

The Outsider

TURNING POINT'S Wakefield-based DRUGLINK service has been working with drug users in prison since 1988. We now have a team of six workers providing services ranging from assessment to acupuncture for drug users in four prisons. In our area, there is one "dispersal" prison where inmates serve a minimum of four years, and two male and one female local prisons with remand as well as sentenced inmates and a very rapid turnover.

Since the introduction of Mandatory Drug Testing (MDT) and the launch of the new Prison Service Drug Strategy, 'drugs' has become a high profile issue in prisons. Although drug work in prisons is extremely patchy at present, many agencies may find themselves considering whether to respond to requests from prisons or whether to approach them directly with contracting in mind. But before doing so, agencies need to acquaint themselves with some of the issues involved.

Evolution of prison drug services

Drug work in prison evolved in an *ad hoc* manner, with community-based services undertaking outreach into local prisons – usually prompted by the fact that a proportion of their existing clientele were already there. In the early nineties, this began to be put on a more systematic footing, with specialist prison drug worker posts funded through a variety of sources – mostly originating from the Department of Health.

As might be expected most of this work was developed within the prevailing set of priorities around HIV prevention, and prisons tended to be seen as simply another outreach setting presenting opportunities to make contact with drug users, rather than as customers for services. Much good pioneering work took place at this time, but two particular features tended to characterise prison drug work – the patchy and uneven development of services, and the absence of 'ownership' of the work from the prisons themselves. The first of these features is as true today as it was then. Most drug service input into

In the last Druglink, we introduced the issue of prison drug testing. Here, an agency manager gives the low-down on prison drug work, one of the final no-go areas for drug agencies. And yes, partnership can produce results in the unlikeliest of places!

by
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SUMMARY

Drug agencies working in prisons have to deal with many issues which are not encountered by their peers in the community. Most significant is the fact that they are working in an institutional setting defined by rules and regulations, but there is also often an absence of resources or support within the prisons and a blurring of the boundaries between treatment and punishment. Despite this, there is room for mutually beneficial partnerships in prisons.

prisons (where it exists at all) still tends to be conducted without a contractual basis. There has also been a cumulative decline in the ability of community drug services to provide this work without any external financial assistance, as they become increasingly circumscribed by contracts with their local purchasers.

For DRUGLINK and other services in the Yorkshire region, the landscape changed irrevocably with the disappearance of the Regional Health Authority as purchasers in 1994/5. The RHA had been a keen patron of prison drug work and had financed a number of schemes with several agencies. In the shake-out that followed, some posts disappeared permanently, and for those of us fighting to keep the work alive, it meant having to construct new partnerships.

In the interregnum that followed, there was a sterile dispute over whether the care of drug users in custody was the responsibility of the Home Office or the Department of Health. At a local level this translated into a similar debate between local prisons and district health authorities. The matter was complicated by the fact that prisons often draw their populations from wide areas not coterminous with a particular health authority district, and by the fact that some district health authorities had prisons on their patch while others did not. Whose responsibility was it – the prison the inmate resided in, the district in which the prison fell, or the district from which the inmate originated? Regional purchasing had neatly obscured this difficulty, and there was really only one way forward for us locally although we couldn't see it at the time: joint commissioning.

Partnerships

For DRUGLINK this meant working with district health authorities, the Probation Service and above all the Prison Service for the first time. Many of us were concerned that putting the prisons into a commissioning role would compromise our independence as service providers, and in a sense we were right. What

we have had to rethink though is whether this was such a bad thing after all. Clearly the Prison Service, and in particular individual penal establishments, has its own agenda, but then so do we, not to mention the other commissioning agencies.

In the first year, joint commissioning was little more than a desperately needed rescue package cobbled together to prevent services from going under entirely, but by the time of writing the process has widened to include three of the four prisons where we work, and the principle of partnership has elicited matching funding more than doubling existing resources.

Three unquestionably beneficial things have emerged from the new situation. Resources have increased, services have to be delivered more responsively in relation to the needs of prisons, and a sense of ownership and commitment to services has resulted from the prisons new status as paying customers. The fact that services and prisons have different (though overlapping) agendas is nothing new, but that fact can now be dealt with openly by negotiation rather than expressing itself through a "we know best" attitude from agencies and a lack of cooperation from the prisons.

Working in "The System"

So much for the current state of play. Now for the key issues faced by drug workers in prisons.

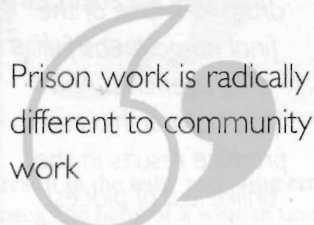
The fundamental point is that working in prisons is radically different to community work. To start with your clients don't want to be there! And where do you stand in relation to the prison authorities – as an independent professional advocating for your clients regardless? Or as part of the prison establishment? These are questions that every drug worker needs to ask themselves, because both your clients and prison staff will want to know where you're coming from.

Prisons are complex organisations with different goals and cultures, many of which can feel alien to workers from a community setting. Working in an institutional setting governed by rules and regulations far removed from your average street agency can be a disorienting experience for inadequately prepared staff. I remember another agency manager telling me he'd had to withdraw a worker who was going "stir crazy"!

Our earlier years in the prison field were dominated by the problem of being seen as "outsiders" with the work being health rather than prison service funded.

The prisons could be regarded as merely "host sites" and the work as just another form of outreach. The reality was pretty different. Prisons are not your run-of-the-mill housing estates or clubs. You only get in, move around and see clients with the say-so of the prison authorities.

Having "outsider" status means that your work is going to be dogged by frustrating practical problems. Firstly, you don't have keys, and this means that you can't move around the prison without waiting for officers at every turn. Secondly, you don't have an office, and this means that you have to travel to do your administration at base. Thirdly, you don't have an interview room, and this means that you have to see clients in "special visits", in competition with their solicitors. As you might imagine, whether you get to see your clients could be a pretty hit or miss affair.



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The time wasted and the steam generated can be unbelievable. And your frustration will simply be taken as just another sign that you really are "outsiders" – do-gooders with no understanding of security and the inner life of a prison.

The problems for us were compounded by the fact that we were ourselves ambiguous about our "outsider" status. I well remember that even the prison drug workers support network in Yorkshire was proudly called the "Outsiders" group, reinforcing the idea that prison drug workers were somehow agents parachuted behind enemy lines! On the one hand, we wanted to see ourselves as sturdily independent professionals whose only concern was with "our" client group. On the other, we wanted keys, an office, a phone and above all professional recognition. The fact of the matter was that these two goals were pretty much mutually exclusive. And our complaint that the prisons didn't really value our service was hardly surprising. After all, they weren't paying for it.

Keeping you under lock and key

Security clearance is often another bugbear. All staff you select to work in this environment will have to be security cleared by the Prison Service (again very

different from the community setting) and this needs to be borne in mind at the recruitment stage. Security clearance also has implications for your use of staff for this area of work. If you find your security-cleared worker is off sick, and you send whoever else is available to cover, they will get a rude awakening at the gate if they are not both cleared and expected. For all of these reasons, having trained, designated specialist staff and clear working protocols with the prison are essential.

The bottom line is that unless you have the full cooperation of the prison you are unlikely to be able to work with your clients effectively. Remember, prisons are ruled by the lock and the key – there is a gate every few yards and your staff will (initially, at least) be trying to work without keys. Get friendly with the prison – get a key!

It follows from this that the goals of your work have to be *consistent* with those of the establishment you are trying to work in. Consistent does not mean identical of course, but if you attempt to give out works and condoms in a prison, you'll be in for a shock!

Treatment and MDT

The introduction of MDT has changed the political environment for prison work and has raised many complex issues for agencies as Anthony Hewitt's article in the last *Druglink* highlighted. Inmates are undoubtedly wary that contact with drug agencies and disclosure of drug use may result in sanctions. There has been a danger in some establishments that MDT may hijack the Prison Service Drug Strategy as a whole and obscure the need for treatment options. DRUGLINK has persistently and successfully argued the case for a clear separation of treatment and MDT in order to maintain the voluntary nature of treatment and to prevent services from being flooded with inappropriate cannabis referrals.

MDT and the accompanying Prison Drugs Strategy has however led to a higher profile for drug issues in prisons. Each prison is now required to form a Drug Strategy Team which can coordinate all aspects of drug-related work, be it prevention, treatment or enforcement. Following the advice of the Prison Service Drug Strategy, some establishments have taken the logical next step and have contracted with drug agencies to provide professional treatment services.

Others however have opted for a variety of officer-led schemes – frequently inspired by the Minnesota Model – focussed on "drug free" wings.

Many of us have been alarmed at the willingness of some prisons to move prison officers from an educational role (running drug awareness sessions on induction, for example) to a therapeutic one for which they may be ill-equipped and which conflicts with their enforcement and disciplinary role. Some of the programmes appear to owe more to the political attractions of abstinence-based approaches for prisons than to a well-considered assessment of inmates' needs.

Throughcare

In many prisons the inmate population is very transient: remanded prisoners awaiting sentence, sentenced prisoners awaiting transfer to another prison, and those awaiting release. It is by no means uncommon to find an inmate-client you were expecting to see next week gone without notice by the time your appointment comes around. All too often clients get lost in the system when remanded or sentenced, on transfer or released. This key problem is acknowledged by the Effectiveness Review, which found:

"A lack of consistency of treatment between prisons, and between prisons and the community, leading to a lack of continuity for drug users passing from one to another. Arrangements for continuity of care on release are often sadly lacking".

In our local prisons at Leeds, Hull and Newhall, inmates may only be there for a matter of weeks. *Every* contact has to count as it may be the only one you make. In this environment picking up drug users rapidly on entry to the prison and plugging them into services on release or transfer is the only way to get any kind of continuity of care, and this is a key aspect of our work.

Prescribing

Prison often means scarce drugs, scarcer works and not much by way of substitute prescribing or detoxification. Under these circumstances drug risk behaviours are amplified, particularly for those who may have entered prison while on a prescription. The ACMD report *Drug Misusers and the Prison System* cites evidence of increased injecting and sharing amongst this group where the prescription is abruptly stopped on entry. While syringe exchange remains off the political agenda, a greater degree of flexibility in prescribing is vital in diverting users from particularly high risk injecting practices. The Effectiveness Review has made welcome recommendations that treatment available in prison must more closely match that in the community. In



The drugworker as outsider: Karen Jenkinson, Druglink's prison worker, outside Armley jail

particular, that methadone should be made available and that maintenance be considered for those entering prison on an existing prescription. Much remains to be done to see that these recommendations are implemented, but the will appears to be there.

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A New Deal

Part of the new deal for us has been making the commitment to outpost staff to the prisons full time with the prisons committing to provide suitable interview and office accommodation and including our staff on the Drug Strategy Teams. The benefits for both sides have been immediate in terms of delivering an improved service to inmates, and the new mood of shared commitment and cooperation is tangible. Far from being compromised by partnership, it has delivered us an unprecedented degree of

influence upon drugs strategy in the prisons. Joint commissioning partnerships have also brought a helpful balance within the different agendas of purchasers – health, offending and demand reduction are all given credence.

I would be lying if I told you that there are not still many unresolved problems in the prisons where we work, or that making further progress will be easy. It is all too easy for us to forget that there are many prisons where no services exist at all. But I believe that the obstacles are surmountable, and the importance of the task demands that both sides make the attempt. Our experience of working in partnership with prisons has been a learning process for all concerned. The mutual stereotypes prison staff and drugs workers entertain about each other are starting to be eroded by the actual experience of working closely together. Prisons have had to embrace a commitment to providing services as well as enforcement through MDT. Drugs agencies have to decide whether delivering services to their clients is worth the compromises involved in working within institutional settings. For us the choice has been a clear one – at the end of the day harm minimisation is all about starting at the point where your clients are. ○