a high, followed by a prolonged relaxed feeling from the heroin. As the effects of the heroin wore off, the men described how they would start the process again, quickly resulting in a cycle of drug use that they said was hard to resist or stop. The effect of injecting heroin and crack cocaine together was difficult for participants to describe. Participants said that they became so accustomed to the pleasurable effect of using them together that they would not contemplate using one without the other. Dealers were said to recognise this, rarely selling one drug without the other.

We started injecting brown (heroin) and white (crack cocaine) together. And that's just when my life just, I couldn't see, I couldn't see me life ever being normal again when I were injecting them both together. (Pete)

Only Adam and Gordon reported that they started using crack cocaine before heroin and progressed to using heroin later, to help them ‘come down’ from the uplifting effects of crack.

Drug Naïvety

As suggested in Andy's quotation on page 152, participants described not knowing what heroin was or its effects when they first used it. Indeed, participants commonly reported believing that the heroin was cannabis, but thought that they were taking it in a different way to which they had become accustomed.

I thought it was just like spliff (cannabis) but like it felt different, you know. And I just thought it was some kind of skunk (a potent strain of cannabis) or something at first, because I didn't see them even put it in because it was just passed in a roll up. And they were like here you are, you know, every time. And because my Mum had just passed away they just kept on you know passing it, and then eventually like, I just got addicted and then I realised it was heroin. And I didn't know what heroin was. (Bobby)

Not knowing what heroin was, was described as a common experience regardless of whether the men first tried heroin in the community or in prison. Whilst both this naivety and the credibility of these claims could be contested, the fact that most participants said this is illuminating, arguably suggesting that this was a predominant experience. The long drug using histories of some participants meant that they started using heroin at a time when there was far less drug awareness and education and heroin use was less widespread. This therefore goes some way to validate their claims regarding not knowing what heroin was when they were introduced to it. For those who started using drugs in later years, their disrupted schooling might have meant that they had missed drugs awareness and education provided there. Yet, why participants tried a drug which they claimed that they did not know or did not know the effects of remains open to speculation. Perhaps the fact that participants were not alone when they tried heroin but were introduced to it by others played some significant role in experimenting with a drug which they did not know. For example, elements such as perceived or actual peer pressure, implicit or explicit coercion, manipulation, a desire to impress and/ or the fear of rejection may have encouraged them to try heroin despite not knowing what it was. An alternative explanation is that perhaps something more positive about their relationships with their initiators, such as trust or the perceived value of the friendship, encouraged them to take a drug which they did not know.

Dawning of Addiction: Developing a Habit

All participants discussed that their recreational drug use increased to such a level that they became addicted. From their accounts, it appears that recreational use quickly changed as their use increased from occasional to weekly and daily use and as injecting became more common. For a time, they said that their drug use often involved a combination of stimulants and depressants, but this usually petered out as heroin use increased. Participants described how heroin use became ubiquitous and involved injecting numerous times a day, from the moment they woke up. This was

described as a physical addiction, having to take heroin in order to feel 'normal' or 'human' as they experienced withdrawal and felt ill without it. Some said that they felt deceived by others who had introduced them to the drug for not warning them about this. These participants suggested a level of resentment, possibly in order to mask some of their own embarrassment at their professed naivety.

When you first start taking it, nobody tells you about how you're going to feel in a few weeks time if you suddenly stop taking it. You don't get that explained to you. It's one of them things once you are into it, it's hard to stop, because if to stop, it's that painful, it isn't gone, you can't do it within two or three days, it's weeks. And it's a frightening experience. (Sean)

Men often described the realisation that they were addicted to using heroin. For most, this happened quickly, almost overnight.

The next thing I knew I was a heroin addict. (Paul)

Like a dawning, participants described 'waking up one day' and being addicted with no option other than to continue using heroin.

All of a sudden you wake up in morning and the first thing you do, well the first thing you think is that you need some more gear (heroin) just to feel human again... You realise you've got a habit, and you're actually addicted and that is the difference between feeling physical right, like the other stage which is like what is it, mentally addicted which is just in your head it's like you can take it or leave it, you know what I mean? Where you wake up thinking yes I want, you know what I mean, that's the difference entirely between the two and that is how I woke up feeling one morning, you know what I mean? You know feeling really rough and the only way round it was to have some more heroin. (Eddy)

From the way participants spoke, this 'dawning' appeared to represent a significant point in their life and drug use. The loss of control over their use was often highlighted in addition, with men describing how heroin had 'taken a hold of them,' almost without them realising. Indeed, participants spoke and presented themselves in a way that suggested they were powerless against the strong drug effects.

This started off only taking it at night and it sort of worked its way back a bit, so it wasn't quite last thing at night. And then eventually you start having a bit in the morning to get going. And then eventually you need something in the middle of the day because it's not morning, it's not late at night. And before you know it you've got a full blown habit. But that didn't feel like it happened for, well certainly over a year, it didn't, I wasn't aware of it having sort of having hold of me for over a year or so. I dare say it probably did but I just didn't notice. (Al)

The use of crack cocaine was seen as a more psychological addiction than that of heroin. This was because participants said that there was no physical necessity to have crack cocaine in their bodies as they would not experience physical withdrawal from not using it. Nevertheless, the pleasant euphoric effect of taking crack cocaine was described which contributed to the men wanting to use it. They said that they found it very hard to resist this desire.

Once you've had it (crack cocaine) once, you want it again and again because it's really mentally addictive. (Wayne)

Criminal Activity and Behaviour

Participants identified that the continuous desire for drugs had a major impact on their lifestyles, most notably on committing crime and the consequent implications. When examining men's reported criminal behaviour 'relieving boredom', 'cycle of drugs and crime' and 'escalation of crime' were identified as significant.

Relieving Boredom

As identified in Chapter 4, men reported long and complex histories of antisocial and criminal behaviour, which intensified on using illicit drugs, in order to obtain money quickly to purchase drugs. However, a few reported that they had started committing crime when they were young, before using drugs. For them, crime was often linked to what they described as few activities to relieve their boredom and it gave them 'something to do', if only temporarily. They said how they quickly became accustomed to having money from committing crime and they were later introduced to illicit drugs.

It wasn't like we was going out robbing for smack (heroin), it was we were going out robbing just for money so we could have money to go out and do things, do you know what I mean? It wasn't specifically going out thinking right we are going out and we are going to go graft (commit crime) to get some gear (heroin). It were never like that at first. We were just wrong 'uns really, do you know what I mean? As little kids, we were just wrong 'uns. We were out just robbing things and just being little shits really, do you know what I mean. Sat on park getting drunk, smoking weed (cannabis), taking drugs basically. Just being wrong 'uns and then it started off just nicking (stealing) cars, just for laugh and stuff like that. That's how we started thieving and all that. And then once we started making more money we just started buying more drugs. It were just like we were doing it every day then because we had the money. (Pete)

Pete, like many participants used colloquial words and euphemisms in his interview to describe his activities. On account of my experience of interviewing injecting drug users, I was used to hearing such terms but I had never closely analytically considered their use. For example, 'grafting' was commonly said when participants spoke about committing crime. Grafting is often used in the English language as an informal term for working hard. I therefore considered that participants used it to suggest how hard they worked when committing crime in order to secure their supplies of drugs, possibly in order to combat society's stereotypical views of drug users not working and being lazy. Furthermore, I questioned whether by saying grafting, they were trying to deceive me and also themselves regarding the serious, unlawful nature of their actions. I considered that this was because it sounded less severe and thereby downplays the seriousness of their actions, and to some extent may act to legitimise them in their eyes. 'Earning' money for drugs is another example of the vocabulary participants used to mask their criminal activities as this suggests that money was made through more legitimate employment than the illegal activities to which they were referring. Indeed, 'grafting' and working hard to 'earn' money to use drugs to some extent closely mirrors patterns of regular working life by providing routine, purpose and stress and requiring commitment and dedication to reap the associated rewards, albeit different rewards in the form of money for illicit drugs. An example of this is provided by Jack's quotation on page 160.

Cycle of Drugs and Crime

For most men, their criminal activity started or increased in line with their illegal drug use and subsequent desire for drugs. This crime was said to be committed in order to make money to purchase drugs. This had what they described as an unintended consequence because as they used more drugs, their drug tolerance increased, resulting in needing more to feel the drug effect. In turn, they said that they committed more crime to afford more drugs. This increase in crime was said to be outweighed by the beneficial and pleasurable effects of using the drugs. Men described how this soon meant that their lives became a cycle of committing crime and using drugs and this was very difficult to break. This was often described very matter of factly and in a way which suggested a powerlessness to the effects of the drugs or a passiveness to using them and committing crime for them. For participants, not using drugs caused intense physical withdrawal symptoms and as alluded to in the Dawning of Addiction they described *having* to take drugs to feel 'normal' and function properly.

When I first got out of bed on a morning I would have to take three or four £10 bags in one spoon, in one injection just to make myself feel normal. I wouldn't get a hit or owt (anything) like that, that were 30 or 40 quid just to feel normal.
(Kev)

Gareth's account below also reiterates that participants felt powerless against heroin.

I liked it in my body, and my body needed it. That is how I felt. My body needed it to make me feel normal again.

CT: How did you feel if you didn't have it?

Oh horrible, really horrible, like I just wanted to kill people. It's a horrible drug. But once it takes hold of you, that's it. (Gareth)

Consequently, men described how their lives became centred on obtaining money and 'scoring' and using drugs. The amount of money earned (legally or illegally) was said to determine what amount of drugs participants used – the more money they had, the more drugs they used.

Every bit of money goes on heroin or crack. You can't even afford to go buy yourself a half ounce of tobacco. You're out on street picking dockers (cigarette butts) up 'cos you can't even afford to buy tobacco. Well you can

afford to buy it but if you spend that £2.50 on a packet of tobacco, hang on a minute that's £2.50 towards a bag of heroin, forget the tobacco, 'let's go out grafting' (committing crime). Then you're out robbing all the time and stuff like that you know, it's a bad lifestyle, it's worst lifestyle ever. (Kev)

Participants' preoccupation with spending all their money on drugs had inevitable financial and social consequences. Men described how this way of life became the sole focus of their existence from day to day.

I'm 20 now and I started taking drugs when I was 16. And through that time I started injecting straight away I was using heroin and then a few months later using crack as well. And over the years it just got worse and worse. I started sleeping rough in Leeds City Centre. I started to beg, people showed me how to ask people for money and I started to beg and then for over a period of about two years from being 16 to 18, that, that was my life. I got up on a morning and begged all day to like 2 o'clock the next morning and I would go to sleep behind (name of shop) or the train station. I'd wake up at 8 o'clock in the morning and do the same thing over again. And then all the money we used to earn we used to spend on drugs. (Jack)

Like Jack, Kyle suggests the repetitive and routine nature of these daily activities.

All you think about then, is just getting your next score (amount of drugs), or getting the money to score. And it's just one big circle, you wake up, have your drugs, go out, make your money, score, back, do your drugs, go out making money, score. Round the circle again. That's all you do. (Kyle)

They often described how they and their lives became 'ruled' by drugs.

Pretty much constant all day in the past, like, that was my life, do you know what I mean, that was what I lived to do really. It was just an existence, it wasn't really a life. It was just, I existed to take drugs. (Andy)

The routine nature of using drugs was described as hectic, as they had to ensure every day that they had enough drugs (or money to purchase drugs) before the physical withdrawal of not having any drugs took hold ('rattling').

It's hectic really. You get up, you go out, you obtain some money, then you try your best to buy the best gear (heroin) that's about, which you take. After so long you stop getting high you just become normal and you start all over again the next morning. (Adam)

Participants said that ensuring they had enough drugs before experiencing physical withdrawal meant that they would frantically go to great lengths to obtain drugs or acquire money to buy them when in need. They said that they would disregard possible risks on the spur of the moment in order to obtain drugs.

No matter what it is, even if it means ragging (mugging) someone off the streets, it gets to that desperate state. A heroin addict will do anything to get that drug. That drug is the most important thing in his life and he will do anything to get that drug. (Kev)

Al highlights the continuous nature of living this lifestyle which could soon be jeopardised by having insufficient money.

It was a continuous thing. You had to go and get stuff and then go and sell it and then go and buy drugs and then use them, and then go and get stuff straight away because if you didn't keep going you run out of money and then you would be ill (in drug withdrawal) and then you wouldn't be able to go and do something. And then you get yourself caught into a downward spiral where you don't feel well enough to go and do anything or be able to do it and keep sort of any kind of keep subtlety. Yeah, so that is all a, that was a very much a sort of continuous grind. (Al)

As men described how their lives became dominated by using drugs, they said that the enjoyment of using was lessened and was overshadowed by the routine of needing to use. They frequently expressed resentment about this and its impact.

I can honestly mention to you now right, I love heroin, but I hate the lifestyle. (Keith)

Escalation of Crime

As their drug use became heavier and more regular, participants, irrespective of whether their drug use started before committing crime to obtain money or vice versa, reported that their level and seriousness of crime committed also increased.

As I got worse on drugs, the crimes got worse. The more I took, the more crime I had to commit. (Andy)

They described how committing crime when regularly using drugs became a necessity. Crime also became more spontaneous and involved taking more risks. For some men, such as Chris, Pete and Kev, crime was seen as exciting and providing a 'buzz.' This was often linked to the adrenalin rush of taking risks linked to committing illegal activity and avoiding getting caught doing so. Elements of danger associated with committing crime, particularly more violent crime towards other people, became overshadowed by what men said was the extreme need, urgency and often desperation to acquire money for drugs through committing impulsive crime.

I wasn't thinking about the consequences or what could happen. I were just doing mad ram raids, burglaries and I wasn't even wearing gloves do you know what I mean? I were just thinking about the fix (drugs). I wasn't even taking care or anything. So that's why I ended up doing a long time (in prison), because of the crime I did. It wasn't petty crime do you know what I mean, it were like dangerous, what could end up with serious injuries, me and the other people I did it to. (Ian)

The crime committed became less planned but more focussed in the moment.

As I got more and more into drugs and I were more you know, wanting it more, you had to (commit different crime). Like with armed robbery, you've to plan it all out. It takes time to plan it out. When you're wanting a £10 bag and you're rattling (in drug withdrawal) you can't sit there and plan out an armed robbery for a week down the road 'cos it just isn't gonna happen. You've got to do something there and then. So it's either kicking someone's door in or just robbing something out a garden, anything just to get that £10. (Kev)

In some interviews participants tried to highlight their own moral codes and stance. These discussions focussed on what crimes were considered acceptable. For

example, Benji, Chris and Steve stated that whilst they had thieved, they had never burgled a person's home or mugged someone as they felt that this was immoral.

I don't burgle people's things because I am not saying that my crime isn't as heinous as his but I try to take from people who can afford – I'm not saying it is right or wrong, I'm just telling you as it is. (Benji)

Whether they said such things as a sincere demonstration of their ability to make moral distinctions or as an interactional strategy to downplay the seriousness of their criminal behaviour and, possibly, to impress me or gain my understanding, is unknown. Nevertheless, it is interesting that a number voluntarily made mention of what they felt was, and was not, acceptable since I did not seek to elicit these views, suggesting that they wished to distance themselves from their criminal identities. During these discussions shoplifting was commonly described as a quick and easy way to obtain money for drugs. Participants overwhelmingly rationalised this by saying that it did not require much planning and there were many shops to target. It was also generally seen as more morally acceptable since it did not directly involve hurting an individual, unlike theft from a person or their property or assault.

I always did have a different sort of moral presumption or perspective that may not be right, I mean I'm sure it isn't, but for me, I never liked street robberies and I never liked sort of snatching old ladies handbags or any of that sort of thing. I didn't really like house burglaries but never felt concerned about nicking from offices or shops or cars. (Al)

I know stealing from shops and stuff like that isn't right but you're not personally hurting anybody, who have personal feelings do you get what I mean? It's not like you have to rag a purse off an old lady or an old man and hurt them doing it, or going through somebody's personal drawers at home. (Steve)

In Chris's extract below he rationalises the type of burglary he committed. It is significant that he mentions his upbringing and his children, possibly to try to position himself as a 'normal' person/ father and to address any negative judgements that I might have about him. His use of 'never' and 'always' are also interesting as he tried to legitimise his previous behaviour.

Never houses, never. That is something I've always been brought up, you don't steal off other people. I mean commercial burglaries you're stealing out of a factory, where a factory's always insured, technically, whereas a house isn't always insured. They're not always going to get their stuff back. Plus you could always be stealing off other people's kids and I can't do with that neither because I've got kids of my own. It were always commercial burglaries, always factories. (Chris)

Yet, committing crime was very much viewed as a necessity, and thus participants' feelings towards what they had done were rationalised against this. Whilst some said that they did not regret the crimes they had committed, more remorseful discussions were common. This could be because participants genuinely felt remorseful about their behaviours. At the same time, they may have felt embarrassed describing their criminal activities to a young, well-educated, female researcher so spoke with a degree of rectitude.

There have been times when I've been on out (not in prison) and I've sat there in flat and just literally cried to myself saying why haven't I got no remorse, why haven't I got no remorse for what I'm doing? And then I just shrug it off, do you know what I mean? Because it's bad when you get like that, you're just not bothered about no one.

CT: And how do you feel about it all now?

Well I feel sick. Literally sick at some of the stuff that I have done. I don't think there's any other way of describing it. I've learnt by the end of the day. I've done my crime and I've done my time. You know what I mean? I have been punished for it. I think it's time for me to move on. (Gareth)

I had mixed feelings when participants openly spoke about a lack of remorse over their previous behaviour. On one hand, I was pleased that they appeared to talk honestly, on the other I questioned why they told me. Did they think that it would impress me or were they trying to intimidate or unsettle me? I found sequences such as that reproduced below challenging to deal with on many levels.

I ended up stabbing him

CT: How do you feel about that now then?

I'm glad I did it really. But I mean I'm glad, because I tried to kill him at first. I wanted to kill him. But I was glad I didn't kill him. But I am glad I did it. (Jamie)

At the time of interview, a few men were keen to tell me that they were no longer committing crime (Bryan, Jason, Derek, Eddy and Jamie), again possibly trying to position themselves as having changed or to present themselves to me in what they may perceive as more acceptable or alternatively to try to conceal their current criminal activities for fear of possible reprisal.

Imprisonment

Information regarding participants' prison histories is provided in Table 4.2. Chapter 4 reported that participants had long and complex histories of being imprisoned, some from a young age.

I were the first one to go to prison. So I were one of the big lads now do you know what I mean? And everyone sort, it was like everyone sort of looked up to me after I had been to prison. (Pete)

'Fear' and 'inevitability and relief' were identified from the interviews as themes associated with being sent to prison.

Fear

The interviews discussed participants' first ever prison experience. Fear was a common issue recurring throughout the accounts and the majority of participants described feeling scared when first sentenced to prison.

The first time I went to prison, the first time I went in and that, from when I first got onto the wing and that, I'll be honest, I was scared, I was scared. (Matty)

I remember them doors slamming behind you. It's like when you go in through the gates and that you can hear the gates slamming behind you like, do you know what I mean, it's like a shiver goes down your back do you know what I mean? Thinking well, because I didn't know what to expect like, do you know what I mean?

CT: How did you feel then?

To be honest, pretty scared. (Tony)

Participants' narratives about being sent to prison were littered with strong words describing the extent of their fear. Adjectives such as 'dreading,' 'scared,' 'devastated,' 'gutted,' 'terrified,' 'petrified' and 'daunted' dominated accounts.

I were wounded, I were gutted. I felt like crying to be honest with you. (Matty)

They subsequently described their reactions to being sent to prison. Like Matty, some described feeling so upset that they felt like crying. Others, including Pete, Jason, Kyle and Andy described actually crying when going to Young Offender Institutions or prisons or at the start of their first sentence. Even though these participants were teenagers aged between 15 and 18 years when they were first imprisoned, they had been committing crime for some time, often with older peers. However, their vulnerability was often revealed in their accounts.

I cried in Group 4 bus all the way to (Young Offender Institution 1). Yes. It were really scary. I were really scared, really, really, really, really scared. I am not a soft person or owt like that, but it knocked it out of me. I were really terrified, scared, gutted didn't know what to do. But I had also lost support of me family and stuff like that because I had been sent to prison. (Pete)

In the extract below, Andy uses the analogy of 'crying like babies.' Whilst this is a common figure of speech, its use here possibly suggests a level of emotional immaturity and helplessness when sent to prison.

At first we (he and co-accused) weren't bothered like, while we was in the courts and that. We just thought that it (4 month sentence), would fly by, do you know what I mean? All the people what we knew had been to prison and that and they said that it just flies, do you know what I mean? So we assumed that it would go quick. And as soon as we got to the prison, the doors closed, oh it was a nightmare, honestly. We both just cried like babies. It was horrible. (Andy)

Although sincerely conveyed, it is possible that admitting to crying was also an attempt to self present as sensitive and vulnerable. This is where I consider that being a woman interviewing men might have had a specific influence on the interview as participants might not have admitted to crying to another man. No men who had been older when they first went to prison described crying when they had been sent,

but they often described feeling fearful. Other responses to being imprisoned were also mentioned in the interviews. Gareth, who was first in custody when he was 15 years old spoke openly about self harming by cutting his arms when there. What he said about these cuts suggests that they were not deep enough to permanently scar.

I was scared (when first sent to prison). Like I say I was shocked because I didn't think I'd go because I was so young and obviously I did go. Don't get me wrong, when I was first there, first couple of nights I did, I tried slashing (cutting) my arms and I didn't make a good job because on the other hand I got no marks from where I did it but it were just sort of scratches? (Gareth)

Sean was 22 years old when he was first sent to prison. Talking ten years later, he also alluded to self harming when first in prison. Whilst he said that this was linked to not having any medication to help his drug withdrawal, he was not prepared to go into further detail about his scars in the interview. This may be because his scars were a reminder of what was actually a failed suicide attempt which he was embarrassed or ashamed of or he was concealing other events which had caused the permanent scarring.

I have scars on my hands and things like that, that's all I'll say. (Sean)

Even though some participants' first prison experiences had occurred many years ago, it was clear from some of their non-verbal behaviour and how they responded to being asked about it that they could remember vividly being sent to prison. For example, some participants shuffled in their chairs, rolled their eyes, sighed or shook their heads when I asked them about their first prison experiences. Furthermore, I considered how they recalled their experiences in detail, often employing minutiae to illustrate them. The possibility of providing embellished accounts cannot be discounted. However, the nature of some of the detail and the way in which imprisonment experiences and stories were recounted suggested the events were particularly memorable due to the significance that they held. In providing such information, the men spoke in a way which suggested that the experiences were more recent than they actually were. Indeed, their accounts suggested that they would never forget their first imprisonment experiences. Andy, talking 11 years after being first sent to prison, highlights this:

The first time I went to prison I was 15. I'd just turned, my birthday was that day. And I was only just old enough to go by that day, do you know what I mean? And that's why the courts had me come back to court that day so they could send me to prison. And oh it was a nightmare. Honestly, I remember that day like it was yesterday. (Andy)

I probed the men's fear of going to prison to ascertain of what, and why, they were scared. There was a certain element of unfamiliarity and being unaware what prison was like. Not knowing what to expect instilled in some a sense of fear.

(I felt) frightened (going to prison the first time). That is the only word I can say really. Very frightening. Very daunting.

CT: What was it you were frightened of?

Just the experience, the not knowing what's happening to you. (Sean)

Linked to this, men said that they were scared because they had heard stories or rumours about what happened in prison from people who had been. Participants including Kev, Justin and Al said that they felt scared as they had expected to be intimidated and bullied by other prisoners, suggesting their vulnerability and possible defencelessness. Others including Derek, Pete, Gareth, Tony and Bobby were particularly fearful of the risk of actual physical assault through fights and violent incidents. The perceived risk of sexual assault was also reported to have instilled a heightened level of fear amongst participants. For example, Pete, Matty, Gareth, Tony and Al described feeling worried that they would be raped by other male prisoners, although no men reported ever having being sexually assaulted in prison.

You hear all these like rumours and that like do you know what I mean?

CT: What rumours were you worried about?

Like rape and stuff and stuff like that like do you know what I mean? And like what if you get a pad (cell) mate that, do you know what I mean, gets (attacks) you in the middle of the night or something like that do you know what I mean? Fucking starts bumming (raping) you and shit like and gives you a good braying (beating) do you know what I mean? You never know what to expect when you go to jail. (Tony)

Revealing fear linked to concerns of being physically and sexually intimidated or assaulted further contributes to discussions regarding participants' presentation in

the interviews. In such cases, it seemed that some participants felt able to talk about their vulnerable feelings. This may have possibly been because I am a woman or because they perceived some benefits, such as loading about a sensitive subject or looking for sympathy or understanding in talking about their fears.

For Gareth, Kev and Bobby, the reputation of particular prisons was described as a cause of fear. Kev was scared knowing that he was being sent to a high security prison containing the most dangerous prisoners which I found ironic since he had been classed as dangerous enough to be sent there. Gareth and Bobby said that they were scared by events that occurred at the establishment they were being sent to. This included hearing about physical and sexual assaults on prisoners, prisoner suicide and murder. Moving from Young Offender's Institutions into a prison which also housed adult male prisoners had also caused fear for Jack and Pete, particularly as Jack reported being moved to an adult prison when he was 20 years old. This fear was linked to feeling young in comparison to adult prisoners and being taken advantage of or manipulated by older, more experienced prisoners possibly as they realised that they had been bullied or vulnerable to manipulation by older peers in their pasts.

As highlighted, not all men had used drugs at the time of their first imprisonment. However, for those such as Jack and Pete who had, fear of experiencing intense feelings of drug withdrawal was sometimes mentioned. This was linked to the uncertainty of whether they would be able to continue using drugs in prison and whether they would receive medication to help combat withdrawal. This is demonstrated below by continuing Andy's earlier extract in which he described 'crying like babies':

We both just cried like babies. It was horrible

CT: Do you know why you were crying? I mean, that might sound strange but...

(Interrupting) Yes, yes. I think it was because, it was the reality, do you know what I mean, we're going to rattle now, do you know what I mean? We're going to have to withdraw now and as well as withdrawing, like with nothing, not even paracetamol. (Andy)

Inevitability and Relief

Those who reported having been in prison many times (see Table 4.2) had usually received a number of relatively short sentences, typically for committing offences which were serious enough for prison, but only for short periods. For these men, being sent to prison was an inevitable consequence of lives fuelled by the need and desire to use drugs.

I were well sick (upset) when I got that four (year sentence). But it were inevitable wasn't it, because I was selling gear (heroin) and I knew I were going get caught. (Barry)

Participants described that they became accustomed to prison and were less fearful when they were sentenced on later occasions.

It is interesting because now prison doesn't hold anywhere near the kind of concern or fear. It really was abject fear before I had gone. (Al)

Rather, participants frequently expressed that they had wanted to be sent to prison. For those who had served in prison numerous times, being sent to prison, particularly on shorter sentences, was often seen as an attractive alternative to their life in the community. Men linked this to the provision of food and accommodation, knowing what prison was like and being reunited with friends. Some had spent so much time in prison that they called it 'home'.

(Being sent to prison) it feels like I'm going back home again. (Kev)

Men also portrayed later prison sentences as presenting an opportunity to get away and 'have a rest' from the hectic nature and routine of drug using lifestyles and from committing crime. Hence, these later sentences were often welcome.

(Going to prison) was sort of a relief, you didn't have to try and score every day. (Gordon)

In many accounts, there was a tension between the relief men associated with getting away from their community life and the reality of going to prison. The example quotations below highlight the somewhat paradoxical nature of being sent to prison to 'escape' from community drug fuelled lives.

Sometimes you were glad for it (going to prison). You know, and you were, 'oh thank fuck for that' when you'd had enough of things or things were going bad at the time, you know, you would think, 'oh thank God for that'. And then at other times if you know, you'd just think, 'oh fucking hell, banged up again'. It just depends on the mood what you were in. I know it sounds daft but it does, it depended on the mood. I've known loads of people put themselves into prison. You know, just as a way to get away from it all. (Steve)

I were gutted in a way because I were leaving (girlfriend). And in another way I were relieved, you know, because I was sick of it. I was just sick of the drugs, I was sick of the life, and prison, you know, a lot of people see it as this big, dark, place, which it is. Don't get me wrong, it is a horrible place, but sometimes you see it as a place to get away from, you know, get away from all your troubles, because you do. You're getting your meals in there, you're getting your bed. You've got your telly, you can get showers when you want, everything, you know what I mean? And it does, it puts your mind at rest a lot, but you still worry about things. It takes a lot of weight off your shoulders, which I were relieved and gutted in the same way. (Kyle)

Chapter Summary and Discussion

Building on Chapter 4, this chapter has described many behavioural patterns around the community use and intravenous injection of illicit drugs, which were primarily determined by the interaction of the social circumstances and practical and economic considerations in which the men found themselves at the time. Men's drug use largely started recreationally, experimenting with stimulants and later involved using depressants to overcome the uplifting drug effects. Reflecting the sampling criteria, all men had injected drugs before their last imprisonment, and polydrug use (particularly of heroin and crack cocaine) was common. Analysis of CARAT data relating to a similar time period (2004/05) identified that 39% of CARAT prisoners had used both heroin and crack cocaine in the 30 days before imprisonment and heroin was reported as the main problem drug overall, particularly for those on remand (51%), in their late twenties (55%) or in their thirties (51%) and those with sentences of under a year (48%) (May, 2005).

Other people were influential in men experimenting with drugs and learning behavioural techniques to use them, highlighting the social influence of others not only on their initial drug initiation but also on their developing knowledge and skill in order to use drugs to achieve the desired effects as their use progressed. This raises some interesting questions about how easily influenced participants were into experimenting with illicit drugs and how susceptible to manipulation they were from others. It could be speculated that those in the current study were highly vulnerable and easily led by the presence of others around them, and this might be relevant to return to later when considering what they said about their drug use when in prison.

Most participants had started using heroin by smoking when teenagers, although many claimed to not know what heroin was at this time. Using crack cocaine and the practice of injecting generally followed heroin use. Most men (24/30) started using heroin in the community and six were initiated in prison, as more fully described in the next chapter. This study identified links with existing UK research conducted with injecting drug users about their drug initiation and progression. For example, the finding that participants experiment and use drugs as teenagers (Pudney, 2002) out of curiosity and/ or boredom (Boys, Marsden & Strang, 2001; McIntosh, MacDonald & McKeganey, 2006) or in response to negative and unsettling life circumstances echoes other studies. The order of drug experimentation when younger, from stimulants to depressants also concurs with analysis of studies including the Youth Lifestyles Survey, a representative sample of nearly 4,000 young people aged 12 to 30 living in England and Wales (Pudney, 2002). This survey found that the average age of first use of glue/solvents and cannabis was 14.1 and 16.6 years respectively, compared with 17.5 and 20.2 years for heroin and cocaine respectively (Pudney, 2002). This again concurs with other UK conducted research such as that which highlights how participants could vividly recall their initiation into heroin and recollect the occasion in considerable detail (Best, Manning & Strang, 2007). It also concurs with research which points to the experimentation with crack cocaine after heroin. Finally, the finding that most men initially used heroin by smoking and then progressed to injecting later in their drug use on the grounds of economical choice resonates with other studies conducted about drug using trends in the UK. The influence other people played on the participants starting and continuing drug use also corresponds to British studies considering this (Best, Manning & Strang, 2007; Greaves et al., 2009).

Whilst men described initially enjoying the immediate and pleasurable pharmacological impact and physiological and psychological effects of using drugs, they soon found themselves addicted and in a cycle of use that was hard to stop, characterised by less recreational, more ubiquitous, habitual and entrenched use which became the focus of their daily lives. This finding speaks to other UK qualitative research with drug injectors which described how using drugs became the focal point of their lives and identified different stages in a drug user's daily cycle, from waking up through to using and enjoying illicit drugs (Buchanan & Young, 2000). Participants' sometimes romanticised accounts of drug experimentation reduced as they spoke more despondently about their drug use. I consider that this might be linked to the relatively self selecting nature of the sample, whereby men who felt comfortable talking about their drug use took part and were more contemplative of their injecting than busier injectors.

This chapter also identified that men's involvement in crime increased as their drug use progressed and increased. As this continued, men's enjoyment of using drugs lessened and the seriousness of their crime often escalated in order to make money to purchase drugs and their crimes became focussed in the moment of drug acquisition. Men's criminal activities ultimately led to their prison sentences. Imprisonment was initially a frightening experience on account of their vulnerable mental health state, their perceived exposure to significant risk, their anticipation of serious consequences and/ or their loss of control over their environment (Killias, 1990). This experience was so significant that they will never forget it, but participants found imprisonment less frightening with more prison sentences. However, imprisonment became seen as a relief, providing welcome respite and a chance for participants to escape the hectic nature of their community drug using routines (Crewe, 2006; Tompkins et al., 2007a), a finding which may be due to the increasing provision of prison drug treatment over the years. Indeed participants articulated benefits of being in prison like those identified in studies conducted with prisoners in England, such as the improved access to healthcare services (Condon et al., 2007), food and accommodation and reacquainting with friends. This is perhaps not surprising given the ubiquitous nature of participants' drug use which had taken over all aspects of their lives, including their personal health and wellbeing, their unstable housing situations and their fragmented relationships with family and friends. However, it must be speculated that they told me about their more familiar and less frightening prison experiences in order to normalise them and downplay their seriousness as there were still tensions linked to being sent to prison after the

first time, particularly linked to the experience of drug related violence as later explored. For example, whilst participants openly outlined what they saw to be some of the benefits of imprisonment, they did not initiate such open discussions about the more deleterious consequences of imprisonment and this only came from more probed discussions and more reflective participants. Even then, the more negative consequences of imprisonment were arguably sometimes masked in the interviews. This may be because participants feared acknowledging these or it might be linked to participants' desire to present a more credible and/ or hardened masculine image to me as a female interviewer, particularly when talking retrospectively about previous served sentences which they might have been keen to forget. Nevertheless, I consider that the rich and relevant interview discussions about drug use and imprisonment histories provided important contextual, sensitive and individualistic information and data for the specific topic area of prison drug use behaviours, the findings from which are discussed in the next chapter.

Chapter 6 - Drug Use During Imprisonment

In line with the objectives guiding the research, this chapter explores participants' accounts of their sentences with particular reference to their drug use behaviours when in prison. Akin to the **previous chapter**, a detailed presentation of the many categories identified from the analysis relating to the participants drug use during any prison sentence is provided. The categories identified and discussed are Initiation of Illicit Drug Use in Prison, Imprisoned with a History of Drug Use, Illicit Drug Availability and Supply, Illicit Drug Cost, Illicit Drug Effects, Consequences of Illicit Drug Use in Prison and Strategies to Prevent Detection and Minimise Risks. A summary and discussion of the main findings presented is provided at the end of the chapter.

Initiation of Illicit Drug Use in Prison

Six participants (Benji, Gareth, Kev, Barry, Jamie and Clive) said that they first experimented with, and started using, heroin when in prison. Like community drug use initiation, the influence of others, drug naivety and the drug effects were identified as key factors which ran throughout the experiences and were said to contribute to men starting using drugs in prison.

Influence of Others

The social influence of other prisoners was suggested as the main reason why the six men first tried using heroin in prison. They described how, on a previous prison sentence they had shared a cell with one or more heroin users who had given them it to try. Whilst no men said that they were physically forced into trying heroin, their accounts suggested that they felt they had little choice. This appeared to be further pressurised by the presence of more than one person at the time of initiation. Gareth implies how he felt manipulated into trying heroin by a group of prisoners. The way he talks about his initiation suggests that he felt a level of manipulation by the prisoners who freely gave him heroin, pretending it was something else. His account illustrates parallels with community drug initiation accounts in terms of naivety and the drug's effect.

They just invited me into their cell and give me it. Obviously the first time I had I was sick all over. I didn't, I didn't want it because I saw it on the foil and I just

didn't even know what it was. Obviously, I'd smoked a bit of weed, spliff and that and I'd drunk and that but I had never tried owt (anything) like this. But to start with they told me it was cannabis, it's just a different way of doing it, you know what I mean? So I ended up smoking, I think I only had about one line and I threw a whitey (was sick) straight away and then I ended up going back to my own cell. And then the next day they came and got me and give me some more. They just kept giving me it. (Gareth)

As with those who first used heroin in the community, some participants described how coercion, ignorance and misleading information given by other prisoners contributed to them first using heroin in prison. This was particularly prevalent for men deciding whether or not to try heroin when introduced to it when locked in the cell with their initiator with nowhere to go and no activities to pass the time. Trying heroin in order to satisfy their curiosity, alongside appeasing their cell mate and feeling accepted by fellow prisoners, was suggested to further impact on the situation, culminating in participants' first experiences. None of the six participants who first tried heroin in prison described actively seeking it or had verbally agreed to try it or had to pay for it on first use. Whilst believable, there is a possibility that participants were trying to present themselves to me as easily influenced by their peers, to some extent at least, in order to reduce their personal accountability as none of them spoke about attempts they made to refuse the drug in the first place or subsequently. This calls into question many subtle factors which might have been at play and contributed to their experimentation such as the nature of the relationship with their initiator, the influence of peer pressure and a desire to be accepted. Later, in a quotation from AI on page 179, we see how the giving of free drugs to prisoners early in their sentence was reported to have been a deliberate strategy by other prisoners and a way of manipulating prisoners. This could extend to and explain the initiation and provision of free drugs by other prisoners to non drug using prisoners such as Gareth.

Drug Naïvety

As Gareth identified above, and others who were introduced to heroin in the community, not knowing what it was when the fellow prisoner introduced them to it was described as a common experience. As the drug was being smoked by their initiators, participants either assumed, or were told by them, that it was cannabis, as

suggested by Kev's extract below³¹. Whilst the men said that they often had prior experience of using cannabis, they described being much more naïve to heroin and its effects³². For instance, Gareth said:

I thought it were just cannabis and I thought it was just, I were just whitey-ing (an undesirable reaction to smoking cannabis) because I was smoking it in a different way. But then, once I found out it was heroin, to tell you the truth, I didn't know what to think at that time. Because I'd never heard of it. (Gareth, talking about when he was 15 years old)

Kev said that he had more of a discussion about the drug with his initiator, possibly as they were 'mates'. However he said that his 'mate' lied and deceived him about the true identity of the drug prior to his first use. This raises questions about the nature of their friendship.

I were padded up (in a cell) with one of my mates and he were into it (heroin) you know what I mean? And he offered me some one day. He said, 'Do you want some of this?' I said, 'What is it?' He said, 'It's cannabis oil.' I said, 'Well don't you put it on skins (rolling papers)?' He said, 'No, you do it like this, the best way to do it is like this,' you know, running it. So I were running this cannabis oil, what I thought were cannabis oil and about six hours later when I came round I said, 'That weren't cannabis oil, that.' He said, 'No, it were heroin'. (Kev)

Maybe participants highlighted such deception to suggest that, with the benefit of hindsight, had they known the drug was heroin, they believed that they would not have used it. However, this is subject to speculation and would be difficult to determine due to the retrospective nature of the reporting. Irrespective of the nature of the relationship with their initiators, what seems common for those who tried and

³¹ Approaches and techniques of smoking heroin and cannabis can differ. For example, when smoking heroin, the powdered drug is usually put on aluminum foil and is heated by a flame from underneath. As the heroin heats, it melts and flows across the foil, giving off a cloud of smoke which is inhaled through a tube. Whereas to smoke cannabis, the drug is mixed with tobacco, rolled into a 'spliff' or 'joint' and smoked like a cigarette. Using a 'bong' or water pipe to inhale cannabis smoke after it has bubbled through water into an expansion chamber is an alternative but less common way of smoking cannabis.

³² Whilst no man mentioned this, it is possible that the colour of the heroin contributed to them thinking that it was cannabis since street heroin is brown, the same colour as cannabis resin.

started using heroin in prison was that they did not initially refuse the drug. This possibly highlights the complex interplay of implicit feelings such as coercion and peer pressure from others with participants own curiosity and willingness to experiment and take unknown drugs in such situations.

'It Made me Sick, but I Liked it'

Two of the men who first tried heroin in prison described being sick immediately after smoking it. Consistent with those who started using in the community, enjoying the physical feeling of heroin was an overwhelming experience shared by the men after first using it. After smoking heroin, the men described feeling happy, with no worries. Benji describes his first experience of trying heroin:

He (cellmate) got it out from the back of his watch and then put some on the foil and said, 'Have a few lines of this.' I had three lines and threw my ring up (was sick) in a bucket, because it was still slop out (no toilets in the cells) in them times and it used to be three to a cell. Like I mentioned, I was sick and a very apt tune came on called Comfortably Numb by Pink Floyd. And I was on my bed just floating and that was my first experience with heroin. I didn't like the taste, but I did like the effect. (Benji)

All participants who were first introduced to heroin in prison said that they continued using it, some for a substantial number of years. This shows how men portrayed first trying heroin had a huge influence on their subsequent drug use and criminal activities and the significance that they attached to using the drug that first time.

Imprisoned With a History of Illicit Drug Use

Most participants were not introduced to illicit drugs in prison, it being far more common for them to have used drugs in the community prior to imprisonment. This section considers the effects of drug use on these participants when in prison and outlines their perception of help with drug use from Her Majesty's Prison Service.

'Rattling': Experiencing Drug Withdrawal

Participants described having experienced drug withdrawal from heroin at some stage during their time using illicit drugs. The experience of having been in drug withdrawal in prison was overwhelmingly common, particularly if participants were sent directly from court or the police station without having either used drugs or

received substitute medication in prison. This was described as a time when participants felt particularly vulnerable, which was easily identifiable to other prisoners and meant that they could potentially quickly capitalise on the new prisoners' evident vulnerability.

I saw it happen to a lot of people. They arrived in jail. They'd been locked up for a day or a day and a half and they arrived really, really ill and the first thing they'll do is go and, and there's plenty of people that'll give you it (illicit drugs) on tap (for free) on the first few days, because they know they have got you then. And they will take everything that you have got. (Al)

Similar to how participants spoke about their first experience of imprisonment, they often provided vivid descriptions when talking about prior experiences of prison drug withdrawal and said that the experiences were very memorable. As previously discussed, participants used slang terminology such as 'rattling' when speaking about withdrawing from heroin. Stopping using drugs with no medical assistance or substitute was referred to as 'going cold turkey' or 'doing it bareback.'

When I went to (Prison 2) I knew I was going to do a cold turkey. (Pete)

As briefly alluded to in the Dawning of Addiction in Chapter 4, being in drug withdrawal was described as a very physically intense, painful experience which could only be alleviated by using more drugs or by receiving an adequate substitute prescription. However these feelings appeared to be intensified when in heroin withdrawal in prison, mainly due to the imposition of the confined and restricted nature of the prison regime. Furthermore, participants' accounts were littered with descriptions of unpleasant symptoms and side effects. Whilst heroin withdrawal can affect individuals differently and manifest itself in varying ways, it was ubiquitously described as unpredictable, uncomfortable and painful. It was characterised by flu like symptoms such as stomach cramps, muscle ache, vomiting, sweating, shivering and lack of sleep. Justin likened the experience to being on a 'roller coaster' as it felt scary and out of his control.

It was terrible. Trying to sleep on the floor and that, because you're moving around every two seconds, do you know what I mean? And your back feels like it's breaking in half, stomach cramps, wild stomach cramps, sick all the

time, can't eat, light headed you know, like really dizzy. If you stand up you just feel that you're going to faint. That's what it feels like, it's awful. (Andy)

Chris, an amphetamine user, said that his experience of witnessing his cell mate withdrawing from heroin deterred him from trying it.

I were actually padded up (in a cell) with a lad who were on heroin, and he was having his, because in them days methadone wasn't really given out as much, so he were doing his turkey in there. And the state that he were getting in, the spew and the rattles and the shakes and him creased up and the pain that he were in, it just put me off it full stop. I mean I even actually had to get moved out of the pad (cell), because I couldn't bear to put up watching him being in so much pain. (Chris)

The impact of being in withdrawal was that participants said that they were largely unable to function. They had difficulty eating and taking part in prison life until the symptoms subsided, which often took a number of days.

I reached there (prison) and I rattled for 15 days. I thought I was going to die. And I was just spewing up all the time, I never ate nothing. It was horrible. (Keith)

Trying to establish regular sleep patterns whilst withdrawing from drugs was described as difficult and frustrating in prison, when so much time was spent confined to their cells. Participants also commented that getting into a stable sleep pattern took a number of weeks, which contributed to their frustration particularly if they were only serving a short sentence. Being in acute physical withdrawal was also said to be extremely emotionally draining and upsetting and had a negative effect on mental health such as increased levels of anxiety. Additionally, participants described withdrawing from other opiates in prison, particularly methadone, when prisons had not prescribed them the same level of methadone as they received in the community or if the prison had heavily reduced their prescription. Participants often felt this was a harder 'rattle' than heroin, as methadone was perceived as more addictive.

A number of factors appeared to influence the severity of heroin withdrawal in prison. Firstly, participants said that there was historically little help to relieve withdrawal in prison, as demonstrated by Barry's quotation on the following page. Furthermore,

prison drug withdrawal was compounded by not always being able to access sufficient illicit drugs of the strength and quality to which they were accustomed to avoid withdrawal. Additionally, prisoners could not always use drugs in their preferred manner in order to quickly alleviate withdrawal due to the difficulties of sometimes accessing drug using equipment in prison, particularly needles. Accessing illicit drugs and equipment when in prison is discussed at greater length later in this chapter.

For participants, the consequence of experiencing (or fearing) drug withdrawal was that it encouraged them to use drugs when in prison to avoid the unpleasant effects. This was particularly so on short prison sentences since they considered it too difficult to overcome the effects of drug withdrawal whilst only briefly in prison. However, others thought that prison was sometimes a good place to try to withdraw from drugs. This was due to a combination of the uncertain access to what were perceived as sufficient good quality illicit drugs alongside the provision of food and shelter and medications to help prevent drug withdrawal. They thus tried to use prison as an opportunity to consider reducing or stopping illicit drug use, particularly if they had longer sentences and engaged in pursuits, such as using the prison gym.

When they said I was going to jail, I thought, yes another chance to get off the drugs. Because when you're out here, nobody really wants to get off the drugs. There is no real incentive because you can get hold of it too easy. Prison's usually a good reason to come off the drugs. (Sean)

More recently, the provision of substitute medication for opiate dependence played an important role in using prison as a time to reduce or stop illicit drug use.

Receiving Substitute Medication

As participants had long histories of imprisonment, they often provided historical accounts of the prison provision of medication for drug dependence, comparing how things were when more recently in prison with their earlier sentences. For example, they spoke about previously not having received any substitute medication to help with their dependence or only receiving basic pain relief such as paracetamol or aspirin.

If you've got a habit they are going to sort you out these days. I mean when I got locked up in '79 and that, it were aspirin water. There were no methadone. (Barry)

Often they said that the receipt of medication depended on luck, the personality of the prison doctor and on disclosing drug use and presenting for help. However, some had been deterred from presenting to prison health services as they felt that being known as a drug user in prison meant being subject to greater monitoring and unannounced searches, increased stigmatisation from prison staff and reduced opportunities, such as work in prison.

On previous sentences, participants had received the opiate painkiller, dihydrocodeine (also referred to as DF-118) for opiate dependence. However, the overwhelming feeling was that the dose provided had been insufficient, had not been provided for long enough and dihydrocodeine was inappropriate for treating heroin addiction and combating withdrawal.

When you've been doing 80ml of methadone a day plus using (drugs) as well, DFs ain't gonna touch nothing. They're a joke. And as for them stopping them after seven days I don't see how they can expect anybody to come off methadone on seven days. It doesn't work like that. You stop methadone like that, and you're going straight into a serious rattle and a methadone rattle is worse than a drug rattle. (Adam)

However, participants thought that prison drug dependence medication and prescribing policy had improved over the years, although Sean suggests a difference between state and private prisons.

Over the last few years the Prison Service has now, when you go in they're not supposed to leave you rattling and that, they're supposed to help sort you out so you're not going to do a bad rattle when you go in. Private prisons give you absolutely nothing. It's like going back to the 1990s again. (Sean)

Improvements included the types of medications provided, the length of time they were prescribed for, the prison continuation of community prescriptions and vice versa. Participants' accounts reflected some of the policy and practice changes made in prison drug dependence prescribing over the years, as outlined at the start of Chapter 2. For example, participants recognised that more recently prisons would continue community prescribed maintenance medication if they were in receipt of it when they were sent to prison.

If I was on a methadone script and I got sent to jail I would expect that script to be carried on while I was in prison. Because they can't just expect to take you off methadone like that when you've been, say you've been taking methadone for like eight months, like every day and all of a sudden you get sent to prison and it stops like that I mean obviously it's going to hurt. (Paul)

Participants also said that they would be eligible to receive detoxification medication on reception to prison if they declared a history of drug dependence, even if they did not receive medication in the community. This was perceived as beneficial in combating withdrawal.

If you get methadone as soon as you step in, because I think they give you about 30mls to like everybody, it'll stop the rattle and I think it will make jail a hell of a lot easier. If I went now I wouldn't be worried about nothing. I wouldn't worry about the rattle because I know methadone would cover it. So that is a good idea. (Derek)

Receiving drug dependence medication when received into prison was said to account for some participants previously going to prison on purpose.

I went to prison on purpose, got caught on purpose so I would get on a script. (Rob)

Yet the view that the medication received depended on the doctor seen still prevailed amongst some participants.

They give you a detox in there or, maintain you depending on which doctor you see. Whether it's a good day or a bad day.

CT: Right you have different experiences with the different doctors inside?

Yes, some doctors are a bit skinty and some are a bit lax. (Adam)

Between them participants had received varying medications for opiate detoxification and maintenance on their last sentence reflecting some of the more recent policy and practice in this area. These were primarily dihydrocodeine, methadone or

buprenorphine (also known by the trade name, Subutex). Participants often commented on the effect of the medications which they had been prescribed.

If you don't have your drugs obviously you're going to rattle (withdraw) and you start sweating and having cramps and you don't want to go to work, you can't sleep, you can't wash, you don't eat. Subutex comes along and makes you 110% normal. A smile on your face, you've no worries. If there is food you'll eat it. If you don't want it, you don't want it. It makes you part of society again, does Subutex. (Clive)

I were in a bit of a state, you know, so all I wanted to do was just get that (methadone) sorted, which I did. They give me 30ml the first night I was in there, then 50ml the second day and then they maintained me on the 90ml of methadone throughout the rest of me sentence. Which were all right, you know, I am glad they did. (Kyle)

What medication they had received depended on which prison they last served in, when their last sentence was and the prescribing policy of the prison at the time. Hence it is difficult to compare their experiences. However, the general feeling amongst participants was that assistance for drug dependence in prison had improved over the years although the lack of certainty and consistency presented problems for some participants and did impact on drug use.

When they're giving out decent detoxes as well there's no need to do any (drugs). (Wayne)

Additionally, the prescribing procedures were seen as more standard across prisons and did not rely so heavily on individuals having to declare their drug use. Despite this, participants still said that the fear of drug withdrawal prevailed and they took this into account when engaging with the prison medical services.

If I was using one bag (of heroin) a day, I won't go into prison and say, oh yes I am using one bag a day, and they give you 10ml on methadone. I'd tell them that I am using six bags a day to try and get 50ml out of them. So I make sure I don't rattle (withdraw). Because they are not going to keep putting it up for you, like they do on an outside script. They just give you a set amount and that is it. If you rattle with it, that is tough. (Wayne)

Andy offered a discordant view about the current provision of medication in prison, saying that he did not agree with the prescription of maintenance medications. This was linked to him wanting to be completely drug free and he felt that receiving prescribed substitute medication would not help him to achieve this. Like many others, his account was reflective of his earlier prison sentences.

I would have been better off if they'd have just stopped my script full stop, do you know what I mean, all together, like they used to. They didn't used to give you anything, do you know what I mean? And it was better then, because you could get off it quite quick, do you know what I mean? Whereas nowadays if you're on a script or whatever, they'll leave you on it, but if it is a high one they'll reduce it straight away and that's just dragging it out, do you know what I mean? Before you used to be able to just get it, get it done and that was it. (Andy)

Even though participants had been given some medical assistance when more recently in prison, they still felt sometimes that the amount provided was insufficient to prevent some drug withdrawal and combat their temptation to use drugs. In these cases, participants said that they used illicit drugs whilst in prison alongside prescription medication. However this use was as much linked to experiencing pleasurable or beneficial effects from the illicit drugs rather than physically needing to combat withdrawal.

If you're on a detox you get 30ml methadone yeah and that's it, you know what I mean, it's like, I mean that's not going to help you sleep, all it does it make you feel normal. You know what I am saying, but you have got some, if your gear's more than 30ml methadone and you've got some gear (heroin) on you, I mean then obviously, I mean if you've got some gear you're not going to feel as bad as what you would do. (Eddy)

Ironically, the recent provision of buprenorphine and methadone medications accounted for participants misusing them to help them relieve withdrawal but also to obtain a high, as discussed in Diverted Prison Pharmacy Prescriptions later in this chapter.

If drugs run out in prison and you didn't get your drugs then you start buying prescription drugs which there's absolutely a lot of. It's very rare that a person actually takes his, very rare that a person takes his medication from the prison because, there's people in prison who've been on drugs and they don't want to continue so they buy medication off what other lads have been given off the doctor, who'd prefer to be taking heroin than having their prescribed drugs. (Clive)

The provision of prison medication that continued on release through community prescribing services was described as a relatively new occurrence again reflecting more recent policy change. This was seen as beneficial, as it meant that drug users could go to prison using drugs and receive medication for their use in prison which would continue after their sentence. However, receiving a prescription on release was dependent on a number of factors, notably, the linkup between the prison and community prescribing services. Despite this, a number of participants had successfully experienced the continuation of prison prescriptions in the community.

The day I got out I were put straight on a script and I continued to use it from there and I have stayed clean since then. So it's helped me a lot. (Rob)

The receipt or not of prison medication for drug dependence was seen as a contributory factor in whether or not a participant had used illicit drugs when in prison. Importantly, the continuation of this medication also sometimes played a role in participants' drug using practices when released from prison, as discussed in Chapter 7.

Illicit Drug Availability and Supply

Participants provided a diverse array of views regarding the availability and supply of illicit drugs in prison.

Issues Influencing Availability

Nearly half the participants contended that drugs were more available and as easy to obtain in prison than in the community. Participants believed that more drugs were available on the prison reception and, ironically, on 'drug free' wings even though these wings operated mandatory drug testing.

They have one or two drug free wings, but in every prison, this is where the centre of the drugs start. So I went on drug free wing and obviously there is more drugs on there than anywhere. (Clive)

A few participants including Rob, Eddy and Kev upheld the view that drugs were less available and harder to obtain in prison. There was recognition that drug availability varied and fluctuated between prisons of varying categories, believed to be most available in open and privately run prisons. This was said to be due to less stringent conditions in open prisons allowing prisoners to collect pre-arranged drugs from close by external locations. Participants felt that illicit drugs were less available in Young Offender Institutions and high security prisons. Participants such as Gareth, Jeff and Sean, who reported to have served in higher security category prisons stated how the reduced time out of their cells limited the time to communicate with other prisoners to access drugs. Yet in these situations they said that accessing drugs became the focus of their out of cell time and sometimes contributed to feigning a reason to be let out when they were supposed to be confined, highlighting amongst other things, a degree of ingenuity and their willingness to manipulate their situation when they wanted or needed to.

(You try to get drugs) all the time when you get out your cell. There are times when you're blagging it (lying) to get out your cell. You know pretend you have got a phone call and you've got to go and make a phone call, this, that and other. And they will let you out and then as soon as they let you out that is it, you are off, you're at doors all over wing, trying to get drugs. (Gareth)

There was wide recognition that prison drug deals were much smaller than those in the community and the quality of the drugs was lower. Participants also believed that the Prison Service recognised that the presence and availability of illicit drugs helped to keep prisoners happy and maintain a level of harmony. As prison establishments are meant to enforce the law, such claims from participants could be contentious and imply some form of official or unofficial complicity. It must be considered that participants made these suggestions in order to normalise and/ or excuse the extension of their illicit activities when in prison. Yet, given the frequency of these claims from participants and the extent of drugs and misdirection of them in prison, it seems likely that some prison officers may be turning 'a blind eye' to their presence and use in prison.

Six main methods were identified from the interviews to account for how men obtained illicit drugs when imprisoned. Five of the ways related to the supply of any illicit drug: smuggled on open visits, personally smuggled into prison, obtained from fellow prisoners, obtained from prison officers and arranged community deliveries. The sixth route identified, diverted prison pharmacy prescriptions, was unique to the supply of licit prison prescribed opiate dependence medications, mainly buprenorphine (Tompkins et al., 2009; Tompkins & Sheard, 2009) or methadone which were reported to be widely used illicitly by prisoners.

Smuggled on Open Visits

Commonly, participants said that they had illicit drugs smuggled to them whilst in prison through their community visitors, accounting for how they had accessed drugs during some of their sentences.

I have had people bring me them (drugs) in a few times. But I wouldn't say it were easy, but they knew what they have been doing anyway because they'd been in jail themselves. (Jason)

Men also admitted to having previously smuggled and supplied friends or peers with drugs when visiting them in prison. They did this despite knowing that there were severe penalties if they were caught doing so, possibly highlighting their propensity to take risks or their lack of consideration of the risks at the time of committing the offence. Derek said that he had previously supplied drugs to his friend in prison with whom he used to commit crime and use drugs with. He also described having been paid by a drug dealer to visit an unknown prisoner and smuggle him drugs. His account suggests that he felt like he had no option but to smuggle the drugs on these occasions.

He was like my grafting partner, so you feel like you've got to, like the loyalty side of thing, to take them, you know, things in (to prison) for them. So I felt like I had to. But I've actually taken it in (to prison) for when I've got paid 'cos the dealer we were working for, it was for his cousin or his brother, we don't really know, we didn't want to know. We took it in for him. I took it in for him and actually got paid for that. (Derek)

Men reported that open visits involving drug smuggling required some level of prior arrangement, usually through telephone conversations or letters, and the visitor

agreeing to the instructions. Benji, Chris and Gareth said that being imprisoned in an area away from people willing to take them drugs made visiting and subsequently receiving drugs on visits difficult, if not impossible. This sometimes happened when a prisoner had been transferred from a closer, local prison, to one further away, consequently disrupting drug supply. Despite prisoners' often dedicated attempts to arrange drug deliveries, they reported that these did not always materialise. The fear of the prisoner or the visitor being caught in possession of illicit drugs, particularly if the visitor was someone who the prisoner cared about, was said to deter some including Paul, Rob, Derek and Bobby from arranging to receive drugs on visits on some sentences.

Participants reported that under their instruction, female partners, wives or friends purchased drugs in the community and took them to prison during an arranged visit. As outlined below, participants described a number of clever and disguised ways how visitors discreetly passed them the smuggled drugs during the visit or how they themselves had previously passed drugs on a visit. Participants sometimes expressed a belief that women visitors were less rigorously searched by the prison authorities and so were favoured to take them drugs.

He was getting about an eighth every week brought in for him off his sister, off a few friends, the dealer was, you know, getting people to bring it in you like, sort of prostitutes, just sort of girls to bring it in basically because they don't seem to search girls more than lads. (Derek)

Where participants had arranged for women to smuggle drugs, the parcels were reported to be mainly smuggled into prison in the mouth and passed to the prisoner through kissing. Alternatively, smuggled drugs were initially concealed in clothing or internally hidden in their bodies and transferred to their mouths at an opportune moment when inside the visiting room.

After I got arrested I was in the nick (prison). I picked up the phone and I said to her (wife) you have to come up as soon as possible because I am poorly. And when I say poorly she knows what's wrong. So what we used to do in (Prison 1) she used to get a parcel, she used to stick it up her (conceal in her vagina), she used to walk into (Prison 1) and into the toilet and used to take it out her again, she used to take it back out her, unwrap a bit of wrapping, stick in her mouth, walk into the visit and that is it. (Keith)

Participants described equally as ingenious and surreptitious ways in which drugs were passed to prisoners when visited by a man. For example, when they perceived that they were not being closely observed by the prison security during the visit, visitors took the smuggled drugs from where they were stored (usually in the mouth or concealed in clothing). They then put the drug parcel into a food packet or a drink in the visiting area for prisoners to transfer the drugs into their mouth under the disguise of eating or drinking.

If they were male (visitors), they'd bring it in their mouth. There is a technique where you half swallow and you can regurgitate something. If it's a woman seeing, she'll bring it through either her bra, her bust area, her knickers, her vagina and half way through or coming to the end of visit, they'd go off to the toilet, take it from wherever they had it hid, where they're not allowed to look, usually put it their mouths, and then have a little kissing session and exchange it that way, through mouth. (Clive)

Other methods for passing smuggled drugs from prison visitors to prisoners during an open visit were also mentioned, such as swapping shoes with drugs hidden in them, which had again required a degree of planning and prior preparation on behalf of the prisoner and their visitor.

I had these trainers. I'd write to somebody would get another pair of these trainers, fill sole up with drugs, on the visit under the table you would swap your trainers. And there are many other ways as well. And that is what I were doing at (Prison 1). (Clive)

Participants explained that on receiving drugs, irrespective of who delivered them, they longed for the visit to end quickly in order to return to their cells to use the drugs. Drugs received on a visit were stored by the prisoner in the mouth or swallowed. Swallowed drugs were said to be retrieved by the prisoner forcing themselves to be sick after the visit or after they passed naturally through the body. Accounts such as Gareth's below suggest how participants planned the visit when they were to receive drugs and also that they were prepared to tolerate a certain level of discomfort in order to receive and retrieve drugs.

I would just swallow it on visit. And then just basically shit it out the next day. Or same night I would just make sure I had some laxatives. Or sometimes I would go on visit and I would drink gallons, litres and litres of water before me visit and because everyone knows heroin is light and it floats, so once I swallowed it would stay up here and as soon as I got back to the wing I could spew it out. (Gareth)

Older participants and those with longer prison histories including Jason, Benji, Chris and Sean, commented that over the years the security surrounding visits tightened as prisons became aware that drugs were received during them. Measures such as the introduction of closed circuit television, greater observation by prison security staff, increased prison searching of visitors and enforced prison rules limiting the levels of physical contact between prisoners and visitors were described. Some of these measures were reported to have deterred them from trying to arrange drugs to be smuggled to them on visits.

I can't understand why it is so rife in prisons, why there's so much different drugs in prison that you can get hold of. Because I only got two drops off this time, in this last sentence, because it's that hard to get it. In my eyes it is. Even, one of the lads even, one of the lads that brought it in for me, he'd brought it in before years ago for me before, even he said it is hard, too hard and he wouldn't even bring any more in next time 'cos of the amount of stuff you have to go through. I've never done visiting people normally in nick (prison), well I haven't really and he were telling me what they have to do going through all the machines and locks and security. What? Because when I visited people when I was younger you just walked straight in through the main gates with your visiting order you could just go straight through. Just a quick pat down and you were in. Now it's all security, it's all machines and dogs and all sorts, so it's a lot harder. (Chris, talking about his last sentence, served between 2003 and 2005)

Furthermore, the increase in punishment for visitors smuggling illicit drugs and prisoners receiving them was reported by participants including Chris, Sean and Justin to have led to an increased wariness of arranging and obtaining drugs through visits, although the wariness did not necessarily always stop them from trying to obtain drugs this way.

I know what it's like when you can't, when people don't want to bring in it, 'cos if they get caught with it, I know they're going to get banged up (imprisoned) themselves. And I don't want, I feel bad then, somebody getting put in prison 'cos of me. And I won't have that, so fair enough if you don't want to bring it in. If he wanted to bring it in, he'd bring it in and if he didn't there's nothing I can do about it. (Derek)

Participants stated how this combination of factors led to a reduction of illicit drugs supplied through open visits. They also said how this subsequently encouraged them to investigate alternative supply routes and influenced the use of different drugs, particularly illicit use of buprenorphine, as later discussed.

Personally Smuggled into Prison

Taking community acquired Class A drugs into prison with them was described by participants as the main way drugs were available on more recent sentences. Some participants had also taken cannabis and prescribed medications into prison with them. Nearly half the participants said that they had taken drugs into prison with them by internally storing drugs in their bodies by wrapping them using cling film, a condom or a balloon to form a package and then secreting it internally, mainly up the anus into the rectum (referred to as 'plugging').

You like wrap it up in like cling film, roll it up like really tight and that and then you just put a bit of lubricant and just pop it up your bum. (Paul)

Some men, including Jason, Rob, Steve and Andy described swallowing drugs to store them in the stomach. Men reported retrieving the drugs upon arrival in prison. Swallowed packages generally took longer to retrieve as they relied on the body's natural processes.

If I've got enough time basically I'll plug it which is like putting it up your backside 'cos it's easier to get back out you know what I mean? But if it's like on top and the police are there and I've got to do it quickly then I will swallow it, do you know what I mean? But I would rather not do that because you have got to wait obviously a day or two for it to come back out. (Rob)

For those who wanted to continue using drugs in prison, their motivation for taking drugs into prison was said to be linked to this desire. Taking drugs into prison was

described as requiring careful and timely planning and preparation, particularly for those who knew that they would receive a prison sentence. Taking drugs in required money and time as participants said that they had to obtain sufficient funds to purchase a larger supply in order to internally conceal them in time for a court appearance. This highlights how knowledge of a court appearance and the threat of prison could focus their mind in a way to prepare themselves for going to prison. A few reported that they could not contemplate going to prison without being 'prepared' by having drugs on them, demonstrating how they could focus on ensuring that they had a supply of drugs to take with them if they believed that they would go to prison.

I already had some plugged, some heroin plugged, because obviously I knew I was going down (being sent to prison) so I thought I'd be prepared. (Paul)

When I got sentenced I'd 40 odd Subutex with me. (Jason)

Participants who reported being less sure about the judicial outcome also said that they stored drugs internally if they could afford to purchase extra in case they were sent to prison. Jason, Paul, Rob, Jack, Chris, Tony, Eddy, Kev, Justin, Keith and Andy all spoke about this, saying that were not prepared to risk not having any drugs with them when in court. They explained that this was because being without drugs in the event of being sent to prison could result in drug withdrawal unless adequate medical assistance was received. This was something which they explained that they felt physically and psychologically unable to contemplate, so they would do what they could to minimise the possible likelihood and impact of this if they could.

When it's not in your hands and it's not in your barrister's hands yeah, then you just don't take that chance. So even though I believed I was going to leave court, I still wasn't going to show up without no drugs in the possibility that I did go (to prison). (Jack)

I've been on it that long now, I've always been prepared. As soon as I know I'm going to court, when I'm on the verge of getting my sentence, I always take something with me. (Chris)

Some participants said that they had sometimes been 'unprepared' and had no drugs with them when they were sent to prison. This occurred if they did not expect to be sent or if they could not afford to take drugs with them.

If I know I'm going to jail I'll take some with me. If I don't know I'm going to jail, its luck of the draw, if I've got something on me. If I haven't, I haven't. (Jason)

I took some benzodiazepines and some opioids, not heroin, with me into court to go to prison.

CT: Why not heroin?

Basically because I couldn't afford it. The heroin I bought the night before I'd saved just enough to have a dig (injection) before I went to court. (Jeff)

Some participants commented on keeping their Class A drug supply plugged when in the community to safeguard against being caught in possession of them. They said that this occurred irrespective of whether or not they were wanted for arrest by the police or were due to appear in court, as they knew that there was a high possibility of being caught committing crime. They said that they felt reassured that they had a supply of drugs to take into prison if they were arrested and sent straight there. This highlights a potential level of forward thinking and contingency planning by participants, demonstrating the strength of their intentions to have drugs with them in prison and the comfort which they attributed to knowing that they had drugs in these circumstances.

Even if I wasn't on run (wanted by the police) and I was out on graft (committing crime) I'd walk around with drugs on me all the time in case I got caught and then I wouldn't be rattling (in drug withdrawal) when I got to jail.....I would have about 100 quid's worth on me. And I would have it in between my arse cheeks and then as soon as it came on top (increase in police activity) I'd push it straight up (into anal passage) so I'd get it in prison. (Gareth)

Some reported doing this as they had previously been arrested and sent straight to prison for committing crime.

I didn't even have nowt (nothing) on me, because I wasn't expecting to get caught. (Matty)

Others who had been sent to prison when they did not have any drugs on them said that they did not want to go to prison without drugs again, demonstrating their

intentions to use drugs when there. Furthermore, participants described that through their prior prison experiences they knew that they would be strip searched on reception, but were extremely unlikely to be internally physically searched. This meant that they felt confident that internally concealed drugs would not be detected by the prison, or had at least convinced themselves that being physically searched was not likely. It also shows again how they were prepared to take some level of risk in order to ensure that their drug supply continued in prison. However whether this was because participants considered that the risk of successfully smuggling the drugs into prison with them outweighed the risk of being caught with them or, whether the possible risks of being caught smuggling the drugs were not considered or ignored, is less certain.

I were a bit, a bit dubious but with it being plugged they don't search you that badly in there, it is is like, all it is you are stood there, you strip off, and you are in like a little cubicle and they just watch you take your clothes off, there is no squatting or anything like that. It is just you take your clothes off and you put prison clothes on. There is no searching or owt (anything) like that. So I wasn't that bothered you know what I mean 'cos I knew where they was I knew they weren't going nowhere and like I say they were like – I tried getting them out that night but I couldn't get them out, so the next morning I went to the toilet and they came out. (Bryan)

I've done it (taken drugs into prison by plugging) loads of times you know, they're not going to check are they, you know what I mean? So why be scared, do you know what I mean? It's an impossibility for them to check every prisoner that goes in, you know what I mean, it's an impossibility. So unless they have got reasonable suspicion that you are going to do that they've got no reason to do it (search you) because they would have to bring a doctor in especially to examine you. (Rob)

Participants' knowledge of how prisons operated from their prior prison experiences further influenced their decisions to take drugs into prison with them. For example, they said that knowing that they were not allowed visitors during their first few weeks on reception into custody encouraged some to take a supply of drugs with them. They said that this helped prevent suffering drug withdrawal while they were unable to obtain drugs through visitors or receive sufficient prescribed substitute medication.

If you're caught on the hop yes, where that basically means if you're not knowing that you're wanted, and you get grabbed and put on remand or say you get x amount of time, you've got no money, you've got no drugs, you've got nothing. Basically all you've got is your detox in jail, yes. So basically if you've got no money, it takes, say you got sent a postal order, that'll take two weeks, well to come in and then you've got three canteens (prison shop allowance) coming, you've got to wait another week for that, so it is basically two weeks before you can get anything done. So if you've got drugs on you at least you can sort things out straight away. (Eddy)

Participants' narratives revealed having taken drugs into prisons in other ways including drugs sewn into clothing, hidden in shoes or hidden within wrist watches. Taking drugs into prison by such methods also involved a degree of prior planning and ingenuity. However, on account of this, these ways were chosen infrequently over plugging and were considered less desirable as they did not always have the time to do this and plugging was quicker and was perceived to be less likely to be detected by the prison authorities.

Participants also reported having previously smuggled needles and syringes required to inject illicit drugs into prison. Rob, Derek and Jack said that this was achieved by cutting down the syringe and putting the plunger and needle inside it, and swallowing or plugging it for later retrieval. These accounts further suggested a certain level of discomfort which they were willing to tolerate in order to obtain drugs and equipment. Bryan and Tony also spoke about prisoners smuggling needles in the sole of their shoes, which they had taken apart prior to imprisonment and glued back together after concealing the needle in them. This also demonstrates the extent of some participants' preparation for going to prison and also their ingenuity in finding ways to successfully smuggle drugs into prison with them. The smuggling of illicit drugs and equipment between prisons, often in different security categories, was also discussed.

Obtained From Fellow Prisoners

Participants said that illicit drugs were commonly obtained from other prisoners. The reports suggested sophisticated levels of drug dealing operated in prison, whereby prisoners obtained regular supplies to sell to fellow inmates.

I was in a nick (prison) called (Prison 5) yes, and I was in the exercise yard, and it is like being on the street, there were drug dealers at every single edge of the yard. (Keith)

In some cases, this represented an extension of community activities, whereby prisoners said that they operated on behalf of community drug dealers, adapting to their new circumstances to exploit the new opportunities it presented the dealer.

The first few month they were just giving me it for nowt (nothing) and then we was on a visit once and they went, 'why don't you try making us some money in here?' So I went, 'alright then'. I couldn't say no, I couldn't say no because they were sorting me out. (Gareth)

In Gareth's quotation above, and in Eddy's quotation previously, they speak about being 'sorted out.' Being 'sorted out' by being provided with drugs by other prisoners was described as a common experience. This is an interesting term which suggests an informal short hand for being provided with drugs without any of the possible negative connotations. It also somewhat lessens the seriousness of having illicit drugs in a controlled prison environment. Participants told me that having previously supplied someone with drugs in prison, by 'sorting them out' meant that the receiving prisoner would be expected to reciprocate in the future. Findings linked to obtaining drugs from other prisoners are expanded upon in the Sale of Drugs in Prison.

The influence of social networks appeared to be central to obtaining drugs from other prisoners. Whilst participants said that prisoners did not need to know fellow inmates personally to obtain drugs, knowing them was said to facilitate transactions.

In Leeds in (Prison 1) and (Prison 5) and that they are all mainly Leeds lads in there, and with me being from Leeds, I know them all, so I know who has gear (heroin) and who hasn't got gear. And a lot of dealers get locked up (sent to prison) with lots of gear on them stuff as well. So they've all got gear on, so you knew who to go to. (Wayne)

Participants said that they had received drugs from friends and fellow prisoners who they knew from the community and suggested the reciprocal nature of this, highlighting the importance they attached to these existing social relationships in obtaining and maintaining prison drug supplies.

A couple of mates that I've just either seen, that have just come on the wing and that and they have slipped me a spliff under the door or like half a ten bag (£10 bag of heroin) under the door, and things like that. Good mates that I've been to school with and all that. And like they'd know that I'd do the same thing for them. (Kyle)

Participants commented that not knowing fellow inmates, particularly when imprisoned away from their local area had made it more difficult to obtain drugs since they did not know who to approach. On the same point, participants reported feeling wary about supplying drugs when approached by unknown prisoners. In these instances, they said that they attempted to make and maintain relationships with inmates who had regular access to drugs to ensure that they could obtain a supply.

Participants reported being able to identify which prisoners had a supply of drugs in prison by the increased prisoner presence outside their cells. They reported having to be careful as this activity could attract suspicion from prison officers, leading to being closely observed and potentially caught, as later described in Conduct and Behaviour on page 227. Sometimes this risk was said to be mitigated by 'employing' other prisoners to distribute drugs or distributing them through alternative methods. Examples spoken about here include attaching drugs to a length of string and distributing them by swinging them between cell windows (as described in Wayne's quotation on page 288).

Obtained From Prison Officers

Prison officers, colloquially referred to by participants as 'screws,' were commonly believed to supply illegal drugs (and other contraband items) to prisoners.

Half them prison officers are dodgier than us, believe it or not. And that's no word of a lie. They used to bring mobiles in and everything. (Ian)

Participants believed that prison officers were involved in the supply of drugs because it was profitable for them. Officers supplying drugs to prisoners was not reported to extend to buprenorphine. Although I did not ask all participants outright, none claimed to have first hand experience of obtaining drugs directly from an officer.

I think there's screws (prison officers) bringing into (Prison 1) because it's that rife in (Prison 1) with drugs now.....It's got to be coming in from some other way in my eyes. Personally.

CT: Have you ever known of any?

No. And if I did, even if I did, I'd tell you. (Chris)

Whilst some spoke of knowing fellow prisoners who had obtained drugs from prison officers, the lack of confirmed first hand experience makes this contention somewhat questionable. It may be that participants were wary of reporting their experience of obtaining drugs from prison officers to me. Like others, Steve and Kev said that they had not received drugs from officers but they displayed knowledge regarding particular officers.

CT: What about officers taking it in?

It has been known and I've known a couple myself.

Yes?

Yes. (Officer's name), he got nacked (caught) for it. My mate were getting it off him.

CT: He got caught?

Yes. I don't know what happened to him, I think he got two and a half year (prison sentence) or something like that, three year (in prison) for it. (Steve)

Kev's self confessed liking of the officer suggests some level of direct collusion between himself or other prisoners and the officer.

There's a really good screw in (Prison 1), I liked him. He were in a lot of debt with, you know his gambling and that, and I know he used to get paid £1000 every week for fetching an ounce of each in, an ounce of heroin and an ounce of crack. So it happens. Screws will fetch it in. They like them back handers, they don't get paid that much. (Kev)

Arranged Community Deliveries

Participants discussed planning and arranging for drugs to be received into prisons via parcels thrown over prison walls, disguised and hidden in balls or other objects. This was said to occur irrespective of prison category, although Paul and Barry amongst others considered that this was easier in lower category prisons where

security was perceived to be less stringent. Men explained that these parcels would be retrieved when inside the prison grounds.

They used to chuck it over the wall on B wing, do you know what I mean on exercise yard, you used to see all parcels flying over do you know what I mean? And when the screws weren't watching, do you know what I mean, you just used to scoop down and pick them up. (Kev)

Participants stated that this route was effective until prison authorities identified it and increased barrier security, such as hanging netting to intercept parcels. Sean spoke about how prison drug dealers arranged for illicit drugs and mobile phones to enter prison from outside through his cell window as his cell was near the prison wall. Participants said that they had also arranged for drugs to be mailed into prison when detained away from their local areas, through writing coded letters. Drugs were then concealed in the replies, such as in the grooves of raised greetings cards. This had to be done carefully in order to avoid detection as participants described that mail was searched prior to distribution and again highlights a level of ingenuity and determination on the part of the participants who engaged in these practices.

Diverted Prison Pharmacy Prescriptions

In the case of the illicit use of prescribed buprenorphine and methadone medications, participants most commonly reported obtaining these through prisoners who were prescribed them by the prison. Rather than taking them as prescribed, participants reported that prisoners used various techniques to divert the medications. In the case of buprenorphine, participants said that illicit use by snorting was often favoured over licitly dissolving it under the tongue as prescribed.

The doctors was prescribing it (buprenorphine) in (Prison 2) at one point to the adults. And a lot of people, a lot of people wasn't taking it; they were bringing it back onto the wing to sell to other drug users, and that's how it was getting brought back and everybody was buying it. And I bought it. (Jack)

Most frequently, participants said that prisoners obtained buprenorphine by quickly taking the crushed or whole tablets from their mouths when prison nurses or officers dispensing the medication were not looking. Men said that they spat the tablet or particles from their mouths and concealed them under their upper body clothing or put them into a container.

If you haven't been caught trying to get it out, they (prison) keep giving it you in the full tablet. And if you have been caught trying to get it out they will crush it... People who get it crushed still get it out... they take a little empty medicine pot with them that they get the Subutex in that they have anyway and just go to (pharmacy dispensing) hatch, put it in their mouth and then when they have stood up, because they have to stand against a wall being supervised, but all it takes is a split second for the officer to turn round and then it's like, they spit it straight in a pot... put it straight in their pocket. (Gareth)

Another way men reported having obtained prison prescribed buprenorphine was by storing it in the mouth and retrieving it on return to their cells. Participants described that whole tablets could be divided into amounts and sold to other prisoners to use straight away whereas crushed tablets had to be dried before being used or sold.

The diversion and illicit use of methadone was less frequently mentioned, although was sometimes discussed.

I've done it with me methadone, sold me methadone in there (prison), when I have been on me arse you know, and I ain't got no money sent in, for the first couple of weeks, like I say, you have got no canteen, so I've sold me methadone in there like that so... And you've just got to do it like, when you take it, you just like drink it and leave it in the cup and then drink that and then hold it in your mouth, you know, for say like 20, 30ml. Go back put it in a cup, and like one of other pad (cell) mates, I was selling it to him, just like 20ml a day or something, and he were giving me like half ounce, a quarter of baccy for 20ml. (Kyle)

As Adam alludes to, as with the diversion of buprenorphine, this practice also relied on acting quickly in order to successfully deceive the prison authorities.

CT: Can you firstly describe with methadone how people were getting it out?

They'd either have a little bottle which they would turn and pour it into when the screw (prison officer) wasn't watching, or they'd keep it in their mouth,

which is not a very good way 'cos nine times out of ten they ask you to open your mouth so would automatically swallow it. (Adam)

Illicit Drug Cost

Dominant areas identified from the interviews under this category are expense, trade and sale of illicit drugs in prison.

Expense

Participants commonly said that drugs, even small quantities, were expensive in prison due to their illegality and prisoner demand for them. It was acknowledged that, because of this, drugs were a very powerful commodity in prison.

If they found out someone has got a quarter (an amount of drugs), which is like about £400 worth, which is probably worth about a grand (£1000) in jail, it's a lot of money to them and it will make their, it will make few years of hell of a lot easier because they would be able to buy phone cards and get in touch with their family. They would be able to you know, get stereos, buy a little stereo off somebody and be able to buy a few DVDs off somebody or get a DVD. They would be able to buy trainers, clothes off someone, someone who has come in with some brand new, I'll give you a few bags for that, yes go on like. You know it makes life a lot easier so you know it's power, it's money. (Derek)

The cost of drugs in prison was influenced by many factors, including their availability, drug type and the deal size. Their cost was said to contribute to men's decisions whether or not to use them and how frequently to use. For example, being unable to afford to buy drugs was said to lead to reduced use or meant changes in drug choice. An example of this was snorting buprenorphine over using heroin, as despite its cost, it was cheaper overall.

It (buprenorphine) don't cost as much as a prison, a prison bag of heroin 'cos a prison bag of heroin goes for like an ounce and a half of burn (tobacco) up to five item, five packs of burn and you only pay one pack of burn for it and you're getting the same effect. (Gareth)

Linked to the reported high costs of drugs was how participants afforded to pay for them. Participants spoke **about trading** and exchanging things in order to obtain drugs in prison. The more formalised sale of drugs in prison was also mentioned.

Trade

As money was reported to be limited and spending was monitored in prison, men described how they obtained drugs without paying money for them.

You're swapping things, you're buying things, you're running around doing this, that and the other, all to get these little bags of drugs. Whatever you've got you will use to get it. (Clive)

They said that drugs were commonly paid for using any 'item' that the prisoner with the drugs would take in exchange. The most common items which participants had exchanged for drugs were telephone cards/ credits, tobacco and toiletries. Exchanging clothes and food were also mentioned. Cannabis and/ or prescribed medications such as buprenorphine, diazepam and nitrazepam had also been exchanged by participants for other drugs.

Where participants had had insufficient money or tradable items, they described having performed 'favours' for other prisoners in exchange for drugs. For example, Jeff who had worked as a cleaner in the prison laundry said:

It was favours for people – doing their washing, you know, when it wasn't their wash day, or putting it in and folding and taking it to their pad (cell) for them and then you would get rewarded for it. (Jeff)

Being 'employed' by prison drug dealers to deal drugs, collect payment from other prisoners or perform related duties was also 'paid for' in drugs. Whilst less commonly mentioned, this accounted for how Benji and Clive acquired drugs to use in prison.

The kind of favours, you sell their drugs for them in exchange for canteen (prison shop allowance), telephones, food and you got a little payment out of it. Other favours, there's a lot of hours in prison, and if a gang or another person interferes with other certain people you can get paid in drugs to go and stab a person up. Hit him over the head with billiard balls. Even cut him up in shower and you get paid quite handsomely in drugs. (Clive)

Participants described that they had also paid for drug using equipment in prison, mainly foil to smoke heroin or needles to inject. What they had exchanged for equipment was said to have depended on what the prisoner wanted.

You'd have to sort of give them either a bit of heroin, or if they wanted tobacco or if they wanted a phone card or something, if they wanted the phone card to make phone calls and that. So depended what, whatever they wanted obviously, if you had it, you wanted the needles so obviously you had to, you know, give them it. (Paul)

Whilst a few men, including Adam, reported having paid money for foil or needles, this was less common than paying money for drugs. Again, telephone cards and tobacco were traded in exchange for drug using equipment.

I had like an ounce of tobacco so I gave half of it away for a bit of foil. Because I'm not bothered if I have half ounce less. If I have got a bit of foil, I am happy. (Bryan)

Participants commented that illicit drugs also acted as an important commodity when approached by others in search of foil or needles as they realised that they wanted the equipment in order to use drugs. They said that they used this to profit from the situation by demanding drugs in exchange for the equipment.

One day a lad came up to my (cell) door like with my mate, do you know what I mean, and says, 'I might be able to get you a couple of pins (needles) like', do you know what I mean, 'but it will cost like three bags' (of drugs). (Tony)

Participants described having exchanged drugs for equipment on numerous occasions. They commented how prisoners also exchanged between themselves for other items or favours, such as drug free urine in order to evade prison drug testing.

Participants felt that being given drugs without having to pay for them in one way or another in prison was rare. There appeared to be only two situations when drugs had been given freely in prison. As alluded to earlier, this happened to those who were introduced to drugs in prison. This maybe because their initiators felt confident that prisoners would use drugs, thereby cunningly generating a market which they could

supply. Others had received drugs without paying if the prisoner had a good relationship with the drug supplier, such as with someone whom they knew through their drug use or crime involvement from the community prior to imprisonment, demonstrating how the benefit of these relationships transcended the prison walls.

As soon as he (crime partner from community) offered me, I was still rattling, been up like a night so I thought yes, I'll take it. And it is free as well, you don't get many free drugs in jail, not at all. You've got to swap things or you've got to do things for it. You've got to deal for somebody or pass you know things on or you've got to take a visit for somebody or something like that, you know get drugs in over a visit. You've got to do pretty risky stuff to get drugs normally in jail and just to get handed it like that, I took it. (Derek)

The cell mate who was a drug dealer used to sometimes be paid for drugs with Subutex. And he'd just say, 'Do you want one?' and I would go, 'Yes,' you know after we got friends and he'd just give me it. (Al)

Sale of Drugs in Prison

Participants stressed that prisoners, overwhelmingly, had to pay for drugs if they wanted them and this depended on an individual's access to money. Rob, Pete, Tony, Eddy and Al amongst others described having reduced access to money in prison as the amount they had depended on how much was given to them by their families, their prison privilege status³³ and whether or not they worked. Prisoners who worked were paid more than those who didn't and prisoners on an 'enhanced' privilege status received more than those on 'basic.' Irrespective of this, participants said that prisons imposed limits on how much they could spend. Participants noted that their access to money in prison was different to the community where they said they could always make money by committing crime.

If you didn't have money outside there was always the availability that you could get it. Whereas in jail you just didn't have that. If you didn't earn it or you didn't have someone sending it in, you weren't going to get it. (Al)

³³ In accordance with the prison Incentives and Earned Privileges (IEP) scheme which was introduced in 1995 to regulate prisoners' entitlements according to their behaviour (Jewkes & Johnston, 2006).

Participants described a few ways which they had circumvented some of the prison rules regarding money in order to obtain money to buy drugs in prison. Due to the high drug costs, Benji and Pete had sometimes clubbed money together with fellow prisoners to afford them. Cash send outs were identified as another way, described as when a prisoner obtained drugs after a pre-arranged payment had been credited into the prison dealer's external bank account. Participants explained that this removed the financial transaction from the prison environment and economy, subsequently reducing the likelihood of being detected by the prison authorities through their transactions and ensuring that their behaviour could continue in prison.

The way it usually works is you get the money sent to someone's house, then once they've got the money, you get the stuff (drugs) given to you on the wing. (Gordon)

Participants had also paid for drugs in cash after postal orders had been credited into prison accounts. Paul, Rob and Pete all spoke about this in their interviews. Financial gain by selling drugs to other prisoners at an elevated price was a reason men gave for taking illegal drugs into prison, splitting the smuggled drugs between those for personal use and those for sale. Participants described that selling drugs in prison provided them with greater resource to either buy more drugs or other goods or luxuries to ease their time there. They suggested that this eased their sentence until they received private money or prison wages.

Say for example I were going to go to jail now, even though I am not on drugs, I would still take it in, because you can sell it, do you know what I mean, you can get more tobacco or you can basically live better you know what I mean, so why live on, I know it is wrong, but why live on £2.50 or whatever a week when you don't have to? (Rob)

During analysis, I found this desire for accumulating goods or luxuries intriguing given that the participants had spoken about how used to living lives in the community with few or no material possessions. For example, I posited whether there was something significant about having and accumulating material possessions in prison that inferred something about their status and regard to other prisoners. Alternatively, I wondered if having possessions provided them with some level of comfort as it would mean that they had capital to use as currency to swap and trade with other prisoners for drugs should they want or need to later during their sentence.

I live like a king in jail. It's 'cos I've got drugs coming in on visits and stuff like that. It's, I mean there's loads in here. I'll tell you when I'm in jail there isn't nothing I want for in jail. I've got all my tobacco all my toiletries. I've got numerous amounts of sauce, all my food and everything like that. I can sit there drinking coffee all day long. (Kev)

The size and strength of the drug deals was noted by participants to influence how much was charged. In the case of buprenorphine, larger or stronger tablets were more expensive and participants reported to have paid between £20 to £80 for whole 8mg tablets. Further, price was said to depend on availability. For example, buprenorphine was cheaper in prisons where it was prescribed than in those where it was not, showing how they would be able to financially profit from these situations.

In (Prison 1) you can get one for half an ounce of baccy (tobacco) because loads of people get prescribed them from the doctor. In (Prison 3) there is no prescription drugs whatsoever. So one in there would cost you £45. (Keith)

Some participants described occasionally selling drugs in prison. Others such as Gareth, Kev and Barry however operated in what was portrayed and can be interpreted as a business like way on behalf of community drug dealers. Gareth and Barry reported being paid in cash or drugs when operating for an outside drug dealer.

They'd give me my eighth of gear (heroin) and then they would give me another eighth of gear on top, but that were to sell. Do you know, to people who get cash send outs? So people would send cash to their address or to a blag (false) address and then as soon as the money landed then I'd give them the gear. (Gareth)

Other participants said that they had sold or traded illicit drugs if they had more than they personally needed which raises questions about how they managed their addiction and their medication for their dependence in prison. Operating for oneself meant that profit made was not shared with others.

In relation to snorting buprenorphine, participants said that whole tablets were more attractive as they could choose between selling them whole or as particles.

You get an 8mil [mg] and you split it into 1mils [mg] and in (Prison 1) we get an item, like either half ounce of tobacco or toiletries for each 1mil [mg] so you get eight items for it. In other prisons you split it into eight and get £10 for 1mil [mg]... Or if you sell it all at once you get about £50-60. (Kev)

Participants explained that a lot of money could be made if the prisoner was transferred from a prison with illicit drugs or buprenorphine to one where they were less available. Keith's quotation below highlights this and alludes to the inconsistency of drug treatment prescribing policies across different prisons during his last sentence.

I used to buy them (buprenorphine tablets) in (Prison 1) for a half ounce, knowing that I'd eventually get moved to an ordinary jail. So when I got moved to (Prison 3) I had them all with me so I knew how much they were worth in (Prison 1) and how much they were worth in (Prison 4), how much they were worth in (Prison 3). Obviously because (Prison 1) half the jail actually gets them off the doctor, you actually get them for next to nowt (nothing). Whereas (Prisons 3, 4 and 5), and things you don't, you're not allowed anything off the doctor there, any drugs whatsoever. So in there they're a lot harder to actually get so a lot more expensive. (Keith, talking about his last imprisonment served between early 2006 to late 2007)

The demand for drugs in prison was said to lead to increased prices and profit for prisoners who sold or traded them. Participants described how prisoners sometimes therefore sold products feigned as illicit drugs, such as paracetamol crushed and traded as buprenorphine.

Illicit Drug Effects

Participants identified differences in the effects of using particular drugs in prison. Three issues were identified from their accounts, 'you don't want to be up in prison', relaxation, sleep and the passage of time and snorting buprenorphine.

'You Don't Want to be up in Prison'

An overwhelming feeling expressed by the men interviewed was that the prison environment was not conducive to the use of stimulants which produced heightened mental awareness. This meant that participants who had used stimulants prior to

imprisonment, either on their own or combined with heroin, largely said that they reduced or stopped this in prison. Some reported having tried using stimulants in prison but had been deterred from using them again or limited their use.

If the chance has been there I have had a little bit here and there (crack) but not much, because I'm not too much on uppers when I am locked up. (Adam)

Men's accounts of the use of stimulants during imprisonment centred on their physiological and psychological effects. Stimulants were considered unsuitable to use in prison due to their effects, which participants explained would be suppressed by being in stale and controlled prison environments. They also described how stimulants would need to be used at a heightened level and with a greater intensity and reduced supplies of them in prison would make maintaining this use difficult. Knowing that using crack cocaine would produce increased energy, restlessness and euphoria was described to be pointless when locked in small prison cells, unable to go out. They reported that being confined to a cell would be irritating and frustrating as they would be unable to enjoy the drug effects. This shows how their decision making about what drugs to use in prison took into account the environment and the different drug effects and were heavily modified by these.

When you're in jail, you want to be on a downer you know, to get your head down, chill out and go to sleep but amphetamine you can't, you want to be up and about and basically only drugs you can really get in jail is heroin. Heroin, subbies, Subutex and cannabis that's the main drugs in jail. You don't find nowt (nothing) else. (Jason)

I've never come across it (crack), I've never even heard of anyone having it, you know. But it's one of them drugs that it's not a jail drug. You can't take it and lie down on your bed sort of thing. So I don't think it's a jail drug sort of thing. Because you need to be out and about, like with crack or Es. (Bobby)

Coupled with this, participants suggested that using crack cocaine would likely result in a psychological craving for more and bingeing, due to the short lived high associated with its use and the more mental rather than physical effects of using it.

It (using crack in prison) seems a pointless thing to do because it would just be a wind up because especially with crack, you need a big bit to enjoy

yourself you just can't have a couple of licks because you want more. Because that is the stereotype for crack users, they want more and more. It's true, it's true you want more and more but if you take sort of gear (heroin) you can take it and it is about 20 hours later you want more but with crack cocaine, you want more straight away. (Derek)

Using crack cocaine was described as different to heroin. Whilst participants saw heroin use as necessary due to the physical addiction, crack cocaine was seen as addictive in more of a psychological way as there was no associated physical necessity to use crack cocaine in order to prevent drug withdrawal like with heroin, but it was used to obtain a high. This meant that the use of crack cocaine in prison was viewed as more of a choice for individuals. This extended to participants who had used both heroin and crack cocaine together before imprisonment. Increased levels of anxiety and paranoia associated with using crack cocaine was also a reason given by men including Steve, Bobby and Andy for them not using it in prison as they felt that it would be hard to seek solace from these feelings within the confines of the prison environment.

It (crack cocaine) would get you paranoid. You'd be climbing the walls, you would just, I don't know, I can't explain it. It's not, you know, it's not a jail thing. (Bobby)

Additionally, the higher perceived cost of buying crack cocaine in prison was said to prohibit use by some including Ian and Kyle.

Relaxation, Sleep and the Passage of Time

Knowing that using crack could result in insomnia was not considered ideal in prison because participants argued that being awake represented a sentence extension. Conversely, being asleep overcame the monotony associated with being in prison and facilitated the passage of time and therefore the sentence.

Crack in prison is like trying to take amphetamine in prison. It's a ruling you don't do it. Because when you're in there, say you're doing a 12 month sentence, well you look at it realistically, if you're doing a 12 month sentence and you're in prison, you don't actually do 12 months, you only do six months, because you're asleep for other six months of it. That's the way it is seen. Whereas if you take amphetamine or crack in prison you're making yourself

do that 12 months. because you're away, you can't sleep. If you're on crack you can't sleep, if you are amphetamine you don't sleep. So those are the two drugs that you don't do inside unless you're off your head basically. It is in there, but not to the degree of anything else. It's more you don't want to be awake during a prison sentence, because you are doing twice as long. (Sean)

Participants said that using crack would require them to obtain and use heroin afterwards, to 'bring them down.' The prison environment was seen by participants as more conducive to the continued use of heroin and cannabis due to their more relaxing and comforting effects, bringing participants temporary sanctuary and relief from what they described as the sometimes difficult reality of being in prison.

We used to take us (our) pills and us (our) amphetamines when we were out do you know what I mean, when we were going out to a party or to a club or something, do you know what I mean, and we'd all be up. But to sit in a cell smaller than this room and take ecstasy or amphetamines, you'd be banging your head off the wall. It would be, but no but like your cannabis and your heroin it just like puts you to sleep, makes you gouch (relaxing effect after taking heroin), makes you chilled. Do you know what I mean? That's sort of stuff you wanted while you were in prison. You don't want to be up, you want to be down. (Pete)

Using cannabis and/ or heroin in prison was said to help participants relax which alleviated anxiety, facilitated sleep and accounted for their continued use in prison.

As soon as I got the gear (heroin) I knew I could sleep. It's like a two sort of week sort of sentence turns into four weeks because you're not sleeping, so it's double the time. And to be sat up all night in a room as big as this and you have got your beds to here and you're sat there staring at the wall for about 23 hours it does get boring, very, very boring and sends you a bit mad. And it's best to sleep it off, wake up, you know it's probably the best thing you can do, just sleep your sentence away and if you've got gear you can. (Derek)

There was a general belief that using heroin in prison offered participants a distraction by helping time to pass and overcoming boredom, regardless of whether participants could sleep or not due to its sedating effects.

A small amount would do a great deal which would pass the time away and just make the days a lot shorter.

CT: Right in terms of, how did it help pass the time?

Well you just go into a daydream and the next thing you know it would be dinner time, and they'd open you up and you were going out for dinner, and the next thing you know they'd open you up and let you for tea. And then they would be locking you up. It would just fly by. (Adam)

Pete identified how the effects of heroin helped alleviate his anxieties linked to things happening outside prison.

It (drugs) passed day quicker. The day, you wouldn't, you'd forget you were in prison. Do you know what I mean? It was just like you'd have a smoke and you'd just gouch out on your bed and you'd just dream about stuff really, do you know what I mean? You'd think about other things. You wouldn't think about where you were or why you were there or, why your family aren't talking to you and stuff like that, do you know what I mean? That's what I always thought anyway. It was like you didn't have a care in the world. You weren't bothered you were in prison. (Pete)

Participants believed that the benefits of using depressant drugs in prison extended to prison officers and to the prison environment. This was because participants felt that drug using prisoners were more subdued than non drug users which helped to maintain a calmer environment.

I think prisons run smoother with drugs, prisons do run a lot smoother with drugs.

CT: What is it that makes them run smoother?

The cons are more subdued. More servient. (Jeff)

Clive believed that there would be 'riots' if drugs were unavailable as prisons relied on drugs.

(Prison) relies on drugs because it keeps the prison quiet and happy. I wouldn't like to be in a proper prison with no drugs, it'd be a terrible place. (Clive)

The effect of sedated and drugged prisoners was believed to reduce potential work for prison officers.

It (heroin) keeps people quiet and quite like sedated as such, it keeps people, 'cos they can just smoke their bag and they are asleep, so I suppose the prison officers are quite happy about that. (Derek)

Snorting Buprenorphine

An interesting new prison drug trend, the intra-nasal use of buprenorphine medication, trade name Subutex, emerged from the interviews (Tompkins et al., 2009; Tompkins & Sheard, 2009). Participants, particularly those with many previous sentences, said that snorting buprenorphine had become so common over recent years that it was the most popular drug used in prison, taking over from other illegal drugs.

One of the biggest drugs in prison now is a drug called, it's a prescribed one, it's a drug called Subutex. And that's actually taking over the heroin. (Clive)

This change was reflected in participants' accounts of their drug use when last in prison as buprenorphine was often reported as the main drug used, used in preference to heroin.

I started sniffing subbies (Subutex) and then that's it, I went off brown (heroin) and I stopped buying it, I stopped using it. (Ian)

The experiences of using buprenorphine in prison were overwhelmingly positive, with participants snorting it to be intoxicated due to its long duration of action and strong, pleasurable opiate effect. Participants likened the strength and intensity of snorting buprenorphine to the effect of using heroin.

When you haven't had gear (heroin) for a few, for a couple of days and that, you take like what is it a 2mil [mg] do you know what I mean, it's like taking a £20 bag (of heroin). (Tony)

Unlike heroin however, snorting buprenorphine was said to give an initial stimulating feeling which participants described as similar to the effects of using amphetamine. Participants reported that they largely snorted buprenorphine during the day as this

stimulation provided them with motivation to conduct activities, overcame boredom and helped them to socialise and cope with being in prison. As the stimulation wore off, they described experiencing a more sedative feeling, similar to 'gouching' after using heroin. Men stated that this helped them to relax, particularly at night when confined to their cells.

I used to take Subutex to help me write a letter on a night time. You know, if I were writing it to my ex girlfriend and that. I had, I used to have that whizzy feeling just to get you up and about and having a laugh with pad (cell) mate and that. And then when it starts, it seems to reverse. And then you start getting gouch feeling, after a few hours you get gouchy feeling so you're on your bunk chilled out watching telly or listening to music. (Kev)

The reported longer lasting effects of snorting buprenorphine were said to make it a more attractive option for participants than using other drugs in prison. This prolonged effect was described as helping them 'forget' they were in prison by occupying their mind. In this way, participants believed that snorting buprenorphine helped time to pass more quickly and provided an escape and relief from what was described as the monotony and routine of prison.

I just felt like I was on speed for a day (after snorting Subutex). I just felt like buzzing off it. It just gets rid of the boredom. (Derek)

The main purpose of me using it, truthfully, it was not the effect of it, although that was all very nice. Don't get me wrong, I don't mind that, but it was the fact that you just lost time. And if you took it at the right time at the weekend it would be next week before you knew it, so you could take it very, very late Friday night, early Saturday morning. And that would last you through to Sunday morning and then you could sleep through to Monday morning. (Al)

Some however said that they did not want to experience a stimulation feeling as this would keep them awake, which would in turn make them feel that their prison sentence was longer than if they could sleep. This accounted for these participants not illicitly using buprenorphine. This was an interesting difference, as snorting buprenorphine appeared to facilitate the passage of time, yet there was also the belief that its effects prolonged sentences.

(Subutex) are pointless because they keep you awake anyway and I don't want to be kept awake when I'm in jail. (Eddy)

Having existing medical contra-indications to buprenorphine was a further reason some participants **had** not used it in prison. For example, participants who were prescribed other opiates for substance dependence were uncertain about the effect of also illicitly **using buprenorphine** and therefore debated using it. In these cases they either experimented with the buprenorphine but either could not feel an effect or did not like it, or they did not use it at all.

Consequences of illicit Drug Use in Prison

Irrespective of participants' prison drug using behaviour they identified a range of consequences associated with drugs in prison. Being caught using drugs, drug debt and the risk of resulting intimidation and violence were perceived as the main risks. Participants expressed these dangers as real and as serious as each other.

Being Caught

By virtue of its illegality, participants saw possessing and using drugs in prison as daring and carried the risk of being caught by prison authorities. Getting caught was described as being physically caught in the act of using or possessing drugs or being caught after use through urine testing. The possibility of getting caught meant that prisoners described having to be extremely careful and a 'step ahead' of the officers when possessing and using drugs in prison in order to prevent detection.

You're more careful because you can't afford to lose any of it, you know what I mean, because obviously you've got a lot less, but you have to be aware that there's screws (officers) walking past your door and you could get caught, you know what I mean? And if they do catch you they're going to search your entire cell you know what I mean so if you've got any more squatted away (hidden in anal passage) they're going to get it all, so you are going to be in a mess, you know what I mean? So you've got to make sure they don't catch you. So you are a lot more discrete, but more careful, but quicker. (Rob)

For some participants, this element of risk taking, coupled with the excitement of avoiding detection, contributed to their motivation to use drugs in prison, arguably representing an extension of their pre-prison behaviours.

I know that am sitting in the jail and I am not meant to be doing what I'm doing (using drugs). It just makes it a bit more, this is it, ha, ha, fuck you, I'm doing this and you're out there, you're at my door and you don't even know what I'm doing. So it's just mad.

CT: So the fact that you are doing it and you are not supposed to be doing it

Yes

CT: Also gives you a bit of a buzz?

Oh yes, yes. (Keith)

Participants recognised that prison officers were employed to enforce prison rules and maintain order. Participants felt that officers knew that illicit drugs were available and used inside prisons but overwhelmingly suggested that they turned a 'blind eye' by not actively uncovering drug use in the belief that some level of drug use, particularly depressants, kept prisoners quiet. Turning a 'blind eye' was perceived by participants to facilitate officers' work by minimising what they needed to do to maintain order and harmony. It was also perceived by participants to eliminate the need for prison officers to complete any official paperwork linked to discovering drugs or incidents which occurred between prisoners related to their use. Whether this is actually what participants believed or whether they presented this view to rationalise and therefore reinforce their prison illicit drug using behaviour is worth consideration.

The prison officers know what is going on, but I think nine out of ten of them just turn a blind eye. It's not worth all the bloody hassle and the paperwork. I think that is the way that they see it. You know for a bit of bloody, I'm saying a bit of heroin, it sounds silly, but it is a serious thing isn't it? But I mean half of them (officers), they don't want to be bothered with all the palaver and all the paperwork. (Paul)

However, the belief that officers turned a 'blind eye' did not extend to impromptu situations if they actively caught prisoners with illicit drugs, particularly Class A drugs, in their possession or urine.

Participants stated explicit consequences and penalties of being caught in possession of Class A drugs in prison. These included confiscation of the drug supplies, reprimand by the Prison Governor by spending time 'down the block' in isolation on the segregation unit and having extra time added to an existing sentence. The potential loss of privileges such as the amount of money a prisoner could spend or the 'luxury' items allowed was also noted as a punishment and concerned some participants. The potential loss of wages or prison job, reduced chances of re-categorisation as a result of getting caught using drugs had also concerned participants.

Every week you have to give a urine sample, you know when you are on E wing because it is supposed to be a drug free wing. So if I'd have got caught with that in my system and that, I would've been kicked off of cleaners and been kicked off of wing. (Matty)

There were also consequences of being caught using drugs which were more implicit in participant accounts. For example, being closely monitored by the prison authorities after being caught with illicit drugs would limit their potential to obtain future drug supplies during that sentence. This in turn may influence the nature of their continued drug use on their sentence and also on their relationships with other prisoners if they were involved in the supply and distribution of drugs to them.

There was widespread belief that the punishments given for being caught in possession of some drugs, or having used them were less serious than for others, reflecting their classification.

If I got caught with a lump of weed (cannabis) it was smack on wrist. If I got caught with heroin it was an outside nicking, your visitors got nicked and went to court. (Wayne)

Prison urine tests were widely believed to be unable to detect some drugs, particularly buprenorphine. Participants also largely concurred in their views that drugs such as heroin, were harder to detect as they remained in the body less time than others, such as cannabis. This often contributed to the use of drugs which stayed in the system for shorter periods and the cessation of prison cannabis use.

In my eyes, the worst mistake they (the Prison Service) have ever done is introduction MDTs (mandatory drug tests) for the simple reason that because at one time everybody was just interested in weed (cannabis), hash (cannabis), smoked hash and it made them happy and there was no violence. And then they brought out MDTs and when you smoked hash it stays in your system 14 days, when you smoke heroin it stays in your system three days, so everyone took the heroin because it would get out faster. (Keith)

I had, all this time, smoked spliff (cannabis) in jail. The big problem that ran the risk of, which Subutex, didn't which is why it appealed to me, Subutex comes out of your system very, very quickly, whereas spliff as I understand it, or so perceived wisdom tells you, stays in your system for quite a long time and so with random drug testing or mandatory drug testing you can get caught quite quickly. (Al)

A further belief was that if buprenorphine misuse was detected, the punishment given was less severe than that for a positive heroin sample. For these reasons, participants said that they felt that using buprenorphine was more legally acceptable and tolerated by the prison authorities and carried less risk and a lesser punishment than using other drugs.

If you got a positive for subbies (Subutex) you won't get added days, you just get banged up (locked in cell) or something. If you got positive for heroin you get 21 days on your sentence. (Ian)

Participants did not consider the illicit use of buprenorphine as exciting as using other drugs as it did not involve the same element of risk taking against the prison service or the same element of enjoyment in preparing to use. How participants avoided getting caught using drugs in prison is discussed in Strategies to Prevent Detection and Minimise Risk later in this chapter.

Drug Debt

Debt was viewed by participants as a significant danger of using illicit drugs in prison. This was said to occur as a result of buying prison drugs at an elevated price, or obtaining them without paying the high costs charged and consequently owing prisoners for them. Men, including Benji, Pete, Clive and Kyle explained that taking

drugs without being able to pay for them straightaway would mean that dealers charged 'interest' or up to double the amount for them.

If I lent you half an ounce, I would want three quarters back or if I was doing double bubble (double the amount), I would want two packets of bum (tobacco) back and the same with phone cards. Now if I lent you a phone card, I would put a quarter on it or give me two phone cards depending on who it was, some would double bubble some would do quarter on top (quarter the amount). (Benji)

If interest was not paid quickly, participants reported that prison drug dealers would increase the amount owed until the prisoner paid. The high costs of drugs in prison, coupled with the desire to use them therefore meant that it was easy for prisoners to get into drug debt.

I'd never get in debt in prison, you know, because I've seen some nasty things happen with lads getting in debt. So I'd never get a lay on (drugs for free) in jail. Like say I wouldn't ask a lad for half ounce of baccy, because like you've always got to pay double back in prison, so if I got half ounce of bum (tobacco) I'd have to pay an ounce back. Like I would never do it, because you never know, like you might think your canteen (prison shop allowance) is coming, but there might be a mistake and if you canteen don't come you're in trouble because it goes up to two ounce then, if you don't pay that, up to four ounce, if you don't pay that, you're going to get slashed. (Kyle)

Drugs can get you into a lot of trouble in prison if you let them, do you know what I mean? If you take drugs all the time and you can't pay for them you could end up getting yourself killed. (Andy)

Intimidation and Violence

As suggested, not being able to afford to pay for drugs could result in threats and actual physical abuse between inmates and from drug dealers or their associates in order to enforce payments, assert their authority and protect their reputation. This heightened participants' fear of violent incidents. Intimidation and violence was reported to increase if the debt accumulated to a high amount or if the prisoner was unable to pay promptly. Participants said that the consequent disruptive behaviour

and violent drug related incidents created a tense and threatening atmosphere for prisoners and staff.

There's a lot of dangerous people, so if they know you've took it (Subutex) in, if you're speaking to people, especially in magistrates court, 'oh I am taking a few things, oh I've got a few subbies (Subutex),' you're stupid saying that, because as soon as you get there you might get jumped on by three or four blokes (other male prisoners). They'll take a spoon to your eye or summat, 'give me them or I'm going to poke your eye out.' (Derek)

Benji and Clive said that they had been 'hired' by drug dealers in prison to supply drugs and collect drug debts on account of their volatile and violent reputations. They claimed to have acted as enforcers, employed to intimidate and conduct whatever violent acts dealers deemed appropriate to prisoners who owed money for drugs.

I have been known for violence and things like that. So people know what reputation sort of precedes me and see me as someone who is not going to take any nonsense if somebody's not going to pay or something. So I was hired by most people. (Benji)

Participants suggested that the intensity of the intimidation and violence used mainly depended on the amount of money owed. Generally they said that the violence escalated in seriousness until the debt was paid. Factors such as the amount owed, how long the money had been owed, the nature of the relationship between the prison dealer and the prisoner buying it and also between the prison dealer and the prisoners working on behalf of him, either as suppliers or enforcers, all contributed to the level and intensity of the violence that would be experienced by those in drug debt in prison. Threats and fighting were said to be followed by more serious levels of violence, often involving the use of weapons. Weapons included items available from within the prison, such as steel meal trays, billiard balls and make-shift blades or knives as demonstrated in Clive's earlier quotation on page 203.

No participants admitted to having personally experienced violence as a result of prison drug debt. Rather, many of them reported that they had witnessed a lot of extreme drug related violence towards other prisoners and said that someone who owed a lot of money was likely to be harmed very badly by other prisoners, possibly even physically scarred.

The number of times I heard conversations or witnessed the actual carrying on of people that had borrowed and couldn't pay back or, you know, just got themselves into strife over drugs, basically, and ended up, you know, quite nastily, not necessarily broken legs sort of stuff which is what I would probably have always imagined. But a lot of people getting slashed and things like that so they ended up with great big scars down the side of their cheeks or across their necks. (Al)

The threat of violence linked to drug debt had caused participants worry and anxiety when they were in prison. Some described how other prisoners in these situations had harmed themselves, possibly to try to exercise some personal control over their circumstances or to punish themselves or as way of ensuring attention from prison staff in order to seek protection through changing their circumstances.

They'll keep getting into debt, and getting into debt and getting into debt. And then the next thing is they'll get fucking, I don't know, they may get knocked out or they might get beat up or whatever. And I've seen lads getting their wrists, ripping (cutting) their wrists over it and all sorts. It's horrible. (Keith)

Being placed on the protection wing was discussed as a common experience for prisoners whose drug debts had escalated. Whilst it is unclear whether they reported their drug use to officers or self harmed in order to be placed on the protection wing as this was not discussed in the interviews, this is an interesting prospect as it could be assumed that they might be subject to punishments from the prison for disclosing drug use, particularly if imprisoned when there was an emphasis on punishing prison drug use.

Almost every person that I spoke to who ended up going onto protection wings were doing so because they had got themselves into debt over drugs. Sometimes it can be slightly further set off from directly being about drugs but it could be about say borrowing tobacco off one person to pay for the drugs off another and then owing the tobacco person. (Al)

However, being on the protection wing did not necessarily reduce the risk of violence. Rather, participants suggested that prisoners' families could be physically attacked or

prisoners could be targeted and attacked after release in order to settle debts. This suggests that prison drug issues were not confined to prison environments.

If it (drug debt) goes up to the £1000 mark you're talking somebody who is going to be put in hospital and scarred for life I think. One of the last lads that didn't pay that I knew of, he were a black fella and he had 160 stitches in his back (as a result of drug related violence) at his house (after release) for not paying. (Clive)

Having a supply of drugs in prison was also perceived by participants as risky and could lead to threatening and violent behaviour from other prisoners who may want the drugs and go to great lengths to get them.

If you took crack in it would be a bad idea because if there is a few crack-heads in there you're going to get a knife put to your throat and say, 'Give me your crack.' And that's not a good idea taking it in. It is dangerous. (Derek)

I have seen them come out of that cell and rob that cell and go back to their own, and they're only next door to each other. And it's not as if you can't tell who has robbed it because it's the cell next door to you. And the fights that have broke out over smack (heroin) is unbelievable. (Chris)

Such reports highlight a contradiction with participants' earlier claims about what they perceived as the sedating effects of using heroin in prison. From the analysis I contend that participants mean that prisoners are relaxed after using heroin but they are less so when trying to obtain a supply in order to be able to use, which is when there may be heightened levels of violence between prisoners. Participants also reported violent consequences for prisoners who dealt products feigned as drugs. This was commonly reported in the case of buprenorphine.

He's ripped a lad off on D wing, he'd given him loads of paracetamols (in pretence they were buprenorphine) crushed up for three packets of burn (tobacco). And he has done that and then scarpered and then got moved off that wing onto C wing. So he ended up getting battered (beaten up) in the showers. (Matty)

The threat and use of violence in prison was not solely connected to the presence of drugs in the environment. Indeed, participants also spoke about fights also breaking out amongst prisoners for other reasons, such as general disputes, in what was described as a forced and pressurised environment. Sometimes such fights were linked to what might be perceived by others, particularly those who have never spent time in prison, as reasonably trivial events. For example, one man described having a fight when his cell mate used some of his shower gel. Yet, as we saw earlier, the significance that some prisoners attached to their personal possessions and the fact that they could represent important capital to acquire drugs in prison, goes some way to possibly contextualise and explain some violent prisoner reactions in ruthless environments engendered by drugs. It may be however that sudden and/or unprovoked violent incidents were unlinked to the capital required to fund drug use. Rather, it may be that this was how prisoners released built up anxieties and tensions as a result of being in prison. This was complicated by the need to reinforce their masculinity and be able to protect oneself, one's possessions and territory and not show weakness to other prisoners as this could result in being taken advantage of.

I'm not saying I like this alpha male thing, but you don't want to look weak in there and be took for a muppet (a stupid person), so if someone talks to you like a div (a stupid person), you know what I mean, you've got to back it up, even if you do get a beating, you've still got to do it. (Kyle)

Risks of Administration Route

Participants identified risks linked to prison drug administration routes although these were not articulated as frequently as the other consequences and were not perceived as immediate as the main risks identified above. Participants identified no specific dangers linked to the administration route of smoking per se, other than general risks already identified. The main risk participants spoke about and associated with injecting drugs in prison was linked to the uncertainty of the cleanliness of the needle. There was wide agreement that, due to their illegality, needles were scarce in prison, meaning that they were often passed and used by many prisoners.

Needles are proper scarce in jail. I mean they're there but they're used by dozens and dozens of people. (Barry)

Consequently some participants said that they had previously injected with a needle which had been used by other prisoners, some of whom were unknown to them.

Bryan, Paul, Rob, Derek and Tony spoke about this. Participants said that injecting with a used needle in prison was risky. This was noted as different to injecting in the community where they said that there was greater access to sterile needles through needle exchange programmes. They explained that when thinking about injecting in prison with a used needle they were concerned about who had used it and that person's blood-borne virus status. There was wide recognition that accepting and using a used needle put them at risk of contracting blood-borne viruses. Participants made specific mention of hepatitis C and HIV.

You don't know if someone has got AIDS on wing do you, do you know what I mean? And you're using a pin straight after them, you could catch owt (anything). And it's just through sharing. Sharing's not a good thing anyway do you know what I mean, but sharing in prison, that's just even worse because it's not just one person you're sharing with, you could be sharing with ten other people. (Pete)

Drug overdose was also mentioned as a possible risk attributed to injecting heroin in prison, due to having reduced tolerance on account of reduced use in prison or the reduced quality and strength of prison heroin.

Out here (community) you're bang at it, in there (prison) you're not, you're just doing it whenever you can get it. You might go a month where there's none on your wing, so for that month you can't touch it, know what I mean? So after a month your tolerance is down, if you get a couple of bags on wing it's quite easy to OD (overdose). (Kev)

The risk of overdose was also linked to the prison environment as men said that the illegality of injecting in prison meant that prisoners tended to use at night as this was a quieter time of day with fewer staff. However, it was reported that injecting at this time meant that it was unlikely that a prisoner who was unconscious from injecting too much would be found. Not being found in time was recognised to possibly have fatal consequences as cell mates might not realise and so be unable to call for help or might be concerned about the implications for themselves of trying to seek help. Jason, Rob, Tony and Kev also commented that overdosing on release was a risk linked to injecting in prison as they said that the quality of drugs was poor in prison, meaning that they would have to account for this when injecting on release. Using the same amount of drugs (or more) as in prison when released, could be an

overdose risk if the community drugs were of a higher strength and quality than those available and used in prison.

Additional consequences of using drugs in prison were less commonly expressed by participants. These included initiating drug use, developing a habit due to prolonged drug use and reducing the likelihood of using prison as a time to rehabilitate oneself.

Strategies to Prevent Detection and Minimise Risks

Alongside describing their prison illicit drug use experiences, participants outlined what they did to minimise the associated risks of using drugs when in prison. It is possible to distinguish between the strategies reportedly taken as some were taken immediately prior to prison drug use, or at the time prison drug use was embarked upon. These strategies were largely reportedly taken in order to avoid the immediate risk of being caught or to reduce possible health risks of using drugs. Other strategies however, were reported to have been taken after illicit drugs had been used in prison in order to avoid later detection. Some of the measures participants described that they had adopted were very practical in nature. Others showed more consideration of the nature of the prison environment and the people around them and how they considered these to influence their drug use and subsequent strategies to prevent being caught or reduce the risks associated with using. Overall, strategies to prevent being caught using drugs in prison included considering drug choice, drug administration route, conduct and behaviour, time of day, physical positioning, disguising drug smells, storing and disposing of drugs and equipment and deceiving formal drug testing as now discussed below.

Drug Choice

Some participants said that they had actively thought about which drugs they used when they were in prison in order to reduce the risk of using and the possibility of being detected. Reduced frequency of any illicit drug use in prison was noted as a way participants reduced the chance of being caught in the act of using drugs. However, they acknowledged that this would not eliminate the chance of possible later detection through prison urine testing. Commonly, the longer lasting effects of illicitly using buprenorphine were suggested to make it a more attractive prison drug choice than others, particularly heroin. This was because they said that they did not need to use buprenorphine as often. They generally saw using buprenorphine as less troublesome and risky than other drugs because it could be used quickly, as soon as

it was obtained, limiting the potential of being caught with it or using it, showing how buprenorphine was perceived to be more suited to the nature of the prison environment and the way of prison routines.

In prison you don't need to inject them (buprenorphine tablets), you just snort them, they affect you for much, you know, if you inject heroin, it may last you two or three hours and then you're going to feel ill and you need some more, if you inject crack it's going to last 20 minutes maybe. And then it's gone. Subutex was lasting people 24 hours. (Al)

Drug Administration Route

Linked to considering what drug(s) to use, thinking about the drug administration route when in prison was a way participants said that they had also actively tried to limit the perceived dangers and risks to themselves. As injecting was seen to carry the greatest health risks (such as the transmission of blood-borne viruses, bacterial infections or drug overdose), some said that they had decided to abstain from this in prison to minimise potential risks.

It (needle that had been used by other prisoners) was all rusty, and all bent. Oh God, it was ridiculous, you know what I mean, there was no way that I would use that in a million years, but it happens. (Keith)

For those who said that they wanted to continue using illicit drugs but were more worried about the possible health risks of injecting, changing the route of drug administration to smoking or snorting when in prison was discussed as an attempt to minimise these. Unlike injecting and smoking, snorting was said to be beneficial as it did not require obtaining any drug using equipment, therefore avoiding the blood-borne transmission risks associated with using used injecting equipment. Yet for at least Keith, the quicker administration of drugs through injecting was a reason why he had continued to inject in prison in the past rather than using alternative administration routes. Keith believed that his ability to inject quickly lessened the chance of getting caught using as the drug could be used more swiftly by injecting than if he were to smoke it. Those who continued to inject in prison thought that the possible health risks were minimised by flushing out used needles prior to injecting with them or by asking the person who had used the needle before them if they had been diagnosed with any transmissible bacterial or blood-borne diseases.

You just asked if they had one (needle). If they said yes that would be it, thank you. If it had been used he would say, 'just give it a clean' and you would know somebody else had had it previously and used it. (Paul)

Tony said that he disclosed that he had hepatitis C if his cell mates asked to use his needle, thereby passively leaving the decision whether or not they used the needle up to them. This measure could have also been a way in which he avoided sharing his needle, although he did not directly say this. Knowing the person who had previously used a syringe and trusting them was a further way participants felt they had minimised the potential risks of injecting with used equipment when in prison.

When I have injected it, it's because I've like, I've took a pin (needle) in with me or I know the person who has took the pin in and I knew them very well and I knew it hasn't been around half of D wing or whichever wing. (Rob)

I questioned in my analysis whether reports of cleaning used needles before injecting truly reflected participants' prison practices or if it was socially desirable reporting given the stigma attached to sharing used needles. Whilst on one hand, spending time to flush out or clean used equipment seems contrary to the reported need to use drugs as soon as they were obtained when in the community, it does seem to align with some participants' reports of how they were sometimes more careful when using drugs in prison by measures such as waiting until a time of day when they would be less likely to be disturbed and when they had time to clean equipment. However, it does not concur with accounts which suggested that prison drug use was quicker and involved taking heightened risks whilst avoiding being caught using drugs. This suggests how the complexities and intricacies of different individuals' prison behaviours and how factors such as the prison security category, relationships between prisoners and the type of drugs used may shape and influence reported prison drug using behaviour and any risks to minimise risks.

Conduct and Behaviour

Participants also spoke about deliberately taking care in how they conducted themselves in prison to reduce the chance of being caught with drugs. Examples of such carefully thought through behaviour included not being seen by prison officers to be spending time with, or in the presence of known drug users in order to reduce the chance of officers identifying them as drug users.

With me having drugs on me all the time, I had to keep out of trouble because I couldn't bring no heat on me. So I just used to keep myself to myself, like I say, get cleaners job and do it right under their noses. As long as I wasn't caught at any doors or stuff like that, because that's when they get the suspicions when they see other inmates at people's doors, talking through doors, getting things from under doors. I used to leave that to everyone else. (Gareth)

Furthermore, some participants said that they had used drugs alone when in prison in order to hide their drug use from other prisoners. Hiding use from fellow prisoners was perceived as reducing the likelihood of other prisoners deliberately or accidentally potentially revealing them to either the prison authorities or to the rest of the prison population to be using drugs. This not only therefore limited the chance that they would be caught, but it was also a strategic measure to ensure that they could keep their drug supply to themselves. As such, they felt less likely to being intimidated into giving up their drug supply or sharing it with other prisoners as they kept their supplies a secret.

Time of Day

Participants commonly reported that the physical presence of prison officers largely dictated decisions they made about when they smoked or injected illicit drugs. This was said to be less of a consideration for participants who illicitly used buprenorphine as it could be used quickly, without obtaining any equipment. This meant that buprenorphine was more amenable to use at any time of day and contributed to why its use was favoured. Choosing to smoke drugs on foil or inject them when there was reduced officer presence was said to be preferable, as this minimised the chances of officers interrupting the participants and discovering drug use.

They do like pad spins (cell searches) on a certain time, you know what I mean, so obviously it's safer for you to do it, say like night time when they've all gone home and changed shifts. (Eddy)

Waiting until night time to use drugs, when there were less officers on duty with diminished responsibilities was said to be common, particularly for participants who smoked illicit drugs, mainly heroin, as this took longer than injecting. For participants, this also meant that they would be able to derive as much of the physical effect of using drugs as possible without wondering if they were going to be caught in the act.

Such instances show how participants often used their knowledge of prison operating regimes to inform their decision making about when to use drugs. It also demonstrates a difference with their community drug use practices. For example, we saw earlier that participants said that community acquired drugs were very much used as soon as they were obtained as they could not wait to feel their effects. However, in prison participants spoke about adapting their behaviour to suit the imposed structures and regime by waiting for what they considered was the optimum time to use drugs. This perhaps highlights that the nature of their use and their addiction in prison was sometimes different to how it had been in the community, as it was more careful and controlled as the quotations from Rob and Bryan suggest.

You did tend to wait till night time because you know once like once the night clockie or the last screw (prison officer) to check your cells you know that once he's gone that at like ten past eight, they're not gonna to come back round again you know what I mean, until the morning so you know there is a very slim chance of getting caught you know what I mean? Whereas if you do it through day you've more chance of them coming to your door. (Rob)

Participants said that prisoners were locked in their cell at night and would not be allowed out until the morning. They explained that wing and landing patrols were reduced at night, thereby lowering their perceived imminent risk of being caught in the act of using drugs so once an officer had patrolled the wing, they were unlikely to return until much later. The time immediately after an officer had conducted their night patrol was when most participants said that they had smoked or injected drugs. This highlights again how they reported to have used their knowledge of the prison system and the rigidity of the daily prison routine to their advantage when contributing to their decisions about when and how to use drugs in prison.

You have got to be very careful 'cos there are officers always passing your door. It is like I always have me pad mate sat at door if I've got gear on foil, or doing owt (anything) like that or just do it late at night when there is like only one officer that might clock you that is on and then they only walk about like every hour. So when they have walked about you have got an hour before they are back again. (Bryan)

Some participants described that using drugs at night was more pleasurable and relaxed on account of this perceived reduced chance of being disturbed. This

possibly suggests that they could derive maximum enjoyment from the physical and psychological effects of the consumed drugs, almost certain in the knowledge that they would not be disturbed by prison officers.

You've got to cook it up and everything and you've got to be able to sit and like you know... so of a night time it is best to inject when you are sat in your cell, doors locked and that and you know as long as you are quiet they are not bothering you all the time, the prison officers. So once your door is locked that is it, it is locked until the next morning. (Paul)

Whilst participants sometimes referred to using heroin at this time as 'safer' as they were less likely to be caught by officers, they acknowledged it was not without some risk. This was because they felt that the reality of using heroin at night was not as safe if they overdosed on it, as the reduced officer presence could mean that they may not be discovered in time to be resuscitated if they did overdose. Nevertheless, knowing this potentially fatal risk did not mean that they did not use heroin in their cells at night as it was perceived that the benefits of using it outweighed the potential risks. Smoking cannabis was not limited to night time in prison, unless it was a particularly potent strain due to its stronger smell or unless it was being used to help facilitate sleep. Rather, participants spoke about smoking cannabis at varying times during the day when in prison as they largely viewed this as an extension of smoking tobacco.

Physical Positioning

Participants spoke about where they physically positioned themselves when smoking or injecting drugs in prison in order to reduce detection, showing how they considered such risks when using drugs in prison. Participants said that smoking drugs by the cell window also meant that drugs and equipment could be quickly disposed of out of the window if an officer entered the cell like described in Pete's quotation on page 232. Another strategy discussed in order to prevent being detected using drugs included sitting in the cell blind spot so prison officers would be unable to see them if they looked through the peep hole on the cell door. Participants said that being alert to the possibility of being caught when using drugs by officers was paramount.

When you're tooting (smoking heroin) away in a cell like or whatever like, do you know what I mean, you've got to watch out for the screws (prison officers). (Tony)

For those who had shared cells, using drugs with cell mates was said to assist in taking precautions to prevent being caught by having someone assigned and positioned to 'look out' whilst the other used the drugs like Bryan's quotation on page 229 demonstrated. Given that participants described the sometimes complex nature of prisoner relationships, it may be debated how much choice some cell mates (particularly non drug users) felt that they had in keeping look out whilst their cell mates used drugs. Alternatively this might have been something that they were more manipulated into doing by drug using cell mates, akin to how non drug users initially felt coerced or manipulated into first trying drugs in prison.

We just sat on the bed. I faced backwards to the door, you face that way (the other way). And smoke like that just in case and kept an eye on the door all the time. (Derek)

During my analysis it occurred to me that having to watch carefully for prison officers when using drugs does not sound to be the most relaxed way of participants using drugs when in prison. However, this was not probed further in the interviews so it is hard to know what they thought about this, how it may have impacted on their prison drug using experiences and any difference in the effect of the consumed drug. Careful physical positioning or relying on other prisoners to watch out for officers was not described as a strategy that needed to be used by people snorting buprenorphine as this was a much quicker administration route than smoking, taking a matter of seconds.

Disguising Drug Smells

Even when participants had used drugs at night in prison they said that they were concerned that the smell of cooked or smoked drugs, particularly heroin and potent strains of cannabis, would lead to their immediate detection by officers.

The first time I'd done it (smoking heroin in prison) I was expecting the door to come through any second because I thought they'd smell it and there is no real ventilation so you think it would linger for ages. (Derek)

As a result, they said that as they used drugs in prison they adopted practical measures to disguise or limit the smell to prevent immediate detection. Like some of the other measures, these often also relied on a degree of prior thought and adapting behaviours. For example, most commonly when smoking, participants opened the cell window in order for the smokey smell to leave and/ or positioned themselves near the opened window to blow smoke out of it. Below, Pete shows the effectiveness of the measures he reported to have adopted.

We had to smoke at window obviously because of smell. So we were stood at window smoking it and the flap went, because you've got flaps on your door obviously, do you know what I mean? So it (the drugs) has gone straight out the window and he has come in, he could smell it, and he said, 'Right. Pad (cell) search.' And he searched all the pad (cell) and he didn't find nowt (nothing). (Pete)

Wayne ensured that the window was closed when he used drugs in his cell, in the belief that the draught from an opened window could have the opposite effect and blow the smoke from within the cell, under the door onto the prison landing. Bryan took precautions to prevent smoke travelling under the door into the prison when using heroin at night to reduce the potential risk of immediate detection.

When you are smoking it, it really smells yes, always. It is like in (Prison 1) in your cell you have got windows here and you have got a toilet with like a barrier, so I always sat on the toilet with window the open and blow it out the window so it didn't come into the cell, unless wind is blowing into the cell. And I always have a towel at door. Because there is a gap at the bottom of the door. (Bryan)

Participants also described having tried to conceal the smell of smoke by masking it with cigarette smoke or air freshener. Bryan's quotation above raises further questions about who he was trying to mask the smoked smell from. Whilst it was not clear from his interview (or from other participants' interviews), it could also be that such measures were not only adopted to prevent detection from officers. Moreover, it could be that participants took extra care when using drugs in prison in order to conceal it from other prisoners for fear of some of the possible violent consequences described earlier in this chapter.

Storing and Disposing of Drugs and Equipment

Participants described that the unannounced searching of cells and personal property was more common for prisoners who were suspected of having drugs, were known drug users, were imprisoned on drug charges or who attracted increased activity outside their cell. Being searched after exercise was also said to be common as this was when prison drug deals were often completed as prisoners could mix more freely with one another. Participants therefore described their strategies which they adopted to prevent being found in possession of drugs and/ or the equipment needed to use them in prison as this would have shown their intent to use them or to trade them. They mentioned varying places where they carefully stored illicit drug supplies and drug using equipment in prison. Some, including Benji and Gareth, said that they favoured hiding and storing their supplies in their cell, such as in 'nooks and crannies,' behind a poster or in a crevice in the wall. Others including Paul, Rob, Derek, Jack and Tony however, kept them on their person. Participants sometimes made distinctions between where they kept drug supplies and drug using equipment. For example, keeping drugs plugged, but needles elsewhere – hidden in the cell or in their shoe was discussed.

They never caught me that much because I'm not stupid, I don't leave it all in one place, I'll keep some of it with me. (Chris)

Participants who kept drugs on their person felt that keeping them in their cells was not advisable and those who kept them in their cell thought this was the best approach. A reason that participants gave for not keeping drugs hidden in the cell was that they could be found if officers searched the cell. Yet, the rationale for those who kept drugs in their cells was that, if found, participants could claim that the drugs did not belong to them, and it would be hard for the prison to prove that they did, which prisoners could not do if they were found on their person. Participants perceived that denying owning drugs meant that keeping their supply in their cell carried less risk than keeping supplies on them. Those who kept their supply on them stated that they stored them anally ('plugged') to prevent them being found, as being internally searched by prison staff was perceived as highly unlikely. Plugging drug supplies was also said to guard against other prisoners trying to steal their supplies. Not knowing where safely to store a borrowed needle after using it, before returning it, was a reason Derek gave for not accepting it from a fellow prisoner, stating that he would be unable to swallow it (unlike with drugs or foil for smoking), showing how he

had carefully considered these things before making a decision about whether or not to accept the needle.

Participants said that they also took care to dispose of drug using equipment such as needles and homemade crack pipes in prison away from the vicinity of their own cells. For example, disposing of equipment out of the cell window or in the exercise yard was said to reduce the risk of it being found nearby which itself could result in increased observation of the prisoner if the prison had suspicions that they were using illicit drugs.

I took the pipe down to my mate and just told him to destroy it when he'd finished using it, you know what I mean. But I told him not to throw it in his bin just in case the screws (prison officers) do come in you know just for a check which they do sometimes, you know, they come in your pad and check around to see if you have got owt (anything) what you shouldn't. So I told him just take the pipe apart and take it to bin down the end of wing. I just told him to throw it in bin down end. You know what I mean so it's out of the way. So if screws do find it, they don't know whose it is. (Matty)

In Matty's quotation above it is apparent that he had concerns as to what would happen if his friend did not carefully dispose of the equipment and it was found by prison officers. Whilst this might be because he was genuinely concerned for his friend, it may also be that he was worried that his friend may implicate him if questioned about the equipment if officers found it.

When I finished using them (needles) like, because they get blunt quite easy don't they, do you know what I mean, and you can't use them on yourself when they're blunt anyway, do you know what I mean? You try and discard them the best way you can. (Tony)

Deceiving Formal Drug Testing

Participants also described the measures which they had taken to avoid being caught with drugs in their system after they had used them through formal prison voluntary or mandatory drug testing. These measures differed as they usually had to be considered for a longer amount of time than just the immediacy of the prison drug using situation, for as long as the different illicit drugs remain detectable in the body. For example, participants such as Jamie believed that drinking lots of water,

('watering up') watered down the consumed drugs and therefore made it difficult for tests to detect drugs. In addition, 'strapping up' largely seemed to depend on an amount of advance planning and preparation. This technique referred to obtaining drug free urine from someone who had not used illicit drugs and attaching this to their body so that they could secretly provide it in place of their own urine if tested. Whilst on the one hand it sounds quite improbable, given some of the other ingenious and determined ways participants had said that they had adopted in order to use drugs and evade detection, it might not be so unlikely a technique. Kev described more about what this entailed.

You just have a tube of toothpaste, empty it all out fill it with urine put it between cheeks of your arse then when you go to give a piss test you just pull it down, flick it off, squirt it in. (Kev)

Since the more recent introduction of thermometers on prison drug urine testing devices, Bobby said that he ensured that the obtained urine was kept at body temperature in case he was tested. Again, techniques such as this appeared to have been more considered in advance, possibly highlighting the desire to continue using drugs or the desire to not get caught so doing, or a combination of both. Irrespective of their efficiency, they also arguably illuminate clever and well thought through techniques and an element of guile or at least determination from the prisoners using them.

Strapping up is when you get a bottle of someone's sample who's clean and you sort of tie it round your waist and when they ask you to give a sample, you put the bottle urine sort of thing. You get a kettle of water, and you sort of heat it up with the water in your kettle, you know because it would be cold, and they feel for a temperature so you just heat it up with the water. Because roughly what they do after that, they tell you oh you've got a test, you've got about three hours to give it in, so in that time you can just go and sort everything out. (Bobby)

Despite discussing ways they had tried to minimise the possibility of being caught, participants described that they had previously been caught with drugs and having used drugs. Appealing their innocence after being caught in possession of illicit drugs had sometimes resulted in charges being dropped. This suggests that prisoners were sometimes able to deceive prison authorities convincingly, or were keen to portray

this suggestion to me. From the analysis it was evident that knowing prison protocols and procedures had helped them to avoid reprimand during their sentences. This is because they used this knowledge to determine their behaviour and practices to limit the possibility of being detected, either in the act of using drugs or afterwards, having used drugs. For example, having drug related charges dropped by claiming that they were not present when the officers had discovered drugs or drug traces, suggesting that these could have been planted by corrupt prison officers. This again raises the issue of self presentation in the interviews. For example, did men try to impress me by presenting themselves as clever on account of not having been caught? Some participants claimed to have never been caught using, or in possession of illicit drugs in prison, often despite numerous prison sentences. This, if true, suggests the effectiveness of their precautions and/ or the relative ineffectiveness of prison search and testing procedures.

Chapter Summary and Discussion

This chapter has identified participants' drug using behaviours and specific practices when in prison and how being in prison influenced, motivated and impacted on these. It was not the prison sentence itself that impacted on participants' drug use, but looking beyond their initial practical explanations, it is possible to identify a variety of complex psychological, social, environmental and situational factors which combined to shape and determine their drug using behaviours when in prison. The accounts presented raise a number of interesting psychological questions and issues about the men's reported drug use behaviour when in prison. The summary and discussion that follows considers some of these and the significance of some of the key aspects reported to contribute to participants' prison drug using behaviours in relation to the research aim of exploring the impact of imprisonment on injecting drug use.

Running throughout participants' accounts was the influence of others on them when in prison. Social networks and relationships with fellow prisoners were pervasive and influenced prison drug using choices and behaviours, such as initiation and drug dealing. The implicit pressurised nature of drug initiation in prison was suggested through participants' reported desire to feel accepted amongst their peers, suggesting the intensity of social pressures and their potential to be easily influenced by others. Studies exploring drug initiation have also highlighted initiation in prison. For example Strang et al. (1998) found that 20% of the surveyed sample of adult males from 13 prisons in England and Wales reported first using an injectable drug in

prison, mainly heroin. Similarly, a larger cross sectional survey of 131 prisons in England and Wales conducted in 1995 found that 25% of the heroin users had initiated in prison and concluded that prison was a high risk environment for drug initiation (Boys et al., 2002). With both of these studies it is impossible to know whether the participants would have initiated use if they had not been in prison. The figures could under-estimate prison initiation if participants worried about declaring this use when in prison or could over-estimate use if participants exaggerated their use in order to express negative feelings about the prison system (Boys et al., 2002). Nevertheless, further research into more recent prison drug use initiation experiences may warrant attention to explore the issue further as those in the current research who initiated a new drug in prison reported starting using buprenorphine.

As identified in Chapter 2, relationships between prisoners, particularly those which existed prior to imprisonment, influenced and facilitated their access to drugs in prison, highlighting the influence of others on them and their drug use. This concurs with findings from other English retrospective qualitative research (Hughes, 2000d; Hughes, 2003b; Hughes & Huby, 2000; Tompkins et al., 2007a; Turnbull, Stimson & Stillwell, 1994) and a study conducted in an Irish prison (Dillon, 2001). Varying degrees of sophisticated, formal drug dealing existed within prisoner relationships (Crewe, 2006; Dillon, 2001; Penfold, Turnbull & Webster, 2005), however these relationships were instrumental and were not portrayed as having benefits aligned to more conventional friendships, showing how they were maintained, used and manipulated to serve the function of acquiring and using drugs in prison (Crewe, 2006). Participants who were reunited in prison with community drug using contacts or associates sometimes felt morally obliged or implicitly coerced to maintain the drug using aspects of these friendships (Dillon, 2001; Hughes, 2000d; Squirrell, 2007). Thus while participants might have been motivated to abstain from using drugs in prison, this was complicated by the presence of drug using peers and the physical experience of withdrawal (Hughes, 2000d; Squirrell, 2007; Tompkins et al., 2007a). Imprisonment also presented the opportunity for prisoners to form new contacts and affiliations which were also often insincerely centred on pursuing illicit drugs (Crewe, 2006; Dillon, 2001; George & Moreira, 2007; Hughes, 2000d) or facilitating more formal drug dealing (Matrix, 2007).

Concurring with a finding from the literature review, illicit drugs were expensive and of a reduced quality and deal size in prison (Hughes, 2003b; Penfold, Turnbull & Webster, 2005), also concurring with a qualitative study conducted with drug users in

prison in Scotland (Wilson et al., 2007). This, and fluctuating drug and equipment availability within and between prisons, subsequently impacted on a participant's prison drug use (Bullock, 2003; Hughes, 2003b; Penfold, Turnbull & Webster, 2005; Tompkins et al., 2007a; Wilson et al., 2007). Six main methods accounted for how drugs were obtained in prison, commonly having been smuggled to prisoners on from the community such as on open social visits (Blakey, 2008; Hughes, 2003b; Penfold, Turnbull & Webster, 2005; Turnbull, Stimson & Stillwell, 1994). However, participants reflected that increased security on visits and prison perimeter boundaries made supplying drugs in these ways much harder (Chambers, 2010), reflecting the restricting supply policy focus. The introduction of more closed visits, increased 'airport style' security and the use of Body Orifice Scanner System (BOSS) chairs to detect hidden metal or plastic have been suggested to restrict supply of drugs through visitors (Chambers, 2010). However, as these measures are expensive and closed visits are seen as against prisoner human rights, their universal introduction is unlikely (Blakey, 2008; Chambers, 2010). Rather than deterring participants from obtaining drugs in prison, increased security measures encouraged them to find alternative supply routes. More recently and most commonly, drugs were smuggled into prison by prisoners themselves (Blakey, 2008; Hughes, 2003b; Turnbull, Stimson & Stillwell, 1994). Ingenious and carefully thought through ways were often used to achieve this, requiring a degree of prior preparation and planning which could be seen as contrary to their hectic community existences and demonstrating the extent of their intentions. Yet, as such protective practices were employed in the event of being sent to prison to safeguard against being sent with no drugs, they often formed part of their community behaviour. This is not to doubt their ingenuity or planning, as some of the ways participants had taken drugs into prison with them were only possible with their insights of prison environments and how they operated, gained from their prior imprisonment. When in prison, drugs acted as a significant currency and the swapping and trading of items in exchange for drugs and/ or equipment required to use them resonates with other findings (Cope, 2000; Long, Allwright & Begley, 2004; Penfold, Turnbull & Webster, 2005; Wright, Tompkins & Jones, 2005). Furthermore, having and dealing drugs was viewed as a particularly powerful commodity within the prison economy (Crewe, 2006), but both possessing and acquiring drugs without being able to pay for them were not without significant potential perils.

As identified in other studies, prison officers were also thought to supply prisoners with illicit drugs (Blakey, 2008; Chambers, 2010; Dillon, 2001; Penfold, Turnbull &

Webster, 2005). However, as no participants admitted having directly obtained drugs through them, this could be rumour. Alternatively, they may have felt reluctant to report this due to fear of onward reporting, potentially jeopardising access to drugs if imprisoned again. Participants may have described these beliefs to reinforce and minimise their prison drug using behaviours, imply their uneasiness with those in positions of responsibility or to align with views that officers turned a blind eye to drugs as they helped to subdue the prison environment and maintain some level of order, if largely illegitimate. Yet as the research did not ascertain the views of prison officers or non drug users who had been in prison, it is impossible to know if these claims truly reflect the situation. However, they do seem to concur with qualitative prison drugs research which included prison staff (Keene, 1997b; Penfold, Turnbull & Webster, 2005). Keene's 1995 study in a small local British prison found that officers' opinions about drugs in prisons varied, though most identified the beneficial calming effects and there was ambivalence about tightening up on drugs in prison if it had an adverse effect on control (Keene, 1997b). Penfold, Turnbull & Webster's later research (2005) acknowledged that whilst drug trafficking by prison staff took place, the true extent of the behaviour was impossible to determine although leaked details of a year-long Metropolitan Police investigation estimates that there were around 1,000 corrupt prison staff in 2006 (Chambers, 2010). The confirmed involvement of officers in the prison drug trade³⁴ further acts to reinforce participants' claims of the reach of the prison drug culture, a culture which they argued was needed and beneficial to the prison environment. Their assertions that prisons ran more smoothly with drugs, coupled with their ingenious and resourceful supply routes demonstrates their determination to ensure the availability of drugs in prison and highlights the scale of the ongoing challenge facing the Prison Service to keep drugs out of prisons.

Consistent with previous research outlined in Chapter 2, receiving insufficient or inadequate clinical medication to relieve distressing and painful opiate withdrawal symptoms (Broderick & Kouimtsidis, 2007; Hughes, 2000b; Tompkins et al., 2007a) contributed to heroin use in prison (Hughes, 2000b; Penfold, Turnbull & Webster, 2005; Tompkins et al., 2007a). This was because participants did not consider the risks of using drugs as consciously at this time as they might have done if not withdrawing, thinking about the present moment over some of the potential long term consequences (Hughes, 2000b; Hughes, 2001; Hughes, 2004). However, when

³⁴ Such as Prison Officer Patricia Olliverre who received a seven year prison sentence after being found guilty of smuggling heroin to prisoners in London (Baker, 2009).

compared to earlier sentences, the experience of drug withdrawal had reduced with more adequate opiate dependence medication over time. This change was reflected in participants' accounts as they sometimes saw prison as providing an opportunity to stop drug use, encouraging some to go on purpose (Tompkins et al., 2007a) yet they also spoke about the inconsistency of prescribing across different prisons. Deliberate imprisonment in the hope of receiving substitute medication was not without its risks as provision differed across prisons within the estate, reflecting changing policies over time and concurring with findings from the policy and literature review. Furthermore, receiving medication often relied on identifying as a drug user which they were wary of due to previous stigma and discriminatory doctor attitudes (Tompkins et al., 2007a). This suggests that despite the introduction of the Integrated Drug Treatment System in prisons (Department of Health, 2006), the uniformity and reach of prison prescribing policy and inconsistencies remained, although this will be reflective of when participants had been in prison, as many of their last sentences were before IDTS was formally introduced in 2006. This identifies an area where further research to explore the access and sufficiency of recent prison drug treatment and determine the impact of this on drug use and other areas since IDTS within prison would be beneficial.

There is increasing evidence to highlight the benefits of providing opioid substitution therapy to prisoners, including reduced drug use and drug injecting in prison, improved physical and mental health and preventing disease transmission (Dolan et al., 2003; Stover, Casselman & Hennebel, 2006; Stover & Michels, 2010; World Health Organization, 2005). Yet despite the introduction of substitute medications to assist drug users and control withdrawal, prisoners had commonly obtained prison prescribed medications to use illicitly in prison to obtain a euphoric effect. Whilst reports have highlighted buprenorphine misuse by snorting in prisoners in England and Wales (George & Moreira, 2007; Ministry of Justice, 2007; Penfold, Turnbull, & Webster, 2005), they provide little by way of understanding the patterns and reasons for it. A strength of the current study is therefore the in-depth exploration of this new trend to improve understanding about it and provide evidence to complement existing studies (Tompkins et al., 2009). This is significant considering how it was described to have become the drug of choice in prison, taking over from heroin. This may consequently require different prison clinical treatment and counselling approaches to address it which, given the relative newness of the trend, may not have been sufficiently considered or developed by the Prison Service. Whilst it is unknown whether or not prisoners would have started misusing buprenorphine if its

prescription had not been introduced, participants alluded to its widespread availability across prisons, suggesting that it would have been available irrespectively, although availability through other supply routes may have only increased after its introduction. The relatively little reporting of prison buprenorphine misuse before its prescription ties in with this. Whilst previous qualitative research conducted with 121 serving or recently released prisoners in 6 prisons in England and Wales suggested that prisoners receiving buprenorphine were intimidated into giving it up (Penfold, Turnbull & Webster, 2005), the current study did not find this. Rather, buprenorphine contributed to the potential for violence between prisoners due to having a supply that others wanted, accumulated debt or the sale of feigned medications. Participants may have been reluctant to report intimidating others or having been intimidated for their medication due to issues of social desirability and presentation of self. However, given the extent of bullying, threatening and violent behaviour reported it is probable that participants did not report medication intimidation as they had not experienced this as there may have been access to buprenorphine through other means when they were in prison compared to 2003/4 when Penfold, Turnbull and Webster conducted their research.

Drugs were felt to shape daily life in prison. The impact of loss of liberty associated with being in prison and the strictly enforced timed regime and rules about acceptable conduct and behaviour have been described elsewhere (Cooke, Baldwin & Howison, 1993; Jewkes & Johnston, 2006; Matthews, 2009). For prisoners, having enforced and repetitive, highly structured regimes with few constructive activities to help pass the time, soon became boring and monotonous and these have been shown to negatively impact on the emotional and psychological health and wellbeing of prisoners, making it harder for them to manage themselves and control their behaviour (Cooke, Baldwin & Howison, 1993; Jewkes & Johnston, 2006; Nurse, Woodcock & Ormsby, 2003). Participants gave psychological and emotional reasons for continued use of illicit drugs, using in order to feel a 'head change' from being in prison concurring with Irish (Dillon, 2001) and Scottish (Wilson et al., 2007) research. Participants' choice of drugs reflected the desire for a 'head change', using depressants rather than stimulants, resonating with other research (Bullock, 2003; Singleton, Farrell & Meltzer, 2003) including research with young offenders in prison (Cope, 2000). In particular, 529 male prisoners who admitted to using drugs in the year prior to incarceration were identified as a sub-sample (73%) from the Criminology Survey earlier discussed (Liriano & Ramsay, 2003) were followed-up and interviewed about their prison drug using behaviours (Bullock, 2003). Bearing in mind a number

of methodological caveats linked to this³⁵, a marked tendency in the use of stimulants in prison was found over the use of depressants, namely cannabis and heroin (Bullock, 2003). Cannabis and opiates were also reported to be the drugs most often used in a further quantitative survey of 2,720 prisoners aged 16 and over from a sample representative of all prisons in England and Wales conducted between 2001 and 2002 (Singleton et al., 2005) and in a Scottish interview study (Wilson, 2007).

The physical numbing effects of depressants helped prisoners to relax, overcome boredom, facilitate sleep and pass the time (Cope, 2000; Crewe, 2006; Dillon, 2001; Keene, 1997a; Keene, 1997b; Lester, Hamilton-Kirkwood & Jones, 2003; Nurse, Woodcock & Ormsby, 2003; Penfold, Turnbull & Webster, 2005; Tompkins et al., 2007a), and as such, this drug use acted as a form of self medication. Furthermore, the initially uplifting, but later relaxing, effects of buprenorphine were also described as pleasurable and suited to the prison environment. Use was seen as beneficial in escaping from the monotony and reality of imprisonment and offered participants a way of coping with the boredom of being in prison and reducing their associated worries. In addition, it allowed them to retain some control over their lifestyles by maintaining a connection with the drug using nature of their pre-prison lives.

To some extent, continued drug use in prison (of whatever frequency) may be seen as a way in which participants tried to combat and release some of the psychologically destructive impacts of the restricted and monotonous prison routines and limited choice in what they were allowed to do. The occasional use of drugs when in prison as a 'reward' or 'treat' for not having used them is a useful example here. Using drugs in prison is therefore speculated to have played an important role for participants' emotional and psychological wellbeing in feeling that they could assert and regain (if only briefly), some choice and agency in their actions in response to the lack of stimulation within the heavily controlled prison environment and some enjoyment (if only temporarily), from doing so. To them, exercising this choice had the psychological benefits of feeling more in control and in so doing brought with it other perceived benefits such as feeling relaxed and what could be classed as 'momentarily freer' from the prison, from its restrictive regimes and from other prisoners. Alongside this, it enabled them to feel some mental reprieve and escape from the confines of the conditions of their imprisonment and the length of

³⁵ Such as the non representative nature of the sample due to involvement in the study relying on prisoners self reporting drug use and the disproportionately high number of short sentence prisoners in the sample (Bullock, 2003).

their sentences. The psychological significance of this for the individuals is that it arguably lessened intense feelings of prison-compounded anxiety or depression, evident from such things as their problems sleeping, low and changing moods, episodes of self harm, violent and hostile outbursts, feeling withdrawn and unmotivated with a lack of energy and inability to concentrate. Furthermore it also served to contribute to participants feeling calmer for some time period on account of having exercised some personal control over their situation and/ or at least from the sedating effects of the type of drugs consumed.

Where participants injected in prison they sometimes reported having engaged in risky practices, such as injecting with used needles. However the retrospective nature of the interviews makes it is hard to situate some of their accounts, as it is possible that they were talking about their experiences in prison some years previously. Indeed, they highlighted that going to prison had impacted on their injecting as they largely reduced their drug use in general and reduced their injecting when compared to their community injecting, also concurring with other research using quantitative (Bullock, 2003; Plugge, Yudkin & Douglas, 2009; Singleton, Farrell & Meltzer, 2003; Singleton et al., 2005) and qualitative (Shewan, Gemmell & Davies, 1994; Wilson et al., 2007) methods. For example, the follow up study of the Criminology Survey which identified reduced levels of drug use and injecting when in prison when compared to pre-prison reports. Indeed, 2% of those using drugs in prison, compared with the 35% pre-prison rate said that they had injected in prison, although it may be that these figures under-report the true extent as some participants were in prison at the time of interview (Bullock, 2003).

In particular, injecting in prison had reportedly decreased in more recent years where access to needles was limited through increased security and injecting with used needles was considered risky (Wilson et al., 2007). For participants, it was not the access to needles that was problematic per se, but the access to good quality, sterile needles which did not carry the risk of disease transmission. This demonstrates how they had received harm reduction messages about these things and tried to minimise risks when injecting, such as only sharing needles used by people who they knew and trusted. However, akin to research examining the risk of drug use in prison, it is uncertain how effective these strategies were in eliminating hardy HIV and hepatitis C viruses and reducing transmission (Hughes, 2000b; Hughes, 2000c; Hughes, 2004; Long, Allwright & Begley, 2004; Shewan et al., 1995; Wilson et al., 2007). In addition, making decisions about risk based on the nature of a social relationship

neglects the fact that participants' assumed knowledge about a person may be inaccurate and potentially risky.

The presence of drugs which could be used in ways other than injection, contributed to reduced prison injecting. Whilst snorting buprenorphine in place of opiate injecting in prison arguably reduces risky injecting, subsequently potentially reducing the risk of related complications, blood-borne virus transmission and sometimes fatal overdose (Obadia et al., 2001; Winstock, Lea & Sheridan, 2008), it is not risk free as it did not reduce the risk of individuals developing a habit which could be hard to maintain with fluctuating supplies and/ or getting into debt with peers.

The reduction in prison injecting finding contrasts with Irish research which identified that injecting was the favoured administration route in prison in order to make the most efficient use of the small quantity of heroin available (Dillon, 2001; Long, Allwright & Begley, 2004). Yet the reduction in injecting concurs with other evidence to suggest a reduction of injecting in prison (Shewan, Gemmell & Davies, 1994; Strang et al., 1998) including amongst women prisoners in England (Plugge, Yudkin & Douglas, 2009). It must be considered that participants reported reducing injecting when in prison as they were aware that the current research was investigating the impact of imprisonment on injecting drug use (Wilson et al., 2007). Alternatively the illicit, clandestine and stigmatised nature of sharing needles within drug injectors and the associated social desirability of reporting less acceptable behaviour (Bennett et al., 2000) could mean that the true extent of prison injecting may have been under-reported for fear of negative judgement, reprisal or punitive consequences, thus resulting in a desire for participants to present desirably and minimise certain behaviours. An alternative suggestion is that the reporting of reduced injecting in prison truly reflected the nature of their situations in prison. This would concur with findings of quantitative surveys and may point towards an anti-injecting culture in prison (Wilson et al., 2007) or a desire to distance themselves from the negative connotations and stigma associated with injecting drug use (Crewe, 2006).

Given the risks that participants had been exposed to and the lengths that they had previously gone to in order to inject illicit drugs, in the community or in prison, it is perhaps improbable that they would just stop injecting by virtue of the fact that they were in prison and there were risks of being caught or contracting blood-borne viruses of so doing. Rather, for participants who showed themselves to be risk takers in terms of the illicit activities and pursuits that they had been involved in in their

pasts and who had been involved in drug injecting for so long that the behaviour dominated their way of life and was ingrained in it, it could be more expected that their behaviours and practices in prison would continue as closely to their community behaviours and practices instead of them changing. However, as shown earlier, they adapted their drug using behaviour in prison to the changing nature of the immediate environments in which they were in at the time and managed this in a way that did not necessarily mirror their reported community practices (Crewe, 2006; Shewan, Gemmell & Davies, 1993; Wilson et al., 2007). That is, in contrast to how participants described their drug use before their imprisonment, their drug use in prison appeared to be lower and much more careful and controlled, possibly reflecting the greater element of active choice about what was used and when was used (Crewe, 2006), or possibly reflecting the impact of mandatory drug testing in prisons (Singleton et al., 2005) or a combination of varying other factors.

The impact of drugs on the prison environment cannot be underestimated. This is an interesting contradiction, as on the one hand, using illicit drugs provided a more stable and calm environment when prisoners were sedated from their effects, like identified in a prospective interview study of 29 prisoners (mainly men) in an Irish prison (Dillon, 2001). However, on the other hand, fluctuations in drug supplies and availability created tensions amongst prisoners and a prison atmosphere characterised by uncertainty, increased agitation and volatility amongst prisoners as they went to great lengths to obtain them. This sometimes led to the danger of getting into drug debt, as unpaid debts increased the risk of violence and intimidation (Matrix, 2007), contributing to threatening prison environments (Crewe, 2005; Crewe, 2006; Dillon, 2001; Penfold, Turnbull & Webster, 2005). This highlights the complex impact of drugs in prisons on the power of certain prisoners and on the relationships between prisoners. A novel finding of the current research was how the risk of getting into drug debt, coupled with prisoner's limited access to money, deterred participants from using drugs to the same levels in prison as prior to imprisonment. Revealing this finding might be because the study took a broad view of risk and sought to explore men's reasons and motivations behind their prison drug using practices and experiences alongside their practices, and other studies may have only focussed on the health risks of prison drug use (Hughes, 2003b), or may have been more concerned with the reported experiences, giving less consideration to the reasons. Nevertheless, this finding highlights how the management of their drug addiction was arguably different in prison to the community, in so much that it seemed to be more actively considered than in the community, in a way that is more reflective of the

prison environment which influenced participants' access and use of drugs (Wilson et al., 2007).

Environmental factors such as the risk and punishment of getting caught deterred, but did not necessarily prevent, Class A drug use in prison (Bullock, 2003; Singleton et al., 2005; Wilson et al., 2007). However, these were highly individual and situational and how an individual man perceived them could change depending on their circumstances at the time. Such factors would also be considered alongside the perceived benefits of using drugs, although formal appraisal of the advantages and disadvantages did not take place, as men's decisions whether or not to use drugs and what to use were more fluid and responsive to the situations at the time although where prison presented individuals with negative experiences, the benefits of using drugs were reinforced over the costs and so use continued in some way (Wilson et al., 2007).

Using drugs in prison was daring and carried the risk of being caught. Consequently, the excitement of avoiding detection motivated some prison drug use although using buprenorphine was sometimes deterred as it was believed to be more tolerated by prison authorities so using it was not considered as exciting as other drugs, highlighting another intricacy in participants' account. As getting caught was considered the main risk of using drugs in prison, varying strategies were employed to avoid detection, some which required careful thought, such as considering the type of drug used, the administration method and their general conduct and behaviour. Some of the more practical measures, such as using at night time or evading urine testing, appear to have been more successful at reducing the risk of being caught, demonstrating how prisoners used their knowledge of the prison systems and/ or imaginative and sometimes cunning techniques to their benefit, actively adopting and adapting these where necessary in line with changing prison practices.

Further discussion of participants' prison drug using behaviours on their last sentence is provided in Chapter 9. The next chapter considers what happened to participants' drug use when they were released from prison on return to the community.

Chapter 7 - Drug Use After Imprisonment

This relatively short chapter explores participants' accounts of what they said happened to their drug use when released from prison, a time characterised by leaving highly structured prison environments and regaining liberty to rejoin the wider community. A number of issues were identified to influence release drug use. These included the lack of stable accommodation and drug temptation and these codes are all clustered together and presented in this chapter under the category Release Plans and Use. Finally, the summary and discussion at the end of the chapter considers how the findings relate to the existing empirical literature in the field.

Release Plans and Use

Being released from prison into the community was discussed as a pivotal time in relation to drug use, irrespective of specific prison drug using behaviours. Being released back into mainstream society was often referred to by participants as a time when they were 'kicked,' 'booted' or 'turfed out,' particularly in the case of unplanned or emergency release³⁶. This also made any attempt at planning for after care arrangements, such as with housing, employment, education and social security more difficult. I found participants' use of vocabulary about release interesting since it implies that they commonly felt that they were made to leave prison without much notice or care. Furthermore, it raises the question as to whether they wanted to be released on account of some of the beneficial things provided in prison compared to the community. In many cases, participants described how they had intended not to use drugs on prison release but in reality this was rarely accomplished. Factors which influenced this included a return to previous circumstances, reacquainting with drug users, drug temptation, lack of stable accommodation and sentence length.

Return to Previous Circumstances

Being released from prison was spoken about as a time when participants returned to the lives that they lived before prison. This included poor family relationships, no

³⁶ The emergency release scheme began in June 2007 to ease prison overcrowding in England and Wales due to concerns about rising prison numbers. Prisoners serving determinate sentences between four weeks and four years for a range of less serious offences were eligible to be released on End of Custody Licence up to 18 days earlier than their release date. The scheme was phased out in 2010.

employment, unstable housing, lack of money, few opportunities and using illicit drugs. Whilst some said that they had had an element of hope that their lives and drug use would be different to how they had been, the reality of this was discussed as complex and hard to accomplish. More often than not, participants described there being no support or plans in place, so things had rarely changed for them on release, highlighting the role that official agencies were expected to play in this in helping them to reconnect with their situations on release. Participants said that they felt disappointed and let down when plans and/ or support agencies had organised for their release (or were meant to have been arranged for them) but were not fully realised when they were released, contributing to a lack of distrust in them over time.

I'd been told all these different things that you can do when you get out of jail and they are actually all bollocks, I really didn't have the opportunity to any, you know, they were saying probation can do this for you, they can get you a job here, they can do this that and the other. And when I got to probation they weren't interested, you know, if you wanted a job you had to go to a job centre and get one and you know, they were all the same crap all jobs, there was just no chance I was going to do. And I mean it's not to say boredom. It's not say predictability, it's just sort of when you realise actually that nothing's different you go back to it (using drugs), being the most interesting thing that you know.
(Al)

They explained that feeling let down, often by community services, and nothing having changed for them how they had expected or hoped when they were released subsequently influenced their drug use. They inferred a sense of inevitability about using drugs, by returning to a behaviour which they were familiar with and to a lifestyle which they were accustomed. However, it is possible that this was a way participants rationalised and justified their actions and drug use to themselves. If so, and like the nature of some of the quotations suggests, this highlights that participants portrayed that they had diminished responsibility and active choice for their behaviour on release. Rather, they actively blamed their behaviour and actions on other people and organisations and the failure or the lack of support. Pete spoke about returning to using drugs and committing crime and spending time with the same people on release as he did before prison, even though he became drug free when in prison.

I used to go into prison and you would get clean, you'd be buzzing and you would get clean, but then you build no structure and nowt (nothing) up while you were in prison, so you were coming out of prison and just going back to the same thing. Back to using, back to the same people, back to thieving all the time and that. It isn't no good. It isn't a life really. (Pete)

Sean suggested that his family relationships broke down when he was in prison. He blamed this and the lack of organisational help in finding him housing to account for why he 'looked' to using drugs.

When you come out of prison, when you've lost everything, like I lost my family, my wife, my children and everything. It was a case of you come out and you've got nothing to come out to, they don't help you re-house yourself or anything when you come out and because you've got nothing you are looking for something to take it away sort of thing and that's why I ended up using every time. Because I've got nothing and it's just so depressing. (Sean)

I found the lack of structure on release, as noted by Pete above and in the quotation from Steve below, an intriguing contrast with prison routines which were described as too regimented. Yet it appeared that there may have been some implicit comfort provided by such structure, as being released from structured environments back into society where they had little if any structure in terms of employment, responsibility and family magnified the sharp contrast with prison and felt unmanageable. Steve suggests that he would have benefitted from some help on release from prison.

I got clean and came out and that were it. But there were nowt (nothing) there, there was no structure, there was nothing there at all. It were like you got out of the gate, out of the gate with £50 and there was no help there whatsoever. It were, you were straight back out and like I said from half way through if you have no family you were knackered and you'd go straight back on the street. You would be using within a week again, if not the same day. (Steve)

Reacquainting with Drug Users

The influence of other people, particularly known drug using partners or peers, was described as one of the main reasons that had encouraged participants to use illicit drugs on release from prison. Whilst no one said they had been forcibly coerced into

using drugs again, they described how 'bumping' into people who they had known and used drugs with before tempted them to use, like it had done for some of them when they were in prison. Temptation on release was compounded by feeling that they had little support and few meaningful activities in which to engage. This combination of factors appeared to overlap and interplay to result in post prison drug use.

When you're in prison it is always different, you think right that's it when I'm in here – when I get out I am not using again but as soon as you get out you bump into same old crowds and you end up using again. (Bryan)

I didn't have intentions to use. It wasn't until I bumped into a few people that were going to buy drugs themselves and I knew them really well and I got enticed into doing it. (Jack)

This appeared to occur irrespective of whether they had continued drug use in prison, suggesting the strength of the influence of other people on the participants or their possibly easily led natures. For participants who had continued to use drugs in prison, there seemed to be no question about continuing this use on release, portraying a more active side to their involvement in decisions to use drugs.

I was still on gear when I came out. It was obvious I would go and score when I came out. (Wayne)

If you carry on taking drugs while you are doing the sentence you're going to do them when you get out. (Andy)

However, there were often changes in the drugs used on release and the ways they were used. For example, no men reported continuing using buprenorphine when released from prison, but rather heroin use was reinitiated. Furthermore, the opportunity to inject was described as a welcome change to that of mainly smoking heroin in prison. Participants were conscious of the risk of overdosing when injecting if having not injected for some time and some had previously overdosed when they injected heroin on release. For those who said that their drug use had reduced or stopped in prison, the influence of these other people, combined with the desire to feel the effects of illicit drugs was said to contribute to them 'ending up' using heroin on release. Like earlier, this was an interesting use of language. Whilst it might that

participants used this figure of speech without any connotations, this could be debated as there is an implied sense of inevitability connoted by its use, possibly suggesting that participants felt defeated and powerless to the situation. Alternatively, this might have been an easier way for participants to rationalise their actions, rather than justifying it as an active choice they made.

Drug Temptation

Believing that they would be able to control the amount of their drug use on release, by using occasionally or only using once was also stated by participants as a further factor which contributed to them using illicit drugs on release. This belief may be due to how their use in prison had sometimes seemed more controlled than how it had been before they were in prison, as discussed in Chapter 6. Most participants said that they had engaged in some drug use at some point on previous prison releases. Participants spoke about how occasional drug use or 'dabbling' soon became more frequent and gathered over time. This use then gradually built up and was sometimes described as inevitable, like a 'vicious cycle' or a 'downward spiral' which was impossible to control or stop.

After I got out of the nick (prison) and from my own stupidity like, do you know what I mean, I got back with the old crowd and that and got back on it, do you know what I mean? I used to say to people, 'oh I'm only dabbling like, do you know what I mean?' But you can't dabble on that shit. (Tony)

I thought I could control it, I mean take it or leave it. But it is just like rolling down a slippery slope, do you know what I mean, you can't stop yourself. (Benji)

To some extent, using drugs on release was described as a treat, almost like a reward for having been in prison and was a way participants 'celebrated' their release.

Every sentence I have ever done right, even sentences when I've gone in to get away from it, the first day out I've gone to some sort of drug or other and it's either crack or heroin. Always, it happens every time. You do it as a treat. (Kev)

However, the psychological reward element of this soon disappeared as participants described how use became a more regular feature of their everyday lives. Justin's extract below suggests how his drug use on release increased and crept up on him, like that described in the Dawning of Addiction.

I felt great that I were getting out, you know what I mean, I thought, yeah, brilliant, you know what I mean? But then in other respects I'm coming out of prison, you know what I mean, how am I going to live? How am I going to get a job? Stuff like that. So first thing you do, is yeah, I get a bag (of heroin), I can handle a bag, I will be all right, you know what I mean, so you have one that day, then it is the next day I feel a bit crap, I can get another bag it has been two, its only two days, and that goes on and the next thing you know you are back on it. (Justin)

Not all participants who used on release did so as they could not control the temptation to use. Rather, some described looking forward to prison release as they would be able to use illicit drugs, namely heroin and crack cocaine and feel the effects of them in a less controlled and austere environment than in prison. These participants spoke of feeling excited in anticipation of being released as they knew that they would use drugs.

I'm only in for short sentences and I sleep for the first month, two months. By that time it's counting down to getting out... It is exciting, knowing that you can go out and you can get some (drugs). (Adam)

Furthermore, they knew that they would use money from their prison discharge grants to buy drugs to use. Eddy described the inevitability of this.

Discharge grant went the same day as I got out. But at the end of the day I just went and scored, because obviously like I hadn't done it for four month. (Eddy)

When in prison thinking about using drugs on release was said to motivate participants and focussed their thoughts about release. In particular, thinking about using crack cocaine either on its own or in combination with heroin, was said to dominate thoughts about using drugs on release.

A lot of people score when they get released and it's like basically what it is, you say you've been banged up for X amount of time, yes, you're not thinking about brown (heroin), you're thinking about crack.....It's more psychological with crack than the craving it is with brown, you know what I mean? So that's why you think about the crack when you're in jail, and especially when you're getting near release, that's all you are thinking of, just crack, you're thinking of your first lick on a pipe. (Eddy)

Participants attributed this to feeling that the effect and craving for crack cocaine was more psychological and stimulating than that of heroin which was a more physical feeling. This was not to say that they did not want to use heroin on release, but if they had used drugs in prison these were most likely to be heroin or buprenorphine. Therefore, they felt more excited to use crack cocaine and feel its uplifting effects when released as they had largely been without it in prison. They also felt excited to use crack cocaine on release as the less restricted and controlled environment outside prison would amplify the uplifting effects of the drug, contributing to a more intense experience when directly contrasted with the environment from which they had been released.

Lack of Stable Accommodation

Another factor that participants said accounted for drug use on prison release was being released without anywhere to live, which had been a common experience for participants. This was usually because they had few family who would let them live with them or because they had lost their tenancy or room at a hostel during their imprisonment. This overlaps with Returning to Previous Circumstances and Reacquainting with Drug Users previously described. The reality of not having anywhere organised to live on release meant that participants had either stayed on the streets or spent time with people, mainly drug users, whom they knew from before imprisonment so that they could stay with them rather than sleeping on the streets. If living on the streets, participants said that injecting drugs, particularly heroin was inevitable as it helped block out the cold and facilitate sleep. Knowing that most participants had been in prison many times, I found that their limited reports of trying to secure their own housing on release from prison to guard against some of the risks and issues identified analytically interesting. For me, this raised questions about whether they actually wanted their own housing on prison release and their own belief and ability in actively influencing their situations.

When I were in prison and that, when I were clean (drug free) I thought, yes, there is no way I am going to use again this time, but when I got out to nowhere to live, because I got emergency release you see, so when I got out and that I had nowhere to go, I thought well what, you know what I mean, what's the point, what's the point of me staying off the gear (heroin), do you know what I mean, if I'm just going to sleep on streets. (Matty)

If spending time with other drug users, injecting together was often described to act as a social and bonding activity. It also seemed difficult to avoid, even if participants tried to do so.

You'd go in prison thinking oh yes, I'll get clean (drug free) and that would be the end of it. You'd be straight out on your ear again. Nowhere to live, you know, so it's just defeating the object isn't it? The only people you know are ex addicts or addicts still using. And rather than sleep on the street you'd only get in with them, and you'd only last a couple of days saying no I don't want any and then you'd be back on it. (Steve)

Yet having accommodation on prison release was also said to influence post prison drug consumption. For example, being released on licence³⁷ to live in approved community premises under the supervision of the Probation Service influenced release drug use. Participants said that the nature of living amongst current and former drug users in these communal environments was described as difficult. I found this description intriguing given that approved premises are reasonably similar to prisons in that they house a number of offenders, many with drug histories, they have a reasonably structured regime (but less regimented when compared to prison), they impose rules of acceptable and unacceptable behaviour and have a minimum overnight curfew. Furthermore, residents who breach the rules or conditions of residence are liable to sanctions such as eviction, court or immediate recall to prison to prevent further offences being committed. Yet participants' continued use of drugs whilst living in these environments suggests that these sanctions did not act to deter them but that they were impervious to them. Rather, in some cases, the sanctions may have possibly acted to encourage or reinforce drug use as participants may have preferred to return to prison than stay there. Whilst these things demonstrate

³⁷ Licence refers to the agreed conditions and restrictions with which a released prisoner must comply when they initially return to the community after the custodial part of their sentence.

the complex and combined influence that a lack of stable housing, peer influence and the nature of the environment participants were in participants said had on their reported drug use after imprisonment, it also again suggests a degree of participant passivity for their actions, deferring the responsibility and blame for them to other people or situations.

Sentence Length

Alongside a participant's prison drug using status and their personal situations, the length of their sentence also influenced use on release. Those who had served shorter sentences of a few months duration suggested that there had not sometimes been sufficient time when in prison for them to overcome what they described as the physical and mental desires for drugs or recover from them. They also said that there had been less time to make changes in their personal situations such as in relationships and housing, either by themselves or through working with agencies when in prison. They said that this contributed to the likelihood of using drugs when released, acting to rationalise their release drug use to themselves and again, suggest a reduced element of choice in their behaviours.

CT: Did you think about stopping?

No not really, because there wasn't decent detox in there, and there's no way I was going to go for six weeks rattling, no sleep for months and God knows what else. Especially when I was only doing short sentences, and I knew I would be out in four week, what is the point of doing a rattle for four weeks, coming out, rattling still, not being able to sleep and I'm only going to go back out and go and score again. So it's pointless. If I were doing two years, which I have done two year, then I've stopped. (Wayne)

Those who served longer sentences suggested that they felt more able not to use drugs on release. This was said to be linked to feeling more ready and willing to stop drug use. They had usually spent some time in prison not using and this had proved to them that they could reduce and stop and that they did not necessarily need to use drugs as they might otherwise have thought. This was also facilitated by the stabilisation provided by substitute opiate medication in prison. If this medication was successfully arranged by prison CARAT teams to be continued through community prescribing services, participants said that this assisted them to not use drugs on release. Yet, arrangements for throughcare and continuing medication were not

always realised and participants recounted difficulties they had experienced with this, influencing their propensity to re-instantiate drug use on release.

It took like eight weeks to get myself put on a Subutex script and in that eight weeks I started using every day. So I found myself back, I found myself back with a drugs habit but waiting on a Subutex script. (Jack)

The amount of time participants reported to have refrained from using drugs on release varied considerably, from less than a few hours to a number of days or months afterwards. Sean describes how difficult he found not using drugs for a number of months.

I was clean (drug free) for about three, four months. I just didn't feel right to be honest with you, I didn't feel like I fitted in or anything and it's always there in the back of your mind oh I just think I'll just go and use that once, do you know what I mean? And once leads to twice and twice leads to, doubles up every time. And it's happened every sentence I've done so far. Every sentence, saying I'm not going to use when I come out, and then it's oh I will just use this once and then you get a taste for it and then that's it, bang at it again. (Sean)

Chapter Summary and Discussion

Even though some participants described feeling physically and behaviourally healthier in prison when compared to before they were sent, sustaining this behaviour on release, particularly in relation to injecting drug use was difficult and complicated by varying factors. A key theme running throughout participants' accounts of what happened to their drug consumption on prison release was that their reported plans not to use were not always realised. Indeed, whilst many participants said that they had not intended to use drugs on release, they found this hard and most had engaged in drug use at some point on previous release, suggesting the difficulty they faced in stopping using drugs and possibly, to the help that they required in so doing alongside their own motivation. Whether or not men portrayed that they had tried not to use drugs on prison release in the interest of seeking my compassion or understanding or as a facet of reporting what they thought I wanted to hear or whether they were being truthful about their experiences can be debated, particularly given that they had been in prison and had thus been released

many times. The fact that participants commonly reported wanting and intending to not use drugs on release from prison, suggests that there was something about being in prison that led to them to contemplate this decision. This concurs with findings from a small single centre sample of nine offenders interviewed by Harman & Paylor (2004) where eight said that they did not intend to use hard drugs or hoped that they would stop drug use completely on release. Numerous reasons could account for feeling that they did not want to use drugs on prison release. For example, perhaps this was linked to having more time in a more drug free state when in prison than when in the community and more time to consciously contemplate their previous life and their lives going forward on release. Alternatively, it might be that the men's intentions altered from day to day or that they were deceiving themselves into thinking that they would not use drugs on release in order to justify their prison use. This deception is plausible given that so many men had prior imprisonment experiences and they said that their drug using behaviours on release had not matched up to their pre release intentions.

A 2001 resettlement survey which aimed to assess prisoners' prospects of housing and employment on release and asked questions on drug use and offending found somewhat contradictory findings regarding prisoners' views on their drug use and levels of crime on release (Ramsay, Bullock & Niven, 2005). The survey involved a stratified random sample of 2,011 (1,863 male) prisoners who were about to be released from 76 prison establishments in England and Wales. Unlike the prisoners involved in the current research who were interviewed some time after their imprisonment and who, with the benefit of hindsight, said that they had believed that they had wanted to stay off drugs when they were released from prison and unlike the eight prison participants interviewed by Harman & Paylor (2004), one in five (21%) prisoners (28% men) from the resettlement survey (who were questioned before their release) felt that they would have a problem staying off drugs on release (Ramsay, Bullock & Niven, 2005). This figure rose to almost half (48%) of the sample of those who identified as having had a drug problem before their imprisonment yet only 28% of them had arranged an appointment with an external drug agency on release (Ramsay, Bullock & Niven, 2005). Linked to this, 28% of whole sample anticipated returning to crime at some point on release and 45% of problematic users before prison thought returning to crime was likely for them, highlighting the link between drugs and crime (Ramsay, Bullock & Niven, 2005). Perhaps this identifies the social desirability of the reporting of participants involved in qualitative interview research such as the current study and Harman and Paylor's (2004) work. Another

alternative explanation is that those in the resettlement survey were more realistic at the time of release and felt that they could be more honest due to the methodology employed about what would happen to their drug use on release, maybe on the back of previous experiences and no longer expecting that their lives would change in the future. Other factors may of course also account for this, such as what had happened to their drug use on their prison sentence.

Using drugs on prison release was commonly linked to nothing fundamentally having changed in a participant's life and their release into similar circumstances as before prison (Harman & Paylor, 2004), characterised by boredom and inadequate support. Again, the influence of other people on participants cannot be ignored as reacquainting with drug using friends and associate contacts from their community drug using world often hindered any plans to stop using drugs as they found it hard to reinstate these relationships without using drugs as this was the basis of them. Whilst participants sometimes presented quite passively in relation to drug use on prison release, in some situations they described more active attempts to try to consciously distance themselves from drug using peers and previous acquaintances or engage with them without using, or only occasionally using drugs. Yet, this was described as difficult and fraught with complications and was not practical as they often felt isolated and lonely (Harman & Paylor, 2004), had little family or other support to reinforce and encourage their efforts and intentions or to promote positive changes their behaviour. Consequently they were often soon tempted to use drugs more frequently with their previous acquaintances and drug using peers again. This reinforced the drug using nature and focus of their friendship and showed an inability to maintain the desire to not use, but demonstrated how they succumbed to temptation by choosing to start using again. Peer influence within the nature of the community environment thus contributed to reinitiating drug use. It also shows how individual drug user motivation alone is unlikely to be sufficient without other forms of assistance and support which prisons can provide, such as effective throughcare arrangements for drug users alongside housing and employment (Mitchell & McCarthy, 2001) in order to cease drug use after release from prison.

As outlined in Chapter 2, an important facet of prison CARAT services is to provide throughcare by linking prisoners to community drug services so their treatment may continue on release (HM Prison Service, 2002b). The importance of providing throughcare services to assist offenders leaving prison from relapsing and returning to crime and prison has been discussed (see for example Burrows et al., 2000;

Hucklesby & Wincup, 2010). For example, an early national evaluation of the effectiveness of drug throughcare which involved prisoners who had received CARAT services found that half of the prisoners were offered help to obtain treatment on release and release illegal drug use was reported to be lower than before prison (Burrows et al., 2000).

However, prisoner perceived shortcomings of the CARAT service have also been identified as only a fifth of participants were offered help to obtain treatment had a fixed appointment with a drug agency (Burrows et al., 2000). Furthermore, in a later small scale qualitative study, former prisoners interviewed on release identified the narrow focus of the CARAT service and the failure to effectively address prisoners' practical and resettlement needs when in custody in preparation for release (Harman & Paylor, 2004). Such evidence from these studies and also from some of the difficulties which participants in the current study reported suggest that the CARAT services were not necessarily always bridging the gap between prison and the community as anticipated and the full extent of the service was not always realised. The potential impact of this on former prisoners' release drug use cannot be underestimated.

Concurring with the follow-up interviews which were conducted with 227 men who had been involved in the Criminality Survey but who had since been released from prison, drug use on release was not reported to be as prevalent as it has been before their imprisonment³⁸ (Bullock, 2003). This also resonates with other studies (Burrows et al., 2000; Harman & Paylor, 2004). For example, Burrows et al. (2000) identified that by four months after prison release approximately half of the 112 participants who completed the questionnaire³⁹ were taking heroin every day, 20% less than figures on entry to prison. Furthermore, the six participants re-interviewed shortly

³⁸ Although there are some differences with those followed-up from the Criminality Survey and participants in the current research so care has to be taken in interpreting these findings. For example, people followed-up from the Criminality Survey had largely served short sentences of four months or less and nearly all (90%) had been in the community for between four and eight months since release. The men in the current research however had served a variety of sentence lengths with half having served much longer sentences (between 10 and 84 months) and the time since their last release also varied.

³⁹ Which represents 63% of those who initially agreed to respond to the follow up questionnaire, suggesting that those using drugs regularly since release may have been disproportionately overrepresented as non responders (Burrows et al., 2000).

after their prison release by Harman & Paylor (2004) reported not having returned to dependent drug use⁴⁰, although they reported finding abstaining very difficult.

Release use was initially enjoyable as it was not as fraught with complications and was not reported to be as hectic as their use had been before prison. Yet the use of drugs after release was often at higher levels than it had been in prison (Bullock, 2003) and the nature of their use reportedly soon changed, becoming more hectic. As use became more hectic, this often influenced them to commit crime in order to afford drugs as in earlier times. Indeed, participants described finding themselves back in the cycle of drug use and crime, demonstrating the real impact of reinstating or increasing drug use on prison release.

Being released from prison with nowhere to go has been identified as contributing to homelessness (Maguire & Nolan, 2007) and there is a recognised link between homelessness and drug use (Griffiths, 2002; Neale, 2008; Wright 2002). This research identified that homelessness, or the lack of stable accommodation and/ or support on prison release, compounded participants' situations and reportedly contributed to reinitiating or increasing drug use on release despite sometimes other stated intentions. For example, injecting heroin helped participants with nowhere to stay on release to sleep outdoors as its effects provided comfort and warmth. Approved premises were noted as hindering non drug using intentions due to the presence of other drug users in these environments, again highlighting the influence of others on the men and how behaviours may be adapted to suit the nature of the environment which they were in. There is a dearth of research into the effect of the environment of approved premises on illicit drug use behaviours, although previous English qualitative research identified difficulties in ceasing heroin use in homeless hostel accommodation due to the persistent exposure to drug triggers and the influence of other residents (Wright, Oldham & Jones, 2005). The issues identified about the influence of living in approved premises on participants' drug use raise many other questions which could be the focus of future exploratory research as it was outside the scope of the current study. For example, exploring what specifically it was about the nature of approved premises that seemed to encourage participants to use drugs in a more frequent way than they had in prison and exploring the extent of risk behaviour of using in these environments may warrant future attention.

⁴⁰ Although the authors speculate that the three participants who did not attend their follow-up interview had relapsed to using drugs within the first fortnight of release (Harman & Paylor, 2004).

In a sense, approved premises may be likened to a small scale prison, characterised by newly released prisoners, with different social, medical, emotional and practical needs all living together with communal facilities and rules to adhere to about accepted behaviour. Thus the idea of participants using illicit drugs in these environments after their release from prison resonates with their use when in prison as they were influenced by their fellow residents, negotiated their relationships with them and adapted their drug using behaviour to the social context of the premises. Yet as approved premises are in the community, where drugs and equipment to use drugs are more readily available, they possibly offered participants more drug use options and choices on release than afforded in prison. It is possible that the interplay between the more ready access to drugs within approved premises and community environments than in prison and relationships with others were not as actively initially considered by participants about their intentions regarding release prison drug use. Initially downplaying or ignoring these influences was possibly a way in which participants tried to present as less easily influenced or led by others but shows also shows an element of naïvety about them, particularly given their numerous prior imprisonment experiences. Another explanation might be that they felt ambivalent and they had resigned themselves to using drugs and committing crime as a way of life, at least in the short term.

Following through the findings reported in the previous chapter, the use of drugs on release was sooner after release for those who had used in prison, particularly those who had received shorter prison sentences as this represented a continuation in drug using behaviours. Participants suggested that the length of prison sentence influenced their drug use when in prison and subsequently on release. This resonates with the findings from the resettlement survey previously discussed which found that a greater proportion (25%) of prisoners serving short sentences (less than one year) felt that they would have a problem with drugs on their release compared with 7% of prisoners serving long (four or more years) sentences (Ramsay, Bullock & Niven, 2005). This may warrant attention in the current policy climate whereby there is a drive to reduce prison numbers and give community rather than custodial sentences to mentally disordered offenders and those convicted of low level crime, such as acquisitive crimes (Burki, 2010; Ministry of Justice, 2010b). With this, more serious offences will still receive sentences in prison of a longer duration. Thus in the case of sentenced drug users, it will be interesting to identify if this has any impact on their reported prison and subsequent release drug use given that fewer short

sentenced prisoners with intentions to keep using drugs during their prison sentences will be in prison at the same time as one another. The impact of this new policy in itself may warrant future attention as drug users who typically committed low level acquisitive crime may consciously start committing more serious crimes, which would be sure to carry a prison sentence if they wanted to be imprisoned in the future to offer them some reprieve from their community existences as earlier outlined.

An important finding is that the drugs that participants used on prison release were different to those they used in prison. As they could access a wider variety of drugs of better quality than available in prison, including heroin and crack cocaine, they used these on release, akin to their pre-prison drug using behaviours (Bullock, 2003). The lack of buprenorphine continuation on release and the excitement associated with using crack cocaine (either on its own or in combination with heroin) on release are interesting and novel findings. These findings, when seen in the context of the previous chapter, further highlight how drug users modify their drug using behaviour according to drug availability and environmental influences (Musto, 1999; Shewan, Gemmell & Davies, 1993). Within the context of the current study, prison drug using behaviours were shaped and influenced by the prison environment, as where there was limited access to certain drugs, participants changed their drug using practices and drug of choice in order to fit in. They then reconsidered these choices when released so that their community practices usually mirrored those in which they engaged before their imprisonment. Maybe it was the very nature of the psychologically stimulating effect of crack cocaine that encouraged participants to use it on release, especially after having been in a controlled prison environment. Its use possibly acted as a kind of mental release and a desire for something different within a different and more stimulating environment than that of the confined and monotonous nature of prison in which they had spent their sentences.

There were also changes in the way that participants used drugs when released from prison. Participants noted that there was improved availability of sterile injecting equipment in the community when compared to prison, so they largely returned to drug injecting on release rather than administering by smoking or snorting. However the injecting of heroin or other opioids on prison release and up to the four weeks afterwards, has been identified as increasing the risk of fatal overdose on release (Farrell & Marsden, 2005; Farrell & Marsden, 2008; Merrall et al., 2010; Singleton et al., 2003) as people's drug tolerance particularly to opiates, may reduce whilst in prison. Indeed, drug-related mortality rates identify that newly-released male

offenders are 29% more likely to die during the first week of release compared to their community peers (National Probation Service, 2007). As some participants from the current study had overdosed on heroin on release from prison, emphasising the risks of overdose from injection to all drug users as they leave prison, including to those who not think that they will use drugs on release, is a suggestion which could be followed up from this work. Alongside this, ensuring the prescription of opiate maintenance substitution for chronic drug users leaving prison could be emphasized as this can reduce mortality risk (Dolan et al., 2003). The decision for participants to inject illicit drugs on release was linked to the increased physical effect felt by injecting rather than any economical reason to conserve drug supplies like in prison as their access to illicit drugs in the community was more assured. This is an interesting contrast to their initially stated intentions of not using on release. Rather, they used in the community at an enhanced level than they did in prison and they reintroduced use by injecting.

Based on an analysis of the interview data the last three chapters have described participants' personal experiences of drug use before imprisonment, whilst in prison and after release. The subsequent chapters take a more nuanced analytical look at these experiences and discuss the meaning and implications of these findings.

Chapter 8 - Consideration of Findings

This chapter presents a detailed grounded theory analysis based on the development of the axial coding which followed the analysis presented in the previous three chapters. This analysis identified that six important overarching themes permeated the interview discussions and cut across participants' community and prison drug using experiences. The themes describe and help to explain the participants' lifestyles, behaviour and drug use both within and outside of prison. A bottom up approach to the analysis of the interview data was taken. Thus, whilst the themes presented are an interpretation of the data, they are grounded in it. The overarching themes identified are Age and Stage of Life, Deny Responsibility, Desire for Excitement, Living on the Edge, Resourceful and Adaptable and Complex Social Networks. Each theme has a number of sub themes which were identified within the data that had been categorised to a particular theme as summarised in Table 8.1. Identifying connections between the themes was assisted through writing theoretical memos of my thoughts about the synergy between the data while immersed in the data (Glaser, 1978). This chapter presents and discusses the themes and sub themes identified.

Table 8.1 - Summary of Themes and Associated Sub Themes

Theme	Sub Themes
Age and Stage of Life	<ul style="list-style-type: none"> • Being Young • Growing Older: Enough is Enough
Deny Responsibility	<ul style="list-style-type: none"> • Blame • Victim Identity
Desire for Excitement	<ul style="list-style-type: none"> • The Buzz • Escape Reality
Living on the Edge	<ul style="list-style-type: none"> • Ruled by Drugs • Cycle of Inevitability • Wasted Life
Resourceful and Adaptable	<ul style="list-style-type: none"> • 'There's Always a Way' – Survival and Coping • Testing Boundaries
Complex Social Networks	<ul style="list-style-type: none"> • Fractured Family Relationships • Lack of Real Friends • Them and Us

Age and Stage of Life

All participants made reference to their age and stage of life. This was either done in relation to their earlier life, their current life, or, in some cases, both. This theme featured heavily in the interview data and was pivotal to understanding the men's situations. The sub themes of 'being young' and 'growing older: enough is enough' cluster together under this theme.

Being Young

As described in *Being Young and Having Fun* in Chapter 5, there was an implicit sense of nostalgia which permeated men's accounts of being young. Being young was characterised by participants as a time when they were growing up, from early childhood into their teenage years. However as reported, childhoods were not always portrayed as positive and the men recounted experiences of bereavement, bullying, physical and sexual abuse and of feeling neglected and marginalised from family, friends, schooling and the wider society. These experiences overlap with **victim identity**, a sub theme of **Deny Responsibility** and **fractured family relationships**, a sub theme of **Complex Social Networks** both later discussed.

To a certain extent the nostalgic accounts men provided might be a product of asking about earlier times, yet it is interesting that nostalgia dominated even though participants acknowledged that their younger years were not always problem free. To try to explain why nostalgia dominated accounts, it might be significant that the majority of troubles reported occurring during childhood were presented as out of their personal control, but were blamed on others. This overlaps with the **blame** sub theme of **Deny Responsibility**. Furthermore, it is possible that participants may have ignored or forgotten about these earlier troublesome experiences and their effects. Alternatively, it may be that any negative childhood experiences had become overshadowed by more recent and arguably significantly more serious problems, including ones for which they were more responsible, such as drug use and criminality, accounting for why their childhoods were more fondly remembered.

Commonly, participants described acting irresponsibly when they were younger. Kyle, 28 at the time of interview said, '*I was young and stupid back then.*' There was an element of innocence and naïvety central to these reflective accounts. Indeed, participants said that they had done certain things as they were too young to know better. Additionally, they suggested that they acted more impulsively when they were younger, without much thought about what they were doing or consideration of their

actions. Thereby to some extent participants used their age to rationalise these earlier actions. Steve, like many others, was keen to point out that certain childhood wrongdoings had not been repeated when he was older.

I did a burglary once when I was a kid and after that I didn't like it and it were just a fast way of getting money and I were only a kid when I did it. I didn't know any better. But after that I never did it again. (Steve, 35)

Alongside innocence, participants' accounts suggested an element of bitterness and resentment that their younger years were not as fruitful as they might have been. This is further explored and contributes to the **wasted life** sub theme of **Living on the Edge** later discussed.

Growing Older: Enough is Enough

In contrast to the portrayal of being young, participants described feeling old, despite their mean age of 34 years. It was not their actual age, but the nature of the eventful lives which they had lived which made them feel older than they were. Notably, hectic lifestyles, committing crime linked to the pursuit of drugs and medical problems often linked to using drugs were felt to have aged the men beyond their years. This was particularly true for participants with the longest drug using and imprisonment histories and those with family responsibilities. Participants particularly described how hectic community lifestyles centred around pursuing and using drugs took its toll on their physical appearance, and made them look older than their years.

When I've seen photograph in cop shop (police station) I couldn't believe, I couldn't believe it. I just looked like a skull, like a dead person. My hair, proper grey and everything. But you don't think of that when you're using, never. (Barry, 46)

The effect on their appearance was often visually evident to me when meeting participants and I sometimes commented on this in my post interview field notes.

From the interview discussions, there was an implicit unhappiness with feeling old and what participants associated with it, and a suggested passive acceptance of it. This led participants to describe feeling 'too old' to at least continue with their younger lifestyles. Participants did not state anything specifically about their age or state of health which physically prevented them from continuing with these pursuits.

Rather, these feelings appeared to be more linked to their mental wellbeing. Indeed, feeling tired of earlier hectic lifestyles was a dominant sentiment insofar that they felt weary and mentally drained from them. This contributed to an overwhelming feeling of frustration and that they had 'had enough' with the drug using and criminal aspects of their lives.

I'm fed up with this. I'm just fed up with shoplifting. I always think that when I get caught. Just fed up to the eyeballs with it. (Derek, 31)

You get sick of it, don't you? There's not one addict out there, deep down, you know, they'll give it all that, 'oh I'm not bothered about this and that', you know, but there is no one addict out there, what can really turn round and say, 'I'm happy doing this.' You know, I'd laugh at them if they said that. You just get enough of it. You're running round trying to, you're always chasing your tail, always chasing drugs, from getting up to going to bed, and you know, it's not a very nice lifestyle either. People you meet, are fucking horrible people, and a lot of people, you know, nobody likes doing drugs, it's just the situation, you know. And nobody wants to be an addict. (Steve, 35)

Linked to feeling that they had had enough, participants expressed a desire to end what had become ruinous pursuits in order to try to move on with their lives in more productive ways.

I'm 43 next year, know what I mean? I've had enough. I can't take it no more. I just want a normal life. (Kev, 42)

Some participants, particularly those who were older or who had been in prison numerous times, also described feeling 'too old' to go back to prison.

I'm getting a bit bloody old now, I am 41. I don't want to be going back to prison. (Paul, 41)

(I've) just had enough of it all now, I'm getting too old to be messing about with prisons now. I've had my fair share of prisons. (Wayne, 34)

This highlights how feeling too old for drugs and crime and having had enough of the associated lifestyle fits into the broader theme of **Age and Stage of Life**. Participants

like Keith described feeling old when they compared themselves to others in the same situation as them. This infers a realisation of their age, of which they had previously been less aware, possibly due to their preoccupation with using and being under the influence of illicit drugs. This apparent realisation also suggests that there was something about being in prison with younger people which made them feel less comfortable than previously. For example, they may have felt alone and subsequently more vulnerable to torment or bullying if they did not know as many of their younger, fellow prisoners.

I've had enough. I'm just getting a bit old for it now. It's just getting a bit much now, do you know what I mean? Because I was in there (prison) and I was having a look about and it's all full of lads and you're thinking, I'm too old for this shit. (Keith, 39)

Men who were living in hostel accommodation and approved premises at the time of interview spoke about feeling less comfortable in this type of accommodation. They linked this to the presence of younger and drug using residents who were also staying there. Whilst this was not explored too deeply with participants, it is possible that it was the environment of communal living, either in prison or hostel accommodation that the men found difficult and felt too old for. This is an interesting suggestion, especially given that many of the participants had spent many years in and out of prison and hostel accommodation, as despite such extensive experience, they did not want this to continue for their futures as they grew older.

Barry suggested that continued illegal drug use and crime could likely result in him being imprisoned in his later years. He spoke candidly about what he considered was the reality of these continued behaviours.

I am 46 and I wouldn't want to die in jail. (Barry)

Other factors, such as the lack of significant relationships or the length of time without legal employment may have contributed to participants feeling old and that they had had enough of the lives they had been living. Yet these were not openly discussed within the interviews, suggesting that participants did not consider such factors as having such a significant impact on their sense of ageing and well being. Describing feeling old may be a way in which participants knowingly or not, subtly accounted for or excused other circumstances or feelings. For example, they may

have used this to rationalise why they had not been involved in education or training. Further, 'feeling old' might operate at a deeper level by acting as a way of participants downplaying other feelings. These could include guilt about aspects of their pasts or fear about their futures which they largely described as wanting to be different than their pasts in terms of their involvement in illicit activities. For example, they described wanting more meaningful and responsible relationships with their families and children and more engagement in legal activities.

Central to feeling that 'enough was enough' was an implicit acceptance of the reality of ageing, regardless of the man's actual age. There was also the suggestion of maturity and growing up in the men's accounts. Having responsibilities, such as caring for family members or having their own children or grandchildren also compounded the feelings that their lives were at a stage where they needed to take more control than they had done previously and be more responsible. They said that this could be achieved by stopping using drugs and committing crime to allow more meaningful activities and responsibilities in their lives going forward. For some, like Chris, these feelings were coupled with what they saw as being less physically able to manage using drugs as they and their bodies aged:

If I have my kids on my own, I won't touch it (amphetamine), because they're only young my kids, well the two that I want to see now they're only young, they're only ten and six so I won't even have it in the house. Even when I used to do it when I were with them I used to go out to a mate's house to do it. I wouldn't have the gear in the house, just in case the kids found it, especially with needles. So no, I won't do it near kids. So I know in my eyes myself once I get through that I'll probably stop it and I'm getting old now, I'm nearly 40 now, so I need to stop it anyway, but that's an incentive.

CT: Why do you say you need to stop it? What is it?

'Cos of my age and my body isn't going to keep lasting doing amphetamine all the time the older I get. I mean, I've seen, I know a guy who's 58 and he still does it and he's 58 and he looks horrible. And I don't want to look like him.
(Chris, 38)

This contrasts with **being young**, as the men were keen to distinguish how they considered themselves to be of an age and responsibility that meant that they knew how to behave better than they did in their pasts and they could think more about

how to behave and not act with as much impulse, including in prison. They spoke about having 'grown up' and being 'older and wiser' in contrast to their earlier years.

You just get older and wiser don't you I suppose, you know what I mean? But it's a, it's took ages like, but it's happened. It is just I've had enough, you know what I mean, I have just had enough of the lifestyle. I've had enough of it all. (Keith, 39)

All men, regardless of age also expressed a desire to behave in what they considered as more acceptable and responsible ways in the future. They wanted more 'normal' lives, akin to other adults who were not involved in drugs or criminal activities and characterised by engaging in more 'normal' pursuits instead of using drugs and committing crime. Pete recognised that the more 'normal' activities in which he wanted to be involved were different to those in which drug users usually engaged.

I just want to wake up, go, wake up, go to work, do you know what I mean, get a good job, go to job, or even go to college or something to get a good job, do you know what I mean? I just want to do stuff what most human beings do, do you know what I mean? Not just what a majority of us do, just getting up and going and getting smack (heroin) every day. I don't want that, I don't need that in my life no more. I think it's just about growing. I think I have grown up a lot more. I think I have grown up a lot more up a lot more I think that's what it is. I think that is what it boils down to. I do. I think yes. Just becoming an adult, realising why things have gone wrong and why things have happened. (Pete, 24)

However, whether participants' visions and aspirations were realistic must be questioned. Participants did not provide information about how they knew to behave or think any differently, and, crucially, how to put this into practice. It may therefore be sceptical to believe that they would know how to behave differently to how they had done for most of their lives based on their increased age and intolerance with their situations, as whilst they were getting older, many elements of their lives remained unchanged from when they were younger. The only life change linked to their increasing age that was spoken about was that of having their own children. Feeling a responsibility to their children, as discussed earlier, was a major life change, contrasting dramatically to what could be seen as earlier youthful freedom.

Moreover, having children appeared to act as a focus for the men and contributed to them feeling that they had had enough of using drugs and committing crime and them wanting something different in their futures. This might be indicative of the societally embedded responsibilities linked to having children or of wanting their children to have less fractured family relationships and disturbed childhoods growing up as they had had themselves, recognising how these things had negatively impacted on them in a number of ways.

Feeling that enough was enough was central in accounting for participants adopting certain behaviours at varying stages of their lives and in their drug using lifestyles. For example, this feeling was said to contribute to their attempts to limit or stop their drug use whilst in prison, if only for a short amount of time.

Deny Responsibility

This theme describes how participants denied sole responsibility for their actions, particularly drug use and offending. Central to the theme are two interconnected sub themes, 'blame' and 'victim identity' which permeated the interviews at varying levels.

Blame

Throughout the reporting of the findings, there was an implicit sense from what participants said and how they sometimes said it that they were not to blame for their illegal behaviours. Rather, blame and responsibility was attributed externally. As suggested in *The Influence of Others and Drug Naïvety* in Chapter 5, narratives were littered with insinuations of who or what was more accountable. For participants, the post hoc attribution of blame appeared to assist in the justification of illicit activities. Numerous examples of actual or suggested blame were evident within the discussions. These were complex and a number of factors appeared to be at play, often combining beyond the fault of a single person or situation. The lack of a stable upbringing, feeling neglected during childhood, being bereaved by a close relative or friend, being too young to know better, needing money, the influence of other people, boredom and feeling uninformed about, and powerless to, the physical effects of drugs were, amongst many others, factors which participants directly or indirectly blamed for their actions and behaviours during their interviews. This overlaps with the **being young** and **fractured family relationships** sub themes of **Age and Stage of Life and Complex Social Networks**.

To illustrate the complexity of this sub theme, other drug users or people who introduced participants to illicit drugs were suggested and blamed as the reason, or one of the reasons, for initiating drug use. This suggests a minimisation of personal responsibility for their actions. Benji said that other people are usually to blame for people starting to inject.

It was another resident there who was already injecting. And they say that it's always somebody whose injecting that gets somebody else to inject, you know what I mean? So that's like probably 90% of the case, you know what I mean, somebody's been lulled into doing, do you know what I mean? And that is how I got in. (Benji)

No participants spoke about having introduced other people to illicit drugs, although this may have been possible. This possibly demonstrates how they carefully positioned themselves in the interviews and how they implicitly minimised their own accountability for their actions or those of other people. Committing crime or having fun through using drugs was blamed on having nothing to do and feeling bored. Once participants had started using drugs, drugs themselves were frequently blamed for their subsequent actions. For example, the effect of drugs on the person were blamed for the nature and extent of criminal activity, with participants explaining that they could not function properly without drugs and so committed crime in order to afford them.

I was totally caked up on drugs when I beat up that lad and probably wouldn't have done it if I hadn't been off my head. (Sean)

It is just not a nice thing to be involved in, is it, shoplifting? And you'd never stoop to that level unless you were on drugs. (Gordon)

Committing crime was blamed on not having enough money to afford drugs. As demonstrated by Pete's quotation on page 139 and Jack's on page 284, drugs were also blamed for fragmentation of relationships and the breakdown of communication with families, thus overlapping with the **fractured family relationships** sub theme of **Complex Social Networks**.

Prison was also a factor to which blame was attributed. For example, prison medical services were seen as accountable for not providing medication to help manage

withdrawal from drug dependence in earlier years. Whilst there was some acknowledgement that this had changed over the years, participants had inconsistent views as to whether medication levels were sufficient. Prison was also blamed for being boring and mundane with few constructive activities to pass the time. The combination of these factors, alongside others such as the strength and effect of illicit drugs were blamed for their continued drug use in prison. Furthermore, as discussed in Chapter 6, obtaining drugs in prisons was seen as responsible for causing and contributing to violent and intimidating events between prisoners. Drugs were therefore seen as having a pervasive and insidious influence in prison, playing a part in creating and maintaining volatile prison environments until they were used when they were described as having a more calming effect on prisoners. Prison resettlement services, community services and prison release itself were also blamed for lack of accommodation on release, which was used to justify their use of drugs in these circumstances.

Victim Identity

Linked to the denial of personal responsibility for their actions, participants frequently presented themselves as powerless victims. For example, they presented as victims of circumstance, such as broken homes, fractured relationships, abandonment, neglect, abuse and trauma who had little option but to accept their plight. In relation to these circumstances, there was an element of self pity evident in participants' language and accounts, such as in the quotation from Matty on page 139. This was particularly evident if these affecting circumstances had been experienced when the men were younger, as described in **being young**.

In terms of drug use, participants presented as victims to the strength, intensity, and physical effects of drugs. Interestingly however, these accounts were not as self pitying as those relating to their childhood experiences. On examination, a potential explanation is that this is because the experience of negative events largely predated drug consumption and participants used drugs as a response to these events. Furthermore, not all participants' drug using experiences were negative. On the contrary, participants' early drug using experiences were enjoyable and accounted for their continued recreational use. It was only as their drug use increased, as described in the **ruled by drugs** sub theme of **Living on The Edge**, that their experiences became less enjoyable. This distinction between the initial pleasure of using drugs being overtaken by less beneficial longer term effects that was inherent

in participants' discussions may also account for why their related descriptions appeared less self pitying than some of their other descriptions.

Desire for Excitement

On examining participants' accounts, there were both explicit and implicit references to their desire for excitement, often from a young age. This theme is comprised of two sub themes, 'the buzz' and 'escape reality.'

The Buzz

Excitement associated with committing crime and/ or using drugs was described as providing participants with 'a buzz'. This was linked to feeling the benefit of a reward which was usually a rushed and heightened feeling of enjoyment. Rewards included feeling the physical effects of drugs and obtaining money from committing crime. The buzz was enhanced by trying not to get caught whilst pursuing these illicit activities.

I'm an adrenalin junkie, me. To me, committing a crime it's enjoyment you know what I mean? It's, when I used to go out robbing and that, I used to actually get a buzz doing the robbing. I've known me go out and rob, not for the money, but just for the buzz. It's, I used to get a proper buzz enjoyment from doing it.

CT: Can you explain a bit more about that then, about what the enjoyment was in going out and robbing?

Er it's the risk of getting caught, isn't it? When you're half way through a job, are the police gonna come? Are we gonna get caught? And then there's the chase, after, if the police do come, there's a chase, there's excitement in the chase. (Kev)

The buzz using drugs provided was linked to experiencing a rewarding physical feeling, yet this was different for different types of drugs used. For example, the buzz provided by using heroin was largely linked to the excitement of doing something illicit coupled with the sedate feeling that the drug provided, which participants found enjoyable. Using stimulant drugs also provided the excitement linked to engaging in illicit activities but their uplifting physical effects provided participants with a different kind of buzz in so much that they had overwhelming energy and heightened senses.

When I first have it (amphetamine), it's the rush, it just bring my whole body all alight and happy and lively again. (Chris)

Experiencing the buzz was said to be especially common in the early days of drug use when participants' bodies had reduced drug tolerance. The buzz was also more intense if the drug was administered by injection as this practice carried with it an element of risk and excitement and also meant that the physical effects of the drugs were felt straight away.

I started smoking it (heroin) at first and then we started injecting it. Like I say, better buzz. That is what it was, it was a better buzz. (Pete)

Using illicit drugs in prison was also said to provide a buzz on a few different levels. Initially there was a buzz linked to avoiding being caught by the prison officers. There was also a buzz associated with feeling the physical effects of the drugs. The intensity of the buzz of using illicit drugs in prison was strengthened if participants had not used them as regularly as they did in the community.

If you don't take drugs for ages then you get a better buzz out of it when you do take it. So it is just, it's like your head's not in jail when you are on that buzz. (Jamie)

You're so clearheaded in there (prison), yes, you know, you just, you miss it in a way, you know, in a weird way you do. But I don't know, it's hard to explain. Let me think. I don't know. It's just, it's just the excitement of it, you know, just getting it, you know, being behind your cell, and having a toot (smoking heroin) do you know what I mean, and you're just buzzing. (Kyle)

As identified earlier, the drugs participants most commonly reportedly using in prison were heroin and illicit buprenorphine. The heroin provided them with a buzz linked to feeling detached and sedate from their effects which also helped participants' prison sentences to pass whereas buprenorphine initially provided a more uplifting buzz before more sedate feelings. I found this difference interesting as they explicitly argued against the use of crack cocaine and other stimulants in prison on account of them providing a more stimulating 'buzz' which they did not see as suitable to the environment. Perhaps this was due to the lack of more sedate effects which followed

the heightened feelings or the difficulty in maintaining sufficient supplies of stimulant drugs when in prison to be able to enjoy a prolonged buzz from their use.

There are often overlaps with **the buzz** and **being young**, in that the desire for excitement was a common feature of their younger years. Chris's quotation below infers this when he talks about 'playing' with others, suggesting a childlike activity. He suggests that 'playing' and committing crimes when he was younger made him feel older than his 17 years, like a 'big man.' His quotation also illustrates a shift in his behaviour, from describing how he actively chased the buzz when he started using drugs to how, as his use progressed, his use became more passive.

It (grafting) was just a buzz because it were just something to do when I were younger. But then it got into the stage where I got into the habit of the 'phet (using amphetamine) where I were just going out to do it, just to feed the habit. It was just at first, just to order at first, because like I say it were a buzz for me going out, 17 year old, 18 year old something to do, big man playing with other lads, going out with other lads in cars. And that's, and then it just progressed then further, with just having to do it because of me habit. (Chris)

The buzz was not limited to pursuing illicit activities. For example, later in his interview, Chris refers to the buzz of being imprisoned when he was younger.

It (going to prison) were a buzz. Because that's, it were a big thing for you in them days. If you went to prison you were classed as a big Mr or good lad you know 'cos you're not a grass so you go to prison. (Chris)

Like Kev, Pete also describes the buzz he felt when he was younger. For him, the buzz of committing criminal activities was linked to the buzz of being chased by the police. There is an implicit rationalisation of these actions as Pete said that he wasn't the only one engaging in them and that he was a 'kid' doing 'daft things.'

The buzz, the buzz of just driving someone else's car really. Do you know what I mean? Recklessly. I enjoyed it, we all enjoyed it. Even if we weren't driving the car, just being in it, getting chased by the police and stuff, it was a laugh. We had a laugh doing it. It's a bad thing to say now, when you grow up and you start thinking about it, it's quite bad isn't, you know, thinking about it.

*It is it's quite a bad thing, but it were just daft things I did when I were a kid.
(Pete)*

The second sub theme of desire for excitement is 'escape reality.'

Escape Reality

Linked to experiencing a buzz was participants' desire to feel excitement in their lives through escaping from the reality of them. This was largely because their lives had been marred by troubled upbringings, family breakdowns and criminal activity. Thus participants described how a way to escape from these situations often centred on using illicit drugs, particularly depressants. Participants described how heroin numbed their feelings and, in so doing, provided comfort.

(Heroin) relaxes you, you know what I mean, blanks it out doesn't it I suppose, you know what I mean, escape from reality for a bit. Even though you've got to come back to reality. But at the end of the day, it sometimes, it can make you sleep as well. You know, if you haven't done any for a while, you may get a decent sleep from it. (Eddy)

Similarly, Andy likened the effects of heroin to a protective blanket:

It just wraps you up, do you know what I mean, everything outside doesn't matter, you don't think about it. It just wraps you up in like a blanket and it just blocks everything else out. But in real life everything's still going on, do you know what I mean, you just don't really notice it, you don't really take much notice of what's going on because you're not thinking about it. (Andy)

Ironically, drugs themselves then became a further factor from which participants wanted to escape, but they could usually only do so by using more drugs. Within this sub theme there were parallels between the way in which participants spoke about their community and prison lives. For example, we saw in *Being Young and Having Fun* in Chapter 4 that wanting to escape what were seen as mundane and boring situations when growing up was a reason for using drugs. Similarly, wanting to escape the reality of what were described as boring and monotonous prison conditions accounted for the men's prison drug use and their desire to forget about being in prison.

Even if you're locked up with somebody you like it's still depressing being in a room 23 hours a day when you've got to go to toilet in front of somebody, you know what I mean and things like that, and it's depressing. So you use drugs to, even though it is momentarily, to escape where you are. (Rob)

Participants commonly described wanting to feel a 'head change' when in prison, in order to temporarily escape from the mundane daily reality they associated with it.

It's (using drugs in prison) escaping reality and a head change, you know what I mean because obviously you think about it right, you're in jail, it's the same, same routine 24/7, yes, all right it's a different day, but it's the same. Obviously if you're doing something then it's a head change and it's, you know what I mean. It is 24/7 and you want, you do need a head change, I don't care what anybody says, because it just gets monotonous. (Eddy)

Escaping the reality of other circumstances, such as family or relationship problems was also facilitated by using drugs in prison, particularly when the other circumstances were external to their prison lives and beyond their immediate control.

In prison and that sometimes it's hard. It is really hard, do you know when you have got loads of crap, problems with your family and stuff like that you know what I mean? If you've got problems in your family you feel like you need a head change or something, something to take your mind off your family and put your mind on something else. (Matty)

If I'm in jail and I've not got nowt (nothing) I think about what is happening out here. Is my wife with the next man or whatever. But if you use it's just a case of you don't give a fuck what she's doing. (Keith)

Whilst escaping boredom and reality through using drugs was initially pleasant, their continued use appeared to have the unintended consequence of participants feeling that they had lived muted existences and that they were numbed by drugs. This overlaps with the **wasted life** sub theme, highlighting connections between the higher order themes of **Living on the Edge** and **Desire for Excitement**.

Living on the Edge

The analysis suggests that **Living on the Edge** was developed from the **Desire for Excitement**. **Living on the Edge** describes how participants experienced variable levels of disarray throughout their lives, characterised by living hectic lifestyles and existences. Being 'ruled by drugs', a 'cycle of inevitability' and having a 'wasted life' were identified as sub themes linked to **Living on the Edge**.

Ruled by Drugs

As covered in the Dawning of Addiction and the Cycle of Drugs and Crime in Chapter 5, feeling ruled by drugs and subsequently crime in order to feed a drug habit, dominated the men's accounts. This feeling was associated with increases in their community drug use as it developed from recreational to something more regular. Feeling ruled by drugs resulted in them feeling trapped in a regular, often daily continuous cycle of obtaining and using drugs with no obvious or easy escape. Ironically, this cycle can be likened to some of the features underpinning more legitimate employment. Yet the established features of (paid) annual leave and sick leave linked to formal employment do not extend to drug users making their money for drugs through crime. Committing crime was invariably linked to being ruled by drugs because, as use increased, crime increased in order to pay for drugs.

It was a continuous thing. You had to go and get stuff (shoplifting) and then go and sell it and then go and buy drugs and then use them, and then go and get stuff straight away because if you didn't keep going you run out of money and then you would be ill and then you wouldn't be able to go and do something. And then you get yourself caught into a downward spiral where you don't feel well enough to go and do anything. (A1)

Committing crime was also characteristic of marginalised existences and living on the edge. Engaging in criminal activities in order to pursue drug use carried an inevitable element of risk and danger, namely of being caught by the police or prison authorities. This draws parallels to **the buzz**, described in **Desire for Excitement**. The less well planned the crime was, or the more in drug withdrawal participants were appeared to increase the risks taken when they committed crime, as described in Escalation of Crime in Chapter 5. This arguably heightened their risk of being caught and increased their susceptibility to living more on the edge as a result of being ruled by drugs. Committing quick and unplanned 'kamikaze' crimes whilst at the height of their drug use was an example of this. Furthermore, participants

described how their drug using practices became less careful and more risky as use became more intense and as they became more ruled by drugs. An example of this is provided below when Gareth describes reusing a blunt needle in prison:

I'd use it for about a week, three or four times a day. Half the time it were like, half the time it were like I might have just pushed a spoon in my arm, because they were that blunt.

CT: Right. Did you do anything to sharpen it?

A couple of times I used to sharpen it on mirror. But when you just couldn't be bothered, you just stick it in. And that's how it would get with needles in prison. You just couldn't be bothered with them. You wouldn't bother sharpening. You just, it were there so you thought fuck it just get it in your arm. (Gareth)

As with **victim identity**, men described eventually feeling out of control, powerless and resentful of feeling ruled by drugs. Gordon likened being ruled by drugs to being a prisoner to them.

It's like a prisoner to drugs, you have to score really. You are tied to them, it's like a prisoner to drugs, you can't go anywhere, you have to score. (Gordon)

For some, including Tony and Adam, using drugs was all they had ever known or could ever remember, which made it hard for them to imagine a life without using them despite their negative and deleterious effects. This not only emphasises how participants had become ruled by drugs, but how they expected and acknowledged that they could remain ruled by them in their futures.

It has become like a lifestyle now. Actually getting up, obtaining the money, doing it, and I feel lost not doing it now, I've been doing it for so long. (Adam)

For Tony, using drugs had negatively affected his housing, relationships, employment and personal possessions. Yet he did not think he would stop using them in his future.

I don't think I can give it up if you know what I mean. I like the feeling that it gives me, do you know what I mean? I know its destroying me like, do you know what I mean? Because I've ended up with nothing, do you know what I mean? I have got no home. I am in a hostel, do you know what I mean? I

have lost me family, me ex, I've lost everything. I used to have a job do you know what I mean, I used to have a car, and I used to have a nice house. Do you know what I mean? I used to have everything like do you know what I mean? Like look at me now, I've got nothing. (Tony)

For men like Tony, using drugs had caused so much damage to them and their lives that it was unlikely that continued drug use would result in any additional unwanted effects. Even acknowledging that continued use could potentially result in contracting serious infections or lead to fatal overdose did not appear to make participants reconsider their use. Rather, this was something that participants spoke about candidly, almost like an occupational hazard of using drugs. To some extent, the fact that there was often little to deter participants from using drugs was framed in the interviews to legitimise their continued future drug use. In fact, continuing to use drugs might be safer and easier for them than to try to stop because if stopping they would also need to address the physical, social, psychological and emotional consequences of their drug use. Continued drug use was also portrayed by participants as helping to mute any emotions linked to previous negative life experiences and negate the immediate need to address these. This further highlights how participants were ruled by drugs.

As covered in the next sub theme, **cycle of inevitability**, increased crime was portrayed by participants as an inevitable consequence of using drugs. Imprisonment was expressed as an inevitable consequence of being ruled by drugs and crime. In some cases, imprisonment was sometimes welcomed by participants as it presented an opportunity to stop or reduce their drug use so that they no longer felt ruled so much in this way. Yet imprisonment also represented an opportunity for drug use to continue. As such, feeling ruled by drugs (and to some extent committing illegal activities in order to guarantee supply) was not limited to participants' lives in the community, but extended to their time in prison. Participants spoke about the lengths that they went to in order to obtain drugs when in prison, such as in Gareth's quotation on page 187 where he made excuses to find drugs, showing how being ruled by drugs transcends beyond community drug use:

Everybody is just on the go all the time. Just trying to score themselves and trying to look after themselves. (Gordon)

Within prison, illicit drug use could also involve high levels of risk taking, highlighting living on the edge within these environments.

Cycle of Inevitability

As alluded to above, a cycle of inevitability dominated participants' accounts which they often spoke about in a nonchalant and blasé manner. For participants, inevitability was linked to becoming addicted to using drugs as use increased. However these feelings may be a product of retrospective interviewing as participants said that when they started to use drugs they did not realise that they might become addicted and did not feel the same element of inevitability surrounding initial drug use and subsequent progression. Rather, this was only something that they could reflect on and talk about with the benefit of hindsight. An element of inevitability was also linked to committing crime to afford this increased use.

It was either that (commit crime) or go without (drugs) and I wasn't going without, you know what I mean, I wasn't going to be poorly so it were like wake up, get ready, have a dig, go out, shoplift. (Justin)

For participants, inevitability was consequently also linked to getting caught for committing crime and for being sent to prison on account of their illicit activities.

It were inevitable wasn't it? Because I was selling gear and I knew I were going get caught. (Barry)

It (going to prison) were going to happen, it were because I were in court for burglaries, do you know what I mean? So I were just waiting for sentence, so I knew I would be going to go to jail. (Ian)

There was a passive acceptance of the inevitable nature of events which participants had experienced. Furthermore, the **cycle of inevitability** linked to their involvement in illicit activities overlaps with the sub themes of **blame** and **victim identity**, as participants largely portrayed themselves and their actions as products of their circumstances for which they were not responsible. This overlap therefore links the broader themes of **Living on the Edge** and **Deny Responsibility**.

Wasted Life

Commonly discussed in the interviews and linked to being **ruled by drugs** and the **cycie of inevitability** was a sense that participants had 'existed' rather than lived in their lives.

I thought I enjoyed me drug use but thinking back on it I mean the rattling in the morning and knowing you have to go and graft (steal) 10 or 15 quid (pounds) to go and get a Chappy bag or something Chapeltown bag, a bag from Chapeltown to sort your habit out it was no way of life, you're just existing, you're not living, you know what I mean? And to be ruled by drugs rather than you ruling a drug is two different things. (Benji)

This existing led to an overwhelming feeling that they had 'wasted' their lives. This is interesting as their average age of 34 years suggests that they were still relatively young. There are various elements to the **wasted life** sub theme, as explored below. Spending so much time intensely pursuing and using drugs and committing crime in order to use drugs, rather than other more 'normal' and/or legal activities, contributed to participants feeling that their lives, particularly their younger years, had been squandered. This is an interesting inconsistency as their younger years had been described as when they had the biggest buzz associated with starting to use drugs and having fun. Yet, with the benefit of hindsight they suggested that they felt very different about these times. Thus a degree of remorse and resentment was expressed about their perceived squandered younger years, as participants suggested that they could have lived more full and meaningful lives if they had not become involved in illegal activities and lifestyles. This identifies how **wasted life** can be linked with the **blame** sub theme, as drug use was largely blamed for wasting their lives. This links **Living on the Edge** with the broader theme of **Deny Responsibility**.

Another aspect which suggests that participants felt that they had not made the most out of their lives was that they spoke about holding compromised positions in mainstream society. This includes their reduced family roles and the lack of meaningful roles, such as those obtained through formal employment. For example, some had previously been legally employed but said that they found this hard to maintain when their drug use escalated and had not worked since. Furthermore, as later discussed in **Complex Social Networks**, they had few if any meaningful non drug-related friendships and relationships and often had unstable family

relationships. To legitimise compromised positions in mainstream society, participants often tried to emphasise their higher standing in drug using and criminal underworld societies, including what they had done in order to perceive themselves in this way. For example, Clive spoke about being an enforcer in prison and being known as the 'Daddy' whereby other prisoners were scared to look him in the eyes. However, having held these higher standings in drug using and criminal circles did not mean that participants wanted to carry on these existences in their futures.

I have finished with criminality altogether now. Because what went with it was great, you know you were on a pedestal, like in prison nobody messes with you. You achieve respect you know, you never want for anything. Well now is my time, at the ripe old age, that I enjoy helping lads out, although I've been some sort of an enforcer, I like to put all the lads straight and give them a little talking to, as I've done in here (approved premises where living). (Clive)

A sense of bitterness about having compromised and wasted lives was implicit in some accounts about how participants perceived their lives. For Pete, this was linked to his feeling that he had never had a life.

I want a life. I haven't had, I've never had a life. I've never had a proper life. I've never had, I've never had a, I know this is going to sound weird and it's not going to sound very right, but I've never had a proper relationship. I've never, do you know what I mean, I've never felt love really. (Pete)

Jack felt bitter towards drugs, holding them responsible for not having done things in his younger years and for 'ruining' his life and his family relationships.

It's ruined my life. The fact that me mother, me mum, I'll never have a relationship with her again, through drugs. Me nana, I still see her a lot, but it's not the same, you know what I mean? And it has, it's just ruined my life. There's so much I could have done, while, while I was younger, from the age of 16 I've not done because I've been on drugs. (Jack)

Another element of having wasted their lives, was linked to having spent time in prison, often on numerous occasions. Whilst time in prison was not necessarily always perceived as negative, the general experience of being imprisoned was felt to be wasteful as time appeared to pass slowly with few meaningful activities to occupy

them. These slow more monotonous existences in prison appear to contrast with their more hurried and frantic community existences. It is posited that these slower existences may contribute to participants feeling older, as discussed earlier in **growing older: enough is enough**. Nevertheless, 'existing' in prison paralleled with views of community 'existences'.

When you're in jail, it's not a life, it's an existence because all you're doing is just existing day by day and that's all you're doing because it's the same routine day in, day out. (Keith, 18 prison sentences)

Whilst their community existences could also be routine in nature by virtue of the need to acquire and use drugs, they were far from as constrained and routine as their lives in prison, which were much more heavily regimented due to prison imposed rules, timetables and the monotony and familiarity of the environment day after day. As being in prison epitomised time away from mainstream society and the freedom it afforded participants to do as they wanted, time spent in prison was felt to have further limited and 'wasted' participants' lives.

I've wasted all my life, good ten year of it anyway and I'm only 29 now, do you know what I mean? So I've spent a lot of time in jail. (Ian, 3 prison sentences)

The quotation from Jack below highlights his resentment of his one prison sentence as he consequently 'missed' his 'best years' which he associated with being young.

I think to myself, I wasted a good few years. I wasted, I've wasted two years in prison that I didn't need to waste.

CT: But you are still very young aren't you?

Yes I know but they were my, they're your best years aren't they, your young ones? When you're young and you're growing up and you're going out to clubs and enjoying yourself. I missed all that because I spent it in jail. (Jack)

Furthermore, time in prison was also seen to limit participants' future opportunities, such as reducing possible employment options.

People think it's like good going to jail and being on the drug scene, you know what I mean but it is a nobhead life for nobheads, you know what I mean? It's a waste of a life. And the stigma that goes with it isn't worth bearing you know

what I mean. And like it's bad enough going to prison but going to prison and being a junkie as well or a drug user I mean you're doubly knackered you know what I mean? Because nobody wants to employ you. I am not saying things should be given, just handed a chance on a plate but if they think you deserve a chance give them a chance do you know what I mean? But the world don't work like that. (Benji, 5 prison sentences)

The **wasted life** and **ruled by drugs** sub themes are connected to **growing older: enough is enough**, linking the two higher order themes of **Age and Stage of Life** and **Living on the Edge**. The connection here is significant in that the participants felt that they had lived busy, drug dominated lives and spending time in prison, out of mainstream society. Yet, they were at a stage where they appeared to realise the futility of their drug dominated lives or at least their reported disinterest in continuing living them. It is unclear what prompted this change and no one reason accounts for their disinterest. Rather, a complex interplay of factors such as a participant's age, the length of time using drugs, the amount of previous prison sentences and the nature of their family relationships appeared more significant. The men suggested that they realised the futility of their drug dominated existences at different times and for different reasons. For participants, this feeling meant that they no longer wanted to live such hectic drug using lifestyles or spend time in prison. Rather they wanted to focus on living full and busy lives in more meaningful ways, such as through legal activities and family responsibilities but they acknowledged that making these changes would be difficult. Whilst the men felt aged on account of their drug use and imprisonment, they felt far less so on account of their limited engagement in meaningful activities and in mainstream society. Indeed, they were arguably young and immature on account of their limited significant life experience. Thus whilst wanting to live what they perceived as more 'normal' lives, they suggested feeling vulnerable and anxious about pursuing these with little direct experience. This raises speculation as to how realistic these expectations really were, particularly given their reported enjoyment of engaging in activities which gave them 'a buzz'. That is, unless their pursuit of a 'normal' life, characterised by engaging in more 'normal' activities in itself would be enjoyed and provide them with 'a buzz' in itself.

Resourceful and Adaptable

On account of being ruled by drugs, participants demonstrated very resourceful strategies in their approaches to making money to obtain drugs. Resourceful and

adaptable therefore captures the way in which participants talked about how they adjusted to circumstances in their daily lives. The analysis suggests that **Resourceful and Adaptable** is developed from **Living on the Edge**. 'There's always a way' and 'testing boundaries' are sub themes linked to **Resourceful and Adaptable**. Linkages between the theme and other sub themes are apparent. For example, **ruled by drugs** and chasing **the buzz** influenced participants to be **Resourceful and Adaptable by testing boundaries** in order to **escape reality**.

'There's Always a Way' – Survival and Coping

Many participants suggested that there was 'always a way' to use drugs and commit crime. Participants mentioned various ways how they had made money for drugs through crime or obtained drugs during their hectic existences. For example, some described well thought through and careful techniques which they adopted, such as taking 'orders' from 'customers' about what to shoplift, and adhering to these, almost like a shopping list. However, others committed crime that was more focussed in the moment and was less well planned. Those who committed carefully planned crime had spent many years actively engaging in these activities, allowing them to perfect their techniques and ways of making money. Adam described how he shoplifted:

I use a coat with big pockets on the inside what might be called poaching pockets, old fashioned word for it. And as long as you are not greedy people can't tell what you have got or if you've got anything in your pockets, because your hands are free, they give you the benefit of the doubt as long as they don't see you pick anything up. (Adam)

Even without employing such careful methods, participants spoke with a degree of confidence that they could always obtain money and drugs if they wanted to. For example, participants had obtained illegal drugs when they had no money in the community or in prison and had avoided prison drug use being detected by a variety of innovative ways. There was evidence of determination and of actively manipulating situations in order that their intentions were achieved, particularly in relation to obtaining and using drugs when in prison. This manipulation and determination in what were sometimes chaotic circumstances is testament to the participants' resourceful natures as they often had to act quickly and respond to situations. Their determination and active resourcefulness is demonstrated throughout the findings, such as diverting prison medication prescriptions and exchanging items for drugs and/ or equipment. Finding a way to obtain equipment to use drugs when in prison

was commonly discussed and resourceful strategies adopted included making needles to inject drugs with from biro pens or obtaining foil in a variety of ways in order to smoke drugs. This demonstrates how they actively pursued these activities in the interests of using drugs, contrasting with some of their accounts in which they suggested that they were more passive.

Most of the time I have had no problems. There is always a way around. It is like the old – you know Golden Virginia packets? The old ones, the paper ones, there is foil in them. You stick them in water, hot water and you can peel the paper off and there is foil in between. (Bryan)

Furthermore, prisoners found ways to pass things between themselves when they were unable to get out of their cells.

When you're on lock up and you can't get out of your cell and you want something from three cells down, you get a line with toothpaste round it or something and you swing it out of your window, pass it to them and they will put it on the end, tie it on the end and you just pull it back in again.... there's always a way of getting around everything. (Wayne)

Over the years of their drug use, this knowledge and ability translated into confidence in their skill and expertise that there was 'always a way' to achieve whatever they wanted. This emphasised their determination and also implied their almost unquestionable ability to adapt to situations and circumstances in which they found themselves.

We'll (drug users) find a way around it, we always do. (Kev)

Linked to participants describing that there was 'always a way', are the survival strategies which they adopted in what was often described as a 'dog eat dog' and hostile world. This relates to how participants responded to changing situations such as housing problems, being sent to prison and being transferred between prisons. The descriptions of obtaining drugs when in prison and how they deceived prison medical services to obtain prescribed medications in order to misuse them are good examples of survival strategies and coping in different circumstances. This demonstrates their ability to adopt and adapt to different environments. These further illustrate participants' resourcefulness and show what lengths they said that they

would go to as a result of their lives being **ruled by drugs**. That is, participants acted flexibly and resourcefully within the constraints of being ruled by drugs in order to achieve their drug using needs and desires. This demonstrates the linkages between the higher order theme of **Resourceful and Adaptable** and **Living on the Edge**.

Testing Boundaries

This sub theme relates to how participants continually described how they tested and challenged traditional norms and behaviours by pushing accepted boundaries. To some extent, participants had tested and challenged boundaries for much of their lives. Often they had tested the boundaries and rules which their families had tried to enforce when they were younger by truanting from school, experimenting with illegal drugs, committing petty crime and being involved with antisocial peers. Participants continued to test boundaries as they got older. As their illicit drug use progressed, their activities became more testing and challenging of rules and legal systems accepted by mainstream society in a myriad of ways. There are links between this sub theme and the **buzz** sub theme of the **Desire for Excitement** and the **ruled by drugs** sub theme of **Living on the Edge**.

Accepted rules and laws imposed by society regarding right and wrong appeared to be little deterrent for participants. They each described numerous wrong doings and law breakings, highlighting troublesome natures and initial boundary testing, largely through their increased use of illicit drugs. This culminated in all participants at some point doing something for which their punishment was being sent to prison. However imprisonment was not always a deterrent and participants would not necessarily conform to the rules regarding acceptable behaviour on account of being in prison. Rather, their wrong doing continued in prison, again testing the rules.

It's quite exciting I suppose (using drugs in prison), because it's like you're not meant to, you're in prison, it's kind of against the system. (Rob)

Participants appeared to determine what they perceived as acceptable behaviour, frequently following tacit prisoner rules learnt within the prison context. Whilst testing boundaries and breaking the law did not appear to deter participants or make them question their behaviour initially, largely on account of their drug use, they articulated the consequences of their actions on their relationships with their families, as later discussed in 'fractured family relationships.'

The availability and supply of illicit drugs and the possession, trade and exchange of contraband items when in prison are further examples of disobeying the rules governing prison. Not getting caught committing illegal activities when in prison or the community was portrayed as part of the excitement of testing and challenging the boundaries of acceptable and legal behaviour, linking it to **the buzz (Desire for Excitement)**. It was not only the desire and perceived need to use drugs which prompted them to challenge boundaries and imposed rules, but their thrill seeking behaviour and desire to outwit and potentially embarrass the authorities. For participants, this was a way of succeeding in deceiving and outwitting the police and prison officials.

Only thing that you have to watch out is for the screws, do you know what I mean? Because all right, yeah it's, that's like another buzz in itself like do you know what I mean, you know from trying not to get caught at the same time (as using drugs). (Tony)

Drug dealers are now going onto the clean wings and distributing (drugs) from there, you know what I mean, so it is making a mockery of that. (Justin)

The final theme identified from the narratives was **Complex Social Networks**.

Complex Social Networks

As identified elsewhere, participants' accounts were littered with reference to social networks. These networks and relationships were portrayed as complex and three sub themes are significant here: 'fractured family relationships', 'lack of real friends', and "them' and 'us". Elements of **blame** and **victim identity** from **Deny Responsibility** appear throughout this theme linking the two higher order themes.

Fractured Family Relationships

Participants described their family relationships as historically problematic. This was largely due to not having strong parental influences as a result of spending time growing up in the care of the Local Authority or their parents not being around or having been bereaved during their childhood (see Childhood and Early Life Experiences and Personal Circumstances in Chapter 4). This links this sub theme with the **being young** sub theme of **Age and Stage of Life** and also the **blame** and **victim identity** sub themes of **Deny Responsibility**. Whilst parental absence was

not the case for all participants growing up, the breakdown of family relationships also became a feature of interviews for those whose earlier lives had been more stable. These breakdowns had often occurred as a result of participants getting involved in drugs and/ or crime when they were growing up and the continuation of this over the years. It was not always the involvement in illicit activities that contributed to the breakdown of relationships, but the consequences of this.

I've done everything, I've nicked off my sisters, I've nicked off my Mum, I've nicked off my Dad. I've done everything to get heroin. Everything. And they hated me. (Keith)

Heavily using drugs and going to prison were said to reinforce earlier disjointed relationships and contribute to further fracturing as the years went by. For example, men described losing practical and emotional family support when they were sent to prison and suffered reduced contact with them. Participants perceived having little or no family support was a result of the upset that they had caused and the sometimes unrecognisable and unsavoury person they had become.

My mum said to me when I were in court, she said I aren't coming to see you in prison and it really upset me and I think that is why I were more scared. If I had had me mum and dad coming to see me I wouldn't have been as scared. I wouldn't have been as upset, but just the fact that they weren't sticking by me no more. (Pete)

However, this is not to say that their families would not support them in the future, as some participants expected their family relationships to improve if their behaviour changed.

The consequences of using drugs and committing crime caused fractured family relationships. For example, serving in prison meant that participants spent time away from their families, partners and children and were less able to care and support them. This contributed to further fracturing as families questioned participants' reliability and trustworthiness. Missing significant events such as Christmas and birthdays as a result of being in prison also affected family relationships as this was when the men felt that they should be with their families. For example, Andy mentioned missing the birth of his son on account of being in prison and Matty was in prison on his daughter's first birthday.

My oldest son is ten now and I think I've had one birthday out (of prison) with him in ten year. (Jamie)

Fractured family relationships were demonstrated in many ways, most frequently by participants' lack of reference to meaningful family support networks and their family's wariness and lack of trust in them.

You haven't got much and when you're an addict, you know, it's not very often you have got owt (anything), you know, I'm talking about family and owt (anything) like that, you usually do something along the lines for your families to disown you. (Steve)

In more extreme circumstances, participants described no longer being in contact with members of their families. Paul, Benji and Barry amongst others said that they were estranged from their families and had not seen their mothers for a number of years. Not seeing their children for some years whilst the children were growing up was also a common experience shared by participants. Others spoke about trying to re-establish and repair family relationships, although they said that this was difficult as often their families found it hard to trust and believe them after the upset they had caused. Trying to re-establish relationships was often something participants had instigated themselves, whereas for others it was more as a response to receiving ultimatums from a family member.

She (daughter) says, 'Listen Dad' she says, 'Isn't it about time all this stopped?' I said, 'How do you mean?' She says, 'You, with the drugs and the crime. Isn't it about time it stopped?' I says, 'You know me, what you see is what you get, I've been a crook all my life, that's how I earn my money.' She says, 'Well put it this way, I've had enough of you now. If you carry on the way you're going, you come out (of prison) and I will fuck off and I won't have nowt (nothing) to do with you. (Kev)

The fracturing of participants' family relationships was complex, as it was both a cause and consequence of many interlinked issues, namely of participants' involvement in illicit activities over the years. The overlap and connection between this and other sub themes is significant, namely with **being young (Age and Stage of Life)**, **blame** and **victim identity (Deny Responsibility)**.

Lack of Real Friends

Participants' **lack of real friends** is a sub theme of **Complex Social Networks**. As their lives became more centred on using drugs and committing crime, their peers were other drug users and criminals and they rarely had robust and affirming relationships with people outside these circles. Yet these relationships were casual and purposeful in nature, characterised by using drugs and/ or committing crime with one another and maintaining an element of collective solidarity. These casual 'friendships' were significant in terms of the acquisition of knowledge regarding drug using and criminal practices. Indeed, as illustrated in the quotation from Jack on page 160, participants described having learnt techniques relating to using drugs and committing crime from their more experienced peers. In some cases, this 'teaching' was more formal, whereby peers 'educated' them about what to do and what not to do and how to do and how not to do certain things. There was an implicit sense of gratitude linked to acquiring such knowledge and socialisation.

They (drug users he knew) also introduced me to the whole how to recognize a house that doesn't have anybody in and so how you can get in, burgle the place and get out. And you know, one of the things I remember them telling me was as soon as you get into a place, look for how you're going to get out, so you know that first. Before you go looking for anything you can nick. That is the first, you know, it's little bits of information like that, that just wouldn't occur to you normally, because you would be just quick, find something I imagine, but sort of real life saver stuff that at the time you are just grateful for being told. (A1)

The relationships therefore appeared to be less around building long standing affection bonds with one another or based on the characteristics of normal close friendships, such as support, intimacy, trust, loyalty, honour and benevolence. Participants described these people as associates, or 'people who they knew' rather than true friends. The relationships which they had with them were functional, highly transitional and generally insincere. Furthermore, the relationships which they formed in prison were often very similar in nature and only lasted or served a pragmatic purpose (such as for collective solidarity and protection, for expected reciprocity, to acquire drugs or to pool resources for drugs) when they were in prison. Some participants described how they realised that they had been used, deceived and manipulated by their so-called friends, particularly when they were younger and more

vulnerable, such as during their early years of using drugs and committing crime. The feeling that these 'friends' could not be trusted or relied upon in any circumstance permeated the interviews. Talking with the benefit of hindsight, Steve said:

How I look back at it now, they weren't mates, they were associates but while you're through drugs they're classed as mates because you're always knocking about with them. (Steve)

Wayne further illustrates this by suggesting how a drug using associate would behave differently to what would be classed as a 'proper friend.'

They are just people that hang around one another to get the gear (drugs). They're not mates. They'd stab you in the back if they could. They wouldn't, they wouldn't help you really as such. They are just, you are all one big clan to get gear (heroin). They're not interested in, if you dropped £20 on the floor and that were your score (drug) money, and they saw it, and could pick it up and take it, they'd take it and not say nowt (nothing) to you. That's not a friend. That's an associate. That's someone that will just have you over. They're not interested. Not like a proper friend who would say, 'oh you have dropped your money mate, here you are'. They'd just take it and buy more extra drugs with it. And leave you rattling (in drug withdrawal). Don't care what happens to you. Stab you in the back. Rob you even. You go and buy a bag (of drugs) and they haven't got any money, they'll try and rob you for bag (of drugs). They're just idiots, just associates. (Wayne)

Very occasionally participants distinguished people who were, or had been 'true friends'. These were people who they said that they could trust and had had more conventional friendships with and were rarely associated with pursuing illegal activities. However participants' accounts of true friends largely focussed on losing true friends, primarily through death or imprisonment as seen in Chapter 4.

Most of my proper friends are dead now, you know, like and my last best mate he's over in France, living in France now, so like I haven't got no proper friends anymore over here. I wouldn't say friends, you know, I've got mates, kind of, but they're just people you do drugs with and that, they're not people that you go out for a drink to the pub and that. No. Things like that. It's just all about drugs. (Kyle)

This overlaps with **fractured family relationships** and contributed to a sense that participants had very lone existences, with little emotional and practical support.

'Them and Us'

A further area of participants' complex relationships with others is captured by the sub theme 'them and us'. As demonstrated by the quotation by Ian on page 198, participants suggested strong divisions between themselves ('us') and the authorities ('them') from the police, the prison service and the courts. Authorities were viewed with suspicion and resentment, highlighting participants' possible uneasiness with authority. Participants portrayed 'us' like being part of an allegiance on account of their shared illicit activities and compared themselves with others in similar situations. This not only normalised their illicit activities, but often positively reinforced them. Furthermore, this acted to enhance their more detached roles within mainstream society, at the same time enforcing their roles in drug using circles through these shared activities and interactions. These divisions were reinforced, even if somewhat superficially, when they were in prison and in environments with others in similar circumstances. The implied solidarity with people in similar situations is interesting and overlaps with the **lack of real friends**. That is, even though participants were wary about the trustworthiness of their known drug using associates and had instrumental and strategic rather than meaningful friendships with them, there was still an element of solidarity between them. This was evidenced by the fact that they would generally stick together when in prison so as not to isolate themselves but feel the security of their shared experiences and belonging.

That was the ethos then, to be staunch (stand together, stand firm) do you know what I mean and the camaraderie that was around it was like elatable, you buzzed off it. (Benji)

A further facet of 'them and us' was that participants maintained other drug users' confidentiality by not informing or 'grassing' on one another ('us') to the authorities ('them'). This was most commonly discussed by those with extensive prison histories which dated back many years. Not betraying one another appeared to contribute to a participant's self preservation, perceived integrity and an adherence to unspoken but largely accepted codes of acceptable behaviour. Not informing on one another occurred in prison and in the community, even if it could be more personally detrimental for individuals. For example, Barry claimed he took the blame and the

subsequent penalty of a four year prison sentence rather than 'grassing' for drugs found at his house which belonged to a drug using associate.

I just said listen, it is my house, I'm not saying nowt (nothing), you know what I mean? I wasn't going to grass anybody up. I'd done four year for, I mean yes, I had been selling but that gear (heroin) that they (the police) caught me with that morning were nowt to do with me. (Barry)

This is interesting given the overwhelming feeling that participants did not have true friends. This raises questions about why Barry and others like him might have behaved in this way. It could be postulated that he did this as he feared the potential violent repercussions from the 'friend' or the 'friends' associates' if he had told the police the true story or the implications for his credibility and reputation amongst other drug users which could have long standing consequences, arguably of a more severe nature.

However, there are tensions within this sub theme. At a deeper level, there were also divisions within and between drug users and criminals, as individuals, groups and gangs vied and rivalled against one another, further highlighting complex social networks. As suggested in **lack of real friends**, drug users were suspicious and could not trust one another. Thus to some extent fragmentations and uncertain levels of allegiance between drug users were apparent, demonstrating levels of vulnerability amongst them. This was highlighted by the formation of prison gangs and alliances, often based on drug use or the area of the city or country from which people came.

You've just got people to associate with haven't you? To look after you or watch your back or whatever. Because you find out that they make gangs in some jails and like the Leeds lads will stick together and then there will be Sheffield, Hull. So you just have to stick together in some parts of the country in jails. (Ian)

As Ian alluded to, these relationships served a practical purpose of looking out for one another and providing protection rather than meaningful friendships. The very existence of such allegiances reinforced underworld activities and contributed to the lack of recourse to formal legal rules and structures. Men suggested that the formation of groups, gangs and ad hoc relationships in prison helped them to feel less vulnerable amongst their peers and less at risk of social isolation.

As soon as I walked in the exercise yard, there was me walking round on me own, I saw a few friends and it was sort of, 'Derek, Derek, over here, over here'. And I thought brilliant. As soon as I saw a few people I knew it was absolutely fantastic. I thought oh great. Because you stand with a group of like five or six lads and you're not going to get any trouble because if you're going to get trouble, basically if that lad is going to walk over, he's going to have to deal with five or six of your mates but if you're stood on your own, it's going to be a different story. (Derek)

'Them and us' therefore operates at both a macro-level (authorities and drug using criminals) and micro-level (amongst drug users and criminals). This was most obvious when participants drew distinctions and made comparisons between themselves and their criminal and drug using peers. Rather than reinforcing their collective position, however, this was done to highlight difference, suggesting that 'them and us' operated at complex levels within drug using and criminal fraternities both within and outside prison. Chris spoke about how people from different areas of Leeds or different ethnicities would not mix with one another in prison.

You always stuck together in prison. It's like Bramley would stay at one side of the yard and then you would have Seacroft at another side of the yard, and Gipton down at other. And then unless somebody knew somebody from Gipton and somebody knew somebody from Bramley you never really got round to, so you stayed with your own kind really. It's like it is now, but it is more in black and white now, when you go in, in prison now, which is stupid because half of blacks are from Bramley. They won't stand with people, white people from Bramley. (Chris)

Distinctions were also made between different drug users according to their perceived standing. For example, in Clive's interview, he used derogatory language to distinguish between what he called 'mucky bag heads,' 'street urchins,' and 'fodder' displaying how he perceived some drug users in comparison to others and drug dealers.

It's like a family you know, you have your big guys and you have your little guys, and the little guys I'm afraid didn't mix with the dealers and so called

hard nuts and so forth. They were the people who bought the drugs and used. They were the fodder. (Clive)

Furthermore, reflecting some of the earlier discussions regarding participants' moral views, distinctions were also made between prisoners on the basis of the nature of the crimes that they had committed.

On protection wing you've got your debt heads who owe all money, you've got your grassers that have given people in and stuff like that but you've also got your nonces, you know whose done stuff to women and kids. (Kev)

Participants' narratives identified that they had complex social relationships with their families and drug using friends, often caused and further complicated by their use of drugs and engagement in criminal activities.

Chapter Summary and Discussion

This chapter has identified and described six overarching super ordinate themes which permeated participants' interview narratives and which cut across participants. The six themes were Age and Stage of Life, Deny Responsibility, Desire for Excitement, Living on the Edge, Resourceful and Adaptable and Complex Social Networks. These themes were made up of a number of sub themes which together help to explain participants' drug using behaviours within and outside of prison and help to explore the impact of being in prison on participants' drug use. They also help to understand and explain the lives and circumstances of the men interviewed at a higher level of meaning, beyond participants' generic descriptions of them. The themes offer context and insight, building on from the analysis and explanations provided in Chapters 5, 6 and 7 and for that which follows in the next chapter.

Whilst the literature on drug misusing offenders discusses some of the broader issues presented in this chapter⁴¹, this discussion does not consider how closely the

⁴¹ For example, previous work has also identified the exclusion of drug users from the 'normal' world at the same time as highlighting drug users' lack of real friendships but the more functional nature of their relationships with acquaintances made through drug use (Buchanan & Young, 2000; Crewe, 2005; Crewe, 2006). Previous in-depth ethnographic work has also considered the levels of solidarity and cohesion amongst prisoners and the accepted codes and conventions of prisoner behaviour and how heroin has influenced these (Crewe, 2005; Crewe, 2006).

themes which permeated the interviews align to the existing literature. Rather, the discussion briefly considers some of the overarching intricacies of the themes and key issues which seem to run through them at a deeper level of meaning as this is more beneficial when exploring the role of the themes in the impact of imprisonment on men's injecting drug use.

A number of key issues can be identified from the themes presented. Firstly, throughout the themes there were clear differences in how participants spoke about behaviours in which they had been actively involved and those in which they suggested to have had more diminished and passive roles. It was usual, although not universal, that more socially unacceptable behaviours were those which participants suggested more passive involvement in, such as certain types of acquisitive crime and initiating injecting drug use. Similarly, they were more active in attributing blame for these actions to other people rather than admitting their personal role in them. This could show participants' inability to consider the responsibility for their actions and may be linked to reduced maturity, denial or an inability to express this within the interview situation. Participants were largely more accepting of their later injecting drug use. Whilst expressing many negative feelings towards injecting and the consequences of it, they seemed to be more accepting of their community drug use. This may point towards the social reinforcement provided through engaging in a communal activity and their acceptance of their community injecting identity. However, participants appeared to show reduced acceptance of prison injecting drug use in more recent years, demonstrating how imprisonment did influence and affect drug using practices and how participants thought about their practices when there.

A further issue is that a number of tensions were present within the interview data, as the themes and sub themes highlight. For example, there was a tension between using drugs for enjoyment and using them to escape the reality of life. This was particularly tense as drug use continued, as drugs were then used to escape the reality of the life which had been created and exacerbated by using drugs. There was also a tension between what participants implied and constructed as belonging to drug using and prison communities with the nature of their interactions with other drug users, characterised by short lived relationships and a lack of shared loyalty and trust and fraught with subtle intricacies, such as the largely unspoken conventions of how to behave towards fellow peers and prisoners. This tension shows how it could be difficult for drug users to leave the drug scene once engaged in it due to a lack of meaningful relationships and interactions to positively reinforce their wishes and their

change in drug use and identity as a drug user. This could be even harder when in prison as this is when participants were surrounded by the influence of known associates. This is because it could be speculated that they would lack the confidence and ability to form new relationships outside of drug using circles. It is postulated that this acts to reinforce their isolation from mainstream society at the same time as affirming their positions in drug centred lifestyles which, on deeper examination, were far less characterised by community and belonging than participants initially implied. Rather, the heavily manipulative and passing natures of insecure 'dog eat dog' drug using relationships and 'communities' could further isolate individuals, particularly when operating alongside exclusion from mainstream society.

Perhaps this shows that the drug using participants in this research aspired to feel a greater sense of belonging and purpose than they did but that they did not know how to legitimately go about this for fear of being even further ostracised from society or from their drug using peers and 'communities'. Thus whilst continued drug use in the community or in prison reinforced their divisions from mainstream society, it may provide participants with some comfort and implied security by masking these divisions. Yet the longer term debilitating effects of this continued drug use, such as reinforcing vulnerability and isolation and the inevitability of a living a life ruled by drugs diminished their chances of escaping drug use and crime and integrating into society.

Tensions like these would be ones with which drug users wanting to use prison as a rehabilitative opportunity to change their drug using behaviour in some way would have to grapple with. It can be speculated that the extent to which they would have to face and address such issues would depend on the extent of the drug use behaviour changes which they considered making when in prison and how determined they were for any such drug using changes to continue on release. Next, Chapter 9 considers how participants reported drug use on their last prison sentences changed from that which they engaged in before they went to prison and suggests two models to categorise their prison drug using behaviours which were developed from the analysis.

Chapter 9 - Models of Illicit Drug Use and Administration in Prison

Two categorical models of participants' use of illicit drugs in prison were developed from the grounded theory analysis of the interview data. The first model focuses on the type of drugs used when last in prison and the second on the route of drug administration. The purpose of the models is to identify how participants' drug using behaviours in prison changed due to being in the prison environment when compared to pre-prison use and clarify the diversity and nuances of prison illicit drug using behaviour that participants reported so that potential harm reduction interventions can be considered and targeted appropriately. Both models outline participants' reported drug using behaviour when last in prison in relation to their reported community drug use prior to entering prison, identifying how their drug injecting behaviour changed when last in prison as a response to this environmental change. This chapter outlines how the two models were developed and then describes, illustrates and interprets them before considering the use of the models for those working with drug users in prison.

Introducing the Models

Grounded theory analysis was used to create codes and categories from the interview transcripts and to identify relationships between them (see Chapter 3). The behaviours identified within the illicit drug use and drug administration models, therefore, derive directly from an interpretation of the data provided in the interviews. The starting premise for both models is that participants were community intravenous injecting drug users at the time of last imprisonment or immediately prior to it. The models were developed, and are intended to be used, sequentially in order to describe the variety of drug use and administration behaviours. Firstly, the illicit drug(s) participants reported having used in prison were identified, followed by the drug administration route(s). Four types of behaviour reflecting the reported use are identified within each model: concluding, continuing, converting and combining and in the drug use model only, condensing, a further behaviour was also identified. All these types of behaviour are fully described later in this chapter. Determining a participant's position within each model required careful consideration of his interview and how each is 'classified' is therefore based on, and grounded in, participants' accounts of drug use in prison when compared to their pre-prison use. Once a participant's position has been identified within each model, the outcomes of the two

models can be combined to identify his overall prison illicit drug use in terms of both drug(s) used and route(s) of administration. The value of this classification of behaviours provides some indications as to how prisons may be able to work with different types of drug users, some suggestions for which are later outlined in *Using the Models*.

Developing the Models

The rationale behind the development of the model(s) was to aid comprehension of the complex material concerning drug use and drug administration methods which emerged from the analysis of the interview data in order to identify changes in injecting drug using behaviour when in prison environments and to subsequently consider how such knowledge can help to inform ways of working with drug users in prison. As described below, this process required much development and many reiterations before all participant data and combinations of circumstances could be captured.

A Single Model

Initially I tried to account for drug using behaviour in prison within one model, combining both the illicit drugs used and the methods of administration. Yet, despite many attempts and iterations, this proved too complex and I could not allow sufficiently for the intricacies of reported drug using behaviours present in the interviews which were important to capture, particularly given the complexities of multiple drug use with varying administration routes. Drug use and administration routes were also difficult to incorporate and present diagrammatically. This suggested that integrating and unifying the models may not be appropriate due to the variability in the accounts. Identifying and conceptualising those whose behaviours were reported to be more constant was relatively straightforward.

Early versions of the single model were made up of three main elements of behaviour: concluding (where drug use stopped), continuing (where drug use continued) and converting (where drug use continued but something about it changed). However, it became apparent when working participants' narratives of their drug use when last in prison through to test the model, that this did not account for all illicit prison drug using behaviour. For example, some participants said that they used the same drug in prison as outside but also used at least one other illicit drug in prison and they subsequently did not fit into the model. Whilst to some extent

these participants continued drug use, classifying them as 'continuers'⁴², overlooked their other drug use when they were last in prison. Moreover, on account of using a different illicit drug in prison, they could not be classed as 'converters'⁴³, since they also maintained use of the same illicit drug as before prison. Thus it became apparent that an extra dimension to the model was required to take such factors into account. I therefore considered developing separate models rather than adding an extra, and potentially more confusing, dimension to a single model and so it was replaced by the drug use and drug administration route models, as discussed below.

Reworking and Revising: The Emergence of Two Models

The two models that subsequently developed were subject to many reiterations and revisions as analytical ideas and constant comparison continued. Revisions also occurred as I tried to work individual participant narratives about their last prison drug use comfortably through the separate models. These reiterations were necessary in order that what the participants said fitted the models well rather than forcing the material, taking account of more 'deviant' cases which acted to test and validate the models as they developed. To further illustrate the revisions which took place, the initial drug use model developed did not include buprenorphine as I felt that it was contentious to include a prescribed drug, albeit being misused, as the research focussed on illicit drugs. Consequently, the drug route model did not include snorting as an administration route as it was not mentioned as a way of participants taking other illicit drugs in prison. However, it was clear from accounts examined during the analysis that the misdirection of prescribed buprenorphine medication and its subsequent misuse by snorting made its use illicit, as prisoners used it to obtain a euphoric effect rather than to help manage their drug dependence. Moreover as presented in Chapter 6, participants said that they often used buprenorphine in prison in place of other illicit drugs, highlighting how its non prescribed and therefore illicit use should be included in the models. Buprenorphine misuse appeared as a widespread activity of importance to changing prison drug using practices and an important new finding so I therefore included its illicit use in the drug use model. Subsequently, snorting was included in the administration route model as this was identified as the prevailing method of use for participants when last in prison.

⁴² This is more fully explained and described later in the chapter. Briefly, it encompasses those who continued using the same drugs in prison that they used before prison.

⁴³ This generally encompasses those who continued using drugs but changed the drugs that they used when in prison, as more fully explained later in the chapter.

Prison cannabis use is not considered in the drug use model for a number of reasons. Firstly, as injecting drug use was the focus of the research, the interviews focussed on these practices and behaviours, thus their use of non injectable drugs was subject to less discussion in the interviews. Furthermore, when it was mentioned, participants invariably dismissed it as irrelevant. That is, participants likened smoking cannabis to smoking tobacco and they did not perceive it as comparable to using other illicit drugs which they perceived as more serious, carried more risk and were less commonly used within society at large. Interestingly, participants did not consider cannabis use as illicit, and at least not as illicit as using Class A drugs.⁴⁴ Indeed, they suggested that cannabis use was so widespread amongst their peers that it was a 'normal' activity, whether in prison or not, concurring with the findings from another study of prisoners which suggested that they did not consider cannabis to be a drug (Johnson & Farren, 1996). In addition, whilst cannabis can be used in different ways⁴⁵, it is usually mixed with tobacco and smoked in the form of a rolled-up cigarette or 'spliff'. As a result, the route of cannabis administration was subject to less deliberation or change when imprisoned, further explaining why it was not included in the models.

Based on earlier attempts, I did not integrate the two models for the practical reasons outlined above. Furthermore, I consider the individual models have more descriptive power and clarity when used separately, which allow for examinations to take place both at the illicit drug use and the drug administration route levels and for changes in drug using behaviour to be more readily identified from pre-prison behaviours. The separate models are also considered to be of more benefit when considering how they can be used to help inform ways of working with different types of drug users displaying different types of drug using behaviours in prison.

Describing and Illustrating the Models

Following revisions, the models outlined and presented diagrammatically below were developed. The community and prison drug use behaviours are separated by the presence of the padlock, which represents imprisonment. Whilst the models can apply to illicit drug use on any prison sentence, to illustrate them, participants'

⁴⁴ When the interviews were conducted, cannabis had been downgraded from a Class B to a Class C drug. To some extent, participants' views on cannabis thus reflected its perceived reduced seriousness in terms of its classification.

⁴⁵ For example, cannabis can be eaten or smoked through a water pipe, however it is not possible to inject it.

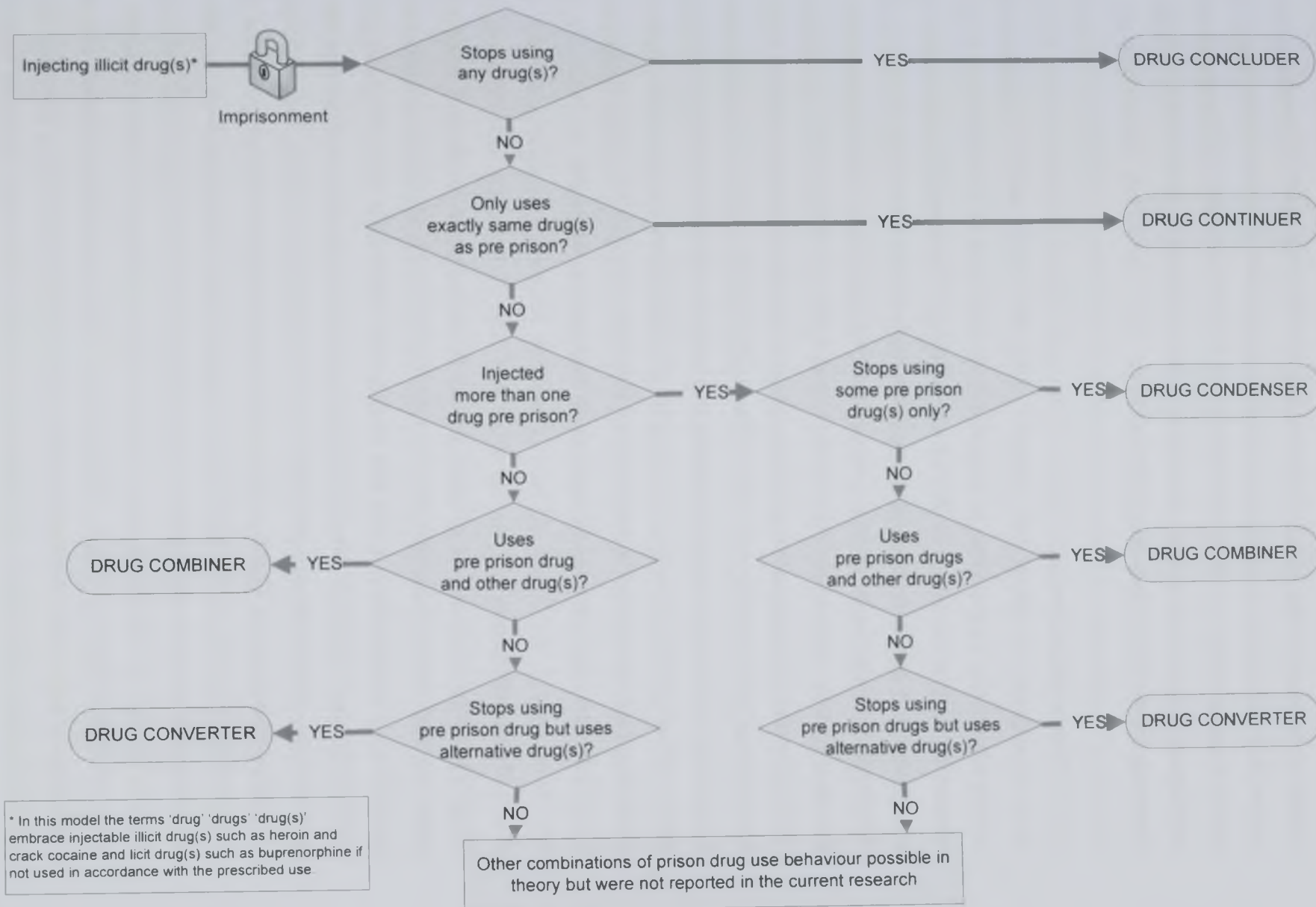
reported drug using behaviours on their last, and thus their most recent, sentence (which for Derek, Jack, Jeff and Al was their first and, at the time of interview, last sentence) are used.

In order to support the analytical claims and illustrate the drug use and drug administration route models, case studies from interviews conducted with Rob, Paul, Pete and Tony are presented where appropriate within this chapter. In including these case studies, the most common types of the identified drug using behaviours on the last prison sentences are illustrated. In all cases, the case studies presented are contextualised by providing relevant information regarding the participant. For the case studies, the participants were worked through the drug use and drug administration route models based on their reported drug use on their last prison sentences, and their position on the models determined from their accounts.

Model of Illicit Drug Use in Prison

The drug use model considers the illicit drugs - and illicit use of licit drugs - that participants reported using in prison. For clarity, the model includes the use of the illicit drugs heroin, crack cocaine, amphetamine and ecstasy, which may all be used by intravenous injection alongside other administration routes such as smoking or swallowing. It also considers the illicit use of any prescribed licit drugs that participants reported using illicitly in order to derive a pleasurable effect. The main prescribed medication to which this applies is buprenorphine, when it was snorted and not taken under the tongue as prescribed. The model does not consider licit use of prescribed drug dependence medication such as methadone or buprenorphine if participants reported using it as prescribed as this recognises that they needed this assistance to manage and control opiate withdrawal symptoms and gradually safely assist them to reduce and stop using illicit drugs. The drug use model is shown diagrammatically in Figure 9.1.

Figure 9.1 – Model of Illicit Drug Use in Prison



The drug use model distinguishes between participants who were drug concluders, drug continuers, drug condensers, drug converters and drug combiners, as explained below. As shown in Figure 9.1, the rectangular box at the bottom of the drug use model states that other combinations of prison drug use were possible. For example, it was not reported in this research but the use of illicit drugs such as powder cocaine or the illicit use of licit medications could be possible. The inclusion of this box in the model thus acknowledges that other drugs may be used in prison, including new and/or different drugs which or may be used or misused in prison in the future, reflecting how drug trends can and do change in prison.

- **Drug concluders**

Drug concluders are those who stopped using illicit drugs whilst in prison. They largely saw prison as providing an opportunity to help them stop using drugs, at least temporarily or they could not or did not access drugs in prison. Bringing together the categories and super ordinate themes presented in Chapters 5, 6, 7 and 8, the influences on participants to stop using drugs in prison were numerous and varied. Practical factors underpinning these decisions such as the provision of substitute medication, the consequences of getting caught, and the perceived expense of illicit drug use in prison overlapped with more psychological, social and environmental factors linked to being in prison. A detailed examination of the data shows that these factors did not stand alone, but overlapped with participant characteristics such as those presented in Chapter 8 and included their age, stage of life, sense of drug use fatigue, desire to live a more fulfilling life and the length of sentence.

- **Drug continuers**

Drug continuers are those who continued to use exactly the same illicit drug(s) in prison as they used in the community before imprisonment. However, the frequency at which they used reduced from that of their use before the community because, whilst drugs were available, accessing the same proportions and quantities as often as they had done in the community was not possible in prison. Typically, drug continuers indicated no intention of stopping using drugs or changing the type of drug(s) used when in prison and did not consider that imprisonment should affect continuing their use in largely the same manner as in the community. The main reasons offered for continued use of exactly the same drug(s) in prison included a sense of being ruled by drugs, alongside long illicit drug using histories and an avoidance of the physical effects of drug withdrawal. Other factors identified and described previously, include the ease of accessing illicit drugs in prison and the closeness of social relationships with other prisoners who had access to illicit drugs

or people in the community who could provide them with drugs when they were in prison. On the surface, these appear largely practical reasons. However, it would be too simplistic to take these reasons at face value. Those who stopped using illicit drugs had similar issues to contend with, yet they managed to stop using. On closer examination, there was an implicit sense of fear about stopping drug use in prison amongst drug continuers. This is exemplified in the section illustrating the model. This sense of fear seemed to be linked to the fact that many participants had used drugs for such a long time and, as such, they were uncertain how to manage their lives and occupy their time if they stopped. The continued use of drugs therefore appeared to act as a diversion and a way to escape both the realities of being in prison and the possibly broader and more complex issue of addressing their drug dependence.

- **Drug condensers**

Drug condensers continued their use of illicit drugs while in prison but reduced the number of different illicit drug(s) used when in prison from those used in the community. An example of a drug condenser is a polydrug user who injected both heroin and crack cocaine prior to imprisonment but who changed his use in prison by only using heroin. As with the drug continuers, drug condensers gave practical reasons largely linked to illicit drug availability and drug cost for continuing drug use in prison but changing the drug(s) used. The more implicit reasons for continued but condensed drug use appeared to be largely congruent with those identified for the drug continuers. However, condensers appeared more considered in their drug use in that they balanced different options in making seemingly more agentic and informed choices about what, how and when to use. For example they considered the price and effects of using the different drugs, the risks associated with their use and issues of drug availability. Furthermore, the frequency of condensers' prison drug use was more subject to change than that of the continuers as their use was more occasional, reflecting factors such as the costs of drugs in prison and the quality and quantity of drugs available. Although drug condensers would seek drugs to obtain and use in prison, this was less the focus of their prison lives than the drug continuers, recognising that being in prison provided them with an opportunity to consider their drug use in a way that they might not have done in the community.

- **Drug converters**

Like the drug condensers, drug converters continued their use of illicit drugs while in prison. However, unlike the drug condensers, drug converters changed the main drug used from that used in the community by using an alternative drug(s) instead.

To explain further, for pre-prison polydrug users, drug converters changed their drug use in prison by changing from using the original drug combination to only using one of the pre-prison drugs but with at least one other drug. By way of an example, someone who injected heroin and crack cocaine prior to imprisonment but who changed his use in prison to heroin and illicitly using prescribed buprenorphine would be classed as a drug converter by the illicit drug use model. Like the drug continuers and drug condensers, drug converters also offered practical reasons for continuing drug use in prison but changing their drug of choice. These included the availability and cost of certain illicit drugs and the perceived lower risk of using some over others. The underpinning reasons for continued but somehow changed drug use appeared congruent with those identified for the drug continuers. However, like the drug condensers, converters appeared more considered in their drug use in that they balanced different options in making a seemingly more agentic and informed choices about how and when to use. For example they considered the relative costs of drugs, the risks associated with their use and issues regarding drug availability. Furthermore, the frequency of their prison drug use was more subject to change than that of the continuers who used as often as they could. Like the drug condensers, whilst some drug converters did try to use reasonably frequently, their use was typically more occasional, reflecting factors such as the costs of drugs in prison and the quality and quantity of drugs available. Whilst these men would often seek out drugs to obtain and use in prison, again, their prison lives were generally less centred around this than the drug continuers.

- **Drug combiners**

Drug combiners represent a further extension of continued drug use in prison, which describes a range of different prison drug using behaviours. As demonstrated by the model, drug combiners used a number of illicit drug(s) when in prison and/ or used prescribed drugs illicitly, often continuing with their pre-prison drug use but also using another different drug(s) when last in prison. The combined use of more than one drug does not necessarily mean that these were used at the same time, but that they were both/ all used during the same prison sentence. By way of an example, a drug combiner would be someone who only used heroin before imprisonment but who used heroin and also illicit buprenorphine when last in prison. Perhaps, of all the drug behaviours identified within the drug use model, drug combiners showed the least intention of stopping drugs as the types of drugs taken whilst in prison actually increased typically irrespective of the policy in place in the prison at the time or the operating regime of the prison in which they were in. Furthermore, the frequency at which they were used varied from opportunistic use of a drug when it was available,

such as when they were given them for free by people who they knew well from the community, to more regular and persistent use. Linking into the analysis reported in Chapter 8, the excitement of pursuing and using drugs, linked to the desire to feel a buzz and the desire to escape reality, appeared to be the major influences on the combining and experimenting with different types of drugs when in prison. In this sense they appeared to present more opportunistic drug using behaviour than the drug continuers, drug condensers and drug converters.

Table 9.1 below overviews how all participants were categorised according to the illicit drug use model, based on their reported drug use when last in prison. The table shows that whilst most participants were identified as drug combiners on their last prison sentence, there was a spread of drug using behaviours, covering concluding, continuing, condensing and converting, with continuing being reported by the fewest number of participants.

Table 9.1 – Summary of Participants' Illicit Drug Use on Last Imprisonment

Prison illicit drug use behaviour	Drug Concluder	Drug Continuer	Drug Condenser	Drug Converter	Drug Combiner
Description of behaviour	Stops using any illicit drug	Only uses exactly same illicit drug(s) as before prison	Reduces number of illicit drug(s) as used before prison	Uses an alternative drug(s) to main drug used before prison	Uses pre-prison drug but also uses another different drug(s) as well
Participants	Benji Bobby Gordon Justin Kyle Rob	Barry Chris Paul	Bryan Eddy Pete Sean Wayne	Al Gareth Jack Matty Steve	Adam Jason Andy Jeff Clive Keith Derek Kev Ian Tony Jamie

Illustrating the Model of Illicit Drug Use in Prison

Drug concluders on last sentence

Six participants reported that they did not use illicit drugs during their last prison sentence. Before they were imprisoned, Benji, Rob, Gordon, Bobby, and Kyle used

heroin and crack cocaine. Benji, Rob, Gordon, and Bobby through 'snowballing'. It was unclear from his interview if Justin was using heroin and crack cocaine separately or concurrently. Kyle, the remaining drug consumer, had used heroin in his past but had stopped before imprisonment. Prior to last being sent to prison, Kyle reported injecting crack cocaine and was in receipt of a methadone prescription. All drug consumers stated that they received substitute medication when last in prison which they used as prescribed to help manage their dependence. As identified earlier, this licit use is not considered by the model.

All six drug consumers had been in prison before, from three to as many as 20 times, and all reported using illicit drugs during previous sentences. When this was explored in a detailed analysis, there were subtle but important differences in the participants in terms of their thoughts, feelings, experiences and actions. Those who concluded their drug use in prison can be further categorised as either enforced or considered consumers, as explained below.

- Enforced consumers

When examining what motivated and influenced participants not to use drugs when last in prison, it is interesting that Benji, Gordon and Bobby provided financial and environmental reasons. When exploring this during the interviews, they all explained that they had wanted to use drugs on their last sentences. In particular, they wanted to use heroin to feel its effects because they believed this would help them 'escape' the reality of prison, relieve boredom and stave off withdrawal symptoms. At the same time, as explored in Chapter 8, they described having felt relieved to be in prison as it provided a break from what they deemed to be an attritional lifestyle centred on obtaining and using illicit drugs. Despite wanting to, they did not use illicit drugs on their last sentence. However, this was more enforced rather than planned and was due to a number of practical reasons. Firstly, none of them took illicit drugs into prison with them as they could not afford to purchase extra drugs in the community before being sentenced. Secondly, they did not purchase drugs in prison as they could not afford to do so. Thirdly, they said that the prison environment and prison routine made it difficult for them to access drugs as they spent most of their sentences locked in their cells, so limiting their contact with prisoners with access to drugs. Furthermore, despite serving sentences of no more than five months, they had also received substitute medication in the form of methadone detoxification on their last prison sentence, which contributed to helping them not use illicit drugs. Their accounts regarding not using illicit drugs when last in prison highlight the complex

issues facing drug dependent prisoners and the complexities of the realities by which their behaviour is shaped and determined.

What appeared to be different about Benji, Gordon and Bobby, who felt unable to buy or access drugs, was that they were not in prison at the same time as any friends or associates. Moreover, none were from the local area or had family or friends living locally. Benji described having been in prison so many times that his family and friends had had enough of supporting him and he did not keep in contact with his family when he was last in prison, possibly out of guilt or to protect them in some way from what he had done and the realities of their imprisonment experiences. Gordon had been bereaved by three siblings and his remaining family lived in other countries and Bobby had been bereaved by his parents when he was younger. They all linked the lack of close family and friends with why they did not have the money or resources to afford to buy drugs in prison. Whilst their initial reasons for not using drugs in prison appeared very practical, it is likely that they would have been able to overcome these hurdles if they had wanted as other participants in similar prison establishments with similar little out-of-cell time and little money did access and use drugs on their last sentences. By implication, it seems that their desire to use drugs was not as strong as that of other comparable prisoners either because they did not feel the need or that things such as the lack of access to drugs and money were, possibly, conveniently plausible and 'rational' accounts to offer within the interviews.

- Considered conclusers

Rob, Justin and Kyle claimed to have not used drugs on their last prison sentences because they had had enough of using drugs. As suggested in *Growing Older: Enough is Enough* in Chapter 8, they expressed quite strong views about wanting to stop using drugs and aspired to live more fulfilling, drug-free lives. Kyle had already stopped using heroin immediately prior to imprisonment, arguably substantiating this determination, although he was still injecting crack cocaine. They all described feeling tired of the endless lifestyle of pursuing, using and being ruled by drugs and all had previously tried to stop using drugs in the community, thus for them they saw prison as providing them with the opportunity to break their drug use.

On exploration, it seems that their situations were quite different from the enforced conclusers. The considered conclusers expected to be sent to prison and had decided not to use drugs while inside. As a result, they consciously did not take illicit drugs with them and so appeared more agentic and thoughtful in relation to stopping their drug use, even in advance of sentencing. They were also aware that they would

receive detoxification medication in prison which would help them in their decision not to use **illicit drugs**. Rob and Kyle had received maintenance medication and Justin was provided with a detoxification. Interestingly, these men did not express as much dissatisfaction with their medication on their last prison sentence, suggesting that they were less disgruntled with it than other prisoners or they were more determined and able to work alongside the prison medical authorities in reducing and stopping their **drug** use in accordance with clinical prescriptions. For Kyle, the decision not to use drugs in **prison** was influenced by monetary **resources** and **environmental factors**, as crack cocaine was more expensive than heroin and he felt that the prison environment was not conducive to using crack cocaine. He actively described considering these factors when contemplating prison illicit drug use.

Entering prison without drugs, actively accessing drug substitute maintenance and detoxification medication while in prison, and requesting to be put on drug free wings are ways in which considered conclusers demonstrated their desire not to use drugs in **prison** and realised their intentions successfully. What appears to be implicit from the interviews is that, underpinning these decisions, these participants felt ready and motivated to stop using illicit drugs and were arguably more ready and motivated than other participants. They all spoke about previous and numerous attempts to stop using illicit drugs and their uneasiness with living lifestyles perpetuated by drugs. To some extent, this was the case for some other participants. However the main difference for considered conclusers is that they said that they had not wanted to use illicit drugs when last in prison, and they claimed to be successful.

According to their accounts, the resolve of the considered conclusers not to use illicit drugs when in prison was severely tested as drugs had dominated their lives for many years and they had used them in prison during previous sentences. Moreover, all were from the local area and had spent time on their last sentence in the local prison where they knew many of the other prisoners, from the community or from earlier sentences. Seeing people in prison with whom participants had previously used illicit drugs could have acted as a temptation for them as it did for others. Sharing a cell with someone who was using illicit drugs was a further temptation to use drugs, either in their company or alone. The considered conclusers described refusing offers of free illicit drugs from pre-existing friends and acquaintances when last in prison in determination to stop using drugs. Hence, it was important to find out how these participants had spent their time in prison and they described engaging in more constructive activities during their sentence to pass the time and occupy them in order to stop focusing on drugs. Such activities included reading, writing letters to

family, engaging in education, going to the gym or playing on the computer, all of which they said that they found beneficial and rewarding. Rob's account of his drug use on his last sentence is provided as a brief case study below.

Case Study: Rob

Rob had used heroin for eighteen years and crack cocaine for ten and had been a drug injector for ten years. He expected to be sent to prison when he last appeared in court and was using heroin and crack cocaine through 'snowballing'. In total Rob had been in prison about 20 times, mainly for offences that he linked to his drug use. He reported using illicit drugs during all of his previous prison sentences. Rob last served in a local category B prison in 2006 for twenty one days. He said that had deliberately been caught shoplifting so that he would be sent to prison as he knew from his previous prison experiences that he would receive opiate replacement medication on reception.

The drug use model identifies Rob as a considered **drug concluder** as he did not use illicit drugs when last in prison. He accounts for concluding his heroin and crack cocaine use in prison as he claimed to have had enough of using drugs and the poor quality lifestyle that it brought with it. For Rob, being sent to prison was seen as a good opportunity to cease his drug use as he received substitute opiate maintenance medication on his last sentence. He had expected to be sent to prison and had decided not to use drugs while inside so consciously did not take illicit drugs with him, unlike when he had previously been sent to prison. For Rob, the main motivations for him to not use illicit drugs when last in prison was that he did not enjoy using them anymore and he felt that he 'existed' rather than lived his life as a result of his prior heavy drug use. He said that he wanted to have a future that did not involve using drugs. He felt both mentally and physically ready to move away from using drugs in order to live a different life in going forward. His resolve not to use illicit drugs when last in prison was tested when he was offered them for free by his fellow prisoners who he was friends with, but he refused them. At the time of interview Rob was on 50ml of methadone a day. He had remained drug free since his last prison release and described feeling '*back in the human race*' as a result.

Drug continuers on last sentence

Paul, Chris and Barry described continuing to use the same drug when last in prison that they had before imprisonment and no other drugs. These men were aged 41, 38 and 46 years old respectively, above the mean average age of participants. They had

all been in prison a number of times previously, on at least four separate occasions, with their first sentence dating back to when they were much younger. Paul and Barry continued using heroin when last in prison and Chris continued amphetamine use when he last served in prison. Paul's account of his drug use on his last sentence is provided as a brief case study below.

Whilst their drug use continued in prison, this was explained to be less frequent than their community use due to less regular and consistent drug availability. Nevertheless, they described using the drugs as often as they could, demonstrating their continued desire to use them and feel their effects, offering them temporary respite from imprisonment. Whilst all men spoke about the presence of other drugs in prison, they said that they did not use any alongside their first choice of drugs. On examining the interviews, this was because the men drew on their prison experience to access sufficient quantities of their drug of choice and thus did not want or need to use additional drugs. Continued use relied on obtaining a supply of drugs. As such, participants described how they went to great lengths to ensure supply. Two main factors contributed to them being able to access their first drug of choice. Firstly, the men took drugs into prison with them as they had time from being arrested to appearing in court to obtain drugs to do so as they did not want to attend court without drugs in case they were sent to prison. Secondly, their existing social networks with other prisoners facilitated access to illicit drugs. Both heroin users suggested that buprenorphine was used illicitly by other prisoners. They did not offer any reason for not using it themselves, although it might have been that when they were in prison on their last sentences, buprenorphine had not yet formally been introduced or was not as available in the establishments in which they served.

For all three drug continuers, their knowledge of the prison system and how things operated there appeared to facilitate continued drug use. For example, they all planned and took drugs into prison with them on their last sentence in order that they could use them as soon as they arrived in order to prevent drug withdrawal. Based on their prior prison experiences, they knew that they would be strip searched and assumed that they would not be internally searched. Furthermore, knowing that they would not be allowed community visitors (who could take them drugs) for their first few weeks was said to motivate them to be prepared by taking large quantities of plugged drugs with them to be able to continue to use. A further factor given for continuing drug use in prison was also linked to their prior prison experiences. The participants all perceived that there was not adequate prescribed substitute medication to assist in combating and controlling drug withdrawal. For Chris, this was

because there is no prescribable substitution for amphetamine. Paul and Barry said that they had not known prisoners in the past to be given sufficient medical help with their drug use, which translated into a fear about the prospect of being in prison without illicit drugs and experiencing the unpleasant withdrawal effects. This suggests that they used the perceived inadequacy of substitute medication received to justify their choice to continue using illicit drugs when last in prison.

These drug continuers said that they wanted to continue to experience the buzz of using their drug of choice, suggesting that they still enjoyed using drugs, outweighing any other feelings about using. Escaping the reality of their lives and of being in prison were further factors motivating their continued use in prison. The influence of other prisoners also played a major contributory role in continuing drug use. As they were last imprisoned in establishments close to their local areas, they knew a lot of their fellow prisoners. This was said to facilitate access to illicit drug supplies when their plugged supplies ran out as they were close enough to be visited by friends from the community who took them drugs. No family members were involved in supplying them with drugs whilst they were in prison and in fact the men stated that their families did not know that they used drugs. In concealing drug use from their families, it is possible that the men were also in denial themselves that they were drug users, suggesting a passive acceptance of using drugs and a subsequent passive continuation of actions when last in prison without consideration of questioning them or changing them.

Case Study: Paul

At the time of interview Paul had been using heroin for five years. He expected to be sent to prison when he last appeared in court and, at the time, was using heroin daily. He was sentenced to six months and was sent to a semi open prison close to where he lived. He said that, since he knew he would receive a custodial sentence, he had an eighth (roughly £100) of heroin up his anus when he was sent to prison. He described that, having been in prison on three previous occasions, he knew that he would be strip searched but not internally searched unless the prison authorities suspected that he had drugs on him. However, he said that, as he was not known as a drug user to the police or the prison authorities and his offence had not been attributed to his drug use, he felt confident that the hidden drugs would not be found. He said that his prior prison experiences meant that he knew that he would be able to access drugs when in prison. Indeed, when his initial heroin supply ran out, he bought more from fellow prisoners using money sent by his mother.

The drug use model identifies Paul as a **drug continuer** because he continued using heroin in prison and did not use any other drugs. He accounts for continuing his heroin use in prison in a number of interlinked ways. He said that he knew that it would be painful to experience drug withdrawal and considered that the dihydrocodeine tablets provided as substitute medication by the prison doctors would be insufficient and inadequate to control 'intense' heroin withdrawal effects. He said that he was not prepared to experience the 'horrible, horrible' feelings associated with heroin withdrawal. Paul said that continued use of heroin when in prison also helped him to sleep and contended that it was accepted by the prison authorities since the presence of drugs maintained a level of harmony in the prison.

Drug condensers on last sentence

Five participants (Bryan, Pete, Eddy, Wayne and Sean) were identified as drug condensers. Prior to their last prison sentences all injected crack cocaine and heroin simultaneously. However, in prison they changed and reduced the illicit drugs used to solely using heroin. The account from Pete is provided as a brief case study below to illustrate this.

Overall, their drug use histories had lasted a minimum of seven and a maximum of 16 years, highlighting the potentially ingrained and intractable nature of their drug using behaviours. Their last prison sentences were typically short, as they had all been sentenced to serve eight months or less, apart from Sean who was sentenced

to 24 months. There were subtle differences between these men and those who continued with the same community drug use when last in prison. Their main motivation for changing and reducing their drug use by not using crack cocaine in prison was that the prison environment was not considered suitable for using crack and it was expensive if it was available. The reasons given for only using heroin were linked to its relaxing properties. They said that they welcomed heroin's potential to help them to sleep and forget that they were in prison and thus overcome the boredom which they experienced. This suggests an ingrained reliance on heroin in order to relax. To some extent, there was a suggested social aspect of this use, helping them to relax with other prisoners, such as cell mates. Whereas all drug continuers were prepared by taking a supply of drugs into prison with them, this was not the case with the drug condensers as only Bryan and Wayne did this. Whilst they had all been caught committing crime, Pete, Sean and Eddy had no illicit drugs on their person when they had been arrested by the police. Bryan and Wayne however said that they had a limited supply of drugs on them when they were caught which they managed to conceal from the police. A possible difference with these men from the drug continuers was therefore that they were less prepared on the basis that they did not have time to plan for going to prison as they were sent straight there.

Pete, Sean and Eddy said that because they did not have any heroin on them when they went to prison, they actively sought it when they were there, having bought or been given it from other prisoners. All five drug condensers said that they had not arranged for drugs to be supplied to them by community visitors when they were last in prison. They also stated that they felt less need to take drugs into prison with them as they were certain that they would receive substitute medication for their drug use although this did not eliminate concerns about experiencing drug withdrawal. This can be linked to the fact that they had all been in prison on at least one previous occasion during their history of using drugs and had some prior experience of being in withdrawal when on these earlier sentences.

When working through the models and the participant narratives, Bryan was noted as different to the other drug condensers on a number of accounts, despite reporting the same type of drug use. These factors are important to identify and are teased out below. For example, all drug condensers except Bryan received a detoxification on their last prison sentence. Despite the receipt of detoxification medication, they said that they all accessed and used heroin when last in prison. The reasons which they gave for this were complex and varied, yet they all accounted for using heroin by saying that the medication received in prison was not of a sufficient strength or for a

long enough time period to completely relieve them of heroin withdrawal symptoms. Moreover, even after receiving a detoxification, establishing a regular sleep pattern was difficult. The use of heroin assisted with this. A main difference between those who continued exactly their same drug use and the drug condensers who changed an element of their drug use in prison by reducing the use of the number of drugs was that the drug condensers, apart from Bryan, appeared keen to use the time as an opportunity to not continue with their drug use to the same levels as before, but to see imprisonment as providing a chance to limit and reduce their use. Apart from Bryan, they did not describe going to such great lengths to ensure that their use continued as the drug continuers. This suggests that the drug condensers were generally more prepared to consider not using illicit drugs whilst in prison. Bryan, however, was different here. He commented that when last in prison he had a lot going on in his life and was upset due to a relationship break-up. As a result, he felt that he had nothing to live for and said that he wanted to use as much heroin when in prison as he could to numb his distress. Bryan's case is therefore interesting in testing the model. The only difference from the drug continuers is that Bryan did not continue using exactly the same drugs in prison as prior to imprisonment as he did not use crack cocaine. Yet he cannot be classed as a drug converter as he did not use a different drug to his community drug use when last in prison and he cannot be classed as a drug combiner as he did not introduce or use any other drug(s) alongside heroin when last in prison.

Unlike drug combiners, drug condensers did not introduce another illicit drug alongside the heroin when last in prison. Eddy, Wayne and Sean provided practical reasons for not combining heroin use with buprenorphine, namely because they were concerned as to how the opiate blocker in the medication (designed to reduce some of the effects of opiates) would affect them whilst using heroin. Eddy did not want to use buprenorphine as he knew that it would provide a euphoric effect and prevent him from sleeping, which concurred with Pete's reasons for not wanting to take stimulants such as ecstasy or amphetamine.

Case Study: Pete

Prior to his last imprisonment in 2003, Pete said that he had been using about £150 of heroin and crack cocaine a day. He was caught by the police when shoplifting to support his habit. As he was arrested and taken straight to court the next day, he described being in severe drug withdrawal, sweating and shivering when in court since he had not used drugs to prevent this and had not received adequate relief when in the police cells. He feared that going to prison would contribute to his withdrawal. He was sentenced to serve four months. On receipt into prison, he went onto a detoxification wing, like a long hospital ward with about ten other people who were all withdrawing together. He said that it was a 'horrible' experience. He was provided with a lofexidine detoxification for two weeks which, whilst he said it was not great, had mitigated his immediate heroin withdrawal symptoms. Pete said that, when back on the main prison, someone who knew that he had been on the detoxification wing offered him heroin.

The drug use model identifies Pete as a **drug condenser** because he changed and reduced his drug use when in prison by only using heroin and not using crack cocaine. He said that he accepted the offer of the drugs as he thought that it would help combat the boredom and feeling that the days dragged whilst locked in his prison cell most of the day. Despite having some prior history of recreational stimulant drug use, he did not combine heroin with any other drugs in prison, stating that using ecstasy and amphetamine would have provided him with increased energy not suitable for the environment. Heroin, conversely, was said to facilitate sleep. Pete also spoke about how using only heroin in prison helped him to bond with his cell mate, describing how they pooled their telephone cards in order to pay for it, which they then used together. He said that he enjoyed using heroin in prison because he did not consider his behaviour to be as hectic or as out of control as it had been in the community.

Drug converters on last sentence

Five participants (Steve, Gareth, Jack, Al and Matty) were identified as drug converters. Prior to their last prison sentences all of them had injected heroin, four of them (Steve, Gareth, Jack and Al) simultaneously injecting this with crack cocaine whereas Matty only injected heroin. However, when last in prison they changed the illicit drugs used as only two men used heroin when last in prison and the misuse of buprenorphine was widespread. Steve changed to illicitly using prescribed painkiller

drugs, such as tramadol⁴⁶, Gareth and Jack changed to use heroin and illicit buprenorphine, Al to use crack cocaine and illicit buprenorphine and finally Matty changed from using heroin to crack cocaine and illicit buprenorphine.

In terms of the demographic characteristics of the drug converters, they ranged in age from 20 to 35 years, below the mean average age of participants and some years less than the drug continuers. Their drug use histories were long, ranging from four years up to 14 years. Unlike the drug condensers who had typically short sentences, the drug converters last prison sentences were longer, for a minimum of ten and a maximum of 48 months and they had been released from their last sentences within two years of being interviewed. This suggests that there might be something about the length of the prison sentence which they were given that meant that they continued to use drugs in prison, possibly linked to the monotony and reinforcing reality of the same prison daily regime. Yet, something about this drug use changed and they were more receptive to changing drug use or the use of different drugs on account of the length of time in prison. Furthermore, all the drug converters reported having received a detoxification at the start of their sentence when last in prison. Between them they had been prescribed a range of different medications for this detoxification including methadone, dihydrocodeine and lofexidine. None of them had been prescribed buprenorphine, including Gareth and Jack who were interviewed within a week of their last release, a time when this medication was being prescribed in prison as part of detoxification regimes. Despite the varied prescribed detoxifications prescribed, they did not feel that the detoxification quality, quantity or length were adequate and so they said that this contributed to their illicit drug use when last in prison. It could be speculated that there is also something about the timing of this detoxification for these men who were on longer sentences that encouraged them to continue to use illicit drugs in some form when in prison as after their initial detoxification, they still had a reasonable amount of time to serve in prison.

Similar to the drug condensers described above and different to the drug continuers earlier described, these men were less prepared with drug supplies when they were last sent to prison. Indeed only Jack took drugs into prison with him, which is possibly curious, given that it was his first ever prison sentence. Yet, not having their own drug supply when in prison did not affect their ability to acquire drugs to use when in prison. Indeed, Jack, Gareth and Al (for whom, like Jack, his last prison sentence

⁴⁶ An opiate which may induce opiate like withdrawal symptoms if misused.

was also his first) had all bought drugs on their last prison sentence reiterating their continued desire to use drugs when there and Steve, Al and Matty had all been given them when last in prison.

The misuse of buprenorphine amongst drug converters in prison was widespread, and its use was said to provide a euphoric feeling. It is possible that for participants this euphoria acted to somehow replace that euphoria associated with using crack cocaine as Gareth and Jack did not use crack cocaine when last in prison but used buprenorphine and Steve illicitly used tramadol. As discussed earlier, some drug converters were concerned as to how the blocker in the buprenorphine would affect them alongside using heroin. However, unlike them, drug converters Gareth and Jack introduced illicit buprenorphine use alongside heroin when last in prison. This highlights how they adapted their drug use according to drug availability as when they went to prison their preferred drug of choice was heroin but as this became less widely available, their illicit use of prescribed buprenorphine increased. Neither Gareth nor Jack reported negative side effects of using both heroin and buprenorphine on their last sentence, possibly demonstrating that there was some length of time after using heroin in prison before using buprenorphine. The change in drug use when in prison to incorporate crack cocaine by Al and Matty is interesting as this goes against participants' predominant feelings that stimulant drugs were largely not conducive to the prison environment. When exploring their accounts further, this crack cocaine use was very occasional and opportunistic, and was only when they had freely been given the crack cocaine and felt that using it would help relieve boredom.

Drug combiners on last sentence

Eleven participants fulfilled the drug combiner criteria based on their accounts. Drug combiners were characterised by adding and using at least one other illicit drug when in prison on their last sentence to that which they used before going to prison. This combined use of drugs does not necessarily refer to concurrent use of these drugs, but to their overall use during their sentence.

A range of drugs were apparently used in combination with one another when last in prison. Buprenorphine was used illicitly by all drug combiners, accounting for a significant amount of the combined drug use. Combined use of two different drugs was most common, possibly indicating that there was little if any intention or ability for combiners to stop illicit drug use when in prison. Rather, they ensured that it continued by adapting their drug use to encompass one, if not two, extra drugs to

those used in the community. Only Adam, a heroin injector, and Tony, a snowball injector at time of imprisonment, combined using three drugs (heroin, crack cocaine, and illicit buprenorphine) during their prison sentence. Later, Tony's account is provided as a case study. Commonly, heroin and buprenorphine were used during the same prison sentence by participants who were community heroin injectors. This may be linked to the similarities in the physical effects of using these drugs.

When examining those who combined their drug use when last in prison, it is notable that their last sentences were typically long. In fact, for all but four drug combiners (Derek, Tony, Adam and Andy), their last prison sentences were of a minimum of 18 months (Kev) and ranged up to 84 months (Ian). These sentence lengths reflected the seriousness of their last offences, many of which involved violent assault or the use of a weapon. However, not all of the drug combiners had previously been imprisoned, as for Derek and Jeff their last sentence was also their first. For the drug combiners, using drugs during their last sentence was often an occasional pursuit. Reasons that the drug combiners gave for using drugs whilst in prison mirrored some of those which the other continuers offered, including how drugs helped sleep and relieved boredom. Something particularly mentioned by the drug combiners was that using drugs in prison provided a 'head change' and helped them to forget about their worries and being in prison. This is something which may be seen as influenced by sentence length since escaping the reality of being in prison was discussed by drug continuers, drug condensers and drug converters. However, it was more commonly discussed in the interviews with those who were identified as drug combiners. Having longer prison sentences also seemed to influence the availability of drugs as men described getting to know more prisoners from whom they could buy drugs and coming into contact with more prisoners whom they knew from the community. This again facilitated access to drugs in that these contacts often gave participants drugs for free.

The drug combiners who combined heroin with illicit use of buprenorphine said that using these drugs complemented the prison environment since they had a largely sedative effect, unlike crack cocaine. Participants said that heroin and illicit buprenorphine could be used reasonably concurrently or separately. To some extent their use patterns reflected the reported changing nature of drug use in prison, having taken in and used heroin more towards the start of their sentences and progressed to using buprenorphine.

Case Study: Tony

At time of interview Tony was 38. He described a long history of using illicit drugs which initially started with amphetamine and had been using heroin for the last 15 years. He said that he had used drugs for so long that he thought that he would never stop. Prior to his last imprisonment he was snowballing heroin and crack cocaine. Tony said that he was selling drugs and was last arrested by the police on suspicion of possession with intent to supply. When he was selling drugs he kept his personal drug supply plugged so that he had it in the event of being arrested and sent to prison. He was found guilty of supply and received a six month prison sentence. When he was sent to prison he had ten £10 bags of heroin and five £10 bags of crack cocaine plugged.

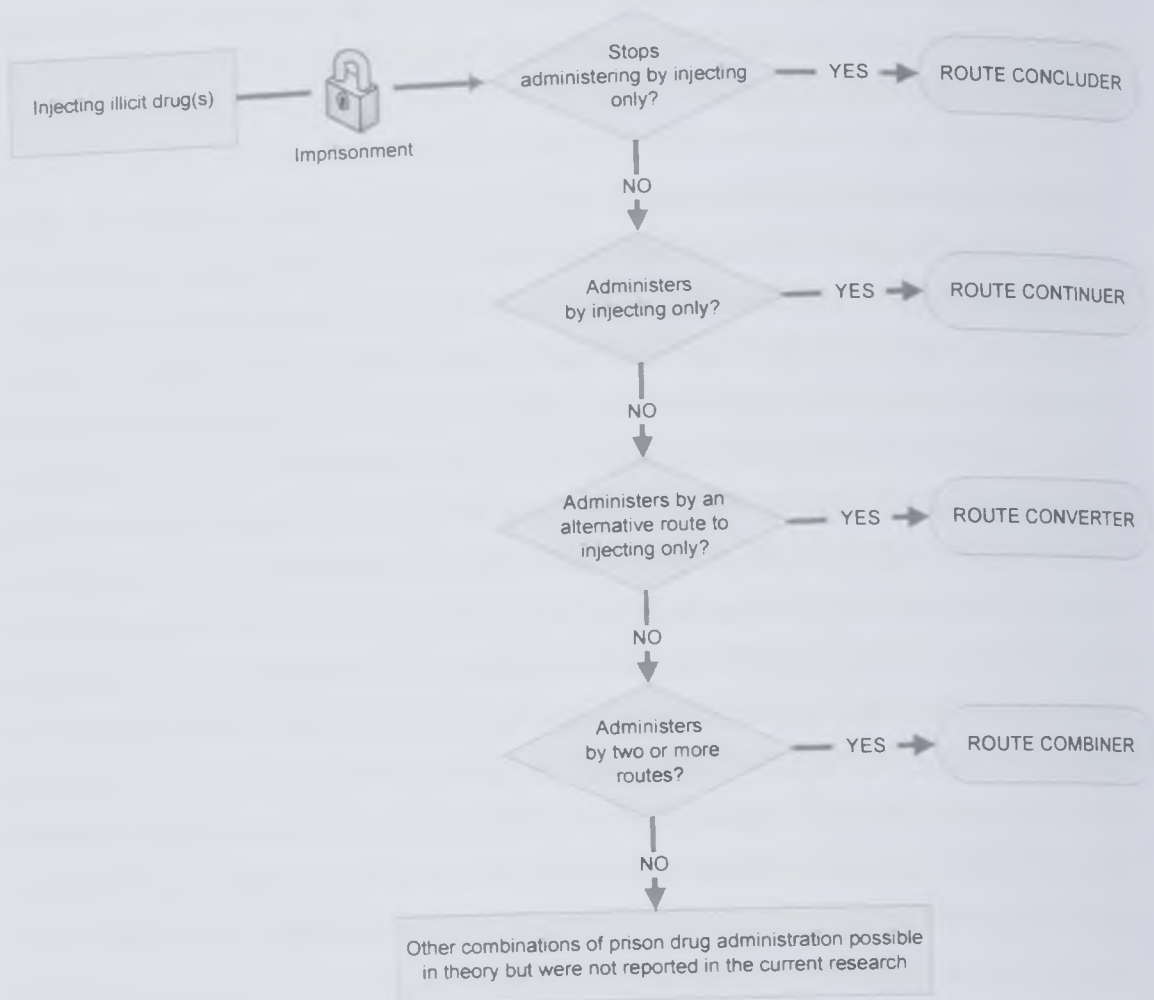
The drug use model identifies Tony as a **drug combiner** because in prison he used heroin, crack cocaine and buprenorphine illicitly. Tony had previously been in prison on seven occasions and said that he had never received drug substitute medication other than dihydrocodeine. Tony said that he used his personal supplies of heroin and crack cocaine and obtained buprenorphine from other prisoners. When his heroin supply had run out, he accessed more from other prisoners. It is not clear from his interview if he obtained more crack cocaine. This is because he said that the crack cocaine made him feel 'wired.' For Tony, his motivations for using drugs in prison was largely linked to the fact that all he has ever known was using drugs and he was so used to using them. He said that he enjoyed the buzz that drugs provided and helped him to feel normal when he woke up in the morning or when he was due to go to sleep in the evening, helping him to relax. For him, these things helped the time in prison to go more quickly and he felt that prison was easier with drugs than contemplating it without. Coupled with this, he said that using drugs when he knew that there was a risk of being caught contributed to the excitement and enjoyment of using them. He said that he preferred to use heroin in prison over crack cocaine and buprenorphine due to its effects since it was stronger and helped to knock him out.

Model of Illicit Drug Administration Route in Prison

As outlined earlier in the thesis, there are varying ways in which illicit drugs may be taken depending on numerous factors including for example, personal choice and the type of drug. Next, the illicit drug administration route model considers the ways that illicit drugs, as described in the drug use model, were reportedly administered on their last sentence in prison. Four different routes of drug administration were identified in the interviews and taken into account in the administration route model.

These are intravenous injecting, smoking, snorting, and swallowing. As shown in Figure 9.2, the drug administration route model differentiates between route concluders, route continuers, route converters and route combiners and these categories are explained below. Unlike the illicit drug use model, there is no condenser in the illicit drug administration route model.

Figure 9.2 – Model of Illicit Drug Administration Route in Prison



As shown in Figure 9.2, the rectangular box at the bottom of the model acknowledges that other combinations of prison drug administration routes were possible. For example, whilst it was not reported in this research, administration methods such as the rectal insertion of illicit drugs (which has been promoted by harm reductionists as an alternative to injecting) (Grund, 2005) or the dissolving of drugs under the tongue could be used in prison as other ways drugs can be taken. Furthermore, the inclusion of this box acknowledges that new and/ or further different

prison drug administration routes may be undiscovered and/ or may exist in the future, in order to reflect changing drug trends and drugs of use in prison over time.

The chapter now describes and explains the different types of drug route behaviours identified and then illustrates these with some case studies.

- **Route concluders**

When using illicit drugs in prison, route concluders ceased using the same drug administration route that they used prior to imprisonment, that is, injecting. To be included in the research, participants had to be injecting drug users. Thus route concluders were participants who stopped using illicit drugs by intravenous injection when in prison. Bringing together the categories and super ordinate themes presented in Chapters 5, 6, 7 and 8, the influences on participants to stop using drugs by intravenous injection when last in prison were numerous and varied. Practical factors were said to influence participants to stop intravenously injecting and underpin these decisions. These included the provision of substitute medication when last in prison and the lack of sterile needles and syringes when there when compared to the community. This lack was perceived to be due to the difficulty of taking these into prison because of their size and the improved detection measures employed by prisons in more recent years. In addition, the potential health and transmission risks of blood borne viruses such as HIV and hepatitis associated with reusing or sharing needles and syringes with others when in prison also deterred injecting when in prison as due to their scarcity, needles were reused by many prisoners, including prisoners who were unknown to them. A detailed examination of the data shows that these factors did not stand alone, but overlapped with participant characteristics such as those presented in Chapter 8 and included their age, their stage of life, their sense of drug use fatigue and their desire to live a more fulfilling life by ceasing to using illicit drugs more generally. These reasons given for concluding injecting overlapped with some of the reasons drug concluders provided for not using drugs in prison, as outlined previously.

- **Route continuers**

As shown in Figure 9.2, route continuers are considered as any participants who used illicit drugs in prison in the same way as they did in the community, that is, by intravenously injecting. Continuing injecting in prison obviously relies on accessing needles and other paraphernalia required to inject, such as equipment used to cook drugs on. However, as outlined in Chapter 6, accessing such equipment was not always straightforward when in prison.

- **Route converters**

Route converters describes participants who changed the way they administered drugs in prison from intravenous injecting. A range of factors influenced participants to change their route of illicit drug administration. As with the route concluders, these were mainly practical factors such as the lack of injecting equipment available in comparison to the equipment needed to smoke, snort or swallow drugs. The health and social risks of sharing or reusing injecting equipment also heavily influenced a change of administration route away from injecting. Changing the illicit drug(s) used in prison also often resulted in changing the route of administration due to the different characteristics of different drugs. For example, the illicit use of buprenorphine was achieved overwhelmingly by snorting crushed tablets rather than other methods of administration such as injecting or swallowing.

- **Route combiners**

Route combiners were identified as participants who used at least two different drug administration routes when last in prison. The combined use of more than one administration route does not necessarily mean that these were used at the same time, but that they were both/ all used during the same prison sentence. An example of route combining is that of someone who intravenously injected and smoked illicit drugs during the same prison sentence. As with the route converters, the ready availability of equipment to use drugs at the time they were obtained also influenced the administration route chosen and meant that a combination of routes were sometimes used. Like with the drug combiners, perhaps, of all the drug behaviours identified within the drug administration route model, route combiners showed the least intention of stopping using illicit drugs. This is because the ways of administering the illicit drugs when in prison actually increased when compared to their pre prison practices.

Table 9.2 below overviews how all participants were categorised according to the illicit drug administration route model, based on their reports of how they had used illicit drugs when last in prison. The table shows that most participants were identified as route combiners on their last prison sentence and whilst there were some route concluders and converters, there were no route continuers. That is, no participants reported to have solely used illicit drugs by intravenous injection when last in prison, representing a change in their illicit drug administration route when compared to their pre prison drug administration routes used when in the community.

Table 9.2 – Summary of Participants' Illicit Drug Administration Route on Last imprisonment

Prison illicit drug administration route	Route Concluder	Route Continuer	Route Converter	Route Combiner		
Description of behaviour	Stops administering by injecting only	Administers by injecting only	Administers by alternative route to injecting only	Administers by two or more routes		
Participants	Benji Bobby Gordon Justin Kyle Rob	None	Barry Eddy Pete Sean Steve Wayne	Adam Al Andy Bryan Chris Clive	Derek Gareth Ian Jack Jamie Jason	Jeff Keith Kev Matty Paul Tony

Illustrating the Model of Drug Administration Route in Prison

Route concluders on last sentence

On account of ceasing drug use on their last sentence, the six drug concluders were also route concluders. This is logical as not using illicit drugs in prison meant that no administration routes were required. The factors influencing the conclusion of drug administration routes overlap with those identified and presented earlier for the conclusion of drug use more generally. For example, they did not take illicit drugs or any equipment in order to use them into prison when they were last sent as they all described feeling tired of the endless lifestyle of pursuing, using and being ruled by drugs. They had all previously tried to stop using drugs in the community, thus for them they saw prison as a providing them with the opportunity to break their drug use and their practice of drug injecting. There were no other route concluders identified from the reports of the prison drug using experiences. This is because if their drug use continued in prison but they stopped administering their illicit drugs by intravenously injecting, they changed to one or more alternative administration route(s) and would not be classed as a route concluder. Rather they would be either route converters or route combiners, as later described. Rob was identified by the drug administration route model as a route concluder and his account is provided as a case study below.

Case Study: Rob

To continue with the case study of Rob who was identified by the drug use model as a drug **concluder**, the drug **administration** route model identified him as a **route concluder**. Prior to imprisonment, Rob was intravenously injecting heroin and crack cocaine. However, he stopped using illicit drugs when in prison by his administration **route**. The reason he concluded injecting as his route of drug administration in prison was linked to Rob stopping using all illicit drugs when he was there and not starting to use any illicit drugs. He also expressed reservations about using needles in prison due to uncertainty of their cleanliness.

Route continuers on last sentence

As suggested earlier, based on reported accounts of drug use on their last prison sentence, no participants were identified to be route continuers. This is an important finding, showing that, at least in the sample studied, no participants chose intravenous injection as the sole route of drug administration when they were last in prison. This is not to say that participants did not chose injection as a method of drug administration but those who did, did so alongside other administration routes, and as a result were route combiners. The models highlight that, at least theoretically, participants could be both drug and route continuers meaning that they continued using the same illicit drug in the same way in prison as prior to imprisonment. However, whilst there were three drug continuers there were no route continuers identified amongst those interviewed, meaning that no participants were both drug and route continuers. This is considered to be a particularly revealing finding and a marked change in men's behaviour when compared to reported pre-prison drug use. We can only speculate as to why there were no route continuers identified by the model of illicit drug administration. It is considered that the reported issues linked to the practical difficulty of accessing sterile needles combined with the desires to take the opportunity afforded by prison to be drug free, possibly with the help of medication to control drug withdrawal, overlapped to mean that no men used illicit drugs solely by intravenous injection when last in prison.

Route converters on last sentence

Six participants were identified as route converters on their last sentence. Most route converters changed their route of drug administration from community intravenous injecting to smoking when in prison. Four of the route converters, Pete, Eddy, Wayne and Sean were drug condensers who changed from snowball injecting to smoking heroin when last in prison. Steve, another route converter was also a drug converter

who changed from snowball injecting to swallowing prescribed drugs. Barry, the remaining route converter, who changed his administration route of heroin injecting to smoking, was a drug continuer. Pete's account is provided as a case study below.

The overwhelming reason given to account for mainly changing their route of use from injecting to smoking was that there was reduced access to sterile needles in prison. The increase and advances in prison security measures over the years through greater searching of prisoners on reception into custody and the searching of community visitors, alongside the use of metal detectors, was acknowledged to have made taking and smuggling needles for injecting into prison much more difficult. As identified earlier in Chapter 6, the lack of needles in prison was said to mean that any that were available were often passed around between many prisoners and prisoners were unsure who and how many other prisoners had used them before they considered using them. The route converters identified that the health risks associated with a previously used needle meant that they chose not to inject in prisons, but changed their route of administration to smoking which was associated with less risk. On examination, it was not the sharing of the needle per se that particularly concerned the route converters, but the fact that there was no way of knowing who, and how many, had used the needle before them. This meant that they could not be certain about the health status of any of the prior needle recipients. The particular health risks which the route converters noted were that of contracting blood borne viruses such as HIV or hepatitis. Eddy's other concern about using a needle that had been used by other prisoners was that, because needles were used by many people, their points became blunt and prisoners sharpened them to prolong their use. This increased the risk of needles snapping on use as they were thinner and more fragile. For Sean, a further reason for changing his route of drug administration from injecting to smoking was that there was limited access to other components of drug equipment required in order to inject when in prison. In particular, citric acid required to break heroin down when cooking was not available and he was not prepared to use an alternative such as lemon juice or vinegar as he believed that these substitutes could cause blindness. These reasons meant that changing the drug administration route from intravenous injecting to smoking was seen as a more viable option when in prison, although participants noted that obtaining foil in order to do this was not always easy. This was particularly complicated after prisons had stopped or reduced buying confectionary and canteen items to sell in the prison shop which were traditionally wrapped or packaged in foil, such as yoghurts with foil lids.

Case Study: Pete

To continue with the case study of Pete who was identified by the drug use model as a **drug condenser**, the drug administration route model identifies Pete as a **route converter**. In the community, Pete intravenously injected heroin and crack cocaine simultaneously. However in prison, he changed his route of use to smoking. Pete said that he obtained the foil required for smoking from the foil lids of yoghurts or orange juice cartons. He said that he had often obtained the foil in exchange for a few cigarettes from fellow inmates. Alternatively, he obtained foil for smoking from carefully scraping the paper backing from the shiny inside of a cigarette packet. He said that he smoked with his cell mate, which they always did standing by the window. This served the double purpose of being able to blow smoke out of the window and provided a quick and easy way of disposing of the drugs and equipment if a prison officer came in. Pete stated that he did not inject when he was in prison. This was because he knew that needles for injecting were often passed around. He did not want to share needles and had always used clean needles for injecting in the community which he had obtained from the local needle exchange.

Route combiners on last sentence

The drug administration route model identifies that there were 18 route combiners when working participants' accounts of their drug use on their last sentence through the model. These route combiners encompassed all of the 11 drug combiners, reflecting that the use of a number of different drugs often required the use of a number of different administration routes. Reporting using two drug administration routes during the last prison sentence was most common amongst participants. This was largely smoking and snorting illicit drugs through the nose. Injecting and smoking, snorting and swallowing drugs through drinking them were also identified. The maximum number of administration routes used by participants on one sentence was three. Three participants, Jeff, Tony and Keith, reported injecting, smoking, and snorting illicit drugs whilst on their last prison sentence. Paul was categorised as a route combiner on his last prison sentence and his account is provided as a case study below.

Reasons that participants combined different administration routes in prison were varied but largely included the ready availability of drug using equipment at the time that the drugs were obtained and the changing drug using practices to encompass the use of a variety of drugs, particularly the illicit use of prescribed buprenorphine.

Case Study: Paul

To continue with the case study of Paul who was identified by the drug use model as a **drug continuer**, the drug administration route model identified him as a **route combiner**. Prior to imprisonment, Paul was injecting heroin into his veins. Whilst Paul continued using heroin in prison, this was mainly by smoking it on foil and, when he could access a needle, by injecting it. Paul said that his prior prison experiences meant that he knew that he would be able to obtain the equipment needed to ensure his continued use when in prison so he did not take any drug using equipment in with him. He obtained the foil for smoking from confectionary wrappers when in prison and asked other prisoners who he knew for injecting needles, trading items such as phone cards for them. He said that, whilst he was worried about the health risks of sharing needles, he had flushed them out with boiling water to try to eliminate risks of HIV and hepatitis. Paul said that there was a difference between when he smoked and when he injected in prison. Injecting was said to depend on obtaining a needle and that it took time and skill to cook the drugs. Thus Paul said that, when he had a needle, he injected more at night when there was less chance of being caught by the prison authorities since the activity around the prison was reduced. Once he had obtained a needle he would inject with it as many times as possible before it went blunt, when he would dispose of it.

Tony was also categorised as a route combiner on his last prison sentence. His case study account is provided below.

Case Study: Tony

Tony was identified by the drug use model as a **drug combiner**. The administration route model identified him as a **route combiner** because in prison he used heroin by smoking and injecting, crack cocaine by smoking and illicit buprenorphine by snorting. He said that he didn't take drug equipment with him because he would be able to get needles and the other paraphernalia when in prison. His decisions to inject or smoke in prison were dependent on being able to access a needle. When he could obtain a needle, he said that his first choice was to inject the heroin because the effect of the drug was both quicker and stronger compared to smoking. On his last sentence he said that he had traded three of his plugged bags of heroin in exchange for two needles and obtained lemon juice to break the heroin down from the kitchens. He said that he injected in his prison cell with his cell mate on his last sentence and that it was nice to be able to inject, particularly if he had not done so for some time. Tony said that he and his cell mate had an arrangement that, since it was Tony's heroin, Tony injected first. They used the needles until they went blunt, when he would discard them. Tony said that he didn't think about the consequences of using and reusing the needle at the time because the desire to feel the buzz outweighed any such considerations, although he did try to clean it using hot water from the kettle in their cell. Tony disclosed in the interview that he had hepatitis C. He said that he had told his cell mate about this and, having informed him, left the decision to his cell mate about sharing the needle. When he smoked drugs in prison he did so using foil inserts from tobacco packets. For him the downside of smoking, in comparison to injecting, was that it took longer for him to feel the drug effect. He said that he had also snorted buprenorphine although, as he had used heroin during his sentence, this sometimes increased his feelings of being in drug withdrawal.

Using the Models

Once all participants were worked through both models based on their reported drug use and drug administration when last in prison, it is possible to identify how the two models converge. By way of an overview and for clarity, Table 9.3 below identifies how all participants were categorised according to both the illicit drug use model and the illicit drug administration route model. The Table can be read in either direction, whereby the black font identifies the drug use behaviour and the red font distinguishes between the administration routes used.

Table 9.3 - Convergence of the Illicit Drug Use and Drug Administration Route Models

		ILLCIT DRUG USE				
		Concluder	Continuer	Condenser	Converter	Combiner
DRUG ADMINISTRATION ROUTE	Concluder	Benji Bobby Gordon Justin Kyle Rob				
	Continuer					
	Converter		Barry	Eddy Pete Sean Wayne	Steve	
	Combiner		Chris Paul	Bryan	Al Gareth Jack Matty	Adam Jason Andy Jeff Clive Keith Derek Kev

Table 9.3 above provides a useful way of considering the convergence of the two models. It shows the distribution of participants involved in the current research across both the illicit drug use and drug administration route categories identified. As seen, the table has a number of shaded grey squares, shown in the drug concluder column and the route concluder row. This shading shows the intersection of drug using behaviours which were not possible. For example, if someone is initially identified by the illicit drug use model as a drug concluder, they could not be identified as a route continuer, a route converter or a route combiner as they would not have any drug administration route on account of stopping their drug use. Thus the only possibility is for them to be a route concluder, as evidenced by the names of six men (Benji, Bobby, Gordon, Justin, Kyle and Rob) who appear in this intersection. Similarly, the shaded boxes in the route concluder row highlight that if a participant reported continued drug use when last in prison, but they stopped injecting, they

would not be identified as a pure route concluder as they changed their drug administration route. Rather, these participants would be classed as route converters (if they changed their route for another route) or route combiners (if they combined one or more administration routes).

Perhaps the most interesting dimension which is particularly evident by this presentation is the absence of any participants in the drug administration route continuer row. This highlights the main finding that no one continued using drugs by only injecting when last in prison. Furthermore, the intersection of the drug and route behaviour types identified that there were no illicit drug continuers who were also route continuers. This demonstrates that no one's drug use behaviour in prison was exactly the same as what they reported it was before they last went into prison, in terms of the illicit drugs used and route of drug administration used. In addition, the convergence table shows that in terms of illicit drug use, most participants were drug combiners as the column shows that 11 men were drug combiners. In terms of the drug administration route, the table shows that most participants were route combiners. Indeed, reading along the drug combiner row identifies that 18 men were route combiners. The table readily shows that the most common area of drug use and drug administration behaviour convergence was of drug combining and drug route combining, with 11 participants fitting these criteria. The second most common area of convergence identified by the table is of drug concluding and therefore also route concluding, with 6 participants fulfilling these descriptions according to their reported behaviour on their most recent prison sentence.

The convergence table also shows some of the less common drug use and drug administration route combinations which participants had reportedly engaged in when last in prison. Indeed, less common combinations were identified as a drug continuer and a route converter as the name of only one participant (Barry) appears in the box where these behaviours converge. Similarly, only one participant (Steve) was identified in the box where the behaviours of drug converting and route converting converge in the table. Whilst the table identifies that some men were route converters, it also identifies that there were no route converters who were also drug combiners, as shown by the empty box where these two behaviours converge in the table.

Understanding the variety of prison drug taking behaviours and the influences on them and on the way in which they may change in prison when compared to community drug consumption practices from the view of drug users who have been

in prison is extremely useful information for practitioners. For example, they provide insight into different types of behaviour and subtleties within it, rather than assuming that drug users may all engage in the same type of drug using behaviour in prison merely on account of them all having a history of community intravenous injecting. The applied value of the illicit drug use and illicit drug administration route models for those working with drug users in prisons, such as clinical staff, CARAT workers, prison psychologists and prison officers is therefore now considered within the prison setting. This is linked to the objective of using this empirical research to consider the theoretical and practical implications of the findings to help inform evidence based policy and practice, guided by the principles of harm reduction. In so doing, it acknowledges that there may be moral, political and ethical difficulties of working with drug users in prison. Indeed, there will be particular political challenges if institutional approaches rely on the Prison Service accepting the presence and reality of drug misuse within prisons, as this could be publically interpreted as tolerating prison drug misuse and opposing the underlying premise of prisons as places of punishment (Paylor, Hucklesby & Wilson, 2010).

As the models describe past reported behaviour, there are some challenges in considering their practical applicability for use with drug users in prison, not least relying on prisoners to disclose their illicit prison drug using intentions when assessed by prison medical and CARAT personnel on arrival. The tension that prison drug using behaviours can and do change over the course of a sentence, reflecting things such as changing drug availability or prisoners access to substitute medication must also be considered. Consequently, their reported intentions (if honestly known and disclosed on arrival in prison) may change through their sentence. Yet the value of the models is that they distinguish between five different types of drug use behaviours and four different drug administration route behaviours (and features underpinning the different behaviours). Such information gleaned through the models could be used by professionals to identify and possibly indicate a prisoner's intended drug using behaviour when in prison or at least where they were in the theoretical cycle of change model (Proschaka & DiClemente, 1982). This would provide a starting point for professionals, from which they could work alongside prisoners during their sentences, review progress and from which policy and practice may subsequently develop. This acknowledges that that a simple 'one size fits all' approach to working with drug misusers in prison is unlikely to be as beneficial as more tailored individual approaches which consider some of the different types of prison drug using behaviour identified. Yet this is not to dismiss the need for well

planned institutional interventions alongside more individual approaches, which would both need to consider the intricacies and context of the prison setting.

To illustrate the utility of the models, out of the types of illicit drug use identified by the drug use model, drug consumers, particularly the considered consumers reported a real desire to stop using drugs, so they went to prison to realise this and find stability. There are clear opportunities here for considering pragmatic institutional and individual harm reduction interventions with this group who already showed a determination to change their behaviours and a decreasing attachment to injecting drug use. These prisoners will have passed through the two stages of precontemplation (where a user is largely ambivalent to change) and contemplation to a stage where they are more accepting of the benefits of change and want to take action to maintain the change (Proschaka & DiClemente, 1982). Drug consumers are therefore the most likely to respond to professional intervention. They may also be easier to target prevention interventions at, as the type of interventions are likely to be subject to less political sensitivity than others, such as those aimed at drug consumers.

Given the strength of the drug consumers' wishes it is likely that they would present to prison medical and drug services openly expressing their desires to become drug free and conclude their drug use in prison. Thus practical and psychological intervention measures will need to work quickly and efficiently with such prisoners and embrace their motivation to change. At the heart of this, good trusting therapeutic relationships between medical, psychiatric and drug counsellor professionals and the prisoners to encourage and support them would be important. Not all prisoners who want to use prison as an opportunity to stop using drugs will serve short sentences like the drug consumers identified in the current research. Nevertheless, the need for timely baseline assessments on reception into prison and regular progress reviews will be vital if prisons are to help those who present with determination to change address their drug use as soon as they enter in order to build on this throughout their sentence and move towards maintaining the changes to prevent relapse.

Alongside the provision of suitable substitute medication for opiate users, those wanting to abstain from drug use in prison might be further encouraged to do so and benefit from motivational interviewing (Miller & Rollnick, 1991), the setting of goals and the provision of targeted harm reduction information in prison in both the interests of individual and public health. For example, sessions identifying their

triggers and risk factors for reinstating drug use on release to alert them to these and guard against them act as helpful protective factors in remaining drug free. Furthermore, prisons could also work with motivated and committed prisoners who want to be drug free by linking up with the education, training, employment and housing support services to help them to make future plans which would build on their desires to change so that they are released with maximum opportunities in these areas. Ensuring links and appointments with community prescribing services would also be pertinent here if the drug consumer is in receipt of a prison prescription to try to guard against reinstating use on return to the community, particularly if they had few close family relationships, like the drug consumers in the current research. It would also be most pertinent for the prison professionals to consider the prescription of medication with an opiate blocker in it for these prisoners when in prison and definitely prior to their release in order to work alongside their motivation to cease drug use.

It is recognised that more individually orientated suggestions such as those outlined above would be quite resource intensive, and would not necessarily be cheap to implement as they would require sufficient staff with sufficient time to take them forward. This might raise concerns in the current economic climate characterised by efficiency and reduced spending. However it is postulated that, assuming the combined interventions were successful and the prisoner abstained from future drug use, the long term saving of not treating them or sending them to prison again would outweigh more short term spending. Furthermore, the current economic climate could encourage other innovative ways of developing and delivering prison harm reduction education interventions, such as the use of peer educators (Kerr et al., 2004).

This approach and some of the suggested targeted harm reduction measures would be unsuitable for those identified as drug continuers or drug combiners. This is because they presented in a more precontemplative way, showing the least intentions to change their behaviours when in prison (Proschaka & DiClemente, 1982). Early assessment could identify such ambivalence to change and it would assist in developing more appropriate and tailored ways of working with these individuals. Whilst some harm reduction interventions are ethically and politically controversial and there are obstacles to implementation, acknowledging that drug use does exist within prison environments and some individuals will engage in its practice means that information about the safest ways of continuing drug use in prison may be more appropriate for these groups than emphasising abstinence. For example, emphasising the potential overdose risks of combining the use of certain

illicit drugs in prison (alongside the receipt of prison prescribed medication) would be more important to point out to the drug combiners and route combiners in order to prevent drug-related prison deaths, especially those misusing prescribed medication alongside other illicit substances. Route combiners who may be injecting illicit drugs in prison may also benefit from information regarding the safest ways to clean shared equipment in order to minimise their risks of blood-borne virus and disease transmission, with the aim of protecting both individuals and the wider public health of the prison population. They could also benefit from information to try to support transitions to different routes of drug administration from injecting (Southwell, 2005).

There is arguably more clinical and psychosocial CARAT intervention and motivational work that could be done with those who were identified as drug converters and drug condensers as they appeared to be more contemplative of their prison drug using behaviour so these considerations could be built upon. For example, both of these groups did not find that the detoxification provided at the start of their sentences had been long enough. Thus ensuring more stable and sufficient medication to them could make them more receptive to motivational work and receiving harm reduction information such as about reinstating crack cocaine use on return to the community. Thinking beyond the clinical and psychosocial suggestions to ways which the wider prison may be able to assist in reducing the harm of the drugs used and fostering possible contemplation to change behaviour, finding appropriate ways to engage these types of prisoners in prison life is likely to be beneficial. For example, relieving boredom and the temporary escape from reality were frequently cited as reasons for drug use. Thus considering constructive regimes and encouraging these participants to engage in prison activities to fill their time such as education, employment or the prison gym merits some attention as such constructive activities were reported to help those who remained drug free in prison and reduced their demand for drugs. Yet, this would have to be considered carefully, within the context of individual prisons and their security classifications.

Similar work could be incorporated into clinical and psychological assessments and motivational work with prisoners who identified as route concluders and route converters as their consideration of the risks of injecting and sharing used equipment contributed to them ceasing injecting in prison. Reinforcing the reverse transition of stopping injecting and their identity as non injectors would be beneficial when developing their strategies for coping in desensitising situations in prison or on release (Southwell, 2005). For route converters, this could also act to support them to enhance their efficacy of using other administration routes, such as drug smoking or

snorting and their identity as users of drugs in these ways. The aim of this would be to encourage less risky behaviour patterns adopted in prison to become longer term patterns of use by them continuing on release rather than transitions back to injecting.

Chapter Summary and Discussion

This chapter has identified participants reported prison illicit drug use on their last prison sentence when compared to their reported pre-prison use. From these accounts, a model for illicit prison drug use and a model for illicit drug administration route were developed from a grounded theory analysis (see Chapter 3). The models both comprise different aspects of illicit drug taking behaviour, as summarised in Tables 9.1 and 9.2 and as brought together in Table 9.3.

Careful analysis of the interview data and the testing of individual narratives against the conceptualisation offered in the models gives confidence that the models reflect what participants described as their illicit drug use behaviours when last in prison when comparing it with their prior injecting community drug use. However the models of drug use and administration in prison do not account for all prison drug use and administration routes and a number of limitations with the models can be identified.

The transferability of the models to populations beyond men who injected illicit drugs prior to imprisonment who were studied here is untested. The research did not consider men who entered prison with no history of drug injecting, other sub-groups of male prison drug users, women, or young offenders who had a history of injecting drug use and imprisonment. Further research with these groups is therefore required in order to test and develop the models and identify if there are different, or other, psychological, social, systemic, and practical influences on prison drug use for these populations. In addition, these models do not make distinctions between different prisons where participants had served their last sentence in terms of their security category, but rather it considers all prisons together, irrespective of their category. The limitation of this is that the models do not pick up any possible differences in drug using behaviours and findings which might be apparent between those who served their last sentences in prisons of a higher security category and those who were last imprisoned in lower security category prisons.

A further limitation in the use and applicability of the models is that they cannot predict drug use behaviours in prison. These are descriptive, categorical models

which do however provide a foundation for understanding and beginning to address drug use in prison since they identify and expose issues concerning illicit drug use in prison, how drug use and administration routes change from pre-prison drug use and how there are different types and nuances of behaviour. The models can categorise and conceptualise a man's drug use and route of drug administration based on their self-reported behaviours and are receptive to the fact that there may be transitions in a man's prison drug use. For example, a man may be a drug continuer for a long time but factors may mean that he changes his use of drug and becomes, for example, a drug converter or concluder. The models would pick up on these behaviour changes through working through the models using updated drug taking information. As suggested in Using in the Models, the models are also able to use these detected changes to aid clinical, psychological and educational interventions by pointing to areas where such interventions could be considered and prioritised.

Whilst the sample for the current qualitative study was relatively small, there is reasonable spread of participants across the different types of drug using behaviour identified, suggesting the representativeness of the sample in this regard. Yet there was less spread of men across the different drug administration route behaviours identified, particularly given the lack of administration route continuers. Whilst this might reflect the picture of what happens to drug administration routes in prison and how they change from community practices (Wilson et al., 2007), it is hard to be certain of this and it would be beneficial to explore in further research. This could be done by trying to theoretically sample men who only continued drug injecting in prison to explore this phenomenon, including their reasons for so doing and for not stopping injecting or for not also using other administration routes. An area for future research could be to conduct a much larger scale representative quantitative survey of prisoners' drug use on their last sentence. This could test the models and categorisations developed through this initial qualitative exploration and determine the most common prison drug use and drug administration behaviours. Perhaps such research could also take into account prisons' different security categories and aim to identify if there are obvious changes in drug use behaviour in prisons of higher or lower security categories. For example, it could test prior assumptions or hypotheses such as that there would be more administration route concluders in higher security prisons than in lower security prisons or that there would be more drug condensers or converters in higher security prisons. In so doing, such investigative research would not only be considering individual practices but would also actively consider the role of different prison environments on drug use in prisons. Furthermore it would, with a sufficiently large sample size, be able to perform robust statistical analysis and

possibly sub group analysis to test such assumptions and identify different trends and behaviours and changes in behaviours.

Despite some of these limitations, the models strength is that they accurately consider, ground and capture the accounts of participants prison drug use on their last sentence. The models highlight how the prison environment acted as a modifier of drug using behaviour when participants were there, as the decisions that they took about their use of drugs were often linked to the characteristics of the prison environment which they were in. In terms of the use of illicit drugs, for participants who continued with their illicit drug use during their sentence, as continuers, condensers, converters or combiners, prison represented an extension of their lives in the community, albeit significantly modified. Their use of illicit drugs per se therefore remained largely unchanged, although the frequency of their use reduced due, largely, to problems accessing drugs in prison compared to the perceived ubiquitous availability of drugs in the community. Furthermore, participants sometimes revised the type of drugs used and route of administration. They saw little advantage in changing their drug use behaviour in prison because they were pessimistic that improvements would be maintained after release. As shown in the preceding chapter, by deciding to continue their drug use in prison, these participants took reasonably high levels of personal risk and went to great lengths to continue using the desired drugs by the desired means and at the desired frequency, particularly when acquiring and using illicit drugs. Their decision and will to continue using drugs of some kind and in some manner, therefore dictated many of their actions such as taking drugs into prison and organising drug acquisition in prison, obtaining and sharing drug equipment in prison. Yet this is not to say that the level of risks taken in prison were necessarily higher than those taken by individuals in acquiring and using drugs before prison. Rather, in some cases it might be that the level of risk taken in prison was maintained or indeed was lower than before prison, again demonstrating how the prison environment acted in a way to modify aspects of their drug using behaviour (Bullock, 2003; Plugge, Yudkin & Douglas, 2009; Singleton, Farrell & Meltzer, 2003; Singleton et al., 2005; Strang et al., 1998; Wilson et al., 2007). In other instances, aspects of the prison environment contributed to the decision to not continue intravenously injecting illicit drugs when in prison (Wilson et al., 2007). This highlights how prison can modify drug using behaviours and lower associated risk behaviour if drug use was ceased altogether.

When examining participants' reports of their last imprisonment drug administration experiences, it is clear that there was a reduction in injecting behaviour in prison

when compared to their pre-prison practice. This is captured by the lack of route continuers in the drug administration route model, possibly on account of the difficulty of obtaining sterile injecting equipment on more recent times in prison or possibly because of the rise of the use of other non injectable drugs in prison, or a combination of these things. As also identified by the drug administration route model, if participants did inject when they were in prison, they did so alongside other administration routes and were classed as route combiners. Yet, this was uncommon, highlighting the reduction in injecting practices during their last prison sentences. Rather, combined smoking and snorting were the more prevalent administration routes either individually or in combination with one another. These routes were possibly engaged in and suggested as a way to distance themselves from the negative identity associated with injecting drug use in prison (Crewe, 2006; Wilson et al., 2007). This concurs with some of the research findings reported earlier in the review of the literature in Chapter 2 about the reduction in injecting drug use practice when in prison environments in more recent years (Bullock, 2003; Plugge, Yudkin & Douglas, 2009; Singleton, Farrell & Meltzer, 2003; Singleton et al., 2005; Strang et al., 1998; Wilson et al., 2007). This also offers useful perspectives from which to consider the politically controversial issue of prison needle exchange (Dolan, Rutter & Wodak, 2003; Kerr et al., 2004; Wilson et al., 2007). Indeed, there seems little evidence from the perspectives of drug users gathered in the current research that the introduction of needle exchange programmes in English and Welsh prisons would be beneficial, other than to a minority of participants who chose to continue to inject when in prison, combining it with other administration routes. Rather, time in prison largely seemed to offer injecting drug users time to consider their drug using behaviours and the context of being in prison mainly offered them reprieve from injecting as their administration route.

There is arguably a reduction in the health associated risks of blood-borne virus transmission and overdose linked to the reduction in prison injecting. However as participants discussed in preceding chapters, there are still personal and physical risks linked to the use of drugs in prison per se, regardless of the administration route taken. Given the widespread reported practice of snorting buprenorphine, it might be that research into this administration route would be helpful to identify if there are any particular health risks linked to this route or this in combination with other drug administration routes. In the final chapter that follows, more suggestions for future research borne out of the current research are made. The chapter also concludes the thesis by summarising the main findings and considering the implications of them.

Chapter 10 – Concluding Discussion

As an exploratory grounded theory study, this empirical research provides an examination of how imprisonment impacted on a sample of 30 drug using men, in particular on their illicit drug use behaviours and specifically on their practice of injecting drug use. To do this, the research used in-depth interviews with men in England who, between them, had extensive injecting drug use histories and who had all previously served in prison but had been released since 2002. The interviews examined various aspects of drug use among participants and the impact that social and environmental prison settings had on an individual and their experience of drug use. In so doing, the interviews considered the extent to which male injecting drug users changed their drug using behaviour in prison from their community behaviours and how time spent in prison impacted on them in general. In particular, the interviews considered the nature of these changes, in terms of the drugs used, the administration routes used, the specifics of participants' prison drug using practices and how the context of the prison environment shaped men's thinking about drug use and influenced their associated choices and practices.

Whilst the study has some limitations as outlined earlier, at the end of Chapter 3, the findings make an important contribution to the literature on men's prison drug use, being one of the first recent English qualitative studies to explore this. In so doing, the research provides an improved understanding of men's prison drug using behaviours from a harm reduction perspective and from which effective responses to prison drug use can be developed and based. This concluding chapter brings the thesis together, building on the discussion sections at the end of the earlier empirical chapters. The chapter initially provides a brief summary of the key findings. It then discusses the practical and theoretical implications of these findings in relation to policy and practice, harm reduction and psychology before suggesting some possible areas for future research arising from it.

Summary of Key Findings

There are numerous main findings from this research, as outlined throughout the previous chapters and as further discussed below. It is important to identify that the main findings and key contributions of the thesis are not just the identification of the drug using behaviours which were engaged in when in prison. Rather, identifying the reasons and motivations for the behaviours and uncovering *why* and *how* certain

drug using choices were made are crucial findings and also key contributions of the current study. The exploration of these areas was enabled through the use of in-depth qualitative research which was informed by a pragmatic harm reduction approach, thereby starting with an acknowledgment that those with a history of community illicit drug use may engage in illegal behaviours that carry risks whilst in prison rather than more preventative, punitive or less tolerant approaches. The resulting findings thus provide a key contribution to both the academic and practical study of drug misuse and drug misusers in general, and most specifically to their behaviours within contemporary English prison environments enabled through adopting a harm reduction perspective.

This study has highlighted many differences and intricacies in terms of how imprisonment impacted on men who have a history of injecting drug use when they go to prison, how they thought and behaved about their illicit drug use both in the community and when in prison and their more general thoughts and behaviours when in prison about themselves and their lives. It identified how various different practical, emotional, psychological and social factors overlapped to influence men's drug using thoughts and decisions when in prison and the reasons underpinning these. Early in the thesis we saw that the interviews identified that these men had complex and often disrupted lives which contributed to them experimenting with and using drugs. Whilst initially fun and providing comfort from troubles and perceived vulnerabilities, as this drug use became more ubiquitous, it became a physically and psychologically ingrained part of their daily lives and their social identity. It is therefore not surprising that this highly entrenched and physically and psychologically addictive community behaviour could therefore transcend prison walls, particularly when prisons were described as places where drug users were reunited with one another and where there was a void of time with few constructive activities to fill it.

A key finding of the current research in relation to being imprisoned was that participants were often relieved to be sent to prison. This was linked to a break from the never ending cyclical nature of committing crime in the community to finance their drug use. Indeed, prison offered a respite from drugs, or at least some time away from using them in the same way and with the same degree of intensity as in the community before prison. Yet, this is not to say that drug use stopped when in prison. Paradoxically, using drugs when in prison sometimes provided participants with a temporary respite from the confines of being prison and helped them to cope, offering them a distraction in providing their bodies and minds a temporary relief from boredom and the often stressful psychological and personal circumstances they

associated with being in prison. Despite this, a key and unique finding of the current research is that interviews and analysis identified that participants appeared to demonstrate a greater level of choice and control over their drug using behaviours when compared to their pre and post prison community drug using behaviours. This appeared to be a way in which they asserted some element of personal choice and control over their actions in largely restrictive prison environments. Furthermore, operating such choice and control suggests that a combination of factors, such as the nature of the prison environment and illicit drug availability, operated alongside participants' thoughts and feelings to modify drug using behaviour when in prison. Thus the impact of imprisonment is complex as for some participants it served a more restorative and rehabilitative function when considering their illicit drug using behaviours than of general punishment. This is a unique finding as working with prisoners' motivations and desires to exercise choice and have rehabilitative respite from intense community drug use behaviours when in prison offers numerous opportunities for harm reduction interventions as later discussed.

Related to how the men viewed their time in prison, the finding that prisoners frequently took illicit drugs into prison with them through preparing themselves by 'plugging' community supplies before imprisonment and the reasons for this preparation are further key contributions of the thesis. Again, using qualitative research to explore this practice and the motivations for this behaviour is at the heart of these important findings. These findings particularly challenge some of the drug users' claims about the hectic nature of their community lives and more commonly held public stereotypes about the uncontrollable lives which drug users may have. This is because such practice required a level of resourcefulness and advanced preparation which does not necessarily conform with such claims and stereotypical perceptions of illicit drug users. On the contrary in fact, it suggests more pre meditation, awareness and determined ingenuity than drug users may be given credit for. Most importantly, it suggests their ability to make choices about their drug use and exercise these not only when in prison. Linked to this was the compelling finding that illicit drugs were a pervasive influence in prison environments contributing to them being taken into prison regardless of whether someone would use them when there or not. Indeed, drugs were identified to play a significant part in daily interactions and transactions between prisoners, showing how the knowledge of this acted to shape and determine drug users behaviour in planning and preparing for prison by taking them in, despite the potential for drug debt due to their high price, disputes and social and violent consequences due to the demand for drugs.

A further key academic and practical contribution of the thesis is the development and presentation of two models which help to identify how participants' drug using behaviours changed in prison when compared to their pre-prison practices. These offer a useful way of considering the types of illicit drugs the participants used in prison and by which route(s) of administration. The illicit drug use model identified the continued use of illicit drugs in prison, but with some changes. Firstly, the model identified that participants frequently used a combination of different illicit drugs in prison. Secondly, it showed that whilst illicit drugs were used in prison, to reflect the nature of the prison environment, the drugs of choice changed when compared to those used in the community. For example, in prison there was reduced use of stimulants in favour of using drugs such as heroin which increase relaxation, lower inhibition, boost self confidence, distort senses, alter perceptions and change conscious awareness. These provided participants with the opportunity to 'escape' from the reality of their situations, at least temporarily and feel psychologically 'freer'. Linked to this, the relatively new trend of snorting buprenorphine was identified to have become widespread in prisons. Whilst buprenorphine misuse in prison has been highlighted previously, the key contribution of the current study in relation to this was not necessarily the snorting of the medication, but the reasons why this happened in prison, resulting in a peer reviewed publication (Tompkins et al., 2009) and much subsequent interest. Furthermore, the illicit drug administration route model identified that drug injecting heavily reduced in prison but other methods of drug administration increased, such as snorting, and, unlike pre prison practices, numerous different administration routes were used. Understanding such motivations and changing practices when in prison thus offer a helpful way for prison practitioners and harm reductionists to work with prisoners, as discussed in Chapter 9.

The study also offered valuable insights into drug user's views of the provision and developments regarding medication provision over more recent years, being one of the first studies to consider this and to sample participants based on when they had last been in prison and when they had subsequently last been released. Whilst there was a lack of consistency reported between participants in terms of the medical interventions and prescribing received when previously in prison, the experience of receiving drug substitution medications in prison had generally improved over more recent years. Yet whilst a prescription of opiate dependence facilitated participants to not use drugs in prison, this was not always sufficient to stop drug users from being tempted to use illicit drugs when in prison, suggesting that the receipt of a prescription alone is insufficient in helping long term injecting drug users overcome their ingrained drug using practices and provides more scope for intervention work.

A further novel finding which resulted from the current in-depth study was linked to the main dangers of using drugs in prison. Indeed, taking a wide view of risk rather than solely focussing on the health risks of using drugs in prison, the study highlighted that the main dangers of using drugs in prison were considered to be more social - linked to being caught by the authorities or suffering drug related violence from other prisoners. Whilst the risk of the transmission of blood-borne virus infections was mentioned, this appeared to be less of an immediate concern to participants. This shows a departure from more traditional harm reduction research which has more commonly focussed on the risk of transmission of blood-borne viruses in prison, enabled through taking a broader view of risk for the current research. Linked to this, the study offers an area for policy, practice and harm reduction to consider approaching the issue from to complement more traditional approaches that may focus on transmission risk.

Finally, an advantage of the current work was retrospectively being able to explore with participants how prison drug using behaviours were then influenced on release from prison and on return to the community. Indeed, a compelling finding is despite what drug using practices men adopted in prison, the use of drugs on release was very common, particularly when there had been no change in participants' circumstances on release as they felt that nothing had changed for them. Not using drugs on prison release required more than just commitment to not use from participants but also was influenced by their housing, employment and relationships with others on release.

Next, the implications of the current study and its findings are discussed.

Implications

Such findings and this detailed understanding of how imprisonment can impact on an individual's injecting drug use has important implications for the existing literature on harm reduction and drug misuse in prison. These findings also have implications for future policy and planning, particularly in relation to psychological services offered in prisons in England and Wales. Speaking in-depth with a number of injecting drug using men about their drug using practices in prison and how these differ to their community practices and how these may change on release demonstrates a number of important issues.

Firstly, the population are not a homogenous group on account of their drug using and imprisonment experiences, as evidence from this study about their varying drug using behaviour when in prison suggests. As such this highlights (particularly from a harm reduction standpoint) that it is clinically and psychologically inappropriate to treat all prisoners with a drug injecting history the same way. For example, assuming that all prisoners want to stop using drugs when in prison through promoting approaches to achieve abstinence is not reflective of all drug users' experiences and thus could be a waste of time and resources for those prisoners who do not want to stop using drugs when in prison. This is not to say that encouraging or condoning their continued prison drug use would be appropriate. Rather, promoting the safest ways of continuing to use drugs when in prison using a harm reduction approach would at least limit the risks of the user (and the extended network of other prison drug users) finding themselves at risk of any unwanted complications of continued use. The controversial and political nature of this suggestion is of course acknowledged, particularly for those whose role it is to control and maintain the prisoner population at large and protect society from people who have been removed from it. Yet given that the presence and use of illicit drugs remains in British prisons despite years of policies and practices with the intentions to try to control and limit them, perhaps it is now time to acknowledge that the current preventative measures are not working for all drug users. Rather, in light of this recent research, it could now be beneficial to consider how current harm reduction approaches could be further developed and adopted in order to reduce potential dangers or risks for different groups of drug using individuals who engage in drug using practice when in prison. This would include the different types of prison drug user and the different types of administration routes used when in prison (Newcombe, 1992; Riley et al., 1999; World Health Organization, 2005). For example, the finding that the social risks of using drugs in prison were considered as significant, if not more so than the health risks is worth further exploring and developing harm reduction messages around.

Of particular significance to the practice of prison psychologists and clinicians (including doctors and drug workers) arising from this research are the models which have been developed. Whilst possible controversies and difficulties of using these, it is hoped that these will at least provide a starting point for their work, considering how working with drug continuers may differ from drug condensers or drug combiners in terms of the applicability of clinical and psychosocial interventions, as discussed in Chapter 9. Recognising that drug users in prison are different and have varying circumstances and motivations and desires when in prison and trying to understand these might go some way to balancing the approaches of how best to

engage and work with them on appropriate individual levels within the confines of the prison environment and within a framework of harm reduction. Of course using these models in that way would rely on open and trusting relationships between prisoners and clinicians as clinicians would need to identify current drug using practices or intentions regarding these during imprisonment. Given some of the negative views expressed by participants about those working within the prison healthcare systems and fears of possible reprisal, this may be easier said than done, even when working under harm reduction principles. Yet the development of good therapeutic prisoner – clinician relationships are worth exploring in so much that the provision of counselling to prisoners with a current or former history of drug use could be beneficial to both prisoners, those working with them, the wider prison estate and the harm reduction in prison agenda more generally. Such counselling could not only help uncover and address their views on using drugs in prison but why they use or have used drugs prior to imprisonment. This is a key issue in the case of people who, like the participants in this study, have many issues in their lives to overcome before trying to overcome their drug use, as this use is often a direct consequence of some of these other issues. This individualised approach is likely to be very time and cost intensive, particularly during the current time of economical restraint. Yet if successful in helping someone address their drug use and work towards rehabilitation, the costs of more harm reduction measures involved compared to the costs associated with committing crime, continued imprisonment and health care linked to complications resulting from injecting drug use, are likely to be minimal and so thus warrant serious consideration.

Finally, it is noticeable that the illicit use of buprenorphine became the drug of choice when in prison for men who were largely heroin and crack cocaine users before they were imprisoned. As mentioned earlier, this emerged as a pertinent new area during the conduct of the research. Yet the research can make no claims that this finding is generalisable to all male prisoners with a history of injecting drug use in England and Wales as the experience of misusing illicit buprenorphine was not considered as a sample monitoring criteria. Whilst buprenorphine was not all obtained from diverted prison pharmacy prescriptions, some of it was. Despite the historical nature of the data, a review of prison prescribing and prison dispensing methods may be both advisable and timely to see if this is still an issue or if it appears that changing prison prescribing practices have had an influence on this. Given the widespread reports of the use of violence and intimidation for drugs when in prison, an implication here is that improved control of prison medication dispensing and supervising may limit the risk of individual prisoners being bullied or intimidated for their prescription and thus

may possibly improve the atmosphere in the prison for all concerned. Yet this may be unlikely and unrealistic given the determined and resourceful natures of participants when in prison and their often desire for material possessions.

Areas for Future Research

This study points to a number of areas where further research could be conducted to complement the existing literature in the fields of drug use in prison and harm reduction and contribute to the knowledge base from which policy and service developments are made. As in any research, it must be recognised that the level and extent of future research that is felt to be appropriate will depend on an individual's moral, political and ethical viewpoint and what they consider to be the most pertinent areas to follow up. For example, those with a desire to control and limit the supply and use of illicit drugs in prison may take a significantly different view on what research work should follow this in-depth study than those who have professional clinical healthcare responsibilities for prisoners with drug dependence or those who are working within different academic disciplines, such as psychology, criminology and sociology and those concerned with minimising harm. It is bearing these differences and possible tensions in mind that the future research suggestions arising from this current research are made.

Whilst future research suggestions have sometimes been made in the preceding chapters⁴⁷, there are also other areas of further research which this study points to which have not yet been discussed. For example, in-depth qualitative work could be conducted with more people with prior prison experience to see if there are parallels with this work conducted. This would include groups who were not considered in the current study, namely women and younger offenders to highlight if there are particular differences in their prison drug using experiences and the factors that influenced and shaped them. This would then build a fuller picture from which the evidence could be considered in the future.

It might also be beneficial to conduct research with non injection drug users either in prison or who had been in prison to see what they perceive of the drugs culture in

⁴⁷ For example at the end of the preceding chapter further research was recommended about conducting a much larger scale representative quantitative survey of prisoners' drug use on their last sentence to test the models and categorisations developed through this initial qualitative exploration and to determine the prevalence of different types of prison drug use behaviours and the different types of drug administration route behaviours.

prison, how it impacts on them, how tempted they were to initiate drug use in prison and how they avoided this in order to develop and share any educational harm reduction messages to prisoners at risk of being in similar situations in the future. Alongside this, determining the prevalence of buprenorphine misuse amongst prisoners with a history of drug injecting prior to imprisonment and those without will provide valuable insights into the initiation of this and reasons for it. It will also determine if those in prison misusing buprenorphine are solely those with a prior history of community drug misuse. If it highlights misuse amongst non community drug users, it might be helpful to consider how educational and harm minimisation messages about the risks of this practice could be shared with them prior to their introduction to it in prison and how these risks could be reduced if they continue to engage in its misuse when in prison.

Further suggestions for future research extend beyond research with prisoners and former prisoners to include staff working within prison. For example, an area which warrants possible attention is research with prison officers to explore their perceptions of the drug situation in prison, examining participants' claims regarding how officers turned a blind eye to prison drug use. This work would have to be conducted sensitively to try to access accurate views. Whilst qualitative research would offer a valuable insight into their views, an anonymous staff survey could be considered, the benefit of which would be that a larger scale study would be possible, such as a national survey. The anonymous nature of it might also encourage more candid officer views regarding the potential perceived advantages and disadvantages of drug use in prison. Finally, with the diversion of prison medications being a reality faced by the Prison Service over recent years, some research into different dispensing methods or with those involved in prison dispensing may identify possible ways to reduce prisoner's potential to misdirect and divert their prescribed controlled medications. This would be pertinent if the Prison Service is keen to maintain the historically pervasive emphasis of the control of drugs within prison environments and the punishment of those found to contravene these rules. Yet, from a more pragmatic and harm reduction perspective, perhaps these are areas of research which would be less necessary and fruitful given the current economic climate and the spending cuts to research and service provision. That said, from a harm reduction standpoint, rather than researching medication diversion with the view to control it, it would be more beneficial to research the possible physical, psychological and personal risks for users of diverting and misusing their medication, so that any relevant learning can be developed and fed back to users in the hope that they would consider this and reduce any harm caused through its practice.

Further future research suggestions extend beyond the prison setting to release from prison as this study did not focus too deeply on this. The case for conducting research on release is strengthened when we consider that the rate of reconviction for drug users is high and many return to prison, due to the cyclical nature of drug use and offending. In this sense, research identifying release drug using practices after serving in prison is effectively the same as that identifying pre-prison drug use for those who are re-incarcerated. The issue here which needs to be considered becomes what happens to these practices when re-imprisoned, particularly if the community practices involve higher levels of drug and risk taking as alluded to by this sample. This shows how community drug use can and does play an important part in influencing prison drug using drug using choices and practices and as these may shift over time, so too may prison practices. For example, the reduction in community injecting risk practices with the proliferation of harm reduction such as needle exchanges and safer injecting advice and increases in knowledge about the spread of HIV and more recently hepatitis C, is thought to have influenced the decline in injecting using shared needles, a practice which may have also influenced the reduction of high risk injecting behaviour in prison.

Bearing these things in mind, post prison research would be helpful to examine how prison buprenorphine misuse impacts on subsequent community use. There was little suggestion in this study that the misuse of buprenorphine in prison continued in the community. However, given the relatively new nature of this prison trend it would be prudent to follow this up in the community, particularly as it would be easier to obtain and use buprenorphine in the community and also sterile injecting equipment is more readily available should there be a desire to inject the buprenorphine. Where and how to conduct this research would need careful consideration as people misusing their prescribed community medication might not truthfully report this if the research was carried out in community drug services or pharmacies for fear of medication being withheld. Yet, if drug users are misusing the medication by snorting it, they might not present at services such as needle exchanges, although if they are injecting it, it would be beneficial to identify this. If community buprenorphine injecting is identified, follow up work about the risk practices linked to this would be worth consideration. Furthermore, if post prison use identifies risk practices and changes in drug use practices such as injecting buprenorphine, then the wider question of what happens to this if and when the person goes back to prison is both interesting and relevant to consider, as this might lead to new prison drug using behaviours. Prison release behaviours would be best captured by some longitudinal release research,

whereby users are surveyed soon after release and then again at some later time points, say at six and twelve months to identify if and how their drug use has altered. After all, in determining the true impact of imprisonment on injecting drug users, we must not only consider the time people spend in prison and what their practices are when there, but we must determine how their practices can and do change on release back into the community, when their liberty is restored as this is a significant time in a drug user's life, a time when drug using behaviour choices and modifications made when in prison and the rehabilitative success underlying a period of imprisonment can arguably be more accurately gauged.

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Appendices

Appendix 1 – Database Search Strategies

CINAHL Search Strategy

	Query	Limiters/Expanders
S31	(S17 and S29)	Limiters - Published Date from: 19950101-20101231; English Language Search modes - Boolean/Phrase
S30	(S17 and S29)	Search modes - Boolean/Phrase
S29	S18 or S19 or S20 or S21 or S22 or S23 or S24 or S25 or S26 or S27 or S28	Search modes - Boolean/Phrase
S28	TI custod* or AB custod*	Search modes - Boolean/Phrase
S27	TI imprison* or AB imprison*	Search modes - Boolean/Phrase
S26	TI imprison* or AB imprison*	Search modes - Boolean/Phrase
S25	TI gaol* or AB gaol*	Search modes - Boolean/Phrase
S24	TI jail* or AB jail*	Search modes - Boolean/Phrase
S23	TI inmate* or AB inmate*	Search modes - Boolean/Phrase
S22	TI prison* or AB prison*	Search modes - Boolean/Phrase
S21	(MH "Public Offenders")	Search modes - Boolean/Phrase
S20	TI criminal* or AB criminal*	Search modes - Boolean/Phrase
S19	(MH "Prisoners")	Search modes - Boolean/Phrase
S18	(MH "Correctional Facilities")	Search modes - Boolean/Phrase
S17	(S1 or S2 or S3 or S4 or S5 or S6 or S7 or S8 or S9 or S10 or S11 or S12 or S13 or 14 or 15 or 16)	Search modes - Boolean/Phrase
S16	TI substance abus* or AB substance abus*	Search modes - Boolean/Phrase
S15	TI substance us* or AB substance us*	Search modes - Boolean/Phrase
S14	TI substance misus* or AB substance misus*	Search modes - Boolean/Phrase
S13	TI drug us* or AB drug us*	Search modes - Boolean/Phrase
S12	TI drug* inject* or AB drug* inject*	Search modes - Boolean/Phrase
S11	TI drug misus* or AB drug misus*	Search modes - Boolean/Phrase
S10	TI drug abus* or AB drug abus*	Search modes - Boolean/Phrase
S9	TI inject* drug* or AB inject* drug*	Search modes - Boolean/Phrase
S8	TI intravenous drug* or AB intravenous drug*	Search modes - Boolean/Phrase
S7	TI drug dependen* or AB drug dependen*	Search modes - Boolean/Phrase
S6	TI drug addict* or AB drug addict*	Search modes - Boolean/Phrase
S5	(MH "Amphetamine+")	Search modes - Boolean/Phrase
S4	(MH "Heroin")	Search modes - Boolean/Phrase
S3	(MH "Crack Cocaine")	Search modes - Boolean/Phrase
S2	(MH "Substance Dependence+")	Search modes - Boolean/Phrase
S1	(MH "Substance Abuse+")	Search modes - Boolean/Phrase

Embase Search Strategy

1. exp Drug Abuse/
2. exp "Drug Use"/
3. exp Substance Abuse/
4. exp Intravenous Drug Abuse/
5. exp Drug Dependence/
6. exp opiate addiction/
7. heroin dependen\$.ti,ab.
8. amphetamine-related disorder\$.ti,ab.
9. cocaine-related disorder\$.ti,ab.
10. opioid-related disorder\$.ti,ab.
11. drug addict\$.ti,ab.
12. drug depende\$.ti,ab.
13. exp Street Drug/
14. exp cocaine dependence/
15. intravenous drug\$.ti,ab.
16. inject\$ drug\$.ti,ab.
17. drug\$ inject\$.ti,ab.
18. drug abus\$.ti,ab.
19. drug misus\$.ti,ab.
20. drug us\$.ti,ab.
21. substance misu\$.ti,ab.
22. substance abus\$.ti,ab.
23. substance us\$.ti,ab.
24. crack cocaine.ti,ab.
25. amphetamine.ti,ab.
26. exp diamorphine/
27. 1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 or 20 or 21 or 22 or 23 or 24 or 25 or 26
28. exp PRISON/
29. exp PRISONER/
30. exp offender/
31. criminal conviction.ti,ab.
32. prison\$.ti,ab.
33. inmate\$.ti,ab.
34. jail\$.ti,ab.
35. gaol\$.ti,ab.
36. correctional institution.ti,ab.
37. custod\$.ti,ab.
38. incarcerat\$.ti,ab.
39. imprison\$.ti,ab.
40. or/28-39
41. 27 and 40
42. limit 41 to yr="1995-2010"
43. limit 42 to english language

Medline Search Strategy

1. exp amphetamine-related disorders/
2. exp opioid-related disorders/
3. exp cocaine-related disorders/
4. exp substance abuse, intravenous/
5. exp Crack cocaine/
6. exp Heroin/
7. exp Amphetamine/
8. exp Street Drugs/
9. exp heroin dependence/
10. drug addict\$.ti,ab.
11. drug depende\$.ti,ab.
12. intravenous drug\$.ti,ab.
13. drug abus\$.ti,ab.
14. substance misu\$.ti,ab.
15. substance abus\$.ti,ab.
16. substance us\$.ti,ab.
17. inject\$ drug\$.ti,ab.
18. drug\$ inject\$.ti,ab.
19. drug misus\$.ti,ab.
20. drug us\$.ti,ab.
21. heroin depend\$.ti,ab.
22. 1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 or 20 or 21
23. exp Prisoners/
24. exp Prisons/
25. exp criminals/
26. imprison\$.ti,ab.
27. prison\$.ti,ab.
28. inmate\$.ti,ab.
29. jail\$.ti,ab.
30. gaol\$.ti,ab.
31. incarcerat\$.ti,ab.
32. custod\$.ti,ab.
33. criminal conviction.ti,ab.
34. correctional institution.ti,ab.
35. offender\$.ti,ab.
36. 23 or 24 or 25 or 26 or 27 or 28 or 29 or 30 or 31 or 32 or 33 or 34 or 35
37. 22 and 36
38. limit 37 to yr="1995-2010"
39. limit 38 to english language

Appendix 2 – Literature Review Data Extraction Sheet

Author		Year	
Aim			
Setting			
Participants			
Methods overview			
Findings overview			
Limitations/ Comments			

INCLUDE
EXCLUDE

DECIDE LATER
EMAIL AUTHOR FOR MORE INFO

Appendix 3 - Research Governance Approval Letter

Bradford 
South & West
 Primary Care Trust

Research & Development Unit
 Allerton Health Centre
 Bell Dean Road
 Allerton
 Bradford
 BD15 7NJ
 Tel: 01274 322859/60
 Fax: 01274 322861

Our Ref: 862/Approval

Date: 27 February 2006

Miss C Tompkins
 Research Fellow
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 71-75 Clarendon Road
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www.bradfordsouthwest-pct.nhs.uk

Dear Miss Tompkins

Re: Impact of Imprisonment on Injecting Drug Use.

Thank you for sending your project to the Research and Development Unit, (R&D Unit) Bradford South and West PCT for Research Governance Approval. As you will be aware the R&D Unit provides Research Governance Approval for all Primary Care Research across Bradford, Leeds and Wakefield.

After considering your project I am pleased to inform you that your project has been approved by the R&D Unit, subject to Ethics Committee Approval and I would be grateful if you could ensure the research complies with the following requirements throughout.

- Consent for us to audit your project on a regular basis and where necessary until its completion.
- The research activity should comply with requirements of the Research Governance Framework for Health & Social Care (2001).
- The principle investigator should ensure that health and safety and data protection policies are adhered to where appropriate.
- The R&D Unit will also need to see a copy of your Local Research Ethics Committee (LREC) approval letter.
- A final report should be sent to the R&D Unit on completion of your project and a copy to the appropriate Primary Care Trust.
- Should any adverse event(s) occur throughout the course of the research this should be reported immediately to the R&D Unit.



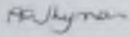
Director: Dr Shahid Ali

If you require any clarification regarding any of the points raised above, or have any further queries in relation to the approvals process then please do not hesitate to give me a call.

Finally, may I take this opportunity to wish you well with your study and look forward to hearing about your progress in due course.

Kind regards.

Yours sincerely



Dr Shahid Ali
Director R&D

CC:

Dr J Fear	Director of Public Health, Leeds West PCT
Mrs P Newbound	R&D Manager, East Leeds PCT

Appendix 4 – NHS Research Ethics Approval Letter

Leeds (East) Research Ethics Committee

Room 5.2, Clinical Sciences Building
St James's University Hospital
Beckett Street
Leeds
LS9 7TT

Telephone: 0113 2065652
Facsimile: 0113 2066772

24 April 2006

Miss Charlotte N.E. Tompkins
Research Fellow
Centre for Research in Primary Care
71-75 Clarendon Road
Leeds
LS2 9PL

Dear Miss Tompkins

Full title of study: **Impact of Imprisonment on Injecting Drug Use**
REC reference number: **06/Q1206/55**

Thank you for your letter of 13 April 2006, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Ethical review of research sites

The Committee has designated this study as exempt from site-specific assessment (SSA). There is no requirement for other Local Research Ethics Committees to be informed or for site-specific assessment to be carried out at each site.

Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Application		13 February 2006
Investigator CV		13 February 2006
Protocol	Revised	01 January 2006
Letter from Sponsor		06 February 2006
Interview Schedules/Topic Guides	1	02 February 2006
Advertisement	2	13 April 2006
Participant Information Sheet	2	13 April 2006
Participant Consent Form	1	16 December 2006
Response to Request for Further Information		13 April 2006
Supervisor's CV		

Research governance approval

You should arrange for the R&D department at all relevant NHS care organisations to be notified that the research will be taking place, and provide a copy of the REC application, the protocol and this letter.

All researchers and research collaborators who will be participating in the research must obtain final research governance approval before commencing any research procedures. Where a substantive contract is not held with the care organisation, it may be necessary for an honorary contract to be issued before approval for the research can be given.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

06/Q1206/55

Please quote this number on all correspondence

With the Committee's best wishes for the success of this project

Yours sincerely

Dr John Holmes
Chair

Email: ann.prothero@leedsth.nhs.uk

Enclosures: Standard approval conditions

Copy to: Clare Skinner
Research Grants Manager
University of Leeds
Faculty of Medicine and Health
Room 7.11 Worsley Building

R&D Department, West Leeds PCT

**Appendix 5 – University of Leeds Psychological Sciences Research Ethics
Approval**

From: stoet [g.stoet@leeds.ac.uk]
Sent: 20 July 2009 14:02
To: Charlotte Tompkins
Subject: RE: Ethics form received

Dear Ms. Tompkins,

Herewith, I can confirm that your study "Impact of Imprisonment on Injecting Drug Use" has been fully approved by the Ethics Committee of the Institute of Psychological Sciences on the 10th of July 2007.

Sincerely yours,

Gijsbert Stoet
Chair Ethics Committee

--
Gijsbert Stoet, PhD
Institute of Psychological Sciences
University of Leeds, Leeds, LS2 9JT
Phone: +44(0)113 34 - 38579



Have you ever been in prison?

Were you injecting when you were sent to prison?

I would like to speak with **men** who were injecting drugs at the time they were sent to prison. The interviews will form the basis of a University research project into the impact of imprisonment on injecting and drug use.

Any information provided for the study will remain completely confidential.

Interviews can be arranged at a time convenient to you. They will last about an hour. You will receive reasonable expenses for being interviewed.

If you are interested, please call **Charlotte** (0113 3436966) or speak to a member of staff for more details.

**Men needed....
...for study about drugs & prison**

Have you injected drugs...?

Have you been to prison...?



All you have to do is attend a confidential interview
(arranged for a time convenient to you)

You will receive payment for being interviewed

Interested? Call Charlotte (3436966) or speak to a
member of staff for more details

Appendix 8 – Pre-Interview Information Slip



Participant Screening Questionnaire – Impact Of Imprisonment On Drug Use Project

Needle exchange / service _____ Date _____

1a. Name _____ 1b. Age _____

2. Ethnicity

 White British
 Black Caribbean
 Asian British
 Asian Other

 White Other
 Black African
 Pakistani
 Chinese

 Black British
 Black Other
 Bangladeshi
 Other (describe) _____

3. Drug injecting at time of imprisonment (circle)

Heroin

Amphetamine

Crack

Other _____

4. Current drug use and route of administration

5. When released from last sentence – and from where

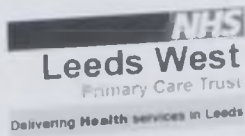
Released _____ HMP _____

6. How long last sentence

7. Total number of times in adult prison (roughly)

CONTACT NUMBER/DETAILS: _____

Appendix 9 – Participant Information Sheet



Interview Participant Information Sheet – Impact of Imprisonment on Injecting Drug Use

I would like to invite you to take part in a research project. The project explores the impact of imprisonment on drug use among men who were injecting drugs prior to being sent to prison. Please read the following information carefully and ask any questions you have before you decide if you wish to take part.

What is the purpose of the study?

I am speaking with men who were injecting illicit drugs prior to being in prison. This study is the project that I have chosen to conduct for my PhD at the University of Leeds. I want to explore what happens to people's drug use when they are sent to prison. The study will take a total of 3 years, starting in April 2006.

Why have I been chosen?

You have been chosen to take part in this research as you have previously said that you were injecting drugs when you were sent to prison. About 20 other men will also take part.

Do I have to take part?

It is your choice if you want to take part. Not taking part will not affect your access to, or receipt of services. You can withdraw from the study at any time without needing to give a reason.

What do I have to do?

A researcher will interview you about what happened to your drug use when you went to prison. The interview is expected to take about an hour. The interview will be conducted in private, in a needle exchange or an appropriate health service. You will not have to take any medication or be involved in any medical tests. The information you provide will help us to identify what happens to people's drug use when in prison.

If you agree to take part, you will be asked to sign a consent form. You must be aware that if you disclose details of a very serious crime, such as one involving children, this will have to be reported to an appropriate agency. However, we will not ask about particular crimes and you should not answer any question you feel unhappy about.

Your help is therefore invaluable.

Any information given will only be used for the purpose of the research. Information will be treated in strict confidence. The interview will be recorded and your name will not be on the recording. The recording will be stored securely and will be destroyed after it has been transcribed. Any reference you make to family, friends or peers during the interview will be anonymised.

A report will be written when the work has finished. You will not be identifiable in the final report. Anything that you say might be used as a quotation in the final report. However, your name will not be included in the final report and your words will be anonymous.

What if I have a complaint?

If you have a complaint about the project contact Charlotte Tompkins. There are no special compensation arrangements if you are harmed by taking part in this research. If you are harmed due to someone's carelessness, then you may have grounds for legal action but you may have to pay for it. If you have any concerns about any aspects of the study, the normal National Health Service complaints system may be available to you.

Many thanks for your time. You will receive reasonable expenses for contributing to the work.

If you need any further information or have any questions regarding the research, please contact Charlotte Tompkins on 0113 343 6966. (Version 2, 13th April 2006)

Appendix 10 – Participant Consent Form

Impact Of Imprisonment On Injecting Drug Use Consent Form

Please read carefully. This consent form applies to the Impact of Imprisonment on Injecting Drug Use project. The research is a PhD project being undertaken by Charlotte Tompkins at the University of Leeds.

	YES	NO
Have you read the participant information sheet?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had the opportunity to ask questions?	<input type="checkbox"/>	<input type="checkbox"/>
Have you received satisfactory answers to your questions?	<input type="checkbox"/>	<input type="checkbox"/>
Do you understand how you will be involved in the study?	<input type="checkbox"/>	<input type="checkbox"/>
Have you received enough information about the study?	<input type="checkbox"/>	<input type="checkbox"/>
Do you agree to take part in the study?	<input type="checkbox"/>	<input type="checkbox"/>
Do you agree to the use of anonymised quotations in the final report?	<input type="checkbox"/>	<input type="checkbox"/>

Do you understand that you are free to withdraw from the study:

At any time;	<input type="checkbox"/>	<input type="checkbox"/>
Without having to give a reason for withdrawing;	<input type="checkbox"/>	<input type="checkbox"/>
Without it affecting your health care or support?	<input type="checkbox"/>	<input type="checkbox"/>

I agree that the discussion can be recorded using audio tape providing all tapes are kept in a locked cabinet and erased after transcription and my identity remains confidential with any information reported in accordance with the Data Protection Act 1998.

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Name in block capitals.....
Signed.....	Date.....
Witnessed (Researcher)	Date.....

Appendix 11 – Initial Topic Guide

TOPIC GUIDE: IMPACT OF IMPRISONMENT ON INJECTING DRUG USE

Introduction

- Introduce self & PhD study
- Emphasize non judgmental position. Not involved with services. Not a counsellor
- Assure confidentiality regarding all aspects from all services. Particularly important
- Check permission to use tape recorder
- Mobiles off
- Thank for contributing (No right or wrong answers. Your views and experiences are fundamental)

1. General background information

Could we start by you talking a little bit about yourself and your current lifestyle?

What do you do / how do you spend your time?

Where do you live / with who?

Relationship and contact with family before prison

2. Drug Use and Injecting History

I'd now like to talk about your history of using drugs. Can you give me a little bit of background about your drug use?

Initial drug use & Progression

How did you start taking drugs? What was this? How long ago?

How has your drug use changed and progressed since then?

Probe re change in routes of administration?

Current drug use

Can you describe your current drug use?

What? When? How? How much? Which main drug?

Is your family and friends aware about your drug use?

3. General Prison History and Experiences

Now can we talk about the time that you have spent in prison?

How have you found life in prison? / How would you describe prison life?

How would you describe your time in prison? What was your experience of prison like?

How many times sentenced?

Which prisons served in? Idea of amount of time served and longest/shortest sentence?

What would you say are the differences in different prisons you have served in?

Offences related to drug use? If so, how?

When you have been in prison how important was it for you to have contact with family / friends? How? (Visits, phonecalls, letters?)

How would you describe the environment / your relationship with other inmates / prison staff?

How did you spend your time in prison? Probe re routine and work. Boredom?

4. Last Sentence

How long is it since you were released from your last sentence?

Which prison? How long sentenced? How long served?

How much did you move between prisons, wings and cells?

Which wing?

Was the offence for which you were sentenced related to your drug use? If so, how / how not?

Did they do what they were convicted for?

How would you describe your time on that sentence?

Did you have any contact with family / friends? How? (Visits, phonecalls, letters?)

5. General & Mental Health

How would you describe your health before you went to prison / when you were in prison / now?

Did you ever feel down when you were in prison?

Can you describe how you felt? What happened? How did you deal with this feeling?

Did you need any help with mental health issues?

Self harm attempts? Suicide attempts? Anti depressant medication? Counselling?

6. Experience of Injecting Prior to Imprisonment

Can you describe what your drug use was like before you went to prison?

How long been using? How much and how often?

How often did you take risks when you were injecting when outside prison? How?

Did you know you were going to prison? What happened the day of imprisonment? Did you use?

Did you take drugs in with you? How?

How did you feel about going to prison with / without drugs?

What happened on first night in prison? Medication?

7. Experience of Drug Use in Custody

Can you tell me what has happened to your drug use when you have been in prison?

Did you use? Why / why not? Which drugs?

Start sentence, during sentence, at particular times??

How easy is it to get drugs in prison? Exchange/trade for drugs?

Were there any differences between different wings or different prisons?

Have you ever used drugs whilst being held in police cells? What was this like?

If continued drug use

Can you describe how you used when you were in prison?

How easy was it to obtain drugs? How? Visits? Bought? Took in?

How did your drug use in prison differ to your drug use outside?

Why did you continue to use drugs when you were in prison?

What did you think about using when you were in prison?

What were your experiences of using in prison?

How important were your relationships with other people in the prison to help you obtain drugs / use drugs? (Cell mate, inmates, officers)

How did you prepare your drugs when in prison? How was this different to preparing drugs outside prison?

Who did you use drugs with? Someone or alone? Cell mate? Who?

Did you try to stop using drugs? Why did you not stop?

Injecting/Smoking equipment

How did you access the equipment you needed to be able to smoke/inject? How easy this was?

What did you have to do or exchange for equipment?

Where and how did you store equipment?

What happened with the equipment after you used it? Disposal? Pass onto others?

Did you ever get caught with equipment? What happened?

What would you have done if you could not get any equipment?

Did you know of any officers or prison staff bringing drugs or equipment into prison?

Would you have injected if you had a needle?

Did you ever use injecting equipment that had been used by other people? Who? Did it matter?

What did you think about this?

What about the smell when cooking heroin? How concealed?

If stopped drug use

Why?

How easy was this? What did you do to help you not use?

Substitute medication? Other medication?

Did you receive any counselling or other support?

Living arrangements – alone or shared cell?

When did you feel most tempted to use? What did you do?

8. Experiences of Others (if little personal information / experiences being offered)

Do you know other people who used/ did not use drugs in jail?

What were the experiences of others like? Friends / drug associates?

9. Risks / dangers of drug use in prison

What do you think are the main risks of using drugs in prison?

What do you think are the differences in risk between smoking and injecting in prison?

How often did you take risks when you were using drugs in prison? How?

What was different about the risks that you took when using drugs in jail in comparison to using drugs outside?

Did you ever use injecting equipment that had been used by other people?

What did you think about this?

What about others people they have known in similar situations in prison?

10. Receipt of help and support for drug use

What help and support did you receive for your drug use in prison?

From who? Family? Prison healthcare? Other inmates?

Counselling?

Did you use any medications in prison that weren't prescribed to you? Bup? Meth?

Why? How easy?

How was your drug use addressed and treated in prison? e.g. by healthcare

11. Release

Can you describe what has happened on the days when you have been released? (Prompt to drug use, medical care, support)

How long served?

Released from where to where?

Who did you see that day? Family, friends, other users?

How long was it after you were released until you used drugs?

Did you get any help when you were released with your drug use?

12. Changes

What could've made your time in prison easier?

What needs to be done to help drug users in prison?

What changes need to be made to make things easier for drug users in prison?

13. Future

How do you see your drug use and life continuing? Crime?

Anything that is relevant to add that has not been covered

14. Close

Thank for time

Reiterate confidentiality

Give incentive

Complete receipt

Appendix 12 – Revised Topic Guide

TOPIC GUIDE: IMPACT OF IMPRISONMENT ON INJECTING DRUG USE

Introduction

- Introduce self & PhD
- Emphasize non judgmental position. Not counsellor / involved with services
- Assure confidentiality & check permission to use recorder
- Mobiles off
- Thank for contributing (No right or wrong answers - views and experiences are fundamental)

1. Background Info

Could we start by you talking a little bit about your current situation?

2. Initial Drug Use and Injecting History

Can you give me some background about your drug use?

Why did you start taking drugs?

How did your drug use change and progress since you first started using? (Probe re drugs and changes in administration routes)

How often did you take risks when you were injecting when outside prison? How?

3. First Prison Sentence

Can you tell me about the first time you went to prison?

What was your drug use like before you went to prison? (How long? How much? How often?)

How did you feel when you were in prison?

Did you know you were going to prison? What happened the day of imprisonment? Did you use?

What were your thoughts about drug use when you knew you were going in, or had just arrived?

How did you feel about going to prison (with / without drugs?)

What happened on first night in prison? Medication?

4. Drug Use During First Sentence

What happened to your drug use when went to prison that first time?

Did you use? Why / why not?

Which drugs? When during sentence?

What did you do to get drugs? (Exchange/trade)

SEE PROMPTS RE CONTINUED OR STOPPED DRUG USE & RISK

5. Drug Use After First Sentence

What happened to your drug use when you were released after this sentence?

6. Last Sentence

How did you feel when you were in prison?

Which prison? How long served?

What was your drug use like before you went to prison last time? (How long? How much? How often?)

Did you know you were going to prison? What happened the day of imprisonment? Did you use?

How did you feel about going to prison (with / without drugs?)

How much did you move between prisons, wings and cells?

Was the offence for which you were sentenced related to your drug use? If so, how / how not?

How would you describe your time on that sentence?
What contact did you have with family / friends? How? (Visits, phonecalls, letters?)

7. Drug Use During Last Sentence

What were your thoughts about drug use when you knew you were going in, or had just arrived?
What happened to your drug use when you were last in prison?
Did you use? Why / why not?
Which drugs? When during sentence?
What did you do to get drugs? (Exchange/trade)

SEE PROMPTS RE CONTINUED OR STOPPED DRUG USE & RISK

8. Release

What has happened on the days when you were released?
How did you feel when you were released?
What did you think would happen to your drug use when you were released?
How long was it after you were released until you used drugs?
Did you get any help when you were released with your drug use?
Who did you see that day? Family, friends, other users?

9. Current Drug Use

10. Differences Between Prisons and Sentences?

What were the differences in your drug use between different wings or different prisons that you have served in?

11. Health & Support

How would you describe your health before you went to prison / when you were in prison / now?
How did you feel when you were in prison? How was your mood?
Did you need any help with mental health issues? (Self harm / suicide attempts? Anti depressant medication? Counselling?)
What help and support did you receive for your drug use in prison? From who? Family? Healthcare? Inmates?
Did you use any medications in prison that weren't prescribed to you? Bup? Meth?
Why? How easy?
What could've made your time in prison easier?

12. Future & Close

How do you see your drug use and life continuing? Crime?
Anything to add? (possibly on prison and prison life in general)
What do you think about your time in prison?
Which prisons served in? Idea of amount of time served and longest/shortest sentence?

How would you describe the environment / your relationship with other inmates / prison staff?
How did you spend your time in prison? Probe re routine and work. Boredom?

Thank for time

Give incentive & complete receipt

Appendix 13 – Section from Transcript

39 **So can you tell me what happened from there then?**

40 We just started messing with other drugs. Just started, started trying other things, trying other
41 drugs, just after a better buzz really.

42 **When you say other drugs what do you mean then?**

43 Like amphetamines, ecstasy, stuff like that. And then you were taking your uppers and then
44 you were getting stressed out after your uppers and you wanted something to come back
45 down on and so we were all smoking weed to come back down on. And it just gets to the
46 point where it is not doing nowt for you. You're not, you're still feeling rough after you have
47 a few joints and its not nowt for you so you end up looking for something else like smack. We
48 ended up where someone says, try this, do you know what I mean, it will bring you down. do
49 you know. So we tried it once and it were nice. I'm not going to lie to no one, I did enjoy it.

50 **Did you know at the time what it was?**

51 No, no. Didn't have a clue. It were another drug. We knew about drugs. We'd been dabbling
52 in drugs a while. We were, I were about 15.5, nearly 16 at this point and I'd tried most drugs.
53 I had tried most drugs by my 16th birthday I'd tried most drugs. So at it was, just always
54 chasing a buzz that is what it were. But it was a laugh though, it wasn't like, it had not took
55 over my life, it were like I was enjoying it. I was enjoying trying these drugs. It was. I was
56 enjoying trying the drugs and seeing how different they were and what they were like and
57 that. It were a laugh.

58 **So talking a little bit about this first time that you actually used heroin then. You knew
59 what it was at the time?**

60 Well no we didn't. We just knew it were another drug. We didn't know what it were. We
61 didn't know you could get addicted to it or owt like that. We didn't have a clue about that.

62 **How did you feel then when you were taking it that first time?**

63 Sick, horribly sick. It were, it were once I had thrown up and that it were a nice buzz. I
64 enjoyed the buzz. It were a good buzz. Because don't get me wrong I tried a lot of drugs and I
65 did enjoy it. I did enjoy taking drugs.

66 **So how old were you then this time with the heroin?**

67 I was nearly, I was 15, just coming up to me 16th birthday I were when I first took it.

68 **Right and when you first took it can you remember what sort of feelings you had before
69 you took it?**

70 Just wondering what it were like, what it were going to do to me, or what it were like. It was
71 just another drug we were trying. It were like, there were like about six or seven of us as
72 friends and it were like, we were always, it was always like one of us, like ecstasy and
73 amphetamines, we always wanted to be the first person to try it, so we could tell everybody
74 else do you know what I mean. It were like my mate (male friend 1), he were the first one to
75 take ecstasy and then because he took it everybody else wanted to take it, and that were the
76 same with heroin and it were like, just I wanted to be the first one to try it, do you know what
77 I mean, I wanted to be the first one to be like, like to be the best, do you know what I mean. I'd
78 done it first, I'd done it before you lot and, do you know that sort of thing that is what it were
79 like. And that's all it was, just wanting to try it at first just to see what it were like.

80 **So did you try it first then?**

81 Yes. Yes. And I didn't like it at first, but then after I had thrown up and all that, because it
82 makes you throw up, well it made me throw me throw up at first, but like once I had thrown
83 up and I were just laid down gouching it like, I didn't have a care in world, and nowt would
84 bother me, do you know what I mean. And it were great. I loved it. I know it's a bad thing to
85 say, I loved taking smack but I did when I first took it. I really did enjoy taking it. When I first
86 took it.

87 **And that first time then how did you take it?**

88 I smoked it. I smoked it. Yes. I didn't start injecting for a while. We smoked it at first.

89 **How long did you smoke for then, can you remember?**

90 Well we were only doing it on like a Sunday, we were only doing it like on a Sunday after
91 we'd been out all weekend at a party or something. We would all sit round on a Sunday and
92 have a smoke and then gouch out for the day and then we'd all be alright to get up and do
93 whatever on a Monday. And it were like, it were like, I don't know, it was, its, is weird, it is

94 thinking back at it now, I know it is a daft thing to say that I enjoyed doing it you know but I
 95 did. I just didn't have a care in the world once I'd done it. It were great. Until it gets a hold of
 96 you and then it fucks you doesn't it.

97 **So how long would you say that have used for that you actually enjoyed doing it?**

98 About a year. It were about a year I were doing it. But I wasn't doing it all the time, it were
 99 just like every so often, like every week, once a week maybe or once a fortnight maybe. And
 100 it would be just good, because we'd all get together and we'd just have a good buzz off it and
 101 it wasn't a problem. It wasn't a problem for a while, it wasn't a problem. I just could do it and
 102 wake up feeling fine again, do you know and it wouldn't bother me for a while I were like
 103 that. For about a year I were like that and then it just, it got to the point where we were a bit

104 older and we had a bit more money and we were just taking it more and more.

105 So can you tell me what happened there then after that kind of year of having enjoyed it?

106 **What actually happened that meant, you said the word, 'problem', what happened that
 107 meant it become a 'problem'?**

108 Became a problem? Having more money, having more money to buy it more often.

109 **How did you get that money?**

110 Because we were robbing a lot more. Unconsciously do you know what I mean, it wasn't like
 111 we was going out robbing for smack, it was we were going out robbing just for money so we
 112 could have money to go out and do things, do you know what I mean. It wasn't specifically
 113 going out thinking right we are going out and we are going to go graft to get some gear. It
 114 were never like that at first. We were just wrong 'uns really, do you know what I mean? As
 115 little kids, we were just wrong 'uns. We were out just robbing things and just being little shits
 116 really, do you know what I mean. Sat on park getting drunk, smoking weed, taking drugs
 117 basically. Just being wrong 'uns and then it started off just nicking cars, just for laugh and
 118 stuff like that. That's how we started thieving and all that. And then once we started making
 119 more money we just started buying more drugs. It were just like we were doing it every day
 120 then because we had the money to.

121 **So that is interesting what you're saying, you're saying that kind of shop lifting or
 122 committing crimes or stealing cars actually came first?**

123 Yes, yes, before. And then because we had the money from the thieving we started buying the
 124 drugs more.

125 **Right okay.**

126 And then it just started becoming a problem and then we was having to go out and rob more
 127 for the drugs. But the crime, yes, the crime actually came before the drugs. Because we were
 128 just little shits really. There was nowt to do on the estate, you know we were all just bumming
 129 about, doing nowt and we all started nicking cars and stuff.

130 **So that is how it all started with actual car theft?**

131 Car crime yes at first.

132 **What was it about the cars then ...**

133 The buzz. The buzz of just driving someone else's car really. Do you know what I mean?
 134 Recklessly. I enjoyed it, we all enjoyed it. Even if we weren't driving the car, just being in it,
 135 getting chased by the police and stuff. It was a laugh. We had a laugh doing it. It's a bad thing
 136 to say now, when you grow up and you start thinking about it, its quite bad isn't you know
 137 thinking about it. It is it's quite a bad thing but it were just daft things I did when I were a kid.
 138 You grow out of it don't you and you realise it were wrong and shouldn't have done it.

139 **So the crime with the cars, let's talk a little bit about that then. You're saying it was the
 140 buzz that you enjoyed about it**

141 Yeah

142 **How did actually stealing the cars mean that you ended up with money to buy drugs?**

143 Because we'd sell wheels and stuff. We'd sell parts of the cars. We had buyers for the parts
 144 for the cars or we'd take the care and we'd go burgle somewhere with the car. Do you know
 145 what I mean, it were just like transport to get somewhere to make money.

146 **So how old were you when all of this was happening then?**

147 It were between 15 and 18.

148 **Right okay. So the cars were either the fun of driving around, but also then when you
 149 had driven around you could get some money from it**

You could get money from it yes.

And also you mentioned burglaries. Can you tell me a bit about that as well?

Well we just used to go, it were like sneaks, we used to sneak houses for keys. Even if people had been in bed we would sneak in their house and we'd get the keys.

Can you explain what you mean sneak the house, cos I've never heard that before?

Right while someone is asleep in bed break into their house

Right okay

And take when you can from downstairs while they're upstairs in bed.

And when you say sneak for keys what does that.....

(Interrupting) it's like whilst someone is asleep in bed you break into their house and you sneak round their house whilst they're in bed and just nick the car keys or nick whatever you can.

Right so looking for car keys as well.

That's what we mainly used to look for, car keys, because we could sell car parts. So the main thing what we used to nick really, was car keys and cars because we could sell car parts all the time to a few people, we had a few people who'd buy car parts off us.

Right

So and that is what we'd mainly nick, we'd nick car parts, but if we were ever short one day really we'd do owt really, owt for them really. Do you know owt as in shoplifting to owt basically.

For who?

For us selves. It was just for us selves to nick money. Just for us. Like I said there were about seven or eight of us, six, seven or eight of us, just lads who just hung about together. We went pulling birds together, went robbing together, went doing drugs together. We were never apart, we were always together. And it were like who were the worst one, who were worst out of the lot of us, who could do the worst things do you know what I mean, without getting caught and stuff like that. It were just who were best, who were best at doing this and who were best at doing that and it were all showing off really. That's what it all boils down to. It were all showing off. That is what it were. We just trying to show off, who were the best, who could the best car, who could make the money and it were like who could do the most drugs and stuff like that. It were bad. Looking back at it now, it were bad. But I think, we all started splitting up when one of us mates died in a car, one of us mates, me mate (male friend 2) died in a car and that is when we all started splitting up then and doing us own thing and I were 18, it was just after me 18th birthday when (male friend 2) died and that's when we all started splitting up and doing us own things and that is when we all ended up getting habits and stuff like that. Do you know what I mean. But I already had a habit by this time. I think I were the only one that had actually got an habit. Do you know what I mean, by this time, but there's like a few, like I know three of them now that have got habits still. Do you know what I mean, (male friends 1, 3 and 4). They have still got habits now, do you know what I mean.

So you mentioned basically there is a big group of you doing everything together but then one of your friends actually died?

Yes.

How did you feel about all that at the time?

Upset yeah, really upset and it were like, because we all stopped nicking cars after that because he actually died in a stolen car, so I just stopped nicking cars after that and but I was still having to make my money for my gear because I had a habit by this time so I was still having to thieve for my money.

So what did you do then?

Then I started shoplifting. So I just shoplifted for years then, for years and years, and that is what I did my last sentence for shoplifting. That is why it were only four months cos it were for shoplifting.

Right okay. So what happened in terms of getting caught then because I am getting this picture that you were doing all of this stuff but obviously you must have got caught in terms of having gone to prison?

204 Yes, but we didn't really **get caught at first**. We got away with it for ages and ages and ages
205 and then I hadn't really, like I say that was **my last**, I've only done, I've only been to prison
206 twice though really, do you know what I mean?

Appendix 14 – Example of Coding Document

FEAR

ID	LINE	DESCRIPTION
1	92	Was scared the first time in prison, with it being his first time
1	552	Was scared when got first sentence (for 2y 9m) as knew was going for a long time
6	71	Was always put off doing crimes because didn't want to go get big jail sentence. Was expecting jail to be really bad as had heard stories, but he ended up being fine as he knew 40% of the wing RELATIONSHIPS
6	83	Expected prison to be bad – beatings, robberies and intimidation but was fine as knew people there. Would've preferred prison to have been worse as it would've put him off doing crime, but wasn't put off at all
6	180	Was a bit worried prior to going to jail but had been told by people who he knew that he would be fine and that it was similar to a hostel but you just can't go out
6	302	Scared first time smoked inside as expected to get caught because of the smell as no real ventilation and thought the officers would come through the door or look through the peep hole TESTING AND DETECTION
6	452	Was shitting himself and scared stiff when previously taking drugs into prison for friend in there as knew that if caught would be charged with supplying HMP which carries a longer sentence than supply
6	566	Was petrified when smoking inside as was worried about the smell of the smoke and getting caught
7	117	First prison sentence to YOI for shoplifting to fund drug habit. Was frightened as didn't know what to expect and scared of feeling drug withdrawals
7	312	Had just turned 18 and was devastated, scared and petrified when sentenced to 3yr in adult prison as knew was going for long time and was not going to be treat like a kid
9	221	'Gutted' to be sent to YOI and cried in bus there. Really, really scared, terrified as didn't know what to do and had lost family support
9	607	Scared when went to Doncaster as knew was addicted and would have to do cold turkey and was already rattling in court and knew that it was only going to get worse RATTLE
9	667	Panicked and was scared when moved from detox wing in Doncaster as realised that he wasn't in Wetherby and was in a 'big prison,' cons prison and he was only young. Had heard rumours like being bummed in the showers, beat up in the gym and was worried in case this happened to him
10	132	Scared the first time in prison as had heard rumours that people get you in the showers but felt ok when bumped into cousin on first day
12	113	Was scared on first sentence (Moorlands 1993) as everything was happening there at the time – rapes, hangings, fights. He was young and couldn't handle it on wings and ended up on hospital wing
12	194	Was scared when first went to prison (didn't expect to go) and tried 'slashing' his arms
14	210	Scared first time went to prison (17 yrs ago) as didn't know what to expect. Can remember hearing gates slamming behind him and a shiver went down his back
14	308	Didn't know what to expect when first sent to prison so was worried- had heard rumours and worried if would be raped or beaten up by pad mate in the night, but ended up being alright and wondered why he had been so worried
16	950	Is scared if he doesn't have support and can't manage without support. When he is scared the way he takes the fear away is by using drug
16	963	'Fear of losing tobacco' (as if get caught lose money) means that he is able to manage without drugs in prison
16	984	'shit himself' when spent night in Wakefield as 'monster mansion' and was paranoid and kept looking over his shoulder in case someone started on him

16	997	Jail is scary and intimidating if you are not used to it – can understand how the first timers feel, but he is alright as has been so many times
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Appendix 15 – Participant Summaries

Name	Summary
Bryan	At the time of interview Bryan was 34 and was living in temporary accommodation with his partner and their 4 year old daughter. He had used heroin for 16 years, initially smoking it for 8 years until he progressed to injecting. He had used crack cocaine for 9 years and, for the last few years, injected heroin and crack together. He had been in prison 18 times.
Jason	Jason was 33. He started using drugs by taking stimulants when he was 21. He was then introduced to heroin through a former girlfriend and had used it ever since. At the time of interview he was currently on electronic tagging. He wanted to stop using drugs and had just started a community methadone prescription of 60ml a day but also injected £10 heroin every night. He lived with his mother and his son.
Paul	Paul was 41 and had previously been an alcoholic for many years. He started using heroin when he was introduced to it by friends when he was 36. At the time of interview he was injecting as much as 5 bags of heroin costing £15 each a day and was waiting to obtain a community substitute prescription to help him reduce his drug use.
Benji	Benji was a 38 year old Black British man. He was first introduced to heroin when he was in prison on his second sentence. He had used class A drugs for 17 years and crack cocaine had been his drug of choice but at the time of me interviewing him at the bail hostel where he was staying, he had not used for 2 months. He had been in prison 5 times, mainly for robbery. He had 2 children but did not see them often.
Rob	Rob was 34 and was not using drugs at the time of interview. He had a heroin using history of 18 years and a crack cocaine using history of 10 years, having used them both together by injection for 7 years. He had been in prison 20 times but said that his last sentence was a deliberate sentence to help him obtain medication for his drug use.
Derek	Derek was interviewed at a needle exchange. He was 31 and had used heroin for 11 years and crack cocaine for 7. He was on 50ml methadone a day and had not used heroin or crack cocaine for four and a half months at the time I interviewed him in September 2006. Despite regularly shoplifting, he had only served one prison sentence, for a total of 2 weeks.
Jack	Twenty year old Jack had started using heroin by injection when he was 16 when he was introduced to it by a friend who was living at the same hostel as him. His crack cocaine use started a few months later. At 17, he was sent to a Young Offender Institution and he had served one adult prison sentence. He had spent 2 years living rough in the city centre, begging members of the public for money. He was living in a hostel at the time of interview and found it hard to not use drugs whilst living there due to the influence of the other residents.
Chris	Chris was a 38 year old White British man with a lengthy amphetamine use history. At one point he used up to £200 of amphetamine a day, although his use at the time of interview was less. He was first sent to prison when he was 18 and had since been in prison a further 7 times, mainly for offences linked to funding and supporting his drug use. His last sentence had been for 24 months for assault.

Pete	Pete was 24. He had started using cannabis and stimulants at 15 and progressed to heroin at 16 to 'bring him down' from the buzz and stimulation that the drugs provided. At this point he started committing crime, especially thieving in order to fund his drug habit and was sent to a YOI in his teens. Later he started using crack cocaine and progressed to injecting it alongside heroin. He had served one sentence in adult prison for shoplifting and prior to this sentence was using about £150 of heroin and crack cocaine a day. He was on a reducing methadone script at the time of interview.
Matty	Matty was a 26 year old White British man who was living in a bedsit at the time of interview. He was taken into care at the age of 6 and associated the start of his drug use at the age of 18 to feeling unloved and bored. His brother and step brother also used illicit drugs. He mainly injected heroin but also smoked crack cocaine. At the time of interview he was trying to stop using heroin and was on a daily 80ml methadone prescription. He had been in prison 6 times, mainly for short sentences.
Ian	Ian was 29 and had been using heroin for 11 years, after being introduced to it through family and friends who used it. During his drug use he used up to £40 of heroin a day and also smoked crack cocaine. However he was trying to reduce his drug use at the time of interview and was in receipt of 60ml methadone a day. He had been in prison on a few separate occasions and his last sentence was for 7 years for burglary. He had committed crime with his brother who also used illicit drugs and they had served in the same prison at the same time.
Gareth	Gareth was 29 and lived in a bail hostel at the time of interview. He had used heroin for 14 years and crack cocaine for 12, starting to inject them after the death of his mother, having first being introduced to them when serving in prison. He had been brought up from the age of 3 in children's homes until his sister later became his legal guardian. He had previously been abused by a baby sitter. He was first sent to a Young Offender's Institution when he was 15 for robbery and had served in prison a number of times since then, in a number of different establishments within England.
Jeff	Jeff was a 33 year old White British man who I interviewed at the bail hostel where he lived. He started drinking alcohol, smoking cannabis, inhaling solvents and taking amphetamines when we was 11 and moved to injecting amphetamine at 14. At 17 he started smoking heroin, progressing to injecting within a couple of weeks. For him, using heroin helped him to cope with being bereaved by close family members, being sexually abused when he was younger and helped him feel more confident. He had also used crack cocaine, alcohol and ecstasy. He had served in prison once, sentenced to 5 years for GBH with intent.
Tony	Tony was 38 years old. When he was younger he had injected amphetamines for 8 years but he stopped after experiencing intense amphetamine related psychosis and splitting up with his long term partner and losing access to, and contact with, his children. Then he began using heroin and had used heroin for 15 years and later crack cocaine. He had hepatitis C and had been in prison 7 times.
Eddy	Eddy was 36 and had started using heroin to help him sleep after going out to nightclubs and taking stimulant drugs. He had been in prison many times, largely serving sentences of less than 12 months. He had last been released in 2006 having served an 8 month sentence. Leading up to his last sentence, he had been injecting heroin and crack cocaine together about six times a day.

Kev	Kev was 42 years old and was not using illicit drugs at the time of interview. He had smoked cannabis since he was 13 and had used heroin for 23 years and crack cocaine for 12. He had previously dealt illicit drugs which provided him with unlimited access to drugs to use. He felt 'at home' in prison as he had been in prison for most of his adult life, at least 20 times. He first started using heroin when in prison. He had a son and 2 daughters.
Wayne	Wayne was 34 years old. He was living in a shared house at the time of interview and had been using heroin for 10 years. He had served in prison 9 times, lastly in 2007 for 1.5 months for shoplifting.
Adam	Adam was a Black Caribbean man and was 42 years old. He was on a daily 70 ml methadone prescription at the time of interview and had used illicit drugs for 26 years. He was a heroin injector and smoked crack cocaine. He was a prolific shoplifter and had been in prison many times and had last been released in 2007 after being sentenced to serve 3 months.
Sean	Sean was 32 and had used drugs for 12 years, having first started using cannabis then amphetamines, ecstasy and later heroin. He had been in prison 7 times, mainly for driving offences although his last sentence had been for 2 years for assault. He was trying to stop using drugs at the time of interview due to a serious health complaint and he had reduced his use to using once or twice a week. He was also on a methadone prescription at the time of interview.
Steve	Steve was 35 and he claimed to have been in prison between 60 and 70 times. His drug use started at the age of 12 and he had used many different drugs, including the misuse of prescribed medication such as benzodiazepines. He was not using illicit drugs at the time of interview but was on a buprenorphine prescription.
Barry	Barry was 46. He had started using heroin in prison. He had been in prison 5 times and was last sent to prison for 4 years for dealing heroin. During his interview he spoke about being wanted by some high profile drug dealers whom he had previously worked for as he had conned them by stealing their drugs and their profit. Consequently he lived his life inconspicuously, in order to avoid being found and reprimanded by them.
Jamie	Jamie was 29. He had started using heroin in prison when introduced to it by his cell mate. His last prison sentence was for 4.5 years for stabbing his ex-partners new boyfriend. He had 3 children, and the eldest was 10 years old.
Clive	Clive was 50. He had been in prison twice and had started using heroin when in prison. Before his last prison sentence he was injecting heroin and smoking crack cocaine. His last prison sentence had been for 5 years. He had previously worked as a club doorman and was known for having a violent reputation.
Justin	Justin started using heroin when he was 18 and was 32 at the time of the interview. He had been in prison 3 times, and linked his offences to making money in order to fund his illicit drug use. He had previously tried to commit suicide but had been found by his sister.
Keith	Keith was 39 years old and was interviewed in the bail hostel where he was living since being last released from prison on licence. He had been using heroin for at least 18 years off and on. At the time of interview he had been released from prison in 2007 having been sentenced to over 3 years for committing a knifepoint robbery.

Gordon	Gordon was 46 years old and spoke with a strong Irish accent. His initial drug of choice was crack cocaine and he later started using heroin to bring him down from the crack cocaine. Had used heroin and crack cocaine for 5 years and was injecting them together every day at the time of interview. His last prison sentence was for 5 months for shoplifting.
Bobby	I interviewed Bobby at a community needle exchange after I was introduced to him by Gordon, who he knew from the hostel where they were both living at the time of interview. Bobby was Asian British and was 26 years old. He had started using illicit drugs in his teenage years when he had been bereaved by both of his parents. Before he last went to prison he was injecting heroin and crack cocaine together and since his release he had been continuing with this use.
Kyle	Kyle was 28. He started using cannabis at age 13, amphetamines and ecstasy at 16, cocaine and heroin at 17, and crack cocaine at 20. At the time of interview he was living with his drug using girlfriend but was uncertain that their relationship would continue as he wanted to stop using drugs but doubted her commitment to this. He had been in prison about 10 times.
Al	Al was 32 and started using stimulant drugs when he was studying an undergraduate degree at University. His drug use soon escalated and he started using heroin. Since then, he had spent a lot of time living rough on the streets with other homeless drug users and was shown how to commit crime in order to make money to get by and fund his drug use. He had served one prison sentence for 4 years for possession of illicit drugs with the intent to supply.
Andy	Andy was an Asian British heroin injector and crack cocaine smoker. He had started using heroin in the community when he was introduced to it by his older sister's boyfriend. He had used cannabis for 9 years and heroin for 11 and was 26 years old at the time of interview. He had been in prison 15 times, lastly in 2007 when he served 5 months for assault. At the time of interview he was on 120ml methadone a day and was trying to stabilise his drug use. He lived with his girlfriend and their two young children.