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School of Psychology

Life Behind Bars: The Experiences of Inmates with Drugs and Alcohol Problems

by

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ABSTRACT

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The literature focusing on inmates with substance problems incarcerated in England and Wales before the introduction of the 1998 Prison Service Drug Strategy has drawn attention to the lack of appropriate detoxification and support. The first chapter of this thesis systematically reviews empirical research carried out in English and Welsh prisons following the introduction of the 1998 drug strategy. The search yielded a total of 3080 studies, only five of which were retained for the data-synthesis. Based on the principles of meta-ethnography (Noblit and Hare, 1998), three second-order constructs emerged from the translation of the studies' key concepts into one another: (i) 'meanings of imprisonment'; (ii) 'through-care: experiences and perceptions'; and (iii) 'environment'. The findings highlighted the need to provide inmates with more empowering experiences of care (in particular for black and minority groups) and to provide more support for inmates with alcohol and prescription medication problems. The review also highlighted a paucity of research focusing on the experiences of inmates with problematic alcohol use.

The study presented in the second chapter highlights results from a research carried out in a London Category B male prison, where ten adult inmates with alcohol problems were interviewed about their experiences. A Grounded Theory approach was used to analyse the data and the core category, 'releasing the imprisoned selves', was developed to embrace participants' experiences. Four higher-level categories were developed: 'perceiving a self out of control', 'choosing abstinence', 'encountering the sober self', and 'foreseeing a self out of control'. 'Releasing the imprisoned selves' described participants' journey into gaining freedom from a perceived alcohol-controlled self whilst implementing strategies to reduce the loss of control induced by imprisonment. Choosing abstinence contributed by partially releasing the self from imprisonment (i.e., the self in prison) by gaining enhanced status and various privileges. Abstinence also appeared to be influenced by the desire to break free from the alcohol-controlled self, which was also perceived as the main contributing factor leading to imprisonment. Choosing abstinence allowed participants to step into a very different self (the sober self), which appeared to be the recipient of those desirable qualities that the alcohol-control self seemed to lack. Finally, despite high levels of commitment and planning surrounding a desire for a better future, participants shared a feeling of resignation regarding their perceived powerlessness against alcohol, and feared the possibility of retreating back to the alcohol-controlled self upon release.

These findings contribute to the understanding of identity transformation within the context of behavioural change in people with problematic substance use. They also draw attention to the need to implement a wider range of treatment choice, reflecting the diversity of alcohol problem experiences, and to be able to respond to the specific environmental characteristics unique to the prison setting.

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To all of them I dedicate this work, hoping it will give justice to their voices and opening the way to a long-desired better future.

ABBREVIATIONS

AA:	Alcoholics Anonymous
CARAT:	Counselling, Assessment, Referral, Advice and Throughcare service
IMR:	Inmate Medical Record
MDT:	Mandatory Drug Testing
PASRO:	Prisons Addressing Substance Related Offending
Rapt:	Rehabilitation for Addicted Prisoners Trust
SOTP:	Sex Offender Treatment Programme
VPU:	Vulnerable Prisoners Unit
VTU:	Voluntary Testing Unit

CHAPTER 1: SYSTEMATIC REVIEW

What is Known About the Experience of Inmates with a History of Substance Dependence Incarcerated in England and Wales from the Introduction of the 1998 Drug Strategy to Date?

1.1 Background

This introduction will firstly outline the prevalence of substance dependence in the general population, followed by a summary of its prevalence within the Prison Service in England and Wales. This will be followed by a description of the challenges and difficulties faced by the prison staff as a result of substance dependence in inmates and a discussion around the need to implement appropriate services in order to support inmates with substance problems and facilitate the work of those who take care of them. In the final two sections the history of services provision within the Prison Service will be briefly outlined, followed by a summary of the empirical research investigating inmates' experiences of the services available prior to the introduction of the 1998 Prison Service Drug Strategy.

1.1.1 The Problem of Substance Dependence in Prisons

The increasing growth of substance dependence in the last three decades has been acknowledged worldwide and it represents an area of great concern (Farrell, 2005;

DoH, 2007). The current Health Profile of England shows that over the last five years there has been very little progress in the area of drug dependence where the situation is described as "stable" (DoH, 2007, p. 19). Alcohol related admissions to hospitals are increasingly high with deaths caused by cirrhosis and chronic liver disease dramatically rising since the mid-1990s, particularly for females (DoH, 2007).

In 2002, research commissioned by the Home Office showed that one third of the crime related to theft can be linked to the purchase of heroin or crack cocaine. Therefore, it is not surprising perhaps that there is evidence suggesting that drug and alcohol dependence is widespread among the prison population (Home Office, 2002). It is estimated that between 30 and 50 per cent of the prison population has a history of substance dependence (Haggard-Grann, et al., 2005). A survey published in 2002 revealed that in the preceding 12 months before imprisonment over half of all inmates had used an illegal drug (Social Exclusion Unit, 2002).

Research in the field has also shown that many inmates continue to use drugs during incarceration (Turnbull et al., 1994; Singleton, Farrell and Meltzer, 1999; Boys et al., 2002; Bullock, 2003; Singleton et al., 2005). More alarming is the evidence reporting stigma attached to inmates with drugs and alcohol problems, in particular for injecting behaviours, which is clearly likely to influence disclosure of dependency (Swann and James, 1998). It is therefore likely that the percentage of inmates reporting drug and alcohol problems might not represent the actual size of the problem (Swann and James, 1998).

The scarce availability of drugs and the long hours locked up in a cell are only a few of the many issues facing the general prison population with a history of substance dependence. As heroin is the second most used drug in prison (Bullock,

2003) the limited amount of injecting equipment represents one of the major problems within custodial care, linked to the spreading of blood-borne diseases (i.e., HIV, Hepatitis B and C). Preventing these behaviours is also important in connection with the danger of these infections being transferred onto the community upon release (Farrell, 2005).

Other important drug-related health problems include overdose and the general health of those who use them. Inmates with substance problems are also more at risk of suicide within the first month of arrival in prison (Shaw et al., 2004). In 2001, sixty-two percent of inmates who committed suicide were identified as having drug problems (Shaw et al., 2004).

Moore (2007) reported that more than 50 per cent of offenders that have substance dependence perceived themselves as very likely to re-offend in the future. For a quarter of them, drugs were seen as the reason leading to further offending. Since drug use is a predictor of recidivism, by reducing drug use within prisons and relapse on release, drug-related crimes could also significantly decrease (Home Office, 2002).

Prison staff are also greatly affected by substance dependence, challenged by inmates' withdrawal symptoms and constantly required to keep a balance between the security of the prison and a 'more human' approach in dealing with a population in distress. The Prison Service undoubtedly faces tremendous challenges in the delivery of healthcare services to inmates affected by substance dependence. Clearly, prisons should provide a standard of support that is not inferior to that received by the general population. Custodial admission of an individual with substance dependence also represents a unique chance of reaching a population that rarely seeks medical support in the community (HM Prison Service, 1998).

1.1.2 Prison Service Management of Substance Dependence

In more than a decade, the Prison Service's response to the problem of substance dependence has been characterised by a slow and difficult process of implementing drug strategies with the double aim of reducing drug supply and satisfying inmates' treatment needs.

The 1995 Prison Service Drug Strategy saw the introduction of random Mandatory Drug Testing (MDT) and focussed on reducing drug supply and demand as well as providing rehabilitation for inmates with drug problems. In addition, the strategy intended to implement a variety of measures aiming at the reduction of potential health damage caused by the use of drugs to inmates, staff and the community (HM Prison Service, 1995). Despite clear intentions to provide rehabilitation to inmates with drug problems, the strong emphasis on control and security measures was clearly prioritised over the implementation of inmates' therapeutic and educational needs (Malloch, 2000b; Hucklesby and Wilkinson, 2001).

Although the strategy stressed the importance of inmates' support, the lack of resources largely affected the implementation of therapeutic services throughout England and Wales. As Malloch suggested (2000b), existing and new budgetary resources were immediately allocated to the highly expensive Mandatory Drug Testing (MDT) and to the improvement of security measures (e.g., security of the perimeter, an increase in searches of visitors and inmates, drug detection dogs, CCTV and so on) (Drug Prevention Advisory Service, 1999).

This inevitably created an inhospitable ground for the introduction of therapeutic and educational support in many English and Welsh prisons. Where

possible at all, support was provided to inmates with drug dependence only, hence excluding inmates who suffered from alcohol problems (Health Advisory Committee for the Prison Service, 1997). The implementation of alcohol-related treatment and support for inmates was not regarded as a priority and in the 1995 drug strategy document no mention was made of it (HM Prison Service, 1995).

In 1997, HMP Downview was the only prison in England and Wales where a therapeutic group for substance dependence was made available to inmates with drug and/or alcohol problems (Health Advisory Committee for the Prison Service, 1997).

It was not until the subsequent 1998 Prison Service Drug Strategy that, following a three-year implementation and with an increasing awareness of the challenging aspects of substance dependence, the emphasis began to shift its focus towards supporting inmates rather than focusing only on increasing security measures. The 1998 policy aimed at reducing both the supply of illegal substances and inmates' demand (HM Prison Service, 1998). For the first time inmates experiencing alcohol dependence were acknowledged and included in the strategy, although still not at a same level of importance as those inmates with drug problems.

The 1998 drug strategy took effect in all prisons in England and Wales and was built around the aims of the Government's ten-year national plan for tackling drug dependence (Cabinet Office, 1998) and accordingly updated in 2002 (Home Office, 2002). The core of the new strategy's aims did not greatly differ from the previous strategy, as it still intended to focus on supporting inmates with substance problems through the implementation of treatment, security and enforcement. However, the Prison Service received additional funds towards the implementation of the new CARATs framework (Counselling, Assessment, Referral, Advice and Throughcare service) (Drug Prevention Advisory Service, 1999). In the history of the prison drug

strategies, the CARATs framework was finally able to provide the much needed link between prison and a variety of agencies in the community, by bridging custodial care to post-release support (Drug Prevention Advisory Service, 1999). In addition, the availability of funds made possible the emergence of programmes such as RAPt's 12-step (Rehabilitation for Addicted Prisoners Trust), although with a strong emphasis aimed at inmates with drug problems. To date, very few prisons in England and Wales have enough places to be able to accept on the RAPt course inmates with solely alcohol problems (CARAT worker, personal communication).

The introduction of drug-free wings (i.e., VTUs - Voluntary Testing Units) was also an important element of the 1998 drug strategy, which met the needs of many inmates who were eager to spend their time in custody within an environment free of drugs (HM Prison Service, 1998). Finally, a new single unit was established in the Prison Service Headquarters with the aim of leading the service's response to the national plan, providing an independent evaluation of the services provided and monitoring the implementation's performance.

1.1.3 Research into Experiences of Inmates with Substance Dependence

Prior to the introduction of the 1998 drug strategy, studies investigating the experiences of inmates with substance dependence have generally highlighted a lack of adequate treatment. In 1997, Keene reported that inmates had feelings of mistrust and uncertainty regarding medical staff's decisions and treatment. In Hughes' study (2000), ex- inmates' experiences of custody (mainly prior to 1998) were characterised by inadequate support for withdrawal symptoms. Prison healthcare was

perceived as inconsistent in prescribing substitute drugs and medications to alleviate the symptoms (e.g., anti-depressants, painkillers). Moreover, detoxification programmes were perceived as being too short and of poor quality.

In addition, there was a general feeling that prison staff discriminated against inmates with drug dependence, a stigma, particularly attached to those who used drugs by injecting (Swann and James, 1998).

Similar findings were reported in a study focusing on female inmates. Malloch's research (2000b) was carried out between 1992 and 1995 and, in addition to a general lack of support for those who were experiencing drug problems, inmates also reported reluctance to disclose substance problems at reception in order to avoid stigmatisation by prison staff. Inmates highlighted that the fear of stigma and the consequent avoidance of disclosure led to the continued use of drugs within the prison.

1.2 Objectives of this Study

The aim of the present review was to gather, explore and synthesise relevant empirical evidence focusing on inmates with substance dependence incarcerated in England and Wales after the introduction of the prison drug strategy in 1998. Here the definition of 'substance dependence' implies: "a strong desire to take (a substance), difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to (substance) use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state" (NTA, 2006, p. 8). The decision to use the word 'dependence' in the present review was

influenced by its wide use in the literature here discussed. This will be at times replaced by other words such as 'substance/drug/alcohol problems' and 'problematic substance/drug/alcohol use'. Ultimately, the review sought to provide an insight into the kind of support (if any at all) that inmates with substance dependence would benefit from. For this purpose both qualitative and quantitative literature was searched for. This choice was two-fold. First, it was determined by the belief that the answer to the question could be found in studies using either approach and/or a combination of them. Second, as the literature suggests (Pound et al., 2005; Dixon-Woods et al., 2006), qualitative methodologies are poorly indexed in most electronic databases and this increases the likelihood of missing many studies of this kind during a search if specifically searching for qualitative research. Therefore, for the present review the search parameters included key terms focusing around substance problems and no key terms specifically concerned with the methodology used (e.g., Grounded Theory) were included. This choice enabled the retrieval of any study that focussed on inmates with substance problems and dependence.

1.3 Methods

1.3.1 Developing a Search Strategy

The review question was broken down into different facets, which were used to develop synonyms, spelling variants and abbreviations. In addition, existing references and systematic reviews in the area were used to select terms for the text terms list. A combination of various groups of terms related to three specific

parameters were used: (1) criminal justice system, e.g., "prison*", "inmate*", "incarcerat*"; (2) drugs, e.g., "substance*", "alcohol", "heroin", "inject*" and; (3) behaviour, e.g., "dependence", "abuse", "misuse". Each facet was used to identify databases' subject headings (e.g., drug$ adj misuse, substance adj dependence).

Where possible, 'high level' terms were 'exploded' to capture narrower terms (e.g., alcoholism, substance abuse, intravenous, substance withdrawal syndrome). Finally, in order to direct the search towards articles of interest for the review, Boolean logic was used to combine the obtained components (i.e., OR, AND only).

The need to develop search strategies that could be sensitive to the variety of databases' indexes and therefore could be used in all, required performing a series of pilot searches where different parameters were tested and compared. This lengthy process was crucial in order to become familiar with the diverse electronic databases. The whole process was also discussed with an experienced professional in the field.

In order to maximise the yield of potentially relevant literature, the final search strategies (see Appendix A) were constructed so as to favour sensitivity (Glanville, 2001). Consequently, these strategies had a very low specificity and a large number of irrelevant papers was retrieved and then excluded. Only studies in English language were included.

1.3.2 Search Methods for Identification of Studies

Eight electronic databases were searched from 1998 (the year in which the Prison Service Drug Strategy was first introduced) to September/October 2007. These are listed in Table 1.

The identification of grey literature, including very recent publications and

published material that might have been missed in the electronic databases, was searched as follows:

The reference lists of retrieved publications were scanned for relevant studies. In addition, the Prison Health Research Network database was searched using key terms related to "prison", "substances" and "dependence" (see Appendix A). The Prison Service Journal, a key journal in the area that includes articles of published and unpublished research as well as key information on policy changes within the Prison Service, was hand searched. The search included all issues from January 1998 (issue 115) to September 2007 (issue 173).

Unpublished research such as dissertations and theses were searched via CINAHL database. Other sources such as conference proceedings and reports issued by government bodies (e.g., Home Office and the Department of Health) were searched using Zetoc database. The University librarian was consulted in order to discuss the relevance of different databases and to make sure that search parameters had been appropriately designed. Finally, the consultation of experts in the area of substance use within the Prison Service was sought in order to identify promising studies.

Table 1

Electronic Databases Searched

Database	Interface	Dates searched
ASSIA	CSA Illumina	1998–October 2007
CINAHL	Ovid	1998–October 2007
Embase	Ovid	1998–October 2007
ISI Science Citation Index and ISI Social Science Citation Index	Web of Knowledge	1998–October 2007
Medline	Ovid	1998–October 2007
Medline Daily Update	Ovid	23 September 2007
Medline In Process & Other Non-Indexed Citations	Ovid	23 September 2007
PsycINFO	Ovid	1998–October 2007
Prison Health Research Network	N/A	1998–October 2007
Zetoc	Mimas	1998–October 2007

1.3.3 Study Selection Criteria

In order to be included in the present review, papers had to meet following criteria:

1. The aim of the study was to investigate the experience of inmates with a history of substance dependence (illicit/licit drugs and/or alcohol) prior to incarceration (either self-reported or assessed);
2. Data collection and participants' experiences of custody took place anytime from the year 1998 onwards;

3. Participants were remanded and/or sentenced inmates;
4. Inmates recruited were adults of either sex (females and/or males);
5. The paper reports findings from an empirical study where data was analysed by using quantitative, qualitative or mixed methods; and
6. Inmates were recruited within prison/s of any category situated in England or Wales.

1.3.4 Study Selection

As one author only undertook the present review, the steps of study selection were shared and agreed with the University assigned supervisor. Following the screening of titles, abstracts and references of relevant papers, a list of promising studies was retrieved for further investigation. The retrieving of full texts also included papers lacking an abstract or studies where the abstract presented inadequate information hence impairing the ability to be discarded or included. Based on the eligibility criteria, studies were finally evaluated for inclusion or exclusion.

1.3.5 Assessment of Methodological Quality

The literature (Pound et al., 2005; Dixon-Woods et al., 2006) shows an ongoing debate about the usefulness of appraising qualitative studies for inclusion/exclusion in a synthesis. As Pound et al. (2005) report, articles of poor quality seem unable to have a strong impact in a synthesis as their contribution is generally very little or

none.

With regard to suggested practices in using meta-ethnography, Noblit and Hare (1988) seem to comfortably disregard the appraisal of articles on the ground of quality before including them in the data-synthesis. The authors agree with Hunter et al.'s position (1982), whose argument is contrary to the exclusion of methodologically poor studies, as this would denature the inductive feature common to all syntheses.

With regard to the present review and in the light of the limited availability of research in the field, studies were not assessed and discarded on quality grounds, but solely if they were found to be incongruent with inclusion criteria.

1.3.6 Data Synthesis

The studies were synthesised following the principles of meta-ethnography, as outlined by Noblit and Hare (1998). This approach is considered an effective and well-developed method for qualitative data-syntheses (Britten et al., 2002; Pound et al., 2005).

Meta-ethnography includes three possible approaches to synthesising qualitative data: reciprocal translation, refutational translation and lines-of-argument (Noblit and Hare, 1988). As outlined by the authors (Noblit and Hare, 1988), a reciprocal translation is used when the studies to be synthesised yield findings that are comparable, whereas a refutational synthesis is preferred when the studies yield findings that stand in opposition to each other. The last approach, the lines-of-argument synthesis, focuses on clinical inference and can be carried out as a further

stage following a reciprocal translation (Noblit and Hare, 1988). At this stage, studies' similarities and dissimilarities are considered in a new interpretative context, hence enabling the results from the reciprocal translation to achieve a further step of analysis (Noblit and Hare, 1988).

1.4 Results

1.4.1 Systematic Selection of Studies

The searches yielded a total of 3080 references retrieved. For detailed aspects of numbers of references retrieved in each database please refer to Appendix A. From the 3080 references retrieved, 1567 abstracts were screened and the full texts of 18 studies were obtained and fully read. The study selection process is reported in Table 2.

Table 2

Study Selection Process

Total references retrieved	3080
Rejected at title	1513
Total abstracts screened	1567
No abstract; paper not available	0
Rejected at abstract	1549
Total full papers screened	18
Rejected full papers	12
Total papers preliminary inclusion	6
Included papers	6
Rejected following, or in the absence of, information from authors	0
Excluded from data-synthesis	1

Note. Duplicates were not excluded from the total number of references retrieved.

Following a meticulous examination, 6 studies were excluded.

Reasons for exclusion were:

[1] The paper does not report findings from an empirical study (3 studies)

[2] Data was not collected in England or Wales (3 studies)

[3] Data was collected before 1998 (5 studies)

[4] Data from Scottish and English prisons and from young offenders and adults was combined. Data collected before 1998 (i.e., 1993) could not be clearly distinguished from data obtained after 1998 (1 study)

For details of excluded studies please refer to Appendix B section.

A total of six studies met the inclusion criteria, five of which were included in the data-synthesis.

Borrill et al.'s study (2003) was initially included in the review as it focussed on the experiences of inmates with substance dependence and met the inclusion criteria, but subsequently this study was excluded from the synthesis. The study (Borrill et al., 2003) used a mixed-methods design whereby qualitative data was collected by interviewing prison staff involved in the delivery of prison-based drug services. Quantitative data concerned with inmates' experiences was obtained through the use of various questionnaires. However, because of the use of a quantitative approach the findings remained at a descriptive level rather than exploring the issues in depth.

Borrill et al.'s study (2003) certainly highlighted a variety of important issues such as inmates' general dissatisfaction with the availability and delivery of drug services, as well as the paucity of services for those who are dependent on alcohol. However, the same issues had been explored in the other included studies and it appeared that the findings highlighted by Borrill et al. (2003) were unable to add new

layers of knowledge to those reported in greater detail by the other authors (Crewe, 2005; Fountain et al., 2007; Smith and Ferguson, 2005; Squirrell, 2007; Tompkins et al., 2007). Furthermore, by excluding the only quantitative study that met the inclusion criteria, the remaining data (i.e., qualitative) could be synthesised using an approach specifically designed for qualitative research (i.e., meta-ethnography).

1.4.2 Meta-ethnographic Synthesis

The five studies retained for the data-synthesis were found to cluster into two 'sets'. Four studies investigated how individuals involved with the Criminal Justice System experienced provision of care for substance dependence (Fountain et al., 2007; Smith and Ferguson, 2005; Squirrell, 2007; Tompkins et al., 2007).

Smith and Ferguson (2005) collected their data from a specific drug rehabilitation unit, which was separate from the rest of the prison. Squirrell (2007) included data about individuals' experience of treatment in the community and Tompkins et al.'s study (2007) focussed on injecting drug users and their experiences of treatment in prison. Similarly, Fountain et al.'s study (2007) was concerned with inmates' experiences of drug services, with a focus on the black and minority groups.

One study examined how drugs, and in particular heroin, influence prison social processes (Crewe, 2005). The aims and focus of Crewe's study (2005) greatly differed from those of the other studies and at the outset it was unclear whether it could be included in the synthesis. However, Crewe's study (2005) contained smaller sections, which specifically focussed on the experiences of inmates with drug problems. Here, similarly to the other four studies, issues of treatment were reported.

This made it possible to extrapolate those sections and to include the study in the synthesis.

Out of the five studies included in the synthesis, one was retrospective (Tompkins et al., 2007) and two included both retrospective and non-retrospective data (Fountain et al. 2007; Squirrell, 2007). During the preliminary stages of the synthesis it was at times difficult to distinguish extracts relating to participants' experiences of custody before and after 1998. Consequently, where in doubt the authors from two studies (i.e., Squirrell and Tompkins) were contacted to seek clarification on whether specific sections of the findings pertained to experiences that took place prior to or after 1998. Both authors were able to provide helpful information in order to guide the process of extracting relevant sections.

In addition, the majority of the retrieved studies included themes concerned with experiences that had happened outside prison, whether in community treatment centres (Squirrell, 2007; Tompkins et al., 2007) or more generally concerned with participants' initiation with substance use prior to entering custody (Smith and Ferguson, 2005).

Moreover, Crewe's paper (2005) included data from inmates that did not have substance dependence and/or did not use drugs, as well as data from prison staff; these sections were excluded. Finally, some sections from Fountain et al.'s study (2007) also had to be excluded from the synthesis as they reported findings from young offenders, prison staff and other individuals involved in supporting people with drug dependence within the community.

Table 3 reports details of the studies included in the data-synthesis.

Table 3

Articles Included in the Data-synthesis

Authors	Crewe (2005)	Fountain et al. (2007)	Smith and Ferguson (2005)	Squirrell (2007)	Tompkins et al. (2007)
Aim/s	To explore how drugs (in particular heroin) influence inmates' social world.	To identify facilitators and barriers to accessing prison drug services. To highlight those affecting black and ethnic minority inmates.	To investigate how inmates enrolled in drug rehabilitation treatment manage and negotiate drug dependence and recovery.	To explore peoples' experiences of the substance dependence treatment provided by the Criminal Justice System.	To shed light on injecting drug users' experiences of treatment in English prisons.
Sample	Adult male inmates with and without substance-related dependence and prison staff.	Black and ethnic minority (N=76) and white inmates (N=73) enrolled and non-enrolled in drug treatment services. 8 ex-inmates from black and minority ethnic communities (adult/young males/females)*	11 adult male inmates with substance-related dependence.	30 adult males and 3 adult women.	51 injecting drug users: 42 adult males (including 6 from a black or minority ethnic group) and 9 adult females.
Data Collection	Interviews and field notes	Interviews and field notes	Interviews	Interviews	Interviews
Setting	HMP Wellingborough (Cat C Prison). East Midlands	8 prisons and 135 community-based drug services establishments in England and Wales	11 Ps were interviewed at admission into a prison-based Drug Rehabilitation Programme, 6 of whom were again interviewed 4 weeks later. England	29 Ps were in community-based dry accommodations and 4 in prison. England	Drug services in 3 locations across West Yorkshire
Substance type/s	Heroin	Unspecified by the authors. The accounts reported the use of cannabis, crack cocaine, cocaine, heroin and prescription drugs	Unspecified by the authors. The accounts reported the use of heroin and crack cocaine	Unspecified by the author. The accounts reported the use of cannabis, crack cocaine, heroin, and alcohol	Amphetamines, crack cocaine, and heroin
Design	Ethnography	Thematic analysis	Grounded Theory (Glaser & Strauss)	Narrative and life story approaches	Framework approach

**Note.* Data was collected from a total of 334 participants and the sample also included young offenders, prison staff and other individuals involved in supporting people with drug dependence within the community.

Since for the present synthesis only relevant parts of the studies' findings were included, the first step was to read the papers many times and to produce a summary of all relevant findings from each study individually. This included both the authors' analysis and comments and the participants' quotes. The summary obtained enabled the generation of a clearer structure that led to an easier identification of those key concepts recurring across them all. In addition, it is important to emphasise that only the concepts with the strongest impact were included in the synthesis and that this inevitably led to the loss of more peripheral (but still valuable) findings (Paterson, Thorne and Dewis, 1998).

As the studies were found to be fundamentally comparable, a reciprocal translation synthesis was carried out. This was followed by a line-of-argument synthesis. Specifically, following the principles of meta-ethnography (Noblit and Hare, 1988), the synthesis started with a careful and repeated reading of the relevant findings from each article (i.e., reported in the summary). This phase yielded the development of first-order constructs or key concepts and their relationship across the studies. At this point, the first-order constructs were translated across studies in order to produce a series of second-order constructs (see Table 4). In the final phase, the resulting second-order constructs were synthesised to produce third-order constructs through a line-of-argument synthesis.

Table 4

Key Concepts and Second-order Interpretations

Authors	Meanings of imprisonment	Through-care: experiences and perceptions	Environment
Crewe (2005)	'It's in prison that I'm able to control my life more [...] I'm happier.' (p.474) 'The real me.' (p.473)		'Deny any suggestion of [drug] dependency or lack of control.' (p.468)
Fountain et al. (2007)		'The staff are not trained.' (p.26) 'It really depends on which worker you get.' (p.57) 'I cannot talk to them [drug services] because I am dyslexic.' (p.34) 'It is not transparent' (p.32) 'No aftercare.' (p.61)	'Using [therapeutic community] as a feather in their cap.' (p.35) 'In front of everyone.' (p.38) 'Guinea pig.' (p.39)
Smith and Ferguson (2005)	'Change the attitudes of the way [...] people look at me.' (p.63) 'The only opportunity I had.' (p.63) 'Having a rest.' (p. 62)	'You can't do it on your own' (p.65)	'It's tempting' (p.65) '[They] tak[e] the piss out of everyone who wants to try [to stop using].' (p.65)
Squirrell (2007)		'[P]rison officers' attitudes towards users are bad.'(p.68) 'The prison officers don't know anything.' (p.66) 'You have to do a couple of years [to get help].' (p.67) 'Let down on completion.' (p.67)	'Exposing those working on their drug problems to risks of relapse' (p.66) 'People sign up for course because it looks good and because they're locked up and it's a special little treat.' (p.66)
Tompkins et al. (2007)	'The safest thing was go to prison.' (p.197)	'It was just luck.' (p.69) 'Self-inflicted' (p.195) 'they don't actually believe that you're ill if you say you're ill.' (p.195) 'It's whether you land lucky or not.' (p.194)	'Influence of other prisoners' (p.193) 'Stigma' (p.195)

Note. The key concepts are reported in the authors' and participants' original words from the studies. These were translated and grouped together within three second-order interpretations.

1.4.3 Findings of the Reciprocal Translation Synthesis

Several inmates commented that, over the past 10 years, the Prison Service's level of treatment and care for inmates with substance dependence has improved. These improvements have particularly affected inmates with heroin dependence. As one participant expressed it: "It has changed quite a bit inside now actually. They seem to have got their act together" (Tompkins et al., 2007, p. 198). However, none of the papers specifically looked at these differences by comparing experiences of care prior to and post 1998; rather, the studies focused on inmates' experiences of the current level of care. The present review focuses on the experiences of inmates with substance dependence in custody in England and Wales since 1998.

The key concepts identified in the studies, and the relationships between them, are reported within the second-order interpretations emerging during the synthesis.

Three second-order constructs emerged from the translation of the studies' key concepts into one another: (i) 'meanings of imprisonment'; (ii) 'through-care: experiences and perceptions'; and (iii) 'environment' (see Table 4).

1.4.3.1 Meanings of Imprisonment

In order to appreciate the experiences of inmates with substance dependence, it is important to understand what was their quality of life prior to custodial admission.

The majority of studies included in the present synthesis reported that inmates experienced their dependence as exhausting and painful. The effects of this dependence pushed many of them to seek treatment during incarceration.

Several studies reported how participants' desire to seek care and treatment was triggered by a complex set of feelings related to their perceived level of

dependence (Crewe, 2005; Smith and Ferguson, 2005; Tompkins et al., 2007). As one of Crewe's (2005) participants stated: "I don't have control of my life, heroin has a control over my life. [...] It's in prison that I'm able to control my life more...and I'm happy, I'm happier" (Crewe, 2005, p. 474). Moreover, as Smith and Ferguson (2005) reported, the motivation to seek help was often triggered as a response to the disapproving attitude of family members and friends: "I just decided that maybe if I helped myself, that it might change the attitudes of the way my family and that, and other people look at me" (Smith and Ferguson, 2005, p. 59). Tompkins et al. (2007) reported that access to detoxification programmes was quicker in prison than in the community and this meant that for many inmates incarceration was not just the only viable option to quickly address their dependence, but also represented a safe refuge able to provide the security of basic needs such as having a bed and three meals a day.

Crewe (2005) reported that living in custody allowed participants to look at themselves in a different light. Compared to life in custody, living outside was described as false and unreal because filtered through the eyes of the dependence. On the contrary, prison life was perceived as the place to face reality, as this participant expressed:

> It's not as if I come to prison and put a mask on. I come to prison and I revert to *me*. This is me, the *real* me. Outside I'm totally false. I'm lying, cheating, swindling, robbing. It's a chemical lifestyle I lead outside. My whole character changes. (Crewe, 2005, p. 473).

Accordingly, Crewe (2005) also reported that, for many inmates, friends made during incarceration, 'with perfectly clear heads', were to be considered real friends, compared to people met on the outside under the effects of heroin (p. 473). In this

sense, prison encapsulated a re-discovered sense of reality that could be finally trusted and relied upon. Smith and Ferguson (2005) also reported that participants regarded imprisonment as a way to interrupt the unbearable vicious circle caused by drug dependence, where taking drugs had lost its pleasurable effect and only served the purpose of escaping from painful withdrawal symptoms. Indeed, the desire for a change and the potential relief given by imprisonment was so strongly welcomed that, as Crewe (2005) and Tompkins et al. (2007) reported, it often reached the point of actively seeking incarceration as the only viable alternative to a life permeated by suffering:

> When I was on the street and on heroin, I knew then that I was ready, I wanted to go to prison, I know it sounds mad. For me, prison, is the only place you can come and get off the drugs and stay clean [...] when I got locked up it was sort of godsend. [...] I was homeless, I was a drug addict, so no I didn't have control of my life.
>
> *Interviewer: 'So is being in prison less bad than being on heroin out there? How do they compare?'*
>
> I'd prefer to be sat here now than I would to be on heroin out there. I know it sounds mad. (Crewe, 2005, p. 474)

1.4.3.2 Throughcare: Experiences and Perceptions

The second factor permeating inmates' experiences of incarceration centred on the experiences and perceptions of care emerging from the accounts. This was divided into the following four sub-themes: prison staff competence and support; accessibility; chance and transparency; and post-rehabilitation/post-release.

1.4.3.2.1 Prison staff competence and support.

The majority of the studies reported that inmates' experiences of staff widely differed across interviews and their perceptions varied accordingly (Fountain et al., 2007; Smith and Ferguson, 2005; Squirrell, 2007; Tompkins et al., 2007). Smith and Ferguson (2005) indicated that, despite the difference in perceptions, all participants emphasised the importance of prison staff support in order to abstain from drugs. Squirrell (2007) reported that many of the inmates who found prison staff unhelpful did so as a consequence of having suffered stigmatisation. The stigma was expressed through derisive comments made by prison officers towards those who, in order to seek help, had decided to disclose their drug use. In Tompkins et al.'s study (2007), inmates' negative perceptions of prison staff also encompassed doctors and nurses; some of them were renowned for refusing to give medications and generally lacking empathy, as one participant recounted: "He [doctor] said to me, 'self-inflicted, nowt but a good 20 press ups and a good wank wont cure'" (Tompkins et al., 2007, p. 195). Once again, other inmates expressed positive views of doctors showing that there was clearly a lack of consistency in the level of care as well as in the attitude of prison staff towards inmates with substance dependence. Tompkins et al.'s study (2007) generally revealed a sense of uncertainty surrounding the unpredictability of staff's attitudes as well as at times the lack of a caring attitude. Squirrell (2007) reported that participants felt that in some cases staff's level of competence and motivation was very limited and inadequate. This perception was particularly prominent when prison officers were running drug-related programmes, as this participant expressed:

> PASRO, short duration drugs awareness courses and relapse prevention courses. They don't work. It's people talking to me. A prison officer's in the

chair and he's telling you and he's had three days' training. They don't want to do it. They're just doing it and that's it. (Squirrell, 2007, p. 66)

Similarly, Fountain et al. (2007) reported low levels of satisfaction with officers who also acted as counsellors as well as staff running group-works; participants felt that they generally lacked knowledge and training to specifically address drug dependence. In addition, officers' attitudes were perceived as discriminatory and predominantly confrontational and this was described as unhelpful as it jeopardised the possibility of engendering self-reflection (Fountain et al., 2007). However, the authors also reported how this view was shaped and modulated by the array of different counsellors and workers that individual inmates had been assigned to. Some participants reported high levels of satisfaction and were able to distinguish between those counsellors who showed dedication to their job and others who were less committed, as this participant clarified: "There are two workers that are brilliant. The rest of them can't be bothered. It really depends on which worker you get" (Fountain et al., 2007, p. 57).

1.4.3.2.2 Accessibility.

Three studies highlighted barriers to accessing custodial care such as doctor appointments and drug programmes (Fountain et al., 2007; Squirrell, 2007; Tompkins et al., 2007).

Fountain et al. (2007) reported that not all prisons provided detoxification upon admission, leading to self-harm and depression amongst inmates with drug dependence. Where detoxification was available, inmates were often faced with the inability to access it due to an array of different contingencies. For example, inmates who were coming from police custody and those who were admitted during

weekends and bank holidays (when it is not possible to test their blood immediately) often failed to be acknowledged as dependent on drugs, since at that point no trace of drug could be found in their blood. Similarly, Fountain et al. (2007) also highlighted how this concern equally applied to inmates who, for various reasons such as fear of reprisal, did not disclose their drug use upon admission and later decided to seek help. One participant explained it as follows:

> If at first you say you don't use, if you come back and say 'I take drugs,' they will do a test to see if it is there in your system. If there are no drugs in your system, then you don't get help with medication, even if you are still feeling aches and pains [withdrawal symptoms]. So if you tell them that you were on drugs as soon as you come in, when it is still in your system, then it may be easier [to obtain detoxification services]. But many people are afraid to tell at that stage because they are worried of the consequences. (Fountain et al., 2007, p. 56)

Squirrell (2007) reported that difficulties in obtaining care arose in particular for inmates who stayed in prison for a short period of time, whether this was due to a short sentence or because they were transferred to a different prison. As Squirrell (2007) and Fountain et al. (2007) highlighted, spending limited time in one prison coupled with the long waiting lists to access drug programmes, jeopardised the possibility of accessing treatment. Squirrell (2007) pointed out that another barrier for inmates with short sentences had to do with entry criteria for courses designed to support inmates with drug dependence, as the majority of these programmes are only accessible to inmates serving long sentences. It appears that the majority of inmates built their hopes and tried to seek help, only to be turned down by the system in many cases. This was received with a sense of disappointment and disengagement

with drug treatment, as this participant recounted: "...takes three or four weeks for them to get in touch and in that time you get frustrated and get a bag [of heroin]" (Fountain et al., 2007, p. 33).

Tompkins et al. (2007) reported how poor communication between service providers outside and inside prison affected the continuity of substitute medications from the community to prison. This represented a major area of concern, in particular for inmates with short sentences who were unable to immediately access their substitute medications at the same dosing level accessed prior to imprisonment. In some cases, as the authors reported, the dosing level obtained in prison was higher than that previously accessed in the community, leading to relapse upon release (Tompkins et al., 2007).

Tompkins et al. (2007) also reported how inmates had difficulties in accessing doctors due to long waiting lists. In some cases, it was felt that access to treatment was dependent upon medical staff's judgement of inmates' requests for help; at times this was perceived to be non-genuine, as this participant explained:

> You've gotta go through umpteen nurses to get to see a doctor and I genuinely, obviously there must be some girls in there that are on the blag [using deception to gain advantage], but they don't actually believe that you're ill if you say you're ill (Tompkins et al., 2007, p.195)

Fountain et al. (2007) reported that, independently from inmates' level of satisfaction with one-to-one counselling sessions, lack of frequency, duration, structure and generally unreliability of the service (expressed in cancellations and lack of information with regard to times of appointments) were common causes of discontent.

Fountain et al. (2007) reported that accessing drug services was particularly

difficult for inmates whose first language was not English or with low levels of literacy skills, as well as for inmates who had never been in custody before and those with short sentences (Fountain et al., 2007). In addition, access to treatment was often jeopardised by lack of awareness and lengthy application forms, which impacted particularly on foreign inmates and on those with poor literacy skills. The authors (Fountain et al., 2007) reported that generally the majority of inmates who were in contact with prison drug services showed awareness of the range available.

However, this was not the case for those who were not already known by the service. This group showed only limited or a complete lack of awareness of the services available. As the authors pointed out (Fountain et al., 2007), information and access to those services mainly occurred through written information and applications to fill in. As a result, inmates with poor literacy skills were less likely to both gather information and be able to receive care. One participant expressed it as follows: "I have heard people say, 'I cannot talk to them [drug services] because I am dyslexic, there is too much paperwork involved' [in applying for drug services]" (Fountain et al., 2007, p. 34). Fountain et al. (2007) also pointed out that programmes such as the 12-Step programme require written homework, and this makes them automatically inaccessible to those with language and literacy problems.

Fountain et al. (2007) reported a scarcity of treatment and services tailored to the needs of inmates with substance dependence issues other than heroin use, including dependence from prescription drugs. In particular those who reported cannabis dependence highlighted how this was not taken seriously by the drug services, which were unable to provide them with access to specific programmes.

Those who predominantly used stimulants other than crack cocaine were also faced with the unavailability of courses and tailored care as well as with a general

paucity of knowledge amongst drug workers. Fountain et al. (2007) also reported that similar concerns were raised by inmates who were dependent on prescription drugs, as one participant reported: "I asked for help with prescription drug use, but was told that CARATs was not for that" (Fountain et al., 2007, p. 65).

Fountain et al. (2007) reported that provision for alcohol dependence varied across the country; some prisons had little or no provision for alcohol dependence and where Alcoholics Anonymous (AA) groups were available inmates faced difficulties in accessing them (Fountain et al., 2007). Prison officers were generally in charge of informing inmates about AA visits and escorting them to the meetings but often failed to do so (Fountain et al., 2007). However, as Squirrell (2007) pointed out, inmates with alcohol problems very often remained undiagnosed.

Finally, Fountain et al. (2007) reported that amongst inmates there was widespread concern with regard to the priority in treatment and care accorded to those who had heroin problems. As one participant explained: "If you're using heroin you get seen straight away. If not, you get pushed to the back of the queue" (Fountain et al., 2007, p. 64).

1.4.3.2.3 Uncertainty and lack of transparency.

The majority of studies (Fountain et al., 2007; Squirrell, 2007; Tompkins et al., 2007) reported a general lack of transparency and reliability in accessing prison services. Many participants interpreted their inability to access treatment as dependent upon uncontrollable forces such as luck.

Tompkins et al. (2007) illustrated how, in the opinion of inmates, chance or luck ruled over medical staff decisions, since at times receiving treatment was felt to be dependent on the attitude of the doctor during the consultation:

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. It's whether you land lucky or not. (Tompkins et al., 2007, p. 194)

Accordingly, Squirrell highlighted how many inmates experienced "access to treatment as a chance happening" (2007, p. 69). Interestingly, Fountain et al. (2007), who also reported a lack of transparency in accessing treatment, found that this was perceived by the black and minority group as indicative of racism, as this participant complained: "You see white people coming to the [drug-free] wing when black people are there on the waiting list." (Fountain et al., 2007, p. 50).

1.4.3.2.4 Post-rehabilitation and release.

Fountain et al. (2007) and Squirrell (2007) reported how inmates were often faced with the inability to secure after care and support following rehabilitation and upon release, and how this was likely to impair their likelihood of abstaining from drugs, as one participant recounted:

> [I]n the TC rehab (prison-based therapeutic community) six months working on yourself, taking responsibility. I was climbing the ladder. Did really well then released back into the system with 1½ years to go. Not released to a drug-free wing, so I picked up and then lost my chance of parole. My daughter started using then. (Squirrell, 2007, p. 67)

As Squirrell (2007) suggested, this was often due to a lack of space in drug-free accommodations as these are also used for inmates who were not seeking rehabilitation. Clearly, where this was the case, inmates were faced with other inmates' drug use and risked relapsing (Squirrell, 2007).

Fountain et al. (2007) also highlighted issues surrounding the inadequacy of

medication offered to inmates following detoxification programmes.

Concerns surrounding post-release support were also strongly emphasised (Fountain et al., 2007; Squirrell, 2007). These involved both uncertainties in accessing treatments upon release as well as doubts about the effectiveness of those services. As one participant explained, drug services outside prison were likely to be known and frequented by drug dealers and the likelihood of maintaining abstinence could be jeopardised, as in his words: "It's like putting cream in front of a cat and saying 'don't eat it'." (Fountain et al., 2007, p. 69)

Finally, the preoccupation with post-rehabilitation and post-release was often triggered by lack of appropriate information within the prison service. As a result, inmates were faced with a sense of uncertainty and feelings of anxiety, as the following quote illustrates: "What is going to happen when I get out on release? I would like to talk to someone, an ex-prisoners' support group, to release my stress. The Probation Service promised all sorts of help but never delivered." (Fountain et al., 2007, p.69)

1.4.3.3 Environment

The majority of studies (Fountain et al., 2007; Smith and Ferguson, 2005; Squirrell, 2007; Tompkins et al., 2007) reported how inmates' efforts and attempts in abstaining from drug use were in many cases jeopardised by the close vicinity of other inmates who carried on using drugs during imprisonment. Tompkins et al. (2007) highlighted how inmates who were eager to abstain from drugs were faced with the difficulty of sharing a cell with someone who was actively using. Inmates in these situations struggled between the necessity of being moved to a different cell

and the tempting prospect of returning to drug use. In addition, the option of moving cell was made more difficult by having to submit a request without disclosing their cellmate's drug use (Tompkins et al., 2007). Smith and Ferguson (2005) reported that similar barriers to abstinence were to be found in supposedly 'clean' environments such as rehabilitation units and drug-free wings. Here, inmates who were still using drugs often tried to discourage those who were trying to abstain by inviting them to take some of their share or by being derisive towards their efforts to stop using. As a result, many inmates felt tempted to resort to drug use as these attitudes clearly impaired their ability to abstain (Smith and Ferguson, 2005).

As several authors reported (Fountain et al., 2007; Smith and Ferguson, 2005; Squirrell, 2007), the presence of inmates who were not committed to abstaining from drug use within supposedly drug-free environments (e.g., drug-rehabilitation units, drug-free wings and rehabilitation programmes) generated discontent in those who really wanted to try. Inmates found it harder to avoid relapse and felt that their effort and personal investment was being devalued.

As Fountain et al. (2007) and Squirrell (2007) pointed out, there were varied reasons that led inmates who did not have a genuine interest in abstaining from drugs to apply for drug services or to be moved to a drug-free wing. Pragmatic motivations such as securing parole or getting paid were coupled with the advantages of being in a drug-free wing, where advantages such as having a single cell and a TV or being out of cell more often and going to the gym were all part of the package (Fountain et al., 2007; Squirrell, 2007). As one participant explained:

> People sign up for course because it looks good and because they're locked up and it's a special little treat. You go upstairs to do the course, get gym everyday, you're out of your cell and you get paid for it. Some haven't got

any money and they get money for doing the drug course. (Squirrell, 2007, p. 66)

1.4.3.3.1 Stigma and confidentiality.

The majority of studies (Crewe, 2005; Fountain et al., 2007; Tompkins et al., 2007) highlighted inmates' feelings of being discriminated against and stigmatised because of their drug use. Particularly affected were inmates who used heroin, with those injecting the drug being more strongly stigmatised (Crewe, 2005; Fountain et al., 2007; Tompkins et al., 2007). As Tompkins et al. (2007) reported, the stigma attached to both being an inmate and injecting heroin enhanced negative and unsupportive attitudes from prison staff and impaired treatment. As a consequence of these attitudes, some inmates would avoid disclosing their heroin use and only admit occasional consumption (Crewe, 2005). As a result, Fountain et al. (2007) reported that inmates were particularly concerned about the lack of privacy in accessing drug services, as one participant explained:

> When they come to you, half the time they talk to you through the door they don't even open the door...They are civilian workers so they don't have keys for the doors...You don't exactly feel like opening up in front of your pad[cell]mate. (Fountain et al., 2007, p. 37)

Fountain et al. (2007) also highlighted a range of situations where confidentiality and privacy were impaired. The authors reported that in one prison, for example, privacy in accessing drug services (i.e., drop-in CARATs' office) was jeopardised by the room being placed in front of everybody's eyes.

In addition, the double role of some of the prison officers who also worked as part of the drug services was often a reason for concern. As pointed out by Fountain

and colleagues (2007), in one prison an officer who acted as drug worker also administered mandatory drug tests during the weekend. This led in most cases to feelings of mistrust and fear of disclosure by inmates with drug problems. Fountain et al.'s fieldwork observations highlighted to what extent inmates' feelings of mistrust towards staff's ability to maintain confidentiality were based on solid grounds:

> In two of the prisons visited, the prison officers in the CARAT team pressed the research team for information given by inmates during interviews. A civilian CARAT worker in another prison also disregarded confidentiality: the researchers were told details, including the inmate's name, about a one-to-one session that had just been conducted. Later, the researchers overheard the same worker discuss the inmate with a prison officer and divulge information from the session. (Fountain et al., 2007, p. 37)

Some inmates feared negative reprisals from prison officers and worried that their care and life in prison could be negatively affected (Fountain et al., 2007). As one participant said: "In fact, what they [prison officers] do, once they know you're using drugs, they'll start using you as a guinea pig, they will pick on you and test you regular." (p. 39)

Finally, the lack of confidentiality and privacy in accessing treatment was a cause for concern for black and ethnic minority groups, as the cultural stigma associated with the use of heroin or with injecting behaviours is particularly strong within these communities (Fountain et al., 2007). In these instances inmates felt in danger of being seen by another member of their ethnic group outside or inside prison, once again impairing drug use disclosure and willingness to apply for drug rehabilitation support.

1.4.4 Line-of-argument

Overall, the experiences reported by inmates were dominated by two factors. On the one hand, inmates seemed unable to successfully address their dependence issues within the community. As Tompkins et al. (2007) suggested, this might be due to the perceived 'slowness' of community drug services compared to the more straightforward level of care found within the prison service (e.g., immediate detoxification upon arrival), a finding also reported by Squirrell (2007). Therefore imprisonment was experienced as an opportunity to 'get clean' and start a new life (Crewe, 2005; Smith and Ferguson, 2005; Tompkins et al., 2007). The second characteristic dominating inmates' experiences was a lack of control over accessing treatment (Fountain et al., 2007; Squirrell, 2007; Tompkins et al., 2007). The expectation of being treated was seldom met and there was also much uncertainty involved in the way in which prison care provided this support. This emerged in inmates' experiences of a treatment that was not given automatically but that depended upon factors such as chance (e.g., knowing the right person) and luck (e.g., being offered a place in a drug-free wing).

Fountain et al.'s study (2007) was able to highlight these experiences from the viewpoint of the black and ethnic minority groups. As discussed, inmates in these groups interpreted the prevailing feeling of uncertainty surrounding access to care as a sign of racism rather than chance. Other barriers such as stigmatisation from prison staff resulted in feelings of shame and fear in connection with the disclosure of one's substance problem, undermining the possibility of seeking treatment (Crewe, 2005; Squirrell, 2007; Tompkins et al., 2007). The synthesis proposes that facing these experiences of uncertainty creates a sense of 'fatalism', which is disempowering and

is likely to generate a sense of reciprocal mistrust between carers and those who are supposed to be cared for. Therefore, the willingness and desire to be treated in custody (e.g., being arrested 'on purpose') appears embedded in a paradoxical ambivalence about seeking help and support in prison and an inability to completely trust the quality and modality of the support received during incarceration.

Unfortunately, little is known about inmates who are choosing not to disclose their substance dependence and those who experience a variety of different kinds of substance dependence as the majority of the articles retrieved focussed on heroin dependence. The synthesis was nevertheless able to highlight how barriers to treatment linked to fear of stigmatisation were experienced by inmates who did not disclose their drug use and how this could jeopardise seeking treatment. In addition, the synthesis also draws attention to the paucity of care available to inmates with different substance dependencies, including alcohol and prescription medications, and the inequality of treatment available when compared to that provided to inmates with drug dependence and in particular with heroin dependence.

In summary, the life and experiences of inmates with substance dependence is shaped around a sense of stigmatisation embedded within loss of control and uncertainty of care. Stigma and fear of discrimination affect substance use disclosure and generate a sense of ambivalence that ultimately triggers the decision to either seek help or to continue to use. In order to seek support inmates have to overcome the fear of stigmatisation, discrimination and the potential negative consequences from prison staff and from others around them (e.g., members of their community). Inmates who are known to the drug services are still greatly affected by stigma and discrimination. Nevertheless, they somehow manage to face imprisonment with a sense of hope by looking at incarceration as an opportunity to 'revert' to the 'real'

self. In doing so, they hope that this opportunity will bring a better, 'happier' life and will change the way others look at them. However, once in custody, inmates who disclose their substance use face uncertainty of through-care, lack of trained staff, long waiting lists, non-transparency in the process of applying and accessing treatment services, and lack of confidentiality.

1.5 Discussion

The purpose of the present review was to highlight the experiences of inmates with substance dependence, incarcerated in England and Wales following the introduction of the 1998 prison drug strategy. The findings highlighted a paucity of treatment for inmates with alcohol dependence and for those dependent on other drugs such as, for example, prescription medications.

The main findings suggested that inmates with drug dependence (in particular, heroin and crack-cocaine) experience access to treatment as uncertain and inconsistent. The findings also highlighted how inmates' experience of custodial care is affected by perceived stigma and discrimination attached to drug use. There appeared to be differences in perceptions of access to treatment between white inmates and members of the black and minority ethnic group. Although both groups reported perceived stigma, in particular for those who injected drugs, white inmates often tended to interpret the inconsistency in accessing treatment as dependent upon chance, whereas members of the black and minority group mostly perceived this as racial discrimination. The findings also suggested that fear of negative reprisal from prison staff may lead to reluctance in disclosing substance use. In addition, for many

inmates fear of disclosure may be exacerbated by the lack of privacy and confidentiality accorded to them, which puts their drug use and dependence at risk of being divulged to members of their community. Inmates' dissatisfaction with treatment therefore appears to depend not only on the quantity and quality of drug services introduced, but also on levels of anxiety experienced in an environment often perceived as unreliable, discriminatory and charged with uncertainties.

Nevertheless, despite the reported negative experiences, the present review also highlighted that many inmates, in particular those with heroin dependence, may seek incarceration as a form of rehabilitation for drug dependence.

The majority of the present review's findings are consistent with those highlighted by empirical studies carried out prior to the introduction of the 1998 drug strategy. Feelings of mistrust and uncertainty experienced by inmates regarding medical staff's decisions and treatment were already reported by Keene in 1997, and perceived inconsistency in accessing treatment was reported in Hughes' study (2000). The paucity of treatment for inmates with alcohol dependence had already been highlighted by the Health Advisory Committee for the Prison Service (1997).

However, none of the studies carried out prior 1998 reported the lack of care for inmates dependent on prescription medications. A similarity of findings in the literature prior and post 1998 is also traceable in the perceived discriminatory attitudes of prison staff directed to inmates with drug dependence (particularly those injecting drugs) (Swann and James, 1998; Malloch, 2000b). The consequent fear of negative reprisal from prison staff, which in the present review appeared as one of the contributing factors in inmates' reluctance in disclosing substance use, was also described by Malloch (2000b).

Inmates' view of incarceration as the only viable option to treat drug

dependence (in particular heroin) were not found in the literature prior 1998. This is probably due to the fact that, as other authors have reported (Hughes, 2000a; Malloch, 2000a), Prison Service level of treatment and management of withdrawal symptoms were quite unsatisfactory until the introduction of the 1998 strategy. Hence, incarceration prior to this date was unlikely to be perceived as an opportunity to be treated.

It is important to emphasise that, out of the five studies included in the data synthesis, four focussed on treatment perceptions (Fountain et al., 2007; Smith and Ferguson, 2005; Squirrell, 2007; Tompkins et al., 2007) and therefore were mostly focussed on the experiences of inmates who had disclosed their substance dependence and were eager to seek support. As a result, the present review was unable to include the experiences of inmates who chose not to disclose their substance dependence. Similarly, the findings reported in the present review have highlighted the experiences of inmates who found their dependence as exhausting and painful. It is imperative to acknowledge the possible existence of other inmates who may have substance dependence but that nonetheless might not suffer to such high levels or at all. Equally, it is crucial to emphasise that not all inmates with substance dependence seek treatment or welcome imprisonment for a variety of reasons including that of not wanting to be treated. This review does not claim that every inmate with substance dependence sees imprisonment as the only viable opportunity to seek treatment.

As previously highlighted, the present review also suggests that little is known about the experiences of inmates with other forms of substance dependence and that, to date, the literature has greatly focussed on inmates with drug and in particular with heroin dependence. Consequently, the present review fails to report findings from

inmates experiencing dependence from substances such as alcohol, prescription medications and drugs other than heroin and crack cocaine. It is therefore advisable that future research should focus on inmates who experience dependence with a range of different substances, as this is likely to increase awareness of their needs and add knowledge to the implementation of specifically tailored services. Moreover, this could also lead to a shift in focus from the existing services, predominantly interested in heroin and only sporadically in crack cocaine and alcohol, to viewing and approaching dependence from a wider perspective; a perspective able to embrace a larger and more varied range of substances. The incorporation of other substances within programmes focusing on dependence seems to be of particular importance in the Prison Service where many inmates experience poly-drug dependence.

Given the focus of the literature to date on inmates who choose to disclose their substance dependence in order to seek support, future research in the area should attempt to gather data from those inmates with substance dependence who are still, for a variety of reasons, unknown to prison drug services. The present review also suggests a lack of transparency and consistency in access to both medical care and services responsible for drug rehabilitation. As previously highlighted, many inmates experience difficulties in disclosing their substance dependence and, where access to treatment fails to prove reliable, it is unlikely that disclosure will increase. Moreover, inconsistency and lack of transparency are possible sources of disempowerment and disengagement amongst inmates. Therefore, it is suggested that Prison Service should focus on improving inmates' access to care as a way forward towards a better quality of support.

As the present review was able to highlight, studies carried out in British prisons have tended to focus on individuals with drug problems, leaving the

experiences of inmates dependent on alcohol mostly unexplored. The paucity of empirical research in this particular area needs to be taken into consideration when reflecting on the high levels of problematic alcohol use reported among the prison population (Home Office, 2002). The following chapter reports details of a recent study which attempted to fill the gap in the existing literature by exploring the experiences of inmates with alcohol problems in a British male prison.

CHAPTER 2: EMPIRICAL STUDY

What is the Experience of Inmates with Alcohol Problems who opt for Abstinence during their Sentence?

2.1 Background

This introduction will summarise the main features and controversies of the disease model of 'alcoholism' followed by the literature on behavioural change in people with problematic substance use and its relationship with identity transformation. To follow, an outline of the literature on the experiences of abstinence within rehabilitation centres and prisons will be presented. In the final three sections, the experience of time during incarceration will be briefly explored, followed by the process of identity transformation in studies carried out within prisons and rehabilitation centres, and finally a brief summary outlining individuals' concerns and fears around a future perceived as uncertain.

2.1.1 Classical Disease-oriented Approach and the Abstinence Controversy

Over the past 40 years, numerous studies have attempted to provide evidence for and against the possibility for individuals with substance problems to naturally interrupt or reduce their problematic use (for example, starting with Winick's 'maturing out' hypothesis, 1962; Sobell and Sobell, 1976; Sobell et al., 1996; Vaillant, 1983;

Blomqvist, 2002; Chen, 2006). One of these studies (Klingemann, 1991) highlighted that whilst the vast majority of individuals who had heroin problems resorted to choosing complete abstinence, this was not the case for natural 'remitters' from an alcohol problem. In the latter case, half the participants reduced their alcohol consumption and were able to return to social drinking (Klingemann, 1991).

The impressive amount of empirical evidence favouring the process of spontaneous remission from alcohol problems has pointed to the need to move away from the authoritarian discourse of the classical disease model which views 'alcoholism' as a progressive, inborn and incurable illness (Peele, 1984; Larkin, Wood and Griffiths, 2006). The disease concept of alcoholism, often attributed to Jellinek's earlier work (Thatcher, 2004; Larkin et al., 2006) emphasises the treatment goal of life-long abstinence and has therefore failed to recognise the possibility of moderate-drinking-oriented treatments (Peele, 2007). This is despite evidence suggesting (for example, Polich, Armor and Braiker, 1981) that for some individuals the possibility of falling back into a pattern of problematic drinking might be higher when abstinence rather than moderate consumption is attempted. Furthermore, the disease model forms an integral part of national policies and treatment programmes (Peele, 1986, 2007) and has led to the use of coercive treatment, and the 'philosophy' of an approach which prescribes total abstinence and is frequently offered as an alternative to job loss or imprisonment (Weisner and Room, 1984).

Self-help groups such as AA (Alcoholics Anonymous), frequently offered in treatment centres and prisons to individuals with alcohol problems, also partake of the disease perspective of 'alcoholism' (Peele, 2001; Thatcher, 2004), insisting on the progressive nature of the illness which has no cure and stressing individuals' powerlessness in controlling alcohol intake (Peele, 2001). From this perspective, life-

long abstinence is the only way to 'arrest' alcohol problems. Social-cognitive approaches to alcohol problems have highlighted how people's self-conceptions and expectations regarding their ability to control their drinking can dramatically influence the likelihood of overcoming problematic alcohol use (Peele, 1984). For instance, studies have shown how individuals who endorse a disease-oriented approach to alcohol problems show poorer prognosis for moderate drinking (Miller, 1983). Similarly, individuals whose beliefs are consistent with the view that any lapse inevitably leads to falling back into problematic alcohol use have more difficulties in remaining sober compared with those who do not endorse the same belief (Heather, Winton and Rollnick, 1982).

While the intensive nature of the AA groups and the emphasis on sharing and opening up might certainly provide a rich environment for identity transformation, the stress on the 'alcoholic's' inability to control alcohol use might enhance a fatalistic view of the new identity (which is powerless against substances) thereby facilitating self-defeating behaviours (Peele, 1984; Granfield and Cloud, 1999).

Similarly, the AA's view on relapse, which is regarded as able to wipe out all progress made, might initiate a self-fulfilling prophecy (Peele, 1998; Thatcher, 2004) whereby individuals might see an inextricable connection between having one drink and resuming their previous identity.

2.1.2 Behavioural Change and Identity Transformation

To date, an extensive number of studies on the process of recovery from problematic substance use have shown a convergence of motivations or triggers for behavioural

change amongst both individuals who recovered 'naturally' (i.e., without formal or lay treatment) and those who engaged in programmes or self-help groups. Studies on individuals with substance problems who engaged with formal treatment described how a state of personal crisis or 'rock bottom' (Brill, 1972; Waldorf, 1983), existential crisis (Coleman, 1978) and profound despair (Bull, 1972) appeared to initiate change. Similar findings were highlighted in a later study (Waldorf and Biernacki, 1981) focussing on the spontaneous recovery of individuals with heroin problems. The authors identified three pre-conditions to behavioural change: personal/existential crisis or 'rock bottom'; rational choice, whereby individuals engaged in the cognitive assessment of pros and cons of carrying on using; and the process of drifting away, which is expressed through a loss of interest and withdrawal from drug use and its network (Waldorf and Biernacki, 1981). Rational choice was also reported by Toneatto, Sobell, Sobell and Rubel (1999) as triggering behavioural change in natural recovery from problematic cocaine use. A number of other authors (see for example, Klingemann, 1991; Blomqvist, 2002; Finfgeld, 1998; Zakrzewski and Hector, 2004) found both personal crisis and rational decisions to be relevant for treated and untreated individuals with drug and alcohol problems.

Waldorf and Biernacki (1981) highlighted how behavioural change seems to take place in conjunction with significant alterations in people's identities and how the process of recovery in individuals with a heroin problem leads to becoming an 'ordinary' person. Similar findings were reported by Jorquez (1983) in a study focussing on both treated and untreated individuals with heroin problems. In this study, behavioural change also appeared to be strongly connected to identity transformation and to the adjustment into a more conventional social reality (Jorquez, 1983). The author also pointed out a variety of strategies that individuals

used in order to successfully maintain abstinence; leaving the area and the network of friends associated with heroin use was often reported but also foreseeing negative consequences of relapse, using distraction techniques, substituting with other substances (such as tobacco and alcohol) and praying (Jorquez, 1983).

In the same year, Biernacki (1983) refined his analysis on natural recovery and showed how the process of becoming 'ordinary' implies a decisive separation from the self embedded into the drug culture. Furthermore, the process displays different paths of identity transformation which appear to be consistently determined by the individual's level of immersion in the world of drug use. Biernacki explains how the process of identity transformation can follow three different paths; individuals who have irrevocably damaged their pre-drug use identities focus on the construction of a completely new self (identity emergence). Those whose former selves have not been damaged by their involvement with drug use are able to resume their former unspoiled identities (identity reversion). Finally, where the previous identity has only been partially damaged and appears to have co-existed with the drug use identity, the process of becoming 'ordinary' implies an extension of the unspoiled and former self (identity extension). Crucial to any process of identity transformation is also the availability of 'identity materials', such as vocabularies and social roles, which can be used as mirrors to support the extension, re-establishment or emergence of a new and more desirable self (Biernacki, 1983).

In 1986, Stall and Biernacki were able to expand the theory of spontaneous remission and identity transformation by comparing the findings on heroin use to other studies which focussed on untreated individuals who had undergone behavioural and identity changes to resolve their problematic use of tobacco, alcohol, drugs and food. A more recent grounded theory synthesis of the qualitative literature

focussing on a variety of behavioural changes (Kearney and O'Sullivan, 2003) has also found evidence for the connection between change and identity transformation as well as similarity across studies with regard to motivations that can initiate this.

However, Kearney and O'Sullivan also pointed out that while distressing life events, which provide evidence for the imminent loss of personal goals and values, can be of crucial importance, individuals' ability to initiate change heavily relies upon the self-appraisal that those events trigger. Consequently, the inability to focus and engage with a self-assessment, for instance due to lack of time or by being too overwhelmed by other duties, can seriously hinder individuals' ability to initiate change. The synthesis also highlighted how the newly acquired identity can be negatively affected by lack of confidence, social pressure and feelings of alienation from social networks (Kearney and O'Sullivan, 2003).

2.1.3 Choosing 'Coercive' Abstinence in Prisons and Rehabilitation Centres

Empirical studies have highlighted how individuals generally interpret their alcohol or drug use as a way to manage emotional distress and cope with life struggles (for example, Zakrzewski and Hector, 2004; Smith and Ferguson, 2005). Studies also report how, following long-term use, the prolonged consumption of substances becomes functional in avoiding withdrawal symptoms to the extent where individuals' choice to carry on using becomes a means to maintain and stabilise physiological and psychological well-being (Smith and Ferguson, 2005). The consumption of drugs or alcohol during incarceration appears to carry out analogous functions, although it relates more specifically to a need to manage the stresses of

being in prison and to cope with long hours of isolation (Crewe, 2005). Fear of detoxification and withdrawal symptoms has also been found by studies on individuals entering prisons and rehabilitation centres (Allen et al., 2005; Condon et al., 2007). In the context of incarceration, fear of withdrawing is often triggered by difficulties in accessing appropriate support (Condon et al., 2007).

Studies carried out in prison settings have suggested that both adult and young inmates with drug problems often regard incarceration as a valuable opportunity to receive detoxification and treatment (Ashkar and Kenny, 2008; Crewe, 2005; Tompkins et al., 2007; Condon et al., 2007) and generally feel empowered as this provides them with the possibility to choose whether or not to stay abstinent during imprisonment and following release (Tompkins et al., 2007; Ashkar and Kenny, 2008). For many, choosing abstinence is connected to an assessment which sees the negative consequences of drug use outweighing the positive aspects (Smith and Ferguson, 2005). Many inmates express unhappiness about the stressful demands of a life focussed on seeking and consuming drugs and a desire to ameliorate their lives after release, to avoid future withdrawal symptoms and to acquire a new and more positive identity within societal and family networks (Smith and Ferguson, 2005; Crewe, 2005). Participants also stressed the importance of being ready and determined to change one's life (Smith and Ferguson, 2005).

Inmates' post-release goals often appeared connected to avoiding future imprisonments and usually aimed at cutting ties with the drug network and interrupting illegal activities (Ashkar and Kenny, 2008; Smith and Ferguson, 2005).

In Crewe's study (2005), choosing abstinence implied avoiding any contacts with the prison drug market and with those involved in the selling and the consumption of drugs. This created a powerful network of inmates who were

involved in supporting each other in the management of current and future abstinence (Crewe, 2005).

However, it is important to note that not all inmates with drug problems perceive imprisonment as a way to change their lives, and that avoiding drug use can also bear different meanings. Smith and Ferguson (2005) reported how some participants planned to resume drug use after release. This decision had different meanings, such as feeling insufficiently ready and strong to embrace complete abstinence and regarding drugs as more effective than medications in managing emotional distress (Smith and Ferguson, 2005). The literature has also highlighted how choosing abstinence or reducing drug use during imprisonment is often influenced by the scarce availability of drugs (Crewe, 2005; Ashkar and Kenny, 2008) but also by the position obtained within the prison hierarchy, with those "at the bottom" of the hierarchy reporting very much reduced access (Ashkar and Kenny, 2008, p. 590). Three studies on inmates from different group ages (Cope, 2000; Crewe, 2005; Squirrell, 2007) also reported how choices around drug use during incarceration were often based on 'strategic thinking'. In particular, many inmates who chose abstinence did so in order to achieve a variety of goals that appeared to have a priority at a given stage of imprisonment, such as for example obtaining parole, security re-classification, being transferred to a different prison or spending more time out of the cell.

2.1.4 Time and Imprisonment

The tedious time of prison life often induces individuals to carry out introspective self-assessments (Schmid and Jones, 1991) the occurrence of which is crucial to the process of identity transformation (Kearney and O'Sullivan, 2003). The literature suggests that this natural occurring process might be similar to what people experience at critical moments of their lives, when time is at stake, such as for example amongst individuals who are terminally ill (Adam, 1995). It appears that while people have a tendency to experience time more unconsciously and take its existence for granted, time "becomes the explicit focus of attention" and is experienced more consciously by those who perceived it as externally controlled, such as for example in prison (Cope, 2003, p. 163). Accordingly, Cope's participants (2003) perceived imprisonment as an opportunity to reflect on their past involvement with illegal activities, a chance to find meaning in incarceration and to mature, as well as providing a relatively stress-free environment to plan and clarify goals for the future. Cope's findings (2003) were also echoed in another study (Ashkar and Kenny, 2008) where the authors highlighted how the triggered reflections generated feelings of regret and emotional distress which inmates dealt with by implementing a variety of coping strategies such as engaging in physical exercise, reading and attending educational courses, but also sleeping long hours and withdrawing from the rest of the prison.

2.1.5 Facing Opposite Identities

The literature on experiences of imprisonment seems to suggest how choosing abstinence with the goal of ameliorating one's life together with having the opportunity to engage in introspective self-assessments might initiate the emergence of a new, positive, sober identity (Crewe, 2005; Horrocks, Barker, Kelly and Robinson, 2004; Smith and Ferguson, 2005). It has also been suggested that, at the same time, inmates begin to acquire a very negative view of the former self prior to imprisonment (Horrocks et al., 2004; Smith and Ferguson, 2005). In striking contrast with the new identity, the outside self is now regarded as bearing all negative qualities, overpowered by drugs (Zakrzewski and Hector, 2004) and embedded in criminal and illegal activities (Horrocks et al., 2004; Smith and Ferguson 2005).

Many inmates describe stories of a reckless former self which are counteracted by the emergence of new identity, able to comply with treatment, to build meaningful relations and maintaining abstinence. Similarly, Crewe reported (2005) how inmates with heroin problems who chose abstinence were likely to perceive their lives, friendships and identities prior to incarceration as false, while life inside prison was seen as lucid and reliable. The very negative nature of the outside self appeared to be discarded together with those relations and friendships belonging to the outside drug network; the 'real' friendships of the new identity were compared to the 'false' ties prior to imprisonment (Crewe, 2005).

As Horrocks et al. (2004) pointed out, while descriptions of the new positive identity almost appeared coloured with an heroic feel, participants were also confronted with the constant presence of the former negative self 'lurking' in the background.

2.1.6 Facing Uncertainty

Many studies carried out within prisons and treatment centres have highlighted how individuals experience fear and anxiety when confronted with the prospect of being discharged or released. These feelings are mainly related to individuals' concerns around risk of relapse (Horrocks et al., 2004; Severance, 2004; Allen et al., 2005) and the fear of resuming the former identity (Horrocks et al., 2004).

Participants in Horrocks et al.'s study (2004) often felt threatened by the former 'out of control' self and perceived even the smallest lapse as able to jeopardise and nullify all efforts towards recovery. In this sense, the all-positive, heroic, new self appeared to be far from a stable and enduring identity (Horrocks et al., 2004). The literature also highlights how participants credited their ability to maintain abstinence to the controlled and artificial environment of treatment centres or prisons, and hence felt uncertain about being able to resist the temptation to drink once discharged or released (Allen et al., 2005; Cope, 2000; Smith and Ferguson, 2005). Cope (2000) and Smith and Ferguson (2005) also reported that in some cases these concerns were heightened by inmates' inability to imagine what life without drugs would be like and by their perceived inability to manage emotional distress without resuming drug use. In Severance's study (2004), concerns about future relapse were described in relation to inmates' perception of a self regarded as "in God's hands" (p. 92). Participants felt that the only protection they could rely on was faith and prayer (Severance, 2004). A similar sense of powerlessness was found amongst men attending AA meetings within the community (Zakrzewski and Hector, 2004), where the authors reported how all participants credited their successful abstinence to AA and "did not know if they could maintain sobriety without it." (p.

71).

The literature also suggests that the vast majority of individuals focus on the implementation of strategies and plans directed to avoid future relapse, such as learning new strategies to manage emotional distress and new ways of coping with life (Zakrzewski and Hector, 2004; Smith and Ferguson, 2005), planning jobs and a more structured life-style, including activities aimed at filling the time which was used in consuming drugs (Zakrzewski and Hector, 2004; Smith and Ferguson, 2005; Ashkar and Kenny, 2008). Squirrell (2007) reported how very often inmates who were addressing their substance problems during imprisonment expressed a desire to share their expertise and experiences following release by providing support to others with similar issues. Other strategies to avoid future relapse included planning to find an AA sponsor immediately after release, avoiding the places and networks of friends who were likely to use drugs (Severance, 2004) and finding the strength in the memory of past negative experiences (Smith and Ferguson, 2005).

2.2 Objectives of this Study

To date, qualitative studies exploring the experiences of inmates with problematic substance use carried out in British prisons have tended to focus on individuals with drug problems, leaving the experiences of inmates with alcohol problems mostly unexplored. The aim of the present study was to fill the gap in the literature by exploring the experiences of adult male inmates with alcohol problems hosted in a Category B prison in London (UK).

Despite efforts to keep an open and flexible attitude during the processes of

data-gathering and analysis, it is important to stress that some of the analytic categories reported here may have been influenced by the prison-based studies reviewed prior to beginning the research. However, it is equally important to note that during the data-analysis the researcher was not familiar with the literature reviewed in the Introduction and Discussion (e.g., the disease model of 'alcoholism', theories of spontaneous remission and identity formation in the process of behavioural change, literature on time and imprisonment and experiences of AA) as the purpose of the inductive analysis was to be guided by the data.

2.3 Methodology

2.3.1 Procedure

2.3.1.1 Recruiting process

Ethical approval was sought and obtained by Her Majesty's Prison Service, the University of Southampton's Ethics Committee and the University's Research Governance Office.

The recruiting procedure followed typical case sampling, where inmates with an alcohol problem were selected via invitation letters. In order to recruit the sample of 10 participants, a total of 150 letters were sent at different points in time. The recruitment procedure combined random and non-random procedures; that is, one hundred letters were sent to randomly selected cells and 50 were distributed by a CARAT worker (Counselling, Assessment, Referral, Advice and Throughcare) as part of a purposive sampling of those with acknowledged alcohol problems. The decision to include random sampling in the recruitment procedure stemmed from the

need to minimise the risk of recruiting only inmates known to the prison drug/alcohol services, hence to attempt reaching a wider variety of inmates including those who had never disclosed their alcohol use and therefore were absent from the CARATs list.

In order to enhance transferability (Henwood and Pidgeon, 1992), an equal number of letters were sent to each of the 4 wings in Heathfield Centre (hosting the main prison population: A-wing= Long term prisoners; B-wing= 'Drug-free' wing, Voluntary Testing Unit; C4= Detox; D-wing= Assessment and allocation) and to all 3 wings in Onslow Centre (hosting Rule-45 prisoners; Vulnerable Prisoners Unit - VPU). Moreover, in an attempt to enhance and monitor sampling variety, the invitation letters included an equal opportunity form aiming at screening for ethnic background. Inmates who did not wish to take part were asked to pass the letter to someone whom they thought could be interested. Adding the use of a snow balling approach to the recruitment procedure was particularly important as many inmates fear stigmatisation and are likely to never disclose an alcohol problem during their time in custody (Swann and James, 1998; Malloch, 2000b). These inmates are therefore unable to receive prison support and are consequently not known by CARAT workers.

The letter was divided in 2 parts; Part 1 (see Appendix C) contained an overview of the aims and procedure of the study as well as confidentiality issues, Part 2 (see Appendix D) contained questions about their alcohol problem, a personal details box (e.g., age, cell number) and an equal opportunity form. In order to take part, inmates needed to return Part 2 to the researcher at the Crisis Counselling office and could keep Part 1 (as detailed in Part 1).

2.3.1.2 Participants

Ten adult male inmates in custody at HM Wandsworth Prison took part in the study. HMP Wandsworth is a male Category B prison hosting adult inmates "for whom the very highest conditions of security are not necessary, but for whom escape must be made very difficult" (Prisoner Advice Service website).

Only two participants replied to the invitation letter sent to randomly selected cells, four were recruited through the CARAT worker and four using a snow-balling technique. Two participants out of the 10 were not enrolled in prison services for alcohol and drug problem, one of the randomly selected and the other recruited through snow balling. However, one of them reported having attended AA meetings during the same sentence and the other participant was frequently engaging in conversations around alcohol problems with a very good friend and fellow inmate who was himself attending AA meetings at the time of the interview. Only two participants were from an ethnic minority group (i.e., African and Caribbean) whilst all the rest were white British. One participant reported a disability. Participants were aged between 23 and 49 years old (M= 36) and their status (i.e., sentenced or on remand) varied. All participants were able to understand and speak the English language and could read and write. None presented with severe mental illness or demonstrated incapacity to making decisions and hence unable to provide consent.

Finally, at the time of the interview, inmates were not presenting signs of risk to harm themselves (i.e., suicidal intention, self-harm) or others (including representing a risk to the prison security and/or to the researcher's safety).

Information concerning participants' suitability to be interviewed was gathered (including participants' mental state) from the prison IMR (Inmate Medical Record), wing officers and wings' respective observation books.

2.3.1.3 Interviews

Consenting participants were individually interviewed after having signed a consent form. The interviews were audio recorded and lasted between 16 and 70 minutes with a total of 6 hours and a half of overall time spent interviewing.

Interviews took place in private interview rooms allocated within the prison. Participation in the study was voluntary and participants were informed of their unreserved right to withdraw from the study at any time. This information also appeared in the invitation letter and consent form. The interview schedule aimed at exploring feelings, thoughts and significant events surrounding participants' relation to the use of alcohol, both prior and during imprisonment. For further details on the interview schedule please refer to Appendix E.

Prior to the beginning of the interview, participants were made aware of the possibility of potential emotional discomfort due to the nature of the interview questions. Participants were also given the opportunity to be referred to one of the prison services following the interview and informed of the possibility of contacting the researcher at the provided address if any concerns emerged at a later stage.

At the end of the study participants were fully debriefed and offered a copy of the debriefing sheet (see Appendix F). Participants were also given the opportunity to request a summary of the research findings by writing to the researcher at the provided address around November 2008.

2.3.1.4 Confidentiality

Transcribed interviews were coded and a number was assigned to substitute participants' names (i.e., Prisoner 1, and so on). A locked cabinet in a locked office was used to store all transcribed data and audiotapes. Documents containing

participants' details (including consent forms) were stored separately from the interview data, in a locked cabinet located in a different locked office. Only one key per locked cabinet was available and these were kept in a safe place and used for the duration of the study by the researcher only. Data kept on computer were protected by password (known only by the researcher) and all audio recordings were destroyed at the end of the study.

Participants' confidentiality was protected at all times; however, participants were made aware of some exceptional circumstances in which the researcher would be forced to notify the relevant people against the participant's will. These are as follows:

- If a court of law tells the researcher to
- If the participant tells the researcher something that makes him/her concerned that he or someone else is at risk of serious harm (e.g., name/s, prison number/s, location/s)
- If the participant tells the researcher something that makes him/her believe that the National security and the security of the prison is at risk (e.g., name/s, prison number/s, location/s)
- If the participant tells the researcher something that makes him/her think that this will help prevent and detect crime or apprehend or prosecute offenders (e.g., name/s, prison number/s, location/s or specific details of events happened in the past)

The confidentiality rules here described also appeared in the invitation letter and in the consent form (see Appendix C and Appendix G). Prior to the beginning of the interview some time was allocated in order to discuss any unclear issue regarding these rules.

2.3.2 Using Grounded Theory Strategies

The aim of the present study was to explore the experiences of inmates with alcohol problems during their stay in prison. As previously highlighted, research in England and Wales to date has mainly focussed on inmates with drug problems, leaving an important gap regarding the experiences of inmates with alcohol problems. As the aim of this study was not that of verifying pre-determined hypothesis, but to explore participants' experiences, a qualitative method of data analysis was used. Grounded Theory strategies (Charmaz, 2006) were applied to the data using a phenomenological perspective, which was regarded as better suited to gaining an insight into participants' perspectives and experiences of the phenomenon under study (Willig, 2001). Therefore, this study does not propose an objective view of participants' experiences from the standpoint of wider social processes but is more interested in producing a theoretical and interpretative account of the "lived experience" of inmates with alcohol problems (Willig, 2001, p. 44).

The present study employed an abbreviated version of Grounded Theory (Langdridge, 2004; Willig, 2001), where the usual procedures of Grounded Theory data-analysis, (i.e., coding, constant comparative analysis, theoretical saturation, theoretical sensitivity, and negative case analysis) are applied only to the original data without the further exploration of categories via theoretical sampling (Willig, 2001). Following Charmaz's social constructivist approach (2006), and in order to minimise the risk of an emerging theory 'imposed' by the researcher's own standpoint (Charmaz, 2006; Willig, 2001), the analysis of the data was kept flexible and open to the emerging categories. Charmaz (2006) and Willig (2001) suggest that the application of a rigid coding paradigm to the data, such as the use of axial coding

and the application of a conditional matrix, often hinders and compromises the necessary flexibility of data analysis and 'may limit what and how researchers learn about their studied worlds' (Charmaz, 2006, p. 62). In order to avoid the risk of potentially fixing and forcing the data onto a pre-defined framework the analysis followed a procedure outlined by Charmaz (2006).

The process consisted of an initial phase where all transcripts were coded line-by-line, which yielded a total of 1,109 lower-level codes, and a second major phase of higher-level synthesis of initial codes through focused coding (Charmaz, 2006). This continued until the construction of conceptual categories and the emerging of a core category. However, as Charmaz suggests, these phases are not entirely separated as during the process of constant comparative analysis, the researcher constantly moves back and forth from one phase to the other in an attempt to construct categories that are grounded in the data. In addition, during the phase of focused coding until later stages, the first interpretative ideas start to emerge and it is therefore only natural to move back to earlier coding stages in order to check the 'ground ness' of the emerging categories and theory. Memo writing was used throughout the process of data-analysis, from earlier stages of coding to the final stages of the formation of higher-level categories. The process was particularly helpful in order to clarify directions, connections and comparisons within the data but also provided an important space for reflexivity, where the researcher's views and assumptions could freely emerge and be analysed. Finally, different stages of data analysis, from initial lower-level coding to the emerging of categories and interpretative accounts, were tested for credibility by the researcher's supervisor.

This process was essential in keeping the analysis grounded in the data and enhancing the overall quality of the study.

Finally, the analysis was based on the inmates' interview data only, as access to records was limited to the purpose of gathering information on participation suitability (as outlined in the 'Participants' section). It was therefore not possible to verify any of the information provided by participants during the interviews including the extent of their alcohol problems and other substance use.

2.4 Results

2.4.1 Overview of Analysis

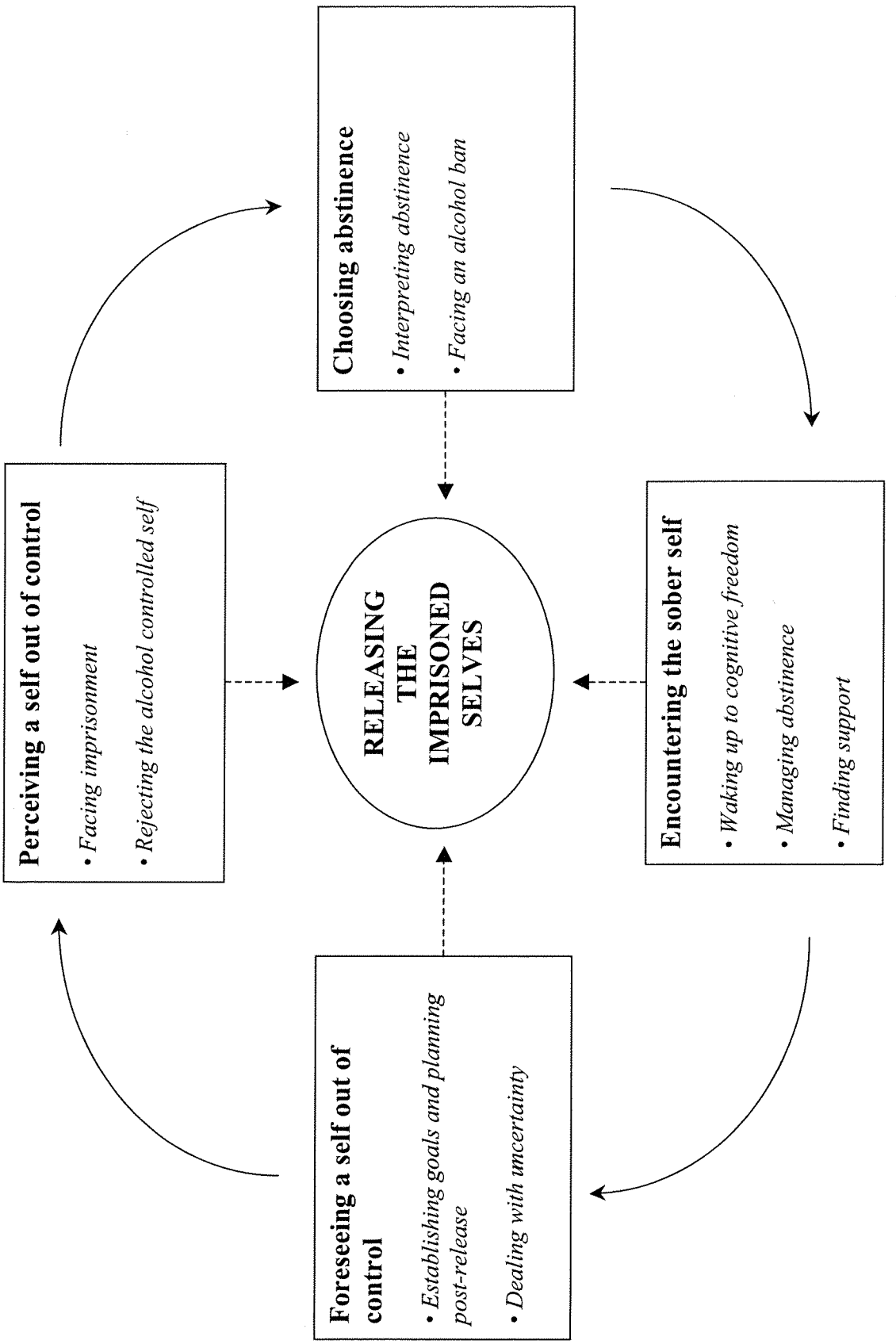
The core category 'releasing the imprisoned selves' was developed in order to embrace participants' experiences (see Figure 1).

'Releasing the imprisoned selves' describes participants' journey into gaining freedom from a perceived alcohol-controlled self, which is seen as featuring highly undesirable qualities as well as being regarded as the main contributing factor leading to imprisonment. This journey also involves implementing strategies to reduce the loss of control induced by imprisonment. Choosing abstinence contributes to releasing the self from imprisonment (i.e., the self in prison) through the gain of enhanced status and various privileges as well as allowing participants to distance themselves from a life ruled by alcohol. As a consequence, participants appear to step into a new and different self (the sober self) during imprisonment, which appears to be characterised by those desirable qualities that the alcohol-control self seems to lack. Finally, despite high levels of commitment and planning surrounding a desire for a better future, participants share a feeling of resignation regarding their

perceived powerlessness against alcohol, and fear the possibility of retreating back to the alcohol-controlled self upon release.

In the following sections four elements of this journey will be considered in more detail. These are four higher-level categories as highlighted in Figure 1 (i.e., 'perceiving a self out of control', 'choosing abstinence', 'encountering the sober self', and 'foreseeing a self out of control') and nine sub-categories (Figure 1).

Figure 1. Core Category's Components: 4 Higher-level Categories and 9 Sub-categories.



2.4.2 Perceiving a Self out of Control

Perceiving a self out of control captures participants' experiences of losing their freedom at prison admission and rejecting the perceived alcohol-controlled self experienced prior to incarceration.

2.4.2.1 Facing Imprisonment

Admission to prison prompts individuals with an alcohol problem to face a sudden loss of freedom as well as, in most cases, the perception of a self who is losing its grip on reality and slipping out of control. Although facing limited freedom at admission is common to all individuals who enter prison, for those who have been consuming large amounts of alcohol prior to incarceration the experience also includes having to deal with difficulties in accessing alcohol, coupled with fear and resignation toward the imminent appearance of withdrawal symptoms.

For one participant, the experience of alcohol cravings during the initial withdrawal stages and the impact of the loss of freedom were heightened during a routine search at admission:

> [W]hen I was admitted [...] I was having bad cramps I was shaking like a good'n [...] and they looked through all my stuff [...] and they found these three cans of Skoll Super and I thought 'uh, I didn't even realise they were there!' and...one of the screws looked at me and he said 'you know what's gonna happen to this don't you?' and he went 'I'm just gonna pop up the tops...' 'No, don't do that' I said 'Look, if you're gonna do anything with them take them home' and he said 'not allowed to' and he went tsh, tsh, tsh and tipped them down the sink and stood there looking at me with a massive

> great smile. I said 'Gov you're out of order you' I said 'There's absolutely no need to do that at all' and the smell of it drifted over from where he was standing and [...] all I could think of was 'I've got to get that. Those cans those cans, I wanna lick the inside of the cans just to get the taste' and that made me feel worse (Participant 4, p. 26)

For the vast majority of participants the experience of withdrawal symptoms was aggravated by the loss of control over how to deal with the symptoms, as obtaining fast relief through alcohol did not represent an option. During those initial stages it was not uncommon for participants to spend a great deal of energy and time in focusing on their case. All efforts were made in the hope of accelerating the sentence process, and obtaining a fast release in order to access alcohol again.

The majority of inmates resorted to taking medications to alleviate withdrawal symptoms, although one participant only obtained medication after two months and another experienced a long wait before he could see a doctor at admission. For the latter participant, the delay triggered a state of confusion to the extent of fearing death as the painful symptoms started to appear:

> When I first came in, I had been in court all day and [...] there was no doctor to give me any medication and like I came in and I felt so old, I was sitting on a box and I was sweating, was dribbling out my mouth, my nose was running snot and I was sitting there wringing my hands, really shaking and thinking 'What am I gonna do? How am I gonna face it? I know I'm gonna be clacking for 4 or 5 days, for a while to get the alcohol out of my system and so forth' and in my mind I was kinda of desperate [...] my belly was tight, I was getting stomach cramps, my bowels was weak, it was crazy [...] I felt like I was about to die or I could die (Participant 8, p. 113)

Only one participant avoided disclosing alcohol use at admission and experienced detoxification without medications. This decision appeared to be connected with having committed a crime that was unrelated to alcohol or drugs, and the fear of negatively affecting the sentence outcome had this information been made public.

Moreover, this participant also stated that he was unaware of prison support for detoxification. This very painful experience was heightened by the impossibility of sharing his suffering with the cellmate as well as by feeling bad about lying.

> [N]ot having to tell the officers the nurses nothing about it I hid it from them....'cause I didn't came here for that [...] it was a private thing [...] Well I didn't know they give you if I was on alcohol whatever I was taking, they would have give me some form of substitute, but I didn't come in here for that! So my mind was set [...] that I had to do it myself, which was painful. It was like coming down when the door is not open [...] shaking not having to eat not having to sleep, which I've lost sense of time [...] I was flushing it down the toilet I wasn't eating it, it was just wanting the flavour within myself I felt very terrible with myself with all I was hiding from my cellmate (Participant 5, p. 46-47)

Although in the vast majority of cases excessive and long-term use of alcohol prior to imprisonment appeared to trigger withdrawal symptoms, one participant who reported high levels of alcohol consumption on a daily basis said he had never experienced withdrawal symptoms. His account was similar to that of another participant who did not report withdrawing at admission and who identified himself as a 'binge drinker'. Both participants shared a similar view regarding the difference between being psychologically or physically dependent on alcohol, where only the latter would result in withdrawal symptoms, although the participant who used

alcohol on a regular basis could not explain his apparent 'immunity' from withdrawing:

> I never had the shakes and never been like seeing anything and all that stuff [...] and I don't know why I really don't know [...] because with the amount of stuff I drink I should do, but all I ever had is a mental thing to wanting to have a drink I never had a physical dependency on it [...]
>
> (Participant 2, p. 11)

For a small number of participants the self out of control was experienced as a consequence of being arrested while under alcohol effects. For some, this triggered the urge to escape in order to drink more, whilst one participant experienced confusion, uncertainty and a sense of defeat when facing the inability to rely on his memory to build a defence against other people's perception:

> [...] I've got put into the cell, gone to sleep 'cause I was drunk, woke up in the morning and [...] I was absolutely gutted and wanting to know why I was there or what I had been arrested for [...] To be honest with you [...] 9 out of 10 times I've always done wrong when arrested and there's only been once or twice when I have been arrested and I've been drunk and I've sat there and I am thinking to myself 'What did actually happen?' or 'I hope I do remember exactly how it was', but 9 out of 10 times if you're drunk when you're arrested you don't remember exactly how it was anyway and it's always different from someone else's perception anyway, isn'it really?
>
> (Participant 2, p. 11)

2.4.2.2 Rejecting the alcohol-controlled self

Following admission, participants seemed to slowly detach themselves from the perceived alcohol-controlled self experienced until imprisonment. The ability to reach such a distance appeared to be induced by prison itself, as the provider of a shelter away from alcohol and from everyday life stresses and struggles, triggers which were perceived by all as responsible for alcohol use. Moreover, participants' unanimous negative view of the self prior to imprisonment and the connected rejection of its qualities seemed to make this distance almost necessary in order to overcome the perceived loss of control. The rejection was often coloured by feelings of shame and remorse as thoughts surrounding the outside alcohol-controlled self prompted many participants to regret their inability to achieve a better quality of life prior to imprisonment.

> [M]y past served no purpose because in the end, who did I actually help? I didn't help nobody...I didn't help myself, the only thing I left behind was pure pain and separation, people I was stealing from, people I was robbing (Participant 8, p. 109)

The majority of participants perceived alcohol as an external and untameable force, which was responsible for generating suffering and destroying their lives. In some cases, participants' perception of alcohol as an external and independent agent appeared to blur the boundaries between their accountability and decisional power over alcohol intake and over behaviours occurring under its effects, including those leading to imprisonment: "[W]henever I'd come back in prison I'd beat myself up [...] I really give myself a hard time but you know these things happen [...] I can't do anything about it" (Participant 3, p. 15). For one participant alcohol assumed the characteristics of an evil agent triggering a state of possession: "[Y]ou know what?

There was a devil out there, I have sold my soul" (Participant 5, p. 56). This account echoes participants' perception of the difference between the alcohol-controlled self and the 'true' self, "[Y]ou really notice yourself that it's not yourself" (Participant 8, p. 108), and highlights its very negative and at times inhuman features: "I know how I became, I became an animal, [...] I didn't like the person I became" (Participant 6, p. 82).

Characteristics of the alcohol-controlled self were widely shared amongst participants and featured the inability to manage past and recent emotions, assess one's needs, or know and look after oneself, and also the tendency to put aside duties and enjoyable activities and the inability to make 'proper decisions': "[W]hen I was out there I felt very imprisoned in my own mind, I didn't know what I enjoyed, what made me happy, what made me sad" (Participant 9, p. 124-125). Some participants also described how the difficulty of relating to and knowing their 'true' self was aggravated by a life focussed around alcohol consumption. In some cases, the daily struggle to obtain alcohol coupled with having to face up to life demands such as duties and work was perceived as a 'full-time job' and meant that there was no time to reflect on oneself. Furthermore, the accounts highlighted how the inability to deal with emotions generated and increased the likelihood of consuming more alcohol and how this contributed to perpetuating the ongoing disconnection between the 'true' self and the alcohol-controlled self.

The alcohol-controlled self was also perceived as unable to truly relate to and care about others, expressed through the dismissal of people's offers of support and a loss of authenticity and empathy when relating to others. For some participants this disconnection also embraced the wider realm of external reality and was expressed

through the perception of a self who lives in day-dream state and is unable to connect and engage with the 'real world':

> [W]hen I was out I wasn't really awake, I went through my days in a day-dream, everyday you wake up in a dream and the world you wake up in is not a realistic world, it's a world that's filled with darkness and untruth (Participant 8, p. 107-108).

The alcohol-controlled self was widely perceived as unable to regulate alcohol intake. Almost all participants described heavy daily alcohol consumption and a perceived inability to function without it. Only one participant did not drink on a daily basis and identified himself as a 'binge-drinker'; for him the struggle in regulating his alcohol intake emerged through the perceived inability to socialise and deal with emotional distress without consuming large quantities. This behaviour was regarded by him as "drinking for the wrong reasons" (Participant 9, p. 121).

Participants regarded drinking as functional on many levels of their lives; as a way to cope with life struggles, to manage emotions, and to avoid physical and psychological distress induced by abstinence. Drinking was perceived as able to generate short-term happiness and temporary relief from negative emotions, as well as providing strength and courage to carry on with life.

Despite the relative ease of accessing alcohol outside prison, barriers to drinking, such as financial impediments, were often a cause of distress amongst participants. Participants described how their everyday lives were shaped and moulded around alcohol consumption and how the inability to access alcohol triggered emotional and/or physical distress. Only two participants reported the ability to manage cravings outside prison and both shared the experience of mild emotional rather than physical distress. One of them explained how being a 'binge-

drinker', rather than being dependent on alcohol together with leading a stable life away from crime, made him less willing to turn to criminal activities in order to access alcohol. This also contributed to his ability to manage abstinence. The second participant reported having always experienced fairly short breaks from alcohol (i.e., one day) and that focusing on the short-term contributed to his ability to endure abstinence. Only one participant reported having never found himself without alcohol and consequently never experienced abstinence-induced emotional or physical distress until his admission to prison.

For the rest of the participants, who perceived themselves as unable to manage cravings and to cope without a drink, the likely solution was to turn to crime in order to access alcohol. The extent and likelihood of committing a crime in order to obtain alcohol did not seem to vary between episodes triggered by physical and/or emotional distress but appeared to be influenced by the intensity of the distress experienced at the time and by the perceived ability to cope with it.

Finally, for many participants, the link between alcohol-related crimes and/or years of repeated imprisonment and detoxifications, served to signal the presence of an alcohol problem:

> You see when I was out there [...] money was there to buy it [...] I never knew of AA, I've never considered alcoholic anonymous class, if you'd get drunk you get in a cab, you get home, but no-one has ever said to me 'you drink too much' nothing you know nothing was mentioned of alcohol (Participant 5, p. 58)

2.4.3 Choosing Abstinence

At the time of the interviews, all participants reported having opted for abstinence from alcohol at some point during their current sentence. The theme 'choosing abstinence' captures the experiences and the reasoning behind this decision. The first sub-category, 'interpreting abstinence', embraces participants' decisions to stay sober in relation to the refusal of a perceived self out of control and the desire to change their life after release. 'Facing an alcohol ban', the second sub-category, illustrates participants' assessments of the pros and cons of accessing alcohol (including limited availability and the risk of being punished) as a crucial contributor to their decision to stay sober.

2.4.3.1 Interpreting Abstinence

'Interpreting abstinence' encapsulates participants' views on the experience of choosing abstinence during imprisonment, including the most influential factors triggering this decision. For all participants, choosing abstinence appeared to be strongly connected to the desire to change their lives after release. In other words, the goal of living a better life was regarded as dependent on transforming their relation with alcohol through an increased control over its use (as further explored in 'foreseeing a self out of control'), and was initiated by all during imprisonment.

Participants' memories of life prior to imprisonment were permeated by loss and suffering. The consequences of a life regulated by alcohol included, for many, a feeling of failure over life's achievements and the loss of valuable opportunities, the breaking of important relationships such as with family and loved ones (including

losing touch with partners and children), but also the potential health hazards of heavy drinking and the realisation that carrying on with such life-style would eventually lead to further imprisonment or to death. A minority of participants regarded the opportunity to stay abstinent as a lifesaver and felt 'blessed' to be alive and in good health. For some, the appraisal of dangerous situations experienced outside prison appeared to influence the decision to stay abstinent. Also crucial for the majority was the perceived defeat over alcohol control which left abstinence as the only possible choice. Only one participant expressed the desire to avoid future withdrawal symptoms as contributing to the decision to choose abstinence.

For the vast majority of participants, the desire to have a better life after release appeared to be connected to the perceived causal connection between drinking and imprisonment, which made opting for abstinence functional in avoiding future incarcerations. In this regard, many participants described the 'mandatory' nature of questioning themselves about the causes of imprisonment and acknowledging the link between drinking and incarceration.

> [W]hen I've come here it's a case of you ask yourself why you are here you know you've got to, [...] and I'm not that stupid not to realise why I'm here it's kind of like every time I've come to jail even when it was down to my drug use as well as my drinking so I'm not stupid not to know that is down to that and why I'm here you know, this is the kind of place you just got to accept it (Participant 2, p. 4-5)

This causal connection became apparent through the experience of repeated imprisonments, whether due to committing crime in order to access alcohol, or linked to criminal behaviours under alcohol effects such as putting oneself at risk in dangerous situations, taking drugs or becoming violent.

> [T]he reality is with me if I go out there and I drink I will come back to prison you know that's reality for me [...] because you know I'll become violent I'll do silly things [...] and I'm getting a bit tired of that now you know I don't wanna spend all my life in these places I feel that I deserve a bit more out of life than this' (Participant 3, p. 15)

Choosing abstinence was therefore connected to the desire to avoid future imprisonment but also, for some, the experience of repeated imprisonment appeared related to the decision to change.

> I stopped drinking ever since I was here but the way my thinking changed is because you walk out there and look around up and down the landings, you see the same faces, you see the same people, who was basically in (Prison name) with when I was sixteen, who's been in and out of prison YOI, youth offenders institute, I've seen people out there, the same faces from 1992 (Participant 2, p. 7)

Having had enough of a life regulated by alcohol and imprisonment was also expressed through the perceived discrepancy between age and incarceration, as described by one participant:

> [A]s I said to myself I'll be fifty 31st of July and that's not my fiftieth birthday spending in here you know and I thought... I said to myself I still can't understand it's my fiftieth birthday and I'm gonna spend it in prison that's not what I came out on this planet to do [...] I'm forty-nine I should have known better I thought when you get older you know better but I was getting more stupid in a sense (Participant 5, p. 47, 50)

Although the use of alcohol was overall described as functional in dealing with life struggles and negative emotions, all participants concluded that the risks involved and the suffering induced by such a life-style greatly outweighed the positive but short-term gains obtained through drinking.

> 'Enough is enough', what am I gonna do? Go back out, still continue drinking, still continue smoking, still continue committing crime and then end up back here, doing a life sentence, that's what's gonna happen if I don't stop, so something is gonna have to happen (Participant 6, p. f79)

Whilst in many cases the fear of future imprisonment appeared to contribute in choosing abstinence, the potential loss of support from external agencies and family seemed also to be influential.

Moreover, the majority of participants looked back at their previous unsuccessful attempts to stop drinking and stressed how their inability to perceive the extent of their alcohol problem had hindered their willingness to seek and/or to accept support. For a minority of participants, looking back at missed opportunities to stay sober created feelings of remorse and failure. The experience of a self unaware of a drink problem also meant that the potential health-hazards of drinking were coupled with the inability to foresee the likelihood of an increased dependence to come. However, it appears that being aware of an alcohol problem only marginally influenced the decision to address it in any way. For some, refusal to see drinking as problematic was functional; it avoided identification with 'alcoholics' and appeared to have its source in participants' unwillingness to regard themselves as unable to control alcohol.

During imprisonment, the unwanted characteristics of the perceived alcohol-controlled self were also evaluated and witnessed through others. Some participants

reported how witnessing other inmates out of control facilitated their decision to carry on with abstinence. For some, witnessing the suffering of inmates with an alcohol problem at admission functioned as a constant reminder of the perceived alcohol-controlled self and served as a deterrent to drink. In this regard, some participants were inclined to sympathise with those unable to opt for abstinence and felt they understood the suffering and confusion that newly admitted inmates were going through. However, other participants showed negative views toward those who carried on drinking, and described them as unable to make the most of what prison could offer. Specifically, inmates who carried on drinking were perceived as incapable of taking advantage of prison courses but also unable to use incarceration as an opportunity to become a better person and to secure a brighter future.

Half of the participants regarded inmates who carried on drinking in prison as unable, unwilling or not ready to change their lives. However, participants usually agreed that those inmates were unable to stay abstinent as the need to drink, linked to the need to suppress negative emotions and cope with prison isolation, was stronger than the prospect of 'recovery' or of the risk of punishment if caught with alcohol.

The negative features of the perceived alcohol-controlled self were also evaluated by some through reflecting on the negative consequences of heavy drinking witnessed in friends known outside prison, such as those who fell ill or died as a result of drinking.

A minority of participants reported how the length of the sentence received appeared to have facilitated their decision to stop drinking. Two participants regarded having received a long sentence as functional in providing the possibility of enrolling in AA. One of them suggested that inmates who received a short sentence were less likely to incur punishments such as having extra days added to their

sentence, and therefore more likely to make hooch. The impossibility of making a real change during such a short time was also mentioned as well as the likelihood of carrying on drinking following release from a short sentence. However, one participant also reported having drunk in the past when given a long sentence. Only one participant regarded his short sentence as positive; in his view, the possibility of avoiding socialising with other inmates and therefore feeling less tempted to drink appeared very worthwhile.

The degree of disagreement between the usefulness of a short or long sentence appeared to be related to participants' experience and perception of the decision-making process leading to abstinence.

The degree of perceived powerlessness against alcohol appeared to be echoed in their experience of the decision-making process when opting for abstinence. In this sense, many participants shared a view of readiness to change as something out of their control, a decision that just seemed to happen.

Some participants suggested that, despite the great influence of external events such as repeated imprisonment, short/long sentence, opportunity to enrol in prison courses, and so on, the decision to stay abstinent ultimately depended on the willingness to change one's life. Moreover, participants reported that, although they valued people's support, choosing abstinence had to manifest itself from within and the decision to stop drinking was independent of the degree and quality of the support received (both by family and external agencies).

> "[I]f you're not ready to stop, no one can't tell you anything, nothing ain't gonna stop you from stopping, you're gonna want it inside, d'you know what I mean, and until that happens then...you're doomed really, all you got it's jail, institution or death." (Participant 6, p. 79)

Linked to this were comments about the sad reality of perceiving oneself as unable to fully support other people with alcohol problem until they themselves were willing and ready to change, but also the perception of a knowledge that is locked up inside and impossible to share: "[T]he worst part of it is all the experience that you've gathered, in your life searching you can put it to no good use, it's all locked up inside you, you're bottled up" (Participant 8, p. 99)

2.4.3.2 Facing an Alcohol Ban

Despite a widely shared desire to develop some control over alcohol, participants' decision to stay abstinent during imprisonment also seemed to be influenced by other factors linked to the prison ban on alcohol. These included the limited availability of alcohol as well as concerns around the dangers of making hooch and the risk of receiving punishment if caught.

The majority of participants reported a very limited availability of alcohol in prison. Access to hooch was described as irregular and insufficient to satisfy the needs of those who were used to drinking large amounts of alcohol prior to imprisonment. Many participants also reported difficulties in concealing and obtaining industrially manufactured alcohol from the outside. Four participants reported easy access to hooch and described having frequently been offered it to buy.

One of them was also able to make it and had contacts with other inmates who were selling it. For another participant, access to alcohol and drugs was facilitated by benefiting from unsupervised movement between wings, resulting from the nature of his job and his enhanced status. Even though for some obtaining hooch appeared to be quite straightforward, participants willing to drink were nevertheless

faced with an irregular availability resulting from the nature of its lengthy process of fermentation and preparation.

Access to drugs was described as far less problematic, much easier to smuggle from the outside and widely available to inmates.

> [I]n prison is not about drinking, is not about alcohol in the prison is about drugs in the prison, and that's being straight up and down between me and you, the things I've told you I wouldn't admit that to an officer (Participant 8, p. 114)

Overall, participants perceived sobriety as the most efficient way to manage the scarce availability of alcohol, and described how difficulties in accessing alcohol meant that for those who could not stay sober the only option was substituting with drugs. However, only one participant reported smoking cannabis at the time of the interview and another described how his experience of substituting with drugs during a past sentence resulted in developing a dependence.

> [P]otentially you could come to prison an alcoholic and go out an addict ... 'cause they make hooch but they don't make as much it's not available as much as in the outside... 'cause you've got more chances of getting drugs... 'cause you can get visits and have drugs brought in and things like that and alcohol it's a bit harder, in'it? Yeah, conceal a bottle of Vodka or whatever. [...] Alcohol isn't readily available here [...] so I have to look for other options, alternatives and that's the problem that's when you start becoming the addict... I was just in prison and I wanted a drink and no drink available so I've had cannabis, heroin, Valium, DF118, Subutex and I was using them instead...It took away how I was feeling it at the time....depressed,

lonely...escapism ...it took away the reality of how I was feeling...

(Participant 7, p. 91-92)

Although participants generally expressed positive views of the prison alcohol ban and the limited availability of alcohol as facilitating their ability to stay sober, a small number of participants also felt in disagreement with it. One participant who reported having drunk during a past sentence, and who was currently smoking cannabis, experienced feelings of powerlessness and anger around the alcohol ban, in particular towards the compulsory nature of his 'choice' to staying abstinent.

Although he described positive past experiences of drinking in prison, he was the only participant who reported being caught with alcohol and had to face a prolonged imprisonment as a result of it.

One participant, who had been abstinent for many years, reported how his feelings of resentment faded away after enrolling in AA. However, he also reported how choosing abstinence was partly influenced by the undesirable effects of drinking in a confined space, such as a prison cell, which triggered in him outbursts of violence and resulted in being locked away in the Separation Unit. His experience of alcohol-induced violence and the risks of drinking in a confined space echoed the views and experiences of two participants who witnessed out of control behaviours in other inmates. In particular, one of them reported how sharing hooch with an inmate who became violent put him at risk of being caught. Their concerns around falling victims of other inmates under alcohol effects through fights and bully behaviours were also shared by a third participant who, despite having not witnessed such behaviours, could nevertheless foresee the risk. In their view, some inmates appeared to be unable to 'handle' alcohol, especially in prison. Despite all three agreeing on the dangers of allowing all inmates to have unlimited access to alcohol,

they also felt partially in disagreement with not being allowed to drink, as they felt that in their case drinking alcohol in prison would pose no threat to others or to themselves. In their opinion, the possibility of drinking controlled quantities of alcohol in prison without risking punishment was valuable in allowing inmates to relax and better cope with the stresses of prison life and sentence:

> I feel resentment against the system 'cause years ago you was allowed drinking in prison, did you know that? ...when I first started going to prison which was back in the 80's unfortunately, you was allowed one long can of say Special Brew, Tennants whatever and one short can, [...] it was nice to get it everyday, my girlfriend used to bring it off for me everyday (Participant 6, p. 73-74)

All participants appeared to refer to past experiences of drinking in prison and/or to known risks involved (either witnessed through others or through personal experience) in the attempt to assess the feasibility of accessing alcohol and the pros and cons of opting for abstinence. For one participant who identified himself as a 'binge-drinker', choosing abstinence appeared to be influenced by feeling uncomfortable with the idea of having to drink behind closed doors and being forced to hide his inebriation, as this would clearly generate suspicion amongst the officers and increase the chances of being caught.

Also influential were difficulties in making hooch, largely dependent on the degree of expertise in the process and the health-risks associated with the possibility of getting it wrong, including feeling ill, losing sight and dying. Other significant risks involved the complexity of concealing the content in prison cells, which were frequently searched, but also hiding the scented gases during the process of fermentation. Participants described how inmates who made and sold hooch usually

obtained a significant number of potential buyers through a system of word-of-mouth 'advertising'. This system appeared to be functional in order to sell as much alcohol as possible before the next cell search. Some participants reported how the decision to purchase rather than to make hooch in the past was influenced by factors such as perceived degree of expertise and money availability, but also represented a way to access alcohol while minimising the risks of being caught.

The punishments if caught with alcohol included facing extended imprisonment, having closed visits (i.e., inmates and visitors are separated by glass screens during visits), losing money or job and losing or jeopardising the possibility of becoming an enhanced prisoner (i.e., status achieved through good conduct which enables inmates to obtain a variety of privileges). Participants' concerns around the risks of being caught and the decision to stay sober also appeared to be influenced by inmate status and enrolment in prison courses and programmes. For the majority of participants, the danger of being caught with alcohol also included the loss of hard won privileges such as access to restricted items (e.g., Playstation, guitar) and unsupervised movement between wings. One participant also described how his unwillingness to be involved with alcohol and drugs was partly influenced by the degree of trust and respect he had built with inmates enrolled in the AA programme and prison officers.

For all inmates, the prospect of drinking during incarceration appeared to be synonymous with transforming prison life into a miserable experience. The constant danger of being caught and punished was accompanied by the increasing likelihood of triggering suspicion in prison officers and becoming an easy target for repeated cell searches.

Nevertheless, past experiences of drinking in prison were largely described in a positive way. The contrast between past experiences of drinking in prison and the prospect of accessing alcohol during the current sentence was specifically highlighted by one participant who reported heavy alcohol use prior to imprisonment. As he described, the decision to stay sober at the time of the interview was influenced by the high levels of distress experienced around his current sentence, stress that in his view would trigger the urge to drink more alcohol and the inability to endure limited access. This contrasted with a previous sentence, where he had no concerns around his sentence and was able to drink a small quantity of hooch on a one-off basis. Other participants' past experiences of drinking in prison also seemed to share a similar pattern of moderate drinking, where the consumption of small or large amounts of alcohol was restricted to weekends or special occasions such as Christmas and New Year. Similarly, these experiences were for the vast majority experienced as positive and functional in order to relax. The vast majority of participants who had accessed alcohol in the past described sharing moments of fun and relaxation with other inmates, as well as feeling able to temporarily escape imprisonment, "I used to love it...it was lovely, it's an escape, I don't feel like I'm in prison, d'you know what I mean, it's party night, as far as I'm concerned I'm having a party, this is my party" (Participant 6, p. 76).

Only two participants reported past negative experiences associated with accessing alcohol; in one case, as previously highlighted, this was the result of being caught and punished, although this negative event did not seem to affect the positive memories of drinking in prison but only the desire to minimise the risk of further punishments by choosing abstinence. For another participant, the previously mentioned experiences of alcohol-induced violence were accompanied by the

memory of a very traumatic experience. This was triggered by the urge to obtain alcohol in an attempt to avoid withdrawal symptoms during a time when inmates were not supported during the process of detoxification.

> It was 1999, I was here and an inmate tried to rape me [...] and yeah [...] I've done everything I could to get a drink [...]. He said he had alcohol I managed to get into a cell with him... but he was lying to me basically, tricking me, he didn't have alcohol, the only thing he had was a razor blade which he tried to put to my throat, that was about it. We were banged up over lunch and he tried to jump on top of me, he said he was trying to be my friend but the alcohol was an excuse to trying to get me. But he didn't get me he got a black eye and life imprisonment sentence, so that's my worst experience yeah. I felt dirty, ashamed, powerless. I needed some more [alcohol], I needed some more to take away the pain (Participant 7, p. 93-94).

Finally, if participants' past experiences of drinking alcohol temporarily provided a release from imprisonment (e.g., escaping isolation, boredom), choosing abstinence and consequently complying with prison rules and regulations appeared to bring a different and more desirable form of release. This involved the opportunity to experience a far less 'restricted' and burdensome time in prison. As previously mentioned, working towards or achieving an enhanced status came with an array of opportunities that were functional and desirable: distraction from being in prison (e.g., working, having access to restricted items, etc.); minimising the risk of punishments and avoiding a prolonged stay in prison; and also in helping participants for the future after release (e.g., enrolling in courses). This explains why, despite the access the majority of participants had to alcohol, they mostly perceived themselves as having no option than choosing abstinence; both the inability to access large

amounts of alcohol and the risks involved made drinking an option that was hardly easy or desirable.

2.4.4 Encountering the Sober Self

During imprisonment and as a consequence of prolonged abstinence, participants reported witnessing a significant transformation from the perceived self out of control to a new, different self. This new self, as highlighted in the first sub-category, 'waking up to cognitive freedom', appeared to hold highly desirable qualities, contrasting with those perceived in the alcohol-controlled self, such as the experience of a different state of mind and an ability to relate more genuinely with life, with oneself and with others. The sober self was also characterised by an increased control in managing abstinence, evaluated through the perceived fading of cravings and an increased ability to deal with their onset, as described in the sub-category 'managing abstinence'. Finally, in sharp contrast with the self out of control, the sober self was also perceived as able to look after itself and more willing to accept and seek support, as highlighted in the last sub-category 'finding support'.

2.4.4.1 Waking up to Cognitive Freedom

The combination of imprisonment and abstinence appeared to provide participants with an opportunity to break off from the perceived self out of control and a life ruled by alcohol. Feelings of relief connected to experiencing daily existence without having to rely on drinking were widely shared throughout the accounts.

Imprisonment appeared to represent a chance to slow down, to concentrate on oneself as well as, for some, an opportunity to take control and responsibility over life. Participants reported how, compared to the outside, they felt overall happier, calmer, more able to manage emotional distress and life problems without consuming alcohol. One participant also reported how as a result of the ongoing abstinence he experienced a renewed sense of physical well-being: "I feel a lot better, feel my hair and my face, a lot better, fresh, fresh throughout my hair, my face, my hair is all fresh and the skin, it's all different (laugh)"
(Participant 10, p. 127)

Sobriety appeared to be accompanied by a renewed cognitive freedom, where the increased ability to focus and manage thoughts allowed participants to engage with life more actively, but also to feel more in control, more alert and more responsive when engaging with the external world.

> [Since in prison] You know, my drinking...not my drinking the sense of me being me I can focus and answer questions and being very alert of what's happening around me my eyes were shut a certain amount of time being there you know but here I couldn't realise that I was simply could have been like that. (Participant 5, p. 51)

Overall, participants reported experiencing a clearer and different state of mind, which, coupled with imprisonment, appeared to provide the ideal ground for acquiring a helpful distance from the alcohol-controlled self, as well as for some an opportunity to survive and to plan the future:

> Well I'll tell you what, by coming to prison I've saved my life by coming in ...because it takes you away from the alcohol for a short time, using time to

> clear up your mind, give you time to reflect, and gives you also time to figure out which direction you're actually gonna go in (Participant 8, p. 115)

Prison's controlled environment and the long hours spent in a cell seemed to trigger an ongoing examination of the outside self, where questions were raised in an attempt to make sense of its nature and dynamics. Participants often reflected on past negative experiences and mistakes in an attempt to chronologically assemble crucial details of a journey which led to a loss of control over alcohol.

> Being here [...] and being locked up 24 hours a day you get to really really analyse yourself, you really get to see yourself but a lot of my problems started in 2005 when I first had a car accident, I was knocked over by a truck crossing a road, all my arms were broken I've got metal plates, I lost all my teeth, I've got metal plates in here, metal plates to the sides as well, [...] when I actually looked at myself in the mirror after the accident there was nothing to my former self I was a handsome guy, ladies' man...but like I just lost my confidence and I started drinking and from there a spiral out of control (Participant 8, p. 107)

Participants also described how, as a result of acquiring a new frame of mind, they felt more aware, and able to regain perspective on themselves, including recognising their own skills and qualifications but also appreciating and welcoming the previously rejected family and/or external support. In this regard, many participants also described how the renewed cognitive freedom and the ongoing abstinence appeared to have opened new channels of relatedness and connection with the outside reality (including other individuals) but most importantly with themselves. A renewed ability to empathise with others was experienced by one participant towards victims of the crimes committed by himself prior to imprisonment. For another

participant the ability to be in touch with himself and his emotions appeared to be at the source of his experience of empathy:

> [W]hen I'm not drinking [...] I'm more aware, more mindful about the people's feelings and I think being adapted to my own feelings and emotions I'm then more able to understand other people more if I can understand myself more (Participant 9, p. 117)

The increased ability to connect to oneself brought to light the striking contrast between the sober self, which for the vast majority had only been experienced in prison, and the perceived out of control self whose life was ruled by alcohol. As a result of this ongoing exploration all participants articulated and described the sober self as a new and/or as a different self: "I know I'm a different person while I don't drink, the change in my behaviour is unbelievable" (Participant 2, p. 7). Some interpreted this new experience as waking up to, reverting or rejoining with a self that had been on hold for a while:

> I wasn't happy within myself so come to prison and being away from drink made me feel more happy with myself, I found myself as a person, which I'm happy with, 'cause I think it can be very hard sometimes to know who you are if you're drinking excessively, it's hard to know who you are (Participant 9, p. 125)

2.4.4.2 Managing Abstinence

Despite the achieved cognitive freedom and the newly acquired relation with the positive characteristics of the sober self, the vast majority of participants experienced cravings during imprisonment. These ranged from a mild desire to a powerful urge to

access alcohol. However, participants also pointed out how both the frequency and the intensity of cravings appeared to have considerably decreased in comparison with that experienced prior to imprisonment or during the withdrawing stages at admission: "I still get those occasional, very occasional cravings, but they don't last more than what two or three minutes" (Participant 4, p. 37)

For the majority of participants, triggers emerging from emotional states often appeared accompanied by flashbacks of past negative or positive events. Participants' ability to manage thoughts and emotions without alcohol was therefore perceived and used by many as evidence of an improved ability to stay abstinent.

Only two participants reported an effortless ability to stay sober in prison. One of them described how this resulted from a long-term abstinence and the consequent increased ability to recognise and deal with cravings more efficiently.

For the other participant, a totally different approach to imprisonment, starting with a withdrawal-free experience at admission (as described in the first category 'perceiving a self out control'), appeared to be at the root of this peculiar reaction. In his view, accepting the limited availability of alcohol together with focusing on oneself during imprisonment were at the root of his ability to switch off thoughts and urges around drinking, allowing him to almost automatically 'revert' to a sober self:

> [I]t's just an acceptance [...] mainly in here it's you can't drink [and alcohol] is not readily available so it's not in your face I don't know but when I come into jail I'll switch off [...] You see out there I drink everyday, to be honest when I think about it now it doesn't cross my mind at the moment, [...] and [...] I'm not having cravings, I think because I've just realistically gone back to where I was when I was clean and my way of thought isn't about me [...]

drinking anymore except part of me trying to get my shit back together.

(Participant 2, p. 4-7)

Triggers for cravings appeared to differ across participants. Nearly half of them described how quite often simple external or internal cues related to alcohol could act as powerful reminders and set off cravings. Watching TV adverts on alcohol, waking up from a dream where the participant was drinking, watching people consuming alcohol on TV, smelling alcohol on an officer's breath or knowing about friends outside going to the pub, could be a powerful and distressing experience.

However, the majority reported missing alcohol when experiencing a variety of emotional states. In almost all cases, negative emotions such as depression, suicidal ideations, loneliness, anger, stress and boredom, could trigger the urge to drink. However, a minority of participants also described how cravings could be experienced as a result of positive emotions such as happiness:

> I've come to realise there's two different variations to wanting a drink, you can be seriously light and happy, you might win the pools, you might get a decent job, you might meet a girl and get married [...] and that's your upstage, your downstage, you could lose someone [...] or your house burns down [...] and either end of the spectrum you feel like you wanna drink.
>
> (Participant 4, p. 42)

Unsurprisingly perhaps, the majority of participants reported how managing cravings also implied dealing with difficult emotions. The range of techniques used to avoid drinking included focusing on cognitive processes such as rationalising emotional states and cravings, engaging in positive self-talk, concentrating on release, foreseeing negative consequences, but also trying to forget and switching off thoughts around drinking. Nearly half of the participants also shared emotional

distress and the onset of cravings with fellow inmates in an attempt to find support and relief. Some felt that the inability or unwillingness to share emotional distress would most certainly lead to relapse. The vast majority of participants also reported engaging in various activities aiming at distracting their minds from cravings. Many of these activities depended on the inmate status (e.g., enhanced status) or on the extent of privileges obtained; these included playing guitar, spending long hours outside the cell, socialising with other inmates, accessing the gym, joining prison courses, working and focusing on the AA programme. Other activities used as distraction included watching TV, reading and writing poetry. Only one participant (as mentioned in the category 'choosing abstinence') reported managing cravings by smoking cannabis. In addition, nearly half the participants avoided the vicinity of inmates who carried on using drugs or alcohol in the attempt to prevent the onset of cravings and thoughts about drinking.

Overall, participants seemed to regard the opportunity to share emotional distress as well as the engagement in out-cell activities as more helpful in successfully staying sober. Only the participant who used cannabis regarded trying to forget about alcohol through smoking as more effective. Finally, the result of successfully dealing with cravings contributed to acquiring a positive view of oneself, a perceived control over the urge to drink and acted as an incentive to carry on with abstinence.

2.4.4.3 Finding Support

The vast majority of participants decided to ask for support soon after admission, with only one participant seeking help later on in his sentence (as highlighted in the

category 'choosing abstinence'). The decision to seek support appeared to be influenced by the degree of awareness participants had around their alcohol problem, although two participants reported a different experience. For one participant, as described in the first category ('perceiving a self out of control'), barriers to accessing support were not being aware of prison support services, as well as fearing the disclosure of his alcohol and drug use. For another participant, the decision not to enrol in AA appeared to be determined by his willingness and perceived ability/strength to deal with his alcohol problem on his own: "I'm strong minded as it is, you know what? I can actually deal with it myself, I don't need nobody to help me" (Participant 8, p. 115). However, despite his decision to avoid prison programmes for alcohol problems, he too, like many others, found support during imprisonment, as many opportunities emerged from other sources, such as prison courses and peer-support. Some participants looked at imprisonment as an opportunity to implement changes in life by attending courses aiming at the acquisition of various skills (e.g., IT, literacy). Others also recognised an opportunity to shelter from an alcohol-controlled life. In particular, one participant described how the need to break off could reach the extent of purposively seeking imprisonment:

> [C]all me cynical but I think a few people often thought they'd get put away for a few months and get detox for a couple of months...people who come into this jail, they get arrested and be happy to be here (Participant 2, p. 9)

The willingness to seek imprisonment in order to access detoxification appeared to be connected to participants' awareness of the improvements prison services had undergone overtime. This was mostly highlighted by those who, through repeated imprisonments, had had the opportunity to witness the changes first hand. However, one participant reported how changes to prison support for inmates with alcohol

problems hosted within the Vulnerable Prisoners Unit were still far from being completely efficient. As he described, the unit's focus on sex offenders coupled with the risks for inmates of sharing AA groups with the main prison population, left little space to alcohol and drug services. In addition, as he had been abstinent for many years and had a lengthy experience of AA, he felt that the unit was able to offer him very little support, jeopardising the possibility of making any significant progress:

> [T]he wing we're on is not affiliated for drugs and alcohol anyway, is more for SOTP and things like that...and if you're in for other type of crime you get anything you want [...] If I'm at another prison where I've got lots of meetings, I've got other things what I can do and I come here and there is nothing, they stopped me in my tracks. So it's hard to keep motivated here to want to change [...] downstairs is for people who are in the main, population of the prison [...] you can't go there 'cause you get beat up by them 'cause they think you're a sex offender...we don't get nothing, they get, we don't, simple (Participant 7, p. 88, 89)

As he continued, the main problem with AA for inmates with alcohol problems hosted in VPU was the limited number of weekly meetings and the fact that those were shared with inmates with drug problems. In his view, this was unhelpful in keeping inmates motivated to stay abstinent and to work on their alcohol problem.

> [W]e get two AA meetings a week [...]. You have to suffer it, the AA people have to suffer it [...] [because] they've got people coming in and talking about drugs all the time, that can't be very helpful for the person who's the alcoholic is it? 'Cause you think 'am I in the wrong place? Is this really helpful for me?'[...] so they should really split the two up and have AA meetings (Participant 7, p. 89, 90)

For those who had already accessed prison support in the past, the willingness to find help again was accompanied by the need to tackle the alcohol problem anew. This usually appeared to be expressed through a desire to reach a different and deeper level of disclosure and understanding of the reasons and dynamics around excessive alcohol consumption.

> I've come in this time I sat down and I thought to myself 'right, what can I do this time that I didn't do last time?' and what I realised was I had to really dig down into the core of what the problem was you know the stuff that when I've been in treatment in prison that I didn't wanna talk about in front of fifteen men in a group (Participant 3, p. 17)

The vast majority of participants were enrolled in an AA programme at the time of the interview. One participant had been enrolled during the current sentence but was no longer going to the meetings. Reasons for this were not reported although he differed from all the others by being the only one who had opted to manage abstinence by smoking cannabis. Participants reported experiences of AA were very positive. The meetings appeared to provide a ground for comparison where different perspectives and stories related to alcohol were shared. This allowed an opportunity to witness the extent and variety of negative consequences of excessive alcohol intake through others and provided a chance to gain insight into personal issues and a possibility to explore and understanding the nature of cravings. The meetings' stress on sharing was reported by all participants and appeared to contribute to emerging feelings of relatedness and belonging, where trust, hope and courage were part of an experience described by many as life changing. Relevant to the programme's focus on sharing, participants also reported different degrees of uncertainty and difficulties regarding opening up within an 'all-male' group. Some participants also described

how their ability to open up had increased over time as a consequence of repeated exposure and/or imprisonment. Similarly, one participant reported how difficulties experienced when he first enrolled in the programme were also related to listening to others' negative experiences. The overwhelming impact of inmates' stories reached the extent of generating a mixture of reactions including feeling high but also fearing others' stories:

> It's like a horror story here, [...] and when I went down the first time I thought 'Damn' I said 'this is like going to the pub, just by listening to them!' I used to detox myself get drunk going in there, I used to go there and get high [...] just by listening to them I thought this is not happening, I was scared to go there and I had to get more encouragement to go [...] I wanted to run out the room and I thought 'oh I don't wanna listen to that' ah, I couldn't tell them that I had to stay there and take it and absorb it [...] and I thought every time I go there somebody say something too frightening, [...] I think 'oh my God destruction is surrounding me' and I thought I've never been in that form of destructionness, God that's what happen when you beyond the point? (Participant 5, p. 55, 56)

Only one participant reported difficulties in carrying out written assignments for the AA programme.

The level of confidentiality perceived within the AA group by members was very high. Generally participants seemed to share feelings of uncertainty toward disclosing confidential material within the rest of prison. This was, for many, accompanied by high levels of anxiety and participants who needed support out of AA hours preferred to share their concerns with trusted inmates who usually also shared an alcohol problem rather that availing themselves of the opportunity to

arrange a meeting with a Listener. Accordingly, none of the participants interviewed reported having sought help through Listeners. One participant held negative views towards inmates working as Listeners and questioned not just their ability to provide real help but also the fear of confidentiality breach:

> I mean you get Listeners...yeah, but they only sort of skim the surface they don't go into deep down, deep inside the things...I think with a lot of alcoholics until they get to that point where they know they can let go safely in a controlled environment without anything going beyond the confidentiality stage, they tend to clam up, that's what I was doing, I didn't want anyone knowing about me or what I used to do (Participant 4, p. 44)

Participants reported how information about alcohol and drug services was very often gathered through other inmates although, for a minority, a history of repeated imprisonment and enrolment in prison services allowed them not only to be fully aware of the range of treatments available but also functioned as a safety net against the risk of confidentiality breach, as they were able to ask for support from drug/alcohol workers known during previous sentences. This was perceived as highly valuable in allowing continuity of care and the opportunity to share concerns, goals and reservations within a trusted space.

Overall, it appeared that whether or not they were enrolled in AA at the time of the interview, participants shared a profound need to increase their knowledge around alcohol problems and perceived prison as a suitable place for this purpose.

Finding support and gaining insight about alcohol problems within the prison environment was also possible through other inmates sharing similar problems.

Nearly all participants reported having been able to make use of an inmate's

support, most commonly a cellmate, who they could rely upon during stressful moments.

For a minority of participants, the reciprocal support also contributed to forming strong bonds during imprisonment and, while the attempts to further explore the dynamics surrounding alcohol problems carried on outside the perimeter of the weekly AA group meetings, these new friendships were also perceived as continuing after release through the planning of joined future goals:

> [M]e and him are good friends...[...] when we were outside we were friends [...] but now we're the closest there can be between him and I it's like, it's a unity, it's not a unity or a friendship that you speak about, you feel it in your spirit, your inner self, you feel that bond [...] we discuss things that led us to the past and now we're looking at ways to be successful in the future, so him and I are sitting down and we're trying to work out a business plan (Participant 8, p. 108, 109)

2.4.5 Foreseeing a Self out of Control

'Foreseeing a self out of control' embraces participants' hopes and plans for the future after imprisonment, as highlighted in the first sub-category's 'establishing goals and planning post-release support', but also looks at participants' concerns surrounding the perceived difficulty of avoiding relapse and struggle to envisage a life-long state of abstinence, as described in the final sub-category 'dealing with uncertainty'.

2.4.5.1 Establishing Goals and Planning Post-release Support

Participants shared a committed desire to live a better life after release and regarded the likelihood of its success as dependent on transforming their relation with alcohol; that is, achieving some control over its use, either via complete abstinence or through moderate consumption. Three participants also highlighted how the goal of carrying on with sobriety after release partly stemmed from the desire to avoid future imprisonment.

Although the connection between post-release drinking patterns and a better life was widely shared, the degree of perceived powerlessness toward alcohol appeared to influence the extent of the desired control over it. Whilst the majority of participants perceived themselves as completely unable to regulate their alcohol intake and regarded life-long abstinence as the only option, one participant aimed at transforming his relation with alcohol via increasing control and reducing alcohol intake after release. In his case, past experiences of drinking only at weekends in prison as well as the current use of cannabis appeared to influence the perceived ability to exert some control over substances.

Another participant who desired to reduce alcohol intake after release had already experienced some form of control outside prison and identified himself as a 'binge-drinker', therefore not relying on alcohol on a daily basis. Although enrolled in the AA programme, which predicates complete abstinence, this participant reported mixed feelings about the prospect of staying sober for the rest of his life. As highlighted in the category 'perceiving a self out of control', he distinguished between right and wrong motivations for drinking, where the latter refers to drinking to socialise better and to numb emotional distress. This distinction and the

consequent possibility of drinking for the right reasons, allowed him to foresee an alternative option to abstinence, which appeared more desirable:

> [I]f I could have a bit more self-control around drink, I'd be more happy and if I was drinking for the right reasons as well...like if I wasn't so much drinking to go out to feel good about myself then I'd feel better (Participant 9, p. 125)

For the vast majority of participants, the likelihood of achieving some control over drinking after release was strictly connected to planning and putting into place the necessary support. For three participants, strategies to avoid losing control over alcohol included planning to attend AA classes on the outside and, in one case, meeting up with the allocated sponsor at the gate on release:

> [T]his time will be different that's why I'm going to secondary and I'm getting someone to meet me at the gate to take me to the secondary, 'cause I know temptation will be there (Participant 6, p. 83)

Only two participants felt able to receive family support after imprisonment and foresaw their positive reaction over the decision to carry on with abstinence.

The majority of participants planned to move area and avoid the known circle of friends who consumed large quantities of alcohol and drugs. For half the participants, planning the future also included finding a direction during imprisonment (e.g., through courses) in order to secure a job after release. Three participants described a strong desire to help people with alcohol and drug problems after release, as they felt they had acquired an expertise in the area. As one participant highlighted, the desire to help others after release partly contributed to his commitment to staying sober:

> [W]hat I realised is that I've such a massive message to give because of my own experience and to be able to share that with someone else and to try and help them... I think is priceless, d'you know what I mean so...that's the plan and I can only do that by staying sober. (Participant 3, p. 25)

Overall, only two participants did not report planning strategies to avoid relapse after release. One participant, as described above, was still using cannabis during imprisonment and looked at decreasing alcohol intake after release. Another participant who had experienced drinking small amounts of alcohol during a previous sentence (as described in 'choosing abstinence') expressed the desire to carry on with abstinence after release, but did not mention plans to support this.

2.4.5.2 Dealing with Uncertainty

Participants highlighted how, as a result of the achievements obtained during imprisonment, (e.g., being able to stay sober, acquiring new skills and awareness through peer-support and prison courses) they had begun to feel more confident and better equipped to sustain sobriety after release or to increase control over alcohol.

However, despite an increased sense of confidence, feelings of uncertainty around the future were also widely shared. For many, concerns stemmed from past negative experiences of repeated imprisonment due to relapse after release, which appeared to shatter hope and commitment.

> I've been to prison say about eight nine times, let's call it ten times, every time I've walked out of prison the first place a person goes is to the off-licence and I'm used to that [...] they say 'A leopard never changes its spots'

> [...] and I know one of my behaviours is when I come out of prison I go straight to the off-licence (Participant 6, p. 83)

However, participants who did not report a history of repeated imprisonment also shared similar concerns. Generally, the descriptions of plans to be implemented after release were coloured by uncertainty and hope. Participants 'hoped' to be able to implement those important changes in life and 'hoped' that the skills and awareness acquired during their time in prison would be enough in order to live a life free from alcohol control. Many participants shared fears and concerns surrounding the perceived inability to cope with emotional distress and life struggles after release.

This resulted in the perceived fragility of holding onto sobriety for a long time and a sense of resignation towards the unknown future:

> [Y]ou can have all these big plans, all these big ideas and then when I get out from here all it takes you is just one episode to push you backwards, and when I say one episode for instance, you might plan your day out right, to go and do something with it and it doesn't actually work out, the business plan might not work out you get depressive and instead of riding over depression and looking ahead and looking up to solve the problem you go back into the easy way out and start drinking again. (Participant 8, p. 107)

For one participant, a history of repeated imprisonment and relapse resulted in avoiding commitments to future abstinence. Despite his firm decision to carry on with abstinence, the prospect of never being able to drink again was able to transform life into something undesirable. In his view, the only way forward was choosing sobriety day-by-day:

> [T]he way I have to kinda of to look at this is to keep it in a day, you know, like today I can't have a drink you know [...] and then tomorrow we'll worry about tomorrow when tomorrow comes 'cause [...] if I project, like if I say I can never drink again that's gonna be so boring and I'm not gonna have a good time you know, I'm not gonna be looking forward to life
>
> (Participant 3, p. 13)

The vast majority of participants felt unable to foresee a future without alcohol and shared similar mixed feelings when facing the prospect of life-long abstinence. Many described feelings of sadness and boredom at the idea of not being able to drink in the future. In the majority of cases, meanings attached to future abstinence stemmed from perceiving drinking as a very pleasurable social activity. The power of alcohol and its legality outside prison acted as a constant reminder and temptation, which participants perceived as highly challenging. Moreover, participants' ability to stay sober during imprisonment, although widely valued, was described as largely due to being restricted from alcohol. One participant described how on release from a previous sentence, he seemed to have forgotten everything he had learned during his time in prison and perceived drinking as a 'natural instinct' in order to celebrate the regained freedom.

> I don't have a problem in staying clean in prison, in staying sober you know but when I get outside the first thing my normal thing to do is to go and have a beer you know I'd forget everything that I've done in prison all I wanna do is have a drink it's you know I am free and I wanna celebrate you know and every time I've been in prison since you know since I was seventeen you know I've done that first thing I've done when I walked out of the gates is to

> go to the nearest pub or the nearest off licence and get myself a lovely cold can of lager you know it's just a natural instinct (Participant 3, p. 14)

Another participant expressed similar concerns, when describing his association between drinking and pleasurable times. In his view, a tendency to forget negative experiences and to keep hold only of the positive ones created an obstacle to his desire to stay abstinent. In addition, his young age and peer-pressure were perceived as partly contributing to his difficulties in envisaging a future without alcohol:

> I suppose it's because I'm young as well and I just feel a lot of peer pressure as well from other people maybe, you know, 'cause it's a hard thing to have to accept that being such a young age that I can never drink again...and that's hard for me to accept (Participant 9, p. 117)

Many participants perceived their alcohol problem as depending on a chronic, intrinsic problem, impossible to prevent or cure. Such views were widely shared and partly reinforced by the AA framework and predicaments, as described by one participant:

> I will never tell myself that I'm cured you know because I don't think there's a cure there isn't a cure there is a there's a saying in alcoholics anonymous and it's 'we can we can arrest it we can we can you know we can arrest it temporarily by going to meetings, by showing what's going on we can never be cured' you know because is a cunning illness it's a really cunning illness and it can get you like that (clicking fingers) it's an illness you know, it's an illness...ehm...that's about all I can say really, I hopefully will do it this time (Participant 3, p. 25)

The prospect of a far from desirable future characterised by a perpetual danger of relapsing, coloured the accounts with feelings of powerlessness and sad resignation.

Only one participant did not share such feelings; his current use of cannabis and the plan to reduce rather than to hinder future alcohol consumption, appeared to underpin his unique experience.

2.5 Discussion

The purpose of the present study was to explore the experiences of adult male inmates with alcohol problems hosted in a Category B prison in London (UK).

The findings highlighted a number of interesting similarities with qualitative studies in various settings (including prisons and community-based programmes for substance problems). The findings also provided some evidence for the occurrence of identity transformation in the context of behavioural change. In addition, the present study draws attention to the possible detrimental effects of a disease approach to 'alcoholism' and the related abstinence-driven views of current formal and lay treatments (e.g., Alcoholics Anonymous), including the potentially disempowering effects that this can have on individuals' emerging identity.

The broader literature on behavioural change and identity transformation appears to be highly relevant to the present study. Triggers for behavioural change reported throughout the accounts were consistent with those highlighted in the literature on treated individuals such as 'rock bottom' (Brill, 1972; Waldorf, 1983), existential crisis (Coleman, 1978) and profound despair (Bull, 1972), as well as appearing consistent with motivations initiating spontaneous remissions in

individuals with heroin problems (Waldorf and Biernacki, 1981). In addition, due to the coercive nature of incarceration, participants' motivations to change can also be regarded in the context of a treated (although coercively) remission. Equally, the experience of being admitted to prison can certainly be considered as a significant event or accident that motivates change.

Rational choice, as highlighted by Waldorf and Biernacki (1981) and others (see for example, Toneatto et al., 1999) also resonates with participants' experience of choosing abstinence. By engaging in a cognitive assessment of the pros and cons of carrying on drinking, a desire to break free from problematic alcohol use emerged widely amongst participants.

The literature on inmates' positive views of imprisonment as a valuable opportunity to ameliorate their life and interrupt substance use by accessing detoxification and enrolling in educational courses (Ashkar and Kenny, 2008; Crewe, 2005; Condon et al., 2007; Tompkins et al., 2007), also echoes the experiences of participants in the present study. Opting for sobriety in order to avoid future imprisonment also emerged in the accounts and echoed other studies with inmates (Ashkar and Kenny, 2008; Smith and Ferguson, 2005).

In addition, other motivations for choosing abstinence were reported which aimed at ameliorating life in prison, for instance by obtaining privileges, enhanced status or in order to avoid punishments. In this sense, while alcohol and drugs were described as providing inmates with a short-term freedom from the 'prison walls', the potential gains of complying with the system and obtaining privileges appeared to guarantee a longer-term release from the daily burdens of imprisonment. The process of 'strategic thinking' described by Cope (2000) and reported in other

prison-based studies (Crewe, 2005; Squirrell, 2007) appears consistent with this particular type of assessment carried on during incarceration.

The limited availability of manufactured alcohol and difficulties of making hooch also appeared to have an impact on participants' choices, consistent with what has been identified by previous prison-based research on drugs (Crewe, 2005; Ashkar and Kenny, 2008).

Furthermore, Ashkar and Kenny's findings (2008) highlighting how access to drugs depends on the inmates' hierarchic position, might shed light on why the experienced availability of alcohol differed so much between participants in the present study.

Overall, these findings are crucial as they highlight how seemingly contradictory triggers to behavioural change (i.e., commitment to ameliorate one's life coupled with choosing abstinence for fear of being caught or in order to obtain privileges) might be unambiguously coexisting in the same individual and equally important to initiating change.

Using substances in order to deal with emotional distress and life struggles (Zakrzewski and Hector, 2004; Smith and Ferguson, 2005) and to avoid withdrawal symptoms (Smith and Ferguson, 2005) were also noted in the present study in participants' recollections of life prior to imprisonment. Also consistent with this study are findings reporting participants' fear of withdrawal symptoms at admission (Allen et al., 2005; Condon et al., 2007), although only one participant reported having experienced delays in accessing medications.

As previously suggested, imprisonment appears to have an impact on behavioural change (i.e., as a significant event); however, as the literature (Kearney and O'Sullivan, 2003) and participants' accounts suggest, the process is greatly

influenced and stimulated by an ongoing self-appraisal. The findings highlighted how participants recalled and reflected upon a variety of past negative experiences, which triggered feelings of regret and guilt and encouraged a detachment from the perceived all-negative and out of control former self. These findings were also highlighted in other studies (Horrocks et al., 2004; Smith and Ferguson, 2005; Zakrzewski and Hector, 2004; Crewe, 2005). Consistent with the literature on identity transformation, the process also led to the appearance of a new all-positive sober identity, as also identified by the literature (Crewe, 2005; Horrocks et al., 2004; Smith and Ferguson, 2005).

Research on the experience of time during life crises (Schmid and Jones, 1991; Adam, 1995) also bears significance in the context of participants' reported inability to focus and reflect on themselves prior to incarceration. These findings also resonate with other studies synthesised by Kearney and O'Sullivan (2003) suggesting the detrimental effects that the inability to engage in self-appraisals (such as for lack of time) can have on behavioural change and identity transformation. In this light, it can be suggested that participants were facilitated in engaging with the process of introspective self-appraisal by the more conscious quality of time experienced during incarceration, as also highlighted by other prison-based studies (Cope, 2003; Ashkar and Kenny, 2008).

The push towards becoming 'ordinary' (Waldorf and Biernacki, 1981) and the desire to adjust to a more conventional social reality (Jorquez, 1983) were also found in participants' post-release plans, through the desire to cut ties with the former identity's network and planning post-release job and activities. These plans were also consistent with the experiences of other inmates (Ashkar and Kenny, 2008; Severance, 2004; Smith and Ferguson, 2005; Crewe, 2005) and were initiated during

imprisonment by avoiding engagement with the prison alcohol and drug network, attending educational courses and preparing for post-release jobs.

The prevailing and widespread disease model discourse needs to be taken into consideration when exploring the present findings. In particular, it is important to note that all participants in this study had had some contact with AA and it is therefore not surprising that this should colour their stories and views on their alcohol problem. This is not to invalidate participants' experiences of suffering, which were deeply touching and real, but to shed light on certain aspects and ambiguities shared by participants, such as for example their perceived inability to control alcohol intake. The irregularity of alcohol availability in prison together with the lengthy and complex procedure to make hooch, forced participants at a time when they were drinking in prison, to manage a wait in order to access alcohol. This highlights an interesting aspect of their perceived inability to control alcohol and the related powerlessness. Although being abstinent in prison might be facilitated by the scarce availability of alcohol, participants' ideas and perceptions of an untameable illness appear to contradict their previous experiences of moderate drinking. Stories of consuming alcohol in the past within prison, although negative in one case, were usually described as positive and isolated events of inebriation or moderate drinking, quickly followed by an apparently smooth resumption of prison life routine.

Furthermore, it is suggested that the AA message of powerlessness might appear confusing and hard to accept; in fact, whilst inmates 'ought' to look at 'alcoholism' as an incurable chronic disease, their past prison experiences of moderate drinking seems to narrate a different story.

A minority of participants felt in disagreement with the prison alcohol ban despite reporting high levels of commitment to address their alcohol problem.

Perhaps this apparent contradiction might shed light on different views and meanings that individuals hold behind the desire to 'address' their alcohol problem. Many inmates might not regard abstinence as the only way forward but might have no alternative than to choose sobriety since this underpins the very core of the only programme (i.e., Alcoholics Anonymous) available in some prisons.

Once again these findings raise questions about the appropriateness of the disease model of 'alcoholism' on which these treatments, which sees the 'alcoholic' as destined to a life-long abstinence, are predicated. Participants struggled to accept a life without alcohol and, similarly to other studies, this made them feel different and alienated (Cope, 2000; Smith and Ferguson, 2005). In addition, it is important to point out how the goal of abstinence within the prison is likely to generate dropouts and unwillingness to seek support by those whose views are different from the AA message. In the present study, one participant left AA meetings for unknown reasons although he then reported the use of cannabis in order to manage cravings. The other participant perceived himself as sufficiently strong to deal with the problem on his own. This might suggest a desire to refrain from engaging with the 'alcoholism' discourse and the disempowering 'alcoholic' identity, which as previously suggested (Kearney and O'Sullivan, 2003) might be functional in re-affirming the stability of the newly acquired identity

Fears and concerns around relapse (Horrocks et al., 2004; Severance, 2004; Severance, 2004; Allen et al., 2005) and resuming the former identity after release (Horrocks et al., 2004) were also found in the present study, together with feelings of powerlessness partially managed through the implementation of protective post-release plans (Zakrzewski and Hector, 2004; Smith and Ferguson, 2005; Ashkar and Kenny, 2008; Squirrell, 2007). Participants in the present study expressed high levels

of uncertainty about their ability to remain abstinent after release. As highlighted by previous studies (Allen et al., 2005; Cope, 2000; Smith and Ferguson, 2005), the prison controlled environment was perceived as artificial, hence unable to provide a real measure to their ability to sustain sobriety. These concerns resonate with Horrocks et al.'s study (2004), which suggested how the new identity emerging during periods of abstinence in prison appeared quite fragile and full of uncertainties.

Interestingly, this was also highlighted in a study carried out within an AA group in the community, where even after many years of abstinence participants still credited Alcoholics Anonymous for their ability to stay sober (Zakrzewski and Hector, 2004). Inmates' accounts in Severance's study (2004) also described feelings of powerlessness and a resigned attitude of placing themselves in the hands of God in order to avoid relapse after release. These findings resonate with participants' views in the present study and, as the author stresses (Severance, 2004), although spirituality might certainly lead to beneficial outcomes (Quinn, 1999) the use of faith in treatment programmes should be approached with caution:

> For some inmates, faith may signify a fatalistic outlook in which success is perceived as out of their control. This tactic should be used cautiously. Inmates who believe they have no control over their own success or failure may be more likely to engage in self-defeating behaviors.
>
> (Severance, 2004, p. 93)

As previously suggested, perceiving oneself as unable to control alcohol use might enhance the view of a powerless identity and trigger self-defeating behaviours, in addition to increasing the risk of a chain-reaction of events confirming a self-fulfilling prophecy (Peele, 1984; Granfield and Cloud, 1999).

Although participants' experiences bore similarities with the literature on behavioural change and Biernacki's description of 'spontaneous remission' (Biernacki, 1983), their experiences also seemed to highlight a struggle to fully stabilise the newly acquired identity and this might partly explain the recurrence over the years of the imprisonment-abstinence-release-relapse cycle. The newly emerged identity is only able to be maintained during imprisonment and vanishes after release, as it is not sufficiently strongly constructed in order to survive life's temptations.

This study shows how people's experiences of 'coercive' treatment and recovery (e.g., in rehabilitation centres or prisons) might differ from those of individuals engaged with lay or formal treatments within the community. This is because whilst treatment received on the outside remains inextricably embedded in the reality of the everyday social world and therefore imbued with a variety and selection of 'identity materials' (facilitating the stabilisation of a new identity), inmates and individuals receiving treatment within an 'artificial' reality, are severely isolated from the social world, hence might lack appropriate 'identity materials' and a real opportunity to test their achievements.

Treatment for alcohol problems therefore needs to be planned with specific attention to the peculiarities of prison setting, including its manifest inability to provide a variety of identity tools. Hence the importance of supporting the process of identity transformation within the context of behavioural change seems particularly crucial in artificial environments such as prisons and therapeutic communities, where little exchange with wider society is available and where the variety of 'identity materials' is limited.

Finally, there is a need to provide and empower inmates with a wider range of treatment choice tailored to reflect the needs and diversity of individuals at different stages in the recovery process and presenting dissimilar experiences and perceptions of their problematic alcohol use, including that of those who describe themselves as 'binge-drinkers'.

2.5.1 Study Limitations

The internal validity of the present study might be compromised by the potentially inhibitory nature of being interviewed about alcohol use within a prison. The voluntary nature of the participation together with the sensitive subject of the study (alcohol stigma and illegality in prison) might have discouraged many inmates who were still actively drinking or taking drugs during their sentences and were unknown by the prison treatment service from taking part. The fact that all participants had had some contact with prison drug/alcohol services might compromise the possibility of generalising the findings to the rest of the prison population. However, the snowball technique might have allowed participants who were recruited through fellow inmates to feel more trusting and comfortable to discuss illegal activity in the prison.

In addition, the role of the interviewer who worked in the same prison as a Health Psychology trainee might have triggered participants to answer questions in ways that they perceived as socially desirable and consistent with a remedial approach as well as with the gender (female) of the interviewer. For instance, participants might have felt that it was 'desirable' to produce a narrative which endorsed a 'rehabilitative' position or, in accordance with hegemonic forms of

masculinity, they might have refrained themselves from showing high levels of distress when recounting their experiences of abstinence to a woman. Similarly, the interviewer/researcher's role might have led her to approach both the questioning and the analysis of the experiences gathered during the interviews from a remedial perspective. In addition, it is important to note that many inmates carry with them an already socially alienated identity (e.g., 'criminals') and therefore might be more susceptible and perhaps willing to accept the 'alcoholic's' label of loss of control as the provider of an opportunity to partly relieve guilt and responsibility over past behaviours. The researcher's critical background is also likely to have shaped and influenced the study by focusing at various stages (including data-gathering and analysis) on certain aspects which were less consistent with a mainstream and conventional perspective (e.g., debates and controversies around abstinence-based treatment programmes and so on).

Finally, as the study was carried out in a male prison, questions arise to extending the findings to the population of female inmates or to a different prison, which might have different services into place for alcohol problems. Similarly, as highlighted in the Methodology section, this study employed an abbreviated version of Grounded Theory (Langdridge, 2004; Willig, 2001) and therefore failed to reach theoretical saturation by refining participants' experiences in the light of new data.

APPENDIX A

Search Strategies

Table A1
ASSIA Search Strategy – Interface CSA Illumina

#	Search Query	Results
4	(AB=((alcohol abuse) or alcoholism or (alcohol use)) or AB=((alcohol misuse) or (drug abuse) or (drug use)) or AB=((drug dependenc*) or (substance abuse) or (substance misuse)) or AB=(substance use)) and (AB=(engl* or wales or britain) or AB=(british or (united kingdom) or UK)) and (AB=prison*)	192 results found in Social Sciences 19 results found in COS Scholar Universe: Social Science 0 results found in Multiple Web Sites Databases
3	(AB=((alcohol abuse) or alcoholism or (alcohol use)) or AB=((alcohol misuse) or (drug abuse) or (drug use)) or AB=((drug dependenc*) or (substance abuse) or (substance misuse)) or AB=(substance use)	25467 results found in Social Sciences 2859 results found in COS Scholar Universe: Social Science
2	(AB=(engl* or wales or britain) or AB=(british or (united kingdom) or UK))	75143 results found in Social Sciences 5547 results found in COS Scholar Universe: Social Science
1	(AB=prison*)	9687 results found in Social Sciences 664 results found in COS Scholar Universe: Social Science

Note. Social Sciences, English only, date range: 1998 to 2008.

Table A2
CINHAL Search Strategy (Cumulative Index to Nursing & Allied Health Literature) – Interface Ovid

#	Search History	Results
1	exp alcoholic intoxication/ or exp alcoholism/ or exp amphetamine-related disorders/ or exp cocaine-related disorders/ or exp marijuana abuse/ or exp opioid-related disorders/ or exp substance abuse, intravenous/ or exp substance withdrawal syndrome/	6651
2	mind altering.mp.	12
3	intoxicating.mp.	8
4	ecstasy.mp.	286
5	exp cocaine/ or exp crack cocaine/	1582
6	exp Drinking Behavior/	5102
7	substance misuse.mp.	333
8	(drug$ adj dependence).mp. [mp=title, subject heading word, abstract, instrumentation]	853
9	(drug$ adj misuse).mp. [mp=title, subject heading word, abstract, instrumentation]	182
10	(substance adj dependence).mp. [mp=title, subject heading word, abstract, instrumentation]	3487
11	prison$.mp.	2781
12	inmate$.mp.	619
13	incarcerated.mp.	433
14	remand.mp.	19
15	sentenced.mp.	69
16	detainee$.mp.	118
17	detention.mp.	263
18	convict$.mp.	570
19	jail$.mp.	464
20	(criminal adj justice adj system).mp. [mp=title, subject heading word, abstract, instrumentation]	209
21	1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10	15937

22	11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 or 20	4159
23	21 and 22	197
24	limit 23 to (humans and english language and male and female and "all adult (19 plus years)" and yr="1998 - 2007") [Limit not valid in: CINAHL; records were retained]	64

Table A3
Embase Search Strategy – Interface Ovid

#	Search History	Results
1	exp alcoholic intoxication/ or exp alcoholism/ or exp amphetamine-related disorders/ or exp cocaine-related disorders/ or exp marijuana abuse/ or exp opioid-related disorders/ or exp substance abuse, intravenous/ or exp substance withdrawal syndrome/	63363
2	mind altering.mp.	17
3	intoxicating.mp.	184
4	ecstasy.mp.	1611
5	exp cocaine/ or exp crack cocaine/	14721
6	exp Drinking Behavior/	7394
7	substance misuse.mp.	626
8	(drug$ adj dependence).mp. [mp=title, abstract, subject headings, heading word, drug trade name, original title, device manufacturer, drug manufacturer name]	14418
9	(drug$ adj misuse).mp. [mp=title, abstract, subject headings, heading word, drug trade name, original title, device manufacturer, drug manufacturer name]	2246
10	(substance adj dependence).mp. [mp=title, abstract, subject headings, heading word, drug trade name, original title, device manufacturer, drug manufacturer name]	634
11	prison$.mp.	5075
12	inmate$.mp.	1064
13	incarcerated.mp.	1326

14	remand.mp.	80
15	sentenced.mp.	202
16	detainee$.mp.	202
17	detention.mp.	993
18	convict$.mp.	1476
19	jail$.mp.	703
20	(criminal adj justice adj system).mp. [mp=title, abstract, subject headings, heading word, drug trade name, original title, device manufacturer, drug manufacturer name]	454
21	1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10	81264
22	11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 or 20	8651
23	21 and 22	1976
24	limit 23 to (humans and english language and male and female and "all adult (19 plus years)" and yr="1998 - 2007") [Limit not valid in: EMBASE; records were retained]	605
25	from 24 keep 1-597	597

Table A4

ISI Science Citation Index and ISI Social Science Citation Index Search Strategy – Interface Web of Knowledge

Combine Sets AND OR	Results	
#33	183	#32 AND #17 AND #11 DocType=All document types; Language=English; Databases=SCI-EXPANDED, SSCI; Timespan=1998-2007
#32	>100,000	#31 OR #30 OR #29 OR #28 OR #27 OR #26 OR #25 OR #24 OR #23 OR #22 OR #21 OR #20 OR #19 OR #18 DocType=All document types; Language=English; Databases=SCI-EXPANDED, SSCI; Timespan=1998-2007
#31	9,093	TS=(intoxicat*) DocType=All document types; Language=English; Databases=SCI-EXPANDED, SSCI; Timespan=1998-2007
#30	1,952	TS=(MDMA) DocType=All document types; Language=English;

		Databases=SCI-EXPANDED, SSCI; Timespan=1998-2007
#29	2,029	TS=(ecstasy) DocType=All document types; Language=English; Databases=SCI-EXPANDED, SSCI; Timespan=1998-2007
#28	7,842	TS=(injecting) DocType=All document types; Language=English; Databases=SCI-EXPANDED, SSCI; Timespan=1998-2007
#27	4,636	TS=(heroin) DocType=All document types; Language=English; Databases=SCI-EXPANDED, SSCI; Timespan=1998-2007
#26	102	TS=(hashish) DocType=All document types; Language=English; Databases=SCI-EXPANDED, SSCI; Timespan=1998-2007
#25	3,176	TS=(cannabis) DocType=All document types; Language=English; Databases=SCI-EXPANDED, SSCI; Timespan=1998-2007
#24	3,664	TS=(marijuana) DocType=All document types; Language=English; Databases=SCI-EXPANDED, SSCI; Timespan=1998-2007
#23	15,647	TS=(cocaine) DocType=All document types; Language=English; Databases=SCI-EXPANDED, SSCI; Timespan=1998-2007
#22	756	TS=("crack cocaine") DocType=All document types; Language=English; Databases=SCI-EXPANDED, SSCI; Timespan=1998-2007
#21	31,819	TS=(crack) DocType=All document types; Language=English; Databases=SCI-EXPANDED, SSCI; Timespan=1998-2007
#20	88,481	TS=(alcohol) DocType=All document types; Language=English; Databases=SCI-EXPANDED, SSCI; Timespan=1998-2007
#19	>100,000	TS=(drug*) DocType=All document types; Language=English; Databases=SCI-EXPANDED, SSCI; Timespan=1998-2007
#18	88,026	TS=(substance*)

		DocType=All document types; Language=English; Databases=SCI-EXPANDED, SSCI; Timespan=1998-2007
#17	>100,000	#16 OR #15 OR #14 OR #13 OR #12 DocType=All document types; Language=English; Databases=SCI-EXPANDED, SSCI; Timespan=1998-2007
#16	56,793	TS=(UK OR "United Kingdom") DocType=All document types; Language=English; Databases=SCI-EXPANDED, SSCI; Timespan=1998-2007
#15	12,732	TS=(Wales) DocType=All document types; Language=English; Databases=SCI-EXPANDED, SSCI; Timespan=1998-2007
#14	25,961	TS=(English) DocType=All document types; Language=English; Databases=SCI-EXPANDED, SSCI; Timespan=1998-2007
#13	24,018	TS=(England) DocType=All document types; Language=English; Databases=SCI-EXPANDED, SSCI; Timespan=1998-2007
#12	13,910	TS=(Britain) DocType=All document types; Language=English; Databases=SCI-EXPANDED, SSCI; Timespan=1998-2007
#11	20,895	#10 OR #9 OR #8 OR #7 OR #6 OR #5 OR #4 OR #3 OR #2 OR #1 DocType=All document types; Language=English; Databases=SCI-EXPANDED, SSCI; Timespan=1998-2007
#10	2,426	TS=(convict*) DocType=All document types; Language=English; Databases=SCI-EXPANDED, SSCI; Timespan=1998-2007
#9	1,127	TS=(custody) DocType=All document types; Language=English; Databases=SCI-EXPANDED, SSCI; Timespan=1998-2007
#8	1,179	TS=(jail*) DocType=All document types; Language=English; Databases=SCI-EXPANDED, SSCI; Timespan=1998-2007
#7	820	TS=("Criminal Justice System") DocType=All document types; Language=English; Databases=SCI-EXPANDED, SSCI; Timespan=1998-2007

#6	344	TS=(detainee*) DocType=All document types; Language=English; Databases=SCI-EXPANDED, SSCI; Timespan=1998-2007
#5	1,530	TS=(inmate*) DocType=All document types; Language=English; Databases=SCI-EXPANDED, SSCI; Timespan=1998-2007
#4	9,070	TS=(sentenc*) DocType=All document types; Language=English; Databases=SCI-EXPANDED, SSCI; Timespan=1998-2007
#3	171	TS=(remand*) DocType=All document types; Language=English; Databases=SCI-EXPANDED, SSCI; Timespan=1998-2007
#2	2,554	TS=(incarcerat*) DocType=All document types; Language=English; Databases=SCI-EXPANDED, SSCI; Timespan=1998-2007
#1	5,983	TS=(prison*) DocType=All document types; Language=English; Databases=SCI-EXPANDED, SSCI; Timespan=1998-2007

Note. **Search Tag Key: TS**=Topic, **TI**=Title, **AU**=Author, **GP**=Group Author, **SO**=Source, **PY**=Publication Year, **AD**=Address, **OG**=Organization, **SG**=Suborganization, **SA**=Street Address, **CI**=City, **PS**=Province/State, **CU**=Country, **ZP**=Zip/Postal Code

Table A5

Medline Search Strategy – Interface Ovid

#	Search History	Results
1	exp alcoholic intoxication/ or exp alcoholism/ or exp amphetamine-related disorders/ or exp cocaine-related disorders/ or exp marijuana abuse/ or exp opioid-related disorders/ or exp substance abuse, intravenous/ or exp substance withdrawal syndrome/	35299
2	mind altering.mp.	20
3	intoxicating.mp.	176
4	ecstasy.mp.	1452
5	exp cocaine/ or exp crack cocaine/	7484
6	exp Drinking Behavior/	17830

7	substance misuse.mp.	496
8	(drug$ adj dependence).mp. [mp=title, original title, abstract, name of substance word, subject heading word]	1033
9	(drug$ adj misuse).mp. [mp=title, original title, abstract, name of substance word, subject heading word]	323
10	(substance adj dependence).mp. [mp=title, original title, abstract, name of substance word, subject heading word]	596
11	prison$.mp.	6636
12	inmate$.mp.	1351
13	incarcerated.mp.	1354
14	remand.mp.	74
15	sentenced.mp.	207
16	detainee$.mp.	195
17	detention.mp.	678
18	convict$.mp.	1601
19	jail$.mp.	782
20	(criminal adj justice adj system).mp. [mp=title, original title, abstract, name of substance word, subject heading word]	375
21	1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10	58088
22	11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 or 20	9878
23	21 and 22	943
24	limit 23 to (humans and english language and male and female and "all adult (19 plus years)" and yr="1998 - 2007")	324

Table A6

Medline Daily Update Search Strategy – Interface Ovid

#	Search History	Results
1	exp alcoholic intoxication/ or exp alcoholism/ or exp amphetamine-related disorders/ or exp cocaine-related disorders/ or exp marijuana abuse/ or exp opioid-related disorders/ or exp substance abuse, intravenous/ or exp substance withdrawal syndrome/	66
2	mind altering.mp.	0

3	intoxicating.mp.	0
4	ecstasy.mp.	2
5	exp cocaine/ or exp crack cocaine/	10
6	exp Drinking Behavior/	23
7	substance misuse.mp.	1
8	(drug$ adj dependence).mp. [mp=title, original title, abstract, name of substance word, subject heading word]	2
9	(drug$ adj misuse).mp. [mp=title, original title, abstract, name of substance word, subject heading word]	0
10	(substance adj dependence).mp. [mp=title, original title, abstract, name of substance word, subject heading word]	1
11	prison$.mp.	12
12	inmate$.mp.	2
13	incarcerated.mp.	5
14	remand.mp.	0
15	sentenced.mp.	0
16	detainee$.mp.	1
17	detention.mp.	1
18	convict$.mp.	0
19	jail$.mp.	2
20	(criminal adj justice adj system).mp. [mp=title, original title, abstract, name of substance word, subject heading word]	0
21	1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10	91
22	11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 or 20	15
23	21 and 22	4
24	limit 23 to (humans and english language and male and female and "all adult (19 plus years)" and yr="1998 - 2007")	1

Table A7

Medline In Process & Other Non-Indexed Citations Search Strategy – Interface Ovid

#	Search History	Results
1	exp alcoholic intoxication/ or exp alcoholism/ or exp amphetamine-related disorders/ or exp cocaine-related disorders/ or exp marijuana abuse/ or exp opioid-related disorders/ or exp substance abuse, intravenous/ or exp substance withdrawal syndrome/	0
2	mind altering.mp.	1
3	intoxicating.mp.	5
4	ecstasy.mp.	65
5	exp cocaine/ or exp crack cocaine/	0
6	exp Drinking Behavior/	0
7	substance misuse.mp.	30
8	(drug$ adj dependence).mp. [mp=title, original title, abstract, name of substance word, subject heading word]	55
9	(drug$ adj misuse).mp. [mp=title, original title, abstract, name of substance word, subject heading word]	15
10	(substance adj dependence).mp. [mp=title, original title, abstract, name of substance word, subject heading word]	34
11	prison$.mp.	186
12	inmate$.mp.	51
13	incarcerated.mp.	69
14	remand.mp.	1
15	sentenced.mp.	9
16	detainee$.mp.	22
17	detention.mp.	32
18	convict$.mp.	64
19	jail$.mp.	25
20	(criminal adj justice adj system).mp. [mp=title, original title, abstract, name of substance word, subject heading word]	21
21	1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10	193
22	11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 or 20	389

23	21 and 22	9
24	limit 23 to (humans and english language and male and female and "all adult (19 plus years)" and yr="1998 - 2007")	0

Table A8
PsycINFO Search Strategy – Interface Ovid

#	Search History	Results
1	exp alcoholic intoxication/ or exp alcoholism/ or exp amphetamine-related disorders/ or exp cocaine-related disorders/ or exp marijuana abuse/ or exp opioid-related disorders/ or exp substance abuse, intravenous/ or exp substance withdrawal syndrome/	14477
2	mind altering.mp.	62
3	intoxicating.mp.	124
4	ecstasy.mp.	1092
5	exp cocaine/ or exp crack cocaine/	7677
6	exp Drinking Behavior/	33194
7	substance misuse.mp.	880
8	(drug$ adj dependence).mp. [mp=title, abstract, heading word, table of contents, key concepts]	1634
9	(drug$ adj misuse).mp. [mp=title, abstract, heading word, table of contents, key concepts]	457
10	(substance adj dependence).mp. [mp=title, abstract, heading word, table of contents, key concepts]	937
11	prison$.mp.	9496
12	inmate$.mp.	3335
13	incarcerated.mp.	2739
14	remand.mp.	131
15	sentenced.mp.	528
16	detainee$.mp.	335
17	detention.mp.	1121
18	convict$.mp.	4488

19	jail$.mp.	1355
20	(criminal adj justice adj system).mp. [mp=title, abstract, heading word, table of contents, key concepts]	1911
21	1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10	44305
22	11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 or 20	18046
23	21 and 22	719
24	limit 23 to (humans and english language and male and female and "all adult (19 plus years)" and yr="1998 - 2007") [Limit not valid in: PsycINFO; records were retained]	164

Note. Including PsycARTICLES 1985 - present

Table A9
Prison Health Research Network Search Strategy – Interface N/A

Key term	Results
Drug	98
Substance	54
Alcohol	42
Cocaine	10
Crack	5
Crack cocaine	3
Marijuana	4
Cannabis	1
MDMA	0
Ecstasy	0
Hashish	0
Heroin	17
Injecting	21
Mind altering	0
Intoxicating	0

Table A10

Zetoc Search Strategy – Interface Mimas

Prison* and substance*	81	Incarcerat* and substance*	57	Criminal justice system and substance*	15	Jail* and substance*	15	Detainee* and substance*	7
Prison* and drug*	376	Incarcerat* and drug*	85	Criminal justice system and drug*	36	Jail* and drug*	67	Detainee* and drug*	12
Prison* and alcohol	60	Incarcerat* and alcohol	19	Criminal justice system and alcohol	6	Jail* and alcohol	9	Detainee* and alcohol	7
Prison* and crack	1	Incarcerat* and crack	0	Criminal justice system and crack	0	Jail* and crack	2	Detainee* and crack	1
Prison* and crack cocaine	1	Incarcerat* and crack cocaine	0	Criminal justice system and crack cocaine	0	Jail* and crack cocaine	1	Detainee* and crack cocaine	1
Prison* and cocaine	4	Incarcerat* and cocaine	2	Criminal justice system and cocaine	0	Jail* and cocaine	1	Detainee* and cocaine	1
Prison* and marijuana	0	Incarcerat* and marijuana	2	Criminal justice system and marijuana	0	Jail* and marijuana	0	Detainee* and marijuana	4
Prison* and cannabis	3	Incarcerat* and cannabis	0	Criminal justice system and cannabis	0	Jail* and cannabis	0	Detainee* and cannabis	0
Prison* and hashish	0	Incarcerat* and hashish	0	Criminal justice system and hashish	0	Jail* and hashish	0	Detainee* and hashish	0
Prison* and heroin	13	Incarcerat* and heroin	6	Criminal justice system and heroin	0	Jail* and heroin	1	Detainee* and heroin	1

Prison* and injecting	24	Incarcerat* and injecting	5	Criminal justice system and injecting	0	Jail* and injecting	0	Detainee* and injecting	0
Prison* and ecstasy	0	Incarcerat* and ecstasy	0	Criminal justice system and ecstasy	0	Jail* and ecstasy	0	Detainee* and ecstasy	0
Prison* and MDMA	0	Incarcerat* and MDMA	0	Criminal justice system and MDMA	0	Jail* and MDMA	0	Detainee* and MDMA	0
Prison* and intoxic*	2	Incarcerat* and intoxicat*	0	Criminal justice system and intoxicat*	0	Jail* and intoxicat*	1	Detainee* and intoxicat*	1
Remand* and substance*	3	Sentenc* and substance*	7	Convict* and substance*	5	Custody and substance*	9	Inmate* and substance*	15
Remand* and drug*	3	Sentenc* and drug*	76	Convict* and drug*	37	Custody and drug*	23	Inmate* and drug*	60
Remand* and alcohol	0	Sentenc* and alcohol	5	Convict* and alcohol	28	Custody and alcohol	6	Inmate* and alcohol	15
Remand* and crack	0	Sentenc* and crack	9	Convict* and crack	0	Custody and crack	1	Inmate* and crack	0
Remand* and crack cocaine	0	Sentenc* and crack cocaine	6	Convict* and crack cocaine	0	Custody and crack cocaine	1	Inmate* and crack cocaine	0
Remand* and cocaine	0	Sentenc* and cocaine	16	Convict* and cocaine	0	Custody and cocaine	7	Inmate* and cocaine	1
Remand* and marijuana	0	Sentenc* and marijuana	1	Convict* and marijuana	0	Custody and marijuana	0	Inmate* and marijuana	3
Remand* and cannabis	0	Sentenc* and cannabis	1	Convict* and cannabis	5	Custody and cannabis	0	Inmate* and cannabis	1
Remand* and hashish	0	Sentenc* and hashish	0	Convict* and hashish	0	Custody and hashish	0	Inmate* and hashish	0
Remand* and heroin	0	Sentenc* and heroin	1	Convict* and heroin	3	Custody and heroin	3	Inmate* and heroin	3

Remand* and injecting	0	Sentenc* and injecting	1	Convict* and injecting	0	Custody and injecting	2	Inmate* and injecting	4
Remand* and ecstasy	0	Sentenc* and ecstasy	2	Convict* and ecstasy	0	Custody and ecstasy	0	Inmate* and ecstasy	1
Remand* and MDMA	0	Sentenc* and MDMA	0	Convict* and MDMA	0	Custody and MDMA	0	Inmate* and MDMA	0
Remand* and intoxicat*	0	Sentenc* and intoxicat*	3	Convict* and intoxicat*	1	Custody and intoxicat*	2	Inmate* and intoxicat*	0

APPENDIX B

Studies Excluded from the Review

Table B1
Excluded Studies

Author/s, date and title	Reason for exclusion
Ainsworth, A. (2004) The special needs of substance misusing women. *Prison Service Journal, 156, 25-26.*	The paper does not report findings from an empirical study
Dillon, L. (2001) *Drug use among prisoners: An exploratory study.* Dublin: Health Research Board.	Data was not collected in England or Wales
Gillespie, W. (2005) A multilevel model of drug abuse inside prison. *The Prison Journal, 85(2), 223-246.*	Data was not collected in England or Wales
Gore, S. M., Bird, A. G., and Cassidy, J. (1999) Prisoners' views about the drugs problem in prisons and the new Prison Service Drug Strategy. *Communicable Disease and Public Health, 2(3), 196-197.*	Data was collected before 1998
Hughes, R. A. (2000a) "It's like having half a sugar when you were used to three" - drug injectors' views and experiences of substitute drug prescribing inside English prisons. *International Journal of Drug Policy, 10(6), 455-466.*	Data was collected before 1998
Hughes, R. A. (2000b) Drug injectors and prison mandatory drug testing. *The Howard Journal, 39(1), 1-13.*	Data was collected before 1998
Hughes, R. A. & Huby, M. (2000c) Life in prison: perspectives of drug injectors. *Deviant Behavior: An Interdisciplinary Journal, 21, 451-479.*	Data was collected before 1998
Hughes, R. A. (2003) Drugs, prisons and harm reduction. *Journal of Health and Social Policy, 18(2), 43-54.*	The paper does not report findings from an empirical study
Lemieux, C. M. (2002) Social support among offenders with substance abuse problems: overlooked and underused? *Journal of Addictions & Offender Counseling, 23(1), 41-57.*	Data was not collected in England or Wales
Malloch, M. S. (2000a) *Women, drugs and custody: the experiences of women drug users in prison.* Winchester: Waterside Press.	Data from Scottish and English prisons and from young offenders and adults was reported together. Data collected before 1998 (i.e., 1993) was not disentangled from data obtained after 1998
Malloch, M. S. (2000b) Caring for drug users? The experiences of women prisoners. *Howard Journal of Criminal Justice, 39(4), 354-368.*	Data was collected before 1998
Jones, D. (2001) Beating the system - prison, drugs and psychodynamics. *Prison Service Journal, 136, 8-10.*	The paper does not report findings from an empirical study

APPENDIX C

Invitation Letter – Part 1

University of Southampton

Cristina Boserman
Crisis Counselling Service
Safer Prisons

Date

ALCOHOL RESEARCH

Prisoners with Alcohol Problems

Hi! My name is Cristina Boserman and I am a Trainee Health Psychologist at University of Southampton. I am carrying out a study of prisoners who are dependent on alcohol. This letter is addressed to those living in this cell, so please share it with your cellmate, if you have one. In order to invite people I picked some cell numbers by chance. This means that you have not been specially selected and I do not know anything about you.

WHY A STUDY OF ALCOHOL DEPENDENCE?

The aim of this research is to find out about the experiences and the needs of prisoners dependent on alcohol. Little is known about prisoners that are dependent on alcohol and this is one of the reasons why there are very few prison services to help them.

I would like to talk to people who used to drink alcohol almost everyday before they arrived here. I would also like to talk to anyone who might have developed an alcohol dependency whilst in prison.

If you feel that you are dependent on alcohol, please go to the next page. If you and your cellmate both would like to take part, please tick the box in PART 2 ('Request for a second invitation letter') and I will send him a new form to complete.

STOP HERE IF YOU DO NOT FEEL THAT YOU ARE DEPENDENT ON ALCOHOL

If you do not feel that you are dependent on alcohol you can still help!

PLEASE, PASS IT ON!

Do you know anyone who is dependent on alcohol? Do you think he might like to take part in this study? If yes, please pass to him all the information you just received (i.e., PART 1, PART 2 and the self-address envelope to the Safer Prisons office).

If you do not know anyone who might be interested, please send everything back to the Safer Prisons office (PART 1 & PART 2). You can use the self-addressed envelope (to the Safer Prisons office). In this way I will know that you opted out and I will not bother you again.

YOUR VIEW IS IMPORTANT!

If you would like to talk about your experience this might be an opportunity to do it! Your contribution will be used to try to help improve the services providing support to prisoners who are dependent on alcohol.

WHAT DO I HAVE TO DO IF I WANT TO TAKE PART?

If you decide to take part, please answer to the questions in PART 2 and use the self-addressed envelope to send them back to me (you can keep PART 1 for your information). As soon as I receive your reply I will check your answers and decide whether or not I am able to select you. If you are selected I will come to see you and we will arrange a date and a time for the interview. If your cell changes during the process do not worry, I will still be able to find you! The interview will last about 1 hour and will be tape-recorded. This is only for me to be able to study it later and it will not be shared with anyone inside or outside the prison.

WILL ANYONE ELSE KNOW ABOUT THE INFORMATION I WILL SHARE WITH YOU?

Your participation to this study is totally confidential. This means that none of the prison staff (including prison officers, nurses, social workers, etc.) will know why I am interviewing you and that none of the things you will tell me will be shared with them. As you might be aware, there are however particular circumstances where I will have to share some of the information you give me.
These are as follows:

- If a Court of Law tells me to
- If you give me detailed information that makes me believe that yourself or someone else is at risk of serious harm (e.g., name/s, prison number/s, location/s)
- If you give me detailed information that makes me believe that the National security and/or the security of the prison is at risk (e.g., name/s, prison number/s, location/s)
- If you give me detailed information that makes me think will help prevent and detect crime or apprehend or prosecute offenders (e.g., name/s, prison number/s, location/s or specific details of events happened in the past)

WILL MY DECISION TO TAKE PART OR TO REFUSE AFFECT ME IN ANY WAY?

Your decision to take part is voluntary and it is up to you whether to take part or not. Either way, your decision will not affect any aspect of your care and/or sentence.
If you decide to take part you have the right to change your mind and withdraw from the study at anytime. If you wish to do so, any data, including tape-recording that might personally identify you will be immediately destroyed. Finally, any information that could personally identify you (including tape-recordings) will only be used for this study and will be destroyed once it is finished (approximately October 2008).

ABOUT THE SELECTION
The selection will be made on a first come first served basis and I am only looking at interviewing 20 people in total. In order to secure a place in the study please make sure you reply as soon as possible. In addition, I am interested in hearing from people belonging to different age groups and ethnic backgrounds, so my selection will also depend on this.

HOW WILL I KNOW IF I HAVE NOT BEEN SELECTED?
If you were not selected I will send you a letter in 2 weeks from the day of receiving your reply. If you have not heard anything from me after 3 weeks your application might have got lost. At this point, if you would still like to take part in this study, please contact me in writing (you will find the address at the top of this letter) and I will send you a new invitation letter.

If you feel that this letter has caused you any distress please accept my most sincere apologies and do feel free to contact me.

APPENDIX D

Invitation Letter – Part 2

I WOULD LIKE TO TAKE PART!

If you wish to take part, please carefully read and answer to the following questions: (Please do so ONLY if you feel that you are currently dependent on alcohol and you wish to take part in this study).

Please tick one ✓ of the following:

1. Do you feel you are currently dependent on alcohol?

YES ☐ NO ☐

During the six months before you were admitted to prison…

2. Did you spend a large amount of your week in looking for alcohol, drinking and recovering from it?

YES ☐ NO ☐

3. Have you ever given up important social, occupational or recreational activities because of your drinking?

YES ☐ NO ☐

4. Have you ever thought about giving up or cutting down your drinking?

YES ☐ NO ☐

5. Have you ever felt the need to be more in control of your drinking?

YES ☐ NO ☐

During the year before you were admitted to prison...

6. Have you ever noticed that you needed to drink more in order to get the desired effect?

YES ☐ NO ☐

7. Have you ever tried to cut down or stop drinking?

YES ☐ NO ☐

7.1 If Yes, were you successful in the attempt?

YES ☐ NO ☐

8. Has a relative, friend, doctor or other healthcare worker been concerned about your drinking, or advised you to cut down?

YES ☐ NO ☐

Since you arrived at this prison...

9. Have you ever been worried about not being able to have a drink?

YES ☐ NO ☐

10. Have you received support for your alcohol problem by 1 or more services in this prison?

YES ☐ NO ☐

10.1 If Yes, which one?
Please tick one or more ✓ of the following:

AA meetings ☐
Detox ☐
One-to-one counselling ☐
Other ☐ Please specify:.....

10.2 Are you still enrolled in 1 or more of these?

YES ☐ NO ☐

10.3 Which one?
Please tick one or more ✓ of the following:

AA meetings ☐
Detox ☐
One-to-one counselling ☐
Other ☐ Please specify:.....

PERSONAL DETAILS

Name: .....

Surname: .....

Age: .....

Prison number: .....

Location: .....

Request for a second invitation letter

Please tick ✓ this box if you would like to receive another form for your cellmate ☐
Your cellmate's name is:
Your cellmate's surname:
Your cellmate's prison number is:

EQUAL OPPORTUNITY MONITORING FORM

1. Ethnicity
Please tick one ✓

- ☐ **01** White British
- ☐ **02** Irish
- ☐ **03** Any other White background, please specify: _____
- ☐ **04** Mixed White and Black Caribbean
- ☐ **05** Mixed White and Black African
- ☐ **06** Mixed White and Asian
- ☐ **07** Any other Mixed background, please specify: _____
- ☐ **08** Indian
- ☐ **09** Pakistani
- ☐ **10** Bangladeshi
- ☐ **11** Another Asian background, please specify: _____
- ☐ **12** Caribbean
- ☐ **13** African
- ☐ **14** Any other Black background, please specify: _____
- ☐ **15** Chinese
- ☐ **16** Any other ethnic group, please specify: _____
- ☐ **99** Do not wish to state

2. Nationality: _____

3. Disability Discrimination Act 1995
Do you consider yourself to have any disability?
(As defined by the Act: "A physical, sensory, or mental impairment which has a substantial and long-term adverse effect on a person's ability to carry out normal day-to-day activities")

☐ 0 Yes ☐ 1 No ☐ 2 Not Stated

APPENDIX E

Interview Schedule

1. When you first arrived in this prison, how did you feel about alcohol?

2. What went through your mind at the time?

3. How has your drinking changed since you arrived in this prison?

4. How is this different from when you were outside prison?

5. Could you tell me about any time, since you arrived in this prison, when you desperately wanted a drink?
How did you feel then? What went through your mind at the time?

6. Could you tell me about any time, before you arrived in prison, when you desperately wanted a drink? How did you feel then? What went through your mind at the time?

7. How do you feel about the difficulties of drinking in prison?

8. What makes drinking in prison pleasant?
Could you tell me a bit more about this?

9. What makes it unpleasant?
Could you tell me a bit more about this?

10. Since you arrived here, was there one particular time that you remember as the worst (that has to do with drinking)? Could you tell me how you felt then?

11. Since you arrived here, has there been any time that you remember as the best (that has to do with drinking)? How did you feel then?

12. What is it like to not being able to drink in prison?

13. Thinking back to when you were outside prison, how did you feel when you were not able to drink?

14. What do you do when you cannot drink here? How do you manage it?

15. How do you manage, if at all, to drink less alcohol in prison?

16. Is there anything else that you feel you might like to say about your experience here in prison?

APPENDIX F

Debriefing

Prisoners with Alcohol Problems
Debriefing Statement

The aim of this study was to find out more about the experiences and needs of prisoners with alcohol problems.
The information you gave me during the interview will be used to try to help the prison service to improve the way they support people with alcohol problems.
The results of this research will not include your name or any other identifying characteristics. You can have a copy of this summary if you wish.
You can also have a summary of the research findings once the study is completed (approximately October 2008). If you wish to receive them please write to me at the address below around November 2008 and I will be happy to send you a summary of the findings.
If you have any further questions please contact me at the following address:

Cristina Boserman
Crisis Counselling Service
Safer Prisons

If you feel upset as a result of this interview, please let me know and I will be happy to discuss it with you and to make a referral on your behalf.

Thank you for taking part in this research.

Signature _____ Date _____

Name Cristina Boserman

If you have questions about your rights as a participant in this research, or if you feel that you have been placed at risk, you may contact the Chair of the Ethics Committee, Department of Psychology, University of Southampton, Southampton, SO17 1BJ.
Phone: (023) 8059 5578.

APPENDIX G

Consent Form

University of Southampton

Prisoners with Alcohol Problems
Consent Form for Research Participants

Information sheet

My name is Cristina Boserman and I am a Trainee Health Psychologist at University of Southampton. I would like you to take part in a study of the experiences of prisoners with alcohol problems. During the interview I will ask you some questions about feelings and issues that affect you and your drinking. The interview will take up to 1 hour and will be tape-recorded. The results of this research will not include your name or any other identifying characteristics. I will not share the information you give me with anyone inside or outside prison. However, there are particular occasions where I will have to share some of the information you give me.
These are as follows:

- If a Court of Law tells me to
- If you give me detailed information that makes me believe that yourself or someone else is at risk of serious harm (e.g., name/s, prison number/s, location/s)
- If you give me detailed information that makes me believe that the National security and/or the security of the prison is at risk (e.g., name/s, prison number/s, location/s)
- If you give me detailed information that makes me think will help prevent and detect crime or apprehend or prosecute offenders (e.g., name/s, prison number/s, location/s or specific details of events happened in the past)

Your decision to take part is voluntary and you may withdraw from the study at any time. Whether or not you decide to take part, this will not affect any aspect of your care and/or sentence. If you have any questions please ask them now.

Signature Date
Name Cristina Boserman

Statement of Consent

I _____ have read the above informed consent form.
[participants name]

I understand that I can withdraw my consent and stop taking part at any time without penalty or loss of benefit to myself. I understand that the information I will give during the interview will be treated confidentially, and that published results of this research will not reveal my name or other identifying characteristics. In signing this consent letter, I am not giving up my legal claims, rights, or remedies. A copy of this consent letter will be offered to me.

(Circle Yes or No)

I give consent to take part in the above study	Yes	No
I give consent to be tape recorded	Yes	No
I understand that these tape recordings will be destroyed after analysis (Approximately October 2008)	Yes	No

Signature Date
Name

I understand that if I have questions about my rights as a participant in this research, or if I feel that I have been placed at risk, I can contact the Chair of the Ethics Committee, Department of Psychology, University of Southampton, Southampton, SO17 1BJ. Phone: (023) 8059 5578.

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