Research paper

Drug treatment or alleviating the negative consequences of imprisonment? A critical view of prison-based drug treatment in Denmark

Torsten Kolind *, Vibeke Asmussen Frank, Helle Dahl
Centre for Alcohol and Drug Research, Aarhus University, Jens Chr. Skous Vej 3, 8000 Aarhus C, Denmark

A R T I C L E   I N F O

Article history:
Received 6 October 2008
Received in revised form 19 March 2009
Accepted 24 March 2009
Available online xxx

Keywords:
Drug treatment
Prison
Criminal justice
Counsellors’ experiences
Denmark

A B S T R A C T

Background: The availability of prison-based drug treatment has increased markedly throughout Europe over the last 15 years in terms of both volume and programme diversity. However, prison drug treatment faces problems and challenges because of the tension between ideologies of rehabilitation and punishment.

Methods: This article reports on a study of four cannabis treatment programmes and four psychosocial drug treatment programmes in four Danish prisons during 2007. The data include the transcripts of 22 semi-structured qualitative interviews with counsellors and prison employees, prison statistics, and information about Danish laws and regulations.

Results: These treatment programmes reflect the ‘treatment guarantee’ in Danish prisons. However, they are simultaneously embedded in a new policy of zero tolerance and intensified disciplinary sanctions. This ambivalence is reflected in the experiences of treatment counsellors: reluctantly, they feel associated with the prison institution in the eyes of the prisoners; they experience severe opposition from prison officers; and the official goals of the programmes, such as making clients drug free and preparing them for a life without crime, are replaced by more pragmatic aims such as alleviating the pain of imprisonment felt by programme clients.

Conclusion: The article concludes that at a time when prison-based drug treatment is growing, it is crucial that we thoroughly research and critically discuss its content and the restrictions facing such treatment programmes. One way of doing this is through research with counsellors involved in delivering drug treatment services. By so doing, the programmes can become more pragmatic and focused, and alternatives to prison-based drug treatment can be seriously considered.

© 2009 Elsevier B.V. All rights reserved.

Introduction

Since the beginning of the 1990s, drug treatment has increased in volume and variety in prisons throughout Europe. This development is in line with the EU action plan on drugs, which emerged in response to the large number of inmates with drug and health problems, and it is also consistent with international agendas on health and prisoners’ rights (Bruce & Schleifer, 2008; EMCDDA, 2006; Kerr, Wood, Betteridge, Lines, & Jürgens, 2004; Møller, Stöver, Jürgens, Gatherer, & Nikogosian, 2007). It has been estimated that approximately 50% of European prison inmates have direct experience of drug use (EMCDDA, 2003); likewise, an increasing number of prisoners are serving sentences for drug-related crimes (Brochu, Guyon, & Desjardins, 1999; EMCDDA, 2006). In addition, studies show a reciprocal relationship between drug problems and criminal behaviour, each of which influences the other (Newcomb, Galaif, & Carmona, 2001). Incarcerated drug users have a plethora of other issues, including physical and mental health problems, psychological distress, and social problems (Vandevelde, Palms, Broekaert, Rousseau, & Vanderstraeten, 2006). The mortality of released prisoners with drug problems is also higher than the average (Christensen, Hammerby, & Bird, 2006; Farrell & Marsden, 2008).

In Europe, before the 1990s, prisoners were not offered drug treatment, although drug users constituted a substantial proportion of the prison population. This was partly because the ideology of rehabilitation was given a severe blow by scientific studies during the 1970s. In particular, the slogan ‘nothing works’ (Martinson, 1974) implied that rehabilitation was of no use (see also Brochu, 2006; Jepson, 1971). In addition, political hardliners in Europe argued that being tough on crime was the only solution for a society in crisis, whereas liberals rejected rehabilitation because they thought it individualised problems that were fundamentally structural as well as masking the inhumane workings of the prison system (Anderson, 2002).

As a consequence,
in the UK for instance, attempts to reintroduce a rehabilitation framework in the 1980s were crushed by a dominant rhetoric of 'punishment' and 'just deserts' (Duke, 2000, 2003). In Denmark, during the same period, the Danish Prison Service operated an 'attenuation ideology', which dispersed drug users throughout prisons hoping that they would then not influence the general prison environment (Kramp, Gabrielsen, Lund, Alette, & Sindballe, 2003).

From the 1990s onwards, things started to change and European drug policy began to converge (Bergeron, 2005). Harm-reduction initiatives, drug-free wings and drug treatment trials were set up in many European prisons including in Denmark. Substitution treatment was also made available, although cross-European differences exist (Stallwitz & Stöver, 2007; Stöver, Casselman, & Hennel, 2006). There were various reasons for this policy change. Most important, was the growing public concern about HIV/AIDS and the fear that the increasing number of drug users in prisons could make them key sites for HIV transmission (Shewan & Davies, 2000). Secondly, the drug problem had reached a level at which it could no longer be neglected. Finally, new winds were blowing and, in particular, the results of cognitive programmes in Canada began to challenge the 'nothing works' maxim (Duke, 2000; Stöver et al., 2006). Recent meta-analyses have documented the positive effects of treatment services, with group counselling programmes and therapeutic communities showing a reduction in drug relapse and recidivism (Egg. Pearson, Cleland, & Lipton, 2000; Mitchell, Wilson, & MacKenzie, 2006).

As a result of these changes, prison-based drug treatment services in Europe have grown in terms of capacity, in relation to various target groups and treatment objectives, and in terms of programme variety (Kothari, Marsden, & Strang, 2002). For instance, the following options are now available: drug courts, motivational pre-trial programmes, detoxification units, drug-free wings, substitution treatment, therapeutic communities and community referrals. In addition, prison services in several European countries have started systematic accreditations of treatment programmes (Asmussen, Kolind, & Nielsen, 2006; What Works, 2001–2002).

Despite the re-legitimation of the ideology of rehabilitation, prison-based drug treatment is not without problems. The results of recent studies show that drug treatment is generally secondary to the prison’s control and punishment functions. The attitude of the prison officers towards drug treatment initiatives is often negative, and the relationship between officers and inmates is often characterised by distrust. A lack of anonymity may make drug users refrain from joining treatment programmes for fear of reprisals from other inmates. Finally, the inmate culture is perceived as unfit for a therapeutic process; in fact, the prison environment can sometimes counteract drug treatment (Carlin, 2005; Craig, 2004; Frank & Kolind, 2008; Kothari et al., 2002; McIntosh & Saville, 2006; Neale & Saville, 2004).

Method

There are 13 prisons in Denmark: 5 maximum-security prisons and 8 low-security prisons, with a total prison population of 2,422. In addition, remand prisons have a capacity of 1,613 prisoners. The data for this article stem from a study of eight treatment programmes in four Danish prisons (2 maximum-security prisons and 2 low-security prisons). Four of these programmes deliver cannabis treatment and four offer psychosocial treatment to male clients already enrolled in substitution programmes. Data include transcripts from 22 semi-structured qualitative interviews, statistical material generated by the Danish Prison Service, and written documents collected throughout 2007 (project evaluations, governmental policy documents, reports from the Prison Service, and laws and regulations).

All treatment personnel involved in the programmes (12 counsellors, 3 treatment managers, 3 treatment supervisors and 3 prison nurses) were interviewed either individually or in groups of two. Additionally, follow-up group interviews were conducted with all counsellors. All interviews were audio-taped, transcribed and independently coded using NVivo software by two of the authors. Coding was compared in order to increase the level of inter-rater reliability. The analysis of our informants’ statements has been guided by ‘grounded theorizing’ (Glaser & Strauss, 1967), in which theory, data analysis and data collection are seen in dialectical interaction. The emergent concepts have then been analysed in terms of their relationship to changes in prison policy and official programme objectives. As a background for interpreting the results, we used previous research conducted by the authors concerning the implementation of self-evaluation in drug treatment programmes in Danish prisons (Asmussen et al., 2006).

The intensification of disciplinary sanctions

In 2003, the Danish Government launched The Fight against Drugs (Regeringen, 2003); the first drug policy to be drawn up in decades. The plan was inspired by US drug policy, and proposed an increasingly repressive response to drugs, including zero tolerance and harsher punishment (Storgaard, 2005). In order to uphold zero tolerance towards drugs in prisons, The Fight against Drugs recommended the introduction of better fence systems, more sniffer-dogs, the application of new technology and, most importantly, from July 2004, mandatory random urine testing. As a consequence, the number of tests taken in Danish prisons tripled from approximately 13,000 in 2003 to 39,094 in 2006 (Kriminalforsorgen, 2006a,b). On average, each inmate is tested approximately every 40th day (before 2004, tests were used only in cases of well-founded suspicion, on imprisonment, and before and after weekend leave. Furthermore, urine was not routinely tested for cannabis).

In addition, disciplinary sanctions following a positive urine test were tightened, as emphasised in an information note circulated by the Prison Service in 2004. The note stated that the individual prisoners must implement harsher disciplinary sanctions against the use, possession and dealing of drugs. Furthermore, the detection of any use of cannabis and ‘harder’ drugs should result in fines (€8–14), solitary confinement (3–5 days) and, most importantly, suspension of weekend leave. Normally, Danish prisoners, after serving part of their sentence, are allowed out every third weekend. Finally, the same sanctions were to be applied if inmates refused to be drug-tested.

Inmates regard the suspension of weekend leave as the severest form of punishment; for some drug users the continuous urine tests mean an almost permanent suspension of weekend leave. As a consequence of this new policy, disciplinary punishments increased by 46% from 10,541 in 2003 to 15,397 in 2006, whereas the prison
population only increased by 4% in that period. A high proportion of the disciplinary punishments relate to the new zero-tolerance policy (Kriminalforsorgen, 2006a).

The new day treatment programme

‘Zero tolerance’ and the tightening of disciplinary sanctions came at the same time as the introduction of a new national drug treatment guarantee in Danish community-based drug treatment (1 January 2004), which stated that treatment had to be initiated no later than 14 days after inquiry (Pedersen, 2007). From 1 January 2007, this treatment guarantee was widened to include the prison population. As stated in the Act on Execution of Sentences:

> Prisoners have the right to free treatment against substance abuse unless they are expected to be released within three months or unless they are deemed to be unsuitable and unmotivated for treatment. Subsection (2) If possible, treatment against substance abuse must be commenced no later than 14 days after prisoners have submitted a request for such treatment to the Prison Service (Straffuldbrydelsesloven, 2006).

In order to comply with this, a new treatment initiative was introduced in all Danish prisons. As a result, roughly 25% of the Prison Service’s capacity was reserved for drug/alcohol treatment, including motivational programmes in remand prisons, drug-free wings, drug-free treatment units isolated from the rest of the prison, and post-treatment wings. Some treatment programmes are for women only.

This new initiative has two components: programmes for cannabis users and programmes for clients being prescribed substitution medicine. Both offer psychosocial treatment. Cannabis treatment in prisons is a novelty in Europe, and many inmates view cannabis as a way of coping with their imprisonment rather than as a problem (see also Carlin, 2005; Keene, 1997), as confirmed by the treatment counsellors and prison nurses in our study. As a case in point, prison nurses report that inmates who refrain from using cannabis often need other (legal) tranquilisers in order to fall asleep and put their minds at rest at night (Dahl, Frank, & Kolind, 2008).

The two programmes function as a kind of out-patient drug treatment, widely labelled ‘day treatment’ as enrolled clients do not live in isolated wings but return to their wings after treatment sessions. They do not have to be or in order to become abstinent in order to be enrolled. Instead, clients can focus mainly on reducing their drug use. Participation is voluntary, and counsellors do not demand that clients are motivated before enrolment. The official long-term goals of the treatment programmes, according to the Prison Service, are to: make clients drug free/make them reduce their ‘abuse’, prepare them for a life without crime, and reduce the amount of drugs inside prison. As we will argue, however, these goals are sidetracked in the everyday practices of the counsellors, where the main focus centres on alleviating the negative consequences of imprisonment.

Public drug treatment centres in the municipalities or local private foundations largely define and run the day treatment programmes. As a result, these are based on a variety of methods and differ in terms of their intensity. For example, some programmes offering substitution medicine comprise individual counselling and therapy for 1–4 h per month. By contrast, one cannabis programme runs for 5 h on 4 days per week and focuses on physical activity, general education and therapy, while another consists only of individual therapy for 1–2 h per week. The programmes have from 6 to 12 inmates enrolled at a time, and run for about 8 weeks. All the programmes face identical institutional restraints and the counsellors express similar experiences and concerns about providing treatment in a correctional setting.

The experiences of counsellors

In general, counsellors show a great deal of pragmatism in adjusting drug treatment to the prison environment. This is consistent with other forms of ‘street-level bureaucracy’ (Lipsky, 1980), in which acts of discretion (the blend of personal and professional judgement) are used to adjust official programmes to suit concrete situations. Despite the efficiency of such discretion in social work (Kolind, Vanderplasschen, & De Maeyer, 2009), counsellors in day treatment programmes identify problems which cannot be solved solely by a pragmatic attitude, but tend to move the treatment in undesired and sometimes unforeseen ways. We will focus on three kinds of problems experienced by counsellors when running treatment programmes in prisons: (a) the (new) disciplinary regime; (b) interaction with prison officers; and (c) the objectives of the programmes.

The (new) disciplinary regime

When drug treatment programmes are implemented in a prison setting, they are usually regarded as being of secondary importance to the discipline and order involved in running the prison (Craig, 2004; McIntosh & Saville, 2006; Neale & Saville, 2004). As a result, such programmes often face restrictions limiting the services provided. For instance, prison managers in Danish maximum security prisons do not allow counsellors to run group sessions, as they fear they will be used to distribute and sell drugs. In addition, inmates are sometimes transferred to another prison without notice, e.g. for security reasons. This naturally disrupts treatment continuity, as counsellors can no longer contact their clients. In relation to the (new) disciplinary regime, counsellors highlight, in particular, the mandatory urine tests and the disciplinary sanctions attached to positive tests. Three issues are important here.

First, counsellors feel that the principles of strict discipline and retribution embedded in the prison ideology, and very much present in the way urine tests are managed (see above), run counter to a treatment philosophy focussing on trust, empowerment and democratically based verbal communication. Instead of punishing clients who relapse, counsellors state that they would prefer to get involved with and work with these clients.

Secondly, counsellors feel that they are sometimes regarded by clients as representatives of the prison system even though they are employed by outside agencies and persistently stress their autonomy. Sometimes counsellors become confused about their role. For instance, this can occur when participating in prison staff meetings to plead on behalf of clients who are facing disciplinary punishment after positive urine tests while, at the same time, seeing the case from the perspective of the officers and giving relevant (though partly confidential) information on the clients’ situation. As one counsellor explained:

> I don’t say much at these meetings. I speak if I am asked – and naturally, if there is something totally wrong. But then again I am seen as an advocate for the inmate. And in principle I am. On the other hand, I should not be too much on that side either. So it is a delicate balance.

The dilemma experienced in such meetings links with the general predicament of providing rehabilitation in prison, as felt by this counsellor:

> You have to find the balance between working for the clients and remembering that they have to serve their sentence. And if they do something which results in additional punishment [e.g. using drugs] – then we have to accept it. They have to be given their punishment, but sometimes I feel it is really hard. It’s a dilemma.
Thirdly, the tension in balancing two systems based on opposite principles also exists in relation to client motivation. Counsellors know that urine testing strongly motivates some clients to seek treatment as the disciplinary consequence of a positive test is suspension of weekend leave. The urine tests therefore play an important part in securing high uptake in treatment programmes; an important measure of success for the prison management. At the same time, however, counsellors want to work primarily with clients whom they feel are genuinely motivated for change. The pragmatic reaction of counsellors is often to accept all clients who seek treatment – including those whose sole motivation is their fear of disciplinary sanctions for drug use. A prison nurse working closely with the counsellors noted:

The only reason [for clients] to stay off cannabis is to be able to go on leave. The clients simply have to stay off in order to get their leave. So, sadly enough, the primary reason is not to stay off cannabis.

It should be noted, however, that motivation is a complex issue in community-based treatment (Kolind, 2007; McKeganey, Morris, Neale, & Robertson, 2004).

**Interaction with prison officers**

Another challenge relates to the counsellors’ day-to-day interaction with prison officers, who play a crucial role in the running of the programmes. Counsellors depend on their goodwill and thus find it important to be on a friendly footing. For instance, when inmates have appointments with a counsellor, it is the officers who escort them to and from the cell to the counsellor’s office. If counsellors have to cancel appointments they have to ask officers to pass on the information, as explained by this counsellor:

If we are sick, it is very important for us that our appointments with the inmates get cancelled. But this is not the way it works. You can call the wing and ask to have something cancelled, but they [the officers] might not pass on the information, because you know, it’s unimportant. Their attitude is like: ‘they [the inmates] are there anyway’.

Besides everyday practicalities, counsellors stress that officers’ support of the treatment programmes is important (see also Dvoskin & Spiers, 2004). For instance, one counsellor who used cognitive therapy to help his clients find more co-operative ways to sell drugs recalled:

If you’re feeling a bit irritated and angry and a prison officer says something to you, well things are almost bound to go wrong. A couple of my clients ended up in solitary confinement because they [the officers] might not pass on the information, because you know, it’s unimportant. Their attitude is like: ‘they [the inmates] are there anyway’.

In conclusion, as experienced by counsellors, the attitudes of many prison officers not only impede the treatment programmes, but can also counteract them.

**The objectives of the programmes**

One final theme relates to the counsellors’ treatment objectives. As mentioned above, in principle the treatment institutions support the official long-term goals of the Prison Service such as making clients drug free/making them reduce their drug use, preparing them for a life without crime and reducing the amount of drugs in prison. However, in our interviews with counsellors it was short-term and rather pragmatic goals linked to the individual client that were emphasised. They centred around two related themes: the deprivations of confinement, and the harsh inmate culture. To summarise, the counsellors’ main goal in providing prison-based drug treatment appeared to be the alleviation of the negative consequences of imprisonment.

From the literature we know that, from the inmates’ perspective, the deprivations of confinement primarily involve a lack of: privacy, prospects for the future, financial earning power and intimate relations. In addition, the prison setting offers few work opportunities and recreational activities, and often results in passivity. Finally, inmates often experience patronising and degrading attitudes from the officers (Cohen & Taylor, 1972; Goffman, 1961; Rhodes, 2004; Toch, 1992). These are the kinds of deprivation that counsellors felt they had to mitigate in drug treatment. For instance, when talking about attitudes inside prison, one counsellor reported:

A lot [of the inmates] say: ‘But you talk to me like a fully normal human being’. You know, they are not used to that, because this is not how the officers approach them. No, because for them it [the relationship with the inmate] is just routine.

Another counsellor has this view about what drug treatment in a prison environment essentially involves:
the client, and the last part to help them put on their facade again.

Inmates. One counsellor reported that during his individual session, counsellors adjust the programmes to match the daily lives of the inmates or to escape drug debts. As a consequence of such predicaments, they pointed to violence and threats of violence, the accessibility of drugs, and strong inmate hierarchies. Drug users sometimes choose the fear of infectious diseases in prisons, changes in policy, and an increased number throughout European prisons, including Denmark.

To summarise, the main focus of day treatment programmes is to make the inmate vulnerable:

They have to be able to function in the hard and hierarchical environment they are placed in. So we have to make sure that every time we follow them back [from the sessions] they have to be able to get themselves back under control again. We spend a long time making sure they are OK. You have to take care not to take too much from them.

For similar reasons, one counsellor refrained from using written material as part of the inmates’ homework, as he feared this could make the inmate vulnerable:

Many of them do not want to carry any written materials with them. Because they fear that somebody else will see it. And furthermore, they do not want to relate to it [all their problems] the whole week.

To summarise, the main focus of day treatment programmes is to alleviate the negative consequences of imprisonment. Furthermore, the counsellors and clients only have sparse contact with each other, and the counsellors have no influence on the counterproductive workings of the inmate culture.

Discussion

Within the last 15 years, drug treatment programmes have increased in number throughout European prisons, including Denmark. Among other things, this development reflects a response to the fear of infectious diseases in prisons, changes in policy, and an increasing number of inmates using drugs. In 2007, a new drug treatment initiative was introduced in Denmark: day treatment programmes for cannabis users and inmates in substitution treatment. This initiative was introduced to enable prisons to fulfil the statutory drug treatment guarantee. This article has analysed these programmes, relating them to the new governmental drug action plan and introduction of intensified disciplinary sanctions, and by examining the experiences of counsellors.

The new national drug action plan – The Fight against Drugs – has increased the existing tension between treatment and punishment embedded in prison philosophy, placing increased pressure on incarcerated drug users. They have been given the alternative of entering treatment or facing increased disciplinary sanctions such as fines, solitary confinement and, most importantly, restrictions on weekend leave. As a consequence, though treatment is voluntary, clients may enter treatment primarily because they fear disciplinary sanctions. This is problematic because motivation for treatment is critical if clients are to become fully engaged in therapy (Longshore & Teruya, 2006; Rosen, Hiller, Webster, Staton, & Leukefeld, 2004). Alternatively, they may refrain from treatment, thus creating a group of inmates who use drugs but do not seek treatment – and who therefore face harsher terms of imprisonment.

It should be noted, however, that programmes explicitly focusing on non-compliant clients can foster motivation among these individuals and improve programme retention (Sung, Belenko, & Peng, 2001).

With regard to the experiences of counsellors, the new treatment programmes are subordinated to the prison institution with its intensified disciplinary focus, which also tends to make the counsellors confused about their own role. The counsellors have to cooperate with officers who have scant knowledge of drug treatment and who sometimes counteract the actual treatment programmes (see also Gjersing, Butler, Capehorn, Belcher, & Matthews, 2007). The official goals of the programmes have narrowed to focus primarily on alleviating the negative consequences of imprisonment. International reviews of the long-term outcomes of prison-based drug treatment show that success in reducing substance use and criminality depends on the following factors: (1) that treatment is offered in a location separated from the rest of the prison; (2) that prisoners in treatment are segregated from other prisoners; (3) that the treatment offered is coherent and continuous, and staffed by experienced therapists/counsellors; (4) that treatment lasts no less than 3 months; and (5) the type of treatment (e.g., therapeutically inspired treatment) can reduce both criminality and drug use whereas counselling mainly affects criminality (Egg et al., 2000; Inciardi, Martin, & Butzin, 2004; Pelissier, Motivans, & Sounds-Bryant, 2005). The day treatment programmes examined in this study meet hardly any of these criteria, so it is more relevant to judge them on their short-term characteristics. In this respect, it would be more accurate to describe the programmes as humanitarian services primarily aimed at alleviating the pain of imprisonment for those facing severe institutional and legal restrictions, and mainly targeting the less affected drug users. We do not necessarily see this as a problem, but recommend that the differences between the official objectives of treatment and the actual situation should be discussed openly.

Conclusion

This article has critically discussed the experiences of Danish counsellors in relation to the implementation of new drug treatment programmes in Danish prisons in a period of increasingly harsh disciplinary sanctions. At a time when drug treatment in prisons is increasing in many European countries (Parker, 2004), it is crucial that we thoroughly consider and research the actual content, competencies and capacity of these drug treatment programmes. It is also important that we consider the views and experiences of the professionals who deliver such services. As a matter of priority, future research should also consider the views and experiences of prisoners enrolled in the treatment programmes. Operating pro-

grammes that do not really provide drug treatment may give the wrong impression of services, prevent discussion of alternatives (e.g. more use of community referrals), and further disadvantage those severely dependent drug users who do not manage to enter treatment.

References


