Care and control

Implementing a prison drug strategy

In 1995, Swansea Prison implemented a local drug strategy. In the last of our series of articles on drugs in prison, we find out how it went and how Mandatory Drug Testing affected it

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SUMMARY

Swansea Prison introduced a drug strategy in 1995. It had two main elements, based on the custodial themes of 'care' and 'control'. Though the supply reduction measures were quite simple to implement, the demand reduction measures required more attention. The introduction of Mandatory Drug Testing in December 1995 had a marked effect in reducing inmates' trust and confidence in the prison's own drug treatment strategy.

SWANSEA IS A SMALL, very busy local prison serving 34 magistrates and five crown courts in south Wales. In 1993, we held about 300 prisoners – all male – of whom about 70 were young offenders and the rest adult offenders. Eighty-five per cent were remand or trial prisoners, either waiting to go to court or not yet sentenced. By their very nature, these prisoners were in custody at Swansea for indeterminate periods.

In 1992, the drug problem reached our prison. There was a discernable increase in the reports of prisoners suspected of being under the influence of drugs or alcohol. Finds of drugs and drug-using equipment increased by a quarter. These finds were usually cannabis related, but there was the occasional needle or syringe. More significantly, there had been a 50 per cent increase in control problems within the prison. Bullying and the 'taxing' of prisoners was occurring more frequently and more inmates were requesting to be removed from normal residential accommodation for their own safety. Violence towards prisoners and against staff increased and there were frequent incidents of bizarre and odd behaviour following prisoners' reception into prison. Corroborative information from our Health Care Centre confirmed that the numbers of prisoners who admitted abusing drugs had increased from 30 to 48 per cent, and that there was a similar increase in requests for maintenance doses of tranquillisers.

Research findings and reports from other sources confirmed that we were probably not the only Prison Service establishment likely to be experiencing these problems. A Home Office survey of 25 prisons found that 34 per cent of prisoners used drugs prior to custody,[1] while another study found that 27 per cent of drug-using ex-prisoners had continued to inject when in custody.[2] In his 1992 report on the prison service, Judge Stephen Tumin had made specific reference to drugs in prison and the effect this was having on the 'control function' of prisons. He described the extent of prison drug use as being a major factor in the replication of street gang culture within prisons.

Our own study carried out in Swansea found that drug use in the community among both current prisoners and ex-prisoners was extremely high – around three-quarters of each group had used drugs prior to custody or after release.[3]

Local drug strategies

This research coupled with our experiences since 1992, convinced us of the need to form a working party to draw up a local drug strategy for the prison. The terms of reference were wide but, of neccessity, had to take account of the fact that our population was transitional with a great deal of interplay with the local community. Accordingly, the working party needed representation not only from within the prison but also from outside it.

The group was chaired by West Glamorgan's senior probation manager, and the security officer, the medical officer and the health care manager represented the prison. Local drug agencies were also represented and it was advised by a community consultant psychiatrist. The Prison governor ensured full management support and the maintenance of what came to be called the "Chinese Wall", separating the prison's 'caring' and 'control' functions.

Carrots and sticks: a prison strategy must have two, apparently conflicting, strands

The key to our strategy was this understanding of a prison's dual functions – to care for prisoners and to control their environment. As an agency of the criminal justice system we are bound by and committed to the obligations of both. Our underlying philosophy was that, on the one hand, we would use whatever security measures and sanctions that were available to create a climate in which drugs were not tolerated. And on the other, we saw drug abuse as primarily a health problem and so we would offer help and assistance to prisoners. In this way, we set out to tackle supply and demand.

Controlling supply

The working party had confirmed the need for a phased approach to the strategy's implementation, not only due to the enormity of the task but also because of uncertainties regarding approval and funding from Prison Headquarters. By July 1994 the policy and plan had been formulated – but it wasn't until May 1995 that Prison Headquarters was able to approve and finance the strategy. When the plan was given the go-ahead, a number of security measures were introduced between April 1995 and March 1996.

Closed circuit television cameras were installed in the visiting room, and inmates and their visitors were given information as to its use. A specially trained team was formed to conduct searches, and a policy document detailed procedures for frequent searches of all staff, inmates and visitors. A trained member of staff and a drug dog were also used for searching residential and visiting areas. Finally, we initiated better liaison with the police and set up a 'drug phoneline', which is advertised publicly and to the prisoners and their visitors.

All prisoners and visitors were notified of these measures, together with the fact that visitors found in possession of drugs would be reported to the police. Prisoners found in possession would be severely punished within the prison. Staff awareness of the strategy was raised by a substantial internal training programme which covered 180 of our 220 staff.

The strategy also contained a proactive public relations element. The Governor and senior members of the group had numerous meetings with community drug agencies, health authorities and criminal justice agencies.

Fundamental to our strategy was the concept of close collaboration and partnership, and to this end, the prison "opened its doors" to inspection from the local media. As for the clinical and medical aspects of the strategy, they are overseen by a full-time Medical Officer, who is also a local General Practitioner with extensive experience of running drug clinics in the community.

Demanding care

In April 1995, we initiated a drug screening procedure for prisoners. This procedure was devised jointly by the local Drug Prevention Team and our working party, and is *not* linked to the national mandatory drug testing programme. All prisoners are screened on reception to the prison for drug use in the last six months. This is done with a non-judgmental questionnaire. Results are confidential and do not result in any sanctions, though the data are tabulated for further assessment and research purposes.

In September 1995, the Well Man Clinic was opened, aiming to provide a lifestyle screening process to get prisoners to look more positively at their health. Those who are likely to be in custody for more than a week are encouraged to use the Clinic and to provide voluntarily a specimen of urine for drug tests. As with the screening, all results are confidential and not linked to punishment.

> A prison's dual functions are to care for prisoners and control their environment

Looking for a health team approach (to emphasise the concept of care and treatment within a custodial setting) we also appointed five qualified nursing staff to work alongside our existing nine prison officer grades employed within the Health Care Centre. At the same time, a full-time drug counsellor was appointed, to supplement the activities of part-time drug workers from community agencies. If a prisoner is identified as a drug misuser, they are encouraged to ask for a full chemical dependency assessment. This is carried out by a drug counsellor or one of the trained members of the health care team. Assessment results are treated as medical, and therefore confidential.

The assessment results are evaluated by the counsellor and health care staff, who will identify and offer the appropriate intervention, be it education, counselling, detoxification or a combination of the three. It is important to note that while prison staff may be aware that a prisoner is receiving treatment for drug abuse, this is not considered an appropriate or

suitable reason for targetting for searches.

We also created a seven bed detox unit within the Health Care Centre, which provides a three week detox programme using methadone reduction protocols supported by daily structured activities. This programme is followed by a week in normal residential accommodation supported by probation, drug counsellors and wing staff.

Confusing the issue

In December 1995, following new legislation and a national directive from Prison Service Headquarters, Mandatory Drug Testing was introduced at Swansea Prison. Previous articles in *Druglink* have explained Mandatory Drug Testing in some detail, but suffice it to say that – in its simplest form – prison governors are required to test a randomly selected 10 per cent of their prison population every month and that positive results attract punishments and sanctions. In other words, it is explicitly a manifestation of the 'control' function of a prison.

> Voluntary screeing was tarred with the same brush as Mandatory Drug Testing

We were ambivalent about introducing Mandatory Drug Testing on the grounds that it might lead to some blurring of our existing strategy and a reluctance on the part of prisoners to volunteer for treatment. On the other hand was the view which prevailed at the time – inmates might be encouraged to accept treatment as a more acceptable option to taking drugs and getting punished.

At the end of 1995, we also experienced another change to the prison. Due to serious overcrowding, it became necessary to close the Induction Unit. Although this unit was not explicitly part of the drug strategy, it was a part of the prison in which new prisoners became acclimatised to the environment in their first week. As well as providing an opportunity to familiarise themselves with all the normal prison services – the chaplain, the probation officers, the Health Care Centre – it also gave us an opportunity to encourage prisoners to take up the offer of treatment for any substance misuse which they may experience.

The introduction of Mandatory Drug Testing together with the loss of this valuable resource dealt a body blow to our own drug strategy. Our voluntary and confidential screening was effectively tarred with the same brush as Mandatory Drug Testing in the eyes of the prisoners, and initially inmates were much more reluctant to take part in initial screening processes than before Mandatory Drug Testing.

There also appears to be a belief that health care urine tests are not confidential and that requests for treatment will lead to targetting for compulsory tests. Over and above this is the belief that we are primarily concerned with punishment – with 'control' rather than with 'care'. Our worst fears were realised regarding voluntary treatment: in October 1995, there were 44 requests for chemical dependency assessments. In December, there were four.

The future of the strategy

The decision to introduce a drug strategy into Swansea Prison has confirmed that we are a dynamic organisation, subject to continuing internal and external influences and change. So far, we have succeeded in overcoming initial shortages of funds, serious overcrowding of the prison, prevailing moods of prisoners and the 'prison culture'. Our efforts at supply reduction have gone to plan.

However, we have also failed – in our assessment of the impact of the closure of the Induction Unit and the introduction of Mandatory Drug Testing on our healthcare approach to demand reduction. These two developments created initial uncertainty and suspicion among prisoners and contributed to a reluctance to come forward for advice or treatment. However, we have found that since the settling-in period of Mandatory Drug Testing, more prisoners have begun seeking assistance again.

Contrary to our initial misgivings, Mandatory Drug Testing may actually have proved to be a blessing in disguise, encouraging prisoners to take up treatment.

What has clearly been successful is the healthcare element to our strategy. And so, encouraged by this, we will continue to promote this positive approach, inviting prisoners to participate in voluntary treatment programmes both within the prison and in the community. Trust needs to be rebuilt. That's all. ❍

PERFORMANCE INDICATORS

It was deemed crucial to monitor our progress, and to this end, the working party formulated a series of Key Performance Indicators which could be used to assess the success of the strategy. These Performance Indicators will themselves be monitored and evaluated on an ongoing basis:

1. Reduction of drug-related finds by 25 per cent (using 1995 as the base year). In reality, we have increased finds by 200 per cent as a direct result of the new security measures.
2. Carry out at least three full post-visit searches of prisoners each month.
3. Carry out at least three searches of residential areas each week by drug dog.
4. Screen all new prisoners with the drug abuse questionnaire and identify the number of refusals or incomplete forms. Since April 1995, we have carried out 1841 screenings, with 1431 refusals. We identified 1345 drug misusers.
5. Carry out Well Man screening process on new prisoners in custody for seven days or more. Ensure that at least 1000 new prisoners are screened in this way by April 1997.
6. Carry out full drug assessment on all prisoners requesting treatment within 36 hours of request.
7. Increase the proportion of requests for assessment among those prisoners who appear to be misusing drugs on initial screening to at least 75 per cent.
8. Provide a full detox programme for at least 100 prisoners within the 1996 calendar year.
9. Provide treatment/counselling/training in the outside community for all those leaving prison who request it.
10. Carry out voluntary urine tests on all prisoners in the detox unit (weekly) and on five per cent of the prison population (monthly). Report the number of prisoners refusing a specimen for testing.

1. Madden *et al.* "Drug dependence in prison." *BMJ*: 1990, *302*, p.180.
2. Turnbull P. *et al.* "Prevalence of HIV infection amongst ex-prisoners in England." *BMJ*, 1992, *304*(6879), p.90.
3. Keene J. "High-risk groups and prison policies?" *International Journal of Drug Policy*, 1994, *5*(3), p.142-6.