

Chapter Ten

Framing and reframing drug ‘problems’ in prison spaces and populations

Karen Duke and Torsten Kolind

Introduction

During the last 20 to 30 years, drug use and dealing have emerged as prioritised ‘problems’ within many prison contexts around the world. Most Western prison systems have responded with dual policies consisting of offering drug treatment and rehabilitation and imposing increasing control and disciplinary sanctioning for drug use and involvement in drug supply. The drug issue is simultaneously framed as both a ‘problem’ of crime and control and a ‘problem’ of well-being and health and these frames often compete, conflict, converge and overlap with one another. MacGregor (2017, p. 133) argues that the drugs debate is framed in terms of oppositions: zero tolerance versus harm reduction; prohibition versus legalisation; abstinence versus maintenance; care versus control; public health versus law and order and so on. Different institutions and stakeholders are associated with the different sides of the debate. When we transfer the drugs debate into the prison space, these oppositions or conflicts become even more pronounced and explicit (Duke, 2003). Due to their histories of offending and sometimes violent behaviour, prison populations can be perceived to be ‘dangerous’, ‘threatening’ and ‘risky’ and in need of surveillance and control. The prison environment itself constitutes a ‘dangerous space’ by exacerbating and often creating problems of violence, harmful drug use, drug dependence, physical and mental illness, and transmission of infectious disease (EMCDDA, 2012; WHO, 2014; Sturop-Toft et al, 2018). Within prison settings, an inmate culture characterised by drug sales, drug debt, threats, violence, and a range of ‘pains of imprisonment’ can work as drivers towards initiation, continuation or increasing of prisoner’s drug use (Crewe, 2005; 2006; Tompkins, 2016).

People in prison often come from marginalised and under-served groups and experience significant health inequalities. Compared to the general population, they experience a higher burden of communicable and non-communicable disease and mental health and substance use problems (Sturop-Toft et al, 2018). World Health Organisation (WHO) figures from Europe (2014) indicate that there are high rates of lifetime prevalence of illicit drug use and injecting drug use among prison populations and many people enter prison with severe drug problems.

A high proportion of people use drugs in prisons and those who inject drugs often share needles. There is a high rate of relapse and overdose on release from prison. There are also high rates of smoking, alcohol use and dependence in prison populations. Mental health problems and co-morbidity (dual diagnosis) of mental health and alcohol/drug problems are common in prison populations. Rates of TB, HIV and Hep C are much higher for people in prison than in the community. People in prison are more likely to self-harm and die by suicide than in the general population. The context of prisons with overcrowding, unsanitary conditions and lack of staffing exacerbates these conditions and practices. As WHO (2014, p.xi) states, ‘prisons are not healthy places.’ A high-risk population is therefore imported into a high-risk environment and eventually released into the community. People who use drugs in prisons can be framed and categorised as ‘vulnerable’ and ‘at risk’ and in need of care, treatment and rehabilitation. Given their increased risk of infectious disease, they can be framed as a threat to public health and in need of monitoring and surveillance. Those involved in drugs in prisons can also be framed and categorised as ‘dangerous’, a threat to ‘order, security and control’ and in need of discipline and punishment, particularly participants in the drug trade. Prisoners can thus be framed as offenders and criminals and/or as patients and clients.

The crime and health framings are present in the prison drug policies in many Western countries, but the emphasis on the individual frames fluctuates across space and time (Garland, 2001). Different countries vary in their placement on this continuum of control and treatment (Duke and Kolind, 2017). Political, social and economic factors shape and influence these frames at national levels. In this chapter, we will analyse how the drug ‘problem’ is framed within prison spaces and populations at the international and national levels of policy, what influences these frames, as well as how prisoners respond to and at times resist these frames. In this view, framing takes place from above and to some extent from below and these different levels of framing can interact and shape each other. We argue that framing is a constant power struggle. Frames can be established at policy level and become embedded over time, but reframing can occur as these frames are contested, circumvented or resisted by different actors in the penal system.

Conceptual Framework

According to Rein and Schon (1993), policy actors construct and make sense of problematic policy issues through a process of ‘framing’ which is defined as ‘a way of selecting, organising,

interpreting, and making sense of a complex reality to provide guideposts for knowing, analyzing, persuading, and acting' (Rein and Schon 1993, p.146). Within this framework, the complementary processes of naming and framing define what is problematic about the issue and suggest what courses of action and policies would be appropriate to tackle the 'problem'. In this sense, policy representations direct how social services act upon certain kinds of issues and social problems (Jöhncke, 2009). In prison drugs policy, framing could highlight issues around prevention, treatment, harm reduction, release and throughcare, drug testing, security, control and punishment. Each framing of the issue is likely to select out and name different features of the 'problem' and ignore or exclude others. For example, in the case of the 'problem' of drugs in prisons, health issues connected with drug use, such as withdrawal, relapse or overdose, could be selected out for attention or alternatively security issues connected with the drugs trade, such as supply reduction or violence, could be highlighted. Once certain features of a situation are named and selected, attempts are made to bind these elements together into a coherent and comprehensible pattern or story. In this way, framing results in different views of the world and creates multiple social realities which often results in tensions between different frames and the corresponding policy actors regarding what constitutes the 'problem'. Within the prison space, the crime and control framing of the drugs 'problem' can conflict, but also converge with the health and treatment framing.

Van Hulst and Yanow (2016) have elaborated on Rein and Schon's original work and suggest first, that framing as an analytical concept should also include a focus on sense-making. That is, policy actors draw on their own knowledge, values and experience to define and frame the 'problem' which results in different solutions and responses. Second, 'categorising' helps to draw distinctions and highlights some aspects of a problematic situation or a population, while occluding or silencing other aspects. Practitioners select certain features of their client populations in order to categorise their clients for different interventions, and in this way, they assist in creating 'institutional selves' in organizational settings (Gubrium and Holstein, 2001). In this sense, they transform the 'problems' of clients into 'more or less distinct troubled identities that match the working logic of the treatment system' (Järvinen and Andersen, 2009, p.865). Policy makers also categorise populations or the targets of policy whereby distinctions are drawn between populations who are perceived to be deserving versus undeserving, legitimate versus illegitimate, worthy versus unworthy, and sympathetic versus threatening (Rochefort and Cobb, 1993; Presser, 2004). Characteristics such as race, gender, class and age are also considered. Often, 'deviants' and other excluded groups do not receive equivalent

considerations; for example, people in prison who use drugs are often categorised as ‘criminals’ and ‘addicts’, and therefore framed as undeserving, illegitimate, unworthy, and threatening. Historically, the discourse of ‘less eligibility’ has infiltrated the development of Western penal policy and ensured that the conditions and services available to prisoners are not superior to those available to the working classes or they will not be deterred from committing crime (Melossi and Pavarini, 1981). However, people in prison who use drugs can also be categorised as ‘vulnerable’, ‘deserving’ and in need of help, treatment and rehabilitation. As Donahue and Moore (2009) have argued from a Canadian context, the institutional identity of the ‘offender’ increasingly coexists with that of the ‘client’ in need of therapeutic attention. A development also seen in other parts of the world, for example in the US, parts of Europe and Australia (see also Fox 2001; Nielsen and Kolind, 2016; Walker et al, 2018). Moreover, with the growth of prison-based drug treatment programmes, drug users in prisons are also represented as people with the right to be treated and served in many Western countries. The way in which affected populations are perceived and categorised by different policy actors and the public are therefore crucial in terms of determining the balance between care and control in policy design (Rochefort and Cobb, 1993; Kolind et al., 2013).

The ways in which the drug issue in prison is framed, debated and the setting out of policy options is influenced by wider forces or a ‘nested context’ (Rein and Schon, 1993, p.154). In this view, policy issues emerge in connection with governmental programmes, which exist within a wider policy environment, which is part of a broader political, social and economic setting, which is situated within a historical era. Features of this context shift and impact on each other, often resulting in the reframing of a policy issue. In this chapter, we are interested in examining the framing of the drug ‘problem’ in prison at the international level through the work of the INCB, UNODC and WHO and the documents and guidance they produce and how these frames attempt to set the framework for the development of policies and practices at the national level of drugs policy in prisons. Our focus drills down from a consideration of policies at the level of international institutions to the European institutional level and then down to certain national examples where there have been analyses of the development of prison drugs policy. It is not our intention to compare national policies.

The framings taking place in policy development and subsequently informing practice naturally have consequences for the prisoners being ‘framed’. That is, the prisoner’s troubles or issues are turned into ‘problems’ and then acted upon. However, it is also important to note,

that even though prison policies and services construct subject positions and typifications (eg. criminal, drug user, sick, empowered etc.), the connection between prisoners' personal selves and troubled identities needs to be negotiated and formed (Gubrium & Holstein, 2001). Naturally, individuals cannot transform discourses or frames at will, particularly inmates whose every movement is surveilled and monitored, but they can relate themselves and their actions to them thereby resisting, rejecting, reproducing or surrendering to the discourses and policies that frame them (Hacking, 1986). This makes room for what we would call re-framing or everyday forms of prison resistance (Ugelvik, 2011) by the 'objects' of policy and practice or those who are subjected to the framing, but also for adaptations to the policy and practice (Crewe, 2009), or even acceptance of the power of the prison if it is experienced as legitimate (Sparks and Bottoms, 1995). After having identified the main framings of drug 'problems' in prisons in the first part of this chapter, we will, in the second, offer examples of such reframing.

Framing from above: framing the drug 'problem' in prison at international and national levels

International level

Historically, the two pillars of the international drug control system have been supply reduction and demand reduction (Babor et al, 2010) with harm reduction emerging during the HIV epidemic in the 1980s. Aligned to these policy goals, the drugs issue has been primarily framed as a 'problem' of crime and/or a 'problem' of health. The UN Conventions 1961, 1971 and 1988 form the basis of international drugs control and prohibit the production and use of narcotic and synthetic pharmaceutical drugs (except for medical and scientific purposes), increased controls around drug trafficking and money laundering and require Member States to criminalise the production, manufacture, sale, possession or purchase of any narcotic drug or psychotropic substance for non-medical and non-scientific purposes, which effectively criminalises people who use drugs. The treaties are overseen by the Commission on Narcotic Drugs (CND), the United Nations Office on Drugs and Crime (UNODC), and the International Narcotics Control Board (INCB). Through the INCB, the crime and control framings are exemplified in its hardline, punitive approach and its emphasis on supply reduction, while the health framing manifests itself mainly through the work of the World Health Organisation (WHO) which provides medical and scientific expertise on the scheduling of substances and

guidance on health responses. As Ritter et al (2017) argue, although historically the treaties and structure afforded little room to manoeuvre within this punitive, prohibitionist framework, this has changed in recent years with a greater emphasis on public health and human rights approaches to drug policy and movement away from criminalization and penalization. For example, there have been moves towards developing more public health-oriented drug strategies, greater recognition of the place of harm reduction services within treatment and increasing support for depenalization and decriminalisation by the UNODC and WHO (UNODC, 2013; WHO, 2014). It is important to note that statements from these international institutions represent the views of a particular set of advocates who have engaged in battles of ideas within these institutions to ensure their perspectives around harm reduction, human rights, depenalization and decriminalization are instituted. These approaches are embedded in Western values and opposition to these ideas and reforms continues to come from prohibitionist countries like China, Russia and the Philippines (MacGregor, 2017).

Following UNGASS 2016, the movement away from penalization can be seen in the guidance of UNODC and WHO on providing treatment as an alternative to conviction or punishment for those people with drug use disorders who are in contact with the criminal justice system. The UNODC (2018, p.22) argues that ‘drug use disorders’ should be treated in the health care system and that providing drug treatment as an alternative in this way is an effective public health and public safety strategy. Such alternatives have the potential to reduce the prison population, overcrowding, and the detrimental effects of a prison sentence. However, this drive from the UNODC to facilitate treatment interventions as alternatives or additions to conviction or punishment, has not been universally applied within individual countries. The UNODC has also put forward a number of principles enshrined in the international legal framework which relate to the treatment of people with drug use disorders in contact with the criminal justice system. Two of these apply directly to those who are in prison settings and aim to frame prison drugs policies at the national levels. The first principle is that ‘prisoners with drug use disorders may not be deprived of their right to health and are entitled to the same level of treatment as the general population’ and the second principle is that ‘drug use disorders are a public health concern requiring responses that are health-centred. Individuals with drug use disorders should not be punished for their drug use disorder but provided with appropriate treatment’ (UNODC, 2018, p.20).

In international law, the right to health is universal and non-discriminatory in application and

therefore applies to people who have been deprived of liberty. The UN Standard Minimum Rules for the Treatment of Prisoners (SMR) (ie Mandela Rules) emphasise the *principle of equivalence* or the idea that people in prison must ‘have access to the health services available in the country without discrimination on the grounds of their legal situation’. The HIV/AIDS crisis prompted further emphasis on access to HIV treatment and services as a human right for people inside and outside custody and on the principle of equivalence for HIV provision and harm reduction initiatives (Csete et al, 2018). This ‘human rights framing’ has been developed into policy and practice guidance by UNODC, UNAIDS and WHO around the treatment of drug dependence. Along with the principle of equivalence, the UN promotes the following treatment principles: treatment must be voluntary; treatment approaches should be chosen and implemented with meaningful involvement of the patient; treatment must be scientifically sound, humane and low-threshold and be overseen by qualified health professionals; people with drug dependence should have access to several kinds of treatment; treatment programmes must not exclude people because of criminal records; women, especially pregnant women, and people with psychiatric co-morbidities should be given priority in treatment; and treatment as an alternative to imprisonment or other penal sanctions should be made available to drug-dependent offenders (UNODC, 2009).

Despite the work of WHO and UNODC on promoting the health of prisoners through effective drug treatment policy, many Member States do not meet their responsibility to protect the health of prison populations and implement the principle of equivalence. Csete et al. (2018, p.179) argue that the human rights protections for people in prison (particularly for those who use drugs) in both international and national law and guidelines are often flouted:

Although the right to health of prisoners is broadly protected under human rights norms, ensuring these guarantees in practice is rare. In reality, the rights of people who use drugs – and of prisoners more broadly – are flagrantly violated in prisons in many countries with no opportunity for complaint or redress.

In practice, research illustrates the complexities surrounding the interpretations and applications of the principle of equivalence in prison settings, particularly within the context of increasing prison populations and their complex health needs, austerity measures and the prevailing focus on enforcement, security and control (Ismail and deViaggani, 2018b). Prisoners are often denied evidence-based treatment options that might be available in the

community such as opioid substitution therapy (OST) which reduces the risk of HIV and Hepatitis C transmission and overdose (Stöver et al, 2004; Degenhardt et al., 2014). In 2016, an estimated 52 countries provided OST in prison – much lower than the number of countries which provide OST in the community (Stone, 2016). However, in practice, even where OST and other proven treatments are offered in prisons, the treatment may only be offered in some prisons and may not be available to all prisoners depending on screening procedures (Larney and Dolan, 2009). Similarly, needle and syringe exchange schemes are available in the community in some countries, but this is not usually part of service provision in prison environments with only eight countries providing this service in at least one prison (Stöver and Hariga, 2016; Stone, 2016). Despite the shifting landscape of drug policy at national and local levels, harm reduction still remains highly controversial politically, particularly for prison populations (de Andrade, 2018; Zurhold and Stöver, 2016). In many countries, harm reduction initiatives are seen to conflict with criminal justice goals of enforcement, zero tolerance and abstinence.

Mold (2018) argues that the public health framing of drug use has started to gain momentum, although this can be defined in multiple ways and exists alongside and sometimes converges with other frames such as the medical/psychiatric and penal/criminological approaches. In line with a public health framing, WHO (2014, p.xi) argues that ‘prison health is part of public health and prisons are part of our society’. Good health and well-being in prison populations is seen to be in the interests of the wider society and cost-effective because it improves the health of the whole community, reduces public health expenditure, improves reintegration into society and reduces re-offending, and reduces health inequalities (WHO, 2015). With prison populations, there is not only an emphasis on public health, but also a preoccupation with public safety. The Doha Declaration, which was adopted at the 13th UN Congress on Crime Prevention and Criminal Justice, focuses on rehabilitation and social integration of prisoners into the community (UNODC, 2017a). UNODC provides Member States with technical guidance on how to initiate and enhance rehabilitation based on the UN Standard Minimum Rules for the Treatment of Prisoners and such rehabilitation programmes are viewed as ‘one of the best and cost-effective ways of preventing their reoffending, with significant benefits for not only the individuals concerned, but also for public safety more broadly’ (UNODC, 2017b, p.1). A New Chance programme has been proposed for future development in order to increase skills, income, employability and self-esteem of prisoners. These types of initiatives frame people in prison as needing transformation and change through rehabilitation and treatment in order for

them to make contributions to society, as well as to protect the public. The emphasis is on converting an 'unproductive population' into productive, active and contributing citizens, who do not pose a threat or risk to the wider public.

In 1995, the WHO introduced the Healthy Prisons Agenda in order to protect and improve the health of people in prisons. The UNODC (2018, p.64) views the criminal justice system as a 'gateway to treatment' and important setting for drug interventions. Although the limits of prison settings in terms of delivering healthcare are recognized and WHO (2014, p.91) argues that 'prisons are not therapeutic institutions', prison sentences are framed as 'opportunities' for improving health and reducing health inequalities through drug treatment. However, when we examine what is occurring with health in prisons at the national level, it is evident that the Healthy Prisons Agenda has not been implemented in many jurisdictions. For example, research conducted in England uncovered various challenges to the implementation of the Healthy Prisons Agenda linked to sectoral, institutional and occupational barriers including constraints on resources and staffing, lack of training around health issues, conflicts between professional groups in prisons and the subordination of the health agenda to that of immediate security and control priorities. Ismail and deViggiani (2018a, p. 94) concluded that within English prisons there is 'widespread prevalence of a command-and-control ethos... underpinned by a prevailing security culture that dismisses prison-based health-promoting activities. Health in prisons is portrayed as an utopian oxymoron, inferior to the punitive aims of the prison'. Similarly, a recent study of the level of infectious risk in prisons in five European countries measured to what extent the prison system adheres to WHO/UNODC recommendations and found low availability of preventive measures. As a result, infectious risk remains extremely high in prisons (Michel et al., 2015).

National level

At the national level, the health and crime framings manifest themselves in various prison drug policy and practice initiatives around the world. For example, in British prisons, there is an emphasis on providing treatment and rehabilitation for those with drug use problems as well as various security and control measures that have been implemented to control the supply and use of drugs in prisons, including searching procedures and equipment, sniffer dogs, drone/mobile phone blocking technology, CCTV, mandatory drug testing and the introduction of a range of sanctions for those who contravene the rules surrounding use and supply. The

intensification of security and control measures, such as mandatory drug testing and increased searching and surveillance, has resulted in prisoners engaging in risky behaviours such as holding drugs and other contraband internally and switching to less detectable substances through testing (eg. opiates and synthetic cannabinoids) (Boys et al., 2002; HM Inspectorate of Prisons, 2015; User Voice, 2016; Ralphs et al., 2017). Although harm reduction was successfully implemented in the community during the HIV crisis in the late 1980s, this was extremely difficult to extend into prisons as it was viewed as politically untenable (Duke, 2003; 2011). The lack of effective harm reduction in prisons has also resulted in risky practices including needle sharing (Swann and James, 1998). Within the prison context and particularly during periods of ‘crisis’, the security and control frames often take precedence over the treatment and health frames in pursuit of the goal to eradicate the drug ‘problem’ and achieve a drug free prison, leaving drug treatment provision under-resourced and low priority. In times of austerity, drug treatment and rehabilitation programmes have suffered major cuts to funding (ACMD, 2017). The crime and health framings conflict with each other as prisoners are offered treatment and care for their drug use problems, while simultaneously punished with a range of sanctions (Duke, 2003). They also converge and overlap; for example, mandatory drug testing is a multi-functional initiative in the prison setting. It is employed as a method to identify and assess those in need of treatment and encourage them to access it, a way to measure the drug ‘problem’ in prisons by providing quantifiable indicators of use, a measure to deter prisoners from using drugs and as a punitive practice to administer sanctions for drug use.

These framings around care and control are also found in prison drugs policies of other countries. In Australia, Walker et al. (2018) reveal the multiple representations of the drugs ‘problem’ in prison drug policy in Victoria and how the merging of a tough, control focused approach with a focus on health, welfare and treatment leads to plurality and diversity in the modes of governing those who are involved in drugs use and supply. They show how the Identified Drug User Programme is underpinned by the dividing practices of care and control and how the conflicting discourses constitute young men as ‘criminal’, ‘untrustworthy’ and ‘deserving of punishment’, but simultaneously constitute them as ‘rational’, ‘self-governing’ and ‘deserving of treatment’. These dividing practices and conflicting discourses produce harmful effects (eg. closed visits) which cause distress and pain to people in prison and their families and limit the way the drug ‘problem’ can be conceptualized in policy and practice. In a similar vein, Watson (2016) argues that the Correctional Service of Canada’s pursuit of ‘drug-free’ prisons and the adoption of enhanced enforcement and zero tolerance policies have

produced a number of adverse effects including continued efforts to smuggle drugs into prison, increased tension and violence, prisoners switching drugs, health-related harms, deterrence of visitors and staff involvement in the drug trade. In the Nordic countries, drug treatment programmes have increased over the last 15 years. Such development might be considered in line with the ‘exceptional’ prisons of the Nordic countries, characterized by more humane living conditions and low prison populations (Pratt, 2008). However, despite this attempt to offer the prison population adequate drug treatment, the ‘treatment’ framing is still competing with the ‘zero tolerance’ and ‘tough on drugs’ framings with these latter frames dominating (Kolind et al., 2013), and prison drug treatment programmes do not meet the same standards as community treatment (Kolind, 2017).

It is clear that two organizing frames of drug policy – health and crime – are present at the international level through the work of INCB, WHO and UNODC and impact on the guidance produced for prisons and their populations. However, there appears to be a clear disjuncture between the international level which has placed more stress on harm reduction, health and decriminalization in recent years and what is happening on the ground in terms of implementation of drugs policy initiatives in prisons at the national level. Many interventions available in the community such as OST, naloxone distribution, needle exchange and other harm reduction techniques are difficult to extend to the prison environment (Michel et al., 2015; Stone, 2016; Stöver and Hariga, 2016). As has been argued in relation to the implementation of health initiatives in some prison systems, this is due to political resistance, austerity, lack of resources and the dominance of the law and order ethos (Duke, 2003; Kolind et al., 2013; Ismail and deViggiani, 2018a). The conflicts between the health and crime framings intensify within the prison space and have implications for the ways in which the people in prison who use drugs themselves are framed by policy makers and for the drug interventions available within this environment, but also for ways in which prisoners themselves respond to, adapt and resist these framings. The next section will explore the framing and re-framing actions and practices of those imprisoned around drugs issues.

Framing and re-framing from below

In prisons, those who use drugs frame and also reframe several different subjectivities. As argued so far, framing drug using prisoners as either ‘criminal’ or ‘in need of treatment’

(sick/diseased) are the two most dominant frames in present political discourse at both global and national levels. These framings inform practice, practices that both restrict and enable the ways prisoners can act, and together framings and practices are important for the ways prisoners understand and identify themselves. However, it is also important to understand that some reframing or even resistance by prisoners also takes place. That is, prisoners challenge, exploit or avoid the more global framings and the practices that follow from these framings. In the following section, we will explore how prisoners reframe the drug using prisoner as ‘criminal’ and ‘in need of treatment’, respectively.

We would like to stress that overarching policy frames are not translated directly into practice. The discretionary practices (i.e. blending personal and professional judgements) of street level bureaucrats (Lipsky 1980) - such as prison officers, prison health personnel and counsellors - change, adjust and modify the policy frames to suit concrete situations. Hence, a difference exists between policy frames and policy in practice (Shore and Wright 1997). For instance, when drug treatment programmes are implemented in a prison setting, they are often regarded as being of secondary importance to the discipline and order involved in running the prison (Craig, 2004; McIntosh & Saville, 2006). As a result, such programmes often face restrictions limiting the services provided (Kolind et al., 2013). But pragmatic adjustment of prison policy may also reverse control as when prison officers turn a blind eye to inmates’ use of cannabis, as too rigid a deployment of control measures could generate conflict (Kolind, 2015a). In this chapter, we do not have the space to elaborate on the consequences of such a ‘policy in practice’ perspective for the framing and reframing of policy representations. However, it is important to be aware that prisoners’ reframings are cast within the policy translations of prison staff.

Reframing the drug involved prisoner as ‘criminal’

As argued above, a ‘tough on drugs’ policy prevails in many prisons worldwide. In practice, such policy consists of, for example, mandatory drug testing, intensive cell searches, and different kinds of punishments (e.g. fines, restrictions on leave, additional days, etc.). The goal of this policy is to stop prisoners from using or selling drugs and, at times, it is also argued as being part of a strategy to motivate/force prisoners into entering drug treatment programmes. While this policy may work at times, it often also has unintended consequences.

First, it can be argued that the strict security and control measures implemented in prisons as a part of framing drug use as a crime ‘problem’ foster the development of low trust and highly controlled environments. In this way, they exacerbate the ‘pains of imprisonment’ (Sykes, 1958) experienced by prisoners, including loss of privacy, deprivation of personal autonomy, denial of social relationships, boredom, and violence. As research has documented, a commonly used strategy by many prisoners to cope with such ‘pains’ is to engage in drug use as a form of self-medication. At times, prisoners start to use drugs in prison while others continue or enlarge their repertoire of drug use after being imprisoned (Strang et al, 2006; Stöver and Weilandt, 2007; Indig et al., 2007). Prisoners prefer using heroin or cannabis due to their sedative and calming effects in order to relieve stress, to facilitate sleep and ultimately to relieve the pains of imprisonment (Boys et al. 2002; Ritter, Broers and Elger, 2013; Kolind, 2015a). Interestingly, studies also show that officers sometimes tolerate or turn a blind eye to inmates’ cannabis use as this tends to help keep inmates calm and quiet and make their work in keeping order on the wings easier, but also because officers recognize that cannabis use helps inmates cope with prison life (see also: Duke, 2003; Carlin, 2005; Kolind 2015b).

Another unintended consequence of the framing of drug ‘problems’ as crime in prisons relates to the prison drug economy. While a strict controlling and sanctioning prison drug policy does not in itself create the drug markets in prisons, it seems reasonable to suggest that prisoners react strategically to and exploit such policy initiatives for their own benefit. For instance, some prisoners gain economically in engaging with drug selling and smuggling in a highly controlled environment. Moreover, not only do they profit economically, they also re-frame or reinterpret the intentions of the policy and exploit it in order to create prestigious social identities. There are limited studies of drug supply and drug dealing in prisons (however see: Munson et al., 1973; Crewe, 2005; 2006; Mjåland 2014a, Tompkins, 2016). Crewe’s long-term fieldwork on drug dealing in a British prison shows that although the financial power of drugs is important, drug dealing in prisons must be understood as more than simply an economic activity. Drug selling is also strongly bound up with masculinity, self-identity, emotions and internal hierarchies. Drug dealing can enhance the dealers’ status and symbolic capital, for instance, by being able to bring drugs into prisons, making connections to outside drug and criminal networks, and displaying courage. Moreover, engaging in the prison drug economy can add to the feeling among inmates that they are part of a larger social group (Crewe, 2005; 2006). In addition, drug trafficking can also carry subversive meanings for prisoners in a highly controlled and stigmatised environment. As Mjåland shows from a Norwegian prison,

diversion of medicine (buprenorphine) is an example of a relatively small and seemingly trivial, rule-violating behaviour, but adds to a feeling of collective resistance among prisoners. Moreover, only rarely did Mjåland encounter more confrontational protests among the prisoners (Mjåland, 2015). Furthermore, drug use and selling in prisons and also drug treatment appear to be linked to ethnic identifications. That is, although ethnic stereotypes are imported into prisons, they become highly intensified in this space because of how drug dealing and selling are organized and articulated inside. For instance, in our study we found that Danish prisoners spending time in a treatment wing were often viewed as ‘soft’ and ‘weak’ by prisoners with ethnic minority backgrounds in regular wings, whereas these prisoners in regular wings were in turn perceived as troublemakers and chaotic by the ethnic Danish prisoners in drug treatment (Haller and Kolind, 2018). In short, the display of, for instance, a prestigious masculinity, street capital (Sandberg, 2008) and an entrepreneurial approach related to drug selling in prisons is on a daily basis negotiated along ethnic lines (Haller and Kolind, 2018). In sum, drug dealing and drug taking play central roles in the forming of important social and personal identities in the prison. However, the illegal prison drug economy is not always violent and focused on individual gain. As Mjåland (2014a) has demonstrated from a Norwegian prison, a culture of drug sharing may also be central among prisoners. However, even in such instances, we see how prisoners reframe or reinterpret the framing of them as ‘criminal’. In this way, policy framings are never neutral, rather, they have consequences for the way people understand themselves and the way they act in order to counter or reframe the social identities inherent in the wider policy frames in which they are subjected.

Reframing the drug using prisoner as in need of treatment

The framing in contemporary prison drug policy of prisoners as not only criminal but also as legitimate recipients of health services also has consequences for the prisoners in their daily lives. As part of the public health framing, we find prison-based drug treatment programmes - both medically assisted (substitutes, eg. methadone or buprenorphine) and/or social pedagogical/psychosocial drug treatment services. In this section, such programmes will serve as the case for understanding processes of reframing of health services as seen from the perspectives of the prisoners.

Although drug treatment programmes have increased in many prisons and are recommended by the WHO (2014) and European Monitoring Centre on Drugs and Drug Addiction (2012),

they are still lacking in many countries (EMCDDA 2012, p.20-26). Moreover, prison-based drug treatment programmes have to adapt to what is still seen as the prisons' primary goal: control and security (see, for example Walker et al., 2018). In this way, the programmes become subjected to the framing of prisoners as criminal. Nevertheless, with the introduction of prison drug treatment programmes over the last 30 years, a 'new' framing of prisoners has developed. As Donohue and Moore (2009) argue, with the growth in prison drug treatment programmes, the traditional 'inmate' or the 'offender' now increasingly coexists with the 'client': a consumer of welfare services who requires therapeutic attention. In this view, prisoners are not only to be punished and controlled, they also increasingly have individual rights and should be seen as the recipients of health services in line with other citizens. This shift in framing is particular to Western liberal progressive societies and coincides with the growing narratives of consumerism and managerialism in recent Western political thought and practice (see also: Moore, 2007). For prisoners, this alternative framing, not only focusing on them as criminals but also as 'consumers', offers new opportunities. However, this framing also make new demands on the prisoner. The 'client' that has emerged in prison drug policy and practice has to be motivated and take responsibility for his/her own treatment and recovery. Clients are seen as rational individuals who actively choose and self-reflectively engage with their own recovery. This also means that those who cannot honour these demands (for instance, the most severely affected and marginalized prisoners who often are more in need of care than treatment) are often left to themselves or left to an intensified criminalization (Kolind 2017; see also Bjerger and Nielsen, 2014). This is because prisons often operate a dual policy: either prisoners are categorized as a motivated and responsabilised prisoner in treatment or categorised as a criminal, irredeemable and face intensified sanctions (Haller, 2015). Moreover, as Donahue and Moore (2009, p. 329) argue:

The notion that people in conflict with the law have choice or empowerment or agency afforded to them by the State is perhaps one of the greatest (if not most effective) mythologies of contemporary punishment. Framing people in conflict with the law thusly, however, is an extremely effective governing strategy that all but erases the potential for resistance or alternate thinking on the part of so-called clients.

However, it could be argued that this is an exaggeration and 'alternate' thinking or practices can exist. A study of prisoners' experiences with drug treatment programmes in Denmark (Frank et al., 2015) shows, that even though some prisoners do buy into the ideology of the

programmes (ie. seeing themselves as active clients who with the help of the counsellors (re)discover their real selves and recover), alternative strategies and reframing also exist. For some of the clients, the treatment programmes were actively used in order to try to reduce or overcome their drug misuse, but also to better individuals' lives both inside and outside the prisons. In short, these prisoners at times actively embraced the framing of them as 'clients' in need of treatment to take on a new direction in life. At the same time however, most prisoners also had a somewhat pragmatic stance to the programmes. For instance, as positive urine tests resulted in fines and deprivation of weekend leaves, some prisoners engaged positively with the treatment ideology of (re)discovering their authentic inner core and they did stay drug free for a period of time. However, several prisoners also admitted that within two to three weeks before their release they would go back to using drugs, as the prison sanction (ie. deprivation of weekend leaves) would not matter much because the prisoners would be so close to their release dates. The framing of them as 'recovering clients', in this way, was useful for a time.

For other prisoners, neither abstinence nor the wish to recover was their key motive for entering the drug treatment programme. Some prisoners started in treatment and displayed overt positive motivation because this would make it easier for them to obtain favourable reports and, consequently, be transferred to an open prison. A strategy that in many ways interfaces well with the Danish national drug action plan and its principle of 'something-for-something' (Regeringen, 2003) or if you behave well, you are rewarded. For other prisoners, it was the brutal side of prison life that motivated them to start drug treatment. A good part of prison life is characterized by violence, threats, fights and drug debts (Crewe, 2005). By moving to a safer dedicated treatment wing and engaging in treatment, some prisoners tried to escape the more violent regular wings. This is not to say that they did not in time become positively involved in the treatment programme, but it is an example of how the framing of the client and the practices that follow are also used strategically by prisoners.

At this point, one might consider Carr's (2011) analysis of script flipping among female drug users in a drug treatment programme in the US. It is a practice characterized by borrowing the language of the powerful (for instance, by acting like a recovering and motivated 'client') and then skillfully redirecting its political force. That is, by skillfully performing prescribed ways of speaking, the women could, for instance, obtain shelter, food or even regain/maintain custody of their children (Carr 2011, p.222). In sum, it appears that prisoners' motives for entering prison drug treatment programmes are related both to prisoners' actual drug problems

and to factors related to serving prison sentences (see Williams, et al., 2008; Kaskela and Tourunen, 2018). One can argue that starting in drug treatment programmes for some prisoners is a ‘survival strategy’ alleviating the pains of imprisonment (Kolind et al. 2013); prisoners ‘play the game’ (Schwabe, 2003) or ‘tell them [treatment staff] what they want to hear’ (Patenaude, 2005).

This section has provided examples of how prisoners reframe the institutional identities and categorisations to which they are subjected as a consequence of the framings in policy and practice. At times, they resist these framings. Often, however, they redirect, deflect, strategically ‘play the game’ or ‘flip the script’, and pragmatically adjust to the framings in order to better survive imprisonment. More to the point, prisoners’ reframing practices are complex. It is not that they either submit to the policy frames and just play out the identities which these frames outline or that they resist and develop alternative and more authentic identifications. Rather, as we have demonstrated above, prisoners alternate between the different frames available depending on what is most opportune and feasible. In addition, they at times resist, adjust or pragmatically exploit the frames within the constraints of the prison space.

The section focuses mainly on individual adaptations to the environment. According to Crewe (2009) the lack of collective resistance among prisoners in contemporary prisons is largely due to the ways in which sentencing is increasingly individualised: incentive schemes, progression in sentencing and individualised discretionary arrangements (see also Mjåland, 2015, p.782). However, it should be noted that resistance also comes from organised user groups in the form of more coherent policy consultations, proposals and critiques. The UK NGO User Voice is an example of this collective resistance. They conduct consultations and research led by former service users. For example, in a recent report they found that young people in secure settings and youth custody in Britain used drugs mainly in order to deal with grief and anger. Moreover, they found that a majority of the young people had no trust in the professionals involved in their care. These results have been used by User Voice to call for action and improvements to service provision for young people (User Voice, 2018).

Conclusion

We have illustrated some of the intricate interplay between policy framings and prisoners' reframing. We have argued that prisoners pragmatically adjust to, exploit, resist, but also subvert the policy frames. In this way, prisoners should not be seen as passive recipients of policy framings and completely subjected to the powers of prison policy and practice. Rather, they are active agents reflecting on and acting within the circumstances they are placed in. Naturally, prisoners cannot resist the formidable powers of the prison and the robust policy framings at will. Prison drug policies set the agenda and parameters for the life prisoners can live, but counter-strategies, everyday pragmatics and ingenious evasions are also put into play. There is limited space to manoeuvre, but the room to manoeuvre and resist these framings are still present. On the other hand, we do not want to romanticize prisoners' counter-strategies. As we also argue below, the rigid policy framings may well contribute to creating prisons as dangerous places. Therefore, in order to analytically conceptualize prisoner's reframing we suggest viewing prisoners' counter-practices in line with what de Certeau (1988) calls 'tactics'. Whereas 'strategies' refers to the institutional logic of the powerful, tactics are employed by those in weak positions. Tactics are subjected to the agenda and actions of the powerful and to the institutional and political logic on which such strategies draw (Desjarlais, 1997; see also Carr, 2011). But tactics are also often defensive and opportunistic. In other words, prisoners do practice some degree of reframing, but they do this from institutionally assigned positions set by the policy framings. To what extent such tactics have the potential to actually reframe and challenge the powerful policy framings is debatable. Nevertheless, tactics can work for prisoners as a way to 'survive' everyday prison life, adapt to rigid policy framings, and to construct alternative identifications for prisoners in their daily prison life that might generate feelings of empowerment.

As Christie (1981) reminded us some decades ago, the intention of prisons is to inflict pain. Framing prisoners as criminals legitimizes practices that are intended to remind prisoners and the general population that people in prisons are secondary and deserve punishment. However, prison populations are also framed as in need of treatment, but only those prisoners who are seen as and can present themselves as in need and also willing to change. However, as demonstrated in this chapter, prisoners often pragmatically play or reframe the framing of them as either criminal *or* in need of treatment. Prisoners often move tactically or pragmatically between the different framings available depending on the situation. In our view, this is a

predicament of the everyday life in total institutions – rules and framings are (re)worked (Goffman, 1961). As a consequence, if the framings from policy levels set too rigid an agenda, those prisoners who cannot comply with and display appropriate behaviour and positions (e.g. the framing of them as sick and in need of treatment), or those who cannot find their pragmatic way in the ‘cracks’ of the framings, they are only left with the framing of them as criminals to adhere to. For instance, long-term drug dependent prisoners who are severely affected socially and psychologically and not sufficiently skilled in ‘playing the game’ most often face disciplinary punishments. Often, they do not manage to stay in drug treatment (as they are discharged for using drugs) and often they are harassed and exploited by more powerful prisoners in the drug market (Crewe, 2005; Kolind et al., 2013). Prisons therefore may unintentionally become dangerous spaces or ‘risk environments’ (Rhodes, 2009) or spaces where a range of factors interact to increase the chances of drug-related harm occurring. As shown, prisoners often constitute a risk population with multiple problems: drug and alcohol problems, health problems, social problems, criminality and psychological problems. When this group of people are ‘imported’ into a prison setting with a detrimental inmate culture, and an everyday existence characterized by a range of pains of imprisonment, and rigid policy framings that favour the stronger and less affected population, then prisoners’ problems may be amplified and we can talk about ‘dangerous places’. Dangerous places that both host, produce and re-produce problems. In line with this, Rein and Schon called for policy actors to consider how their own frames contribute to policy problems: ‘...if actors were willing and able to reflect on their frames, frame shifts – reframing – might occur, and problems that had seemed irresolvable might be resolved after all.’ (van Hulst and Yanow, 2016, p.96). In the case of prison drugs policy, there is a need for policy actors to consider and reflect on the predominant framings and their unintended consequences in further exacerbating existing problems and producing new problems.

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