# Opportunities in prison

***The opportunities have never been better for productive work in prisons***

THREE YEARS ago I wrote an article in Druglink[1] to encourage community-based drug services to provide their services in prisons. Cooperation between drug services and prison management was then rare, partly due to uncertainty about the extent and nature of the problem, and partly because of mutual suspicion. Since then we have learned a lot more about the prevalence and pattern of drug use among prisoners and about effective methods of working; work with drug users is now recognised as an important element in the management of HIV in prisons.

Based on client statistics from the Parole Release Scheme, in 1988 I had estimated that around 10 per cent of the annual prison population had a drug problem – significantly higher than the official figures based on prison medical officer notifications to the Home Office Addicts Index.

More recent, and more authoritative, figures are emerging from an Institute of Psychiatry study suggesting that 11 per cent of the male prison population and 23 per cent of the females were drug dependent to some degree on reception into prison – an apparent confirmation of our earlier estimates and proof that services for problem drug users are an important element of prison throughcare.[2,3]

A more recent study from the Centre for Research on Drugs and Health Behaviour has found that 27 per cent of a sample of 168 recently released prisoners with a history of drug injection had continued to inject while in prison.[4] One in ten of the injectors were HIV positive and three quarters of those who had injected in prison admitted to sharing syringes for this purpose. Each had shared on average with 12 other people. It is clear that this situation needs to be addressed if HIV transmission within prisons is to be controlled.

The Prison Medical Service, which takes the lead in responding to drug problems in prison, has made considerable progress since 1987. At that time a statement on throughcare for drug misusers outlined a vague commitment to multidisciplinary working, but failed to pinpoint specific policy and practice. By 1991 a training manual had been produced with the help of specialist drug workers, which goes into much more detail.[5]

The manual reflected the view, long held in the community, that the only way to have an impact on a drug using subculture was to encourage users into contact with services attractive to them. Consequently it emphasised the importance of offering a reasonable detoxification regime to all new prisoners, including those previously receiving prescriptions. Also raised was the potential value of longer term prescribing and better communication between prison doctors and their counterparts in the NHS. Such recommendations are highly controversial among a prison healthcare staff accused in the past of overprescribing (particularly of the major tranquillisers), so the extent to which they are implemented remains to be seen.

The new training manual aims to be the catalyst for increased training of prison staff in all departments. As an education aid it is limited, but hopefully it puts the issue into focus for prison managers, who now have to report annually on initiatives to provide throughcare for drug users. The crucial role of outside specialists is now emphasised in all policy documents, an approach consistent with the Woolf report on the prison riots of 1990. Woolf said that meaningful activities for inmates and maximum contact with the outside world were the best ways to ensure a peaceful prison system and to improve opportunities for released prisoners. Rehabilitation is back on the agenda.

The results of this new era of openness, promoted by a succession of conferences, workshops, seminars and documentaries, has been an explosion of initiatives around the country aimed at the prisoner with drug problems. In some areas the issue now is not how to get services into prisons, but how to make the best use of them once they are there.

At present most drug services to prisons are initiated as a result of an unholy alliance between prison managers – who want to show they are doing something about the drug problem – and outside agencies eager to be involved in prison work. Because services are not initiated directly in response to a proper assessment of needs, duplication is not uncommon in certain areas, while in others some needs are left unmet.

'Being involved with prison work' should not be seen as an objective in itself. In these days of the contract culture, we should be looking to provide only those services which are appropriate to client needs. A planning process should be worked through before providing a service in a particular prison, the first stage of which should be an assessment of needs.

Around 130,000 prisoners pass through the prison system every year; at any one time the prison population runs between 45-50,000, and we know that a significant proportion are experiencing drug problems. The Parole Release Scheme has found that many use the experience of imprisonment to

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A significant proportion of prisoners have experienced drug problems and may continue to use drugs in prison in ways that risk HIV transmission. Recent official prison policy documents have encouraged contact between prisons, prisoners, and drug agencies in the community. Drug work in prisons should be preceded by an assessment of need and may range from individual casework to group education. Much can be done by prison officers themselves after appropriate training.

## Four types of drug work in prison

### 1 Individual advice and throughcare

- Provided through a one-to-one relationship between the prisoner and a worker fully acquainted with drug issues and imprisonment;
- Usually takes place through a relationship that continues through the sentence;
- It is important that the caseworker can provide continuity of support through the inevitable transfers that a prisoner will experience during sentence;
- Emphasis could be on counselling and support while in prison, on practical advice and referral on release, on preparation of a court report or parole application, or on all three.

### 2 Drug awareness sessions for the general prison population

- Usually arranged as part of a wider programme of educational activities, particularly induction or pre-release courses, during which a group of prisoners attends a series of seminars on subjects ranging from applying for jobs to safe sex;
- The aim is to disseminate and discuss information on drugs and their effects, risks of use, drugs and the law, and treatment options;
- Often groups contain plenty of people with experience of drug use and others with opinions to share, so it is the exchange of views and challenging of each others' behaviour that is most useful.

### 3 Discussion group for identified problem drug users

- Usually a one-off, so the participants have no opportunity to build mutual trust; the level of honesty we can expect is limited;
- Participants have asked to be there and all have experience of drug use, so the emphasis is less on general information and more on methods of rehabilitation, relapse prevention, and safer use;
- Recently PRS has attempted to implement a four-session programme covering reasons for drug use, drugs and health, drug use and offending, and sentence planning, giving more opportunity for fuller discussion and making the best use of prison staff skills.

### 4 Abstinence-based therapy

- Rare because: demands a large resource input for just a few inmates; behaviour change may not be maintained after release; most therapy is based on mutual trust and openness, but in prison it is dangerous to show vulnerability and confidentiality cannot be guaranteed;
- The Woolf Report toyed with the Dutch idea of drug-free wings to create a therapeutic environment within a prison; prisoners apply to go on the wing and receive access to extra facilities in return for accepting a high level of security, backed up by urine testing;
- Such a system could be used for treatment or as a means of enforcing discipline; it is important for any initiative in this country to be clear about its objectives, and the implications for prisoners not eligible for transfer to drug-free wings or transferred back to normal wings.

attempt to move either towards abstinence or towards a safer method of use. They need support and advice in attempting these changes. Prisoners who have never, or only recreationally, used drugs can also benefit from general drug education to minimise their risk of developing drug problems.

A range of responses can be made to meet these needs while remaining compatible with the constraints imposed by prison culture and routine. The Parole Release Scheme has defined the four distinct methods of working shown above. Having selected appropriate methods, the next challenge for the purchaser is to identify possible service providers with the necessary skills and experience.

In practice much of the non-specialist work could be handled by prison staff, who spend most time with the inmates and understand the prison environment and culture: basic information, giving advice in a time of crisis, and appropriate referral, can all reasonably be expected of prison officers, psychologists and probation officers.

Specialists from outside agencies can be invited into the prisons to provide services, but should concentrate on the most effective use of their skills rather than taking responsibility for tasks that can be done by prison staff. This could mean input into specific drug programmes; training staff to be able to provide a service; one-to-one counselling and support; and providing a community contact point for release planning.

It is important that drug workers contemplating working in prison be aware of the very different environment within which their services are being provided; to be useful to the inmate, they must also have a working knowledge of prison rules, home leave entitlement and parole application procedures.

For all services provided to a prison, it is good practice to negotiate a formal agreement with prison managers. Although at this point it is unlikely that the prison will accept purchasing responsibility – governors do not have ring-fenced drug and HIV budgets – it is important to establish the true range and cost of services being provided in support of the prison service's own drug and HIV policies. Such an agreement can also stipulate the prison's responsibility to provide the necessary access and facilities for visitors. ■

### FOR MORE INFORMATION

■ **CONTACT THE PAROLE RELEASE SCHEME at 93 Fortess Road, London NW5 1AG, phone 071 267 4446.**

■ **HIV EDUCATION IN PRISONS. Una Padel *et al.* Health Education Authority, 1992. £12.95 plus £1.70 p&p.**
Book based on SCODA project aimed at HIV workers and prison staff.
*Available from HEA, Hamilton House, Mabledon Place, London WC1H 9TX.*

■ **ISDD'S INFORMATION SERVICE is available on 071 430 1993.**


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