

The Evaluation of the Drug Recovery Wing Pilots

Final Report

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Declaration of interest

This is an independent report commissioned and funded by the Policy Research Programme in the Department of Health (ref no. 011/0056). The views expressed are not necessarily those of the Department.

Acknowledgements

We would like to thank the many prison staff and prisoners that directly took part in, or enabled, this study. We have been struck by the candid way that prison staff have approached the interviews: engaging in the process in a self-critical and honesty way. We are also very grateful to the prisoners who have been involved in the research, for their patient involvement in interviews that were often lengthy and covered many sensitive issues.

We are also very grateful to the Advisory Group that provided such valuable input into the research as it progressed, our research manager in the Department of Health, Dr Ruth Chadwick, for her advice over the course of the study and ensuring the link-up with policy-makers; and to NOMS policy contacts for their engagement with the research and agreeing to interview.

DRW Evaluation Team
May 2017

Summary

Ten pilot Drug Recovery Wing (DRWs) were launched in two phases over 2011 to 2012 in eight men's and two women's prisons in England and Wales, with the intention of delivering abstinence-focused drug recovery services. Prisons were given licence to develop their own DRW models to reflect local needs and the ten resulting projects varied considerably in terms of size, aims, target population, accommodation, regime, and therapeutic content and intensity.

In 2012, the Department of Health commissioned an evaluation of these pilots, which has been undertaken by researchers at the University of York, the Centre for Drug Use Research in Glasgow and the University of Cambridge.

This mixed methods evaluation consisted of five parts:

1. A Rapid Assessment of all 10 pilot DRWs.
2. An analysis of Measuring the Quality of Prison Life (MQPL) data for the 10 pilot DRWs.
3. A process evaluation of 7 DRWs.
4. An impact evaluation of 5 DRWs.
5. An economic evaluation focused on the same 5 DRWs.

These were undertaken in two phases: the Rapid Assessment and MQPL survey over March 2012 to October 2013; and the process, impact and economic evaluations over November 2013 to April 2016. In the course of this work, we have undertaken and analysed 345 lengthy qualitative interviews, obtained and analysed data from 631 detailed prisoner questionnaires in the impact evaluation and analysed the data from 1,246 prisoners taking part in the MQPL survey.

This report focuses in particular on studies 2-4.

Findings

Previous research

- Previous studies have shown problematic substance users to be greatly overrepresented among prison receptions, though substance use generally declines in prison.
- There is a lack of reliable trend data on self-reported drug use prior to, and within, prison. There is therefore a pressing need for a nationally representative survey of self-reported substance use prior to reception and within prison.
- Evaluations of the two most studied prison treatment approaches – Opioid Substitution Therapy (OST) and Therapeutic Communities (TCs) – show positive results but point to the importance of linking treatment in prison with support on release.

Implementation

- DRW pilots were implemented in a rapidly changing prison policy context. Responsibility for all drug treatment services had recently shifted to NHS England and two major reviews of staffing, pay, and conditions were impacting on prisons over 2012 to 2013, both aimed at ensuring that public prisons were sufficiently lean in terms of staffing and resources to be able to compete with private agencies for prison contracts.
- Prisons were given licence to develop their own DRW models to reflect local needs and £30,000 to cover initial set-up costs. The resulting pilots were very varied: capacity ranged from 20 to 140 beds; therapeutic content varied from structured, full-time programmes to little more than the basic support offered elsewhere in the prison; some were run by uniformed prison officers and others by third sector drug treatment professionals; and some were segregated from the rest of the prison while others shared the wider regime.
- The MQPL data and the qualitative interviews showed the DRWs in Manchester, Styal and Swansea represented promising DRW models that improved prisoners' quality of life.
- Key to these DRWs' success appeared to be a mixture of physical separation from the rest of the prison, protection of DRW beds for people engaged in the therapeutic programme, a strong sense of community and good relations between staff and prisoners.
- A strong sense of community seemed to develop in small or medium-sized, well-controlled wings where prisoners underwent treatment as a cohort. Also key was the careful selection of positively motivated officers who were also able to manage professional and personal boundaries well.
- However, none of these features were necessary or sufficient. In particular, shutting off DRW residents from the rest of the prison appeared to intensify relationships and dynamics. This could either result in a close, supportive community where relationships were good; or considerable discord where relationships were poor.
- Despite their name, DRWs did not universally focus on abstinence-focused recovery. In two, the only treatment input was harm reduction. The nature and intensity of therapeutic input varied greatly across the seven DRWs and also across time in some of the individual DRWs.
- Only two DRWs had adopted conventional, well-established treatment models, both run by the third sector. Other, well-received programmes were designed in fairly *ad hoc* ways by prison staff. Prisoners tended to put much more emphasis on peer relations and prisoner communities than they did on the type or nature of therapeutic provision.
- Therapeutic input could not fill the whole day. If DRWs wished to maintain a credible degree of segregation from the rest of the prison, they had to fill the time that prisoners would otherwise spend in employment, workshops or education. Some allowed additional association time, which was received with mixed reviews. Others resorted to lock-up. Perhaps surprisingly, this was not necessarily unpopular with prisoners.
- Mutual aid groups, such as Narcotics Anonymous were very popular: providing prisoners with powerful examples of alternative ways to live their lives.

- Throughout the study, abstinence-focused DRWS experienced difficulties attracting prisoners on OST.
- In all but one DRW, drug availability appeared to be a central problem. In some DRWs cannabis, New Psychoactive Substances and diverted medications were reportedly readily available. Where DRW prisoners were rubbing shoulders with regular prisoners on OST, Subutex tended to be easy to access.

Problems in the past and the present

- A substantial minority of DRW prisoners had histories of mental health problems – in particular depression – and some had been physically and/or emotionally abused as a child. Many had difficult experiences of childhood. The large majority had been excluded from school and, on arrival in prison, most had close friends and/or family members involved with offending and drug use.
- For the most part, prisoners' physical and mental health declined over the course of their time on the DRWs and there was little evidence of improving attitudes or hopes for the future.
- Prisoners were disappointed by the level of preparation for release. Many feared a return to poor housing, expecting to be released to B&Bs, hostels and night shelters where they had had previous negative experiences.

Outcomes on release

- In the impact evaluation, 319 prisoners were interviewed at the beginning of their DRW engagement, 203 prior to their departure from the wing and 109 once they had been living back in the community for six months. The 109 that were followed-up at six months showed considerable reductions in drug and alcohol use, and self-reported offending between the six month period prior to custody and the six month period following release. However, reoffending was still quite common, with 12% reporting shoplifting, 9% theft other than from a vehicle and 9% handling stolen goods in the six months following release.
- The process study provided a complex picture of change. Three interviewees had become entirely abstinent and a substantial additional group had moderated their drug use, particularly where they had found jobs or managed to rebuild key relationships. However, many returned to similar levels of substance use, often with devastating effect on those around them.
- There was a strong tendency in the process study for those that reported reduced substance use and greater social reintegration to report no involvement in offending.
- A central theme of this study is the lack of support for prisoners on release: most of the process sample reported being met by no-one at the prison gate and only six reported receiving professional support.
- Housing was the most important issue for the process sample. The most common experience was being released to a hostel or funded B&B. Hostels were almost universally regarded as deeply unpleasant and criminogenic.

- Narratives concerning employment were more positive, with several finding employment through their personal contacts.
- When asked to reflect back on their time in DRWs, prisoners from the Manchester DRW were positive about their experiences but those from other DRWs were largely negative. Concerns centred on the ready availability of drugs and the lack of preparation for, and support on, release. However, some prisoners did speak positively about the increased access to gym on some DRWs and the associated impact on their fitness.

Conclusions

- This evaluation has demonstrated a fundamental imbalance between the level of these prisoners' past and present problems, and the input that they received while in prison and most important, on release.
- It can be questioned whether DRWs were sufficiently resourced in terms of the £30,000 made available to each, and sufficiently protected within the prison in terms of staffing levels and accommodation. It was unfortunate that the development of the DRW pilots happened at a time of substantial decline in prison officer numbers.
- Some DRWs offered excellent support, delivered by highly motivated and committed staff, but without help on release, such efforts could not make substantial changes to people's lives.
- Incarceration inevitably removes access to recovery capital. It can therefore be questioned whether this widely-accepted, holistic model of recovery can really be applied to a prison setting. Given this, it can be argued that the strongest emphasis should be placed on support in the community.
- One way that damage to recovery capital can be limited is through the provision of extensive family contact. Specialist family support/recovery workers offer one promising model: especially if such work can be continued into the community.
- Many prisoners in this study experienced a 'cliff-face' on release, receiving little or no professional support. There is a pressing need to identify current promising approaches to post-release support for recovering substance misusers and explore the potential for new models. Graduating release through much greater use of Release on Temporary License (ROTL) could form part of such provision.
- Akin to community services, ambitious, abstinence-focused interventions should be reserved for those who have robust recovery capital outside prison and where intensive professional support is guaranteed on release.

- With regard to future provision in prison, the qualitative research suggested that small, intensive regimes such as that developed at HMP Manchester offered promise. Drawing on the American evaluation literature, if such projects could be directly linked to residential programmes on release, this may offer the best chance of impacting on relapse and reoffending.
- Given the problems DRWs have experienced in maintaining a therapeutic regime within a largely unsympathetic prison environment, there may also be potential in considering specialist prisons for recovering substance misusing prisoners, akin to those developed for sex offenders. This is a model that has been adopted in the USA, with some success.

Chapter 1: Introduction

The first wave of Drug Recovery Wing (DRWs) pilots were launched in June 2011, with the intention of introducing ‘wing-based, abstinence-focused drug recovery services’ (HM Government, 2010) for short-term prisoners in five English men’s prisons. A second wave, launched in April 2012, focused on longer term prisoners and included two women’s prisons and a Young Offender Institution (YOI).

The piloting of DRWs in many ways represents the classic model of a ‘test run’ of a new idea in a limited number of geographical areas, with an associated evaluation, the results of which are designed to influence and shape future policy (Jowell, 2003). However, as Ettelt *et al.* (2015) point out, there are multiple possible purposes for government pilots. While the DRW piloting could be seen primarily as an experiment, with an associated focus on impact and cost-effectiveness, it also incorporated a strong element of what Ettelt *et al.* (2015) refer to as ‘piloting for learning’: with an emphasis on exploring how to operationalise a policy and overcome potential barriers. As will hopefully come clear in the course of this report, the DRW concept was not reduced to a single, well-defined approach that could be readily applied to a sample of prisons and its impact evaluated. Rather, participating prisons were encouraged to interpret the idea and produce their own projects, reflecting particular local contexts and needs.

At the core of the DRW development was a simple idea: a wing-based prison substance misuse service that was clearly premised on ‘recovery’. As evidenced by the subsequent, rapid spread of the DRW concept beyond the pilot prisons (Powis *et al.*, 2014; Hearty *et al.*, 2016), there was a strong appeal in this idea for prison senior management. Possible reasons for this might include frustrations with the historically high levels of Opioid Substitution Therapy (OST) in prison (see Chapter 3), the history of neglect with regard to treating alcohol problems (HMIP, 2010) and the sense that, given the salience of recovery and rehabilitation at the heart of Government justice and drug policy, this was an idea whose time had come. However, from our interviewees with prison staff, the avidity with which the idea was taken up by prisons also reflected a basic desire to do something positive: to help substance misusing prisoners break out of the vicious cycle of addiction, offending and imprisonment.

A defining feature of the DRW piloting process was its lack of direction: in the sense that this was a particularly open piloting process, where prisons were given the license to develop their own ideas, structures and regimes. As the Policy Innovation Research Unit reported quite early in the process:

In line with the government’s “localism agenda”, all pilot sites were given the flexibility to design DRW models based on their own experience and understanding of the evidence, and appropriate to their particular context and offender population (PIRU, 2012: 2).

As a consequence, the pilot projects that emerged differed substantially in terms of their aims, target populations, locations, regimes and therapeutic content (PIRU, 2011; PIRU, 2012; Powis *et al.*, 2014; Lloyd *et al.*, 2014¹). This variation clearly had important implications for the evaluation.

The development and oversight of DRWs was clearly interdepartmental: the National Offender Management Service (NOMS) and the National Treatment Agency (NTA, now effectively part of Public Health England) were closely involved in the initial planning and implementation of the pilots and NOMS policy-makers maintained a close interest in the pilots: particularly over the first part of the evaluation. Financial support for DRWs was rather limited. The Department of Health provided pilot prisons with £30,000 each to set up pilot DRWs and beyond this initial investment, DRWs were expected to be cost-neutral, utilising prison and local health resources to deliver their programmes of work.

The Evaluation

In 2012, the Department of Health commissioned the University of York to lead a team of researchers to undertake a detailed evaluation of the DRW pilots. The team is made up of researchers from the University of York, who have been responsible for the rapid assessment and process evaluation, the Centre for Drug Misuse Research in Glasgow who have undertaken the impact evaluation, and the University of Cambridge, who have worked on the Measuring the Quality of Prison Life (MQPL) survey. This was a two-phased, mixed-method evaluation. The first phase consisted of rapid assessments and MQPL surveys conducted in each of the ten pilots. The second phase comprised a process evaluation of seven pilot DRWs and an impact evaluation focused on five DRWs. The rapid assessment has already been reported on in some detail (Lloyd *et al.*, 2014; Page *et al.*, 2016; Grace *et al.*, 2016) and further publications are anticipated. This report revisits some of the findings from this first phase – particularly in reporting on the MQPL findings (Chapter 5) and, to provide some context, in the process site overview (Chapter 6a) - but otherwise focuses primarily on findings from the second phase.

There are a number of introductory chapters that follow the present chapter: the next (Chapter 2) provides a literature review on drug and alcohol treatment in prison, the third chapter explores the policy and practice backdrop to DRWs, and Chapter 4 provides an overview of the research methods that were employed in this evaluation. The next set of chapters focuses on the findings: the MQPL data in Chapter 5, the process evaluation findings in Chapter 6, qualitative follow-up interviews in Chapter 7, the impact evaluation results in Chapter 8 and the analysis of costs in Chapter 9. The final chapter offers a synthesis of the findings from across the evaluation as a whole, discussion and conclusions.

¹ See Appendix 1 for table summarising differences between DRW regimes.

Chapter 2: The Literature

This chapter presents a review of the literature that has focused on drug treatment in prison. This is a varied literature, ranging from Randomised Control Trials of Therapeutic Communities to sociological accounts of prison officers doing ‘emotional work’ in specialist treatment settings. An inclusive approach has been taken here, which distinguishes this review from many others, which have tended to focus either on the outcome literature or the sociological literature. We have taken this approach to suit our mixed methods evaluation.

There are other literatures that are of relevance to this study, including the wider addiction literature on recovery and substantial criminological bodies of work on resettlement and desistance. Some references are made to relevant studies but they could not be reviewed as part of this programme of work.

The rest of this chapter is divided into four: the first section focuses on the prevalence of substance use and drug-related deaths; the second on treatment evaluations; the third on the sociological literature and the fourth offers some conclusions.

Prevalence of substance use and drug-related deaths

Prevalence of pre-custodial substance use among prisoners

There is wide recognition that a much higher proportion of prisoners have histories of problem substance use than the general population from which they are drawn. The 1997 psychiatric morbidity survey of 3,142 prisoners in the UK (Singleton *et al.*, 1998) found that substantial proportions of prisoners had an AUDIT (Alcohol Use Disorders Identification Test) score of 8 or more, indicating hazardous drinking (see Table 1 below). While the usual AUDIT cut-off for likely dependence (20) was not used, 11 to 17% of these samples scored at least 24. Larger proportions reported dependence on drugs and a notably larger proportion of women than men were dependent on opioids.

Table 1: Proportion of prison psychiatric morbidity samples with alcohol and drug problems

	Men		Women	
	% of Sentenced	% of Remand	% of Sentenced	% of Remand
AUDIT ≥ 8	63	58	39	36
AUDIT ≥ 24	14	17	11	14
Drug Dependence ²	43	51	41	54
Opioid Dependence	18	26	23	41

² Drug dependence was measured using five questions from the Diagnostic Interview Schedule (DIS) (Robins and Regier, 1991).

Liriano and Ramsay (2003) report on the findings from the Criminality Survey undertaken in English and Welsh prisons in 2000, involving 1,884 newly-sentenced men. Seventy-three per cent reported using illegal drugs in the 12 months prior to imprisonment and 31 per cent reported using heroin. Of the heroin users, 82 per cent were using at least daily.

Reporting on the Surveying Prison Crime Reduction (SPCR) study: a substantial, prospective longitudinal study of a cohort of 1,457 newly sentenced prisoners recruited over 2005-6, Stewart (2009) described similar levels of pre-custodial drug use to those found by Liriano and Ramsay (2003). Of this sample, 91 per cent of which was male, 69 per cent reported using illegal drugs in the previous year and 31 per cent reported using heroin. The mean Severity Dependence Scale (SDS) score for the heroin users was 11.5, indicating a high level of dependence. Forty-five per cent of drug users reported needing help or support with a drug problem, most of whom had recently used heroin and/or crack cocaine.

Most recently, a thematic review on prison substance use by HM Inspectorate of Prisons (HMIP, 2015a) describes a survey undertaken with a sample of 1,218 prisoners drawn from a range of prison types and stratified to reflect the prison population as a whole. Findings showed that 52 per cent of the sample reported illicit drug use in the two months preceding custody. Fifteen per cent reported using heroin in that period and nine per cent diverted medication.

While drinking problems were included in the psychiatric morbidity survey, subsequent surveys have tended to focus on illicit drug use. Kissell et al (2014) report on a survey of newly remanded prisoners in three men's prisons over 2007 to 2008. Of the 555 eligible participants, 257 agreed to be interviewed. Of the 242 men who completed the AUDIT, 81 per cent were classed as hazardous drinkers (scoring between 8 and 19) and 27 per cent were classed as dependent (20 or over). Prisoners were also asked whether they had a problem with drinking: to reflect standard procedure on reception. A third of prisoners defined as dependent on the AUDIT did not report having a problem and almost all the hazardous drinkers did not report a problem.

As part of full inspections, the prisons inspectorate undertakes a survey of a random sample of prisoners. In a 2010 thematic report, an analysis is presented of the proportion of prisoners responding positively to the question: 'did you have an alcohol problem when you came into prison?' over the surveys conducted between 2004 and 2009 (HMIP, 2010). Of the 13,093 prisoners surveyed, 13 per cent reported having such a problem.

Substance use in prison

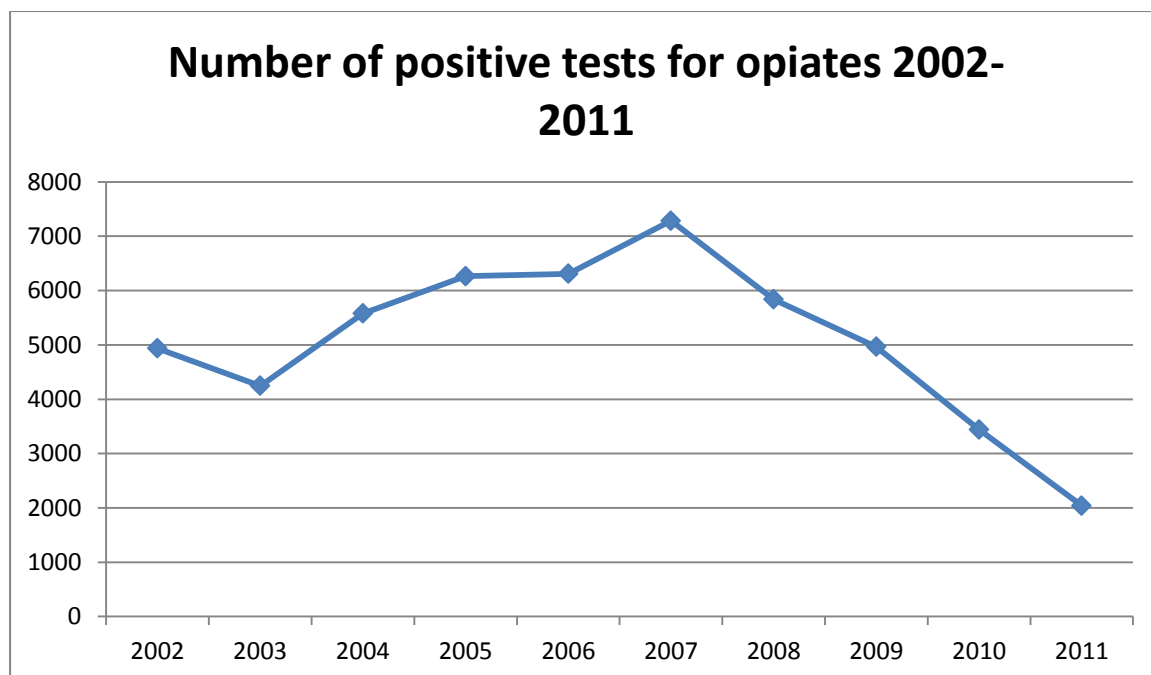
It is generally accepted that most types of substance use drop in prison compared to pre-custodial levels (Bellis *et al.*, 1997; Shewan *et al.*, 1994; Crewe, 2005), although for many, some drug use continues through the sentence according to availability. Analysing data from the prison psychiatric morbidity survey, Boys *et al.* (2002) found that 49 per cent of the sample reported using cannabis at some point in prison (although not necessarily in the current sentence) and 24 per cent reported heroin use. Forty-three per cent of the prisoners that had used heroin in prison had initiated the use

of this drug in prison. However, as the authors note, antipathy towards the prison system and sensitivities surrounding the self-reporting of an illegal drug calls for cautious interpretation of these findings (and, indeed, other findings on self-reported drug use in prison).

Bullock (2003) reports on follow-up interviews over 2000 to 2001, with two samples (total N=529) drawn from the Criminality Survey (Liriano and Ramsay, 2003), although there is limited information on how these samples were accessed. Cannabis use in prison was reported by 54 per cent of prisoners, and heroin use by 27 per cent (the second most used drug). Among those reporting use, daily cannabis use declined from 59 per cent of the sample pre-prison to 14 per cent in prison; and daily heroin use declined from 82 to 3 per cent. While daily use of heroin clearly declined precipitously, heroin use was still reported by 39 per cent of the prison heroin users. When the samples were asked why their drug use had declined, the most common explanation was the relative lack of availability.

More recent findings come from a sample of prisoners sentenced to between 18 months and 4 years in the SCPR study (Hopkins and Brunton-Smith, 2014). These findings show much lower levels of self-reported use: shortly before release, 22 per cent reported using cannabis at some point during their prison sentence; 14 per cent heroin; and 8 per cent methadone or tranquillisers that had not been prescribed for them. These findings relate to prisoners interviewed before release over 2005 and 2009 (Cleary *et al.*, 2012). Recent findings come from the HMIP survey described above (HMIP, 2015a): for which, fieldwork was conducted over 2014. Drug use in the two-months prior to custody is compared with any drug use reported in their current sentence. While reported use of most illicit drugs dropped considerably (cannabis from 38% to 13%; heroin from 15% to 7%), 'Spice/Black Mamba' went up from 6% to 10%. The HMIP thematic report describes the dramatic increase in the identification of synthetic cannabinoids as issues of concern identified in prison inspections over 2011 to 2015 (HMIP, 2015a, p.35). This increase appears to be connected to these drugs being cheap, readily accessed outside prison, undetectable in urine tests and highly profitable for suppliers. Recent research has further borne out this picture, with high levels of use reported in a Category B men's local prison (Ralphs *et al.* 2017) and in a survey of prisoners in nine prisons (User Voice, 2016).

It is difficult to decipher trends in drug use in prison from these one-off surveys which have employed rather different methodologies. However, there is the suggestion of a decline in self-reported cannabis and heroin use. Another source of data on drug use in prison is the Random Mandatory Drug Testing programme (RMDT), introduced in 1996. The RMDT aims to test a random sample of five to ten per cent of the prisoners each month. A failure to take a RMDT drug test is a disciplinary offence. From 2009/10 to 2014/15, the percentage of positive tests has been around seven per cent, with little evidence of a clear trend (MoJ, 2015). Historically, the majority of positive random tests have been for cannabis (Singleton *et al.*, 2005), the metabolites of which can be detected in urine for a considerable period of time after use. More recent data on positive tests for opiates published in Hansard show an interesting pattern (Hansard, 3 Dec 2012 : Column 666W):



While there are many problems associated with using the RMDT data as a measure of drug use in prison (Singleton *et al.*, 2005), it is possible that the pronounced decline in positive opiate tests from 2007 onwards may reflect a genuine decrease in heroin use, associated with the general decline in heroin prevalence over this period (National Treatment Agency, 2013) and the substantial increase in OST instituted under the Integrated Drug Treatment System (IDTS) from 2006 onwards (see next section). One other piece of evidence is the pronounced decline in heroin seizures over this period: from 1,365 in 2002 to 330 in 2011 (Hansard, 3 Dec 2012 : Column 666W). Again, this trend could relate to changes in recording practice or search procedures but may alternatively indicate declining heroin use.

What is clear from the data on drug use prior to and during imprisonment is that, with the exclusion of synthetic cannabinoids, there is a pronounced decline in the prevalence of self-reported drug use on imprisonment. While many prisoners do continue to use, for the large majority, their use is more sporadic and dependent on cash, cost and availability. The implication therefore follows that, while substantial proportions of people arrive in prison dependent on drugs and/or alcohol, there is limited scope for the maintenance of that dependence. The large majority of those arriving dependent on alcohol will detoxify: while they may binge occasionally on illicitly produced alcohol, it is highly unlikely that they will be able to access a regular supply. As will be shown in the next section, the majority of those dependent on opioid drugs will be placed on OST. Only a small minority choose to detoxify. While they may occasionally access heroin and other opioids (including diverted buprenorphine), regular dependent use would be very hard to maintain.

Lastly, this brief review of the evidence on drug use before and during imprisonment emphasises the lack of reliable trend data. Some excellent cross-sectional and cohort studies have been undertaken but they cannot be readily used to provide a reliable, detailed picture of how prisoners' substance use has changed over time. There is no regular, nationally-representative, independent survey of self-reported substance use in the prison population and without such surveys, we are

presented with a patchwork of information drawn from occasional studies and inspectorate reports. The substantial current concerns surrounding NPS use demonstrate the need for reliable, up to date trend data. Moreover, in comparison to general population surveys, self-completion surveys could be conducted in prisons at low cost.

Drug-related deaths on release

As has been shown above, most drug users – including opioid-dependent users – entering prison reduce their illicit drug use. For those not prescribed opioid substitute drugs in prison, tolerance to opioid drugs therefore falls while they are in prison (e.g. Strang *et al.*, 2003), making them vulnerable to over-dose on release. A number of UK studies have shown the first two weeks post-release to be a period of particular risk for overdose events and deaths (Seaman *et al.*, 1998; Bird and Hutchinson, 2003; Singleton *et al.*, 2003; Farrell and Marsden, 2008).

Drawing on the international literature in their meta-analysis of drug-related deaths following release from prison, Merrall *et al.* (2002) found that the risk of drug-related deaths was between 3 and 8 times greater in the first two weeks post-release, compared with weeks 3 to 12. There was considerable variation by country, with the risk multiplier being 7.5 in the UK, compared with 4.0 in Australia.

Evaluations of drug treatment in prison

A particular limitation of the literature is the lack of UK evaluations of drug treatment in prison. The only substantial UK evaluation, which focused on the Integrated Drug Treatment System (IDTS), is yet to be published (NatCen, 2014). A small, qualitative evaluation of the Counselling, Assessment, Referral, Advice and Throughcare (CARAT) initiative was published in 2005 (Harman and Paylor, 2005), involving interviews with ten prisoners and five CARAT workers.

Given the aim of DRWs to reduce substance use and offending and contribute to prisoner recovery, the focus here is on studies and reviews that have looked at related outcomes. However, it should be noted that research in this field has focused on a range of outcomes and that there are major differences between the European literature, largely focused on OST and reducing harms, including drug-related deaths; and the US literature, which is largely focused on TCs and their ability to produce abstinence and reduce reoffending. Notably absent from both literatures are attempts to look more widely at ‘recovery outcomes’ (Neale *et al.*, 2015), such as relationships, housing, health and employment.

This section is divided into research evidence on the impact of OST in prison (and on release); the impact of Therapeutic Communities (TCs); and the impact of prison aftercare.

Opioid Substitution Therapy

In their wider Cochrane review of prison-based drug treatments on post-release offending and relapse, Mitchell *et al.* (2012) included six studies that focused on OST. While there was no evidence of an effect on recidivism, all the included studies found lower rates of post-release drug use in the experimental (OST) groups and the mean effect size was large and statistically significant.

Employing different inclusion criteria,³ Hedrich *et al.* (2011)'s systematic review, which included 21 studies of prison-based OST, concluded that the benefits of OST in prison were similar to those associated with OST in the community, provided that dosage was adequate: i.e. they reduced heroin use, injecting and syringe sharing while incarcerated. OST also significantly increased treatment entry and retention on release. There was some evidence of decreased heroin use on release but the authors conclude that 'it is very likely that pre-release OMT [Opioid Maintenance Treatment] outcomes are mediated by community-based treatment after release' (p.513). Findings concerning impact on reoffending were equivocal and only one included study looked at deaths, suggesting lower post-release mortality for the OST group.

Since this review, three recent studies have addressed the question of the impact of OST on post-release mortality. In a data linkage study of prisoners in New South Wales, Australia, Degenhardt *et al.* (2014) found that post-release OST reduced the four weeks post-release hazard of death by 75%. By comparison OST in prison had an independent but short-term protective effect. Bird *et al.* (2015) report on a data linkage study in Scotland that compared periods before (1996-2002) and after (2003-2007) the introduction of prison-based OST. While they found a significantly lower rate of drug-related deaths over 2003 to 2007 in the 12 weeks following release, against expectations, they did not find a significant difference in the first 14 days. As the authors point out, the reduction in deaths in the first 12 weeks is unlikely to be due to prison-based OST, the comparative protective effect of which will be short-lived, given the increasing tolerance of unscripted opioid-using releasees over the first two weeks. Bird *et al.* (2015) conclude that improvements in methadone prescribing outside prison is most likely to explain the 12 week difference. Most recently, Marsden *et al.* (2017) focused on the impact of being on OST at the time of release from prison on risk of death in a sample of 15,141 episodes of incarceration across 39 prisons in England. Being in OST on release was associated with a 75% reduction in all-cause mortality and an 85% reduction in drug-related poisoning mortality in the first month following release.

In a retrospective cohort study of 16,715 Australian prisoners, Larney *et al.* (2014) found OST to be strongly associated with lower mortality among opioid-dependent prisoners *within* prison. After adjusting for a range of factors, being in OST was associated with a 74 per cent lower hazard of dying in prison. This was driven by an association between OST and a lower rate of unnatural deaths (two-thirds of which were suicides). The authors suggest that the association between OST and low death rate 'may, in part at least, be due to alleviation or prevention of opioid withdrawal' (p.7).

³ Unlike Mitchell *et al.* (2012), Hedrich *et al.* (2011) included non-English language studies, studies comparing different interventions and studies that focused on in-prison outcomes (Hedrich *et al.*, 2011, Appendix S1). Four out of the six studies included in Mitchell *et al.* (2012) were included in Hedrich *et al.* (2011).

Thus, evaluations of prison OST have found impacts on heroin use, injecting, needle-sharing and mortality within prisons. The findings from Mitchell *et al.* (2012) and Hedrich *et al.* (2011) suggest that drug use is also reduced post-release but that this might depend on link-up with post-release treatment. A study undertaken in Australia on in-prison OST (Larney *et al.*, 2014) and an English study focusing on OST on release (Marsden *et al.*, 2017) have demonstrated a substantial protective impact of OST on post-release deaths

Other researchers have focused on coverage of prison OST: particularly in Europe. In a survey of 27 responding European countries undertaken between 2012 and 2013, Zurhold and Stöver (2015) found that 20 countries provided detoxification services and 22 provided continuation of Opioid Substitution Therapy (OST). However, only 17 allowed the initiation of OST inside the prison. Extrapolating from estimated prevalence of opioid dependence in these countries, other commentators have suggested that, in the majority of European states, the proportion of prisoners in OST is lower (often much lower) than the proportion of dependent users in the community on OST - approximately 50% (Hedrich and Farrell, 2012).

Therapeutic communities

As will be described in the next chapter, at least four addiction TCs appear to be currently operating in English prisons. Moreover, a number of the DRW pilots were clearly predicated on a TC model. The TC evaluative literature therefore has particular relevance.

While the majority of prisoners entering UK prisons with identified opioid problems will be offered OST, methadone is only available in just over half of US prisons (McKenzie *et al.*, 2012). Opioid detoxification is the norm in US prisons and the focus on therapeutic interventions aimed at abstinence within prison and on release is therefore stronger. One of the most common models of in-prison substance use treatment in the US – and certainly the most evaluated – is the therapeutic community (TC) (Olson and Lurigio, 2014). While many specifically target people with substance use problems, Prison TCs offer a segregated residential regime which targets the whole person, focusing on changing negative patterns of behaviour and attitude in general, rather than particular offending or drug use behaviours (Olson and Lurigio, 2014; Inciardi *et al.*, 2004; Mitchell *et al.*, 2012).

In their systematic review of the effectiveness of prison drug treatment, Mitchell *et al.* (2012) concluded that TCs were associated with consistent but modest reductions in post-release recidivism and drug use. In their moderator analysis, the authors found that ‘treatment programmes that mandated aftercare after release from incarceration produced larger effect sizes than programs that did not’ (p.30)⁴.

Since this review, Olson and Lurigio (2014) have published an evaluation of the Sheridan Correctional Centre (SCC) in Illinois, which consists of an 848 bed, medium-secure prison devoted solely to a TC regime for substance misusers. Housing units are divided into small units of around 20 to 25 prisoners and operate a hierarchical TC model, involving individual and group treatment and peer

⁴ Although only in the analyses of drug use did the differences in effect size reach statistical significance.

support (Olson and Rozhon, 2011). All prisoners released from the prison are required to participate in after-care, as a condition of their Mandatory Supervised Release (post-prison sentence supervision) and referred to a broad range of services, from 'outpatient counselling' to residential treatment (Olson and Rozhon, 2011). The study focused on 1,501 prisoners who had completed the SCC programme and had been released over 2004 and 2007. This group was compared to a sample of 2,858 prisoners released from other prisons in the same region over the same period, closely matched on a broad range of criminal justice and socio-demographic variables. In the multivariate analyses undertaken, the SSC prisoners were significantly less likely to return to prison over a 7 year period than were the comparison sample. In an analysis of those SSC prisoners who completed after-care, there was a 46% lower likelihood of being readmitted to prison, relative to comparison prisoners, although there may well have been differences between completers and non-completers that had not been measured (such as motivation).

The conclusions both from evaluations of OST and TCs therefore emphasise the importance of post-release treatment and support.

Support post-release

Referencing Wexler and Williams (1986), Inciardi *et al.* (2004) point out that 'the connection between rehabilitation efforts in prison and the process of integration into society after release is probably one of the most feeble links in the criminal justice system'. In their systematic review of drug treatment aftercare in the criminal justice system, Pelissier *et al.* (2007) conclude that people completing both in-prison treatment and 'transitional' (aftercare) programmes have lower rates of recidivism than people completing in-prison treatment alone or people in other comparison groups. Few studies examined drug use as an outcome. However, the authors' raise a number of concerns about studies in this field, pointing out aftercare is poorly described in the literature; interventions are often voluntary (making findings vulnerable to self-selection bias); and problems surrounding variations in revocation and arrest rates.

Sociological literature focusing on drug treatment in prison

Research of a very different kind has focused on the dramatic increase in the provision of prison treatment in prisons across many European countries and what this means for the roles played by prison officers and treatment staff in these therapeutic contexts. Giertsen *et al.* (2015) and Kolind *et al.* (2014) report on a qualitative, comparative study of drug treatment in three prisons in each of Denmark, Finland, Norway and Sweden. Kolind *et al.* (2014) describe how officers on treatment wings tend to be self-selecting, having often applied for jobs in these units. Once there, they are then 'more exposed to rehabilitative thinking and practices than in the rest of the prison' (p.10), further contributing to their treatment-oriented occupational identity. Kolind *et al.* (2014) also note that officers on treatment wings felt 'looked down upon by colleagues working regular prison wings' (p.10): a finding found elsewhere in other rehabilitative contexts (Stevens, 2013; Tait, 2011).

Prisoner attitudes to officers varied, depending on their role: where officers participated fully in counsellor-led group sessions in Sweden and had frequent daily contact, views were positive (Giertsen *et al.* 2015). Indeed in such circumstances, officers could be regarded as a kind of co-therapist, similar to the externally employed drug counsellors. However, where officers had limited contact with prisoners and kept to their offices, they were regarded simply as guards.

In one of the very few detailed British studies of specialist drug treatment in prison, McIntosh and Saville (2006) focused on the role of prison officers in a Scottish prison's addiction centre, finding that prison officer commitment to the treatment role varied considerably and profoundly affected treatment delivery and prisoners' experiences of treatment. Officers described maintaining a difficult balance between discipline and therapy: but that discipline duties 'always come first' (p.239). Attitudes ranged from regarding injecting drug users as 'low life scum' through to a sympathetic understanding of prisoners' need to self-medicate (p.237). As a group, addiction centre officers were thought to be considerably more supportive than officers in the main prison, the majority of whom would rather 'put them against a wall and shoot them' (p.238). The small size of the centre facilitated more relaxed relationships, with officers being on first name terms with prisoners.

These findings raise the issue of what Nylander *et al.* (2011) have referred to as prison officers' 'double commission' of rehabilitation and control. More caring prison officers migrate to more therapeutic roles within prison and once there, are further affected by the environments in which they work. However, research suggests that, while those that involve themselves in therapeutic work may be more popular with the prisoners, they tend to be regarded with deep suspicion by their colleagues working elsewhere.

Conclusions

While problematic substance users are greatly overrepresented among prison receptions, with the exclusion of synthetic cannabinoids and, possibly, some diverted medications, once serving their sentence, there is a pronounced decline in the prevalence of drug use and drinking within prison and consequently, limited scope for the maintenance of dependence on illicit substances. There is the suggestion from survey data and drug testing that there may have been a decline in cannabis and heroin use in prison. However, the most important conclusion to draw on prevalence is the need for a reliable, regular survey of substance use prior to reception and within prison.

There has been a considerable increase in therapeutic and other specialist provision within prisons in the UK and in Europe, which has been associated with increased opportunities for prison officers to take on more supportive roles. While this has been welcomed by those officers who might be classified as 'true carers' (Tait, 2011), such officers tend to be regarded with suspicion by their peers.

Evaluations of the two most studied prison treatment approaches, OST and TCs show positive results but both point towards the importance of linking treatment attempts inside with good support on

release. This may be the hardest aspect to get right but, where it is achieved, is likely to deliver the best outcomes in terms of reduced deaths, illicit substance use and offending.

Chapter 3: The policy and practice context

The piloting of Drug Recovery Wings was almost simultaneously announced in the *Breaking the Cycle* Green Paper (Ministry of Justice, 2010) launched on the 7th December 2010 and the *Drug Strategy 2010* (HM Government, 2010) which was launched the next day. The Green Paper included a strong emphasis on 'getting the offender to recover and become drug free altogether' (p.28) and 'get off drugs for good' (p.27). One way of achieving this was to be the introduction of DRWs:

We believe that, given the substantial investment in drug services, and the strong association between drug use and reoffending, we should be more ambitious in our aims to improve efficiency and effectiveness. We will therefore focus on recovery outcomes, challenging offenders to come off drugs. We will pilot drug recovery wings in prison from June 2011 to help achieve this.

In a similar vein, the Drug Strategy announced that:

We will pilot wing-based, abstinence focused, drug recovery services in prisons for adults (drug recovery wings), as well as encouraging more offenders who have recovered from drug and alcohol problems to become mentors or 'Recovery Champions'.

In order to understand why Drug Recovery Wings were introduced at this point in time and in order to understand some of the constraints that then acted on their operation, it is necessary to take a wider perspective on prison drug treatment policy and practice.

Drug Recovery Wings can be seen as the result of a coming together of two strands of rehabilitative policy, reflected in the two documents cited above. First, the UK Coalition Government (2010 to 2015) had put a 'rehabilitation revolution' at the centre of its approach to reforming the criminal justice system (Ministry of Justice, 2010). The central focus of the *Breaking the Cycle* consultation was on identifying effective ways of reducing reoffending. This theme was later picked up by the 2013 *Transforming Rehabilitation* consultation and associated Offender Rehabilitation Act (2014) introducing 'through the prison gate' services, resettlement prisons and statutory supervision for released prisoners who had served short sentences. The second policy strand is the 'revival' of recovery in the addictions field (Berridge, 2012). While a contested term, *recovery* has become the watchword in UK drug and alcohol treatment, adopted in the title of national drug strategies and local projects alike, representing a radical shift away from long-term methadone maintenance in particular, and a stronger focus on abstinence and social reintegration. The Centre for Social Justice, in particular, has strongly pushed for diverting resources dedicated to 'expensive maintenance prescription' (CSJ, 2009: p.133) towards abstinence-focused approaches, including drug free wings.

Another important influence at this time was the Patel Report. The Prison Drug Treatment Strategy Review Group began its work in April 2009 and published its report two months before the Drug Strategy and Green Paper (Review Group, 2010). Focusing on drug treatment in prison and continuity of care on release, the Patel Report was critical of the fragmented nature of the funding, commissioning and management of drug services in prisons. Putting a strong emphasis on recovery and rehabilitation, and presaging the forthcoming strategies, the report recommended that ‘helping people get off drugs for good must be a crucial ambition for the new drug strategy and for the drug treatment and interventions system both in the community and in prisons’ (p.15). In so doing, The Patel Report recommended an increased use of peer support in the form of ‘Recovery Champions’ and mentoring groups: a theme picked up in the Drug Strategy announcement of the DRW pilots.

Beyond these more immediate strategic influences, there have been important broader shifts in prison drug treatment that also form an important backdrop to DRWs and their implementation. A very significant development has been the shift of responsibility for health services, including substance misuse services, from the Home Office to the Department of Health and ultimately NHS England. In April 2003, in response to increasing concern that health care in prison was much poorer than healthcare outside, responsibility for prisoners’ primary healthcare was transferred from the Home Office Prison Department to the Department of Health. Commissioning responsibility for health care, including clinical substance misuse services, was subsequently devolved to Primary Care Trusts over 2004 to 2006. In 2011, responsibility for commissioning non-clinical substance misuse services was added to the Department of Health brief, making the Department responsible for the delivery of all substance misuse services in prisons, including Counselling, Assessment, Referral, Advice and Throughcare (CARAT) and psychosocial programmes. Finally, in April 2013, NHS England was created, and took over responsibility for commissioning clinical and psycho-therapeutic substance misuse services for prisoners in England. This series of shifts of responsibility for prison substance misuse treatment from prison to health can be seen as part of a wider move towards outsourcing of prison functions to partner organisations (Justice Committee, 2015). The following sections look in more detail at the development of treatment policy for opioid users and alcohol users.

Opioid users

In prison

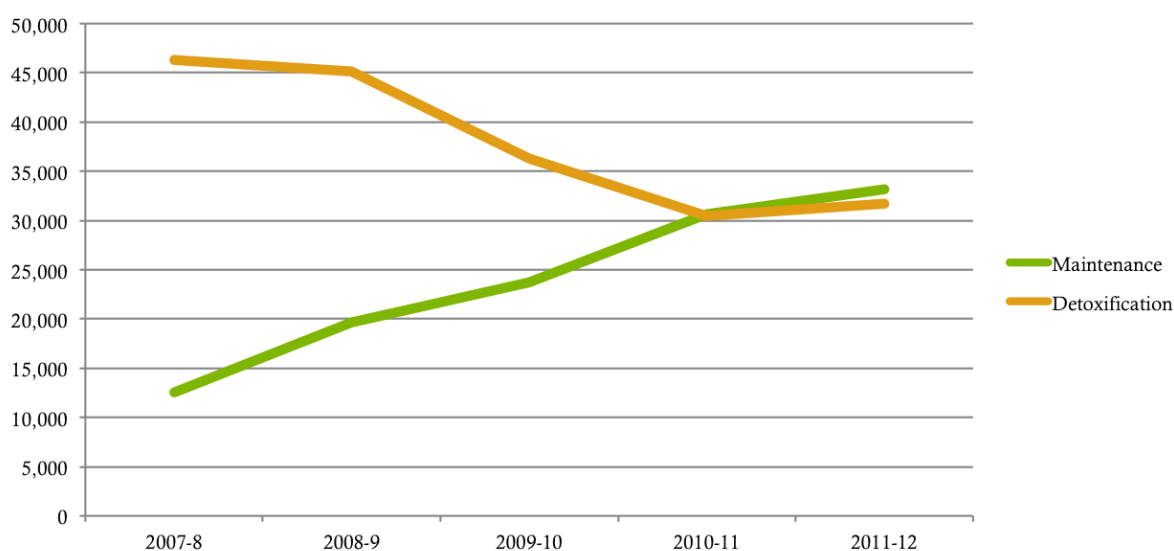
Reflecting the very considerable overrepresentation of opioid users in the prison population described in the previous chapter, much of the focus of prison drug treatment policy and practice over the past 15 years has been on this group. Prior to the 2000s, there had been little attempt to standardise drug treatment in prison, which was the central responsibility of the Home Office Prison Department and the local responsibility of prison governors. However, in 1999, psychosocial services were brought together within CARAT teams and implemented throughout the Prison Estate in England and Wales (May, 2005). While these teams provided a universal drug treatment system, their role was limited to assessing, advising, providing psychosocial interventions and referring to others (May, 2005). Clinical services, including prescribing, remained the responsibility of individual

clinical teams within prisons. Furthermore, at this stage, rapid detoxification remained ‘the solitary prescribing response to drug dependence in the majority of local prisons’ (Department of Health, 2006: p.iii).

This began to change in 2006, over the course of which there were two significant developments. First, the Department of Health published its guidance on the clinical treatment of drug dependence in prisons (Department of Health, 2006). Responding to the concerns about the links between drug withdrawal and suicide in prison, and recent findings concerning the mortality rate of released drug users (Singleton *et al.*, 2003), this guidance challenged prevailing practice by demanding that maintenance programmes and extended detoxification be introduced. These were to be delivered within a more systematic approach, ‘taking into account the patient’s own views on the management of their substance-misuse problems’ (p.1). Second, in November 2006, six prisoners with histories of opiate dependence took group action against the Home Office on the grounds of medical negligence and trespass (for receiving treatment without consent). The six were understood to have been rapidly detoxified on entry to prison against their will, despite being engaged with community treatment services beforehand (BBC, 2006). The Home Office settled this case out of court, triggering subsequent payments totalling £750,000 in compensation to 197 prisoners.

In the following five years, there was a dramatic increase in methadone maintenance in prison: the number of maintenance prescriptions nearly tripled, while detoxification treatments dropped by one third (Hansard 3rd December 2012: column 667W).

Figure 3.1: Annual numbers of clinical interventions with opioid-dependent prisoners
(source: Hansard 3rd December 2012: column 667W)



It was recognised in the 2006 Department of Health guidance that this new model of prison drug treatment would require further resourcing: not least for the anticipated increase in supervised methadone prescribing. Further resourcing and increased standardisation and integration came with

the introduction of the Integrated Drug Treatment System (IDTS) which were rolled out to prisons over 2006 to 2010. Led by a member of the Prison Senior Management Team, IDTS teams aimed to bring CARAT and clinical teams together in delivering more co-ordinated services. They were funded through a combination of Department of Health funding for the clinical element, which was accessed through NHS Primary Care Trusts and NOMS funding for CARAT services and other prison staff costs.

In 2010, the Department of Health provided updated opioid prescribing guidance, noting that while the IDTS had been effectively established (being rolled out to prisons in successive waves since 2007),

‘there is currently some concern that maintenance prescribing is being initiated without systematic review...and therefore the continuation of some prescriptions may be clinically inappropriate’ (DH, 2010: p.1).

The guidance went on to point out that

‘many opiate users, particularly those with longer sentences can be encouraged and supported to use their time in prison as an opportunity to achieve abstinence and this option should be discussed, and facilitated’ (p.1).

The guidance also stated that those service sentences of more than six months ‘should be made aware from the outset that...they will be expected to work towards becoming drug free’. Moreover, whether or not prisoners were on reduction regimes, all prescribed prisoners should have quarterly treatment reviews.

In 2013 the NOMS Director of Health identified the original 2006 DH guidance as the main reason that prisons had not ‘adjusted drugs treatment strategies... away from maintenance towards abstinence-based programmes’ (Home Affairs Committee 2012:202).

Following release

Transfers to community prescribers following release from prison were first made routinely available through measures announced in the Updated Drug Strategy 2002:

aftercare and throughcare services [will be introduced] to improve community access to treatment and ensure those leaving prison and treatment avoid the revolving door back into addiction and offending (HM Government, 2002, p.4)

These were embedded within the Drug Interventions Programme (DIP), and remained a core feature of DIP teams’ work until at least 2010 (Page, 2013). They were, however, notably absent from policy and research literature (e.g. Seddon *et al.* 2010; Skodbo *et al.*, 2007). With an increasing move towards ‘mainstreaming’ services and removing ring-fenced funding for criminal justice drug

services, this role is likely to be taken over by the ‘through the gates’ services and Community Rehabilitation Companies established by Transforming Rehabilitation (MoJ 2014).

Alcohol

As suggested above, the main focus of prison substance misuse treatment policy has been on the opiates. By comparison, alcohol policy has been identified as a neglected issue in the prison context (Duke, 2005). Following the first national alcohol strategy in 2004 (Alcohol Harm Reduction Strategy for England), the Prison Service published its own prison strategy: *Addressing alcohol misuse: A prison service alcohol strategy for prisoners* (HM Prison Service, 2004a). This strategy aimed to introduce a new focus on alcohol misuse, including screening and brief interventions, comprehensive assessment, care planning and the provision of a range of treatment interventions. A good practice guide was also produced (HM Prison Service, 2004b). However, unlike the situation for drug treatment, there was ‘a conspicuous absence of centrally allocated funding to enhance alcohol services’ (HMIP, 2010). In particular, as CARAT teams were not funded to work with people with alcohol-only problems, there was limited access to interventions other than detoxification in many prisons included in the HMIP thematic report on the issue (HMIP, 2010).

Changes to the staffing of prisons

While this chapter has focused hitherto on prison drug policy, the implementation of DRWs was also, inevitably, impacted by changes in the wider prison environment. In particular, English prisons underwent two major reviews of staffing, pay, and conditions: both impacting prisons at the time of ongoing fieldwork for this study (2013) and both aimed at ensuring that public prisons were sufficiently lean in terms of staffing and resources to be able to compete with private agencies for prison contracts. *Fair and Sustainable* sought to streamline management structures and establish a workforce that could be funded over the long-term (POA, 2012: p.5). However, within a year of its 2012 rollout, ‘competition benchmarking’ was introduced with the intention of making public prisons even more competition-proof. Benchmarking involved the rapid reviewing of prisons and the establishment of minimum staffing levels thought necessary to maintain order. A consequence – and indeed an aim – of this initiative was that public sector prisons’ staffing levels would fall (Justice Committee, 2015). Front-line prison officers numbers dropped by 30 per cent between 2010 and 2013 (Howard League, 2014).

The place of DRWs within wider specialist provision

Prisons contain large numbers of people with substance misuse problems of different types and degrees and there is therefore a need for a range of drug and alcohol interventions. Drawing on National Drug Treatment Monitoring System (NDTMS) data, HM Chief Inspectorate of Prisons (HMIP, 2015a) recently reported that 25% of all new entrants into English prison between April and September 2014 started treatment for substance use problems within three weeks of arrival. There is a plethora of substance misuse interventions delivered within UK prisons and, following the shift in commissioning to local NHS England partnership structures, these are increasingly delivered by a broad range of third sector organisations. Many of these programmes are ‘accredited’: i.e. approved by the Correctional Services Accreditation and Advisory Panel (CSAAP), on the basis that they are grounded in evidence-based, theoretical models. Data are collected on the number of prisoners attending accredited programmes (Ministry of Justice, 2015) but they are not available for prisoners attended non-accredited programmes. However, most relevant in the current context is the provision of specialist substance misuse units or wings: that is, physical spaces that are reserved (or at least partially reserved) for the delivery of substance misuse regimes or programmes.

Therapeutic Communities (TCs)

Therapeutic Communities are generally divided into two categories, based on their historical development and operation: Democratic TCs and Hierarchical or Addiction TCs. Both have their roots in a response to the authoritarian psychiatric regimes imposed on psychologically damaged war veterans over the first half of the 20th Century – especially in the UK, where the term Therapeutic Community was coined (Stevens, 2013; Rawlings, 1998; De Leon, 2000). However, there has been a bifurcation of approach between the US and the UK. In the latter, the Democratic model has developed and held sway, with its firmly user-led, ‘democratic’ approach, with peers being actively involved in each other’s treatment. While still having much in common with the Democratic model, the Hierarchical approach has its roots in Syanon, an addictions self-help community set up in Santa Monica, California, in the late 1950s. The hierarchical nature of the programme, involving defined successional stages, was clearly influenced by Alcoholics Anonymous’s 12-steps (De Leon, 2000). US Government funding for the importation of this model into prison has led to the proliferation of such programmes throughout the US correctional system and has been described as ‘the treatment of choice’ in US prisons (Wexler, 1997, quoted in Stevens, 2013).

In the UK, the first TCs to be opened in British prisons were Democratic TCs and did not focus on substance misuse. In 1962 Grendon opened as a long-anticipated experiment in the psychological treatment of prisoners (Genders and Player, 2001) and was initially run outside the Prison Service management system. While, HMP Grendon is often described as a single therapeutic community, as Genders and Player pointed out, it is better characterised as a collection of separate TCs (p.79). There are currently six wings operating as separate TCs. A number of other Democratic TCs have been developed in prisons in the UK, some of which have survived - including those at HMPs Send, Dovegate and Gartree - and others of which have closed.

More recently, Addictions TCs have been set up in a number of UK prisons. There currently appear to be four such TCs currently operating in prisons in England and Wales at the time of writing. The charity, *Phoenix Futures*, runs 'Discover Prison TCs' at HMP Wymott and HMP Garth. The former is a 70 place TC on Garth's K Wing and was opened in new accommodation in 2008, with a clearly separated regime from the rest of the prison. The TC at HMP Garth takes up half of the prison's E Wing: a total of 44 beds. According to a 2014 HM Chief Inspector report, there have been problems with inconsistent deployment of officers on the wing, 'some of whom were not sufficiently aware of the ethos of the unit and few of whom had received training on its aims' (HMCI, 2015:p.29) In common with all Addiction TCs, total abstinence from OST, illicit drugs and alcohol is a requirement and prisoners are closely involved in running the TC.

An additional addiction TC also operates at HMP Holme House, where the 65 bed unit is located on House Block 6. At the time of our fieldwork, this TC was initially run by Phoenix Futures but the service has since been recommissioned. Finally, the TC at HMP Channings Wood is on Living Block 8. However, in common with some of the pilot DRWs (Lloyd *et al.*, 2014), there is a history of prisoners being housed on the TC for non-therapeutic reasons and, perhaps for this reason, drug availability had been an issue – at least at time of the 2012 inspection. Since 1st April 2013, the programme has been described as a 'Recovery Community', run by the NHS and third sector in partnership with the prison, but the programme still appears to be based on the therapeutic community model.

The degree to which these Addiction TCs have adopted the US hierarchical model is not clear from the information available on them. Indeed the main UK research effort has been focused on the Democratic TCs: in particular Grendon (Genders and Player, 2001; Stevens, 2013) and to a lesser extent Dovegate (Genders, 2002), Send and Gartree (Stevens, 2013). There is a pressing need for research on the Addiction TCs in terms of their philosophy, operation and impact on substance use and reoffending.

Drug-free wings

Interviews with policy-makers involved with the original development of the DRW concept have revealed that the roots of the DRW idea came from plans under the previous Labour Government to increase the number of drug-free wings in the prison estate. This ambition was included in a Prison Policy Update briefing paper (MoJ, 2008): 'we will also consider extending the number of drug-free wings where prisoners can access increased rehabilitation and support separate from known drug users' (p.15). This idea was picked up by the Coalition Government and Kenneth Clarke (then Lord Chancellor and Secretary of State for Justice) was still announcing plans to introduce drug-free wings in his speech at the Conservative Party Conference in October 2010, but following criticism over the weeks that followed and also perhaps, reflecting the increased emphasis on recovery and rehabilitation across criminal justice and drugs policy, plans changed and the term 'Drug Recovery Wing' was adopted in the December launch of the Green Paper and Drug Strategy.

The term 'drug-free wing' is an aspirational one: it is almost universally acknowledged that it is currently impossible to completely prevent access to all drugs in any area of a prison, with the

possible exception of cells in a segregation block. However, it is a term that is quite widely used in the prison system. It is also a description rather than a programme: it suggests a lack of drug availability but it does not necessarily follow that there is therapeutic input (and where there is, one would expect an abstinence-focused approach). Drug-free wings are more or less segregated accommodation designed to keep abstinent prisoners away from drug using prisoners (Dolan *et al.*, 2007).

A number of prisons report to have a drug-free wing or drug-free units. For example, Wymott has a 'substance-free unit' on C wing, in addition to the TC, offering psychosocial interventions and the Building Skills for Recovery (BSR) programme. HMP Wayland Prison contains a Drug Free Wing, where prisoners agree to voluntary, regular drug and alcohol testing and there is increased security and AA/NA meetings. HM Swaleside has a 'drug- and alcohol-free unit' on H wing in which a 12-step programme is delivered (RAPt's Substance Dependence Treatment Programme).

Drug-free wings or units therefore appear to have a range of functions and structures. However, they have received little or no research attention in the UK.

Voluntary drug-testing units (VTUs)

Many prisons include voluntary drug testing alongside mandatory drug testing, where prisoners anywhere in the prison can elect to have additional tests in order to support their abstinence. Often, this is in the form of 'Compact-Based Drug Testing' (CBDT), where prisoners sign-up to a voluntary drug testing regime in advance.

In some prisons an attempt is made to separate abstinent prisoners from the rest of the prison population within Voluntary Drug-testing Units (VTUs). An example here is Park Prison which, at least in 2012, had three VTUs for prisoners prepared to sign a compact to engage in at least 18 random voluntary urine tests per year (in addition to Mandatory Drug Testing). Likewise regime information about HMP Sudbury and HMP Nottingham refer to VTUs.

Other specialist substance misuse units or wings

The language used to describe specialist units or wings is variable and appears to be largely determined by individual prisons. Following the introduction of the DRW pilots, many prisons chose to set up their own programmes with a recovery focus. An interview with a policy-maker in NOMS suggested that by late 2014 there were approximately 60 non-pilot DRWs (or similar programmes) in operation in England and Wales. From scanning website regime information, these would appear to include HMPs Deerbolt, Leeds, Onley, Ranby, Wymott, Full Sutton, Birmingham, Durham and Forest Bank. Language is variable, with references to an Abstinence and Recovery Centre, a Recovery Academy and Drug Recovery Units.

Conclusions

The development and implementation of DRWs are inevitably, and perhaps prosaically, best understood within the wider policy and practice environment in which they were situated. Indeed, this is something of a mantra in the policy evaluation field: although no less true for all that. In common with the majority of real world policy developments, DRWs were not forged on a linear, evidence-based policy production line. Rather the idea appears to have developed from a confluence of initial interest in increasing Drug Free Wing provision and broader interests in rehabilitation and recovery.

They have been implemented within a rapidly changing prison policy context. The tremors set off by the switch of commissioning from Home Office/NOMS to the Department of Health/NHS England were still palpable in the interviews conducted as part of this evaluation. And, following the introduction of Fair and Sustainable and benchmarking, the ground appeared to be shaking beneath the feet of many of those most closely involved with the setting up of DRWs in individual prisons. A further major development has been the recent introduction of the *Transforming Rehabilitation* agenda, including the 'through the prison gate' resettlement services for short-term sentence prisoners, predominantly delivered by the new Community Rehabilitation companies (CRCs). While the prisoners in this study were not subject to the new arrangements, discussions about the new arrangements had begun during the fieldwork and undoubtedly contributed to the sense of a rapidly shifting policy context.

When looked at as a whole, the Prison System could be said to contain a rather eclectic mix of specialist wings and units. The DRW pilots were often set up in prisons that had other specialist wings or units for prisoners with substance misuse problems and had to find their operational and functional place within this wider provision. Given their experimental nature, with purposefully limited guidance from the centre, it is clear that DRWs borrowed heavily from some of these models: in particular Therapeutic Communities.

Chapter 4: Aims and Research Methods

Aims

Reflecting the original brief provided by the Department of Health, the evaluation was designed to address the following key areas:

- (1) the institutional, sociocultural, and inter-personal processes which facilitate and impede the daily operation of the DRW intervention;
- (2) the impact of each DRW on participants' drug use and recovery progress at the end of treatment and at six months post-release from prison, the mechanisms of action accounting for the clinical effectiveness of each DRW, and the fidelity of each DRW programme to specified protocols; and
- (3) based on their costs and effects, whether continuing to provide each DRW represents good value for money.

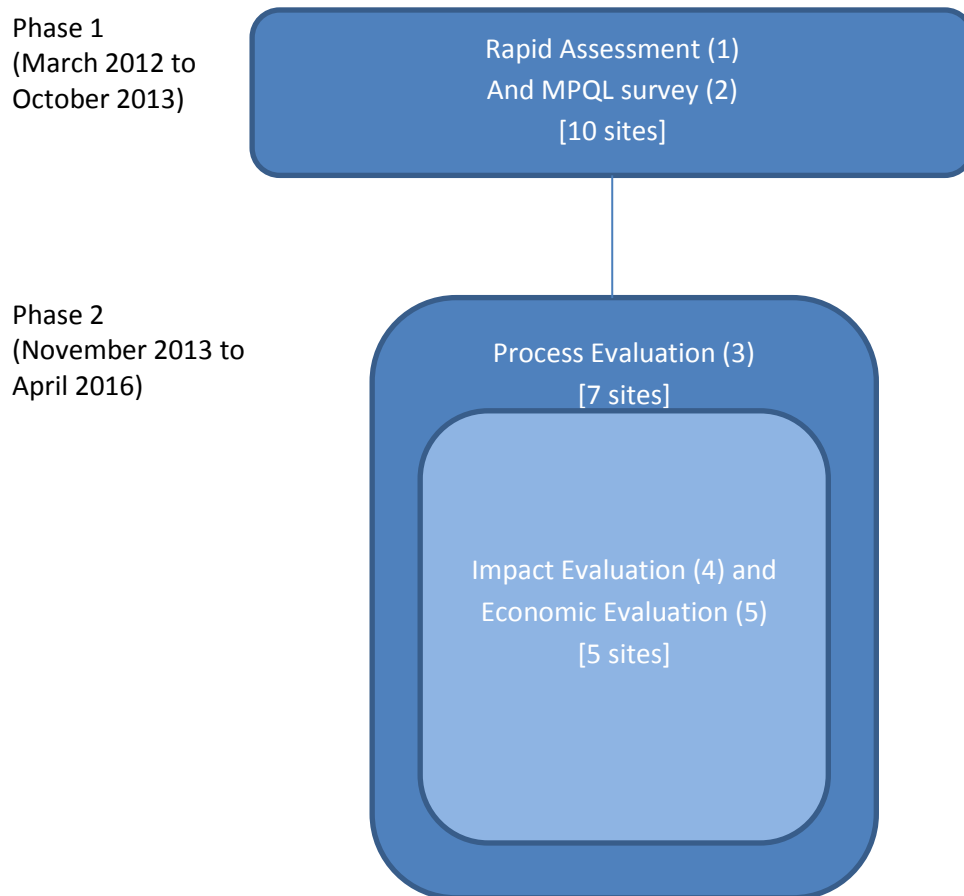
A Mixed Methods Approach

To address these wide-ranging aims, a mixed methods approach was proposed. Within the language of Health Sciences, DRWs might be described as 'complex interventions': i.e. they contain several interacting components and are flexible, target multiple behaviours and have the potential to impact a range of outcomes (MRC, 2006). Over the past 20 years, health research methodology has increasingly turned to mixed methods approaches in such health contexts: a process described as a 'quite revolution' (O'Cathain, 2009). With its roots in medical research and the Randomised Control Trial (RCT), the appearance of qualitative and mixed methodologies has been comparatively late compared with other fields. In the Criminology field, by contrast, the 'happy mixing' (Maruna, 2010) of quantitative and qualitative methodologies has a long history, dating back to early Chicago School studies (Bachman and Brent, 2014).

An important feature of mixed methods approaches is methodological triangulation (Denzin, 1978), whereby different methods are used to explore commonalities and differences across different types of research technique and data. Given the great variation across the DRW pilots which had been established early on (PIRU, 2011; PIRU, 2012) and subsequently commented on (Powis *et al.*, 2014; Lloyd *et al.*, 2014), there was thought to be a need to draw on a range of methods and data to describe the pilots and their possible impacts.

The first of the Department of Health's above aims (1) of capturing 'institutional, sociocultural, and inter-personal processes which facilitate and impede the daily operation of the DRW intervention' was addressed through a rapid assessment in the 10 pilot sites, an analysis of MPQL data in the 10 pilot sites and a process evaluation in seven of these sites. The impact and cost-effectiveness aims (2 and 3) were addressed through an impact study and cost-effectiveness evaluation in five sites.

The following diagram depicts the overall research design:



The diagram depicts the following methods, which are described in more detail below:

1. A Rapid Assessment of all 10 pilot DRWs.
2. An analysis of Measuring the Quality of Prison Life (MQPL) data for the 10 pilot DRWs.
3. A process evaluation of 7 DRWs.
4. An impact evaluation of 5 DRWs.
5. An economic evaluation focused on the same 5 DRWs.

1. *The Rapid Assessment*

The Rapid Assessment has already been extensively reported on (Lloyd *et al.*, 2014; Page *et al.*, 2016; Grace *et al.*, 2016; with other journal articles forthcoming) and given the large amount of research to report on here, findings from the Rapid Assessment are not reiterated. Nevertheless, in terms of methods, we believe this to have been a very successful element of the evaluation: while the 97 staff and 102 prisoner interviews were undertaken rapidly over a 6 week period a by a substantial team of researchers (five field-workers), the quality of the resulting data was very high. A thorough analysis of these data has been undertaken as indicated by the resulting publications.

2. *MQPL analysis*

As planned, the research team has largely been able to depend on data collected by NOMS, which has adopted the MQPL survey as part of its routine performance and audit measurement of prisons in England and Wales. We are very grateful to the NOMS MQPL survey team, who agreed to introduce a question into their survey which allowed us to identify prisoners residing on the DRWs. The NOMS team undertook all of the surveys other than that conducted by the research team in Manchester. Reflecting our aim to compare MQPL scores for DRW residents and prisoners located elsewhere in the prison, we used this location identifier to undertake independent samples t-tests of the two populations to see if DRWs reported a different quality of life. Findings from this analysis are presented in Chapter 5.

3. Process evaluation of seven DRWs

A major part of the evaluation was the evaluation of seven DRWs. Our original aim here was to interview a sample of 5 staff and 10 prisoners in each of the five DRWs included in the impact evaluation, and follow-up as many of the prisoners as possible in the community. However, having undertaken a detailed analysis of the Rapid Assessment data, it was decided to include seven DRWs in the process evaluation. In order to ensure methodological triangulation, the five impact study DRWs were included (Brinsford, Brixton, High Down, Holme House and Swansea). In addition the DRWs at HMP Manchester and Style were included in the process evaluation only. While the low throughput of prisoners made these DRWs unsuitable for quantitative study, the Rapid Assessment suggested that these models were worthy of further qualitative exploration (see Lloyd, 2014, p.60-66 for a more extensive discussion of the selection criteria and process).

We retained our original proposed sampling process for the 7 sites. Almost without exception, five staff interviews represented a full sample of those closely involved with DRWs' running. We also sought a complete sample of DRW residents who were within four weeks of release. Potential interviewees were identified using DRW records, and given Participant Information Sheets (PIS) in advance of the study. Those who were willing to be interviewed were then seen in a private interview room, where a researcher went over the PIS with them. Due to the clear issues of voluntary consent within prison, we emphasized that non-participation would have no consequences. Written, informed consent was then secured, and 98 prisoners and staff were interviewed.

A further revision to our original, proposed process evaluation methodology was the inclusion of Recovery Support interviews. These were supportive friends or relatives, who would know the whereabouts of prisoners following their release, and who prisoners were happy for us to interview. Our aim here was to seek some triangulation of accounts of prisoners' progress on release and to improve our chances of locating ex-prisoners themselves. Recovery supports were contacted six months after prisoners' release date, and were asked for contact details of their relative. Where prisoners had given their permission, recovery supports were also informed about the study, and asked if they would be willing to be interviewed about their experiences of their relative's drug use, offending, and recovery. This yielded a total of 48 interviews, ten of which were triangulated. As it transpired, these interviews proved important for the provision of information about released prisoners who could not be followed up in person.

We thus secured detailed follow-up information about 36 former prisoners. Searches of local news identified that a further seven had been re-imprisoned. Initial interviews were completed between

January and July 2014. The last follow-up interview was secured in August 2015. Delays were caused by participants' re-imprisonment, varying availability, changing locations, and transient phone numbers.

All interviews were fully transcribed. NVivo 9 was used to code and analyse all transcripts, using an emergent and grounded coding system (Seale 2004:243-4). This progressed through an axial coding stage to a fully selective coding system (Seale 2004:244).

The process evaluation sought to address the following research questions:

- 1) What are the aims, structure, regime and operation of the 10 DRW pilots?
- 2) What are functional differences and similarities between each DRW programme and standard drug treatment, or 'treatment as usual', provided within each prison?
- 3) What are staff members' experiences of working in the DRWs? Do staff members believe that the goals set for DRW staff and participants are practical and achievable?
- 4) To what extent do participants engage with drug treatment provided in the DRW relative to any prior drug treatment received in and out-with the prison, and do prisoners feel that their values and goals are supported by the DRW programme?
- 5) To what extent are DRWs and their inmates separate from the rest of the prison and how does this impact on their ethos, safety and access to drugs and alcohol?
- 6) What are the organisational and attitudinal factors which enhance and undermine daily delivery and receipt of the DRW?

In addition, the follow-up interviews in the community were designed to provide a contextualised, three-dimensional account of ex-prisoners' experiences on release, to explore how DRWs may have impacted on them.

The findings of the process evaluation are included in Chapters 6 and 7.

4. The impact evaluation

The impact evaluation aimed to address the following research questions:

- 1) Which DRWs produce the greatest:
 - I. reductions of drug use prior to and following release from prison;
 - II. improvements in the quality of prison life, and
 - III. recovery from drug misuse up to six months post-release from prison?
- 2) Which characteristics of participants' drug use histories moderate the therapeutic effects of each DRW?
- 3) Which DRW intervention components are most strongly associated with positive drug use and recovery outcomes?
- 4) Are positive post-treatment drug use outcomes necessary to achieve positive recovery outcomes at six months post-release from prison?

The Ideal and the Possible

The ideal means of evaluating DRWs within prisons would have been to record the recovery progress of a sample of prisoners randomly allocated to a recovery wing comparing their progress with a sample of prisoners who were randomly allocated to receive standard prison-based drug and alcohol

treatment. For a variety of reasons it was not possible to employ such a 'gold standard' evaluation methodology. First, it was not possible to institute a process of random allocation of prisoners into a drug recovery wing. Rather, it was explained to the research team that all prisoners requesting access to a recovery wing (where such a wing was operating) were to be provided with that access. Second, because of the great variation in the operation of the DRWs referred to above, there was in fact no standard form of drug recovery wing treatment that was being evaluated and which could be compared to the alternative of standard prison based drug and alcohol treatment. As an alternative to monitoring the progress of two samples of prisoners (those randomly allocated to receive or not to receive DRW treatment) we opted, in the outcome evaluation, to monitor the recovery progress of a sample of prisoners from the point of their referral into a drug recovery wing to the point at which they had been living back in the wider community for six months. By monitoring drug recovery wing prisoners progress both on the recovery wings and back into the wider community we aimed to measure both the extent of the progress prisoners were able to achieve in their recovery during the period they were engaged within the recovery wing and to identify the extent to which that progress was maintained following their release back into the community.

The absence of a control or comparison group within this study design was an acknowledged weakness. However, as an alternative to following a sample of prisoners who received only standard prison based drug and alcohol treatment, we are currently monitoring a matched sample of prisoners released from prisons where no drug recovery wing was operating to determine their rate of reoffending post release. Through this means it should be possible to identify whether participating within a drug recovery wing is associated with a reduction in the rate of re-offending following prison release. The data from this matched comparison will only become available following the conclusion of the present study with the results of that comparison being written up separately to the current report.

Methods

In collecting the data for the impact evaluation we have carried out structured interviews and self-completed questionnaires at three points in time; on the prisoner's reception into the recovery wing, prior to the prisoner's release from the Drug Recovery Wing, and six months after the prisoner has been released back into the wider community. The structured instrument used to collect our data from the prisoner on their reception into the recovery wing requested information in the following key areas: use of legal and illegal drugs in the preceding six months, four weeks and forty eight hours before entering custody, periods of drug abstinence (duration and reasons for resumption of drug use following periods of abstinence), diagnosed health problems (mental and physical), prescription drug use, use of novel psychoactive substances, smoking alcohol consumption, goals of treatment, motivation for treatment, misuse of prescribed medication, self-assessed physical and mental health, recent past offending, attitudes towards offending, relationships with family members (parents/siblings), contact with family and friends, income, leisure activities, housing and past employment and past use of health services.

The pre-release instrument, self-completed by prisoners, requested information on the extent of the individuals prisoner's engagement with drug or alcohol treatment provision whilst participating within the recovery wing, the availability, access, and use of prescribed and non-prescribed drugs whilst within the recovery wing, the nature of any health problems diagnosed whilst the prisoner was engaged on the drug recovery wing, the prisoners self-assessed physical and mental health, the

individuals attitudes towards their drug use and offending, their assessment of the drug recovery wing itself in terms of such elements as the contribution of prison officers, drug workers, and other prisoners in furthering or undermining the aims of the recovery wing, the prisoner's assessment of the extent to which their engagement within the recovery wing has assisted their recovery.

The six month assessment questionnaire that was self-completed by prisoners once they were back living in the wider community requested information on their assessment of the availability of prescribed and non-prescribed drugs within the recovery wing, the prisoners use of prescribed and non-prescribed drugs whilst on the recovery wing, the individuals use of prescribed and non-prescribed drugs following their release back into the community, the individual's self-assessed physical and mental health, the individual's engagement in any criminal acts since leaving prison, the extent of any involvement in paid employment since leaving the recovery wing, the individual's living circumstances since leaving the prison (i.e. accommodation), the individual's expectation of what the future might hold over the next six months in relation to such items as where they think they will be living, what work if any they think they will be engaged in and finally what sorts of things the prisoner felt would most likely assist their recovery over the next six months.

The findings from the impact evaluation are reported in chapter 7.

5. The Economic Evaluation

The economic arm of the research aimed to address three questions:

- 1) What are the costs of implementing a DRW within each prison?
- 2) What are the costs of maintaining a DRW within each prison?
- 3) What are the costs and savings to society associated with DRW participants' liberation into the community?

Data on the costs of implementing and maintaining the five impact study DRWs have been collected and are reported on in Chapter 9. An analysis is provided of the number and type of crimes that would need to be prevented in order to recover the costs of DRW provision. However, this analysis is inevitably limited by the absence of control groups.

Our longer term aim is to address costs and saving to society when comparative reconviction data are obtained from the sample matching exercise described above.

Involvement of people with lived experience

A small group of individuals with experience of substance misuse treatment in prison was involved in the development of the research proposal. While it had been planned to continue to involve this group over the course of the evaluation, this proved impossible. Instead, a person with experience of addiction and imprisonment was invited to join the Advisory Group⁵ (which met five times over the course of the evaluation). He attended all of the meetings and was fully involved in the extensive

⁵ The Advisory Group was chaired by the PI and included the DH research manager, policy-makers from Government Departments, academics and the PPI representative.

discussions concerning the evaluation: and thereby on the course and development of the evaluation.

Conclusions

This mixed methods evaluation has yielded a variety of data-sets relating to different samples of the DRW pilots: in particular, Rapid Assessment and MQPL data on the ten original pilots; process data on seven; and impact data on five. Perhaps the central challenge of mixed methods research is the synthesis of findings that have been produced by different methodologies. We have adopted a pragmatic 'side-by-side comparison' (Creswell and Clark, 2011) approach, analysing and presenting the results from the different studies separately and then identifying and discussing areas of convergence and contradiction (O'Caithain *et al.*, 2010). Accordingly, in the chapters that follow we have attempted to develop a narrative which compares and contrasts findings where possible, with the main synthesis takes place in the final chapter.

Chapter 5: MQPL findings

Introduction

The Measuring the Quality of Prison Life (MQPL) tool was developed from qualitative foundations, from a Home Office funded research project designed to assess the 'moral climate' of prisons in the wake of the 'decency agenda' (Liebling with Arnold 2004:13). A brief overview of the survey is provided in the methodological section of this report. In contrast with tools developed in the US, the MQPL's origins leave it particularly well-suited to assessing the climate of UK prisons (Ross *et al.*, 2007:454), though it has also been applied to institutions abroad (e.g. Johnsen 2011; Johnsen *et al.*, 2011). That the MQPL was developed from qualitative research raises some questions about its structure. As Tonkin notes, despite 'complex factor structures ... there is little empirical evidence to support such complexity' (2015:20; see also Johnsen *et al.*, 2011:520). Analyses are also often routinely limited to t-tests; though a recent review of questionnaires for assessing the social climates of secure institutions identified some psychometric characteristics of the MQPL (Tonkin 2015). Here, the internal consistency of MQPL factors was identified as variable, with Cronbach's alphas of between 0.56 (distress) and 0.89 (humanity) (Tonkin 2015:12). Factor structure has also been explored with principle components analyses, with suggestions that these could be simplified to three dimensions focusing predominantly on relationships (Johnsen *et al.*, 2011:520). Tonkin (2015:12) also notes that, whilst there are promising signs of convergence between MQPL findings and concurrent surveys, the tool's reliability has yet to be tested.

Having noted the limited psychometric data available, there are considerable pragmatic advantages to using the MQPL. NOMS regularly carry out full MQPLs of every English and Welsh prison, making routine data available for minimal additional cost. Whilst alternative tools (such as the Prison Social Climate survey) were considered for this study, the majority of these have been sparsely evaluated and are not designed for the UK prison context (Tonkin 2015; Ross *et al.*, 2007). Moreover, the resource implications of conducting full surveys of ten prisons unfeasible.

The main aim of this analysis is to compare MQPL scores for DRW residents with prisoners residing elsewhere in the prison. To do this, we undertook independent samples t-tests (using SPSS 22) which compared mean scores in order to determine if they were significantly different. It should be noted that DRW samples were often small: for example, while all the prisoners in the Styal DRW were surveyed, this only amounted to a sample of 12. Reflecting this, and noting that these are only descriptive analyses, we have included both statistically significant findings at the conventional $p < 0.05$ level but also at the 'marginal' $p < 0.1$ level. We have clearly distinguished between these in the following accounts and tables. A score of 3 is 'neutral': anything above it is a positive evaluation, and anything below it is a negative evaluation.

Ideally, analyses would have controlled for the time prisoners had spent within each DRW (or on another wing). This was unfortunately impossible. The MQPL was developed as a tool for assessing the environment of prisons and this is, we believe, the first study to conduct a wing-level analysis of MQPL findings. As such, no data are collected on the time individuals have spent in any given location.

Bristol

114 prisoners participated in the prisoner survey, 27 of whom were accommodated on the DRW.

Quality of Life score

There was no significant difference between DRW residents' overall quality of life (4.27) and that of their non-DRW counterparts (4.34)

Subscales

Scores for two of the twenty-one subscales differed significantly for DRW and non-DRW residents (see Appendix 2). Family contact scores were considerably better for DRW residents (3.54 vs 3.06; $p < 0.01$). DRW residents were also significantly more distressed (2.84) than their non-DRW counterparts (3.30; $p < 0.05$).

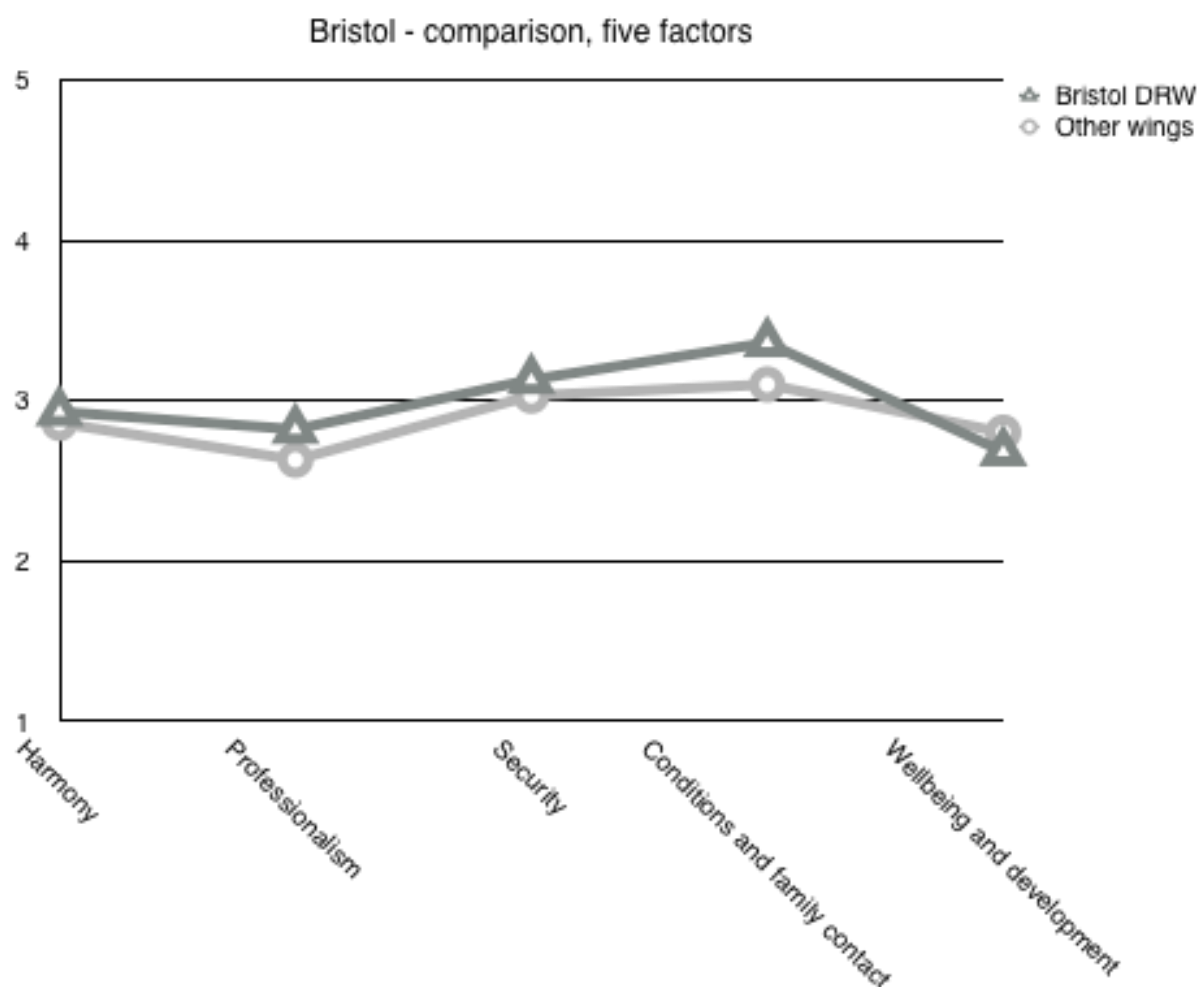
Factors

Reflecting the picture presented by the subscales, only one factor had scores that were significantly different for DRW (3.36) and non-DRW (3.10) residents: Conditions and Family Contact ($p < 0.05$) (see table below). Significance was attained because of the highly significant difference between DRW and non-DRW conditions on the family contact subscale.

Table 5.1

	Bristol: Five factors		
	DRW	Non-DRW	Mean Difference
Harmony	2.93	2.86	0.07
Professionalism	2.82	2.63	0.19
Security	3.13	3.03	0.10
Conditions and family contact	3.36	3.10	0.26*
Wellbeing and development	2.68	2.80	-0.12

The following notation is used in this and all of the following tables: † < 0.1 ; * < 0.05 ; ** < 0.01 ; *** < 0.001



Brixton

137 prisoners participated in the prisoner survey, 23 of whom were accommodated on the DRW.

Quality of Life score

There was no significant difference between DRW residents' overall quality of life (3.33) and that of their non-DRW Brixton counterparts (3.64).

Subscales

A comparison of subscales also yielded no significant (or borderline significant) differences between the quality of life for DRW residents, and those housed elsewhere in the prison (see Appendix 2). No consistent trend was apparent, either: the DRW yielded slightly lower scores than other wings on seven subscales, and slightly higher scores on the remaining fourteen.

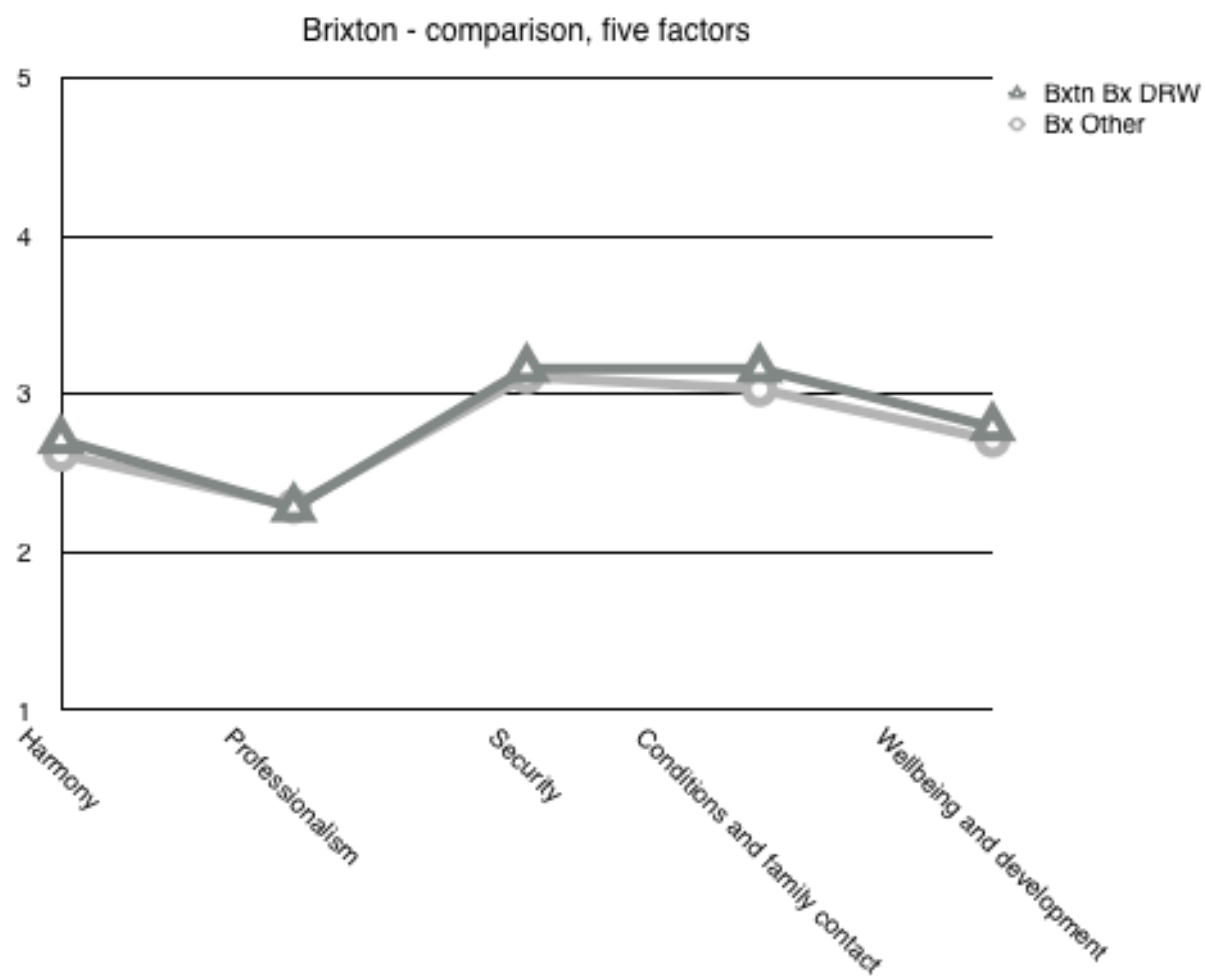
Factors

The lack of significant differences between the DRW and other wings was sustained in the findings for the five MQPL factors.

Table 5.2

	Brixton: Five factors		
	DRW	Non-DRW	Mean Difference
Harmony	2.71	2.62	0.09
Professionalism	2.28	2.29	-0.01
Security	2.79	2.71	0.08
Conditions and family contact	3.16	3.11	0.05
Wellbeing and development	3.16	3.03	0.13

† <0.1; * < 0.05; ** < 0.01; *** < 0.001



Chelmsford

A total of 120 people were surveyed within Chelmsford. Nineteen lived on the DRW; 101 were housed on other locations.

Quality of life

There was no significant difference between the overall quality of life of DRW residents (6.06) and those of other locations (5.74).

Subscales

The difference between two pairs of mean scores reached statistical significance: DRW Prisoners rated staff professionalism (3.60 vs 3.30, $p < 0.01$) and help and assistance higher (3.48 vs 3.15, $p < 0.05$) in the DRW (see Appendix 2).

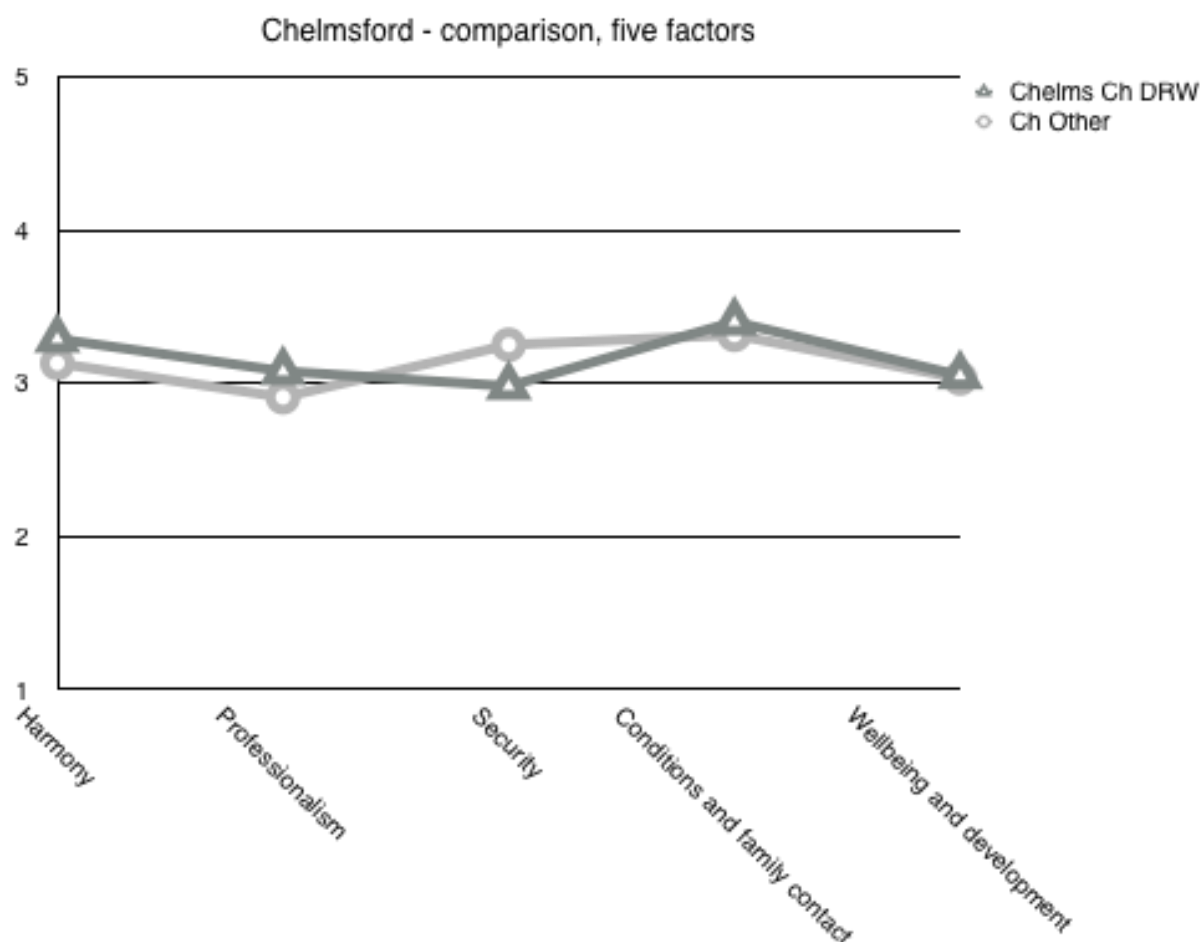
Factors

When looking at the MQPL's five factors, the DRW scored higher in four out of five dimensions. However, only one factor achieved statistical significance: security. The IDTS wing's scores were lower than those for the rest of the prison, suggesting that prisoners felt less secure on the DRW than did prisoners on other locations.

Table 5.3

	Chelmsford – five factors		
	DRW	Other	Mean difference
Harmony	3.29	3.13	0.16
Professionalism	3.08	2.91	0.17
Security	2.98	3.25	-0.27*
Conditions and family contact	3.40	3.32	0.09
Wellbeing and development	3.05	3.03	0.02

† $p < 0.1$; * $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$



High Down

A problem was encountered in differentiating DRW residents from other prisoners in High Down. A total of 139 MQPL questionnaires were secured from the prison, and of these, 34 were from prisoners housed in the DRW (Houseblock 4, Spur C), and 104 from prisoners elsewhere in the prison. However, of the 34 DRW residents, only seven stated that they were engaged with DRW treatment, seven were given questionnaires without the question and 20 stated that they were not engaged with DRW treatment. Analyses were conducted both with the 'definite' seven DRW respondents and with all 34 but neither approach yielded any statistically significant findings. Data for the 34 H4 residents are shown below and in Appendix 2.

Quality of life

In terms of overall quality of life, the DRW offered no significant benefit, with a mean score of 3.7 compared with other wings' score of 3.5.

Subscales

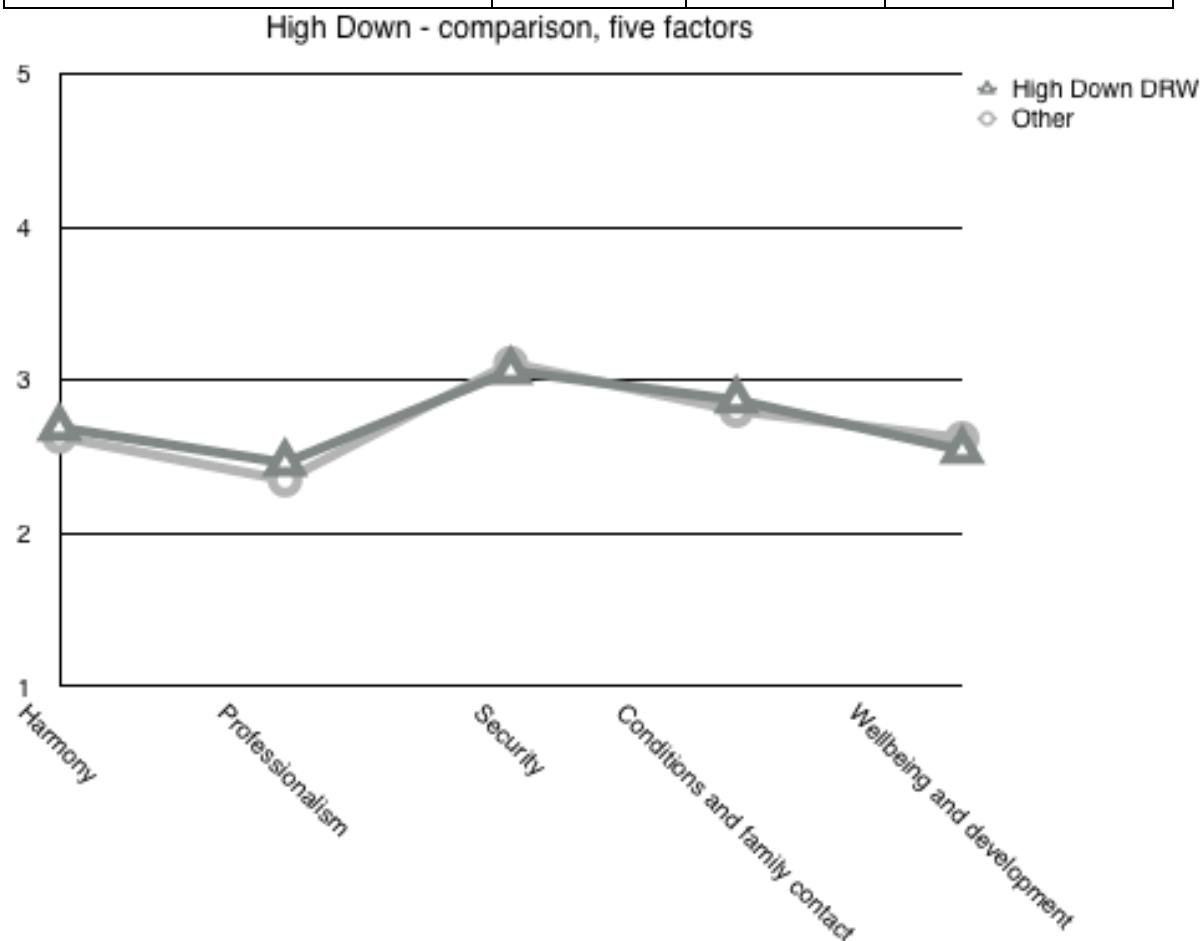
When looking at the subscales, scores were very similar between the DRW and the rest of the prison. While the wing was associated with slightly higher scores on fifteen of twenty-one subscales, the only statistically significant difference was on the 'distress' score, on which the DRW scored significantly worse (2.98 vs 3.33).

Factors

Analysis of the five factors demonstrated no differences between the DRW and other wings. Differences in mean scores were minimal, and in no consistent direction.

Table 5.4

	High Down		
	DRW	Other	Mean difference
Harmony	2.69	2.63	0.06
Professionalism	2.46	2.35	0.11
Security	3.06	3.11	-0.05
Conditions and family contact	2.87	2.80	0.07
Wellbeing and development	2.54	2.62	-0.08



Holme House

A total of 125 respondents were secured from Holme House. Of these, 22 were housed in the DRW, and 103 on other locations.

Quality of life

In terms of overall quality of life, there was no significant difference between DRW scores (4.68) and those of other wings (4.99).

Subscales

Twenty subscale scores showed no differences between DRW and non-DRW wings. DRW scores were, however, significantly higher on one subscale: family contact (3.72 vs 3.07, $p < 0.001$). This could have been attributable to dedicated family visits, which were a feature of DRW provision – and which were highlighted by DRW staff during the rapid assessment as one of the DRW's strongest features (Lloyd *et al.*, 2014: p.220).

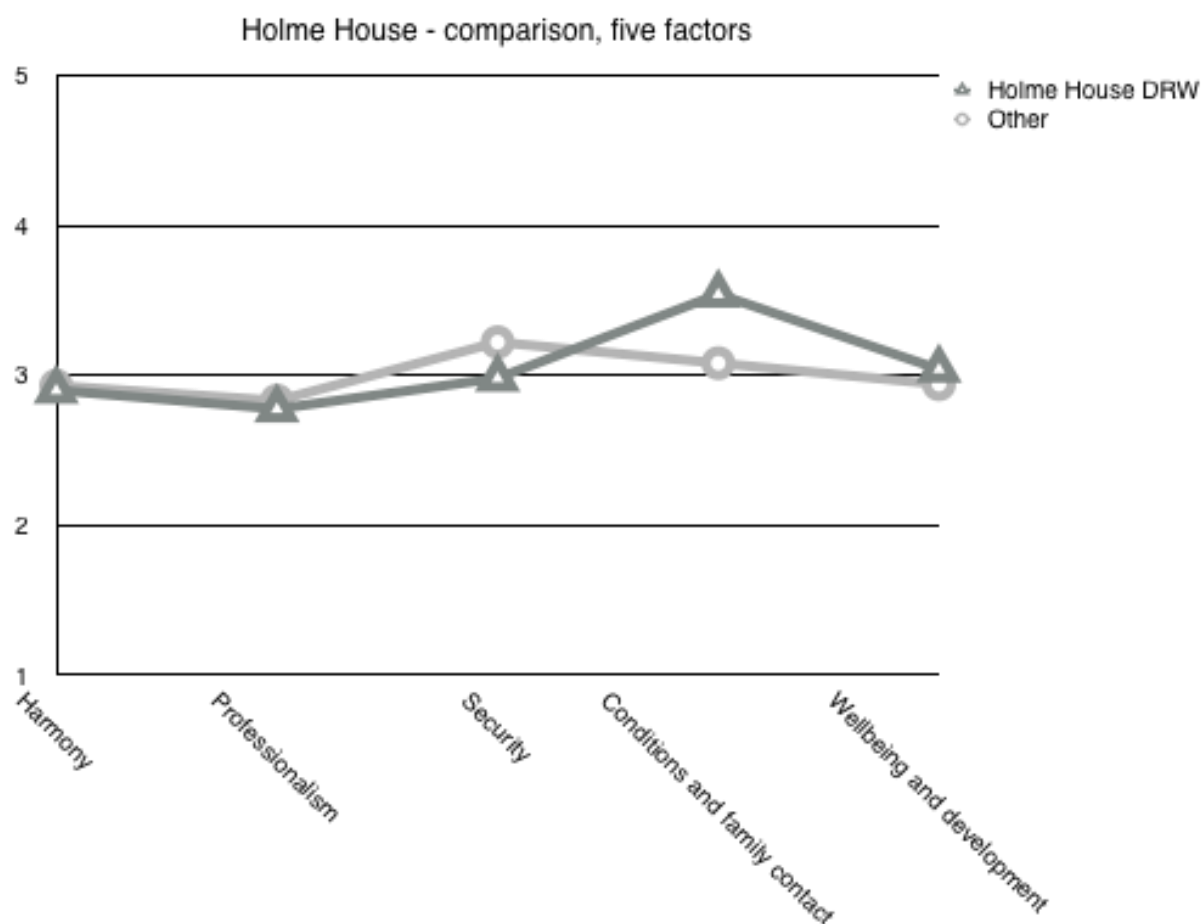
Factors

For the most part, the DRW's scores for the five factors only differed slightly from those of the main jail. However, 'conditions and family contact' evidenced a highly significant difference in the DRW's favour. This may have been heavily influenced by the structure of this factor, which is composed of only two subscales – including 'family contact' (see above). The 'security' factor attained marginal significance, with the DRW scoring lower (suggesting DRW residents felt less secure).

Table 5.5

	Holme House		
	DRW	Other	Mean difference
Harmony	2.90	2.93	-0.03
Professionalism	2.78	2.83	-0.06
Security	2.98	3.22	-0.24 †
Conditions and family contact	3.54	3.08	0.46***
Wellbeing and development	3.04	2.94	0.10

† <0.1; * < 0.05; ** < 0.01; *** < 0.001



Manchester

A total of 128 surveys were secured from Manchester. Of these, twelve respondents were housed in the DRW, and were engaged with DRW treatment. A further 116 were housed in other locations.

Quality of life

Manchester's 12 DRW respondents reported a higher quality of life than prisoners elsewhere (5.73 vs 4.44), although this was only marginally significant statistically.

Subscales

Data from the subscales point to a range of positive findings. The DRW scored higher than other wings on 19 out of 21 subscales and in seven cases, the differences were statistically significant. The DRW was particularly associated with greater help and assistance (3.77 vs 3.18, $p < 0.001$) and personal development (3.81 vs 2.86, $p < 0.001$) These findings may be linked to the presence of a

tight-knit group of therapeutic officers, and the intensive, group-focused work on the DRW (see Chapter 6; Lloyd, 2014; Page *et al.*, 2016). See Appendix 2 for the table.

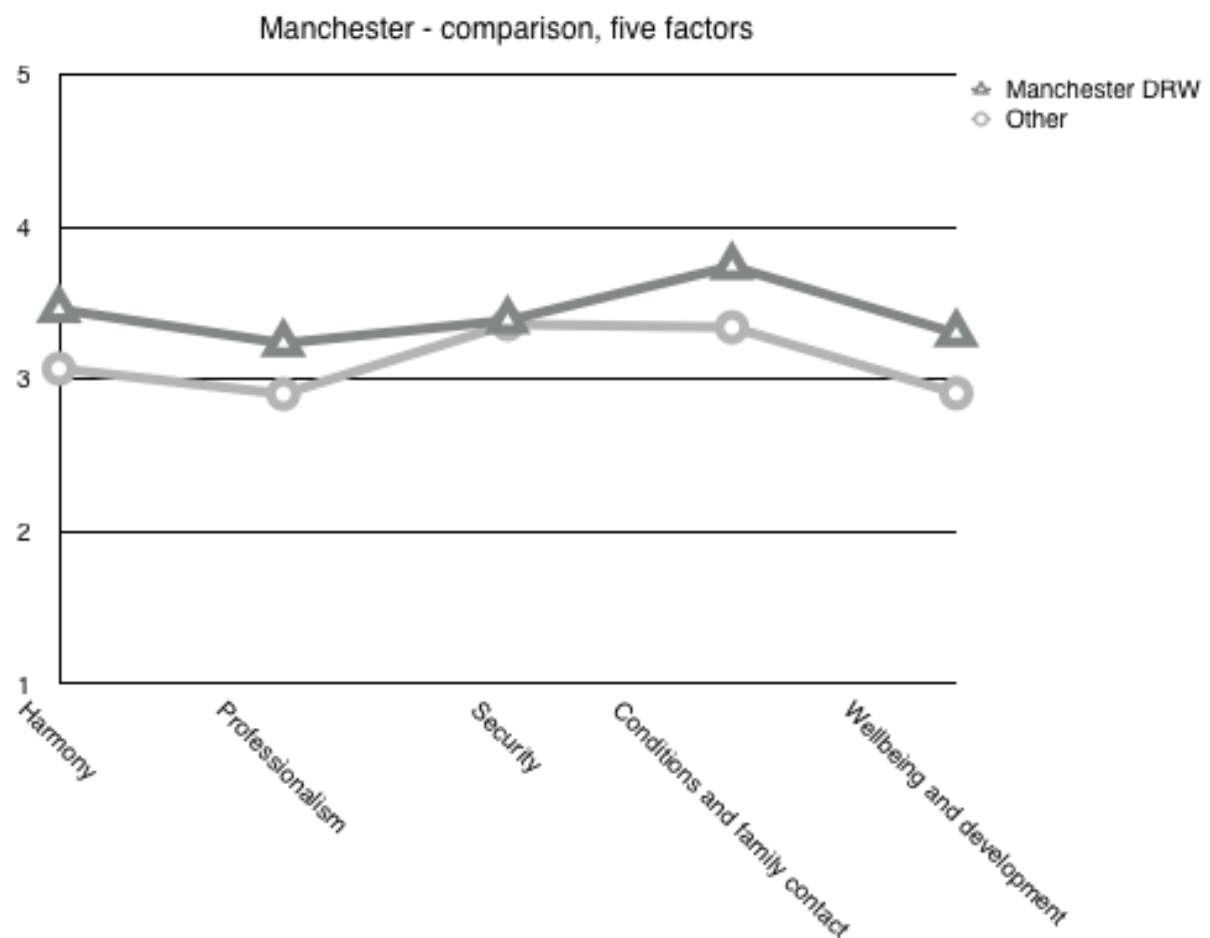
Factors

Scores for the five factors were less clear-cut. Though all five demonstrated scores that favoured the DRW, three approached statistical significance, but none attained the conventional value of $p < 0.05$.

Table 5.6

	Manchester		
	DRW	Other	Mean difference
Harmony	3.46	3.07	0.39 ‡
Professionalism	3.24	2.90	0.33
Security	3.39	3.36	0.02
Conditions and family contact	3.74	3.34	0.40 ‡
Wellbeing and development	3.30	2.91	0.39 ‡

‡ $p < 0.1$; * $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$



New Hall

A total of 130 MQPL surveys were secured from New Hall. This comprised a full sample of all seven women housed in New Hall's DRW, and 123 responses from other locations.

Quality of life

In terms of overall quality of life, New Hall's DRW fared poorly. The mean Quality of Life score provided by DRW residents was 1.9 points lower than the mean for by other wings: 3.67 as against 5.57. Despite the small DRW sample, this difference achieved statistical significance ($p=0.021$).

Subscales

Data from the 21 subscales further developed this picture. The DRW's scores were worse than those on other wings on 20 out of the 21 subscales. Three subscales attained conventional levels of statistical significance, with the DRW's scores being worse in each case: organisation and consistency (1.97 vs 2.84, $p < 0.01$), prisoner safety (2.69 vs 3.48, $p < 0.01$) and wellbeing (1.79 vs 2.86, $p < 0.01$). Four further subscales attained marginal significance (humanity; bureaucratic legitimacy; prisoner adaptation; and drugs and exploitation). Again, all differences were in a negative direction.

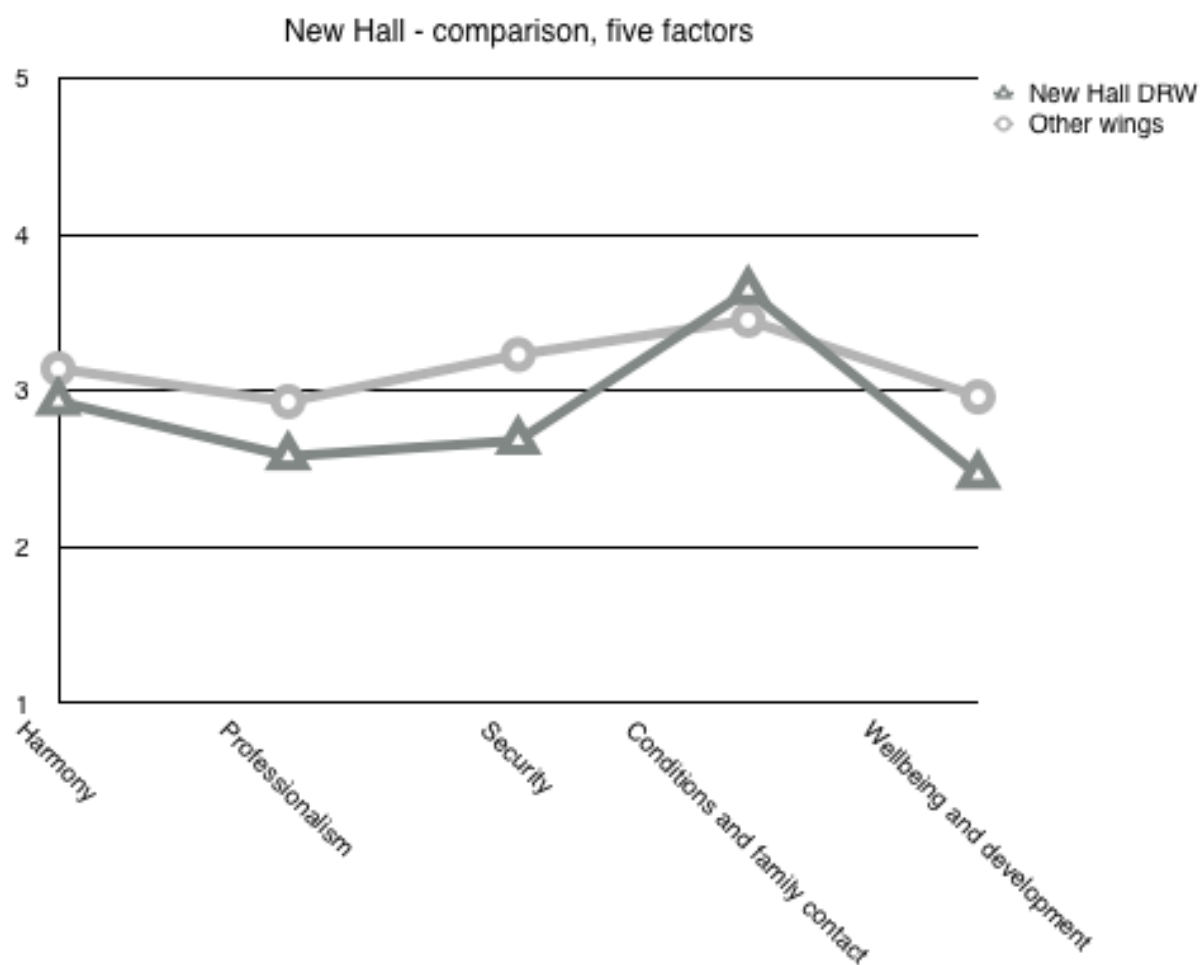
Factors

The negative trend that was apparent during subscale analyses were also evident within the MQPL's five factors. The DRWs' scores were worse than 'main jail' in four out of five factors; two achieved statistical significance (security and wellbeing).

Table 5.7

	New Hall		
	DRW	Other	Mean difference
Harmony	2.93	3.14	-0.21
Professionalism	2.58	2.93	-0.35
Security	2.68	3.23	-0.55*
Conditions and family contact	3.64	3.45	0.19
Wellbeing and development	2.46	2.96	-0.50*

† <0.1; * < 0.05; ** < 0.01; *** < 0.001



Styal

A total of 127 MQPLs were secured from Styal. This comprised a full sample of the 12 women engaged by the DRW, alongside 115 women housed on other locations.

Quality of life

In terms of the overall quality of life, Styal's DRW performed favourably (6.27 vs 5.56), although this difference in means was not statistically significant.

Subscales

DRW residents scored higher than prisoners in other locations on 20 of the 21 subscales. Two of these attained statistical significance: personal autonomy (3.56 vs 3.04, $p < 0.05$) and wellbeing (3.33 vs 2.64, $p < 0.05$). A further five were marginally significant.

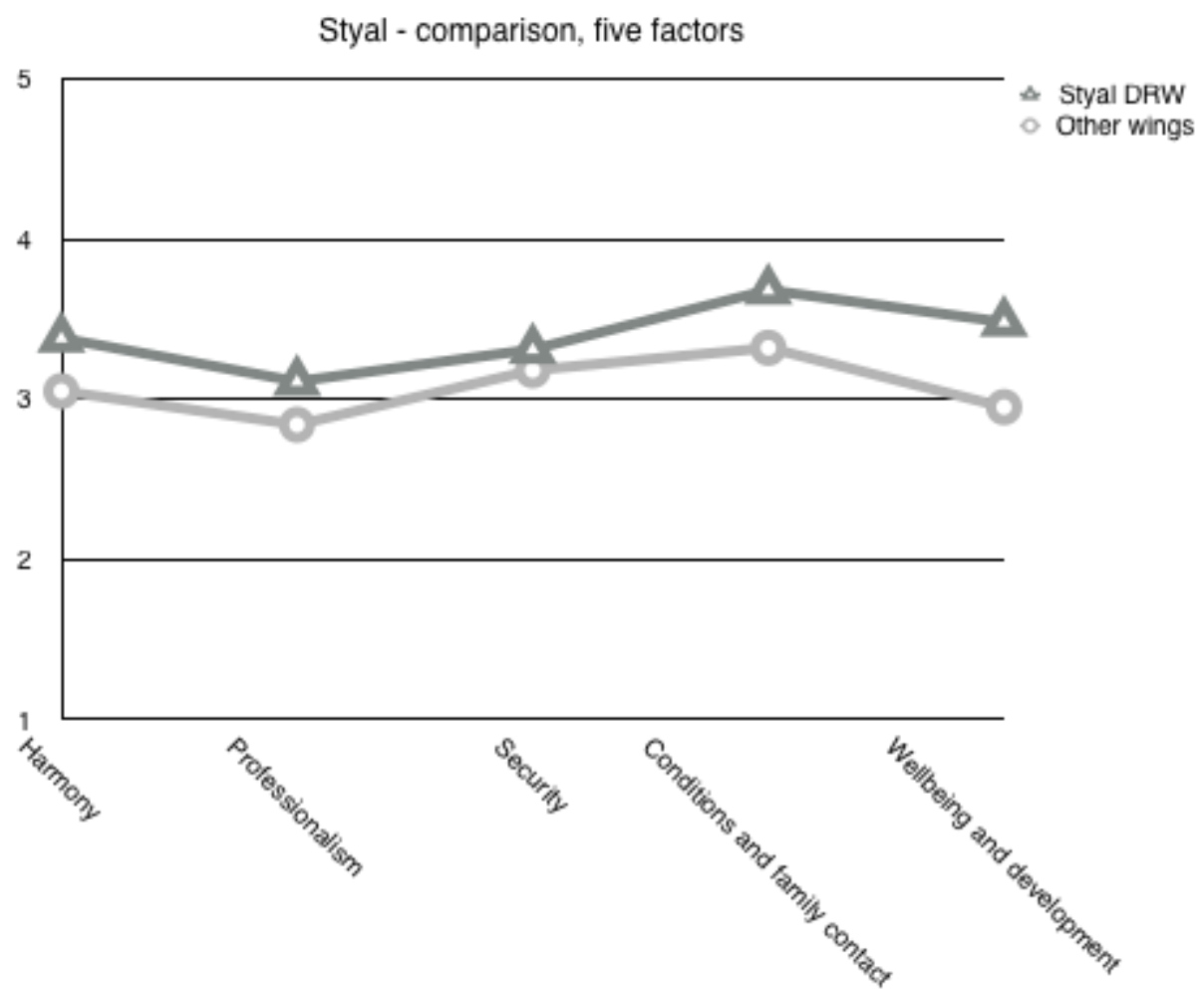
Factors

The picture presented by the subscales was reflected in the analysis of the five main factors. DRW scores were, again, consistently higher than non-DRW scores and the one statistically significant difference was the 'personal development and wellbeing' factor.

Table 5.8

	Styal		
	DRW	Other	Mean difference
Harmony	3.38	3.05	0.33
Professionalism	3.11	2.84	0.27
Security	3.31	3.18	0.13
Conditions and family contact	3.68	3.32	0.36
Wellbeing and development	3.48	2.95	0.53*

† <0.1; * <0.05; ** <0.01; *** <0.001



Swansea

A total of 130 MQPLs were delivered in Swansea. Of these respondents, 29 resided in the DRW, whilst 101 lived on other locations.

Quality of life

Comparisons of the overall quality of life appeared promising: Swansea's DRW residents rated their quality of life as a full point (out of ten) better on average than that the ratings secured from other wings (5.96 vs 4.96, $p < 0.05$).

Subscales

Scores for the 21 subscales provided further evidence that Swansea's DRW was offering its residents a considerably improved quality of life. DRW scores were higher than those for the rest of the prison on 17 out of 21 subscales. Highly significant differences were found for help and assistance (3.66 vs 3.13, $p < 0.001$) and personal development (3.50 vs 2.95, $p < 0.001$). Positive, statistically significant differences were also revealed for respect/courtesy, relationships, humanity, fairness and organisation/consistency. The larger number of significant differences could be partly attributable to the sample size achieved in Swansea. Larger samples tend to reduce variance and lower variance increases the chances of finding significant differences between means.

Factors

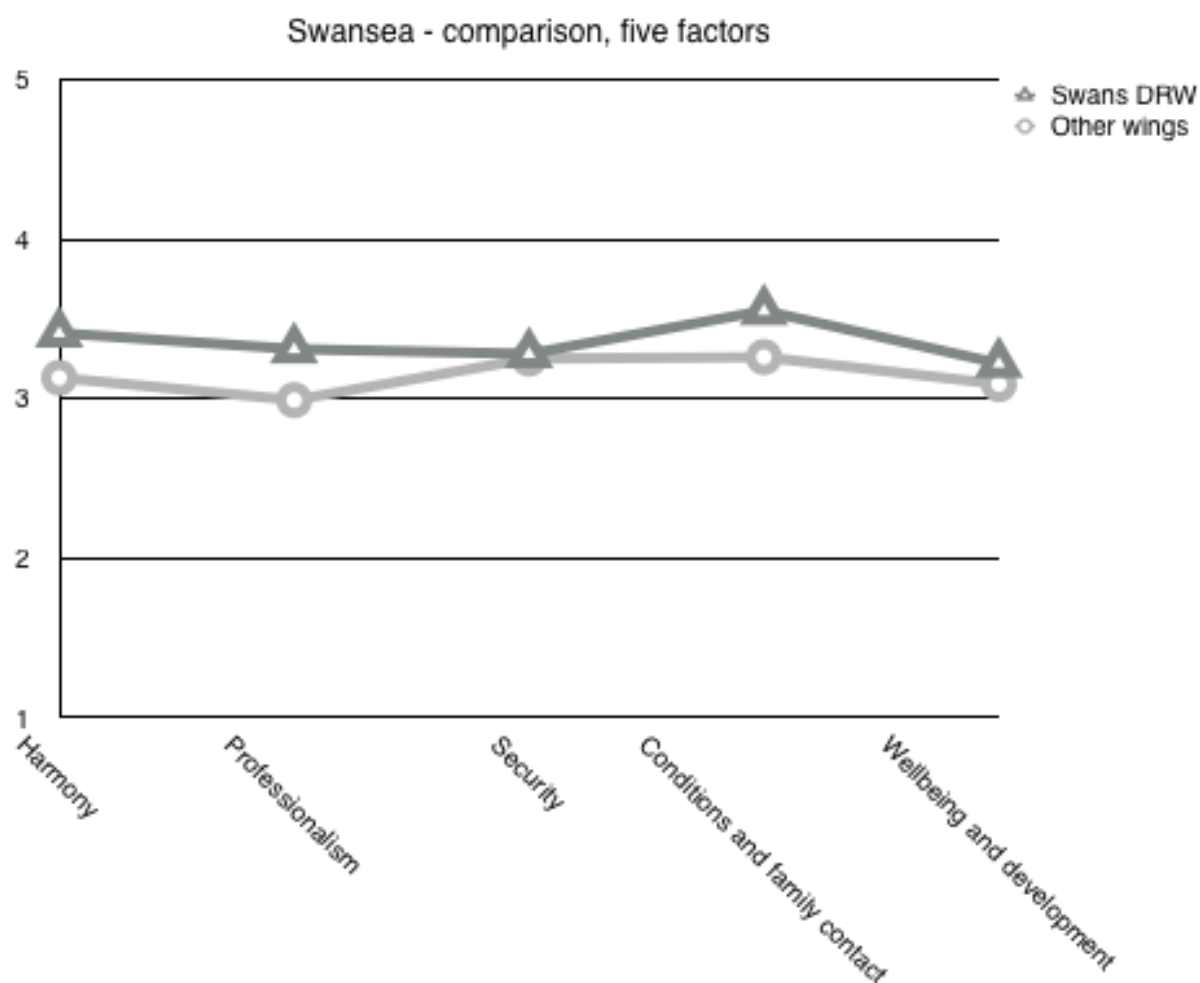
The findings from the subscales were reflected in those for the five main factors. The scores for Swansea's DRW were consistently higher than those for other wings, achieving statistical significance in three out of five comparisons.

The security factor yielded a reasonable score in both samples, suggesting that the improved relationships and treatment came with no corresponding losses in security and policing: a favourable result.

Table 5.9

	Swansea		
	DRW	Other	Mean difference
Harmony	3.41	3.13	0.28*
Professionalism	3.31	2.99	0.32**
Security	3.28	3.25	0.03
Conditions and family contact	3.55	3.26	0.29*
Wellbeing and development	3.22	3.09	0.13

† $p < 0.1$; * $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$



Brinsford

A total of 86 MQPL surveys were secured from the only Young Offender Institution to host a DRW pilot, Brinsford. Though the survey team sought to fully sample Brinsford's 12 DRW clients, four refused to participate. The sample consequently comprised 8 questionnaires from DRW residents, and 78 from residents of other wings.

Quality of life

When assessing their overall quality of life, DRW residents offered significantly lower scores out of ten than residents of other wings (2.00 vs 3.53, $p=0.06$).

Subscales

Findings from an analysis of the 21 subscales showed by far the worst results across the DRWs. Despite the low sample size, DRW scores were significantly lower than those of other wings for 17 out of 21 subscales. Highly statistically significant, negative differences were found on eight subscales: entry into custody, respect/courtesy, relationships, humanity, decency, help and assistance, conditions and personal autonomy.

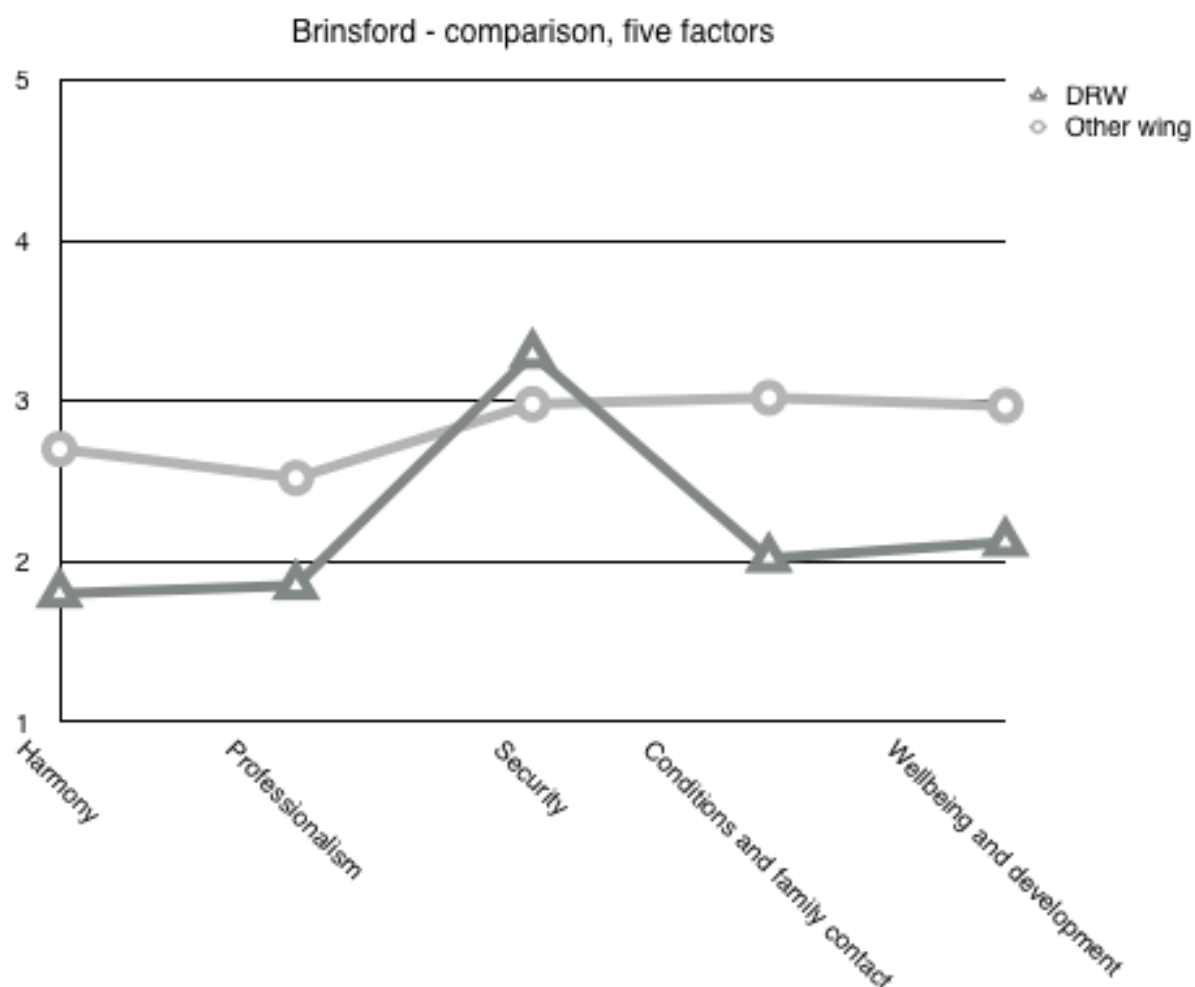
Factors

When looking at the MQPL's five factors, a similar pattern emerged. The DRW's quality of life scores were significantly worse than the scores of other wings in four out of five dimensions. Security was the only factor in which the DRW's scores were higher than those of other units. Security without harmony or professionalism is unlikely to be experienced as therapeutic.

Table 5.10

	Brinsford		
	DRW	Other	Mean difference
Harmony	1.80	2.70	-0.90***
Professionalism	1.85	2.52	-0.67**
Security	3.29	2.98	0.31
Conditions and family contact	2.02	3.02	-1.00**
Wellbeing and development	2.12	2.97	-0.85***

† <0.1; * < 0.05; ** < 0.01; *** < 0.001



Ordinal comparisons

The data presented so far have all focused on comparisons of the means for DRW and non-DRW locations within individual prisons. This final, comparative section seeks to bring these data together to give an idea of how prisons and DRWs compared with each other.

To do this, three sets of scores for the five factors are ranked: unadjusted non-DRW scores; the difference between DRW and non-DRW scores (DRW score – non-DRW score); and unadjusted DRW scores. These can be read to build an overall picture of each prison, with scores reflecting each prison's baseline quality of life, the extent to which a DRW improved its residents' quality of life, and the resulting quality of life on each DRW.

Scores are colour-coded using a traffic light ranking system. In each instance, the top three DRWs are coloured green; the bottom three are coloured red; and those in between are amber.

As a whole, Table 5.10 highlights the impact that DRWs could have on prisoners' quality of life, with DRWs interacting with their parent prisons in nearly every imaginable way.

Swansea is highlighted as a stand-out prison. It was a prison with a generally high quality of life; whose DRW then further improved these scores by more than almost any site, resulting in an outstanding DRW. Contrastingly, both Manchester and Styal made exceptional improvements to unexceptional prison-wide conditions, again yielding consistently strong DRWs.

At the other end of the table, New Hall yielded some of the best prison-wide MQPL scores we encountered. However, its DRW residents felt their quality of life was far worse than their non-DRW peers, resulting in a low-scoring DRW (in a generally good prison).

Three final prisons are worthy of note. Brixton and High Down both had DRWs whose moderately improved MQPL scores lifted them out of the bottom three.

Brinsford, however, was one of the poorest-performing prisons on every measure presented here. Prison-wide MQPL scores were low. The DRW then provided considerably lower MQPL scores, resulting in a DRW that lay in the bottom three in each of these three tables.

Table 5.10 is entirely descriptive. The rankings pay no heed to inferential analyses, and (as noted) many of the differences between DRWs and other wings did not attain statistical significance. This noted, we believe there are strong qualitative justifications for presenting the following tables. Without exception, the picture presented for all sites reflects the accounts secured from rapid assessment and process evaluation interviews from across the ten DRWs.

Table 5.11: Ordinal comparisons

	Non-DRW scores						Extent of improved conditions on DRW (DRW – non-DRW scores)						DRW scores				
Factor	Harmony	Professionalism	Security	Conditions and family contact	Wellbeing and development		Harmony	Professionalism	Security	Conditions and family contact	Wellbeing and development		Harmony	Professionalism	Security	Conditions and family contact	Wellbeing and development
Manchester	4	4	1	2	7		1	1	6	2	2		1	2	1	1	2
Styal	5	5	6	3	5		2	3	2	3	1		3	3	2	2	1
Swansea	3	1	2	5	1		3	2	5	4	3		2	1	4	4	3
Chelmsford	2	3	2	4	2		4	5	9	8	6		4	4	8	6	4
Bristol	7	7	9	6	8		6	4	3	5	8		5	5	6	7	7
Holme House	6	6	5	7	6		8	8	8	1	4		7	6	8	5	5
New Hall	1	2	4	1	4		9	9	10	6	9		5	7	10	3	9
Brixton	10	10	7	8	9		5	7	4	7	5		8	9	5	8	6
High Down	9	9	8	10	10		7	6	7	9	7		9	8	7	9	8
Brinsford	8	8	10	9	3		10	10	1	10	10		10	10	3	10	10

Interpretation and conclusions

In considering these findings, it needs to be borne in mind that each survey was carried out on a particular day or number of days over the period 2013 to 2014. Responses will therefore reflect, to some degree, the particular atmosphere in the DRW at that point in time. Recent events akin to 'the cheesecake debacle' in New Hall (in which prisoners and staff had fallen out over the consumption of two homemade cheesecakes: see further, Lloyd *et al.*, 2014: p.41) which had an - at least temporary - impact on staff-prisoner relations there, may have impacted the responses of some of the small groups of DRW respondents. Moreover, as raised in the Rapid Assessment report (Lloyd *et al.*, 2014) and discussed in the next chapter, DRWs were going through a period of longer term changes over 2013 to 2014. For example, the rolling out of benchmarking impacted on these prisons at different points in time and this may have been reflected in some of their results.

Despite the limitations of cross-sectional analyses, the resonance between MQPL findings and those of the rapid assessment was striking. In this section, we consequently provide a narrative summary of the MQPL findings, illustratively juxtaposed with those of the rapid assessment (Lloyd *et al.*, 2014).

In attempting to draw out some findings across the ten pilot DRWs, there are some clear divisions. In particular, the three DRWs in HMPs Manchester, Styal and Swansea were associated with significantly higher scores on a range of measures, and consistently provided both the highest absolute and comparative scores of any units. Prisoners within the Swansea and Manchester DRWs were clearly in a relatively 'good place', with scores suggesting high levels of support provided within a humane environment and good scope for personal development. While less marked within Styal, DRW residents there clearly reported a better level of wellbeing and development, with a host of other subscales pointing in the right direction (even if some of the differences were of only marginal statistical significance). In the mid-range are Brixton, Chelmsford, High Down and Holme House. Here there appeared to be few differences between DRW residents and other prisoners in terms of their quality of life, although the development of enhanced family visits in Holme House's DRW was clearly reflected in the relevant MQPL measures. Lastly, the DRWs in Brinsford and New Hall were associated with particularly poor profiles of MQPL scores in comparison to the wider prison populations. These did not appear to be simply 'protest' responses, in that scores were not uniformly negative: measures of DRW security and safety were good at Brinsford and the scores on the 'conditions and family contact' factor were at least in the right direction for New Hall's DRW. However, there were clearly problems with the perceived quality of life on these two DRWs.

These survey data provide a valuable opportunity for methodological triangulation with the process evaluation: to what degree do these findings equate with the qualitative research undertaken within this study? The Rapid Assessment clearly identified Manchester and Styal as intensive DRWs with largely segregated regimes and in the latter, a TC-inspired therapeutic approach. While there was considerably less therapeutic content within Swansea's DRW, it represented another segregated

regime where relations between the prisoners and the uniformed officers working there appeared to be unusually good. Indeed, the apparent quality of staff-prisoner relations shown in Swansea reflect the findings of earlier studies, which have particularly highlighted the strengths of Swansea's local staff cohort (Liebling *et al.*, 2005). Swansea, uniquely, also offered process evaluation researchers an opportunity to triangulate an unexpected finding by drawing on the MQPL. Routinely, residents were locked up for twenty-three hours each day. This appeared to sit uneasily with the warm atmosphere and positive conditions described by prisoner interviewees. Swansea's MQPL findings then permitted researchers to clarify that DRW residents in Swansea who were locked up for more than six hours each working day not only felt they had a better quality of life than similar prisoners on other wings; they provided better quality of life scores than *all* prisoners on other locations.

Manchester and Swansea DRWs were able to protect their cell accommodation for prisoners referred for substance misuse problems, rather than serving, in part, as units for prisoners who could not be housed elsewhere. Styal was never able to secure similar levels of protection: though the TC-like regime supported the development of a self-policing group (see Page *et al.*, 2016; Grace *et al.*, 2016) who provided each other (and the house) with strong social protection. In some ways, this tight social protection against clear and present dangers appeared to offer greater protection against long-term temptation than the isolation and locked doors that offered situational protection in Swansea and Manchester's DRWs.

At the other end of the spectrum, the Rapid Assessment of Brinsford DRW found a low level of therapeutic provision, some evidence of bullying, and unclear expectations about behavior on the wing. Early reports identified Brinsford as being 'in a difficult state of transition' (Lloyd *et al.*, 2014: p.33). Looking at the above data, it appears that Brinsford was a poorly performing prison, holding a DRW that was making these difficulties worse.

New Hall DRW prisoners were particularly critical of staff working there and there were mixed feelings about the therapeutic content (see Grace *et al.*, 2016). During the rapid assessment, there were nonetheless some positive signs. The unit was well-segregated, and there appeared to be limited access to drugs. These improvements were not so apparent in comparative MQPL scores. While New Hall was one of the most positively-reviewed of the host prisons, its DRW was one of the worst. Conversations with senior staff towards the end of 2014 suggested that the DRW had undergone persistent difficulties and, finally, had been closed.

While the other DRWs appeared to perform in a fairly similar way, the qualitative research found them to vary significantly. The availability of well-reviewed, intensive treatment programmes at High Down and Brixton made it somewhat surprising that the MQPL scores were so unexceptional. This perhaps points to one of the key differences between the rapid assessment and the MQPL: whilst the rapid assessment (and process evaluation) took drug treatment, and intensive treatment cohorts, as a key focus, the MQPL reviewed broader conditions on the wings. Here, it seems significant that rapid assessment and process evaluation interviewees in both sites consistently criticised the physical conditions of their prisons. Particularly following its re-rolling to a Cat C/D prison, Brixton's cramped and insanitary Victorian conditions were a real source of frustration for individuals throughout the prison (see Lloyd *et al.*, 2014). Physical conditions in High Down appeared

to be viewed in a negative light partly because two outstanding, enhanced houseblocks made other wings look comparatively unfavourable. Between the rapid assessment and the process interviews described in the next chapter, the DRW was moved from an enhanced houseblock to a standard mid-1990s residential unit. Across sites, these mid-1990s units still offered some of the best accommodation encountered in any host prison. Nonetheless, it was portrayed in dark and uncompromising terms by interviewees (see Lloyd *et al.*, 2014).

Finally, three DRWs offered consistently mediocre MQPL scores: Holme House, Bristol and Chelmsford. It seems striking that these were the only three units that specifically targeted former heroin users, recruiting prisoners into mid- to large-sized wings entirely filled with people prescribed Opioid Substitution Therapy (OST). None developed robust treatment programmes, and Bristol and Chelmsford ceased operations shortly after the rapid assessment. In this context, it may be worth noting that Bristol and Chelmsford's DRWs, which housed every OST client in their prison, were not seen as *worse* than other locations – which might have been anticipated if former heroin users were seen as particularly stigmatized or undesirable company (see, for example, Page 2016; Crewe 2005; Lloyd, 2013). As a handful of interviewees suggested during the rapid assessment, this may also have been because OST recipients felt protected by being surrounded by communities of the stigmatized; being the only OST client on a full wing could be a very lonely existence indeed.

In conclusion, the MQPL data bore out many of the Rapid Assessment findings and were also reflected in the process evaluation findings that follow: in particular, those DRWs that were found in the course of the fieldwork to be popular with prisoners and 'successful' - at least in terms of their day-to-day operation - were those found to score highly on the MQPL. The two DRWs that were clearly struggling at the time of the Rapid Assessment scored low on the MQPL. The next chapter turns to the process evaluation and effectively updates the earlier picture provided by the Rapid Assessment.

Chapter 6: The Process Evaluation.

DRW overview and interviews in prison

This chapter reports the findings from the prison process evaluation in the included seven DRWs: Brinsford, Brixton, High Down, Holme House, Manchester, Style and Swansea. We interviewed 32 DRW staff and 66 prisoners in these prisons, following the methodology described in the research methods chapter. The rest of this chapter is divided into three sections: in section A an updated overview is given of the seven DRWs included in the process evaluation; section B focuses on the staff interviews; and section C focuses on the prisoner interviews undertaken in prison.

Section A: Site overviews

The following accounts briefly update the ‘story’ for each of the DRWs included in the process evaluation, drawing on the process interviews⁶.

Brinsford

Prison description

Situated on the edge of rolling Staffordshire countryside, Brinsford is described by the Ministry of Justice as a ‘modern establishment... constructed in a single phase on a greenfield site.’ The prison first opened in 1991, and in its life to date has experienced some changes to its structure and role. New residential and educational buildings were added in 2001 and 2008. In January 2010, the prison stopped housing juveniles due to changes in youth imprisonment:

Pressure on the over-18 estate, and falling numbers in the under-18 estate, had accelerated plans by the Youth Justice Board to move out of ‘split sites’, holding both under- and over-18 year olds (HMCIP 2009:4)

Brinsford can house approximately 580 young men, aged 18-21. During fieldwork, two of Brinsford’s five houseblocks had specialist roles. Houseblock 1 acted as the prison’s induction centre. Houseblock 5 had in-cell showers and acted as the prison’s ‘enhanced’ unit. Houseblocks 1-4 were subdivided into two ‘L-shaped’ wings, with each wing identified by a unique letter (A, B, C, etc). Within wings, closed and gated lower and upper landings were designated ‘1’ or ‘2’. Brinsford’s DRW was situated on houseblock 4, H1.

⁶ Detailed accounts of the 10 pilots derived from the Rapid Assessment can be found in Lloyd *et al.*, 2014.

The Drug Recovery Wing – description and evolution

Throughout the process evaluation, Brinsford's DRW remained in the same location: H1. This comprised one of four 32-bed landings within a 'residence'. Each landing held a small administrative office and communal room, alongside sixteen doubled-up cells. Residents of each wing could communicate with other wings by shouting out of their windows, and by congregating at the gates that divided them. This was not seen as a particularly important issue, as segregation was not a core part of Brinsford's DRW model. Clients were expected to attend work and education in the 'main jail' as a core part of their programme.

The DRW's psychosocial treatment was managed and delivered by the same contractor for the duration of the study. Whilst this offered a measure of consistency, provision still remained in flux. Over the course of a year, three (of six) staff members left, and four new members were recruited. Staff came from eclectic backgrounds. Three had prior experience of delivering prison drugs work, whilst others came from services offering relevant experience including children's homes, homeless hostels, and vocational undergraduate degrees. No staff held responsibilities that were specific to the DRW; all worked prison-wide.

In terms of provision, changes in the staff member responsible for delivering group programmes led to two wholesale re-assessments of both prison-wide and DRW-specific treatment. By the time of the final round of staff interviews, DRW residents had exclusive access to two mutual aid meetings each fortnight, consisting mostly of AA and Recovery is Out There (RiOT). All other provision was delivered in the prison's education hub, with young offenders from across Brinsford allocated to groups according to their assessed needs. For most of the fieldwork period, this rarely exceeded one or two groups (delivered across the full prison) each week. However, by the conclusion of fieldwork a dedicated group leader had been employed and was delivering up to ten (educational and harm reduction) groups each week. Again – these were not DRW specific, and were available to any of Brinsford's 120-140 service users.

Throughout the process evaluation, Brinsford's DRW was confronted by particular, local challenges. Following a very negative HMIP report in late 2013, the prison's governor was removed and a process of radical reform initiated. In the words of one interviewee,

Because we were in special measures, as it were, there's been a bit of a knee jerk reaction and there's been lots of money thrown at the prison, lots of kind of new initiatives. There you go bang bang bang bang. Better....management has been put in place. And...it's in process. But...because it's so slow moving, we haven't seen results yet (Psychosocial, Brinsford).

A key part of this was the physical refurbishment of older residences. One 'res' at a time was being refurbished, leading to a shortfall of approximately 120 beds within the prison. This impacted on the DRW in three ways. Firstly, staff felt that the work of the DRW had been (temporarily) deprioritised as other reforms took priority. Secondly, with a severe shortfall in beds prison-wide, DRW staff felt that they had lost control of DRW recruitment:

We haven't got a presence, we haven't got control. It's just two spurs on a wing. That's what we've got at the moment. (Psychosocial, Brinsford).

The problem is that ... we don't have a right to those beds ... And a lot of times, we've had someone put on [the DRW] who's from the block [segregation]. Or...or, you know, or bullies and things like that (Psychosocial, Brinsford).

Reflecting these difficulties, by the time of the final round of staff interviews only eight (of thirty-two) DRW beds held prisoners who were engaged with the Drug and Alcohol Recovery Service (DARS). Three of these were in segregation, following recent violence arising from gang conflicts on the wing:

They've put a whole load of Manchester lads on [the DRW] together. So they've decided [they're] like, running the wing. And then [that]... turned into a bit of a race thing with the Asian lads upstairs...So it went, over the last few weeks it went quite haywire over there. (Psychosocial, Brinsford).

Finally, the psychosocial staff office had been relocated. Whilst it had originally been attached to the DRW, it had been moved to the far side of the prison (approximately ten minutes' walk from the DRW). During the rapid assessment, informal contact through colocated staff had comprised the DRW's main intervention. Relocation had reduced this contact, leaving the DRW with little formal or informal therapeutic input.

Brixton

Prison description

HMP Brixton is a town centre prison, situated in the middle of a multi-cultural area of London. It is a Victorian establishment, with a great deal of original architecture; and a certified normal accommodation of approximately 800 prisoners. At the outset of this research, Brixton was a Category B men's prison. However, around the time that fieldwork began, it was re-roled to Category C-D status. In consequence, the prison underwent a substantive programme of change. Additional work and education opportunities had to be developed, and for the duration of fieldwork workshops were being built on-site. The prison also gained a flagship training opportunity in the form of The Clink, an on-site restaurant catering to the public, and providing training opportunities to Brixton residents.

The Drug Recovery Wing – description and evolution

As one of the first tranche DRWs, Brixton received £30,000 of capital expenditure for set-up costs. In Brixton, this was used to support the creation of a segregated 'wing within a wing' by sectioning off two half-landings with a Perspex screen (Lloyd *et al.*, 2014). Whilst the Perspex prevented physical contact between prisoners, they could still see each other and communicate. Even when working perfectly, DRW staff felt this was problematic:

It will be even better when we do move locations, because at the moment it's just an attachment off another wing... It's only separated by a piece of plastic, temptation is still there (Psychosocial, Brixton)

The segregated DRW held sixty beds, spread across two floors. The lower landing held three communal tables, facilities for playing pool and table tennis, and a group room. The upper landing was open, looking down onto this arrangement. Wing officers inhabited a converted cell beside the Perspex screen.

The size of the DRW was seen as a persistent problem. As a result, staff struggled to exercise control over selection and recruitment, and from the time of the rapid assessment aspired to move to a smaller wing.

I: If you could make one change to the DRW, what would it be?
R: Changing the location. Complete separation, and a smaller wing (Psychosocial, Brixton)

Over a third of beds were routinely given over to lodgers, and the Victorian conditions of the DRW's double cells were also seen as suboptimal for a therapeutic environment.

From the outset, psychosocial staff designed and delivered a programme of DRW interventions. Initially, this was also overseen by the custodial manager in charge of drug strategy, though (following benchmarking) this involvement diminished as the evaluation progressed. Core levels of DRW provision remained broadly similar over the course of the evaluation, based on a full-time programme of groups delivered by three dedicated DRW staff.

Brixton's DRW also worked with a unique population, due to the prison's re-roling. Instead of working with large numbers of newly-arrived, chaotic people, the transition to Category C/D status meant that staff in all areas of the institution found themselves engaging a more stable prisoner cohort. This seemed to open up the potential for recovery-oriented work:

You can do a lot more with the clients because I've been here when it was a remand prison and you'd assess them one day and they'd be gone the next and you can't really do anything. It was all brief interventions. That's when the harm min stuff really works. But when you've got them for about a year you can do some proper changing work with them. (Psychosocial, Brixton)

With few exceptions, prisoners with histories of opiate use had also transferred from Category B prisons, which had provided initial stabilisation and detoxification work. The role (and prominence) of opioid substitution medication within the wing was consequently of a different order:

A lot of them, by the time they get to us, have already detoxed off their script. They come into remand [in Cat B prisons] in a bad way, withdrawing. They're gonna have to be scripted. We are seeing different men. A Cat C prison theoretically should be of a different nature and of a different background, composition (Psychosocial, Brixton)

The wing consequently encountered fewer problems centred on the diversion and supply of illicit medication, or related to supporting prisoners through detoxification.

However, Cat C/D status was also attended by challenges. Having a large group of prisoners leaving the establishment each day was thought to greatly increase the availability of both illicit drugs (specifically cannabis), and New Psychoactive Substances (NPS).

For the duration of the evaluation, drug treatment within Brixton was provided by the same contractor. Four full-time psychosocial workers were allocated to case managing the DRW's forty (or so) clients, and delivering a full-time programme of DRW groups. This offered a considerably better staff:prisoner ratio than other locations. Prison-wide, seven psychosocial staff carried a caseload of 280-300 people.

High Down

Prison description

High Down is a men's Category B local prison, built in 1992 on the former site of Banstead Lunatic Asylum. The prison shares a site with Downview Women's Prison, and can house up to 1,103 sentenced and remand prisoners. The prison serves Guildford and Croydon Crown Courts, and draws approximately four-fifths of its residents from Surrey, Croydon, Bromley, Lambeth and Sutton.

High Down has six residential houseblocks. Houseblocks 1-4 date from the prison's original build. Each holds up to 181 prisoners in double cells, split equally between three spurs. In 2009, High Down gained houseblocks 5 and 6. Each new houseblock has two spurs, with each spur holding up to 90 prisoners. These new houseblocks effectively acted as the prison's enhanced accommodation. Cells were designed to a high standard, providing single accommodation with in-cell sanitation and courtesy keys⁷ for cell doors.

The Drug Recovery Wing – description and evolution

Over the course of the evaluation, High Down's drug recovery wing underwent one of the most radical changes across any site. Established under the remit of an enthusiastic governor, the DRW was originally situated on Spur A, Houseblock 5. A separate 'stabilisation wing' housed all prisoners in receipt of Subutex and methadone on Houseblock 6. However, movement between the wings was rare: during the rapid assessment, just one of the DRW's sixty clients had a history of opiate use (over the counter codeine; see Page *et al.*, 2016). Stabilisation wing residents were felt by staff to be reluctant to progress to the abstinence-focused DRW because of an intrinsic lack of motivation, and because the living conditions of Houseblock 6 were too comfortable for them to want to leave. One manager surmised:

We had the [stabilisation wing] and the DRW [and] they were separate. Yes, we had a lot of [stabilisation] clients on treatment that were on 0.4mls [of Subutex] or ten mls and under

⁷ These allowed prisoners to lock their own doors to other prisoners, though not against staff keys.

of methadone. So it wasn't... there was no clinical reason. But it was their safety net.
(Psychosocial, High Down)

Staff widely presented the lack of heroin users and prolific offenders on the DRW as a failure of the original treatment model.

The arrival of a new governor shortly before the rapid assessment brought with it transformative plans. Houseblocks 5 and 6 were reallocated to vulnerable prisoners and full-time workers, whilst the Drug Recovery and Stabilisation wings were merged into an integrated unit in houseblock 4:

I: What's changed, how's it worked, and how has it gone?

R: Oh, god... Ok, so they moved us onto a substance misuse unit, which now houses everyone on treatment and clients on the drug recovery wing. They moved all the case managers and the Bridge team here as well, so they've moved offices. All the dreams that we've had have changed... (Psychosocial, High Down)

In this new, envisioned model Spur A would be for the prison's medicated new arrivals, following induction. Spur B would be for those who wanted to make some changes to their drug use or medication regime. And Spur C would be the Drug Recovery Wing, housing clients undergoing abstinence-focused programmes. The driving rationale for this centred on making the DRW's abstinence-focused approach more visible, through the establishment of an integrated, co-located treatment pathway:

I think what Number One's hope was, if clients that are on prescribed treatment could see other clients on the abstinence programmes, could see the benefits, they would want to automatically do it. (Psychosocial, High Down)

At the same time, staff hoped that moving the stabilisation and Drug Recovery Wing to a materially impoverished houseblock would discourage unmedicated prisoners from applying to intensive drug treatment simply to access enhanced conditions (an issue identified in the Rapid Assessment: Lloyd *et al.*, 2014), and medicated prisoners from staying on methadone or Subutex for any longer than was absolutely necessary. Whilst the enhanced wings once housed prisoners receiving clinical or psychosocial drug treatment, the same conditions could now only be secured by those who exited treatment.

In practice, this treatment model was never fully realised. Spurs A and B became undifferentiated OST wings. Spur C housed all DRW clients but due to population pressures, also had approximately one third of its beds filled by OST 'lodgers' by the end of fieldwork.

For the duration of the evaluation, drug treatment within High Down was provided by the same twelve-step provider. Four psychosocial frontline workers and one manager were responsible for case-managing all but 24 of High Down's treatment caseload. Another four diploma-level counsellors and one manager were responsible for case managing the remaining twenty-four, who were engaged by the other mainstay of the counsellors' work: two full-time treatment programmes. One of these was the Bridge Programme, which only engaged people who were fully abstinent from OST. The other was Stepping Stones, a six-week preparatory programme available to all Houseblock 4

residents that sought to encourage participants to consider change, and enhance their motivation for it.

Holme House

Prison description

Holme House is a Category B men's local prison, situated on the Northernmost edge of Stockton's Portrack Interchange Business Park. Holding up to 1,210 prisoners, it is the largest prison in North East England and the tenth largest in the UK. The majority of prisoners come from four local areas: Stockton, Middlesbrough, Darlington and Hartlepool.

The prison contains a total of seven houseblocks. Houseblocks 1-4 date from the prison's original build in 1992. During fieldwork, three of them served specialist functions. Houseblock 2 housed the prison's full-time workers; houseblock 3 contained a vulnerable prisoner unit; and houseblock 4 acted as the induction and reception centre. Houseblocks 5-7 were built in the late 1990s, and during fieldwork contained a specialist resettlement unit (houseblock 7) and the prison's Drug Recovery Wing (DRW) and therapeutic community (TC) (houseblock 6, spurs a and b respectively).

The Drug Recovery Wing – description and evolution

At full operational capacity, houseblock 6a holds 78 beds. However, during all fieldwork people were only accepted onto the DRW *programme* if they could be allocated a keyworker. Ten DRW officers (who filled standard disciplinary posts) keyworked five clients each, yielding a programme capacity of 50 clients. The remaining 28 beds housed a population of older, foreign national, and DRW waiting list 'lodgers'. The DRW's 50 clients represented less than a fifth of the 270 clients in treatment during early fieldwork. Every houseblock in the Holme House had its own medication hatch, meaning that OST patients were dispersed throughout the prison.

In theory, Holme House's DRW held a well-defined place within the prison's treatment pathway. At the start of the pathway lay the majority of prisoners prescribed methadone or Subutex. These were expected to be on maintenance (or very slow reduction) doses, whilst receiving minimal psychosocial intervention. Those who were sufficiently motivated towards abstinence could apply to the DRW which, in principle, offered a recovery-oriented community supported by enhanced one-to-one provision, and some group treatment. Those prisoners who reduced their medication sufficiently could then progress to an abstinence-based TC. This offered a structured programme of groups, delivered by a core team of six externally-funded discipline officers. It accepted referrals for prisoners who were prescribed 10mls of methadone or less, and who had at least six months of their sentence left to serve. A DRW officer spelt out the DRW's notional place within the treatment pathway:

In an ideal situation, someone will go on there, in my concept, on 50mls. Within the space of four month he's now on 10 ml reducing 1ml a week, he's then got the choice of going on to the TC if he meets the time criteria. So he moves from the first night or induction centre into recovery into going to a different regime altogether. So you've got your cards on the

table: this is what we're about. This is what we do. Do you want to buy into it? If not, there's other facilities in the jail. (Discipline, Holme House)

This defined a clear primary task for the DRW: recruiting opioid-prescribed prisoners, and reducing their medication.

Therapeutic provision on the wing was provided by discipline officers. Originally, this consisted of two full-time therapeutic officers who were meant to be excused from other duties. As fieldwork progressed, dedicated staffing became harder to maintain. Following competition benchmarking therapeutic officers were regularly cross-deployed to other locations, making it hard to sustain any level of structured provision. An additional change came in the form of strategic changes to officers' roles, which were refocused on security (rather than therapeutic) work. In consequence, officers were withdrawn from therapeutic roles. Following a recommissioning round for Holme House's therapeutic community, six highly trained, long-serving officers were told that they would have to return to standard disciplinary functions, or choose a Transfer of Undertakings (TUPE) to a third-sector provider. The DRW's SO managed to have three of these ex-TC officers allocated to his wing, with the intention of providing a level of enhanced group provision. At the time of final fieldwork, this change was still in process. How it played out remained to be seen.

Two staffing changes substantially affected Holme House's DRW's work over the fieldwork period. Firstly, the prison appeared to have a particularly challenging experience of the benchmarking process. Officers were regularly cross-deployed, DRW residents were rarely reviewed, problem populations were felt to build up, and treatment diminished to very low levels. Secondly, the DRW was realigned with a Category C regime during the process evaluation. In practical terms, DRW residents appeared to have gained little access to new resettlement opportunities. However, it did mean that they had some additional time unlocked, and / or out of their cells. Staff generally viewed this as a positive change, as it opened up opportunities for more hands-off prisoner management:

Cat C I quite like... Everyone's unlocked and they're doing whatever they want to. If they're locked up, you're forever answering the bell. So it frees me up to get on with other things. (Discipline, Holme House)

Manchester

Prison description

Manchester prison, formerly known as 'Strangeways', is a local prison housing sentenced prisoners, and those remanded into custody from the courts in the Greater Manchester area. As a high-security prison, this includes Category A prisoners. As of 1st April 2013, the prison had an operational capacity of 1,238 beds.

The prison opened in June 1868. In 1963 it was decided that the prison would no longer hold women prisoners, and in 1980 it began to accept remand prisoners.

Accommodation in HMP Manchester consists of two Victorian radial blocks (A, B, C, D, E and G, H, I, K) with a mix of single and double cells. All have in cell power points and integral sanitation.

Manchester also houses a Specialist Interventions Unit, for behaviourally challenging Category A prisoners.

The Drug Recovery Wing – description and evolution

For the duration of the Process Evaluation, HMP Manchester offered the most consistent DRW encountered across sites. From the beginning of the rapid assessment until final staff interviews both the location and core staff team remained unchanged. The timetable retained the same outline, though some elements were added as the evaluation progressed.

The DRW, known as Recovery Through the Gate (RTG) was based on H1, a one-time segregation unit offering twenty beds on the ground floor of a wing. Contact with non-RTG prisoners was limited by the delivery of a full-time programme of groups within the wing, which was shut off from other locations by a solid metal door. In principle, a level of contact could still occur. The upper reaches of H Wing were occupied by Manchester's detoxification unit, and there was a risk that lines containing drugs or medication could be dropped to RTG from upper windows. Staff consequently aspired towards even greater segregation:

- I: If you could make one change to the wing what would it be?
R: Put it outside the jail wall, in a staging post between the jail and community.
I: So completely segregated?
R: Yeah, everything independent just for this very fragile stage of recovery, the early stages where they don't need to be tested because they've not built the resilience or the resolve yet. Imagine a fenced off billet with a garden where they could do gardening, they could do baking, there would be so much you could do if you were independent and not worrying about security, it'll still be within the confines of the prison and make it so it was security tight but everything independent. Run our own gym, our own visits, our own healthcare, but it'll cost money [laughs]. (Discipline, Manchester)

Nonetheless, Manchester offered the most robustly segregated location encountered across sites.

All therapeutic provision was timetabled by four discipline officers, who were entirely separate from prison-wide drug services, and whose posts were funded by the NHS:

We're prison officers and we're paid by NOMS but the prison service receives money from the NHS (Discipline, Manchester)

This core team took over the running of the DRW in mid-2011. Prior to this, two officers and a civilian drug worker had sowed the seed of what would come to be known as RTG:

It was basically the same thing. They didn't do the same amount of interventions we did, but they went through the gate with them and they helped them get housing. They got them into rehab. So it was quite successful anyway, before we even come. (Discipline, Manchester)

However, the arrival of the two disciplinary officers who would take RTG forward, led to substantive organisational improvements.

When I came down, I seen that some systems needed to be put in place. It was quite disjointed, and I knew it needed doing... So I got [named prison officer] down here, who was an experienced officer and he sort of mentored me... And when he did come down, he started putting systems in place. And then we got [another named prison officer], who really started putting in a lot of frameworks... So that was how it changed, really. You know, it, there was more of a structure to it. And everybody knew everything rather than one person doing one thing and another person not knowing that much about it.
(Discipline, Manchester)

Star charts⁸ were brought in as a means of carrying out assessments and measuring progress, and a series of groups began to be put in place.

A supportive governor acted as a key enabler for RTG's early work. Indeed, every staff member identified that this governor had been critical to the successful establishment of the wing:

I: What allowed all of those things to develop?
R: In a word, [the DRW governor] [laughs] ... She was basically saying whatever you want, whatever you need, whatever you think will work... Whether it be innovative, new... whether it's been resear... You just tell me what you need. And we were just going at a pace because the model we were creating was based on, "right, what do you think we can prove and what do you think we can do?" So we went to a recovery conference, people saying there, "we're doing this." Right, why can't we do that? So it got very rapid. And with [the four core team members], who are all - you know - have got a lot of energy. It was very positive. (Discipline, Manchester)

As this quotation surmises, this led to the DRW getting access to physical resources, and empowered staff to develop an ambitious programme of both novel and accredited interventions.

Styal

Prison description

Styal is a closed women's facility in Wilmslow, South Manchester. It was originally a Victorian children's home, and is predominantly comprised of houses, on which live around 20 women. These houses are supervised with a light touch by discipline staff. During the rapid assessment, one prison officer was in attendance at key times during the day. By the time of process interviews, the supervision of discipline staff was rare. In addition to these houses, there is a large wing where women generally go after their assessment on the 'first night house.' They may stay on the wing for the whole of their sentence, but will normally progress to live in a house once they have employment. The Drug Recovery 'wing' is based in one of these houses – Fox House – and

⁸ A visual assessment tool covering multiple areas of 'recovery' work, broadly reflecting conventional risk / need domains.

throughout the study, staff aimed to fill all of Fox's beds with drug recovery clients. Fox is located in a quiet area of the prison, with little 'through traffic' of prisoners or staff, offering a level of isolation from the prison's main population.

The Drug Recovery Wing – description and evolution

Styal's DRW had originally been developed as a therapeutic community (TC), delivered by Phoenix Futures – an agency with specific expertise in the running of TCs. During the rapid assessment, it was apparent that recommissioning might affect the sustainability of this operating model (Lloyd *et al.*, 2014:275). Whilst the same DRW clients remained housed in the same location, the DRW's initial cohort of seven staff was reduced to two. Neither had previously worked on the wing, and neither had any experience of TC operating models. Moreover, the challenges of establishing a new therapeutic model were compounded by an immediate requirement for the third sector provider to review prescribing throughout Styal. This, again, withdrew attention and resourcing from the DRW:

The whole priority was around prescribing. So everything around [the DRW] was just keeping settled, and making the transfer over of staff and services as smooth as it could be. I think the view was that here was relatively safe. As a...as a service. Fox, the women were all relatively ok, as opposed to the first night centre where people were coming in... [less stable] (Psychosocial, Styal)

Concomitantly, Styal underwent 'competition benchmarking,' triggering shortages in discipline staff:

We used to have an officer in the office every day and he'd be here all day, then he'd go away at night and do his rounds. But now they've got no money, so they've taken all the officers off the houses, which will result in people... One of the officers told us, "it won't be until somebody's actually hanging that they're going to get us back on here." (Prisoner, Styal)

And several changes in discipline leadership. In the nine months between the rapid assessment and process interviews, drug services experienced three changes of Drug Strategy governor.

Faced with considerable change, the early reimagining of the DRW's programme had not been straightforward. Every aspect of the TC came to be seen as unworkable, and an alternative programme was puzzled together from scratch:

We just couldn't do treatment with only [the two DRW staff] really. So we were looking around for structured groups... One bloke did a stint of a couple of weeks of structured group work. [An external agency] did a couple of groups. Me and [my colleague] did a couple of groups... [The women] just weren't bonding at all. It just. It was just fragmenting. So. Erm. we looked at what we could put in place and we came up with that. (Psychosocial, Styal).

The loss of the TC model (and staff) was a real frustration for some residents:

I was expecting more TC rather than... It's horrible. You imagine, you wake up in the morning without any coffee, you go downstairs and get psychoanalysed for half an hour.

Then you go off and then you do gardening, then you come back and you get psychoanalysed again. It's enough to send a sane man absolutely barmy. [In rehab] you're getting psychoanalysed by proper professionals. Not by somebody who's telling you stuff that's absolutely... who can't read you properly (Prisoner, Styal)

Women were no longer asked to discipline each other, and the principle that treatment should be an all-encompassing aspect of women's daily lives – treatment *as* community – had been retracted in favour of an assumption that treatment consisted only of structured groups. A couple of residents now described a low-level backdrop of disorder and drug taking by both DRW clients and non-programme 'lodgers' in unsupervised hours:

It gets quite daunting [when there are no staff on the wing] and I think it would be better if they had staff, recovery staff that were on here all the time to give that support. Because when they're not here it's different... [It's] just a different environment really. Staff don't know what's going on in the houses when they're not here. (Prisoner, Styal)

The DRW thus appeared to have lost something, both in the depth, reach and consistency of its treatment model; and in the community on the wing.

Despite an apparent weakening of the DRW's treatment model since the rapid assessment, prisoners still felt that the wing offered advantages compared to other locations. Women found support in their peers:

I've found that being on the house, this house, has helped me a lot because I've been associating, making friends with other people which is something I don't do outside in my life... So being in prison has put me in social settings where I mix with other people and I have made a few friends. (Prisoner, Styal).

Others commented that the wing had 'a better atmosphere,' and 'not so much bitching' as other residences.

These advantages were relatively short-lived. Styal's DRW unexpectedly ceased operations between fieldwork visits, in mid-2014. As we lost contact with former DRW staff, we do not know the reasons for this closure.

Swansea

Prison description

HMP Swansea is in a built up area in the centre of Swansea. It is a Category B male local prison with a total capacity of about 435 prisoners.

Despite the prison's Victorian design, the prison's accommodation is not built to the standard radial design. Instead, houseblocks took the form of individual, L-shaped residences.

In 2012, HMP Swansea was invited to develop both a DRW and a Drug Free Wing (DFW). This required some significant changes to the layout of the prison, particularly related to the location of the induction wing, and these changes were a difficult time for the prison and its staff. The prison completed a needs analysis, involving consultation with both staff and prisoners, as part of the development of the DRW/DFW.

The Drug Recovery Wing – description and evolution

Swansea's operational model – rolling cohorts of prisoners approaching release – made it possible to fit fieldwork into condensed bursts. Indeed, only three visits were necessary for all rapid assessment, process evaluation prisoner, and process evaluation staff interviews to be secured. This condensed fieldwork process served to highlight one of the more striking features of Swansea's DRW: its peripatetic nature. Each time members of the research team visited, the DRW was in a new location. Moreover, shortly after fieldwork ended the DRW was closed. Plans were afoot to re-open it at some point in the relatively near future – again, in a new location.

The DRW began its life in B wing, a former detoxification unit with medication hatches fitted to support detoxification. Within six months, this had become unsustainable: the prison needed a detoxification wing, meaning that B wing had to be reclaimed.

We had to implement a detox unit in the establishment and where we were housed had special doors for detox prisoners, and they couldn't be moved to any other part of the prison. So the move was forced upon us for safety reasons, for the prisoners. (Discipline, Swansea)

The DRW was consequently moved to the 49-bed C wing. From an outside perspective, C wing appeared to offer some material advantages: not least, the only full-sized snooker table encountered across sites. Prisoners shared this view, and this supported prisoner recruitment:

C wing is known for being a better wing, if you know what I mean. Everyone likes C wing... It's got a reputation for being a good wing so you never had trouble with people coming down (Prisoner, Swansea)

However, C wing was attended by design problems. A large, open metal gate lay at the back of the wing, out of view of the staff office. Prisoners from other wings regularly congregated here, compromising attempts to segregate the DRW cohort. The wing also held the prison's only resource of safer custody and segregation cells and, relatedly, was partly staffed by longstanding segregation officers.

You had the seg there and you had the DRW wing here, but all the officers were expected to be involved [with both]... Some of the other officers found it very difficult to be more therapeutic when they were used to being more disciplined in the seg, if you like... And it wasn't going to work. It was set up to fail (Discipline, Swansea).

By early 2014, the DRW had therefore moved again. This time, it inhabited A1, a 20-bed unit closed off from other locations by a solid metal door. When staff were interviewed they had only recently

relocated, and had yet to run a full treatment cohort. They were, however, optimistic about its potential:

Bringing the groups down to A1 is, for me, the best thing that's happened. Because now we've got ownership of a wing, there's only 20 prisoners down here and, as you can see, those 20 are up there on the list waiting to do their first course. And it works. It's just the staff have been brought down here as well are, I don't know, more positive. (Discipline, Swansea)

For the duration of the evaluation, drug treatment within Swansea was delivered by a mixture of prison officers and third sector staff. Three handpicked officers delivered half of the DRW's structured treatment programme (two groups per week), and all one-to-one case management work. Concurrently, staff from a community-based drugs agency delivered a further two group sessions each week. Details of prison-wide psychosocial staffing and drug treatment provision were sought, but could not be secured.

Section B: Staff interviews

Introduction

This section starts with an overview of the interviews secured in each site. It proceeds to explore the aims, goals and aspirations of DRWs, with a particular focus on their approaches to recovery. Next comes a section on DRW selection and recruitment processes, followed by an outline of DRW provision (and the principles steering provision across the wings). After this comes a section on DRWs' exit pathways, which includes an exploration of DRWs' resettlement pathways and partnerships. Finally, this chapter concludes with three sections focused on the main challenges identified by DRW staff in establishing and delivering operational units; the strongest features of DRWs; and staff aspirations for future changes.

Interviews

Staff interviews were conducted at the end of prison fieldwork, with the earliest (Swansea) carried out in January 2014, and the latest (Manchester) completed six months later. Table 6.1 describes the key characteristics of interviewees in each site. Throughout, 'discipline' staff refer to prison officers.

Table 6.1: Key characteristics of interviewees in each site

Prison	Total interviews		Employer	Main role	Position
Brinsford	5	1	3rd sector	Psychosocial	Team lead
		2	3rd sector	Psychosocial	Case manager
		1	3rd sector	Psychosocial	Group facilitator
		1	3rd sector	Psychosocial	Recovery supporter
Brixton	5	1	3rd sector	Management	Deputy service manager
		1	3rd sector	Psychosocial	DRW lead
		2	3rd sector	Psychosocial	Case manager
		1	3rd sector	Family	Family worker
High Down	5	1	3rd sector	Management	Service manager
		1	3rd sector	Management	Programme manager
		2	3rd sector	Psychosocial	DRW programme delivery
		1	3rd sector	Psychosocial	Case manager (prison-wide)
Holme House	5	1	Discipline	SO ¹	DRW / TC management
		2	Discipline	Psychosocial	TC case manager / facilitator
		1	Discipline	Psychosocial	Discipline & therapeutic roles
		1	3rd sector	Management	Peripatetic TC/DRW support
Manchester	5	4	Discipline	Psychosocial	DRW programme delivery
		1	Discipline	Psychosocial	CARAT worker
Styal	2	1	3rd sector	Psychosocial	DRW lead
		1	3rd sector	Psychosocial	Group leader (prison-wide)
Swansea	5	1	Discipline	SO ¹	Managed 3 wings (incl. DRW)
		3	Discipline	Psychosocial	DRW programme delivery
		1	Discipline	Psychosocial	CARAT worker

¹ Supervisory or Senior Officer

We sought to secure interviews with five staff involved in the delivery of DRWs in each site, and achieved this in six sites. Styal's DRW ceased operations before five staff interviews could be secured.

The homogeneity of most staff samples stood out, when compared with staff interviewees from the rapid assessment. No governors were offered for interview. For the most part, interviewees in each site were all employed by the same agency. Clinical staff were not identified as core DRW partners in any site. In this, there was a sense that DRW partnerships had diminished, and that they were now delivered by small, core teams of frontline staff and junior managers.

Aims, goals and aspirations

DRWs sought to operationalize recovery in one of four main ways: person-centred; harm reduction; abstinence focused; or a mixture of all three.

i. Person-centred

The most common account centred on user-led goals steered by clients' own interpretations of recovery:

We will ask: 'what does recovery mean to you?' And that's why we make everybody's interpretation that's different. Because I can sit here and say what I think it is, but that's not helpful, is it? (Brinsford).

The principles of DRW is that it's up to the individual whether it's abstinence or control. I suppose I naturally, personally, tend to look at the completely giving up a substance, although I obviously accept that's not the way for everybody (Swansea).

Clearly, narratives of entirely individualised, user-led recovery are hard to fully reconcile with the development of structured programmes of provision. All DRWs consequently supplemented 'user-led' accounts with some form of more directed provision.

ii. Harm reduction

Even when DRWs claimed to be delivering person-centred treatment, they often aligned practical provision with harm reduction principles:

I: Do you feel that harm reduction is a part of recovery?

R: It is, yeah, because if they're gonna relapse, if they're gonna go out and use, it's best to do it safely and, you know, awareness is always good because it can help them make up their mind what they want to do (Brixton).

I: What's the work pointing towards?

R: I would say... harm reduction [and] increased knowledge of substances. How to use more safely. And, yeah, where to go for help...once they've left (Holme House).

Reductions in drug use, or switching to less harmful drugs were seen as key:

We don't tend to work on abstinence. We tend to work on, what is your goal? [...] And if they see cocaine as an issue because that's led to their offending behaviour but cannabis not so much, we'll work on the cocaine and then tackle the cannabis when they're in more of a... (Brinsford).

...you might just have someone who's a heroin user, but still wants to smoke marijuana. If we get him off heroin that's a success (Swansea).

Approaches to Opioid Substitution Therapy (OST) were largely consistent. Brixton, High Down, Holme House and Swansea all asked that people reduced. Styal stood out from this pattern, adopting a more open-ended approach to medication assisted recovery:

I: Is there any pressure to reduce?

R: No, no, no. Not at all. Definitely no. It's not a prerequisite for coming on... It's what the individual's comfortable with, in their recovery. And obviously medication is a part of that (Styal).

OST was not an issue in Brinsford, where no DRW residents had a history of opiate dependence.

iii. Abstinence-focused

An additional set of DRWs expected prisoners to attain OST abstinence before their release (Page *et al.*, 2016), with the intention of segueing into post-release abstinence from drugs and alcohol. Two DRWs, High Down and Manchester, wanted all residents to achieve this:

Abstinence is what we... it's not the be-all and end-all...but it is our end goal (High Down).

R: Obviously the goal of [this wing] is being substance free. So the client, if he's on a substance, he comes off that substance.

I: What does substance mean?

R: Alcohol, drugs.

I: Subutex? Methadone?

R: Yep, yep (Manchester).

To support these ends, these DRWs were positioned at the end of their prisons' treatment pathway. Prisoners who did not express a willingness to work towards medication abstinence were housed on other wings.

iv. Mixed treatment models

Two DRWs held staff who held different understandings of 'recovery.' Two Brixton staff elucidate:

For these guys, they would have to be looking at abstinence (Brixton)

[The DRW] is not abstinence-based (Brixton).

A third offered a layer of nuance:

What does recovery mean? I suppose, well obviously, it's abstinence from drugs or mind altering substances. [But] not necessarily within prison because some people, it keeps them stable whilst they're in prison. And it might be a short time after they get out, until they sort themselves out (Brixton).

Swansea offered a similar mix:

Other staff ... you're going to talk to later on [laughs] will have a different view to me, because we had words in a group when we did it together. They're going for abstinence. Total abstinence. That's where they're coming from... (Swansea).

Staff presented this as a strength of the wing, as professionals with different perspectives could offer support that fit with individual prisoners' preferences. This appeared to be discrete from 'person-centred' models, as prisoners could only access the directive approaches of a variety of staff; staff were not tailoring their own approaches to prisoners' individual needs.

Operationalising Recovery: Broader Goals

Developing service users' 'recovery capital' was situated at the centre of the 2010 Drug Strategy (HM Government 2010:18). This is defined by White and Cloud as...

...the quantity and quality of internal and external resources that one can bring to bear to initiate and sustain recovery from addiction (2008:29).⁹

Along these lines, DRW staff sought to address their clients' multiple, complex problems by offering interventions that reached beyond drug-related needs:

...when you sit down with individuals, their lives are chaotic. They've got nowhere to live, that's the big thing. They've got no income, because they're bouncing around in nowhere land. They've got no self-esteem as well (Holme House).

Recovery for me means first of all.... getting people to a stage in their life where they're happy. I don't believe anybody can take substances - they're in and out of prison, their family's fallen to pieces, and their health is terrible - is happy. When you're in recovery, you're happy. Or have the potential to be happy. I think it's rediscovering a person you've not seen for a long time. People have had their brain fogged - their emotions...fogged... sometimes coming off substances lays bare a lot of stuff that you don't like. That you're rather embarrassed, ashamed, disgusted... whatever it is. A lot of guilt as well about coming out of substance misuse and going into recovery. But it's all... at the end of the process, you're going to have a happy healthy person (Swansea).

Such wide-ranging recovery models were often described as 'holistic':

⁹ For more discussion on the Recovery Capital concept see p.256.

To look at things holistically, even if we can support them in terms of getting housing, getting employment, and things like that. It's all going to be of benefit to them when they leave. So it's about ensuring that you identify those needs (Brixton).

It's not just substance misuse, your recovery, you know...everything. It's looking at what issues you've had in your past. And I don't know, focusing on basic living... things. Skills: like budgeting, cooking, gaining employment... finding out your place in society and where you fit in. and where you're comfortable with where you fit in. Family relationships. Anything like that: education...hobbies, fun (Brinsford).

A couple of these interventions were structured, DRW-specific and well-resourced. Manchester, for example, invited in third sector partners to provide prisoners with pragmatic support for release (see Chapter 6A). More often, though, the pragmatic assistance offered on DRWs was a standard part of prison-wide treatment, whilst 'holistic' psychosocial provision was often equated with discussions about broader issues than just drug use.

The extent to which such programmes could be described as 'holistic' also invites some questioning. Best and Laudet, for example, identify the bulk of 'recovery capital' as being rooted in childhood, and structural opportunities; and note that even the most robust community-based recovery services are likely to be able to do little more than support individuals' progress towards broader life transitions (2010:7-8). In this context, even highly ambitious 'holistic' psychosocial programmes seemed likely to be constrained in their potential reach and impact.

Summary

DRWs chose to operationalize recovery in several ways. The most common involved staff notionally supporting service users in following individual and person-centred recovery goals (though the structured support on these wings often focused mostly on harm reduction). Two DRWs also sought to support all residents through full detoxification from OST, as part of a programme that focused on treating an underlying 'addiction' with abstinence from all drugs and OST medication. Finally, DRW staff widely sought to acknowledge that their residents were afflicted by multiple difficulties in their lives. In this context, they often sought to offer some pragmatic or psychosocial support for needs beyond (but often related to) drug and alcohol use. Though these were widely described as 'holistic,' this begs some questions about the meaning of this term within prison-based services.

Selection and Recruitment

Approaches to selection and recruitment defined the prisoner cohorts that appeared on wings. As such, they established who would be worked with; and, often, the limits of the work that could be meaningfully delivered. Approaches fell broadly into two main camps. As set out in Page *et al.* (2016), sites either engaged prisoners who were motivated towards abstinence, irrespective of their drug of choice; or former heroin users prescribed OST, with less importance placed on motivation towards abstinence.

Motivation towards change

By far the most common criterion to dominate DRWs' selection and recruitment processes was motivation towards change (see Page *et al.*, 2016).

You want motivated lads. Respectful. Lads that want to address their substance misuse. You know, they're not just engaging because they have to for their sentence plan. They actually want to make some positive changes and some positive steps on their recovery journey (Brinsford).

Manchester – a very small wing – was able to take this approach further than many units. Staff sought to unpick motivation, and applicants' wide-ranging aspirations towards change:

We try to ask some very open questions. Asking them about how they feel about their motivation, where they think it's at, what do they need to do, all the sort of stuff that they've got to generate an answer to, rather than just saying "do you want this course?" "Yeah." And it stops there. So we've become very proficient in asking these open questions, and getting a feel. Because funnily enough, there is a set of lines that gets thrown out to you. "I'm ok, me. I'm going to get a job with my brother, he's got his own business." What business?" "Well, it's just doing this and that." "OK, is it regular?" "Well..." "Is it going to pay the bills? What are you going to be doing on the days that you're not working? Are you going to be paying tax?" So already, you're committing them to pro-social [goals]... (Manchester).

In all sites that prioritised motivation, drug of choice was seen as an irrelevance:

I've never actually even considered what drugs somebody is using (Swansea).

It's down to motivation of what they're saying: is it a problem, so does it cause them trouble in life, do they want to change? Whether that's cannabis or that's heroin (Manchester).

The dominance of motivation over drug of choice was taken to its logical conclusion in two sites, where staff said they would engage a compulsive gambler with no history of drug dependence, provided they were motivated to change.

OST

During the rapid assessment, few OST-focused DRWs were found to offer promising recovery models (see Lloyd *et al.*, 2014, p.43; Page *et al.*, 2016). Thus, during the process evaluation fieldwork, OST dominated the selection criteria of just one site: Holme House. This decision had been shaped by the criminal justice priorities of discipline staff and prison governors, who developed the DRW's operational model. Reducing reoffending was their stated primary goal. They consequently followed a well-trodden path in explicitly targeting the most prolific offenders, former heroin users (see, for example, Godfrey *et al.*, 2001; Jones *et al.*, 2007).

Supporting change in OST clients proved an endemic problem for all DRWs (see Page *et al.*, 2016). In Holme House, this was exacerbated by a problematic division of responsibilities. Psychosocial staff were responsible for recruiting DRW residents, and were willing to relax recruitment criteria in order to fill the DRW's beds. Therapeutic discipline officers delivered treatment, and would have preferred selection criteria to be rigorously adhered to – meaning only motivated OST clients would be recruited. Frustrations then arose when officers felt that many of the clients who were sent their way had little desire to change.

If you've got a clear aim and we're saying we want you to come off methadone, then you need to advertise it and recruit the people that you know want to do that. No smoke and mirrors. Don't get people in on false pretences, they need to know exactly what's on offer and what's expected of them (Discipline staff, Holme House).

Few residents achieved the DRW's stated goal of OST abstinence (see Page *et al.*, 2016). Holme House's division of responsibilities, and positioning of motivation as a 'second order' recruitment criterion (after OST status), appeared to be causing real difficulties in establishing a therapeutic regime.

High Down had also made some steps towards targeting OST recipients. A new Governing Governor saw the DRW's historic record as problematic: during the rapid assessment, just one (of sixty) DRW residents had a history of opiate dependence, despite the existence of a full wing of 180 OST recipients next door (see Page *et al.*, 2016). The DRW was consequently moved, so that it occupied one sixty-bed spur on a three-spur houseblock. The other two spurs were allocated to prisoners receiving OST. This had some effect on OST recruitment, though it had not lived up to early expectations:

I think it's working, but it's a trickle. And it's not as good as I thought it would be (Psychosocial, High Down).

Staff delivering intensive psychosocial treatment estimated that between one-fifth and one-third of DRW clients now had histories of opiate use.

Selection and Recruitment: Creating Motivated Communities

Two wings consistently filled their beds with highly motivated clients. Manchester's processes and structure were clearly pointed towards this end. The wing was tiny: fewer than one in fifty of Manchester's prisoners inhabited the DRW. Moreover, two additional, large treatment wings were dedicated to other drug users (detoxification; and compact-based drug testing). Keen to protect their wing's recovery ethos, and able to 'cream off' only the most motivated few (e.g. Pawson 2006; Lipsky 2010), staff took a considerable amount of time to probe the enthusiasm of any and all who sought a place on their wing:

Selection has given us a better grounding, the quality of our clients has stepped up a bit and we're getting the people who want to change... They've decided that the life they're living, as in drug use, chaotic lifestyle, pro-criminality, they don't want to do it any more (Discipline, Manchester).

This seemed to be working very well: all staff interviewees felt that their cohorts had been getting progressively better as the months and years progressed.

Despite less promising processes and conditions, Swansea staff also saw their DRW cohorts as motivated volunteers who had found out about the programme from other prisoners:

We don't want to force people to be here, you want, basically, volunteers that want to come down because they're spreading the word that they're feeling they're getting something out of it.. I like that ethos – the fact that they think it's working and they're recommending it (Discipline, Swansea).

This appeared to be quite an achievement, given the low priority given in recruitment processes to characteristics other than stated motivation. Even known troublemakers could be accepted so long as they professed a willingness to change:

For me, there's never a wrong reason [for applying for the DRW]. But that's just me, because I know, I've sat here and I've had boys sit here and they go "I'm only doing this because I'm in court and I want a good report." And I go, "that's fine. We'll see if you feel like that at the end of the course. And nine times out of ten when you get to the end of the course and you'll say to them, "do you remember you said you were down here for a good report?" "Yeah." "Do you still feel that way?" "Oh no. I've taken so much more from it. Much more than... that report isn't important to me any more" (Discipline, Swansea).

To be honest, I don't think it's very hard to select. We've had people I've seen on the list, and I've thought, "what is he doing on here?" And then I've started a group and they've opened up more than anyone. ... That's my opinion, I don't think there should be a selection process because what you do then is you start cherry picking who you want to come down. And I don't think that's fair (Discipline, Swansea).

Selection and Recruitment: Challenges

For the other five sites, selection processes were rarely straightforward. Of these, Styal's difficulties were the most pronounced. By the time the process evaluation staff interviews were conducted, seven DRW clients lived alongside fifteen 'lodgers' in a twenty-bed house¹⁰. All five of the DRW clients that we interviewed had longstanding difficulties with serious mental illness (see Section C), and none were due to be released within two years. No new DRW clients had entered the wing for over six months. One staff interviewee felt that this was entirely attributable to the wing's reputation:

We sometimes get a bad reputation from those that come off... Because we probably moved them for poor behaviour. So that spreads like wildfire (Psychosocial, Styal).

¹⁰ Styal was originally built as an orphanage for destitute children. The main prison residences consist of a single new-build wing and a series of large Victorian houses. Each house would have originally held a house master and a cluster of children in dormitory rooms. They now held groups of approximately twenty women in two- to four-bed rooms.

However, it also seemed likely that this reflected a broader withdrawal of resourcing and support for the DRW from the wider prison. Earlier phone calls established that Styal had undergone a wholesale reorganisation in the months leading up to fieldwork, leading to several changes of management. Drug services had also been recommissioned. DRW staffing levels dropped considerably (see Grace *et al.*, 2015) and referring and recruiting women became a low priority for the prison.

Across DRWs, some other problems were recurrent. First amongst these were 'lodgers': prisoners who had been housed on the DRW because they needed a cell rather than because of any stated interest in drug treatment. In a best-case scenario, lodgers were prisoners with identified drug and alcohol problems who might be open to treatment:

Because the unit is quite a big unit, what tends to happen, if there are spaces on there then we get them filled with lodgers. So people from reception that might have just said oh, yeah, they've got a drug or alcohol problem. But nobody has assessed them properly... (Psychosocial, Brixton).

However, prisoners could also be referred to DRWs without consideration of their needs, leading to large groups of (sometimes disruptive) wing residents with no drug problem:

We've just done a review on it now: we've got sixteen clients in the DRW that shouldn't be on there, that weren't referred by us, that we had no knowledge of (High Down).

I think sometimes the prison views the DRW as a bit of a dumping ground, so anybody who they are having problems with on another wing gets moved to us. That takes up a hell of a lot of my time, resolving issues like that. Which is frustrating (Brixton).

In a worst-case scenario, such prisoners could look down on drug users and trigger disorder:

You've got a group of people who actually want recovery, but a lot of the times... we're working with these guys but dealing with people who don't really want to be on here, who at times can be quite disruptive (Discipline, Holme House).

Several interviewees spoke of occasions on which known drug dealers had been allocated to DRWs. In Brinsford, this was a persistent problem:

[One resident] has been found twice bringing or dealing substances...and has been repeatedly moved back on to the wing (Psychosocial, Brinsford).

Indeed, Brinsford was one of the more troubled DRWs. Like Styal, it had suffered a withdrawal of both resourcing and attention. By the time of staff interviews, twelve DRW clients occupied a thirty-two bed wing. Few wing residents were ever purposefully selected; some had been housed there as lodgers, and were only considered DRW clients because of their historic engagement with prison drug services. At the time of interview, staff noted that several of these were engaged in open gang warfare and four had been placed in segregation following a serious incident two nights earlier.

Selection over Time: IDTS, Medication and Abstinence

The apparent challenges of recruiting OST recipients into abstinence-focused treatment units described above invites some consideration, and staff in Holme House had been reflecting on similar issues for some time. Two prison officers had worked in the prison's TC for over a decade and, in this time, had noted a prominent change in its client base. The TC had once been entirely filled with former heroin users:

Everyone that we got through our doors was all opiate. And we never seemed to have any problem with filling that, we never even thought about, we never had to worry thinking; "how are we going to fill, how are we going..." Because we just were [filling it]. We had a waiting list, that's how good it was (Discipline, Holme House).

However, the presence of heroin users on the wing had changed as IDTS and prescribing guidance came in:

Then I would say five years ago we started to think of people getting referred with alcohol, cocaine, antidepressants, mixed with cannabis, steroids. And at one point it tilted, we still had opiates so then most of the group work we were doing we were starting to think; this just isn't matching up anymore, everyone's coming in saying; 'I was heavily [using] alcohol, I started coke, mixing it with antidepressants, I was smoking cannabis and it was just...' And I said to [my TC colleague], me and him started thinking 'we're just not getting anyone with opiates now.' And, before we knew it, within a year the whole wing, we had three opiate users and over 60 with cocaine and alcohol, and we started thinking; this has just gone really... [IDTS] certainly started hitting, they seem to have been offered [medication] earlier... because they decided at what level intervention was required on in reception... We asked our manager, [name] at the time, we said; what's going on? We're running this programme and then on another house block we've got an absolute drain on our potential clients here, they're all getting referred to... short duration programmes and IDTS... And everyone we would have normally got referred to us were getting straight onto house block four and that was it, stopped it (Discipline, Holme House).

In the eyes of these officers, the availability of prescribing and the introduction of IDTS had created two discrete treatment populations. Those who could access OST were choosing to stay on either maintenance or very slow reduction regimes. Those arriving with any non-opioid drug of choice had no option of long-term medication, and were abstinent (and eligible for abstinence-focused services) by default. They were consequently accessing an entirely different set of services.

The separation of opiate and non-opiate clients was a particularly dominant issue during the rapid assessment (Lloyd *et al.*, 2014), and still clearly played a part in shaping Holme House's DRW during process fieldwork. As will be shown (See Chapter 6), the DRW continued to be dominated by OST clients, very few of whom sought (or achieved) OST abstinence.

Summary

DRWs adopted different approaches to recruitment and selection. Motivation towards change was the criterion chosen by most sites, with the intention of recruiting DRW cohorts who were considering abstinence. Contrasting with the rapid assessment (Lloyd *et al.*, 2014), only one DRW adopted OST status (an active OST prescription) as its paramount selection criteria. This caused some difficulties which, combined with an unfortunate division of staff responsibilities, made it hard to ensure that wing residents were motivated towards change. Staff in Manchester and Swansea also positioned DRW communities at the centre of their selection strategies, seeking to recruit prisoners who would work well together, and who were very highly motivated towards change. Finally, no matter how robust the strategies, real-world difficulties often complicated practical processes. Key amongst these were ‘lodgers’ – prisoners who had no drug-related needs, and who were housed on DRWs because they needed somewhere to sleep. In a worst-case scenario, such ‘lodgers’ could be highly disruptive.

Finally, two long-serving prison officers from Holme House’s Therapeutic Community (TC) provided some reflections on changes in recruitment over time, and the factors that made it hard to recruit OST clients into abstinence-focused interventions. The abstinence-focused TC had once been filled with prisoners whose drug of choice was heroin. However, the arrival of IDTS and enhanced access to OST had coincided with a switch to only being able to recruit alcohol, cannabis, and cocaine dependent clients. They thus saw the ready availability of OST as having a direct impact on the possibility of recruiting former heroin users to abstinence-focused interventions.

DRW Provision

This section focuses on the two main features that shaped DRWs’ provision. The underlying principles of the programme – its core ethos – determined the content of the groups that were delivered. The intensity of group programmes and the extent to which treatment cohorts were protected from ‘lodgers’ and unmotivated prisoners, then shaped the extent to which treatment programmes could engender trust between participants and support ‘deep’ change.

Core ethos

Two sites structured all DRW provision entirely according to well-established treatment models. In Brinsford, this was harm reduction. Every group centred on topics such as cannabis awareness, alcohol awareness, safer injecting, or blood borne viruses. As the team’s group facilitator described, this was premised on the assumption that DRW clients would return to using following their release:

They are gonna go back to the weed. They are gonna go back to the heavier drugs. But what I try to say is, give them the support systems out there. And also do it sensibly, so you’re not gonna be a statistic. You know, you’re not gonna hit the bulls-eye first time. You’re not gonna (Psychosocial, Brinsford).

Though this account suggested abstinence was a notional end goal, none of Brinsford's timetabled groups centred on anything other than harm reduction.

High Down took a diametrically opposed stance, targeting abstinence with a structured group programme based on the Minnesota twelve-step model¹¹. The following quotation explains how groups progressed, and is filled with twelve-step terminology and concepts:

We break it down. We write it out. Powerlessness, powerlessness, unmanageability¹². We look at each word, addict, come to believe¹³... and we ask them. We put it on the board and debate, "so, what does this mean to you?" We break it all down, and we look at that. And I think that helps them understand it. And then we do a step 2, step 3, and at the last week – just quickly – look at higher powers (Psychosocial, High Down).

This theoretical backbone of the group programme was further bolstered by a requirement to attend mutual aid meetings. Narcotics Anonymous, Alcoholics Anonymous and Cocaine Anonymous each delivered weekly meetings, and those engaging with intensive treatment were expected to attend all three irrespective of their stated drug of choice¹⁴.

The other five sites took a more *ad hoc* approach to developing treatment programmes. In Brixton and Styal, wide-ranging eclecticism was described as intentional:

I think it's a good thing... that it is so varied as a timetable, it's purposefully varied. That's why it is so, so you have 'po[sitive]s and neg[ative]s' on a Monday. You can't escape looking at yourself in that group. That's why it's there. You're looking at negative and positive behaviour attributes... And they give each other honest feedback. And Tuesdays, art therapy. And SMART. Wednesday, gardens. Thursday, structured group... We took off the gym and put in... different workers coming in and doing different groups (Psychosocial, Styal).

In Holme House, an early mix of harm reduction and community-oriented groups (was felt to balance expertise drawn from the prison's abstinence-focused therapeutic community with the needs of the DRW's more chaotic, transient treatment cohort. By the start of the process evaluation, only five 'induction' harm reduction groups remained.

Swansea and Manchester also offered eclectic treatment programmes, but for different reasons. Each had been developed by prison officers with little prior knowledge of treatment models, and who had no clear template (such as Holme House's TC) to draw on. Their treatment models were developed *ad hoc* and opportunistically, filling timetables with modules that looked potentially useful. In each case, officers' value systems and preferences played an important part. A 'holistic'

¹¹ Essentially the twelve step approach, adapted for treatment settings

¹² Step One: 'We admitted we were powerless over our addiction, that our lives had become unmanageable'

¹³ Step Two: 'We came to believe that only a power greater than ourselves could restore us to sanity.'

¹⁴ This is not an exceptional approach. Narcotics Anonymous centres on 'addiction,' rather than any specific drug of choice. Cocaine Anonymous adopts a similar line, and uses unadulterated AA literature (including the AA foundational text, also known as the 'Basic Text'). Professionals working within a twelve-step framework often approach mutual aid in a similar fashion, suggesting that people may benefit from attending a range of fellowship meetings. In many areas, this may not be a choice: AA holds considerably more community meetings, and more people with longer 'clean time' than either NA or CA.

module in Swansea's programme was developed by one officer, who prioritised person-centred treatment:

Holistic means that we speak and are concerned about the person as a whole, so I say to the group; what are you besides somebody who's been in active addiction? So sometimes they look around and I have to say: well, you're somebody's son, lots of you are a father. And then we look at...making the point that you're a whole person, your active addiction is one part of that person. ...I think it must be awful to just be...for somebody just to consider you to be your flaw... Some of the boys that are here are fabulous sportsmen, some are musical, some are brilliant with children (Discipline, Swansea).

Other modules drew other officers' particular expertise, whilst a full half of Swansea's programme was delivered by a third sector partner and consisted entirely of harm reduction.

Manchester had similar roots, with officers developing a recovery programme from scratch. It seemed significant that none of our Manchester staff interviewees were able to summarise the DRW's ethos succinctly. Reflecting the PE background of one DRW officer, physical fitness was central to the Manchester model. Other components included pragmatic sessions and resettlement support, peer-led groups, SMART recovery, and a week of victim awareness.

Intensity of treatment

Levels of provision varied greatly between sites. Brinsford and Holme House offered little DRW treatment. Brinsford's DRW relied on 'recovery plans,' which sought to match prisoners' needs to available groups. Consequently, the very small number of DRW clients meant dedicated DRW groups would not work:

It's very difficult at the minute to run psychosocial groups down there because we've got a limited amount of clients. They're not recovery planned for the same group at the same time type of thing, so that's a difficult one (Psychosocial, Brinsford).

Thus, all groups were held in a central location, and had no structured relationship with the DRW. Staff framed this in a positive light:

Obviously they're on the wing with their friends. ... And then they can go off and do their group and come back. So ... they've got the best of both worlds (Psychosocial, Brinsford).

In practice, particularly given the wing's violent context (see Section A) this left the DRW with little positive to offer its residents – at most, priority access to fortnightly mutual aid meetings.

Holme House's restrictions came from other sources. Following competition benchmarking, the prison's officer cohort was substantially reduced. The DRW lost some of its most experienced therapeutic officers, as they chose to take redundancy payments. Other officers found themselves routinely called to work on other wings, in order to ensure that a basic regime could be run. By the time of staff interviews, induction groups rarely ran; SMART recovery had been cancelled; a

continuing programme of groups was non-existent; and case management rarely took place. As one interviewee reflected:

We call ourselves a Drug Recovery Wing when we're not doing any drug recovery work. And that's a frustration... [We're] not working to our strengths, delivering the group work sessions, the peer mentoring, adding to what we do. We seem to have gone through a period where we've taken things away... (Discipline Holme House).

There were ambitions to restart the wing's therapeutic offering, but the then-current situation appeared bleak.

Swansea's therapeutic programme was marginally more substantial, with prisoners attending two two-hour groups each week. In addition to treatment, staff sought to provide prisoners with some additional time unlocked. However, the wing was premised on the principle of complete segregation from other wings. Drug Recovery Wing residents could not access work or education on other locations and so, with the exception of three wing cleaners, were locked behind their cell doors for the equivalent of six full-time days each week. From an outside perspective, this appeared to be a very sparse regime. However, MQPL results identified that prisoners were nonetheless happy – those DRW residents who regularly spent more than 6 working hours each day locked behind their cell doors were far happier with their quality of life than those on lockdown in other locations¹⁵.

Styal's offering was a considerable step up from this, with treatment groups occupying five mornings each week. During the rapid assessment, the DRW had been run to therapeutic community principles by seven experienced group facilitators:

So [our original contractor] had [the DRW] and [the] programmes [delivery contract]... And I think as a staffing group previously, they were all [trained in delivering] programmes. So the house ran in, in that way. Because that's where their training is, that's their expertise. Is in delivering groups (Third sector, Styal).

When a new contractor took over, the DRW's staffing cohort had been reduced to two people. Maintaining a substantive level of provision was consequently seen as a real achievement.

The final three DRWs offered highly intensive treatment offerings, though these were structured and accessed in different ways. Brixton's eclectic, full-time timetable was available to any DRW resident, including lodgers. Sign-up sheets were posted every week; those who put their names down first could attend. With topics as diverse as yoga, creative writing and men's health, this understandably attracted a wide audience. The presence of lodgers and the peripatetic nature of group membership then defined the limits of group work.

¹⁵ For full MQPL results, see Chapter 5. This specific analysis was carried out after hearing particularly positive accounts from Swansea's DRW, despite the very considerable amount of time residents spent behind locked doors. Independent t-tests were carried out on several core MQPL measures. On three out of five MQPL factors (Harmony, $p=0.003$; Professionalism, $p=0.010$; and Family and Conditions, $p=0.033$), and on one Quality of Life out of 10 variable ($p=0.048$), prisoners who were locked up >6 hours each day on the DRW ($N=23$) had significantly better scores than those who were locked up for >6 hours each day on other locations ($N=42$). Indeed, this is only a partial account – a very similar picture emerged when comparing DRW residents who were locked up for >6 hours each day ($N=42$) with *all* residents from other locations ($N=98$).

It's like being in a treatment centre or a rehab and having four guys come in, four people, and they're like: I don't want to be here. "This is all bullshit." So that obviously creates a bit of tension and breaks down those bonds that you've already got with the clients (Third sector, Brixton).

Staff thus remained wary of the dangers of taking groups and issues 'too deep.' As one reflected,

We don't go too deeply into what's going on, because you're talking about people who have been medicating probably from feelings for a very long time. So if something comes up, we need to make sure we can manage that (Brixton).

Structured intervention, then, was intensively scheduled but delivered with a light touch.

Both High Down and Manchester had intensive, cohort-based offerings. All group members started together, finished together, and went through the same structured full-time group timetable together. Tensions were proactively managed, with an emphasis on monitoring group processes:

We have a very open policy here. We don't let problems build up. That's why we have Our Time¹⁶, so they can talk to their peers in confidence and then that can be passed back to us and we can try to resolve any issues. We also say "any problems, come to the office and talk to us" (Discipline, Manchester).

This allowed for greater group cohesion, group trust, and therapeutic depth:

You don't have time to talk about their childhood. [But] you do one session on trauma, to help you connect with that... I'll say, "just tell me about your childhood, just talk me through it." And nine times out of ten there's been violence, there's been parents on drugs, and they've been in homes. It's awful (Third sector, High Down).

Though they shared an intensive, in-depth group focus, there was one key difference between Manchester and High Down. Manchester's RTG occupied a twenty-bed wing. Whilst twelve people underwent treatment together, the other residents were either programme graduates or awaiting the start of the next group. Contrastingly, High Down's DRW occupied a sixty-bed wing. Many residents would never access intensive treatment, and a third of all beds were occupied by non-programme 'lodgers'. In this context, Manchester's programme was far more immersive; High Down's residents returned to a relatively standard prisoner community at the end of every day.

Summary

DRWs developed their treatment programmes according to different principles. Of particular note, only two units – both led by third sector agencies – implemented programmes that were framed entirely by single, conventional treatment models (harm reduction, and twelve-step). Contrastingly, Brixton and Styal – again led by third sector agencies – developed eclectic programmes of groups. They described this as an intentional decision, purposefully adding variety to their timetables. The

¹⁶ A peer-led group

treatment programmes of the three officer-led sites were developed as more of a patchwork, with staff developing individual programmes according to individual expertise, or securing well-reviewed treatment modules from elsewhere.

Treatment programmes were also diverse. At one extreme, the only dedicated treatment Brinsford's DRW residents could access was fortnightly mutual aid. Holme House was in a similar position, notionally offering an 'induction' programme of five harm reduction groups – though during process fieldwork these had not been delivered for some time, due to staff shortages. In each of these prisons, DRW residents were expected to spend much of each day undertaking 'purposeful activity' – work or education – on other locations. Swansea and Styal's group programmes were rather more intensive. Styal's occupied five mornings each week. Swansea's only consisted of two groups per week, with residents on 'bang up' most of the rest of the time. Nonetheless, something seemed to be working particularly well in Swansea, as residents appeared to be particularly happy with their quality of life. Finally, Brixton, High Down and Manchester all offered full-time, intensive programmes. The potential of Brixton's programme was constrained by the presence of lodgers (and other unmotivated prisoners) in groups. However, High Down and Manchester both offered intensive programmes to small cohorts of highly motivated prisoners.

Recovery Champions

Alongside announcing an intention to introduce Pilot DRWs to adult prisons, the 2010 Drug Strategy announced that the Government would be....

...encouraging more offenders who have recovered from drug and alcohol problems to become mentors or 'Recovery Champions' (HM Govt 2010:12).

However, this theme did not appear with any strength in staff interviews; none identified senior peers as a mainstay of their treatment offering. Prisoners' perspectives on peers are presented in Section B.

Transfers and Moving On

This section provides an overview of pathways out of DRWs. It begins by reviewing exit pathways within prisons – the routes that DRW graduates might take, if they were not returning immediately to the community. It then proceeds to focus on two elements of aftercare and resettlement provision: in-house support delivered by prison workers, which was available as part of the prison regime; and partnerships with external third-sector agencies, who sought to pick up resettlement support where prison agencies left off.

Within prisons

Only one site, Brixton, positioned its DRW as the only end-point of treatment in prison. Unless they were removed for disciplinary reasons, Brixton's DRW residents served out their sentence and returned to the community from the wing. All other sites had a model of progression, mandated by

some sense of programme completion¹⁷. When DRWs delivered cohort-based treatment programmes, 'completion' could be easily defined. In other sites, it took on a range of different meanings. Holme House operationalized completion in terms of medication reduction: DRW clients could progress to the TC once prescribed fewer than ten milligrams of methadone per day. Perhaps reflecting the relatively disorganised state of their therapeutic programmes, neither Brinsford nor Styal offered any clear sense of what completion constituted. In an ideal world, both envisioned their residents reaching an undefined point at which they eventually moved elsewhere.

Progression within the prison could take one of two forms. Two DRWs delivering cohort-based programmes (Manchester and Swansea) offered a small number of full-time worker and mentor positions, which allowed clients who had made good progression to stay on the wing and continue contributing to groups. Styal had no structured arrangements for progression at the time of staff interviews, but aspired to implement something similar. At the time of interview, ideas remained vague:

We're still developing what that [mentoring] role is, so in my mind... when we originally looked at it, what we'd do is... we'd do the training. We let allocations know so we can keep them on [the DRW], and then we do appointments, co-facilitation of groups and supporting people coming on. Doing some of the file work with them. Doing the induction really. And explain some of the, what the file's about, what the house is about... (Third sector, Styal).

Alternatively, wings could look to transfer programme graduates to other locations. As mentioned above, Holme House offered clear progression from its medication-focused DRW to its abstinence-focused TC. Brinsford and High Down aspired to support DRW graduates in moving to enhanced locations:

The governor has now said that actually once they finish Bridge, if they're working and they want to move houseblocks, [they can transfer] to houseblock 5. Which is now the workers enhanced unit (Third sector, High Down).

Swansea had historically transferred its graduates to the prison's Drug Free Wing, and (for the handful of residents who were not immediately released) Manchester transferred graduates to a voluntary testing wing.

However, in nearly all institutions a distinction had to be drawn between ideal and actual progression. Approximately one and a half years elapsed between the Rapid Assessment and final staff interviews in Brinsford. Throughout this time, staff spoke of their hopes to establish a route of progression to the prison's enhanced units. Yet confounded by difficulties within the prison and a troubled and disintegrating DRW, no more than a couple ever made the transition. A similar

¹⁷ This was qualified in Manchester, where the DRW's explicit goal was to support residents through the release process. However, the wing's cohort model meant that a small number of people finished DRW treatment with time left to serve, and these mostly returned to the prison's voluntary testing wing.

situation emerged in Holme House, where DRW residents were not reducing their medication enough to transfer to the abstinence-based TC¹⁸.

Data secured during the rapid assessment identified that of 112 DRW completers in 2012-13, three people transfers to the TC. No-one had transferred thereafter.

In High Down, staff were wary of progressing programme graduates to other locations, as over one-third of DRW beds were filled with lodgers. Transferring more clients elsewhere would have meant yet more beds filled with people who had no interest in drug treatment. Additionally, mutual aid meetings were only held on the DRW, and these were felt to offer ongoing support:

You need to give them access to fellowship meetings. [Sending graduates elsewhere] would mean they need to be coming back on here, or you move the fellowship meetings to a central location that everybody in the prison can attend (Third sector High Down).

Staff consequently resisted transferring graduates:

We don't want to just move someone off if they're in recovery and doing well with us. We want to be able to find them a space in the wing (Third sector, High Down).

Early intentions to move graduates to other locations were thus seen as practically problematic.

Contrastingly, Swansea's progression pathway was removed by the prison. During a restructuring process, the Drug Free Wing ceased operations and DRW graduates began being dispersed to general population wings instead. Staff sought to present this as a positive opportunity for DRW graduates, testing out their coping skills:

I: [How has the loss of the Drug Free Wing worked in your experience?]

R: Not very well, I must say. Because [clients'] attitude is "oh, you've given me all of this now and you're sending me back up there." But then we've argued with them that "up there, outside, what's the difference? You have got to cope wherever you go." So we're trying to sell them that at the moment, that even though they're going back up to A Wing or D Wing they've still got the responsibility to say no to substances, and to be responsible for their choices (Discipline, Swansea).

Nonetheless, the loss of the wing was clearly a blow for some of their clients:

I remember taking one of the lads ... and putting him back on the fours [the fourth floor landing]. A4. And I felt for the guy. I thought, "we're just dumping him back up there." I thought, "this isn't right" (Discipline, Swansea).

The extent of this loss should not, perhaps, be overstated. Swansea worked with twenty-four person treatment cohorts. Even in the most optimistic of situations, transferring all twenty-four to the DFW

¹⁸ Prior to 2013 and the rapid assessment, the TC only accepted prisoners who were fully medication abstinent. Shortly before the rapid assessment, this was changed so that DRW residents could move to the TC once they were prescribed 10mls of methadone or less. The change was implemented so that detoxifying prisoners had additional support from those who were already abstinent.

had never been realistic. The loss of the wing consequently represented a partial loss of therapeutic progression, rather than the wholesale removal of universal support.

Release: In-House Throughcare Workers

The second route of progression centred on prisoners who returned to the community directly from DRWs. All DRWs had some form of release-focused provision in place, with the exception of Styal. Styal faced no immediate pressure to develop any such arrangements, as during final interviews no DRW residents were within two years of release. In other sites, release provision took two forms: prison employees who supported prisoners through release; and partnerships with external agencies.

Three sites had implemented models in which DRW staff supported prisoners after release. Holme House had originally deployed five prison officers as dedicated DRW 'IOM link workers,' with each dedicated to building resettlement resources within a defined release area. To the chagrin of DRW staff, following benchmarking this level of resourcing had become unsustainable:

We had five IOM workers in the major areas, which has gone down to two. Well, that's sending out the wrong message straightaway. They need picking up at the gate, they need taking out of the community, they need better accommodation setting up, they need better places, they need help with their benefits: so from day one they've got something they can manage on, they've got a little bit of money, they've got a place to live, they've got some food, obviously a prescription if they're on a script (Discipline, Holme House).

Both Brinsford and Manchester sought to offer a similar level of continuity, though each site did this by allowing prisoners' case managers to support them through the prison gates. Across all sites, Manchester's model comprised by far the most robust through-the-gates support. Indeed, this aspect of provision was seen as so central to the DRW's operational model that it had been rechristened 'Recovery Through the Gates.' All staff emphasised the key importance of providing a familiar face at the moment clients returned to the community:

A lot of the lads, even the initial hour...never mind that hour, the first ten minutes - when all of that good work that you've done is there. They get down to reception. They're waiting in that room waiting to get out. And then all of a sudden, that tentacle of the past life comes to tickle the back of their brains (Discipline, Manchester).

An RTG case manager offered an illustrative case study:

I've had one person where literally, I've sat in the car, they went in the shop and never came back. And the bizarre thing was he was under no conditions so he was running away from something where he just didn't have to. He could've just said: 'look, [name], I really need a bit of time on my own.' That would've been fine, but I don't know if he was embarrassed but I've never seen him again. No phone, no nothing (Discipline, Manchester).

A level of ongoing contact and support was then offered for a minimum of three months, and often more:

We act as a backup service. If there's a problem we can do some mentoring or we can pop out (Manchester).

Through the gates work had become more difficult following benchmarking and the loss of what was seen as a supportive governor. Nonetheless, it was still a central component of RTG's treatment.

In principle, Brinsford's model worked on similar principles. Post-release work was still in the early stages of being developed. However, several staff members had accompanied clients to appointments at drug services, probation or housing agencies.

We phone a lot more lads when they're getting out, see how they're getting on. They all have DIP appointments, I went and met withal lad on Friday, got released two weeks ago. Met him and went to his appointment with him (Third sector, Brinsford).

This service was not an exclusive DRW service, but was available to all Brinsford releases. However, it stood out as an example of a positive change: at the outset, Brinsford's DRW offered no resettlement support at all.

Release: Third Sector Partnerships

With the exception of Styal (for the reasons described earlier), every DRW had some external resettlement partners. With few exceptions, they presented these as wide-ranging both geographically, and in terms of the support offered.

We have a lot of organisations that we're linked with: that we can refer into, in different areas ... The links are good. And [our administrator] and that do research to try and find something in the area if we're not familiar with the area (Third sector, Brinsford).

Two officer-led sites presented a slightly different picture. Prison-wide drug teams took responsibility for resettlement in Holme House and Swansea, leaving officers disengaged:

I don't hear about [aftercare]. I know there's a lot more done than it used to be, the DAAT teams sort of pick up the baton and run with it after we sort of finish our little bit (Discipline, Holme House).

I: Is aftercare good at the moment?

R: I'm sure it is but then... that information isn't being fed back (Discipline, Swansea).

Insofar as challenges were identified, they centred on three themes. Firstly, robust partnerships could be hard to establish when prisoners were released to a wide variety of areas. Brixton, for example, regularly released prisoners to 52 local authorities:

To be really honest it depends on what borough you're from... Like Tower Hamlets, Lambeth, very proactive about coming in....They'll come in and do a bit of work with them

Whereas other boroughs which are just a nightmare to get to come in to do that because they haven't got the staff or the resources (Third sector, Brixton).

Secondly, housing cropped up as a perennial concern, even in DRWs that otherwise had access to a broad range of resettlement support.

I started talking to him one day, I said '[name], have you not had enough of this yet?' He said: 'yeah, but what chance have I got? I go out, they put me in a hostel up the road and to be honest it's a hole of a place, surrounded by drug dealers, people who are getting out from Holme House...' And that's his life... He hasn't got that permanent fixture in this life just to take him away from this. It's just like as soon as you get out, you're just going straight back in the lion's den and you're living with people who are dealing. It's a coping strategy for him: he started taking drugs, started drinking alcohol again... And he ends up coming back to prison (Discipline, Holme House).

I: What are the biggest gaps in terms of aftercare provision?

R: I'd have to say accommodation really. It's always an issue, accommodation, always, always will be because by the time you've got somebody that's been in half a dozen places and burnt their bridges there where, do you put them? It's really hard (Discipline, Holme House).

Finally, staff widely commented that funding cuts had made it progressively more difficult to secure robust resettlement support. Staff in High Down reflected that an apparent lack of buy-in from resettlement agencies made it very hard to encourage prisoners to attend pre-release meetings:

We used to do a keywork meeting with eight weeks until the clients got out... [But] we were getting to the point where it was just the case manager, maybe someone from treatment or probation work that would turn up. And then some clients were feeling well, what's the point in this? Nobody has turned up, which clearly shows maybe they think I'm not important enough (Third sector, High Down).

Summary

Theoretically, nearly all prisons had transfer pathways for DRW graduates. These tended to centre on referrals to enhanced locations or other treatment units (including voluntary testing wings). Several sites also offered a small number of graduates the opportunity to stay on as mentors or 'peers.' In practice, transfer pathways were rarely realised. Swansea's drug free wing closed. High Down staff were wary of transferring DRW graduates to units where they would receive minimal support. Styal's open-ended programme had no working model of 'graduation,' and Brinsford and Holme House both struggled to progress DRW residents to a point where they could 'graduate.'

Several prisons also provided in-house support for prisoners who were returning to the community. Holme House's DRW had originally accessed five dedicated 'IOM link workers,' tasked with establishing resettlement partnerships in five key release areas. Brinsford and Manchester worked to slightly different models, with DRW case managers offering some practical support (e.g. lifts to / support during meetings) to released residents.

Most DRWs also had resettlement partnerships with third-sector agencies. These tended to be seen as both broad and supportive, though therapeutic discipline officers identified that they were not always informed of resettlement work. Across the board, housing was identified as the most challenging area to secure meaningful support in. Staff also voiced some concerns that cuts in funding had led to a reduction in the resettlement support they could access.

Challenge and Change

This section reviews the challenges identified by staff in establishing and sustaining an operational DRW. These very often came back to one theme: staff shortages following changes to national policy, and the perceived impact this had on a wide range of operational issues (see Chapter 3). We first describe the impact of reductions in prison officer numbers arising from two national reviews of prisons' staffing and conditions on all DRWs. We then proceed to explore the impact of these changes on officer-led sites, which were more vulnerable to changes in officer numbers. After this, we proceed to review experiences of recommissioning, wherein service providers were occasionally replaced, with potentially serious implications for DRWs' operational models. We conclude by reviewing staff perspectives on three levels of managerial support: NOMS, Number One Governors, and other governor grades.

Staff shortages: Fair and Sustainable, and Competition Benchmarking.

As introduced in Chapter 2, two major reviews of staffing, pay and conditions impacted on DRWs during process fieldwork: 'Fair and Sustainable' and Competition Benchmarking.

Across all DRWs, the resulting decline in prison officers numbers were identified as seriously affecting treatment. As a manager in Holme House reflected...

The benchmarking period took our good staff. There was four... off the TC staff that left... And then I got another three or four off the DRW.... And then they just felt they weren't getting no pay rise, more political things were going on and it was a case of trying to keep them motivated and to keep them working (Discipline, Holme House).

Similar concerns were raised in every site except Styal, and caused a range of problems.

- With discipline:

...we do get detached staff [from other prisons or units] but... they don't know the prison and they don't know the lads. The lads can take the mick with them as well...because they don't know them (Third sector, Brinsford).

- With maintaining segregation:

Now the new regime's happening... during lunchtime, that gate [separating the DRW from another wing] is left open and [the DRW] is just a part of A wing. That happens a lot at weekends. It happens during evening association. So I might remove somebody from the

unit because their goal is not recovery, and I'll come in at lunchtime and I'll see them quite comfortable in the unit, and there's nothing I can do about it. Those times, it doesn't feel like a recovery wing (Third sector, Brixton).

- With the delivery of therapeutic groups:

We normally have a CA meeting on Tuesday afternoon ... I was told this morning that we may not happen because we've only got four officers... Over the last two months, virtually every week I've had a fellowship meeting cancelled because of the lack of staff (Third sector, High Down).

We lost about thirty officers. So that's really kind of impacted on the regime... Sometimes we can't run groups because there's not enough staff [to unlock them], or we can't get prisoners out because there's no staff [to maintain order] (Third sector, Brixton).

Interviewees in several locations further noted that changes to regime greatly affected prisoners:

They come in really angry: 'I haven't been to the gym', they're supposed to get three gym visits a week, and it's all about this... un-thought-through decision to lay off all these officers... So there's a lot of anger (Third sector, High Down).

This, in turn, affected groups. Staff might have to work through group members' immediate feelings of anger and disappointment, before they could progress to delivering any planned group content. In sum, reduced officer numbers impacted on every area of DRW provision that relied on officers; and this comprised nearly every aspect of DRW regimes.

Officer-Led Sites: Fair & Sustainable, Competition Benchmarking, & Changes to National Policy

Four sites developed models that were highly reliant on therapeutic prison officers: High Down, Holme House, Manchester and Swansea. In Manchester and Swansea, discipline officers were commissioned to deliver therapeutic work by health commissioners (originally as a part of CARAT or prison-wide psychosocial teams). For such staff, therapeutic work was the mainstay of their role. In Holme House and High Down, very small groups of officers were drawn in from other wings, and freed up from a portion of their disciplinary duties in order to deliver some therapeutic work. Only two such workers were made available in each prison, delivering no more than one or two groups each week.

In Holme House and High Down, Benchmarking and Fair and Sustainable effectively removed the prisons' capacity to 'free up' staff. In High Down, officer-led provision (a mixture of SMART recovery and *ad hoc* groups according to perceived needs) was completely withdrawn when the DRW changed location in early 2013. This, however, was not a critical blow, as officer-led therapy had always been a small component of High Down's provision.

Holme House found benchmarking harder to negotiate. Across the prison, staffing numbers fell:

You need the staff to deliver [a DRW]. Last year the ratio was something like one in twenty something, twenty three I think, now it's one in thirty (Discipline, Holme House).

The skill-base of the DRW's staff cohort also changed drastically:

From the staff that were trained I had... 24 staff up here, eight staff on the TC and 16 staff trained up in basic drug recovery work [who] could deliver group work and were gaining a great understanding from in-house training and experience. I was left with two out of the 16 from the originals, I was given staff who came up here who had no interest... (Discipline, Holme House).

This led to a considerable period of time with no groups running at all:

I: So benchmarking had a...

R: Huge impact.. Huge, huge impact. Well, it just... up until Christmas there were still groups going on. Still key work going on. Referrals were fine. And then after Christmas, new regime, benchmarking... just decimated it (Discipline, Holme House).

Swansea's DRW had been similarly affected by benchmarking::

Since benchmarking there is no fat to the bone. As soon as somebody goes sick or... a prisoner has to go to an outside hospital, it has a profound effect on everything in the establishment. And we are seen as an easy target (Discipline, Swansea).

As in Holme House, the availability of individual staff members could no longer be protected, making it impossible to guarantee that a full programme of groups could be delivered, or that clients could be offered continuity of care.

Alongside Fair and Sustainable and Benchmarking, an additional change to national policy brought some potential benefit to Holme House's DRW. This redrew prison officers' roles so that they could no longer deliver therapeutic work (see policy chapter). The reasons for this policy were poorly understood by many staff, and it came as a blow to those who were heavily invested in therapeutic work:

I think the biggest problem has come with not having the clarity from why we lost the Prison Service staff (Discipline, Holme House).

Eight longstanding and highly trained officers were consequently no longer able to fill commissioned therapeutic roles in Holme House's therapeutic community (TC). However, three of these officers had transferred to the DRW. Whilst they would formally be employed in standard disciplinary roles, there were hopes that they would be able to find some time to rekindle the DRW's group provision and case management.

Manchester's DRW officers were similarly affected, but had no alternative therapeutic roles to move into. Long-serving officers felt that they had seen the officer's role progress substantially in a direction they believed in, only for this to be subjected to sudden, radical change:

When I joined the job it was...almost frowned upon to be involved in any kind of work of this nature. And it's taken a long time for people like me to be turned around and to think: no, no there is more to the job. You can get involved. You don't. You don't need to just do the very basics; you can do a lot of interpersonal work. You can do a lot of. You can do a lot of good... And gradually they've made it so that officers are involved in rehabilitation and they know about rehabilitation. And they seem now to be saying 'no, prison officers core work is...security: putting people behind doors. Making sure people get visits. Making sure people get... the meals. Making sure people go to work and are supervised.'

The terms Manchester's officers used to describe the loss of their therapeutic roles were visceral and physical: it felt like a 'kidney punch, 'being winded,' or a 'real kick in the teeth':

It's just a complete and utter nightmare, I feel like the whole...the team is in a bit of chaos really, because we've...I feel like because the governor and NOMS don't want us to run this service, they're, kind of, not really interested in us anymore... I mean we're very, very positive down here, we never take anything as...the one thing that did our motivation when they told us it was going private, and that was a... we'd spent 12, 14 months building a model up that we thought was a really good model, we were gearing up to win the bid, we'd done all the figures, we knew we had a really good chance of winning the bid because of what we were delivering and we were really ready to go. And just for your boss to come in and say; you're all coming out... We took a big hit with that and we couldn't really...we were in shock for a while, we just couldn't get our heads around what was happening (Discipline, Manchester).

Officers were sceptical of the reasons for this move. They believed that they brought significant additional benefits to the role, and attributed the reasoning behind the policy entirely to financial savings:

It's come from the top, it's come from London: NOMS, the very top minister, basically my personal opinion is they've looked at it and thought; we can get this service a lot cheaper. If I'm paying an officer...an officer's on, say, roughly £30,000, a drug worker could be on £15,000 to £16,000. - so that's a massive difference, so for one of me they could have two people. That's my view of why they're doing it, to basically get us back on the landings and then take it out to private providers and have it more community based (Discipline, Manchester).

For committed therapeutic officers, this change in national policy felt like more than a procedural change. It also carried emotional connotations, signalling a perceived end to an era of officer-led rehabilitation.

It's got to a stage now where for me it's taken a lot of the good stuff away and that seems to have affected the staff, with them just thinking "well, all they want us to do now is come to work, open the doors and let them out and then when they want locking up again we'll lock them up" Whereas before there were more interventions going on and good quality stuff. Where something's had to go, it's a lot of the quality stuff that's gone. Which is a big frustration (Discipline, Holme House).

Recommisioning

For Manchester's DRW and Holme House's TC, recommisioning was synonymous with national changes to the prison officer role. Officers could no longer be commissioned to deliver drug treatment; new services had to be brought in. If job descriptions remained the same, then officers could notionally transfer to new providers with their conditions of employment protected. However, this was unlikely to be the case. Contractors were looking to employ frontline drug workers, not discipline officers – several of whom had over twenty years of accrued benefits and service. Reductions in salary and benefits were expected to be harsh and, in consequence, only one interviewee was seriously considering leaving the prison service:

I applied for a job outside the prison service... The thought of working on a wing...in a traditional role as it was...for a further ten years. Fills me with horror. So: it was for working in, working for the NHS...as a recovery worker... I would have had to negotiate top of the pay scale orr next to it. Still taking a cut but not so much that I couldn't cope. And then I thought who knows where the opportunities will come - you know years down the line (Discipline, Manchester).

Three Holme House officers had the option of transferring to standard officer duties within the DRW. All other therapeutic officers were looking to return to standard disciplinary duties elsewhere.

In practical terms, this meant that officer-led DRWs faced a complete break in provision. Staff groups and lines of accountability would change completely, as new providers came in. New providers would also have no compelling rationale for maintaining existing timetables or programmes. Interviewees consequently thought it would take some time for DRWs to get off the ground following recommisioning:

With the best will in the world, they've got no experience of doing this... There's no knowledge of how a prison works. There's no knowledge of how prisoners work -how they are with you...to come in with no knowledge at all is going to be hard for them, and I think they're going to struggle (Discipline, Manchester).

For other sites, recommisioning could have effects that were just as drastic. Brinsford's services were recommissioned in 2012. As a part of this, NHS contracts were taken over by a new contractor. Staff were given the opportunity to re-interview for new posts with substantially lower salaries; and all but one chose to seek employment elsewhere. As such, the team that bid to run the DRW was no longer in post; no manager was in post for approximately four months; and the entire prison had just two drugs workers for approximately six months.

Though Styal's recommissioned contract passed from one third-sector agency to another, this still triggered a wholesale change in DRW provision. The original contractor had longstanding expertise in delivering therapeutic communities; and during the rapid assessment, its well-staffed and tightly-structured therapeutic community was identified as one of the most promising operational models across sites. By the time the process evaluation had started, another agency had taken responsibility

for delivering the psychosocial drug services' contract. Staff had been re-allocated to prison-wide services. The TC operational model had been abandoned as unworkable.

Managerial support: NOMS

When describing the support they felt they needed from managers, interviewees commented particularly on the role of NOMS. These comments fell into two categories: those that identified NOMS as the progenitor (and absentee 'owner') of DRWs; and those that held NOMS responsible for the development of an increasingly challenging working environment.

In the first category were several interviewees who said they had had very little contact from NOMS:

[NOMS?] I've personally never heard anything (Third sector, Brinsford).

Discipline officers were particularly vocal on this front. Senior staff in Swansea, Holme House and Manchester said they felt abandoned or deprioritised, particularly after a burst of attention in DRWs' earlier days:

It's almost like you're a forgotten little project. You're a pilot project and you kind of feel like, 'no. This is the time where we should be looking at how to make it work, and what resources and stuff like that.' And I think people bang those thoughts around, but the actual delivery of that I just don't think it materialises (Discipline, Swansea).

The team is in a bit of chaos really, because we've...I feel like because the governor and NOMS don't want us to run this service, they're, kind of, not really interested in us anymore (Discipline, Manchester).

From the outset, NOMS contacts and NOMS-sponsored meetings between DRWs were intended to tail off as the pilot programmes progressed. However, interviewees were not aware of this, and often felt as if support, networking opportunities, and meetings to share best practice had been unexpectedly curtailed.

Reflecting a trend that stood out across sites, discipline staff particularly yearned for more clear guidance and structured input:

I: Would guidance have been useful?

R: Oh yeah [laughs] If the prison service had turned around and said "this is recovery, this is what we want you all to run, these are the sessions or the programmes that we want you to run." Great! We've had to invent our own programmes (Discipline, Swansea).

Conversely, third sector workers were more inclined to welcome flexibility; though managers still lamented the disappearance of NOMS attention:

I: And NOMS?

R: Do you know, I can't remember, I think the DRW has almost died apart from you guys coming for your evaluation, we get no support whatsoever thankfully, because I don't actually see [NOMS] any more [laughing] (Third sector, High Down).

Beyond a perceived absence of attention, interviewees also held NOMS responsible for prisons becoming increasingly difficult working environments. In the wake of Fair and Sustainable and Competition Benchmarking, the frequency and levels of change were a particular target:

Any uncertainty for a prolonged period is no good for anybody: you can perhaps do a week or two, maybe two, three months. But this has been going on for 18 months now and the conveyor belt of change being handed down from NOMS has been at such a rate that it's actually undermining the fundamental principle of change: you change something, you let it happen, you review it, then you go back. They're just basically putting change on top of change and we've not seen the effects of this change, so we've got fair and sustainable, right, benchmarking and market testing, a new core day, there's been no, what I'd call, steady running of the ship (Discipline, Manchester).

Officers in Swansea and Manchester grounded these levels of change in local, historical contexts. In this, they described multiple, brief, promising pilots that were started with enthusiasm; but which had little chance of becoming sustainable, no matter how successful they were:

As an officer, you see it so much. We had [a rehabilitation] unit. It was praised all over the country. We started one off, and I think it was the first one in the country when they'd done it, and it was working, and there was people, they had success story after success story. And when it suited them, it was just gone (Discipline, Swansea).

Viewed from within this perspective, all innovative projects were felt to be vulnerable to capricious fortune; and the long-term prospects of DRWs were felt to be compromised from the outset.

Managerial support: Number 1 governors

In principle, by the time of the process evaluation interviews DRWs were commissioned drug services. They were paid for by health commissioners and, particularly following changes to officers' roles, were managed outside the purview of disciplinary chains of command.

Nonetheless, governors could have a substantial impact on both the day-to-day running and long-term sustainability of DRWs. In rapid assessment interviews, enthusiastic number ones were identified as the key driving force behind DRWs in Bristol, Chelmsford, High Down, and Manchester. However, by the time of the rapid assessment, three of these governors had already left. In Bristol, officers were already mourning the loss of their 'golden age' of provision (see Lloyd *et al.*, 2014) and the Drug Recovery Wing closed shortly thereafter. Following the arrival of a new governor in High Down, the DRW physically relocated. Where once it had been housed in an enhanced accommodation block, it was now positioned in a run-down location next to the prison's full population of individuals prescribed methadone or Subutex. This was intended to promote the DRW's engagement of former heroin users: a particular priority for the new number one (see Page *et al.*, 2016). Finally, by the time of process interviews, Manchester had undergone five changes of

Number One during the DRW's existence. Frontline staff felt that this had stripped them of clear pathways for securing resources and support: though (as the next section describes) the loss of their drug strategy governor came as an even greater blow.

Staff felt that Number Ones affected the running of DRWs in three main ways. Firstly, by the prioritising or deprioritising of various strands of prison work:

The whole prison is geared, at the minute, towards education. We come second, well, third: to education....and employment. That kind of thing. Their big drive is that, and then we're a small package towards the end (Third sector, Brinsford).

Secondly, and relatedly, the support given to a DRW by a Number One could affect the viability of provision on the wing. 'Additional' interventions that required a level of extra staffing or support were particularly vulnerable:

You see... the prison has a different agenda to us. Their agenda is security, and that's it... And they have less resources, sometimes they won't be able to have a group because they don't have another officer. So there's only one officer so they will not open. We used to have problems getting NA meetings into the prison... because the regime doesn't allow for people to be here in the evenings. That's the regime, they can only be here for certain periods of time (Third sector, Brixton).

Even the most fundamental elements of prison drug work could be obstructed, if prison priorities lay elsewhere:

Last Wednesday afternoon, the number one governor told me that I can no longer see any clients in any house block but House Block 4..... It's because he doesn't have the staff to unlock clients in other house blocks... (Third sector, High Down).

In High Down's case, this meant that the prison's drug team would be unable to provide support for anyone but the c.180 prisoners housed alongside their team offices. In a prison holding around 1,200 people, this was a real concern.

Finally, without governors' support, DRWs could be allocated 'old school' discipline officers who had little faith in rehabilitative interventions. A third sector worker in Brixton described how this could affect the DRW:

The governor needs to grab the bull by the horns, go: "ok let's have a look at who's being deployed here. Let's have a look as to the reasons that this person's potentially not suitable." When I go on the wing and I've been here over 10 years so I know most people, I always ask them., "how do you find it on here?" These are uniformed staff. And they go, "meeeeehhh, it's like rubbish innit, bollocks innit, it's just there, there's more drugs here than anywhere else." You get all these kinds of negative comments (Third sector, Brixton).

As wing officers were a constant presence on the DRW, this presented a real concern.

In sum, whilst the therapeutic elements of Drug Recovery Wings were not paid for by prison budgets, Number One governors and prison priorities could substantially affect their operations. And in so doing, could greatly affect their viability.

Summary

Two main processes affected prisons' staffing levels during the process evaluation. Both Fair and Sustainable and Competition Benchmarking contributed to a 41% reduction in officer numbers across the prison estate (Howard League 2014). This affected all DRWs in some ways, complicating discipline, the maintenance of order, basic issues of programme delivery, and key features of some wings – such as segregation. The impact of these changes on sites with officer-led DRWs were even more noticeable, and were exacerbated by an additional policy which prevented officers from working in therapeutic roles. Holme House, Swansea and Manchester had all had to drastically re-envision how their DRWs would work, and officers who were returning to standard disciplinary duties often mourned the loss of opportunities to take on more caring work. Finally, recommissioning was an ongoing issue for all DRWs. Officer-led sites were facing a wholesale change in provision – if they were to be sustainable. However, recommissioning could also impact on the staffing levels and operational models of any Drug Recovery Wing. Brinsford appeared to have never fully recovered from a challenging recommissioning process at the outset of its DRW's life, whilst Styal's highly promising therapeutic community had been replaced by a more limited programme of groups overseen by less than one-third the number of staff.

Across the board, and at all levels, interviewees described a sense that they had lost managerial support. Though NOMS had originally offered a level of support for the first tranche of DRWs, none of our staff interviewees had received any further contact since the start of the rapid assessment. The loss of opportunities for DRWs to share best practice was widely mourned; and discipline staff, in particular, identified a strong desire for clearer guidance on what DRWs 'should' look like.

Number One governors were also identified as a prominent force in DRWs' sustainability. Whilst they were not directly responsible for commissioning DRWs, the decisions they made could affect every other aspect of a wing. Location, resourcing, and the availability of staff were three issues that were particularly highlighted here

Section C: Prisoner Interviews

This section provides the analysis of the prisoner interviews which were undertaken while prisoners were still within the DRWs. It begins by briefly describing the samples interviewed and proceeds to explore several dimensions of recovery capital¹⁹: family of origin; education; employment; and

¹⁹ Defined by White as 'the quantity and quality of internal and external resources that one can bring to bear to initiate and sustain recovery from addiction' (White and Cloud, 2008:29)

mental health. Subsequent sections explore their index offences and offending histories, drug use, experiences of DRWs, and aspirations for the future.

Interviews: overview

In each site, we sought to interview ten DRW residents who were due for release within four weeks. In Brixton, High Down, Holme House and Swansea – large units with high levels of turnover – this proved straightforward. Securing ten interviews from Manchester – a very small unit with a cohort-based treatment model – required more fieldwork visits, but was readily achieved.

Securing full samples from Brinsford and Styal proved more challenging due to the local challenges each unit was facing. Each held very few clients, with little throughput.

Table 6.2: prisoner interviews

Prison	Prisoner interviews	Mean age	Mean sentence length (months)
Brinsford	7	19	18
Brixton	10	31	24
High Down	12	31	20
Holme House	12	35	24
Manchester	10	38	26
Styal	5	42	40
Swansea	10	31	12

Recovery Capital: Family of Origin

Physical and sexual abuse

Experiences of difficult childhoods were the norm, and were one area where gender appeared potentially significant. Only two interviewees identified that they had been sexually abused in their childhood. Both were in Styal, with one woman describing a particularly harrowing situation that persisted until her late thirties:

I: What did your life look like before you came in here?
R: Well I was being abused by my dad still, sexually... And he was threatening my life. I had no friends, I used to sleep on a mattress on the floor in a flat that I had and my dad had access to get to me whenever he wanted... But because of my mental health issues, I used to take drugs to try and suppress what was going on and to block it out... I was suffering from psychosis and I think because of my dad bothering me all the time I couldn't get away from him so I didn't want any friends in my life to see what was going on to me.

Perhaps unsurprisingly, this interviewee described having a primary problem with historic abuse rather than drug use *per se*. She had not begun using drugs until she was thirty, and identified that by far the most useful prison-based services had been the support groups provided by the National Association of People Abused in Childhood.

Whilst no male interviewees described childhood sexual abuse²⁰, a handful of interviewees described violent upbringings. Such accounts were stark, describing extreme and persistent physical and emotional abuse that clearly impacted on every aspect of young people's lives:

My dad used to like batter the fuck out of me... I mean he used to proper fucking lay into me and that... After that I got to about the age of 13 it didn't really bother me. I was like, I would... come home, know what's waiting for me, walk in the door, get battered... Come back the next day, same old shit... I went to a pretty rough school and... fucking I was fighting loads in there... I'd be looking at someone and think "you could not hurt me as much as my dad's hurt me". So I thought fuck it and... I'd have like 2, 3 fights a week in school. And fucking got kicked out of school. Went to loads of different centres. Got kicked out of all of them. Went to college got kicked out of there and then just thought fuck education, you know what I mean. Not for me. And then I got to the age of 15 (Brinsford).

I was abused by my dad, beaten, physical beating, verbally abused. Put in kids homes and then started a life of crime, as you'd say... What my dad did to me, he'd be - if they'd brought the laws out they've brought out now... he'd be doing time (Manchester).

Such accounts were, however, in a minority. Whilst it is likely that some interviewees chose not to disclose historic abuse, the majority described childhoods that were neither abusive, nor gilded.

Parental separation, and family bereavements

In nearly every site, experiences of parental separation or divorce were more prevalent than experiences of secure and stable family units²¹. A small number saw this as incidental to their later life:

²⁰ One prospective Manchester interviewee did identify that he had been sexually abused in his childhood. He chose not to participate in this study as he felt too vulnerable to be interviewed: he had recently disclosed, was finding ongoing discussions with his solicitors and the police very hard, and was approaching the end of a methadone detox.

I never met my dad, which wasn't an issue. Never has been, because I had a nan who was amazing... to be honest with you, I had a really good upbringing. Really good (Styal).

Others, however, situated parental separation at the root of their problems, triggering emotional upset, offending, and drug use:

I came from a broken home really, I'm the eldest of four and we moved around a lot when I was a kid and my mum was an alcoholic and we had guys flitting in and out of our lives and I ended up in care like at a pretty early age. I started experimenting with alcohol when I was about 11, discovered amphetamines when I was 13, started IV using when I was 13 and just never looked back from there really (Prisoner, High Down).

They separated, never divorced... I started off shoplifting and then after that it was burglary, shop burglary, getting the cakes out of Greggs, and then after that... (Holme House).

Other themes also became prominent. Every prison sample included between one (High Down) and four (Manchester) people who had been taken from disruptive home contexts into local authority care. Again, many felt that this had triggered cycles of disruption and serious behavioural changes, opening doors to both drug use and crime:

I was never a violent criminal up until then, and basically they put an unruly certificate on me meaning that I couldn't be controlled at home and put me in care. So then from care I just started getting worse, kept running away to be at home then my parents would give me back because they said it was the right thing to do, so I wouldn't go home, I'd go to other people and get in the wrong crowd (Holme House).

As one DRW resident reflected, 'there wasn't any care in care' (Manchester).

Early bereavement had also acted as a keystone event for several interviewees. Six people (distributed evenly across three prisons) identified that one or both parents had died, throwing them into considerable turmoil:

I lost my dad when I was five, and my mum got terminally ill when I was fourteen... And that's when I really started to spiral out of control (Brixton).

Others had lost siblings, sometimes resulting in wider patterns of disruption to their family and home lives:

My brother died, unfortunately. He was 12 at the time, I must have been about 8. So I think that affected me in a big way from earlier, I went through homes and, you know, stepmothers and that... (Brixton).

²¹ High Down was the sole exception; six of ten interviewees described relatively secure families of origin

The relationship with lost siblings was even more acute for two Swansea residents, each of whom lost an identical twin. For one interviewee, whose twin had introduced him to drugs, this had been a turning point:

My identical twin, he's committed suicide a couple of years ago... [pause] It hit me like a sledgehammer but then I had to think; "do I want to still be like this?" And I just put a stop to the injecting [amphetamine]. But then I hit the can hard, I drunk a lot (Swansea).

Perhaps of equal significance, the second made no mention of his twin, and described himself as an 'only son.' The death of his twin brother only came to light when interviewing his mother, who identified that the 'good' twin had been employed and drug-abstinent at the time of his death, whilst our interviewee was already immersed in a cycle of repeat offending and heroin use.

Positive childhoods

Even in the most disadvantaged prisons, a small number of interviewees were keen to assert that they had been part of robust, supportive family units. Support in these instances was described as comprehensive: emotional, financial, and pragmatic, sometimes remaining available through multiple prison sentences.

My mum and dad are... I couldn't ask for better parents. They took my son on for six month (Manchester).

I've not had a silver spoon, but I've had a good upbringing. Good parents (High Down).

For such individuals, explanations of their own offending consequently centred less on childhood or social factors:

I've had family support. Everything. My family's been there for me. I don't know why I keep mucking up (Holme House).

Positive reflections comprised a small proportion of the narratives offered by interviewees. Nonetheless, they should not be overlooked – particularly as, in several such cases, interviewees remained in contact with supportive parents who were prepared to offer considerable practical assistance following their release.

Summary

Looking back, interviewees described a wide range of childhood experiences. The most prominent of these was parental separation, experienced by a majority of interviewees across sites. Beyond this, accounts were diverse – a small number had been seriously physically or emotionally abused, some described fairly innocuous childhoods, and a small number offered glowing reviews of their early years. Significantly, several interviewees who described positive childhoods remained in contact with their parents, who looked able to offer continuing practical assistance on release.

Every site also provided at least one interviewee who had grown up in care – and this was widely described as a disruptive, uncaring, and criminogenic experience. The only experience to distinguish

any one site's interviewees from the others centred on disclosures of sexual abuse. We encountered two such disclosures in Styal; and none in any other site. Issues around disclosure (particularly in a one-hour interview held in a prison environment) may be pertinent to the lack of identified historic sexual abuse in men's prisons.

Recovery Capital: Education

Interviewees' levels of educational attainment reflected the cohorts specific DRWs engaged. Interviewees in Brixton and High Down described relatively intact family lives. Perhaps in consequence, interviewees drawn from these sites also described reasonably robust engagement with education. Approximately half of our interviewees in High Down and Brixton had secured robust qualifications, with many of these progressing to reasonably stable careers. Our Brixton cohort also held two university graduates, one of whom aspired to postgraduate study following his release.

Very different narratives emerged from other sites, with just a handful interviewees in Swansea, Holme house and Manchester remaining in school beyond the age of 14. Indeed, there were some striking accounts of educational disengagement here, with truancy or 'mitching' dominating accounts from Swansea:

In year nine I got kicked out of school because I just couldn't behave, I was too wild, and then I went to four different schools and I just kept getting kicked out, kicked out, kicked out, until I was having an hour a day in school and ended up to having three days a week in school. And it just went down from there.

Other accounts centred on children who were unsupervised by family members or authorities and 'just stopped going' (Holme House), or who were expelled at a young age following accusations of serious criminality:

Someone burnt the bus and it wasn't me ... And I was kicked out of the school, I went to a place for people who don't go to school and [pause]... I just started getting into a life of crime, petty crime (Manchester).

The age at which prisoners had stopped attending school sometimes suggested comprehensive systemic failings. A considerable cohort of Swansea interviewees described being expelled from primary school, and engaging with no structured education after this point. Several were still unable to read or write.

Recovery Capital: Employment

As with education, interviewees' experiences of employment varied by DRW. Gender seemed particularly pertinent here: not one of our women interviewees had an employment history, though most identified as 'stay at home mums.' Indeed, more generally, women interviewees described their lives more in terms of the relationships that they had than the professional (or criminal) roles they had assumed (see Grace *et al.*, 2015 for a fuller description of women's DRWs).

Contrastingly, not one male interviewee described himself as a sole, full-time, or stay-at-home parent. However, though few had formal qualifications, robust employment histories were commonplace. At least half of our interviewees in each site described longstanding engagements with work, mostly in manual trades:

I was a French polisher... I done a four year apprenticeship. Stripping furniture and then going on site doing staircases, and the tops of bars, counter fittings (Holme House).

I always earned my own money: it might have been through robbing, but I worked as well.... Because that was the sort of family I come from... As long as you're earning your money and you make an effort and put food on the table for my kids and my partner I would be respected. It's like 'he's a heroin addict but he does look after his kids and his family... he earns the money that he spends on drugs' (Manchester).

Prominent trades included roofing, garden work, working on market stalls, scaffolding, fitting, roofing and general labouring.

Where differences seemed apparent between DRW cohorts, they were mostly in two areas: motivation for work; and white collar jobs. Swansea and Holme House held some of the most disadvantaged interviewees and, in each site, approximately half of our interviewees expressed no desire to find work. Secondly, High Down – whose cohort described particularly robust family and educational backgrounds – had a cluster of people in white collar jobs. These included a former manager for an international corporation, and multiple interviewees with solid portfolios of work in client-facing jobs in the service sector. Some white collar workers had previous experiences of explaining away periods of imprisonment to potential employers. All expected to return to work, supported by considerable self-belief in their persuasive and talking abilities.

Recovery Capital: Mental Health

Whilst experiences of depression and anxiety were commonplace in all sites, serious mental illness was less common. Nonetheless, in each site a small number of interviewees described experiences of mental disorder – mostly involving psychosis (often drug-related):

I've had enough. I can't let alone. Literally I'm losing my head in there. The other day I was hearing voices and that in my head. I thought I heard him say I was nailing it, like I was shouting abuse, and it was calling and calling, and it was doing my head in man (Brinsford).

For those with histories of serious mental illness, this often defined their experiences of living in the community. Several described being driven to clear and intentional suicide attempts:

I've attempted to kill myself. I've jumped out of windows. I've attempted to slit my throat (Brinsford).

Others – particularly individuals with histories of heroin dependence – described historic overdoses with mixed motives, being neither entirely suicidal, nor entirely accidental.

Personality disorders also shaped the lives of several interviewees, clustered in Holme House and High Down. Such disorders, by definition, are characterised by severe and persistent difficulties in relating to oneself and others, and they were consequently widely seen to play a part in the behaviour that led to interviewees' drug use and offending. This link could be seen particularly clearly for one interviewee diagnosed with Emotionally Unstable Personality Disorder, whose offences (harassment, and breach of a restraining order) were driven entirely by his dysfunctional approach to relationships:

And when relationships break down for me, it's just, oh my God, what do I do now? ... Impulsivity kicks in, so it's all like the... overwhelming sensation in my body is just I need to find a fix or something to cope with me... cope with it all... I'd sit there on my mobile phone, I'd send horrible texts, I'd... I'd ring someone a thousand times a day just so that I could talk to them... I've self-harmed quite a lot, I've tried to kill myself in May four times, just because I couldn't feel worth living... I put on Facebook I've got a gun, I'm going to shoot me, so I had the police after me and stuff (High Down).

Other interviewees with diagnosed personality disorders described similar patterns of problems; though not to so extreme an extent, and without such a direct link to their index offence.

Post-traumatic stress disorder (PTSD) also affected a small group of interviewees, all housed in Brixton's DRW. The reasons people had developed PTSD were highly varied: one first-generation immigrant attributed his diagnosis to war trauma; a second had witnessed his partner's traumatic late miscarriage and subsequent stillbirth; and a third had been serially victimised whilst street homeless. It thus seemed highly unlikely that their experiences were linked; that each diagnosis preceded interviewees' imprisonment also suggested that this clustering had little to do with service level effects (e.g., Brixton having mental health professionals who were particularly strong at identifying and diagnosing PTSD).

Finally, the mental health of interviewees in Styal was also striking. Serious mental illness comprised the norm here, with nearly all women describing longstanding histories of depression, hearing voices, psychosis, and / or schizophrenia. Three had been hospitalised during florid psychotic episodes:

I've been in psychiatric hospitals, I've been sectioned about four times. And I don't think they helped. It's like they section you and then kick you back out, so that's why I've ended up here (Styal).

The severity of episodes could lead to trauma and fear, with women struggling to manage their daily lives:

I was on a medical ward, and I've got up and I've gone to the toilet. And as I've come back out I've overshot my room, and there's a man in my bed. So I've gone over to him and I shook him and he farted. But then I noticed he were dead, right. He'd died, and he was actually dead, he was laid out, he'd died in the night, right. So then I've gone walking to say like, this is what set me off, was like I thought there was some dead man in my bed. I've walked in to the ward, the ward that there'd been two young girls on, and there were two old ladies on there, right, with this yellow plasma stuff, right. Now I thought...and I saw

nurses injecting into the bags. Well, I thought that the nurses were trying to kill us, right. So I tried to jump out the second storey window. It took two nurses to pull me back, right... I went somewhere, come back [laugh], it was night time this, and I thought that somebody had taken over the world proper, normal, proper apocalyptic (Styal).

Two women had been temporarily transferred to hospital during their current sentence – a situation not described in any other DRW. One described how her levels of self-harm had proven unmanageable for prison staff:

I ended up being moved into a hospital from prison because they couldn't cope with my self-harming myself. I cut my wrists and that and they couldn't cope (Styal).

The second had been removed to hospital during a psychotic episode.

Summary

Interviewees' levels of recovery capital clearly pointed to the considerable difficulties they were likely to face in achieving social reintegration following release. In Holme House, Swansea and Manchester, very few interviewees had attended school until the age of 16, and educational qualifications were nearly non-existent. In Swansea, a cluster of interviewees described dropping out of school at a very young age – during primary education. Brixton and High Down's cohorts showed some signs of clusters of strengthened recovery capital. Supportive family units appeared to be related to greater completion of secondary (and even higher) education, and this – in turn – opened additional doors. Four interviewees in High Down had worked in the service sector, with some progressing to managerial positions. Such careers (and career progression) were described by no-one in the other men's DRWs, where manual work histories were far more common. Motivation to find employment also seemed to be related to broader patterns of recovery capital, with interviewees in two of our most marginalised sites expressing notably less interest in finding paid work.

Reflecting findings from other studies, women also appeared to face particular barriers to employment. This appeared likely to have been exacerbated by their experiences of serious mental illness, often grounded in experiences of historic abuse. Whilst serious mental illness was a notable presence in other DRWs, it was the norm for our women interviewees and of a severity such that their normal daily functioning was routinely impaired.

Index Offence and Offending History

Index Offence

Most interviewees were imprisoned for violent, acquisitive, or violent and acquisitive offences. Indeed, roughly equal mixtures of such offences characterised the cohorts of Manchester and Brixton. However, other crimes occurred in small numbers across all sites. These included breach of

a restraining order (N=6), possession with intent to supply (N=5), driving offences (N=3), and threats and harassment (N=1).

Some site-specific patterns also emerged with regards to interviewees' index offences. Overwhelmingly, interviewees in Holme House and Swansea (two DRWs with particularly marginalised cohorts) had been imprisoned for acquisitive offences: predominantly burglary, alongside a couple of shoplifting offences. Suggesting impulsive, opportunistic and broadly disordered lives, these were often described as petty, unplanned, and drug-related:

I wasn't intentionally robbing him... I was living upstairs in my brother's flat, it's upstairs and he lives downstairs, the bloke does, he called me down for a couple of drinks and I didn't have no money on me at the time so I said; "yes." So he gave me a couple of pints and he was prescribed Valium and so he gave me half of his script... I had a black out, don't know what the hell happened. Then the next morning I woke up and there was a digital camera in my pocket [and a] phone... I don't know what the hell happened (Swansea).

Amongst these acquisitive offenders, purposefully violent offences were very rare.

Contrastingly, violence was the norm for Brinsford's young, male prisoners, nearly all of whom had been imprisoned for offences that were either exclusively violent, or which involved serious violence for acquisitive ends. Moreover, without exception, this was violence enacted against strangers or distant acquaintances rather than relatives or partners. There was a sense that several young offenders revelled in descriptions of violence, recounting blow-by-blow re-enactments of their original crime and glorying in their financial gains:

This geezer was getting proper mouthy. I didn't even say nothing... I turned to this geezer, hit him. I've laid him out cold. He had a Rolex on: nice watch...really nice watch. Took it. He had a Chanel bag. He had a suit on. Took his Chanel bag, Gucci bag and that. There was a 500 pound bag in there. I thought, give it to my babymum²². And this bird was hitting me. I was that angry. Couldn't feel her. So I smacked her. She was knocked out. Then I walked off. Pretty mad feeling (Brinsford).

High Down's cohort stood out in another way: perhaps reflecting our interviewees' higher levels of recovery capital, they described fewer offences of financial desperation; however, offences against partners or parents had led to the imprisonment of a third of our interviewees.

The offences of women were, once more, also strikingly different. Victimisation seemed a particular theme, causing one interviewee to be arrested after multiple years of victimisation 'for arson, setting my flat on fire with myself in it trying to commit suicide'; and a second to assault her partner in self-defence:

Then I started seeing this guy called Paul who was a horror, brought me back, kicked me in the head, gave me a brain haemorrhage, nearly died. I was in a mess.... He attacked me basically, and I fought him off... I had to get a stick, because he'd put my head in the bed

²² Youth slang: *lit.* baby's mother. Often – though not invariably – a former romantic partner.

and I couldn't breathe. And I was grabbing at things, and I battered him with this stick behind the head... I got arrested for GBH and I got five years (Styal).

Offending History

Interviewees' offending histories varied substantially by site. Brinsford's residents were young; and most were serving their first, second or third sentence. Nonetheless, they often emphasised that imprisonment had been the end result of a long series of close calls:

I nearly got jailed four times. And the fifth I got banged up (Brinsford).

Interviewees in High Down and Styal also had relatively short criminal careers. No Styal interviewees had served more than two previous sentences, and most of our High Down interviewees serving their first or second sentence. This seemed to fit with a broader pattern of social conformity in our High Down cohort.

Our interviewees in Brixton described a mixed bag of criminal careers. Approximately half were serving their first or second sentence, and identified strongly with pro-social norms:

I'm a Muslim. My parents...they didn't know that I drank... And the most upsetting thing was, see when I was in gaol, I phoned my mum one day, and she's crying and that. I'm like, "what's wrong?" She's like, "I know why you're in gaol." Because I lied to her; I said that I had a fight with someone. She's like, "I know why you're in gaol; you've been drinking this time." Like, "what are you talking about, mum?" She's like, "the DVLA have sent the letter asking for your licence, and they are saying that you've lost your licence because of your drink driving." That really hurt me, because, like, see where I come from, like, if you drink and that, it's really embarrassing, because we're not meant to drink at all (Brixton).

At the other end of the scale, our remaining Brixton interviewees had been imprisoned so many times that they had lost count, a situation shared by many of the prolific recidivists that defined our interview samples in Swansea, Manchester and Holme House.

Too many times. I've forgotten, to be honest with you (Holme House).

For such interviewees, prison had often been a constant presence in their lives, stretching back to their early years:

I've been coming to jail since 1989 and now for the last ten years it's all been alcohol related and just violence... Just stupid little charges... just totally shit (Manchester).

Some sought to estimate how much time they had spent in prison. One Holme House interviewee estimated twenty years, a second guesstimated eleven years, and a third noted that he had not spent Christmas outside of prison for over six years.

Summary

The majority of our interviewees were sentenced for either violent or acquisitive crimes, with a handful of exceptions (prominently, breaches of a restraining order and possession with intent to supply). Some patterns distinguished the interviewees from various sites, often reflecting the patterns of recovery capital that were apparent in our cohorts. Those from Holme House and Swansea had overwhelmingly been sentenced for unplanned, often petty acquisitive offences. Contrastingly, interviewees in High Down had committed few acquisitive crimes, but were responsible for several offences against partners and relatives. The other adult men's DRW samples contained mixed balances of violent and acquisitive offenders, and victimisation appeared to be particularly important in the offences of our interviewees from Styal. Perhaps reflecting their youth, most Brinsford interviewees said that they had been imprisoned for violent offences

Offending histories also differed by sites and, again, appeared to bear some relationship with interviewees' age and recovery capital. Very few people in Styal, Brinsford or High Down had served more than a couple of previous sentences. A small number of Brixton interviewees also described strong attachments to pro-social norms (and pro-social families), and concomitantly few previous sentences – though several others were prolific offenders. The final three adult men's prisons held our most marginalised interviewees, and were defined by prolific recidivists, many of whom were unable to recall how many previous sentences they had served.

Drug and alcohol use history

Age of Onset

Our interviewees showed broad similarities in the age at which they first picked up drugs or alcohol. For most, this involved taking a portfolio of drugs between the ages of 13 and 15:

From about 14 onwards, I was sniffing gas, sniffing glue... Then I started on amphetamine, whiz.... And I just liked it. It used to make me feel alright. So I just went through a spate of 20 odd year on just that (Holme House).

I started when I was fourteen... Cannabis, acid, Es, coke, mushrooms... do you want me to go on? (Holme House).

However, some also described starting very young. Most of our Brinsford interviewees claimed they had begun to use drugs or alcohol between the ages of 11 and 12:

Fucking started when I was 12 like. Got in wit this fucking kid and that that I met at school... I went back to his house and that to stay over, and he was going, ah, you ever smoke weed and that, I was like, no, I've never smoked weed, and he was like, ah, do you wanna? So I thought fuck it, you know what I mean. Fucking. Went upstairs. In the room he shares with his big brother and that, fucking you know what I mean. Smoked about 4 spliffs of that... (Brinsford).

Swansea similarly provided a number of interviewees who started using drugs or alcohol at a very young age – between six and twelve years old:

I started taking heroin when I was nine years odd. I'd seen a family member smoking it, and his friends, and he put it down, and my mate seen it and we nicked it... I was injecting by the time I was 13, I spent a lot of time in jail then (Swansea).

I was injecting amphetamines at about the age of 12 (Swansea).

This seemed to resonate with the educational backgrounds of Swansea interviewees (described earlier), with several expelled from primary school.

Very few of the people we interviewed had started using drugs later in life. Indeed, such experiences were confined to three people in Swansea, who identified that they had been entirely drug and alcohol abstinent until after they turned 18:

My life hasn't exactly been blighted by drugs, not from an early age anyway, I started taking drugs at about the age of 18, started off with cannabis and alcohol.

Another small subset – distributed across sites – had drunk alcohol from an early age, but felt this had only become a problem after key life events (losing a partner, losing a parent, or losing a job).

Patterns of Drug Use

Interviewees' patterns of usage often stabilised around early adulthood. As noted, a large group of interviewees described transient, experimental phases during their adolescence in which they experimented with a portfolio of (mostly recreational) drugs. For a substantial subgroup, adolescent drug taking progressed into becoming a 'raver' during their late teens or early-twenties:

I was into quite a few drugs, acid, pills, MDMA, because I'm part of the rave scene, like me and my friends, we organise raves and that, and where there's a rave there's drugs. It's all part and parcel, isn't it? (High Down).

For those who identified their main problem as alcohol, cannabis or cocaine, these experimental early years transitioned into stable and sustained patterns of drug use and dependence. Use of these drugs was also widely seen as compatible with other areas of stability, such as securing (and maintaining) paid employment, and developing a family life.

Interviewees with histories of amphetamine and opiate use, however, often described some changes to their drug use over time – particularly centring on a move away from heroin, after accessing OST.

A move towards amphetamines characterised the experiences of a handful interviewees of formerly heroin-dependent prisoners in Holme House and Swansea. Often, this switch happened after multiple years of heroin use, and multiple previous sentences. Though amphetamines were vastly cheaper than heroin, this had not always been a propitious change:

I was more chilled out [on heroin and crack] than when I was on phet. When I was on the phet I was 90 mph all over. I ended up being sectioned a few times over it. But when I was heroin and the rock and that, just I never really got sectioned then (Holme House).

Contrastingly, a cluster of interviewees with OST prescriptions in High Down had taken an alternative pathway, towards alcohol and cocaine dependencies. Again, despite the strong body of evidence associating heroin use (in particular) with crime, there were real signs that our cohort had often found alcohol or cocaine more problematic. The following quotation comes from the only long-term heroin user we interviewed in High Down:

When I entered into [OST treatment] I was 100 per cent serious about it... I stopped using [heroin]... but I was drinking and that's, yeah, been my downfall pretty much. That's what landed me in jail. Not using drugs, actually alcohol (High Down).

A final subset – mostly in Holme House and Manchester - had switched from heroin to diverted pharmaceuticals. The impact this had on their lives depended on the particular drugs they switched to. For a couple, moves towards pharmaceutical opioids had provided an added element of stability in their lives:

I gave up gear about... I'd say about properly gave it up over ten years ago. [Subutex] is longer lasting, it seems to carry on for a good 24 hours easy (Manchester).

It's not particularly heroin. Yes more like painkillers Tramadol, Subutex, Temgesic, pharmaceutical (Holme House).

Contrastingly, switching to zopiclone – a sleeping pill – had proven disastrous for an older former heroin user in Holme House. Taken in large quantities, zopiclone has a tendency to induce blackout and amnesia; this interviewee's most recent sentence had been for stealing coal in broad daylight and whilst highly intoxicated, an offence that he had furiously denied until police officers pointed out that he was black from head to toe due to a liberal covering of coal dust.

A final note. As in other preceding sections, the experiences of women seemed somewhat different. Though each of our Styal interviewees had a history of heroin use, each had wobbled both towards and away from opioids. In each case, their changing patterns of drug use were not so much associated with clearly defined personal choices – rather, they were shaped by the relationships women were in. The following is a highly abridged account from one interviewee:

I started to like Methadone, but I was using gear as well at the same time. [Dave], my son's father... was in the scene, and that's where I met him... Then I got pregnant with [my son]. Stopped taking drugs, happy little family... So yeah, [Dave] died. And that's had a great impact on my life that, a big one. So I was using drugs, and I met [Mike] through it, he was a drug dealer... And then I started having a relationship, don't ask me why, with a woman... And she was working in a pub, and then she became manager of a pub, and we were living upstairs in it. I was working in there then, so I felt brilliant, but the drink took over...

This account – with drugs of dependency following relationships – characterised the using careers of other women, too; as did trauma. Particularly for those with long (and even ongoing) abusive relationships, drugs had proven a very effective way of blocking out traumatic memories and the life-impairing symptoms of traumatic stress.

Opiates

Across sites, the vast majority of interviewees identified that they had histories of alcohol and / or opiate dependence, often accompanied by some secondary or tertiary drug use. Marking a change from the rapid assessment (see Page *et al.*, 2016), a considerable proportion of interviewees in every adult site²³ either had an active OST prescription, or had detoxified from OST whilst imprisoned. In Holme House, this figure was 100%, for operational reasons: the DRW could only be accessed by prisoners with active OST prescriptions. In other sites, engaging heroin users still appeared to be a persistent challenge. As one High Down interviewee reflected:

I have to say when I started [intensive treatment] I was, kind of wary... because I was the only IV heroin user on the whole group (High Down).

High Down staff agreed that primary heroin users were scarce – and rarely comprised more than a quarter to a third of any treatment cohort. Perhaps reflecting the relatively robust recovery capital of our High Down cohort, most of the people we interviewed who had been prescribed methadone on entry to the prison were also young: under 30 years old, with few previous sentences.

Table 6.3: opioid status and goals

	Opiate dependent @ prison entry	Already detoxed by interview	(Of detoxed, want retox)	Goal: detox before release	Goal: no detox before release
Brixton	6	3		2	1
High Down	6	5			1
Holme House	11	2			9
Manchester	4	2		1	1
Styal	3	1		1	1
Swansea	4	3	(2)	1	
Total	34	16	(2)	5	13

²³ This distinction is important – opiate dependence is rare in young offender populations, and just three young people in Brinsford were prescribed methadone when we first visited. All were housed in the prison's healthcare wing.

Site-specific patterns appeared apparent in interviewees' approaches to OST. Most strikingly, Holme House (a site whose interviewees were lacking in recovery capital) provided 9 of 13 interviewees who had no intention of being medication abstinent before release. Within the wing, reduction regimes could be slow:

I: And what's your reduction?

R: Just the minimum, one mil each month (Holme House).

This resulted in some unusually precise doses, with interviewees on 59mls, 37mls, and 68mls of methadone. These were the result of reduction schedules that began from high levels, and often proceeded at 0.5-2mls per fortnight – very slow regimes, when compared with other sites²⁴.

Moreover, reflecting traditional harm reduction approaches, interviewees framed release as a stage on a medication assisted recovery journey, as opposed to a point by which abstinence 'should' be reached. For a couple of interviewees, this meant looking to change medication:

I want to change drug, and [clinical staff] said that's okay. I want to change drug on to Suboxone (Holme House).

Others aspired to reduce by specific (and seemingly rather arbitrary) quantities by the time of release:

[I'm prescribed] forty-nine mls... I want to get to 45, me. You know. I've got 2 grandkids. I've got 4 kids of me own. It's no good (Holme House).

As an OST-focused DRW, this general chariness of medication abstinence and the complexities of unpicking individual 'motivation' from structural contexts resonated with the findings of the rapid assessment (see Page *et al.*, 2016). However, there were intimations that some interviewees were only a short distance away from final reductions. Three were prescribed just 10-20mls of methadone, and one identified that he was 'thinking of doing one of those rapid detoxes when I get out.'

In all other DRWs, recruitment explicitly included an expectation of OST detoxification. Holding back from detoxification was thus exceptional, and accompanied by exceptional reasons. One High Down resident had detoxified during previous sentences, and had found that this did not work:

I came in scripted, and I'm going out scripted which is a big change because I've always come in and said; I want off this, off the methadone, reduce it down, come out fuck upped. Went out of Lewes, came out with money, no script, it took me about three months to get another script, that's why I ended up in prison (High Down).

He consequently intended to go out prescribed so that he could detoxify with his trusted drug worker in the community. Interviewees in Styal and Manchester had health-related reasons: serious mental illness in Styal, and the sheer physical exhaustion of Interferon treatment for Hepatitis C in Manchester.

²⁴ In every other site, interviewees only described increments of 5mls for any dose above 30mls.

Two other site-specific patterns also appeared noteworthy. Although three Swansea interviewees had undergone full detoxification from OST, two wanted to be ‘retoxified’ – picking up a new prescription for Subutex or methadone before they left prison:

The main thing is getting me scripted before I get out and at the end of the month now they’ve booked my appointment to go down healthcare, and she’ll prescribe me something for when I get out so, hopefully, I’ll be on methadone or Subutex (Swansea).

In this context, it seems worth noting that Swansea was the only Welsh prison included in this study. As IDTS clinical treatment was not funded in Wales (HMIP, 2015b), this may have affected both the availability of OST, and prisoners’ desire to retoxify after attaining OST abstinence. Certainly, neither Swansea interviewee described particularly powerful aspirations towards medication abstinence. One had detoxified because his family had ‘heard bad things about me,’ whilst the other ‘was getting fed up of walking down every day for [my prescription], and I just stopped going for it.’

Contrastingly, five of six interviewees with histories of opiate dependence in High Down had fully detoxified by the time of interview. Not all of these had been driven by deep, personal motivations: two had their scripts reduced when they first entered prison, but decided to use this as an opportunity:

I was on 80/90 mils out there. I came in here and these lot are putting me down straightaway to 30 mils and I thought, “no, this is going to kill me... I’ve got to stop”, and then the first couple of nights was really rough for me, you know. [But] In the end I just thought, no, there’s no point going back up on my methadone, I’ll just as well stick to 30. Maybe it did rattle me for a couple of days and then I thought, no, I’ve got a good chance here to bring myself back to normal, you know (High Down).

Others were more driven. For this handful of prisoners, the presence of a robust abstinence-focused treatment programme acted as a particular spur to seek medication abstinence:

I felt that I wanted to come out of here completely abstinent. I don’t want to be intoxicating my body even with cigarettes. [And] you need to be abstinent, completely abstinent, from anything to start Bridge, and I wanted to do that (High Down).

Again, motivation seemed to be linked to individuals’ access to other resources. Reflecting Cloud and Granfield, those who had more to detoxify *for* were generally more enthusiastic about medication abstinence (2008:1979).

Alcohol (and non-opioid drugs)

In all adult sites except Holme House, alcohol was a mainstay of our interviewees’ dependencies. Again, there were some differences between sites. Most Mancunian drinkers identified alcohol as their only drug of choice, whilst Swansea’s drinkers identified a wide range of second (and third, and fourth) drug preferences. These included, heroin, cannabis, and – prominently – amphetamines:

I had no life, I just [pause]...just drinking and taking speed every day. So looking back now I'm like; oh my God, I can't believe, but at the time, no, it didn't [pause] come into my mind that I had a problem, I always felt in control, if you like (Swansea).

Meanwhile, a distinct cluster of drugs was described by interviewees in Brinsford, Brixton and High Down where a total of fourteen interviewees described heavy use of cannabis, alcohol, and (in adult DRWs) cocaine. Despite the recognised health risks, including cardiotoxicity (e.g. Pilgrim *et al.*, 2013), multiple interviewees framed cocaine and alcohol as highly complementary:

There's no cocaine without drinking, and there's no drinking without the cocaine. That's the thing, yeah. There's none without the other (Brixton).

Moreover, in High Down a pattern of alcohol/cannabis/cocaine was associated with broader patterns of social conformity in work, education, and/or family relationships. Four interviewees described weaving drinking (in particular) in around their working day:

Yeah. I used to do that all the time at my desk. I used to mix it in a Lucozade bottle, or even I used to take the mickey and have a Red Bull can on my thing filled with vodka or something, and then what I'd do, wherever I worked, I'd find co-conspirators, people that I could co-conspire with and like loads of times going to the pub. And things like that. I'd fall asleep at my desk, and when you're in sales and your phone is constantly ringing it's probably the wrong thing to do (High Down).

Drugs that were more associated with social conformity were thus more associated with other patterns of conformist behaviour.

A final group of interviewees merit an additional note: those who described no history of either opiate or alcohol dependence. Here, a small number of Brinsford and Manchester residents had only ever seen cannabis use as a problem:

I was smoking a lot of weed and that. Yeah, I don't really drink if I'm honest. I just weed man. No fucking yardie bud that's full of seeds, no fucking spice. Skunk. Just like the straight green shit (Brinsford).

A Brixton resident had found that methamphetamine, in controlled doses, helped with his work:

It made me stay up, that's why I first started using it, because it makes you stay up for three days. And I'm dyslexic, so I find it really hard to memorise things. So it just makes you focus. So I'm on the computer drawing all these designs and I'm there for three days constantly (Brinsford).

Marriage, family life and full-time employment led to ten years of relatively stable methamphetamine dealing and use, but the collapse of his marriage then coincided with him being made redundant. His methamphetamine use then 'spiralled out of control.'

Finally, one Swansea and three Brinsford residents identified as all-out polydrug users, with no clear drug of choice or drug preference.

Alcohol: recognising hazardous drinking

Some interviewees appeared to have little conception of what comprised heavy or dependent drinking. One Brinsford resident claimed to have been drinking approximately 472 units per week, approximately twenty-two times the highest levels identified as safe in government guidelines:

At night I'd drink three litres of, of Frosty Jacks. It filled my confidence up and made me more cheerful... [And at work] my girlfriend would meet me at dinner with a three litre and then I'd buy a three litre, maybe more, on the way home. And then I'd sit there and drink it in my bedroom on my own (Brinsford).

Despite these high levels of drinking, he was adamant that he had not been dependent on alcohol. Two adult interviewees in Swansea described similar relationships with alcohol. Neither felt that alcohol was particularly problematic in their lives, despite describing highly hazardous levels of alcohol consumption:

- R: And that just got into everyday life, I'd just wake up and I'd think; what to do today, if I don't have a smoke today I'll have a drink, and that was all the way through.
- I: Do you think you've got a problem with alcohol?
- R: No, not really, I don't...
- I: How much were you drinking on the outside?
- R: Oh, I'd drink up about 12 litres of cider a day, I drink cider or anything basically.
- I: You drink 12 litres of cider every day?
- R: Near enough every day, yeah.
- I: That does sound a bit like a problem to me.
- R: Does it?
- I: So you'd been drinking a fair amount before you came in?
- R: Four, maybe five bottle of Frosty Jack.
- I: Were you thinking that was a problem?
- R: It was getting to a problem, yeah, but if I didn't come in on the sentence it was going to turn into a bit of a problem.

Conservatively assuming that the first interviewee was referring to low-alcohol cider (e.g., Woodpecker, 3.5% ABV), the levels of consumption he describes would equate to approximately 294 units per week. If he were drinking strong cider, this figure would be doubled. Frosty Jack's (7.5% ABV) was conventionally sold in 1, 2 and 3 litre bottles meaning our second interviewee was describing consumption of between 210 and 788 units per week. In either case, there was a real sense that these exceptionally hazardous levels of drinking were not being seen as problematic by interviewees.

Summary

Whilst the majority of our interviewees began using drugs or alcohol in their mid-teens, a small number – particularly in Brinsford and Swansea – started using hard drugs at a very young age.

Whilst interviewees' teenage years often involved a considerable amount of polydrug use and experimentation (including a number of 'ravers'), patterns of drug use often began to settle down and stabilise as interviewees entered early adulthood. For men who had not picked up crack cocaine or heroin, ongoing drug and alcohol use tended to centre on various combinations of alcohol, cannabis and powder cocaine. Often, these were accompanied by reasonable levels of social conformity in other areas – particularly with regards to employment, and sometimes relationships, too. Despite the widespread prevalence of harm reduction groups, there were clear suggestions that not all drinkers were aware of safe levels of drinking. A handful described very worrying levels of alcohol consumption – well in excess of 200 units per week – with no apparent awareness that this could be seen as dangerous.

For those who had picked up heroin (in particular), engaging with OST treatment often appeared to coincide with a move towards more prominent changes in primary drugs of dependence. Few of our OST-prescribed clients still identified heroin as their main drug of dependence, with a variety of former heroin users progressing to pharmaceutical opioids, amphetamines, and alcohol.

Interviewees' approaches to OST varied, and showed some site-specific patterns. Of the thirteen interviewees who had no intention of attaining abstinence before release, nine were in our low recovery capital cohort from Holme House. No other cohort produced more than one. At the other end of the spectrum, five of the six High Down interviewees who had been prescribed OST on entry to prison had already fully detoxified. Despite their opiate dependency, several High Down interviewees were notable for their youth; and they widely identified that the DRW's intensive, abstinence-focused programme and the possibility of escaping the prison's two somewhat chaotic OST-focused wings had provided strong motivation for detoxifying.

Our small group of women interviewees described rather different pathways through opioid use. For each, their patterns of drug and alcohol use had been fundamentally relational – varying, as various substances were introduced to relationships, or provided stronger responses to difficulties in coping with trauma.

Selection and recruitment

DRW interviewees described a full range of experiences here. At one extreme, not one Brixton resident had applied to be on the DRW:

I come straight onto the DRW; I didn't know nothing about it... I didn't feel like I wanted to even give up (Brixton).

I: Why did you apply for this wing?

R: I didn't. I was dumped on it. [Laughs] I didn't apply for this (Brixton).

High Down narratives similarly identified that people were often allocated to the DRW on the basis of a superficial reading of their offence characteristics, or their prescribed medication:

I just said, look. I was [selling heroin] to get money to buy more drugs, and that's the bottom line... So that's basically why they put me on here (High Down).

They moved me here because obviously this is detox, I was on methadone, so they moved me over here. It's just where I was put (High Down).

Resistance to being transferred was, however, relatively light in these two adult DRWs, which were not viewed as particularly problematic by residents of other locations. This was not, however, the case in Brinsford; where the DRW had gained a reputation for holding vulnerable and weak residents, exploited by predators and bullies. A cluster of interviewees consequently described putting up more resistance to being recruited:

I: Did you want to move to [the DRW]?

R: I said "no" at first, and they said "if you don't go on, we're going to IEP you." So I had to. I'd heard [the DRW] is fucking nonces and that, I don't want to go on there, like. I refused it (Brinsford).

As this quotation suggests, when motivation was lacking, transfers could be ensured by threats of sanctions. This appeared to be a particular problem in Brinsford, where psychosocial staff were worried that transfers were sometimes used in order to move bullies off other locations.

Contrastingly, every interviewee in Holme House, Manchester, Swansea and Styal had applied to move to their DRWs. Reasons for this were diverse, and included the lure of enhanced pay and improved physical conditions:

I got told you got a tenner for being on the wing, and you get your methadone early in the morning (Holme House).

I was told it was single cells and plasma TVs and all that shit, but that was just an incentive to get you down here I think... But that wasn't the reason I came down. And I'd read up on it down here. And I thought, you know what, I'm going to give it a fucking go (Manchester).

And perceived opportunities for reduced sentences or earlier release:

At first, I'm not going to lie, I was doing it because I was getting caught and obviously I wanted the judge to give me a lighter sentence... (High Down).

Despite these apparent temptations, the majority of interviewees identified that their motivation was primarily driven by a desire for personal 'betterment,' and to work towards personal change:

I wanted to better myself. I want to improve my life. I don't want to be in the same life (High Down).

I fought to get on this house... because I didn't want to be drinking (Styal).

Often, this was associated with a desire to access enhanced group programmes:

I started on 20 mil, and I dropped five every two weeks ... I was on B spur... [but] I wanted to move [to the DRW] because I wanted to start the [intensive treatment programme] (High Down).

A specific subtheme also emerged in Holme House, where several interviewees saw their DRW as offering a good opportunity to reduce their OST prescriptions:

I wanted to come on... Because my mindset at the time was to, erm, reduce completely off my methadone and have a chance. It does work. It does work if you want it to... But it's... I thought everyone would be pulling in the same direction, you know [though] you're never gonna get a perfect clean prison (Holme House).

Often, such intentions were intimately associated with an expectation of enhanced access to group treatment. With the benefit of hindsight, such ambitions came to be seen as overly ambitious:

One of the DAAT workers was telling me about [the DRW]... You can do all this, you can go to the gym every day, you can do this, you can do that. There's all sorts of courses running... Very stupidly I wolfed it down, and then I came on here and the reality was completely different. To tell you the truth, if I was doing this time again, I wouldn't come on here, but that's me personally (Holme House).

This gap between expectations and reality seemed to resonate with Holme House interviewees' actual approaches to OST reductions once on the wing – as described above.

Summary

Prisoners' experience of selection and recruitment varied considerably by site. In Brinsford, interviewees had actively resisted being 'recruited' to the DRW. In Brixton not one interviewee had willingly applied, and we also spoke to several (initially) reluctant recruits in High Down. Interviewees in other sites described more initial motivation to apply to their DRWs, and cited a number of reasons. Foremost amongst these was motivation for change – the reason staff also identified as their top priority. (However, enhanced physical conditions, a desire to secure a reduced sentence (or early release), and intentions to reduce medication also featured as prominent reasons for applying.

DRW Treatment

Structure

For an outline of DRWs' operational models and levels of provision, see Section A.

Intensity

Reflecting staff accounts, interviewees described DRW treatment in Brinsford and Holme House as non-existent. Over half of our Holme House interviewees had received no treatment contacts whatsoever, with the others attending between two and six sessions as part of a one-off 'induction programme':

I'm on the list to do something... It's just taking its time, innit. It's like in the future. The next couple of months, or something (Holme House).

Many felt let down:

In June... my DART officer... built this wing up to be so special, excellent, the best that's available and whatever else. So I thought "yes, I'll have a bit of that." I came over to this wing. I waited three months to have my DRW induction. And that was only a morning session. Then that was it (Holme House).

In Brinsford, the DRW added little to prison-wide treatment programmes. At most, this meant that DRW residents were amounted to one or two groups per week (which they would have been offered on any location), with most accessing considerably fewer:

I was hoping for group sessions... I've had a couple [of one-to-ones]... but I don't know [my keyworker] is doing anything to help to be honest (Brinsford).

Structured DRW provision was thus minimal; though wing residents did receive priority access to fortnightly mutual aid meetings. Attendance at these was sparse; though two interviewees were clear that they valued them:

AA is alright. The good thing about AA, they get other people in from the outside that have like different stories and that, so you get to see different perspectives on how their life has been and like their drug use and their alcohol use, man. That's cool (Brinsford).

Brinsford's lack of DRW provision or a DRW-specific timetable also had broader consequences. Virtually none of our interviewees here were engaged in work or education. In consequence, without a DRW programme, five of our seven interviewees spent up to 23 hours each day behind their cell doors. For those on Basic level IEP, this offered barren living conditions:

I: So you still have a TV in your cell?

R: No, no. I'm banged up with my cell mate [who has] no TV as well (Brinsford).

There was no clear sense of how such conditions might be expected to contribute to recovery outcomes, or in what sense this comprised a robust 'recovery' programme.

Swansea's treatment programme was marginally more intensive, at between four and six hours of treatment per week (two concurrent two- to three-hour group programmes). Unfortunately, the timing of fieldwork limited our potential to explore how prisoner interviewees felt about DRW

treatment. We arrived just after Christmas, when the prison had been on widespread lockdown due to staff absences and annual leave. The DRW's new cohort had only undertaken a couple of groups.

One notch above Swansea came Brixton. Here, the structure of the signing-up process meant that assorted interviewees had very different treatment experiences. Those who wanted to were able to avoid groups entirely:

I've done all the drug groups and that and I'm trying to get away from that scene and everyone's talking about it and it makes me think about it, so I didn't bother going to no groups here... So I stay in my cell (Brixton).

Some were also unintentionally excluded, due to timing conflicts between DRW processes, and the wider prison's regime:

They [carry out the signing up process] on the Fridays, and we've got Friday prayers. So by the time you come back, it's all full (Brixton).

This noted, the majority of Brixton interviewees felt able to access groups, and were attending between three and five each week. There were clear favourites amongst these, with four describing mutual aid meetings (delivered by outside visitors) in highly positive terms:

They are the best groups I have ever been to in my whole life! ... For me, whoever shares there's always one for me who stands out more.... Some of the stories, you know, you relate to it so much you think 'god, it's not just you...' When you've gone so low, even the money, some of them earn money, like I used to do... but the way we used to spend it and what we were doing to our body was disgusting. And sometimes I've walked out of there nearly in tears, because it just hits home so much and that. And it's so good to see that some of them are 700 days clean, 1,000 days clean... So yeah, I think they're the most beneficial things you could ever do for a DRW (Brixton).

A handful had also attended Stepping Stones – a six-week, cohort-based intensive course. Without exception, they were again highly positive about their experiences, describing them in terms of highly therapeutic group-building and self-discovery:

They could not have picked a better group. Some of us were young, some of us were older. But we all got on well. There was not one of us who did not get on (Brixton).

We stripped ourselves down with everything they gave us to do, and it did, it was the best thing they could've done. Because I felt like they cared. It felt like the CARAT workers cared enough to help us (Brixton).

This noted, Stepping Stones was not a dedicated DRW programme; prisoners from any wing could attend. In consequence, it could not be seen as a specific component of 'DRW treatment.'

Styal's offering was still more intensive, with practical and therapeutic sessions running on most days. Morning groups were widely appreciated, with women seeing them as an effective means of building trust within the group:

Since I've been here I've learnt a lot. I've met a lot of people and a lot of girls in here and I've talked to them.... You do groups, it's a nice house, it's a good environment where everybody is kind of pushing each other on a bit. People help each other in a way (Styal).

A similar theme suffused accounts of the cohort-based treatment models in Manchester and High Down, where interviewees underwent full-time morning and afternoon treatment groups together (reinforced with three evenings of mutual aid meetings in High Down). Cohorts fostered trust; undergoing treatment together encouraged prisoners to take chances, and consequently to make therapeutic gains:

The group become closer like a family in there and, you know, we look out for each other, you know what I mean. If we see each other around and see someone doing wrong I can address them and say, you know what, that's not the right way. We was in group together, you wanted to change your ways so try your best to stop drinking or whatever, stop taking drugs; so we can give them words of encouragement at all times not only inside but when we get outside as well if we do meet up and see each other (High Down).

I think it's after the meetings it's really important that...because the meetings bring you together but it's what you do outside them that keeps you together. In a small environment like this we have a, and I see this is an advantage, is when we come out the meeting we're all back on the same wing together so we're immediately socialising together and we bond really quickly (High Down).

In Manchester, DRW cohorts had little choice but to stick together; there was no-one else to socialise with in their wing. Contrastingly, High Down residents lived alongside a large cohort of non-DRW clients. Apparently as a consequence, they described forming a tight-knit friendship group, both attending treatment and socialising together. In each of these sites, there was a sense that – for prisoners – peers were just as important, if not more so, than specific treatment programmes.

Ethos

Across sites, the most prevalent form of group centred on harm reduction. Such groups constituted the entire structured treatment offering in Brinsford²⁵ and Holme House, formed the backbone of Brixton's groups, and constituted one of Swansea's two concurrently-delivered treatment programmes. These were met with mixed reviews, particularly by those who had attended harm reduction programmes before and felt that they were learning little new:

I: Do you feel you learn much from [groups]?

R: No, I do and I don't, I know a lot about drink and drugs anyway because I've been working with YOTs and probation and stuff since I was like, 14, 15. So I've done hundreds and hundreds of groups, you know what I mean. So I know everything I need to know (Brinsford).

²⁵ Not counting externally-delivered mutual aid meetings

Sometimes I want to [go to groups]. But the alcohol awareness, I've heard the same stuff every time I go in. It's the same thing over and over and over, you get nothing new coming in (Brinsford).

In this, there was a sense that harm reduction was essentially educational. Once a topic had been 'learnt,' learning it again added little new. This noted, a very light sprinkling of interviewees felt that they had taken away useful lessons from such groups. These prisoners were particularly clustered in Brixton and Swansea, and the gains they made seemed to be particularly tied to a lack of previous exposure to harm reduction lessons, and the way groups were managed and run:

Just learning what you can catch off the drugs, like hep and stuff [has been useful]... What else have I learnt? Drugs are bad [laughs], I learnt that (Swansea).

It seemed notable that, in such instances, identified gains related more to group processes than to the content of group sessions *per se*.

Beyond harm reduction, four DRWs (Brixton, Manchester, Styal and Swansea) delivered locally-developed group programmes, whilst High Down delivered a structured twelve-step group programme.

Staff in Styal and Manchester developed individual modules *ad hoc*, instead of attempting to establish programmes with an overarching thematic coherence. Styal's programme comprised a repeating programme of weekly groups (SMART, psychoart therapy, 'pos and negs,' gardening, and one structured group delivered by outside staff). Of these, 'pos and negs' and structured groups delivered by outside professionals (usually twelve-step facilitators) were particularly appreciated:

Yeah, it's good. [laughs] It's positives and negatives, it only happens once a week that group, it's on a Monday, and it's looking at, and you know me full negative behaviours. You know you can stop taking drugs but if you haven't got rid of your own negative behaviours, it's just going to take you back to taking drugs in the long run. But there's also positive gains, I've been negative minded for ages... (Styal).

Contrastingly, gardening received more mixed reviews. Whilst a couple of women saw it as a productive way of building skills for the future, others were less convinced:

On Wednesday we do gardening and I *hate* it. I've brought it back, [Worker] was making me dig bloody potato things, trenches. I've got a broken spine, do you know what I mean? (Styal).

Brixton's programme ran along similar lines, though with different groups often running each week.

Manchester's programme was both time-limited, and more varied. Assorted modules were allocated to various weeks of RTG's treatment programme, covering a wide variety of themes including pragmatic topics (budgeting, healthy living, PE), SMART recovery, and groups delivered by outside agencies. Two of these stood out as interviewees' particular favourites. Firstly, a group delivered by Narcotics Anonymous

There was a chap and a lady, both ex users and what amazed me the most is he only got out of jail 2010 and he's been coming ever since, this chap. He were telling us his life stories, about drinking, what made him use drugs... He was just saying... 'don't think you can't do it, because I'm living proof' and she was exactly the same. She's not took drugs for eight years. She said she was 50 years of age. I would never have thought it. I wouldn't put her a day over 40, and she was an ex heroin user and you would have never have put it, never (Manchester).

You need someone who's been - the only thing I found good - this was ironic, this. We had two guys come in from NA, they'd been clean for over two years. They came in a couple of weeks ago and I knew one of them straight away. I was in the same rehab when I was in, 12 stepper... but I didn't last... I looked at him and I thought, "fuck me, if I hadn't have walked out those doors I could have been sat where he is now." That's the only thing that's given me motivation on this course, really. Seeing someone I know that was like I was... and look at him now, glowing... Seeing him has made me realise, fucking hell, if he can do it, surely I can. I know about him sitting in groups and all that doing his modules on his steps, on his 12 steps (Manchester).

Secondly, a staff-developed victim awareness programme received very high praise. Prisoners consistently identified that it had offered them new insights into their own offending, often leaving them feeling highly emotional about the crimes they had committed:

We was always grafting, like break in an house, take a laptop, run out, and that was it. Go and swap that, right, give us as much heroin as you will for that laptop. I've robbed laptops and turned it on and it's come on and it's been a woman and three kids and I've just dismissed that, going 'have they got a password on it or not?' And then when we were doing the victim awareness course... there was a couple of things about victims whose houses had been burgled and who'd had a daughter who was disabled and all their photos they had of her was on the memory of the laptop. And then the daughter had died and all their memories had gone because the laptop had been stolen. And when we were both talking about it, 'what did you think about that,' and we were both crying... (Manchester).

Such insights provided Manchester interviewees with new and potent reasons to change.

Whilst Swansea's programme had been developed from the ground up, groups nonetheless evidenced a degree of thematic coherence. The officers in charge of developing the programme had sought to position a coherent model of 'addiction' in a rolling programme of groups, with each week addressing a different subject area (families, bereavement, relationships, etc). A couple of interviewees were positive about previous experiences in these:

You're split into two groups to do exercises like what it means to you and how can you better yourself. I've learnt from each one of them ... I've gained more confidence, more self-esteem basically, and more than anything is I haven't thought about drugs (Swansea).

However – as noted earlier – interviewees' capacity to comment was limited as most had yet to take their first group

Finally, High Down delivered a programme that was well-established in other prisons ('the Bridge programme'), defined by and delivered according to clear twelve-step principles. Without exception, Bridge graduates felt that the programme had offered them substantial, insight-focused gains:

At first I didn't believe I was an addict, I was like, 'no I'm not like these people,' I'm judging other people in the group thinking, you know, I'm not that bad, I'm not that bad, I'm not this I'm not that, but my behaviour patterns when I was out there were similar in a different way. I remember I was talking to the group and I was saying I remember one time I went up three or four o'clock in the morning to Brixton from Epsom to get a bit of cannabis and that's sort of addictive behaviour, do you know what I mean? (High Down).

Since I've been on The Bridge programme, I've learned a hell of a lot. I've been taking it in and that, and it's all unmanageability, and powerlessness, isn't it? My life was completely unmanageable, like most of the people on here, their lives are completely unmanageable. That's why they're in here. (High Down).

Additional benefits came in the form of confidence and personal development. For a number of interviewees, the Bridge programme had provided the first group environment in which they had felt able to flourish:

I've gained my confidence to talk. Erm. I think that 6 weeks was the perfect length for it. It gave me time to get into it. I was tentative at first. Shy. I've really opened up, I think. I don't feel the same as I do, I feel completely different now from when I started it. More confident. I feel really... happy (High Down).

Finally, peers were seen as one of the real strong points of Bridge. Forming groups from prisoners with a variety of drugs of choice was seen as a real boon, encouraging participants to reflect on shared and distinctive experiences across 'addictions':

I think it's good to have heroin addicts with other addicts and sniff heads with crack heads. It's a good way of everyone clicking together because you know what a crack head would use and then the sniff heads use exactly the same thing but it's washed up, so it's pure pure thing. Then you've got the heroin addict will connect with someone that's been doing ketamine or MDMA and stuff like that. Because ketamine is just like... I see ketamine and heroin as just must be exactly the same thing. When you go in a hole you're going in a heroin way (High Down).

As a whole, impressions of High Down's treatment programme content were the most positive encountered across sites.

Recovery Champions

Recovery champions identified as a key part of the 2010 Drug Strategy, alongside the development of pilot Drug Recovery Wings (HM Govt 2010:12). However, no staff interviewees mentioned recovery champions (see staff interviews), and no prisoner referred to them in these terms. However, some DRWs' operational models sought to make use of peer workers, and a number of

prisoners referred to peers (Brixton), mentors (Manchester) or expeditors (Holme House) who were paid for taking on these roles. In Manchester and Swansea, peers were recruited and paid by less direct means. Jobs as wing cleaners – whose working hours meant they could not attend groups – were given to programme graduates and other trusted prisoners. Finally, High Down had no structured peer system, but graduates of the DRW's intensive programme often remained on the wing, and offered something in the way of an informal support system.

Where benefits were identified, they tended to lie in the development of trust and a sense of community, particularly when prisoners first arrived. One Brixton new arrival had felt able to disclose his problematic cannabis and cocaine use for the first time:

I was quite quiet about my addiction. I didn't really want to talk about it and that. I didn't feel like I even wanted to give up... [But] two peers come up to me and said 'what's your plans? Have you got an addiction?' The first time I've ever admitted that I have, I've gone 'well yeah, I have.' They said 'do you want any help with it?' And then they just offered me a variety of things, and it's gone from there really (Brixton).

Similarly, a Manchester resident who was well known in both the prison and his home community had helped several new arrivals:

I'm from Salford and he must have found out off someone because he came in my pad and went, 'are you alright?' I went 'yeah, yeah.' [He asked] 'no coffee and that?' And I went 'no, no.' I thought he was coming to say, 'give me some coffee.' But he went one minute ... and he came back with some sugar, milk, coffee, and went 'here you are, let me make you some. You're from Salford, aren't you?' And it just broke the ice straight away' (Manchester).

Other interviewees identified that this peer, who had a strong twelve-step background, had led them to give serious consideration to attending mutual aid meetings following their release. Perhaps unsurprisingly, similar patterns played out with peers who had attended High Down's twelve-step programme. Some graduates were seen as highly visible advocates for mutual aid attendance, in addition to supporting a positive, pro-recovery wing environment:

They're still going to AA, CA, and NA. Like [name], he always tries to find people that needs help and he'll say 'oh yes, this is good for you, that's good for you.' And I find [him] quite an inspiration, to be fair... He's so energetic and positive about everything, and it's, like, wicked, you know? It makes you feel better (High Down).

Despite the absence of recovery champions being referred to in these terms, DRWs thus appeared to have developed a series of responses that made use of programme graduates and peers.

Despite these positive accounts, in both Brixton and Holme House, we spoke to notional recovery champions who had become sceptical about their role. For one, the 'politics' of active engagement outweighed any benefits from providing active support:

I don't participate in the programme as much as I should. I am there as an ear and a shoulder for the people who are struggling ... but when you involve yourself in the midst of

everything that's going on, the politics so to speak, you are then more vulnerable as a product of the system. Whereas if you can stay on the fringes of it and not get drawn into it too much it kind of makes your life a bit easier (Holme House).

A second peer, based in Brixton, had become deeply cynical about the wing's management and treatment offering:

I'm a peer supporter and, yeah, they fucked up in here. And I couldn't be arsed to fight with [staff] for the last two months, but you know what... I don't need your prison £2 extra money, mate. Or you letting me out of my cell for another half hour. I don't want that, man. I'm alright. I just don't want to get disturbed. ... It doesn't bother me what happens on here (Brixton).

This second interviewee had felt let down by the reality of wing provision, and had smoked cannabis on the DRW several times. Swansea also had experience of drug-using peers or mentors. Shortly before the rapid assessment, two full-time workers were removed from the DRW after being caught selling Subutex. Their position as trusted workers required them to spend time outside of the DRW's segregated location, offering them a unique opportunity to participate in drug markets (see Lloyd *et al.*, 2014).

Summary

Prisons with more intensive treatment offerings also had prisoner cohorts who spoke more clearly of building – and participating in – meaningful recovery communities. Other aspects of treatment also seemed to support the evolution of communities, with cohort-based models (in particular) bonding prisoners together through their shared experiences. Across the board, mutual aid groups were one of the most consistently welcomed aspects of DRWs' treatment models.

With few exceptions, prisoner interviewees saw harm reduction (the most prevalent treatment option) as being of limited use. Such groups tended to focus on education, and this yielded rapidly diminishing returns. Those who had undertaken specific harm reduction groups once, felt that they learnt little new by being re-taught' group contents a second time. Locally-developed programmes (a considerable component of Swansea, and the mainstay of Manchester and Styal) received mixed reviews. Prisoners developed individual preferences for certain treatment components. This was particularly apparent in Styal, where RAMP (a twelve-step group) was consistently praised, and 'gardening' divided women into lovers and haters; and Manchester, where peer led groups (Narcotics Anonymous) and Victim Awareness were widely seen as very strong course components. Interviewees' praise of twelve-step approaches also fed into feedback about High Down, whose structured, intensive twelve-step programme held the most positively-reviewed programme content of any DRW.

Finally, the term 'recovery champion' had not been taken up by any DRW site. However, several sites had developed alternative roles for senior peers and programme graduates, some of whom were paid. Comments on these prisoners were scarce, though a handful of interviewees were highly positive about individuals who had provided them with outstanding one-to-one support –

particularly when they first entered the DRW. The peers we interviewed demonstrated less of a commitment to the values and aspirations that notionally underpinned their DRWs.

Challenges

Drug availability

Interviewees raised drug-related concern in every site.

In six DRWs, this primarily centred on the availability of illicit drugs. In Brinsford, these were primarily novel psychoactive substances and cannabis:

Since I come back here, I've had 4 or 5 [smokes of cannabis] in two weeks. And I've been in [the DRW] all the time. An officer came on last week, said "I've never ever smelt it this strong and I'm Jamaican," and I said "the funny thing is this is meant to be a Drug Recovery Wing." Black mamba, spice, that's down here. And you do get weed as well (Brinsford).

As the following quotation identifies, even if interviewees were motivated to change, they felt that the widespread availability of intoxicants made this very difficult:

Yesterday for instance I was in the sosh room and someone's rolling a big one in the chair. People are smoking it in there and everything. Like I ain't gonna say I wanna stop smoking weed but I can't do it in here I don't think anyone can do it in here. It's expensive and that, but that don't stop you, because you see everyone else high and that in the wing and you want to do it... (Brinsford).

Similar problems – in terms of the predominant varieties of drugs, if not quite to the same extent – also characterised Brixton. From the rapid assessment through to the conclusion of fieldwork, cannabis was seen as an endemic problem with a smell of marijuana often noticeable on general population wings:

When I first come on here, I was like, what's that? [sniffs] I thought someone was growing cannabis on the wing [laughs] (Brixton).

Whilst the availability of cannabis was generally felt to be less pronounced within the DRW, the re-rolling of Brixton to Category C/D status was felt to have exacerbated the problem as a considerable cohort of prisoners worked in the community each day.

In all other prisons, synthetic opioids were identified as interviewees' main concern. In High Down and Holme House, Subutex was thought to be rife:

If you want drugs in this jail the drug recovery wing is where you buy them (High Down).

[Subutex] is the new currency in prison now... Everything is Subutex (Holme House).

The restructuring of High Down's DRW was felt to have caused significantly more problems for wing residents, too. Where once the DRW had inhabited an enhanced wing separate from 'main jail,' a desire to engage more former heroin users had led to it being relocated to a houseblock alongside the prison's two cohorts of OST patients. Whilst the availability of diverted opioids was seen as a relatively small issue during the rapid assessment, they had now become so readily available that market forces had come into play:

[Subutex] sells for a quarter here for about two mils: a quarter of tobacco. But if you take two mils from here to any other wing it's half ounce, so that's because it's rife here because everyone is on them (High Down).

The status of Subutex as both a commodity and a currency also had consequences within prison wings. As a Holme House interviewee commented, the winners and losers in this black market could be clearly identified by a quick look at their cells. Those who were capitalising on illicit opportunities were seen to be thriving:

You always know the people who's doing it, and that, because you can tell by what state their pads are in... I mean, the ones with a pad that's chocca, like, they've got everything, Playstations and loads of posters and loads of toiletries and canteen and stuff like that... and quilts and stuff like that, rugs and that, curtains; proper curtains and stuff. Yeah you can just see [laughs], it's plainly obviously, like (Holme House).

Contrastingly, those who were struggling and trying to sustain a habit found themselves rapidly enmeshed in cycles of victimisation, bullying, and debt.

An addendum should be added to the Holme House accounts presented above, distinguishing drug availability from prisoners' perceptions of drug availability as a substantive problem. Whilst ready drug availability would seem to be an obvious problem for a Drug Recovery Wing from a rehabilitative perspective, none of our prisoner interviewees raised it as a concern, as a challenge, or as one of the wing's most difficult features (unlike in other DRWs). Instead, the widespread availability of drugs appeared to be accepted as one of the wing's general features. This perhaps related more broadly to the wing's context – and interviewees' clear shortfalls in recovery capital, and concomitant motivation to change.

Finally, drugs appeared to be less available in Styal and Swansea. In Swansea, prisoners identified drug availability as a low-level concern. Only a couple of prisoners commented on Subutex being readily available, though several commented more broadly on the existence of a black market (and consequent debts) related to tobacco. For the women in Styal, drugs were generally presented as far less available than on other locations – particularly when compared with 'the wing,' a two-spur residential unit that housed newly-arrived and detoxing prisoners. However, interviewees also described an undercurrent of occasional use within the house, and a substantial party had taken place on the Easter Bank Holiday weekend just before one interview. Over this period women described only using pharmaceutical tablets (particularly tramadol and Subutex), and this had created some tensions between those who had partied, and those who wished to remain drug free:

I basically told [staff], 'it's been frantic over the weekend. People had to isolate or lock themselves away,' which I did... I didn't want to know because I didn't want [drugs], and they were all acting so obviously... (Styal).

This event should, perhaps, also be taken in context: women were clear that drugs were generally not a real problem within the wing, and this party had been seen as exceptional by both women and staff.

Co-locating OST and non-OST clients

Manchester was the only DRW where no interviewees raised drug availability as a concern. However, a separate issue was raised: the presence of people with methadone or Subutex prescriptions on the wing. This was not raised as an issue of diversion. Instead, interviewees noted that detoxifying prisoners found it very hard to engage with intensive group programmes, whilst people with histories of drug use often found it hard to live alongside those who appeared 'smashed' on licit prescriptions:

It's like [a peer] was saying yesterday when everyone was in here, he thinks everybody should be detoxed before you get on the wing, which I agree with. If you're doing your detox on here, your mind's not set on the course, it's set on the detox (Manchester).

It kind of wound me up at first because, not for me again, it's more for the other lads. I can see people coming on and they look smashed. Then there's people on here you can see that they're anxious because they know that they've been on something and it's fucking hell, they've probably got a craving from that then. It's not fair on them (Manchester).

Similar concerns were raised in both Brixton and High Down, where prisoners who were medication abstinent were disgruntled by the presence of those receiving OST:

I believe personally that [pause] in order to be clean you need to be abstinent, that's my personal belief... But, up here, most people up here are on methadone (Brixton).

I don't think it helps [being co-located with OST recipients], for people that are serious about recovery and they're putting them in the steps like Stepping Stones and the Bridge, people that are serious about it, it's no help at all (High Down).

Tensions were particularly clear in High Down, where the DRW's structure meant that – of necessity – prisoners who had detoxified from OST but who still wanted support had to live next door to the prison's entire OST caseload.

Reinforcing the significance of OST as a social identifier (for a broader discussion of the social significance of OST, see Page *et al.*, 2016), interviewees in Holme House raised exactly the same issue, presented from another perspective. Nearly all DRW residents had active OST prescriptions; several identified that they would appreciate the removal of all OST-abstinent, non-programme 'lodgers' from the wing, as they felt they were looking down on them:

R: I don't think they should put people on here who's not on the drugs, you know, methadone and that. Like you know lodgers and that.

I: So what effect do lodgers have?

R: Like "methadone heads, smackheads" [with vehemence] like you know... I've never actually heard them say it but I've heard people talking about it.

I: And you can feel it?

R: Oh aye. Oh aye. Not many. But there'd be a good 15, 20 of them out there not on methadone. If not more. You know what I mean (Holme House).

Indeed, the role of opiates as a marker for recovery capital (and individuals' places within prisoner hierarchies) seemed apparent from this account. Whilst OST-free prisoners framed their concerns about living alongside OST cohorts in terms of medication and intoxication, the stigma associated with heroin use and the fundamentally different offending, employment, educational and relational histories of the two groups also offered a clear social fault line with the potential to further discourage inter-relating.

Accounts from prisoners thus appeared to highlight the individual and social challenges inherent in trying to mix the two groups. Not one prisoner interviewee saw this as a desirable combination. Strikingly, this uniformity of opinion was not shared by staff: who widely felt that OST clients needed to be housed alongside OST-abstinent prisoners, if they were to be supported through detoxification (Page *et al.*, 2016).

Bang-up

If prisoners were to be unlocked, they felt they needed access to a full regime. Half way through fieldwork, Holme House switched to a new regime wherein the DRW was reclassified as a Category C unit within a Category B prison. When not at work or education, DRW clients were generally free to socialise, shower, and carry out other activities. Interviewees found this very hard to manage, identifying that time dilated and arguments escalated when doors were opened:

If 'owt you've got too much association I think. A bit less would be better... People start getting bored and stuff starts happening. Just daft arguments over daft things.... Bit too much freedom. I think it's all right how it was before (Holme House).

I don't like it, me... It's all just open now... You can't explain [why you don't like it]. You'd have to be in a while to do it and experience it, because you can still go in your pad and shut the door and you'd still be banged up really, but because you know inside your head everybody else is out and nobody's banged up, it just seems to drag. But if everybody's behind the door and you know they're behind the door it just seems to go to faster (Holme House).

As with the colocation of OST and non-OST prisoners, prisoners' accounts contrasted starkly with those of staff, who invariably presented additional time unlocked as a pro-social, therapeutic, community-building exercise.

In Swansea, prisoners described marginally more ambivalence towards long periods of 'bang-up'. On the one hand, a small number of interviewees found the wing's current regime (which included twenty-three hour bang-up on three of five week days) difficult, and criticised it for offering a lack of recovery support:

I don't think that's helping you recover just locking you in your cell for 23 hours a day (Swansea).

However, others supported the Holme House view. Again, the issue of time management was a prominent concern:

I: So you're 23 hour bang up?

R: Yeah. Nightmare, but I'd rather be banged up than let out because it goes quicker behind your door if you keep yourself occupied (Swansea).

As in Holme House, Swansea had no resources with which to provide additional programming, or to support additional groups should DRW residents be more routinely unlocked. Moreover, Swansea's DRW sought to segregate its residents on principle; they were not allowed to access purposeful activities (work or education) on other wings. As such, additional hours unlocked would have meant time devoted to unstructured 'community building,' the perceived limitations of which were amply described in Holme House²⁶.

Challenges: Groups

The final set of prisoner concerns centred on groups. Interviewees in Brinsford, Manchester and Swansea voiced some frustration at the perceived repetitiveness of group programmes, whilst those in Brixton were frustrated that groups were often cancelled because of staff shortages:

Well, we try and get [NA] once a week or once a fortnight, but it's the prison, the prison sometimes block it and they don't tell us till the last minute. It really is the most frustrating feeling. Sometimes they don't even tell the people till they get to the gate; no, we can't do it tonight because there's no staff. But that's the prison, that's prison rules and that's the way it's always going to be (Brixton).

Additionally, a small number of interviewees highlighted core group processes – group leadership and peer behaviours, in particular – as problematic. In Styal, concerns particularly centred on the perceived youth and inexperience of staff:

[Worker 1] is quite... she's very young, [Worker 1]. I mean there's some things that I say, and she doesn't understand what I'm talking about... And. She treats us like children. Shouts a lot. "You will have this, you will get a warning if you do this." I think sometimes I think they're a little bit [with emphasis] *out of their depth*. That's how it sometimes comes across (Styal).

²⁶ The – rather unexpected – presence of a full-sized snooker table within Swansea's DRW might have lessened these pains, though it would have struggled to provide ample entertainment for the wing's full fifty residents.

In four prisons (Styal, Brinsford, Brixton and Swansea), interviewees had greater concerns about confidentiality within groups, and more broadly about their peers:

In here if you say you've tried crack or heroin, you get bullied for it. If I had a problem with heroin, I wouldn't tell people on the wing. I'd end up having a fight. Because I wouldn't let them say to me what they're saying about other people on heroin. In one DARS group, someone said it and everyone laughed. They were taking the piss for weeks. Getting tea bags and that and putting them in his face, saying here's some gear. You know what I'm saying (Brinsford).

Though such accounts were often a minority (particularly in Styal and Swansea), for those prisoners who felt unsafe around their peers vulnerability and disclosures were impossible; and so therapeutic gains became concomitantly hard.

Summary

Prisoners identified a range of challenges within their DRWs. Leading these concerns was drug availability, which was only identified as non-existent in Manchester. In other sites, novel psychoactive substances, cannabis, and synthetic opioids were the most widely available illicit substances and, in High Down, the physical proximity of the DRW to OST wings apparently meant that Subutex was half the price here than on any other location.

A second set of concerns centred on the colocation of OST and non-OST clients. The stigmatisation of opioid users has long been noted (Lloyd, 2013) and, in the rapid assessment, there were strong indications that these populations did not mix. By the time of process interviews, most DRWs had come to hold a mixed balance of OST and non-OST clients. However, neither group found this a comfortable balance. Those engaged in intensive treatment programmes felt that OST (and detoxification) prevented their peers from engaging in group processes, and could trigger cravings for those with histories of opioid dependence. Contrastingly, OST recipients felt that other prisoners looked down on them and, as such, could hinder their capacity to make progress.

Thirdly, interviewees noted that 'bang-up' was an issue, though not in entirely obvious ways. A level of disquiet was apparent, when prisoners were locked up for extended periods of each day. However, prisoners were far more vocal about their dissatisfaction when their doors were left unlocked all day without access to a programme of purposeful groups. Whilst staff saw this as community-building, prisoners clearly felt uncomfortable about being unlocked, saying that time dilated and they faced a perpetual risk of being badgered by unwanted peers.

Finally, group processes were felt to be suboptimal in some sites. In Brixton, twelve-step groups often could not be delivered, because of the availability of officers. In Styal, several women felt that groups were sometimes badly managed due to an inexperienced staff cohort. And individuals in Brinsford and Brixton felt that leaky and judgmental groups made confidential disclosures high-risk.

Resettlement

Situating Resettlement

Resettlement was often one of interviewees' predominant concerns. A young man in Brinsford had moved to the DRW with the specific hope of accessing improved aftercare support, whilst prisoners in other locations had often experienced multiple indignities following release from earlier sentences. All understood that resettlement was where the real difficulties were likely to begin, and where any gains made in a Drug Recovery Wing would either flourish or fall.

The biggest thing for me, I need help when I get outside. It's not like putting everything into this, getting outside and re-offending and coming back to prison. What's that going to achieve? It's going to achieve nothing is it? (Manchester).

Basically I'm just getting out and I'll be on my own. I will be getting out on my own. Even though I've got help in here now with the DRW and that, when I get out there it all starts. (Holme House).

The problem for me has never been in here, it's always when I'm faced with reality when I leave them gates. I can be the model citizen and prisoner in here (Swansea).

The quotations above represent a very small subset of those covering the same theme. Real anxiety centred on release; and, for all but those with very robust family support and guaranteed exit plans, was an overriding concern.

Resettlement: Professional Support

Across all sites, thirty-six interviewees were reliant on prison-based services to secure housing for them following release. Virtually all were within four weeks of release, yet only four reported having been seen by anyone working for or with a housing provider. None had seen any benefit from these appointments by the time we spoke to them:

I'm waiting on St Giles to get back to me, which is concerning now... (Brixton).

I had a meeting with St Giles, and... I thought that was useless, wasted my time going down there (High Down).

Employment support appeared to be similarly lacking. Of the fifty interviewees who were approaching imminent release and who had no definite work lined up, seven had been seen by someone working for or with an education or employment agency²⁷. Two had found the experience unproductive, or actively discouraging, identifying a sense that resettlement services were uninterested in – or unresponsive to – their stated needs:

²⁷ Three Brixton residents were also awaiting appointments with Working Links, though no time or date had yet been established.

A guy from [an employment agency]... came over, spoke to me, and I was explaining about maybe wanting to go into further education, learning, changing my trade.... So I said, "I want to go back into uni and maybe do something." And do you know what he guided me towards? A factory job. He said, "do you not want to go on the production line in a factory?" I'm not better than anyone else, and there's nothing wrong with factory working. But a factory job, it's a slow death. I may as well be in here (Holme House).

One interviewee was more cautious, hoping that a promised opportunity would come through:

They've said they're definitely going to get me a job within the first one or two weeks. But they said they'd see me this week; but it's already Tuesday. I'm just waiting on them... People just love to say things to you, just to get you out the way... (Brixton).

And four – all in Manchester – described positive experiences of employment agencies. Here, one conventional employment agency was well-reviewed in preparing interviewees for a broad range of resettlement needs, including work:

[Achieve] help you with getting a job, not just voluntary, paid work. They've got me a bank account opened. They've got me a citizen's card so I've got identification. What it was is I need to make the best impression I possibly can on the army when I apply in nine month's time. It's probably a bit of a selfish reason for doing it, but if I go for voluntary work and the army look at me and say, well, he's been voluntary for the last nine months... So I'm going to do that (Manchester).

A nationally-recognised offender employment programme was also operating throughout Manchester, and one DRW resident benefited from this, describing the clearest example of employment success encountered in any site:

I had a job interview ten weeks ago with [a national chain of cobblers and keycutters with a reputation for outstanding resettlement support]. He's offered me a position, but I've got to wait for a position to arise. I'm out in three weeks but there's not a definite position going to be there in three weeks, so I've got to wait. So I need to keep myself busy, that's why I'll do voluntary work (Manchester).

Though he had robust family support, his prospective employers had also made it clear that they would offer an additional safety net – including help with housing and available finance for immediate financial needs.

Resettlement: Housing

Given interviewees' widespread belief that safe and secure housing would be hard to access, several looked towards alternative sources of provision. Foremost amongst these came placements in residential rehabilitation or specialist supported housing, secured through prisons' in-house psychosocial teams. Manchester and High Down appeared to have been particularly streamlined processes, with four referrals accepted between them:

[My counsellor has] done... she done all my work to get me into rehab, she went to the funding board... I'm going to a 12 Step rehab in Weymouth, I'm going there... Honestly I cannot tell you how grateful I am. Never in my life before have people fought so hard for me (High Down²⁸).

I've gone from heartache to absolute glee. On Wednesday, last week I had an interview for a place in South London. They turned me down. And yesterday, [another service] manager came in... I got accepted straight away... It's supported housing It's a dry house, I can move in there, do groups, go to AA. And start my life again (High Down²⁹).

One further interviewee had his application for residential rehabilitation refused, on unknown grounds; a second lost his funding after being re-sentenced for a new offence.

A very small number of interviewees had also managed to retain strong access to secure housing, having held on to tenancies whilst imprisoned. Such tenancies were not always uncomplicated; but they were, at least, a home to go to:

I say I've kept my flat, but my housing officer said: 'you get one more custodial and you're going to lose your flat,' [even though] none of the offences were committed in or around or had anything to do with the flat. But I am in arrears for water rates, there may be a problem there but I don't think it's something that I can't solve or resolve (Swansea).

Brinsford interviewees were also in a strong position here; though few elaborated, three identified that they had been guaranteed access to very cheap, secure, self-contained accommodation.

A further group of interviewees knew that they could return to live with their partners or parents. For a handful of young or first-time offenders with relatively robust recovery capital, and for older interviewees with stable families, this was their preference:

I've got everything at my house. Mum and dad have been out and bought me all my weights. I've already got my treadmill there, so I'm alright when it comes to fitness regime at home. My mum and dad are, I couldn't ask for better parents (Manchester).

However, for others this was a last resort. Family relationships had often been strained by years of drug abuse and offending, often against parents or partners. Some interviewees also placed family members at the heart of their using, with several girlfriends and brothers identified as key triggers for previous relapses and / or periods of exceptional drug use:

If I get out there this time and I don't get a B&B I'll be living with my brother, and me and my brother's going to relapse together because he's drinking out there now he is. So I don't want to be going in that environment and putting myself at risk, going in there knowing I'll have a pint, a pint will lead to speed, speed will lead to heroin and heroin will lead to benzos then [laughs], I'll be honest with you, it's tricky (Swansea).

²⁸ This interviewee was reimprisoned within approximately two weeks. He is pseudonymised as Mike (and his mother Jane) in the follow-up chapter.

²⁹ After a period of stability in supported housing, this interviewee returned to alcohol, was ejected from his supported housing, and was reimprisoned. He is pseudonymised as Colin in the follow-up chapter.

I've told [my partner], I've said; look, when I leave prison I'm going to sort out the probation and the services and everything to get a place sorted so that I've got somewhere to stay where I can bring my kids, somewhere I can get my head down and do what I've got to do. And she's hell bent on trying to get me to move back in with her and I'm like; you're not listening to me, you're not listening to me... (High Down).

Paradoxically, many such reluctant returners felt that prison and community housing services felt *able* to reject them precisely because of this fallback. Housing services were felt to be performance managed on the basis of housing, rather than individuals' return to drug use or reoffending; and so the needs of those with drug dependent or criminogenic relatives could be deprioritised, as they were 'only' likely to end up being reimprisoned or drug dependent – not 'street homeless.'

Lacking both structured support and secure family arrangements, a clear majority of interviewees expected to return to the lowest rungs of the housing ladders: night shelters, hostels, and B&Bs:

Unless they come and tell me something before I get out I'll be getting kicked out of the gate with no money and just my travel pass to get back to Sheffield. On the streets. I know where [a night shelter] is, and I have to go every day to see if there's a space what comes up or if I'm on the street or whatever (Holme House).

Those who were dependent on such accommodation had often lived in similar places before, and almost invariably saw them as a very poor outcome likely to greatly impair their chances of staying out of prison and / or drug free:

I got no confidence in getting out at all. I'd rather them sit and say "what do you want, what do you think will keep you out of jail?" Than just throw me in a hostel full of criminals. That's what they did last time. And I've been burgling with them all in the past. I just wanna go [to] a place where... there's no idiots running around knocking on your windows smoking weed saying "when you coming out?" (Brinsford).

Considering my housing problem is so important, housing haven't seen me here, you know, they still haven't been in touch with me. If it's that important to my recovery, and you want me to do well, shouldn't I be a priority? I'm supposed to see someone six weeks before I get out, I'm now down to four weeks and I've still not seen them... The system is not set up for helping people when they get out of jail (Manchester).

For all but a lucky few, safe and secure housing thus appeared to be unlikely.

Education and Employment

Paid employment

Our interviewees not only lacked professional support around education and employment, many also lacked resources of their own. Reflecting the section on previous employment above, in each of High Down, Manchester and Swansea, two or three people expected to return to manual trades:

I've phoned my old boss. I've got in contact with my old boss. He said, look, if you can come and show me that you've changed I'm more than willing to give you your job back. You know, it's a second chance and there's not many people who get that second chance because I've been here, I've seen it (High Down).

I've got a job when I get out [as a] labourer for my uncle. He's got me a job (Swansea).

Despite this lack of job opportunities, many interviewees expressed a profound desire to work. This was particularly the case in Brixton, Manchester, and High Down where employment dominated interviewees' aspirations for the future:

In five years' time, hopefully become an electrician, working as an electrician (Brixton).

Again, it appeared striking that in High Down, such aspirations often centred on service-sector or white collar work:

What I'd like to eventually do is get out and train to be an outreach worker or something like that, they say do what you know and I know addiction. I'm not really qualified to do anything else but addiction is one thing I understand and addicts are one thing I understand. And I think the whole 12 Step philosophy is about one addict helping another and I believe that is my niche in life, that is my mission (High Down).

In other sites, the picture was more complex. When asked (in depth) about their ambitions, only three Holme House interviewees identified a desire to work. Reflecting the low recovery capital of our interviewee here, the others placed their focus on more basic goals: being housed; reducing their drug use; not returning to prison:

My goals? Don't know, just stop coming to jail, really. Stop crime. Innit (Holme House).

I'd like to live just a nice peaceful life, stop coming to jail (Holme House).

And in Swansea, interviewees were evenly split. Five identified that they either had secure positions, or intended to seek out every available opportunity:

I like retail, I enjoy it [pause] I wouldn't particularly want to work in a factory, I'd like to see different people every day and obviously in retail you see so many people on a regular basis (Swansea).

However, five were also clear that they had no intention of working. For one, this was because his mental health was his priority:

That's one thing I need to get sorted is my depression and stuff like that and paranoia, but that's with the amphetamine, the paranoia I mean. So I'll probably be going onto Income Support or the sick (Swansea).

For others, a broad wariness of structured activities – including employment – shaped their goals and ambitions. For such interviewees, a lack of interest in employment often seemed to be broadly tied into difficulties in conceiving of the future, or believing they could achieve ambitious goals.

Education

Very few interviewees were seriously considering further education following release. One Brixton resident aspired to take up vocational training:

In five years' time, hopefully become an electrician, working as an electrician, get married (Brixton).

A handful of interviewees also identified long-term ambitions to work in settings that might involve further study – particularly as addictions counsellors or academics:

[I'd like to be] sitting where you're sitting. Interviewing someone sitting here... Trusting someone. I would love to help people from prison, man. I would love to (Brixton).

A small number also stated a desire to start University, though this only seemed like a tangible proposition for one – who already held an undergraduate degree. Of the others, one was a prolific offender in his early forties with no formal educational qualifications, and the second lacked A-levels (or equivalent qualifications). Neither had received any support from prison-based services in identifying realistic pathways to continuing education.

Prescribing

Prescribing was barely raised as a resettlement issue by interviewees. Those who had detoxified whilst in prison had no need for a transfer to a community provider. Those who were not intending to detoxify, and those who were intending to retox, often had multiple previous experiences of imprisonment and release. Though many were anxious about other resettlement issues (such as housing, relationships and work), none voiced any concerns about the smoothness of transferring to community prescribers. Indeed, interviewees suggested that they felt more able to achieve ambitious goals in the community, and often provided narratives that framed the community as the place to achieve abstinence³⁰:

³⁰ This was particularly the case for a High Down interviewee, who described a longstanding relationship with a trusted drug worker in the community. He felt that he wanted to detoxify under her supervision, rather than in the chaotic atmosphere of a prison. His belief that this was the right path for him had been reinforced by previous experiences of abstinence followed by relapse.

Two milligrams of Subutex. That's what I came in with. People are surprised by that but I've thought, no, I don't want to really go up. My key worker wanted me to go up so I've kind of compromised and stayed on two mls, I asked her actually what she reckons I should do, she knows me better than anyone and she said; stay on the two mls, detox when you're outside... Yeah, she said; detox when you're outside (High Down).

I want to be off it to be honest with you. I've been thinking of doing one of those rapid detoxes when I get out, because I've had enough of it. Thirty six year old... (Holme House).

Though few interviewees contextualised achieving abstinence with reference to other forms of stability – for example, being in secure housing – being medication abstinent before release was nonetheless widely felt to present a particular risk of returning to using heroin or offending once out.

Despite this, it seemed striking that no interviewees identified risk of overdose as their primary reason for wanting to stay on a prescription – though this was presumably underpinned many drug workers' reasoning for ensuring prisoners returned to the community with a sustained prescription:

[My prison drug worker] keeps saying to me that he'd like me to go out on a couple of mls of methadone as a safety back up. I want to get out on no methadone but the rattle pack – what we call it in here when you're coming off the methadone – it's no good to man or beast basically (Holme House).

Throughout these accounts, interviewees talked about aspirations to attain abstinence, and – occasionally – specific processes that might get them there. However, none were entirely nailed down – no interviewee had gone so far as to arrange an actual referral to a detoxification service, or set a defined end point to a continuous and progressive reduction regime.

Summary

A broad range of prisoner interviewees identified that resettlement was their main concern. Many had been in prison multiple times before, and believed that any gains they made within the DRW would either stand or fall once they left the prison gates.

In this context, the relative paucity of professional support seemed noteworthy. None reported having received a concrete offer of housing from housing services. Whilst employment support appeared to be rather more robust, the only four robust and consistently positive accounts came from one site – Manchester. This left many reliant on informal sources of support and, whilst this appeared acceptable to some interviewees with positive and pro-social families, others felt that returning to criminogenic family homes was effectively setting them up to fail.

Most of our interviewees expected to return to the lowest rung of the housing ladder – B&Bs, hostels, and night shelters. However, a handful had improved prospects. Four (in Manchester and High Down) had secured funding for residential rehab, a more substantial group expected to live with (sometimes high-risk) partners or family, and a couple had managed to retain their tenancies throughout their current sentence.

Employment prospects were slightly more optimistic. Two or three individuals in each site had strong expectations of returning to (usually manual) work, with all DRW residents in High Down, Brixton and Manchester expressing a strong desire for work. Our more marginalised cohorts in Holme House and Swansea had fewer expectations; they also held a goodly proportion of interviewees who expressed no desire whatsoever to work. Education held a less central role in prisoners' release plans. A couple expressed some desire for further study, though none had any form of concrete plan, referral, or application in place.

Finally, the continuity of prescribing requires some attention, due to the greatly elevated risk of overdose in newly released prisoners (see Chapter 2). Most of our interviewees with histories of opiate dependence had either completed detoxification, or intended to be OST abstinent before release, meaning that continued prescribing was not an issue for them (though overdose may well have been). However, even in Holme House where the majority of interviewees expressed a desire to be released with an ongoing prescription, this was not seen as a concern. Prescribing 'through the gates' appeared to be working effectively.

Understandings of Recovery

Each of the seven DRWs included the word 'recovery' in their name. This included the two that had been given alternative titles – Manchester's Recovery Through the Gates, and Styal's Fox Recovery House. In tandem with the positioning of DRWs as being at the heart of a recovery agenda, this emphasised the importance of exploring interviewees' relationship with 'recovery.'

'In recovery,' not 'in recovery,' 'recovered...'

In nearly every site, a clear majority of interviewees felt that they were 'in recovery,' with a further few feeling that they had 'recovered.' Every adult site – with the exception of Styal – also held a very small number of interviewees who were either ambivalent about their recovery, or felt that recovery was not a word that they could apply to their current situation. Those who demurred did so for a number of reasons. Some felt OST and recovery were incompatible:

Because I'm on medication... I hate that word, 'recovery.' It's a word I don't like to use (Brixton).

Others felt that recovery was not a helpful word, because it implied expectations that might be hard to live up to, or progress that could prove impossible to sustain:

I: Are you in recovery?
R: No, because by accepting that there is a phase that can quite possibly be never ending where you're susceptible to falling back into drug use, by admitting that and accepting it to yourself, you're almost putting more pressure on yourself and making the job harder. If that makes sense (Holme House).

Still others preferred to use alternative terms that felt more meaningful to them, or to their current situation:

Recovery? No. I've never used the word before, so I wouldn't say... I would say it differently, because I'd say at the moment I've not been on nothing. I've not drank, not took drugs. I'd say I'm fresh [laughs] (Manchester).

This could be juxtaposed with descriptions of other contexts of 'recovery', that left interviewees feeling that it was an inappropriate framework for understanding drug taking behaviour.

Recovery to me is getting better at hospital. This, to me, is choosing not to take something. I don't know. Yeah, I guess I am kinda in recovery. My mum had cancer, though, and she recovered from cancer. And I'm just not doing something like that, and I would never say recovery to someone who had a terminal illness. Because they'd just say: "fuck off. Just don't take it, you wanker" [laughing] you know what I mean? (High Down).

As these quotations suggest, interviewees often implied that they had not reflected extensively on the meaning of recovery despite often having applied to, and being housed in, recovery focused residential treatment units.

Recovery as drug-related

Those who did own the word ‘recovery’ ascribed two main meanings to the term. For a substantial proportion, ‘recovery’ was exclusively about changes to their drug use. In some instances, this meant complete abstinence:

I realise that my body is a temple. [My counsellor] said, you didn’t born an addict. No one didn’t born smoking or drinking. No-one didn’t born that way (High Down).

Recovery, it means being abstinent, being abstinent from drugs and taking every day as it comes. I mean, we all get our down days, don’t we? It’s how you deal with them. Heroin’s not the answer or alcohol (Styal).

Recovery is just... getting off drugs. Recuperating off them (Holme House).

[Recovery] means staying abstinent from drink and all the drugs, I’m going to be in recovery for the rest of my life in a way, like I’m going to be an alcoholic for the rest of my life it’s just a matter of do I drink or do I not, and I’m not going to (Manchester).

This narrative was particularly strong amongst graduates of High Down’s twelve-step intensive programme, where two interviewees included sustained abstinence from cigarettes within their long-term understandings of lived recovery.

Another substantial subgroup understood recovery as being about specific changes to their patterns of drug use. Here, the clearest site-specific message emerged from Holme House. With a DRW filled with OST recipients, for a substantial subset of interviewees ‘recovery’ ideally centred on (community-based) detoxification. Deep reservations about meeting other heroin users whilst attending the chemists for methadone proved a powerful motivator here, as this was seen as integral to sustained behavioural change:

I want to reduce as fast as possible, like I say, because that’s where, you know where I mean like, even though it’s a new town and that, if I’m going to pick up my script, like, get me bottle of meth, like, I’m going to see drug users again. You know what I mean, it’s obvious I’ll probably see a few people that I know from jail and that, you know what I mean, yeah, that’s where it, like, all started (Holme House).

For these interviewees, OST was the substance that shaped their daily routines and rituals, and which led to greater contextual risks of returning to illicit heroin use. Detoxifying from methadone consequently shaped their immediate ambitions, though this did not mean that they aspired to stop using all drugs.

Indeed, for interviewees in all sites the prospect of giving up alcohol was often a bone of contention. For those who did not identify as historically alcohol dependent, alcohol consumption was widely seen to hold both a 'normal' function within weekly life, and to be central to post-release celebrations.

The day I get out I'll have a drink, probably (Brixton).

I'd just drink normal on weekends (Holme House).

The centrality of alcohol to interviewees' social lives was such that a handful of people identified that continued alcohol use was an integral part of becoming 'recovered'. To avoid drinking was also to avoid being 'normal'; and so meant isolating oneself, standing out from the crowd, and avoiding full participation in social events:

It's like if someone gets married, like my nephew or my niece gets christened. I don't want to be the oddball of the family stood there, when everybody's having a toast, with an orange. I want to feel...everybody wants to feel part of the group or part of their family. Nobody wants to be singled out and that's just human emotion. Nobody wants that, but yes, I'd love to...I just want to be normal (Manchester).

Another small group of interviewees saw themselves making changes to their drug (and alcohol) use, but continuing to smoke cannabis. This was a particularly prominent feature in Brixton, where sustained cannabis use was seen to hold a number of important functions. Firstly, it was seen as unrelated to other, more problematic drug use:

I'd be alright with a joint, but I can say no to the smack and crack (Brixton).

Secondly, this meant that several interviewees felt cannabis use could be safely sustained, even when they recognised that they had something of a dependency on it:

I don't want to smoke it, but I know I can't stop it just like that. I want a routine [where] I'm not going to smoke before I go to work, I'm going to work, come home, have a wash, have a shower like you do, eat, and then have a spliff while watching Coronation Street or something like that (Brixton).

Thirdly, cannabis was felt to play an important part in regulating emotions, and helping interviewees to relax.

Weed keeps me calm, you know what I mean. I don't wanna stop smoking cannabis. [But] I wanna stop drinking spirits completely (Brixton).

And, finally, as with alcohol, cannabis was identified as a routine part of normal social functioning. For several interviewees, giving up cannabis would mean giving up their social circles and networks of support:

Cannabis is going to be the hardest one. All my life I've relapsed on the cannabis, but everything else I'm going to stop completely. That's why I think now in my head I ain't

going to touch it but I know if someone's passing a joint around I probably...I'd think about it before I'd take it. Because my mum smokes it... because I've got seven sisters three brothers and they all live over there (High Down).

Aiming for total abstinence was thus hard to reconcile with interviewees' clear desire for continued socialising, and their need for long-term informal support.

Others who were 'in recovery' had distinctive preferences for sustained use that seemed at odds with conventional interpretations of the phrase. One intended to continue using zopiclone, a drug he identified as the main reason he had been imprisoned. Of perhaps greater concern, a second intended to return to crack use, even though this had caused nearly all of his previous imprisonments, and – despite multiple attempts – he had no history of controlled use:

I: So do you reckon you'll go back to using crack?

R: Oh, do you know what, mate, I'm not going to lie to you and say no because I fucking love a pipe, but let's just say I hope not to fall into a heavy use of crack.

I: Have there been many occasions on which you've only had one pipe?

R: No [laughs] (Manchester).

This appeared to be a clear acknowledgment of an impending return to heavy crack use, given this interviewee felt that during his current sentence he had picked up few tools that would help him moderate his crack use.

Broader understandings of 'recovery'

Whilst a substantial group of interviewees only referred to drug or alcohol use when describing recovery, a similar number made reference to broader changes in their global health and citizenship. For these interviewees, 'recovery' centred on progressing towards (or attaining) conventional opportunities, particularly attended by happiness, thriving relationships, and secure employment. The prominence given to specific goal meant these definitions fell into several themes – though all were broadly clustered around the same core. For some, family (particularly children) were their primary goal, presenting their main focus as becoming a reliable carer and provider:

I've got kids now. Yeah, I've got three little girls, six, four and two. They're my world, do you know what I mean. They mean everything to me. It's just taken me...and when I first started having kids, I wasn't ready, you know what I mean, I was quite young and... It's the best thing in my life. It's the only thing that's really worth anything. I'm getting married as well soon ... And I'm looking at things a lot differently and, like, when I speak to my kids it's...breaks my heart, you know what I mean, like, my little girl saying to my missus, oh, is daddy going to stay home this time, you know what I mean. And I...like, before, I was going out to make money and it was...I was doing things for them, you know what I mean, to get by, 'cause I couldn't get a job, but now it's just going have to be, well, if I can't get a job, I'm going to have just keep trying and keep trying, 'cause I can't miss out on any more of them. It's as they're getting older. When they're young, they don't really understand what's going on. Like, my oldest is six now, and she's very intelligent, you know what I mean, and she's, like, top of her class (Brixton).

Stability and slow growth was an important theme here, contrasting with the chaotic or dependent drug use that had often preceded their most recent imprisonment:

Just stable in life. I mean, I'm not going to sit there and say I want my own business and that... But in the next five years I just want to be stable. I want a decent pay cheque every week, I want to be able to look after my daughter and just watch her grow (Brixton).

Employment was also a central bulwark of such goals; and a small number had begun to develop very specific business plans. A young interviewee in High Down was looking for family support to develop an industrial cleaning business, whilst a Brinsford interviewee had worked up a business plan to set up a bouncy castle rental service. These aims were, once more, situated at the heart of broader life gains:

I'd like to have my family, a nice house, and a nice car... Sounds stupid but when I get out I wanna start window cleaning. And then after I've saved enough money... my plan is to get legal, get a car, get me insurance, and start investing in bouncy castles. And once I've bought one bouncy castle, rent it out, get my money back, buy another one, and just keep on expanding (Brinsford).

Despite this wide range of recovery goals, given the histories and current contexts of our interviewees it seemed striking that few positioned being crime-free as integral to their recovery-oriented future.

For me recovery is getting out of the cycle of using and offending and learning to live a normal life but more importantly than that, giving me some sense of self identification and putting some meaning into my life I think. Because for me addiction's been a pretty meaningless existence and I like to have the normal things in life, I'm 41 years old and I'd still like to go and get married, some day, maybe have another child, I don't know. But certainly I'd like to have a job and feel like I was doing something worthwhile (High Down).

This may have been because our questions sought to focus interviewees on the positive aspects of recovery but, nonetheless, the widespread omission of offending from recovery understandings and goals appeared striking.

Therapeutic and insight-focused understandings of recovery

Beyond outwards social conformity and external pressures, a handful of interviewees also offered reflective definitions of recovery. These particularly centred on personal gains: a willingness to ask for help, inner change, or an ability to live life in a different way. Maturity, and beginning to understand personal growth towards change, was one key feature here:

You know some people didn't even start to grow up until they're like, look at me: my first start point at being off drugs from being 17 was 30, 31. We have all these different start points where you mature and you're able to to grow. A lot of people are just at that start point. But I'm further on in me head (Styal).

Others identified a need to change the ways in which they drew on personal resources and social networks, both opening themselves up to greater vulnerability, and seeking greater support for personal problems:

To just take one day at a time, become self-reliant instead of reliant on other substances, I don't know, just trying to stay more positive and if anything gets hard to ask for help, which is probably one of my biggest problems. I find it difficult asking for help. I need to build a decent support network. I need to keep going to the Fellowship meetings, get myself a sponsor, and try and stay more committed, if not for myself then for my kids. (High Down).

This, in turn, could invite reflections on the changes people needed to make to their social circles. Intensive group treatment had been a new experience for several interviewees who, for the first time, were beginning to realise that strong pro-social bonds could offer access to different kinds of friendship, intimacy, and interdependence:

Bettering myself is like... I've done my achievements in life. I've talked about my problems instead of holding them in... I don't want to be in that [violent] environment [in the community]. I've found out who my true mates are while I'm in jail... I've got a couple of mates what are writing, for me, from another jail what was here, but they're in another jail. They're closer to me than my other mates on the outside. I ain't got one letter from them. People in here are more my friends than I do outside. (High Down).

Perhaps because High Down's intensive programme was led by four diploma-level counsellors, it seemed striking that such conceptions were particularly prominent amongst prisoners housed here.

The special case of Brinsford

The responses garnered from Brinsford make it hard to position alongside the other DRWs. Within our sample of seven interviewees, barely any had heard, considered or discussed the word 'recovery.' Many said that questions about 'recovery' came as a surprise. As one reflected,

I've never really thought about it. Now I am thinking, I suppose I am in recovery. Because I've only smoked cannabis three times in, like, six months. And I've only smoked mamba, like, four times. (Brinsford).

Indeed, none were willing or able to own the word 'recovery.' When asked, three interviewees were clear that they were not 'in recovery'; two did not know; one felt that he had recovered ('I haven't had a drink or nothing in six months'); and the seventh framed things in prison language – 'I'm rehabilitated, boss.'

Whatever recovery meant in Brinsford's terms, it clearly did not mean long-term abstinence. Four interviewees had clear plans to have a celebratory drink on the day of their release:

I: Do you have any thoughts [about what you want to do following release]?

R: I just want to have a drink!

One of my mates... is a [pub] manager ... He's saying as soon as I get out, he'll take me out for a drink. But obviously it'll be in a pub or something, so a couple of pints.

Nonetheless, most interviewees aspired to make some changes to their alcohol and drug consumption: none wanted to carry on drinking and using drugs in exactly the same way as they had used them before entering prison.

Unfortunately, it seemed that Brinsford's DRW had provided interviewees with little insight into their patterns of past use. Several expected that their relationship with drink and drugs would change following release, despite historic evidence to the contrary:

I: Do you ever have one drink and then stop?

R: I've never ever in my life had one drink and stopped, no... (Brinsford).

Of particular concern for clients of a recovery service, only one interviewee felt that he had been left with any tools that would support him in managing his future cravings or drug use. Others seemed to be running more on good luck than judgment:

You see... I don't know, until I get out and pick up a drink, I don't know whether I'm going to be back to square one or not. But I've got the mentality when I get out to, like, not go back to my old ways. (Brinsford).

I: You want to go back to drinking?

R: Yeah.

I: Do you want to go back to how things were?

R: No.

I: So what's going to be different this time?

R: I don't know. Like, people have said that, for all I know, I could go out and get absolutely out my face and come back in the next day, but obviously... I'm going to try and make sure that don't happen. Because when I get out I'll spend the first night at home with my mum, so I won't be out, I'll just be having a few beers.

I: You'll be drinking at home?

R: Yeah, yeah.

I: Does that seem risky at all to you?

R: No.

I: Right, okay. Have you ever done that before? And had just a few beers without...

R: No, before I just used to... drink and drink and drink, but because I've not had a drink in... it'll be, like, eight or nine months, I think if I had three or four beers, I wouldn't want any more then, it's been that long, do you know what I mean?

I: Have you ever not wanted more in the past?

R: No. But obviously this is the longest I've been without taking alcohol or drugs in all my life, since I very first started taking them. (Brinsford).

Clearly, maturation and time spent alcohol free could have had a real impact on this individual's patterns of drinking. However, sustained abstinence also poses clear risks – should he have returned to drinking, his levels of tolerance would have been much lower, and his risk of alcohol poisoning very much greater. The apparent lack of both harm-reduction and insight-focused gains, alongside unclear gains related to understanding or conceptualising recovery, thus seemed to suggest a limitation on the part of Brinsford's operating model.

Summary

In each and every adult site, a clear majority of interviewees felt that they were 'in recovery.' The precise meaning interviewees attributed to this word varied considerably, though. In terms of drug use, various interviewees interpreted their recoveries as centring on total abstinence, on OST detoxification (but sustained use of other drugs and alcohol), or stopping the use of drugs that had caused them problems. In this last camp lay a substantial group of interviewees who saw cannabis and/or alcohol use as entirely unproblematic. The widespread social acceptability of alcohol and cannabis use were highlighted as particular issues here. For a substantial group of prisoners, recovery meant returning to some form of 'normality,' and social normality involved recreational drink or drug use.

Other conceptions of recovery involved broader moves towards social integration – (re)gaining employment, rekindling or repairing relationships, and moving towards a plethora of advantages that interviewees associated with mainstream society. For a few, particularly in sites with intensive treatment offerings, understandings of recovery went further still; and embraced personal change, inner journeys, and insights they had developed about themselves.

Finally, the definitions of 'recovery' offered by our Brinsford cohort made it hard to situate their definitions alongside those of adult interviewees. Few had considered the word 'recovery' before being interviewed. None aspired to long-term abstinence. Whilst some identified that they would like to be able to make some changes to problematic patterns of drug or alcohol use, none were able to identify any concrete means by which this would happen, or any tools the DRW had given them that might help them achieve these ends.

Chapter 7: Prisoner Follow-Up Interviews

Follow-ups: Introduction

This chapter is divided into a number of sections. The first details the levels of follow-up interviews. The second section focuses on drinking and drug use, followed by an exploration of interviewees OST prescriptions and experiences of overdose. We then proceed to detail levels of imprisonment within our original sample, followed by an exploration of undetected crime. This is followed by a detailed look at support at the prison gates. We then turn to interviewees' use of mutual aid, and reflections on their DRWs (in general). We then progress to cover several key areas of resettlement: education; employment; and housing.

Finally, we review the experiences of recovery supports – the parents and partners of our DRW interviewees.

Follow-up interviews: overview

We sought to interview each of our 58 former prisoners (see Table 7.1) plus one 'recovery support' six months after they had returned to the community. This does not include two High Down residents who were serving over two years, one Holme House resident who was unable to identify anyone who might know of his whereabouts in the community, or any former Styal interviewees (none of whom were due for release within two years).

Table 7.1. Attempted follow-ups

Prison	Prisoner interviews
Brinsford	7
Brixton	10
High Down	10
Holme House	11
Manchester	10
Swansea	10

Table 7.2. Secured follow-ups

Prison	Prisoners	Recovery supports	Triangulated	Unique
Brinsford	1	3	0	4
Brixton	6	5	2	9
High Down	5	5	2	8
Holme House	3	5	3	5
Manchester	2	4	2 ³¹	4
Swansea	4	5 ³²	2	6
Total	21	27	11	36

As Table 7.2 identifies, there were some variations in follow-up rates by site. Prisoners at Brixton and High Down – the two prisons that provided the least marginalised cohorts of interviewees – proved particularly traceable, whilst those in Manchester and Swansea were hard to track down.

The reasons for failed follow-ups varied, though without any clear differentiation between sites. A handful of prisoners were only able to identify vague contact details for friends, relatives or professionals who might be in contact with them following their release: a name and an area, for example; or a historic address but no phone number. Relatives' phone numbers (both landlines and mobile phones) often changed, or were disconnected. Letters to relatives' addresses went unanswered. Routine searches of local press identified that several ex-prisoners could not be contacted, because they had been reimprisoned.

There were two occasions where we had good reason to believe that a follow-up was being purposefully avoided. The first involved a young interviewee from Swansea. His mother was interviewed, and identified that he remained heavily drug-involved and had served two sentences for shoplifting in the six months between his DRW release and our follow-up phone calls. When we finally managed to contact him, he was resistant to interview – shouting “fuck off!” and hanging up before the interviewer had got through two sentences. We took this to signal an intention to withdraw from the study.

The second active withdrawal was a young Manchester release, who had secured post-release employment whilst in prison. He was widely seen as a glowing success in resettlement terms: securely housed, securely employed, undergoing managerial training, and swiftly starting a new relationship. He even revisited his DRW to talk to his peers about the progress he had made. However, phone calls made during working hours, during out-of-work hours and at the weekends

³¹ The partner and daughter of one former prisoner were interviewed together.

³² Telephone interviews were conducted with the mother and daughter of one former prisoner. We were unable to interview the prisoner himself (a warrant was out for his arrest during RS interviews, and he was re-imprisoned before we could speak to him).

were not picked up. No attempted contact elicited any form of response, and we took this as a sign of an intention to withdraw from the study.

Drinking and Drug Use

Drink and drug abstinent

Across all follow-ups, we identified three people who were fully abstinent from drink and drugs. For Mo (Brixton), his local faith community continued to act as one of his main sources of support. Having been imprisoned for an alcohol-related offence, and having considered the 'haram' nature of alcohol within Islam at some length, he was now keen that it play no further role in his life. The distance he now had from his alcohol dependent days had powerfully changed the way he thought about drinking:

When you start sobering up you feel like. Ahhhh, you feel like a bag of SHIT... It's the most disgusting feeling in the world and... just for me, for me personally it was the boredom... There's nothing to do. Then I drank. And the time will go but by the end of the night it's like, oh man. You feel so disgusting. And then you're sobering up your head feels heavy you feel thirsty it's just disgusting, nothing works, feel unclean. So you kind of look back sometimes and think, what was I doing? (Mo, Brixton).

Mo had touched neither illicit drugs nor alcohol in the six months since his release.

George's (Swansea) abstinence was overwhelmingly motivated by his children. Once a married working father, dependent cocaine and alcohol use had seen him lose everything he had – sacked from his father's business, separated from his wife, and able to see his children only rarely. Prison had acted as a wake-up call. On the day of his release, he visited his children. Six months later, he was speaking to them every day. He did not want to lose them; and for George, this meant any level of drink or drug use was too much to contemplate:

I: Do you ever go out for a social drink these days?
George: No. Completely abstinent. Completely. I don't drink... I just wouldn't go back to that road. I wouldn't drink again. I wouldn't want to go back to where I was.
I: And you think that would happen?
George: Oh yeah.

In the course of a brief interview, George's father confirmed that he had stayed sober, and was prioritising his children above all else. Notably, George had done this without recourse to any formal services or structured support, including mutual aid.

Paul's (Holme House) path was rather different. He had no employment history, had not seen his son for years, and had been heroin-dependent for nearly two decades. After being introduced to Narcotics Anonymous literature whilst in prison, he sought out Narcotics Anonymous (NA) meetings in the community. Following previous sentences, Paul had sought to abstain from heroin whilst continuing to use cannabis or alcohol. This time, NA encouraged him to consider total abstinence:

Through NA I've been forced, heh, to look at the situations I've been in before. Alcohol has never really been my problem but... my, my problem is reality. And all these different drugs and alcohol are all in a toolbox and they're just a way for me to change the way I'm feeling. And in that toolbox is my prize one that does the best job, and once I start opening the box it's only a matter of time before I find my way to the bottom... (Paul).

A transformative experience then led him to be fully committed to total abstinence:

We had a bit of a party thing on Boxing Day and my granddad came and he bought me a bottle of whiskey. And er.... I thought. "I deserve it." And so I didn't get hammered but I had a, a good few whiskies. And. I woke up the next morning feeling quite refreshed... And the first thought on my mind was "I should do that again tonight." And then I thought "whoa. Hang on a minute. That's the first thing I thought about and I've only done it once... What's going on? So I stopped it. And there was an NA meeting on New Year's Eve. And so I attended that. Because... I thought "I just can't do it. I can't do this any more." And so I went to NA on New Year's Eve. And. It's 6 month today actually, my clean time (Paul).

The only three interviewees who described total abstinence thus followed different paths: faith, family, and mutual aid.

It seemed striking that each of these represented a fundamentally social response to historic drug problems; and that each had built their recovery on the foundations provided by highly supportive family members, who both housed them, and assisted them in building on other areas of recovery capital.

Reduced usage

Some other interviewees were not fully abstinent, but had made significant changes to their drinking or drug taking behaviour. These were sometimes intimately connected to their lifestyles. On entering Brixton, Elias had not applied to be on the DRW. Rather, he had been housed there as a lodger³³. A drug worker soon spoke to him, and together they had decided that his alcohol, cannabis and cocaine use had been a real problem. Following his release he found himself homeless, eking out an existence in a self-funded hotel. Whilst he continued drinking and smoking cannabis, he felt that other urgent needs had put his drug use into context:

Elias: I thought maybe a year ago... maybe I was kind of dependent on [cannabis and cocaine] but shall I tell you what it is. When you come out of prison and you're sorting out your... housing for 3 weeks you'll see how, how addicted you are sort of thing. Because you just ain't got time for it... I know it sounds mad but I ain't got time for it kind of thing. I wish I could stop and have a spliff but I just can't.

I: [So] perhaps you've been smoking occasionally but...

³³ A prisoner housed on a wing for reasons of prison population management, rather than any expressed interest in drug treatment.

Elias: Yeah yeah yeah yeah but if you sort of put yourself in my sort of shoes, Geoff. All of my friends smoke... There's not a day when I probably don't smell the smell but the fact is I reckon I've been pretty alright around it.

Indeed, housing had been the issue that dominated Elias' experience following release, spending most of each day trying to secure the money for his privately-sourced B&B, or to find alternative housing. For other interviewees, other resettlement needs had compelled them to moderate their drinking or drug use. This was particularly the case for a small cluster who had found stable employment, and so needed to stick to regular routines and predictable hours. This could moderate both binge behaviours:

Me fortieth birthday was a dodgy one but I held it down. I was tempted. Only a little bit. But it's that fortieth innit. But no. No no no. I was too tired from work mate! [laughing] The thought of going in Monday morning with a hangover, and shifting bananas at 3 o'clock in the morning. Wow! (Rob, Manchester).

And could impose a pattern on individuals' weeks, ensuring that periods of excess were confined to the weekends:

I: Have you managed to stay away from alcohol and cocaine?

Jahan: Like I do have the occasional drink. But I say no to Charlie³⁴.

I: Your aspirations when you came out had been to maybe have 4, 5 shots occasionally... Have you found it difficult to stay in control at all?

Jahan: No. It's actually quite difficult to stay in control but... I only drink on like a Friday night or a Saturday night. And then we'll be in my mate's house we've got a little shed at the back we'll be like chilling. Put some music on. It's like a gathering more like. And I like more a weekend binge thing, you know (Jahan, Brixton).

Employment could open up social possibilities, too. Joe (High Down) commented that finding work had led him to socialise with 'some decent people,' with whom his former patterns of cocaine consumption and binge drinking would have been entirely unacceptable.

Medication assisted recovery (e.g. Strang 2010) also appeared to be a significant factor supporting changes in drink and drug use for a small contingent. Neil (High Down) had returned to moderate alcohol use but, after a small post-release period of binge use, had stopped heroin and crack use entirely:

Neil: Well as soon as I got out I went and got myself four cans. And my friends had a party for me. And we had a party got drunk and everything and it was good. So I won't tell you I don't drink, but I don't drink like I used to. I probably drink like 6 beers a week, if that like.

I: Do you still find yourself craving [heroin] at all?

Neil: I'm not going to go out and use. There's no chance. I wouldn't say I crave it but I do think about it. Which is understandable. Big part of my life (High Down).

³⁴ Colloquial nomenclature for 'cocaine.'

With the support of OST, Jason (Holme House) had made similar changes, and now lived almost entirely drug- and alcohol-free.

Jason: A few cans now and then aye. But that's me only vice now I think. That and being on the methadone.

I: So you're never tempted to use?

Jason: Oh no, no.

I: Weed?

Jason: Nothing. Touched nothing, not even another bloke's water (Holme House)

This meant that Jason was one of relatively few interviewees whose pre-release ambitions had been entirely sustained after his return to the community. He had voiced few ambitions to make substantive changes to his OST prescription whilst in prison and, following his release, it appeared to be acting as a robust stabilising force in his life.

A final subset of interviewees had reduced their drinking or drug use with the support of family. Soon after leaving prison, Clive (Manchester) had met a new partner. He had established a new home with her and her children in a new city, but struggled to find work. In this context, family provided a strong motivation for sustained change; but had to contend with protracted periods of daily boredom. His account of his alcohol use was suffused with a sense that his opioid abstinence might be somewhat precarious:

Clive: [Beer] does cause me problems, it gives me hangovers, but it's not causing me the problems where I'm drinking Special Brews all day.

I: So the things that you need to watch out for are crack, heroin?

Clive: Yeah, but yet it's only usually when I've actually lost my way a little bit for a few days and then the more that I beat myself up and then I'd begin to think; "oh, fuck it, why should I bother [staying away from crack and heroin]?" That's when it gets to me when I think; "what is the point?"

As with Clive, Bryn (Swansea) was drinking at levels that exceeded recommended levels. Nonetheless, alcohol was far less of a force in his life than it had been before prison:

[My drinking] has been up and down. Um. It's. it's not. Been as. As bad as it was prior to going into prison. because um. At that stage it was continuous. No matter what. Now. I have bouts. Rather than it being a. a daily. Occurrence... After I've been drinking for 2 or 3 days I think I've got to stop now because if I keep going. I'm gonna. I'm gonna end up back where I am. And that kind of just reins me in. I might drink one day and then I'll drink another day and then I'll drink another day. And, and that is a bit too much. But I only go so far before I think to myself. "Right I've got to give this a bit of a rest."

He attributed his changing patterns of drinking to rebuilding his relationship with his mum. When he now felt tempted to embark on a sustained binge, reflecting on his rebuilt relationship enabled him to stop:

I: What've been the best moments since you got out, Bryn?

Bryn: Well, first time I went to stay at my mum's, I think! Just that she allowed me to go and stay overnight and yeah. That's probably the best. Thing that's happened to me since coming out to be honest... It's given me something. When I've been drinking and have gone a little bit too far. That's popped into my head that. You know. "No I don't want to do that" (Swansea).

Others who lacked structured activity described distinctly precarious gains. Chris, for example, had managed to abstain from opiates, but a brief stint of selling cocaine had led to a high-risk period of chaotic drug taking. By the time of his follow-up, he had reined this in and was only using alcohol (heavily) and cannabis. (By the time we interviewed his recovery support, he had been imprisoned).

Minimal changes

A health warning should be noted here. Where we were able to triangulate prisoner and recovery support (RS) interviews, ex-prisoners and their relatives broadly agreed. We have thus drawn primarily on prisoner interviews in the preceding sections, as these were invariably more detailed and often offered greater insights into ex-prisoners levels of (and reasons for) change.

However, for sixteen unique cases, we only had untriangulated RS interviews. The reasons we were unable to secure interviews with former DRW residents were complex and varied – but were often because they were homeless, peripatetic, untraceable, or back in prison. In consequence, untriangulated RS interviews were considerably more negative; and almost without exception, suggested that former DRW residents had made minimal changes to their drug use, and / or had swiftly returned to heavy and chaotic use:

He is struggling. Because obviously you know he had a drug addiction. And I think he is back on [heroin] again. (Kerry, High Down).

It's drugs. It's drugs. He can't stop taking drugs, I think. And although I've never seen him taking them and I don't know. I don't always know what he's on. I don't know if it's medication from the doctor or if it's you know illegal or. But there are times when he's really erm. lively and animated. And there are times when he's very quiet. And I don't know which time he's on drugs and which time he isn't. I can't tell the difference, I don't know. (Jane, Holme House).

He was fine [for the first two weeks]. And he's got a job and everything... But he started drinking. Started sitting out in the car drinking. Coming in here being a bit mouthy towards me. Always going towards me all the time. It's all my fault. Everything's my fault. Then um a few months ago he started taking drugs? Alongside his drinking? I don't I don't know if it's a new thing with Nick or not. But his eyes and that. (Paula, High Down).

Robert was straight back on heroin. He'd never tell me but I knew he was back on it. In and out the door, seeing his old friends... Using every day. (Lucy, Manchester).

[Prison], that's the only time he LOOKS healthy. Well he's not on the drugs or drink then, is he? ... As I said. He come out. He was tagged. I think about 4 or 5 nights he was alright. And that was it, then... (Gill, Swansea).

These accounts, accompanied by descriptions of the damage that had been done to people's lives by our former interviewees, dominated recovery support interviews.

Comparatively few former DRW residents offered similar accounts of heavy, chaotic or dependent drinking or drug use. Nonetheless, several described patterns of substance use that very closely resembled those that they described as their pre-prison levels. Though he claimed his use was largely controlled, Frank (Brixton) was bingeing on alcohol and crack cocaine most evenings:

I: Ok, so you're drinking a bit but it's under control.
Frank: Mmmyeah.
I: And toking a bit but it's under control.
Frank: Yeah yeah that's it really.
I: You haven't been tempted by the occasional crack pipe or anything like that.
Frank: Yeah obviously yeah.

Frank was experiencing serious paranoia and anxiety which, in prison, he had attributed exclusively to his crack cocaine use. His using was also making it very hard for him to earn a profit from drug dealing, and rent arrears placed his housing at risk.

Two other self-identified dealers seemed to be treading a broadly similar line. Like Frank, Matt (Holme House) had solid connections in the drug trade, and a history of acting as a capable dealer. Despite using a range of substances every day, in ways that nudged beyond the recreational, Matt nonetheless felt that he was currently holding things down:

I am back in that life cycle again... I suppose [My heroin and crack use] is recreational at the minute... [And] I'm kind of happy at the moment. It's funny isn't it, with regards to that sort of thing, because everyone automatically thinks of drugs and that kind of thing like as a negative. But then you look at it, I don't drink, Geoff. You know and I like. I don't drink. Or well. So you have your own release don't you, sort of thing?

In every way, Ben's (High Down) position was less organised. He had never been a high-level dealer, relying on the beneficence of friends to support him in illicit trade. His drug use, too, remained relatively unstructured, and reliant on the generosity of friends. Throughout his account, he emphasised the role of others in him continuing to use the substances that he had once held responsible for his offending:

If [cannabis] is there I'm gonna smoke it... I can say no to drink. But yeah mostly at the weekends now, all weekend I'm drinking... I think the only time I had a blackout was in a k hole³⁵... I woke up, like, my half body outside the tent, my half body inside the tent. I had cans of beer all over me.

³⁵ Euphemism for being highly intoxicated with ketamine, a dissociative and anaesthetic.

Of greatest concern to him, Ben had returned to occasional cocaine use. Above all, this was the drug he thought had driven most of his prior offending.

Finally, Nick (High Down) had returned to drinking all day, every day. As the interview progressed, sounds of swigging, glugging and pouring came at swift intervals from the other end of the phone. Nor was Nick shy of describing his levels of consumption:

Nick: I lasted about. Was it two days? Yeah two days. I was back on it. About like 6 pints and then 6 pints in the morning and then I'm going down the shop every day and I ended up down the boozers and... In my fridge at the moment I've got 13 cans. They're for tomorrow.

I: And you mentioned that last week you'd put away 3 litres of vodka, was it?

Nick: Yeah-heh-heh. Think it was basically two days... I'd gambled my money away... Gambling's rough. I done. Ah. I don't know. I done 650 quid last Thursday. Done a one-er yesterday.

Despite being employed, Nick identified that he drank at work 'on the sly.' He felt unable to contemplate even a single day without alcohol, and was clearly making himself very unwell.

Summary

The three interviewees who had entirely stopped drinking and drug use had each followed idiosyncratic paths. One had drawn on intensive support from both family, and mutual aid. A second had drawn on his faith community. The third was inspired by his children. Nonetheless, the similarities between these three pathways were also apparent. All three had followed fundamentally social pathways to recovery, and each had received considerable support from parents who had offered them a safe and secure home.

A substantial additional group had moderated their drug use. This was particularly the case for those who had found gainful employment, which put real constraints on daily or weekly consumption patterns; or who had begun to (re)build relationships with partners or family members. There were also intimations that OST had put a damper on the drinking and drug use of a couple of interviewees, who had been heavily using a range of substances before they were imprisoned. Elias' path to reduced use also stood out: his insecure housing led him spend all day, every day searching for housing and trying to earn enough to pay for his current B&B. This, in turn, had put his former drug use into context for him.

Finally, a large group of former prisoners appeared to have made few changes to their pre-imprisonment levels and varieties of drug and alcohol use. Recovery supports, in particular, presented a bleak picture of their relatives' swift returns to drug use and consequent imprisonment. Contrasting with this, most former prisoners (with the clear exception of Nick (High Down)) attempted to frame their substance use as being more controlled, or recreational; though often this contrasted with their descriptions of the problems it was causing them – not least, mental health, physical health, and serious financial problems. Most interviewees who had returned to problematic drug use (again, with the exception of Nick) also described unstructured lives, whilst active engagement in drug dealing appeared to complicate their attempts to moderate their use, too.

OST: in prison, and following release

Brinsford is absent from this section, as no Brinsford interviewee had a history of opiate use.

Table 7.3 Prison * Prescription status and prescription goals at t1; and prescription status at follow-up

		In prison			At follow-up		
	Total	Detoxed	Reducing; goal = abstinence	Goal = released scripted*	OST abstinent	OST scripted, and / or using opiates	Unknown
Brixton	4	2	1	1		3	1
High Down	4	4			2	2	
Holme House	5	2		3	1	4	
Manchester	2	1	1		1	1	
Swansea	2	1	1	1 ³⁶		2	
Total	17	10	3	4	4	12	1

Table 7.4. Prescription status and goals at t1 * prescription status at t2

	Total	OST abstinent	Scripted @ FU	Unknown
Detoxed, goal abstinence	9	4	4	1
Sought retox	1		1	
Goal: Abstinence	3		3	
Goal: Continuous script	3		4	
Total	17	4	12	1

³⁶ Includes one prisoner, who detoxed but was intending to retox before release. All other prisoners who had detoxed were aiming for sustained abstinence.

Released (OST) abstinent; remained (OST) abstinent

Of the seventeen prisoners with histories of opiate dependence, four were OST-abstinent at follow-up. All had detoxified whilst in prison.

However, the relationship between medication abstinence and standard recovery outcomes was not straightforward. Only Paul described an archetypal recovery journey, engaging heavily with family support, mutual aid groups, and full-time employment from shortly after his release. The follow-up interview was held on the day that he picked up his Narcotics Anonymous 'blue' keyring, to celebrate six months' clean time. Support – and housing – from his mother had provided a critical starting point for making sustained gains.

Clive (Manchester) had also stayed OST- and opioid-free, but was uninterested in total abstinence. Though he drank on a daily basis, he saw returning to opiate use as a surefire means of losing all he had gained.

I wouldn't even want to dabble because dabbling... I'd have to do it as a bender, I'd have to hammer it, I can't...there's no little measures so I'd have to be in a bad place to do that... And that's why I like trying to talk about things and not get it to that point.

The relationship he had built with his new partner (and his new step-children) also provided him with housing, and strong pro-social support; and so gave him both the motivation and tools for avoiding a return to heroin use.

The final two interviewees to sustain their abstinence again followed different trajectories. Both were High Down releases. Both were re-imprisoned: one shortly after release; the other between interviewing him, and interviewing his recovery support. Moreover, both felt that they had matured out of opiates by the time they were interviewed in prison. After thirty years of heroin use, Mike (High Down) had been heroin-free (and OST maintained) for three years before his most recent sentence. Alcohol was now his main issue, and he had been drunk when he committed his index offence. Having fully detoxified in High Down, he was released to a residential rehab. Within three weeks Mike had been recalled to prison after getting drunk; though as his mother explained, she saw this as an understandable blip:

He broke his, he breached his conditions. Which was why he got taken inside because, erm, his best friend and his auntie died within a space, within a very short space of time. And he was just devastated and he just got drunk... It was nasty. The whole family went on pretty much of a bender that weekend, to be fair. And he just felt it more because he was all on his own (Jane).

She did not believe Mike had resumed illicit drug use, and felt she had seen a transformational change when he switched to alcohol:

I: What've been the most positive bits for you in your relationship with Mike?

Jane: The biggest thing was him coming off drugs! He couldn't communicate when he was on drugs. He couldn't. I spent ten, twenty years waiting for the phone call saying that he'd been found dead in a gutter with a needle in his arm.

Despite Mike's re-imprisonment, Jane was confident that he had remained abstinent from both opiates and opioids.

Chris had also remained at some distance from opiates. He identified his main drugs of choice as alcohol, cannabis and cocaine whilst in prison; though he also received a limited methadone prescription for the first few months of his sentence. By the time of his follow-up, he had been using each of his drugs of choice – but had not been tempted by opioids, and had no need for an OST prescription.

Released OST abstinent; recommenced illicit opioid use and / or OST

Eight former DRW residents were released medication abstinent, but were either using illicit opiates or had picked up a new OST prescription in the time before follow-up. It seemed striking that unsafe housing and limited access to employment opportunities characterised this group. Just one was able to return to a safe and stable parental home, with others spending considerable periods of time in hostels or criminogenic relatives' homes; none were in employment by the time of follow-up interviews; several had been reimprisoned.

Those who remained in the community described attempts to live a conventional life, which were thwarted by setbacks and failed promises:

I started off not so bad [and] after leaving prison I done a four month work programme with a local authority... They promised the world and then delivered nothing because they had free labour, didn't they. Nothing came at the end of it and I slipped back into the dark and weary world of the drug scene? And and and I'm back now on it out here, because I'd got off it inside hadn't I (David, Swansea).

I'm back with [my prescribing agency]... I come out of prison in February and I started working in April? And... I left the job because the hours weren't good, I was working like 13 hours for like 40 pound a day? And I I left that, and I was depressed, and I started using again (Neil, High Down).

Alan (Brixton) and Danny (Swansea) had fewer opportunities from the outset. Alan had been released street homeless, and swiftly resumed heavy and chaotic drug use. Danny returned to live with a heroin-dependent brother. His recovery support identified that he had instantly resumed heroin use.

Neil (High Down) attributed his return to heroin both to personal setbacks (see above) and to overly-quick prison detoxification. As a result, he intended to take any reductions more slowly now he was re-prescribed:

This time I'm not rushing it. I started [OST] about 15 weeks ago and obviously I started on 40 mil went up to 45 because it weren't holding me. Next Tuesday I'm going down to 40 mil... After I go down this five mil I want to go down two mil. Two mil every month or every fortnight. Depends how I feel within myself (Neil).

David (Swansea), too, aspired towards medication abstinence; though this was a long-term goal, as he was still using heroin occasionally:

I'm not perfect, I've lapsed on the odd occasion. Not going to lie to you I'd be lying to myself otherwise.

He had no interest in putting any time frame on his reduction schedule, or his end goals.

A further group had been re-imprisoned before we could re-interview them. Their recovery supports described swift descents into chaotic drug use, accompanied by a return to prolific offending:

He's always promising he'll change. When he's inside, he promises the world. He's gonna stop using, he's gonna stay out for me and the kids. But it never lasts, it didn't last more than two week. Straight back at it, using and grafting, he meets his old mates and he's out the door. It's the same every time. Every time. I'm sick of it. It's not fair on the kids. It's not fair on me. I don't know how much more I can take (Lucy, Manchester).

As noted earlier, such accounts fed into broader RS narratives of repeated let-downs and failures.

Released OST prescribed; remained OST prescribed

Four interviewees had been released with a methadone or Subutex prescription, and remained on these by the time follow-up interviews were conducted. For the two who remained in the community – both from Holme House – their OST prescriptions provided a source of some stability. Jason (Holme House) had been doing 'just the minimum' reduction whilst in prison, and had stayed completely stable since release:

I: Are you scripted at the moment?
Jason: Oh aye aye.
I: Gone up, gone down?
Jason: No no just the same. Exactly the same.

He had distant aspirations towards abstinence, but was clear that 'you can't just come off it straight away.' Jason had no reduction schedule, or clear plans for decreasing his dose. Nonetheless, he appeared to be a strong example of 'medication assisted recovery' – his OST prescription provided him with considerable stability, he was not using any illicit drugs, and his housing situation had greatly improved.

A final group of interviewees were in a more precarious position. Each had active OST prescriptions, but remained heavily invested in illicit drug and alcohol use; each had been reimprisoned within six months. We interviewed their recovery supports, who described a consistent and repeating pattern.

Within days – if not hours – of their release, they would be drinking and using drugs heavily and chaotically:

He's in and out of prison all the time. The problem is is that when he's out he's got nowhere to live. He hasn't got no money. He's starving. He goes, he goes then and robs food then from supermarkets. And it's just a vicious circle (Carol, Swansea).

These family members had little hope for the future.

Released OST prescribed; attained abstinence in the community

No followed-up former DRW residents had detoxified from OST following release from prison.

Summary

Former prisoners with histories of opiate use followed one of three pathways.

Four had attained OST abstinence whilst in prison, and sustained this following their release. These were not entirely conventional narratives of holistic, enacted change. Whilst relationships and secure housing provided a firm bedrock for two, only Paul had followed a conventional recovery pathway: accessing mutual aid to sustain his medication abstinence. One further interviewee had gained good reason to avoid opiates, in the form of solid housing and a new family; whilst two felt they had 'grown out' of opiates when first interviewed in High Down's DRW, though each was subsequently reimprisoned (license breach, drunk; GBH).

Eight had been released medication abstinent, but had returned to illicit opioid use and / or an OST prescription. Reasons were varied – some felt let down by employers, and a couple had found themselves in very difficult housing situations. Recovery supports identified that four had simply returned to all-out heavy and dependent drug use following their release.

A final four had been released with an active OST prescription, and had retained it. For one of these, OST seemed to have acted as a very robust stabilising force, preventing him (in conjunction with excellent housing⁰ from returning to illicit drugs. This was not the case for the other three, all of whom had returned to heavy drug use.

Finally, through three interviewees identified a desire to do so, no-one who was released with an OST prescription attained medication abstinence before interview. Indeed, only one described any reduction in his prescription.

Overdose

The heightened risk of overdose following release from prison provides a strong harm reduction case for maintaining opioid substitute prescribing in prisons. Of the thirty-six unique individuals on whom we were able to secure follow-up information, seventeen had histories of opiate dependence. These numbers are clearly too small for any inferential analysis but, nonetheless, narratives of overdose

are important; and they have the potential to offer some insight into prisoners' post-release behaviours. Moreover, they have the potential to highlight high-risk behaviours that are not overdoses; but which nonetheless put individuals at risk, as Neil's (High Down) account identifies:

I: Did you overdose at all [when you went back to using]?

Neil: No no no no. it wasn't heroin straight away it was like a [crack] pipe, it was like a pipe. And then I was like hanging³⁷, 'oh I need more more more more.' So I went and got the heroin. To bring me down.. I was sick. I was sick a few times. First time doing it I was sick. I was more like sicklified.

Despite Neil's account of high-risk polydrug bingeing, no current or former interviewees was identified as suffering an opiate overdose.

However, interviewees did describe two non-opioid overdoses, each of which were related to suicidal thoughts and intentions. Chris (High Down) and Nick (High Down) had both left prison drink and drug free, with a desire to sustain their abstinence with the support of twelve-step programmes. However, both had chronic and severe mental health difficulties, which they described in identical terms:

I suffer with an emotionally unstable personality disorder. (Chris).

I have a mental health problem, I'm emotionally unstable personality disorder. (Nick)

For Chris, overdose was consequently part of a pattern of suicidal behaviour, triggered by heavy drug and alcohol use, the breakdown of family relationships, and worsening symptoms. He was interviewed a handful of hours after he was released from hospital:

I: And you've had two suicide attempts since you've been out?

Chris: Yeah, since I've been [in this part of London], yeah.

I: And both of them have been caused by the [breakdown of the] relationship [with your mum]?

Chris: Yeah. Yeah. And other things. Not just that, just like when I didn't have my medication. I was hearing voices. I was seeing things. And things just got too mad. My mum even, when I took that overdose, she was like, I've never seen you like that. I can't remember none of it. I blacked out. I cannot remember nothing. I woke up in hospital. I stopped breathing. I passed out. Before I know it, it's today, I woke up this morning... I took olanzapine, citalopram and aspirin.

Nick's overdose shared some similarities. He had swiftly returned to heavy and dependent alcohol use, had been thrown out of the family home, and a series of overdoses swiftly followed:

I took an overdose in May... And then I took four over doses, so far, I mean, just doing, I've been acting like a fucking lunatic.

All of Nick's overdoses had involved paracetamol and alcohol.

³⁷ Feeling physically unwell.

Both of these interviewees' recovery supports identified post-release overdoses as a continuation of a long history of suicidality. For Chris' RS, mental health services were substantially to blame:

He tried to kill himself. He actually done it twice. He threw himself in front of a car. And then he took all his tablets. That would've been the second time. I was at the hospital for 48 hours with him. I spent the whole time with him when he took the overdose. And the thing was, the mental health haven't helped him. They let him down, the system I felt really let him down throughout his life. I had a meeting with them and they said they were gonna help him they were actually gonna take his medication and give it to him. And as soon as Chris come out of hospital that didn't happen. (Maureen).

Nick's RS described feeling exhausted by her son's longstanding problems, and attributed his multiple overdoses to serious emotional disturbance, combined with a desire for greater attention:

Nick's been taking paracetamol. Like he always did. He used to take loads of them... Trying to do away with hisself, but he doesn't really want to do away with hisself, erm how can I put it. My Nick will phone me and go 'ahhh I don't want to live no more, bury me.' I can't bear it. I said to him 'I can't bury you, you're not dead Nick,' I said to him 'you don't want to die because you're phoning me.' (Paula).

Nick's overdose(s) also had some additional complexities. Whilst he only described overdoses in terms of his consumption of paracetamol, it also seemed likely that he was experiencing regular alcohol poisoning. He described regularly drinking to the point of blackout, and occasions on which he had been unable to stop vomiting. However, unpicking these symptoms from the symptoms of extreme hangovers or full-blown alcohol dependency was not possible:

I've had days. I won't lie. Where I've tried to keep a can of Stella down and it wouldn't go. I'll try again. And it wouldn't go. I'll walk down the beach. I live on the beach, on the seafront. So very often I go down there and I sit down there and have a drink. Sometimes I'm really bad, I can't keep the booze down. So I have to *force* it I have to just physically try to swallow. It doesn't work. Obviously 15, 16 cans a day... does me. Does me. Like I was drinking the vodka and the cans. I tried to come off. After the vodka. I couldn't do it. It was. It was like the taste of. Like the shakes.... Ill. Feeling ill. So I come home and I picked up three bottles of Kronberg [sic] just to try and suppress them down. But it wasn't working (Nick, High Down).

Nick described night sweats and regular two-hour stints on the toilet. He was clearly in worsening physical health, and his interviewer strongly advised seeking medical attention.

Summary

This is a very small sample, and it is unlikely that any deaths from opioid toxicity would have been encountered. Nonetheless, resumed drinking or drug use could be undertaken without direct consideration of risk (or risk behaviours).

Interviewees' experiences of overdose highlight that it was a real presence within this cohort, but for reasons other than opioid toxicity. Two interviewees made purposeful attempts at ending their own lives, with each attributing their attempt(s) to parlous mental health.

Re-imprisonment

We received reliable information that 22 interviewees were imprisoned before their follow-up interview. A further three were imprisoned in the days, weeks or months after. These data were secured from a variety of sources. Sixteen recovery supports informed us that prospective interviewees were imprisoned. Local news detailed the conviction and imprisonment of eight (in one case, we received separate confirmation from a prospective interviewee's father, and from local news. These accounts had almost nothing in common³⁸.) Finally, searches of social media identified that one former DRW resident had been reimprisoned.

We were unable to ascertain the offences leading to the imprisonment of three former interviewees. However, those people with known index offences were responsible for a broad range of offences. At one end of a spectrum, five people were recalled to prison. Two were recalled because they had breached restraining orders. One of these, Elias (Brixton), saw this as an entirely predictable consequence of being released homeless:

[After some time homeless] I got back in touch with my mum and she let me move back in for a couple of months, and then I fell back out with her and so I just moved out and then I was sent back to prison in Tameside and they held me for about, for about 2 weeks... But for a person that has a restraining order there's no way that they should be released homeless, coming out of prison! ... Because the first thing they're gonna do is reoffend by going to the people who... do you know what I'm trying to say? It's like a vicious circle sort of thing.

One young offender (Brinsford) breached his license by stealing a bicycle whilst drunk; and the daughter of a former Brixton resident believed he had simply missed an appointment:

I don't know. I think it was something to do with probation, he missed something to do with probation, but he was at a prison appointment at a different time or whatever? So... (Steph).

Mike (High Down) was recalled to prison after getting drunk, and losing his place in residential rehab. A similar situation resulted in the recall of Colin (High Down) who returned to street drinking after a period of stability in supported housing. James (Manchester) was also recalled to prison after breaching his restraining order.

Ten DRW graduates were convicted of burglary offences, often causing their relatives considerable vexation:

³⁸ Albert identified that Ollie (Holme House) had been reimprisoned for breach of license, following a long and convoluted chain of events centred on the rightful reclamation of stolen clothes. Local news identified that Ollie had been imprisoned for burglary.

He burgled three houses down our road, and another two on [the next estate]. And I said to him, you can't do that on your own doorstep. You can't go doing that... My husband completely lost it with him. Said he'd had his last chance, and he'd blown it. We're never having nothing to do with him again, he's done it too often (Mel, Brixton).

Other reports in local news described offenders getting stuck in windows during failed burglaries; stealing equipment from a school whilst students were present; and entering a back yard and peering through windows, again in broad daylight. One recovery support was also aware that her son had been convicted of theft, though he tried to protect her from the details:

Well to be honest to tell you the truth I don't really know all I really know is that he was thieving again, you know shoplifting. I he don't tell me everything (Ann, Swansea).

Other theft offences included one case of shoplifting. Danny (Swansea) had served two short sentences by the time of our six-month follow-up call. He constituted one of our two intentional withdrawals from this study, offering a succinct 'fuck off' when called. He was due for a third trial within the week. Alan (Brixton) was sentenced for criminal damage, and theft.

Two prospective interviewees were imprisoned for possession (of heroin and crack cocaine) with intent to supply. Both were Holme House releases. The first was also charged with burglary. The second was charged for a battery of offences: burglary, robbery, attempted robbery, and two counts of possession of an offensive weapon. Local press reported that, following this second interviewee's arrest, he had pleaded for a swift return to jail.

Including the license recalls for breach of a restraining order, five prospective interviewees were imprisoned for violent offences, or offences against family members. Two further cases involved GBH / ABH:

He broke someone's jaw in two places. And the reason being is, because where he was. He had all the young boys of 17, 18 around his flat. One of the young ones superglued his lock. And he went to deal with it with the father, the father threatened him and he lashed out... And the judge even said, "although you hit him once. And we know that even the gentleman himself said that you didn't come to fight him. Unfortunately his jaw has been broken and for that reason, and plus your previous GBH, ABH we have to give you a custodial sentence." And that's what they done (Maureen, High Down).

He's back inside again... And what it is, he hasn't been, I think, bad at all. It's just what it is somebody had stolen. Erm. His some of his clothes off of him. And er. He had er. Got his clothes back off the lad but yet hit the lad. And with him being out on license. Er. You automatically had to go back in to finish his license (Albert, Holme House).

Nick (High Down) had originally been imprisoned for several offences of harassment. By the time we interviewed him, he appeared to be close to re-enacting his original index offence:

This girl. I took her out last week and um... I text her every day. Impulsive. I impulsive text her every day. And there's a thing called snapchat... And um... Maybe it's a control issue. I don't know what it is I haven't got a clue. But ever since she started snapchatting me I like

being top of her list and ever since I see other men on it I'm like aawwhhhhhh. Get all wound up. So I just said to her. I said right, listen. I can't do this no more... I was doing like. I don't know. crazy. Like. On snapchat. And then she's telling me she's going to ring the police and I'm like "oh my god here we go." I've got to sort this, I've got to just nip this in the bud.

His mother recognised these patterns of behaviour:

And with Nick, he. He meets these girls and he's got to buy them. This is where it all stemmed up from. And then they don't want him no more and then he gets angry and then he starts... phoning them all the time. Constantly. Well this is why the girl had him over harassment [for his original sentence], because she got fed up with all the calls he threw a brick through her window. Er. You know. he wouldn't leave it alone. But try telling Nick. It was very hard. Because I tried and I couldn't get through to him [And recently] he's met a girl. He's. He phoned me today and told me that she's doing his head in already. And I thought. Oh. Here we go again (Paula).

Police were aware, and had visited him twice. His CPN was also aware, though Nick was attempting to withdraw from treatment. Within two months, he was back in prison for harassment serious enough to make national headlines.

Summary

By drawing on a range of interviewees and local news sources, we were able to identify that twenty-five of our baseline sample had been reimprisoned. By some distance, burglary was the most common index offence for those who returned to prison. A second substantial group had also been reimprisoned for violence, and / or offences against partners or family, with the same number recalled to prison on license. Finally, a couple of prospective interviewees were imprisoned for possession with intent to supply, and one for harassment.

Undetected Crime

All interviewees who remained in the community were asked about their sources of income, and whether or not they had been engaged in any criminal activity, not including illicit drug use. As this section focuses on undetected offending, three interviewees who were subsequently imprisoned have been discounted. Two interviewees who were interviewed after serving additional short sentences are included in this section, as they disclosed offences that were not detected.

Reliance on interviewees' self-reports is an approach with clear limitations. Offending is a sensitive topic. Interviewees were often on license, and aware that they could be recalled to prison. In this context, questions were approached sensitively, and in broad terms. No specifics were sought, and interviewees were always warned that some disclosures (particularly those identifying a risk of harm to self / others) could not be kept confidential. Questions were also approached some way into the interview, by which time other sensitive topics had been discussed, and interviewees appeared to

feel comfortable with both the interview process and the interviewer. In this context, only David (Swansea) appeared to be uncomfortable with our questions:

I: Have you been tempted to go back grafting at all?

David: mmm. I don't know to be honest with you. I'm just taking one day as it comes. And as I tell my mother I never plan anything. Because something can always happen. Rome wasn't built in a day I always say.

I: And you haven't been tempted to make some cash on the side or...

David: I wouldn't say anything that I don't want to say. I've been tempted yeah. To make something on the side. But I know that's not the legal way to go about things.

No more information was forthcoming. As the interview progressed it became apparent that there might be other reasons for David's reticence:

That's another thing that my mother says. She's motioning to me in the background. [Drug use] is another thing that's changed down to my mother's prayers.

Whilst it was clarified at the start of the telephone interview that David felt comfortable talking, it had not been at all clear that his mother had stayed in the room and was listening to his call.

No offending

Of the other interviewees, eleven said that they had no involvement in offending whilst six acknowledged that they were involved in some criminal activity. For the most part, the eleven non-offenders gave accounts that fit well with their broader narratives of social integration. Perhaps unsurprisingly, all of those who had remained drug- and alcohol-free were focused on licit activities:

I: So you don't have the old income streams back?

Mo: No. I don't. that was a long time ago, yeah? (Brixton).

For others, staying crime-free was related to strong relational anchors, tying them to social conformity. Neil (High Down) was trying to rebuild his family. Even when he briefly relapsed on heroin and crack cocaine, his fear of losing contact with his partner and children kept him from committing crime:

I: When you were using, were you at all tempted to go back grafting?

Neil: All legit at the moment yeah yeah... I mean I've used and that but I've never gone. Never gone down a criminal path. The only reason I'll go back to prison is if anybody hurt my family.

Again suggesting the importance of rebuilding pro-social and relational ties, Clive's (Manchester) new family also kept him on the straight and narrow.

Recognised resettlement pathways also played a prominent role in the desistance of several interviewees. For Jason (Holme House), securing excellent housing seemed to provide a real boost. For the first time, he was living independently instead of with his mother:

Like. In the past it's just all been drugs and graft. Drugs and graft and jail drugs graft jail. And it's too much. And I've got like a different mindset now.

Mark (Brixton), Jahan (Brixton), Joe (High Down) and Rob (Manchester) had managed to embed themselves more securely within structured support. All had decent housing (mostly with family members), and robust work histories; and each swiftly found employment swiftly following their release. They were managing financially and, sometimes, too busy to offend:

I just get in and go to bed. That's what I mean. In this job you couldn't get into trouble if you wanted, mate. You know what I mean (Rob, Manchester).

There was only one apparent exception to this link between emotional and social integration, and stopping crime. Bryn (Swansea) had stopped offending, but described his life as quite empty of friends, and of meaningful activity:

If I'm not going to see my friend in Carmarthen or I'm not seeing my mum. I'm pretty much on my own. That does get a little bit. I don't mean lonely. That's probably the wrong word. It just becomes a bit. Quiet. And boring. And there is the boredom, but it's also the lack of human contact sometimes. Can be a bit. Um. You know. It's one thing talking on the phone but you know if you don't have a face to face conversation with somebody for three or four days. You get. It gets a bit cabin fever-ish.

His ability to stay crime-free despite the apparent emptiness of many days seemed to be rooted in his offending history. All of his previous offences were for breaching a restraining order against the same person. For several years, this had led to him bouncing in and out of prison. Following his most recent sentence, the romantic element of this relationship had ended. At around the same time, the restraining order had been lifted. His ex-partner was now the one 'friend' he spoke of in Carmarthen. Without the spark of erotic flair, or the threat of a restraining order, the triggers for Bryn's repeated imprisonment had disappeared.

Active offending

Six interviewees identified that they were engaged in illicit activities. By far the most common illegal pursuit was drug dealing, acknowledged by four interviewees as their main source of income. Not all were involved to the same extent. Chris (High Down) and Matt (Holme House) had longstanding relationships with high-end drug suppliers. Returning to familiar areas and seeing familiar friends thus confronted them with difficult decisions, which were exacerbated when times became hard. Matt felt he had been driven into a return to drug dealing in order to earn enough to escape hostel accommodation that he found intolerable:

I've got a couple of little things going on the side. That was one of the choices I had to make, Geoff. It was difficult losing... it was a really difficult decision. Because I was wanting to like. Do everything straight down the line. You know. Not like veering off the path in any way. But it. Just wasn't realistic. You know. If I wanted to move forward. I... I... had to do something. In an ideal world I'd've got out and been able to walk into a job but it wasn't happening. And I spent 2 month like, no not two month maybe like 6 week. Of. You know.

Standing my ground saying no I'm not going to do anything, I'm not going to do anything, I'm gonna give it a go. And then that hostel was driving me mad. And I wasn't getting anywhere you know. And I just thought. "What can I do? Either. I can carry on like this and I'll end up getting into this lifestyle here. Or something will happen here. It wasn't looking good. Or. Or. [Laughs] doing what I know what to do and get myself ahead. And that's what I've had to do unfortunately.

Chris' motives were perhaps more straightforward. Old friendship networks and the temptation of additional income made cocaine dealing irresistible – until the start of a new relationship.

I: Were you up to a bit of mischief after your release?

Chris: Yeah, I was, yeah. I was trying to earn a living... I was getting more than enough to get by. As a matter of fact, I had to give up about 700 quid a week [when I met my girlfriend] ... I've been round these areas, nearly my whole life now. And I know everyone, everywhere. Especially round [my home borough] and that.

Our other two dealers took separate – and quite distinctive – paths. From the time of his pre-release interview, Frank (Brixton) had been clear that, on release, he aspired to sell drugs more successfully than he had previously, perhaps with a legitimate job for cover. However, Frank failed to secure a job, and lost contact with his old suppliers due to arguments and in-fighting. As such, he had become a lone operator, though – having fallen foul of one of the traditional epithets of successful drug dealing ('don't get high off your own supply') – his business model was failing to thrive:

I'm trying to get some money in you, know what I mean. But I'm not getting enough in, man. Doing a lot of it myself. I've got to find a new trick of the trade to be honest... I've managed to get things up and running, I've just got to get to using a bit less.

Finally, Ben (High Down) was on the margins of society. He had been promised employment before his release, only to find that the necessary paperwork had not been forwarded to agencies in the community. Ben then missed a series of appointments, initially with probation (whilst voluntarily homeless and living in a tent); and latterly at the jobcentre, losing access to all benefits. By the time of the interview, he had no licit income at all. In this context, he had taken to opportunistic dealing – being driven to festivals by friends, and selling whatever drink or drugs he could borrow.

I: Are there dodgy opportunities that can keep you going?

Ben: Yeah probably. Just doing the normal stuff, I go to festivals, innit.

I: So [a local festival] could keep you out of the jobcentre for a while?

Ben: For a few weeks yeah. And then I'll move onto the other festivals after that. From that. I'd just keep on going. Job's done.

Our dealers thus seemed to hold a variety of positions within established drug markets. For the most part what united them was frustrated access to conventional opportunities, combined with networks of friends able to provide ready access to illicit drugs.

Our other two offenders had followed their own paths. Ahmed was involved in non-specific acquisitive crime:

Yeah, man. I been doing a bit of grafting, ya get me. Earning a little bit here and there, y'know what I'm saying? I ain't proud, man, but it's hard when my boys are asking me along (Ahmed, Brinsford).

Elias, a highly motivated interviewee with some entrepreneurial tendencies, had taken to a mixture of buying and selling assorted goods, in a process that included a level of fencing:

Elias: I'd be lying if I said I was squeaky clean. But. It's like I say Geoff. Like when when when we was talking in Brixton it's like the shit I was doing 2 years ago is not the shit I wanna be, sorry for swearing sorry, is not what the fuck I wanna be doing now.

I: So you're making a bit from dodgy means?

Elias: Yeah yeah yeah yeah. Just this and that it's like I'm not rich so. You know what I'm trying to say so if I can make some money I will. If I've got picked up for doing something like [fencing] I mean. I I I can turn around and say "well I've got no housing, I've got no housing since I left prison. So what else do you expect me to do?"

As in previous instances, the importance of missed opportunities seemed to emerge from Elias' account. Repeated failings with housing had made employment – and, indeed, any other form of substantive progress – seemingly impossible; whilst the need for money to pay for his B&B meant he felt compelled to secure a reliable stream of illicit income.

Our sixteen un-triangulated interviews with recovery supports added little to this picture. Whilst they often felt they had decent insights into former prisoners' drug taking, offending seemed more obscured. The majority of such interviews were with the parents, partners or children of former interviewees who had been imprisoned, though two were the parents of Brinsford residents: and both were adamant that their sons had been involved in no offending at all.

Summary

Whilst it is possible that interviewees chose not to disclose offending behaviour, only one interviewee was clear that he was being hindered from such a disclosure (by the presence of his mother in the same room). Of the others, eleven identified that they had committed no undetected crime at all, whilst six admitted to a narrow array of offences. Financial acquisition dominated these crimes. Four people presented their return to drug dealing as rooted in financial need (and access to ready drug markets), with two further interviewees disclosing acquisitive crime – non-specific theft; and fencing.

At the Prison Gates – Day of Release

Released without professional support

Across the board, interviewees gave a strong sense of the importance of swift post-release support, if abstinence was to be maintained for more than a handful of minutes. Many had sought out drugs or alcohol as soon as they could:

I relapsed as soon as I come out practically, so. I don't think I was fit enough to come out at that time... Crack was the relapse. Because I went and took crack again, and I went all thingy. If I didn't touch the crack then I wouldn't touch that. I think crack caused my relapse because if I didn't smoke crack then I would't've touched the heroin. (Neil, High Down).

I: What happened on the day you came out?

Frank: Errrrrr, I went and had a drink and that with me pal. (Brixton).

A large group expressed real frustration that there had been no support whatsoever for them at the point of release, even when such support had been promised. This contributed to a sense of being let down, or abandoned by professionals and services, often compounded by the precariousness and vulnerability of prisoners on the day of release:

I: Did anyone meet you at the prison gates, come and pick you up?

Matt: No, just released. Let out the gates on me own... When I first got out, Geoff there was literally nothing. Nothing. Anything could've happened. I'm here now talking to you, but it could've just so easily been that I was back in prison. (Holme House).

I literally remember coming out of prison and there was literally no one there for me. Like, Geoff. It was so. It was so, so embarrassing. It was unbelievable. (Elias, Brixton)

Indeed, a lack of prison-gate support and a swift resumption of drug and alcohol use was by far the most common narrative to emerge from our cohort of prisoner interviewees. Whilst it is hard to contend that a well-intentioned professional could have substantially altered interviewees' behaviour, these accounts nonetheless suggest plentiful missed opportunities.

There were, however, exceptions. Two interviewees who were released without professional assistance independently sought out strong, pro-social support:

I: What happened on the day of your release? Go out for a beer, or...

George: No, no. I went to see the kids straight away. (Swansea).

I: What happened on the day you were released?

Paul: Well we all walked over to Tesco or Asda to get a taxi. And the lads were like buying cans at like 9 o'clock in the morning. and I just bought some fags, smoked about 6 fags one after the other... I remember. Observing the way I was feeling. And. It was like. Alright. "This is the, this is where it starts." It was almost kind of like. I felt like I was being reborn back into something. And that's what kept me from wanting to change the way I was feeling with alcohol... 51 quid and an NA basic [text], and that's all I had. And I was like, wow. And so I'm reading this on the bus and on the train and on the way back over here. And and like, "I need to find. A meeting. I need to go and explore this, because this this this... This is what I would like to do. but I just don't have the tools to do it, I don't know how to do this." (Holme House).

It seemed striking that Paul and George were two of the three interviewees who remained drug- and alcohol-abstinent by the time of follow-ups.

Released with professional support

Six prisoner interviewees had professional support at the prison gates. In Manchester, this was a follow-on from provision on the wing: RTG (Recovery Through the Gates) officers were able to accompany prisoners to their first appointments. For both Manchester prisoner interviewees, the day followed the same pattern. They were taken by their RTG case managers to the same hostel. They then dropped their case managers, and swiftly sought out alcohol:

[Officers] took us out and took us to the [hostel], but I was more mad for getting to the pub and having a pint and going to the match, me, if you remember, because I wanted to get back to... [Man City]. So that was what my focus was, get out, my first thing was a beer, a couple of pints and then get to the City game (Clive, Manchester).

I: When you left RTG, straight in the hostel that night?

Rob: Yeah [officer] took me down there and that... And then I went to the Carnival and had a little drink you know but.... It's a getting out thing innit been away for two years so. So you convince yourself, as a criminal, that you deserve it.

Provision in other areas was noticeably patchier. In Brixton, four interviewees expected holistic support at the prison gate, but only Mo was met by someone. For him, it proved fortuitous. The Working Links worker was a friend of a friend, and offered him swift access to employment:

He's a mate's older brother. So when I got released that day I'm thinking like, "why is this guy here?" And he's like "yeah I'm with that company." I'm like "yeah ok." He took me, straight away he took me to the office. He gave me some hard hat some PPE, you know the high vis vests and what not and then he said "listen I can get you on site. Tomorrow. If you want it. Because I know you personally. I put you in front of the queue and I get you a job tomorrow." I said to him "listen, I just came out. Give me a week at least. Let me just enjoy some time with my family and that..." But he did keep to his word. He did get me that, he did give me a job after one week.

This did not last; Mo swiftly realised that he was not keen on minimum wage manual labour, and so resigned during his first day on the job.

Other interviewees were met by people with more specific roles. Jason (Holme House) and Chris (High Down) were met by housing officers. Their support was quite limited:

She took us to a viewing for a cottage kind of place, before she kind of dropped us off at me ma's. And the landlord never showed up. So we just went. (Jason).

Well, on the day of my release, I just got picked up by the SOS team.... They work with St Giles. Like a housing team. They took me to my new place. And that was it. (Chris).

Joe's (High Down) experience was more limited still; he refused any further support as soon as he met the person who was sent to assist him.

The geezer who turned up to pick me up looked worse than me. He looked like he was in *trouble* and I just thought to myself, "why? What's the point." He looked worse than me and I thought wow what a waste of a... of a bus ticket or a train ticket. He was from [a twelve-step support agency] in the borough. Don't get me wrong he was doing his duty so it helped him. You know what I mean. Didn't help me (Joe).

Summary

Across the board, experiences of at-the-gates support suggested both missed and limited opportunities. Interviewees most commonly described being met by no-one, and swiftly returning to drink or drug use. Other offerings were either highly limited, or carried out by workers who failed to inspire trust. The only strong case study of promised provision yielding tangible results came from Brixton – and, signally, an interviewee who was able to jump the job queue thanks to his coincidental familiarity with his worker.

There were also clear indications that professional support is a two-way process, if desistance from drug use and crime is to be fully achieved. Two ex-prisoners who were escorted to their hostel after leaving Manchester's RTG went to get drunk, as soon as the officer escorting them had left; and the one interviewee to be secured work by a prison gate contact soon found that manual labour was not to his liking, and so opted for unemployment instead.

Mutual Aid

The DRWs in High Down and Brixton were delivered by RAPt, an organisation with twelve-step roots. Each offered three meetings each week, with people attending High Down's intensive treatment programme required to attend all three. Several other DRWs had passing acquaintances with twelve step meetings, and these were often warmly praised.

In this context, it seemed notable that only two interviewees described attending mutual aid meetings following their release. For Nick (High Down), attendance was a one-off:

The thing is I live in Kent. If you look, if you look at AA... there is meetings every day. But you have to fucking travel to 'em! And no offence but if I'm going to travel to the meeting, I'm gonna want to have a drink. If I'm angry I'm gonna have a drink and I can't drive home. I did go to a meeting when I come out. Once. It was a step meeting. And it was alright. A bloke called Nick was in there. I was like "oh right nice to meet you." And then I didn't go back again (Nick).

For Paul (Holme House), however, fellowship meetings had proven transformative. After stumbling across NA literature in prison, he had written to NA's central office to request a postal sponsor. His sponsor had, in turn, sent him an NA Basic Text; which he was given with fortuitous timing:

My sponsor, through the post, had sent me a basic textbook. But [prison staff] wouldn't let me have it. They put it in my property... Reception. Security. Or something. And the [NA Basic Text] that I had had on the wing, [the owner] took it back. And then when I got released, "there's 51 quid, blah blah blah and there's a book, someone sent you a book." And I was like... Strange! Anyway. 51 quid and an NA basic, and that's all I had. And I was like, wow.

When he got back to his home town, Paul found a strong local NA community, and began attending twelve-step meetings and a 'recovery café' at a local recovery service. In turn, this provided him with first voluntary and then paid employment. This had supported Paul in developing a powerful belief in the transformative potential of peers:

[Personal experience and mutual aid] is the missing link. Now if I'm sat in front of you and you're in prison... Because he's still got the jail attitude and... asks "well what the fuck do you know about it?" "Well actually mate I've been sat where you're sat. I've been. I've been in your position." And this is what I'm doing now. And not just me. There's a fucking army of us out here. "You want to stay in this revolving door syndrome for the next ten years, or do you want to come out now and jump on?" It's never gonna come from the top. It's gotta come from us guys at the bottom and build it up and you know it's recovery in the community.

Moreover, Paul's sustained engagement with mutual aid kept open the possibilities for therapeutic change – the only person who described similar continuing progress across sites. He was open to change, open to being challenged, and cautious of his own limitations. At the same time, his peers ensured he retained a degree of humility:

I've been shredded³⁹ for [my] control issues within NA. I don't even see it. My sponsor's⁴⁰ like, "you ring me." I sent him a text the other day and he rung me up straight away and he's like, "*why did you say that in a text?*" and I was like, "what?"... We were arranging to meet somewhere and I just text him and told him where to be. And I was just like, "be there. And I'll pick you up." And he's like, "but this wasn't a discussion. You're telling [me what to do]..." And I was like "fucking hell, yeah."

Across the board, Paul was the only interviewee to describe a continuing therapeutic journey.

Our interviewees' apparent lack of engagement with mutual aid groups seemed all the more striking, because many of them valorised peer workers and personal experience.

The staff that work on the DRW. There's no... I think like one [worker] admitted they had a problem in the past... But you see the rest of them. They didn't. So. To have someone that don't know what people are going through... What the hell do you know about what we're going through? Maybe you done a bit of paperwork. That don't qualify. It's just like you learnt shit from a book. A book. Not life. (Mo, Brixton).

³⁹ Robustly criticized

⁴⁰ Sponsorship is a cornerstone of twelve-step groups. It bears some broad parallels with mentorship – a more experienced 'sponsor' acts as a first line of support for people in fellowships, and takes them through the 'twelve steps.'

I wouldn't mind doing that, you know like when I was on Through the Gate and you had people coming in talking to you? Because there were a couple of times people came in and it was like looking in a mirror what they'd done and what they'd been through. (Rob, Manchester).

Sometimes [drug workers] try to say bits and pieces to you, to tell you what they've learnt, unless they've lived through the process themselves. They tell my mother on occasions, they counsellors from where I am now. There's only one person counselling in the building who's actually lived my life himself in the past who's had a drug problem himself in the past and so he knows exactly where I'm coming from. Not somebody who's just got a qualification studied up on things and learnt certain aspects because they think they know where I'm coming from but they haven't actually lived it themselves. They don't know where I'm coming from (David, Swansea).

Strikingly, the very same interviewees often had no intention of attending fellowship meetings:

I: Have you had any contact with NA or AA?

Rob: No, because, to be honest with you... I just think if you really want to do something in your life it doesn't matter what meetings you go, it doesn't matter what people tell you, it doesn't matter, if you really want something, if you don't want to do drugs you won't do it, if you don't want to drink you won't do it (Manchester).

I: Have you ever tried NA, AA?

David: No. I've never really worked well in a group situation. One to one isn't so bad. But I've never been able to open up especially in a room full of strangers (Swansea).

I: Have you tried AA or NA?

George: No no. I tried them in the past, and they weren't really for me. (Swansea).

This seemed to point towards a real disjunction between understandings of processes, and understandings of provision. The very processes that many claimed to valorise were embodied by mutual aid; yet mutual aid was not widely seen as a helpful or appealing offering.

Summary

Prisoners widely endorsed peer workers and mutual aid, with meetings in prison receiving high praise (see Section B). It consequently seemed striking that only two interviewees so much as attempted to attend any meetings in the community, with one of these describing one of the strongest recovery narratives encountered in any site.

The DRW: Reflecting back

Prisoner interviewees

Our cohort of former prisoners offered a full range of opinions on the DRWs they had inhabited. To an extent, themes clustered within prisons. Manchester was generally praised:

The officers are better. They understand more. You've more time, privileges. Which is a massive incentive. It's like. If you're opening a breakfast club, you've got to give a decent breakfast to get people in before you start doing groups. Of course. Slowly, slowly catchy monkey ennit. And you're around people who understand recovery. Because some [other] officers think you just fuckin give it up. "Why don't you just fucking give it up?" Fuckin hell never thought of that! [cackling] (Rob, Manchester).

Brixton evoked olfactory memories; and the heady scent of cannabis that suffused each wing:

Shall I tell you what it is when I went into prison when I got into Brixton all I could smell was skunk skunk. Like every other cell I was walking past I just smell cannabis. Like literally I think I think I've had more chance going down Camden town and getting a breath of fresh air than I would in Brixton (Elias).

On the Drug Recovery Wing there was a lot, I think that's where the most drugs and everything else was. Yeah [laughing]... the first time I stepped one foot into the wing and I think, "what's this, someone growing cannabis or something mate?" (Mo).

High Down and Swansea were also recalled primarily in terms of drug availability; and, particularly, the availability of Subutex and mephedrone:

The wing itself, it was diabolical. It wasn't a Drug Recovery Wing it was just a name. It wasn't separated from any other wing, every other wing was just the same. So you're getting people who are in recovery banged up with somebody who was on Subutex. It don't make no sense. [And] that's the wing that [prisoners] go to, to get Subutex and mephedrone. The Drug Recovery Wing. Anyway. So it didn't make no sense (Joe).

Contrastingly, Holme House interviewees reflected on the paucity of provision, and the lack of structured support delivered within the DRW:

I: Not much [treatment] materialised?

Matt: Naw. I mean there was all sorts of excuses off the staff on there. You know. they didn't have the funding. And because of staff cutbacks they were getting moved about and. They couldn't get their teeth into anything. Because they were getting moved onto different wings and things like that. Just all excuses, really. There's plenty of agencies about. But to be honest really the majority of them just didn't have any faith. They'd come in. But at, at the end of the day they couldn't do anything for you.

Strikingly, despite often having lived on relatively enhanced locations, few interviewees reflected on their time in prison in positive or therapeutic terms. The following sections arguably offer some explanation for this.

Preparation for release

Across institutions, perhaps the most common theme centred on the lack of preparation DRWs provided for release. Some interviewees were sceptical that anything could be done in prison to prepare for release, given the two were fundamentally incomparable experiences:

I: Have you stayed in contact with anyone?

Clive: No, because [pause] it's another life, [the DRW]... because, at the end of the day, no matter what, they'll still rob you blind, they'll still rob your grandma blind.

I: You felt that on the DRW?

Clive: You never trust...I never trust anyone like that... I just kept myself to myself and you get on with people, you're polite, you're thingy but it's not somebody you'd have around for tea or that you'd bring home and introduce to the missus (Manchester).

Life out here is different from prison life. It's easy to [stay drug abstinent] in prison, because it's not that easy to get a hold of. And you can focus. You have no other problems. You don't need to be finding money every week. You know: do your house up, get the insurance on your car, put tyres on... or whatever. There's none of them problems there so you can focus more on yourself (Matt, Holme House).

Few reported ever reflecting on their experiences of prison, or the lessons and tools they might have learnt whilst inside:

I: Do you ever think of being back in Brixton or is it just a complete life away?

Jahan: Hallelujah hell no! [laughing] (Brixton).

Unless somebody's sitting there and talking about jail, I've never really sat there and thought about it. Put it behind us and look to the future. It's not a very good place. Do you hear me. Not a very good place. (Jason, Holme House).

Signifying the extent of the chasm between prison and release, even those who had aspired towards fully abstinent, pro-social lifestyles found this impossible when confronted by the challenges of the real world. Optimistically, this centred on prisoners simply finding community life too much, and struggling to hold onto their goals:

I: And did you manage to make it to marijuana anonymous in the end?

Elias: Errrrm, what what what, outside?

I: You said you might go to a meeting.

Elias: Yeah, to be honest Geoff when I came out I don't think I think half the stuff I said I wanted to do I just honestly haven't had a chance... Since I've been out that was a year ago, since I've been out I still haven't had an address (Brixton).

I: You'd talked about potentially looking at longer term abstinence?

Joe: Oh yeah! I did. And actually I did try it when I came out. I went to... an abstinence based course about 3 and a half weeks. And I just thought "nah. I'm finding it a bit too hard to be honest." I thought that was a bridge too far for me (High Down).

In multiple other instances, they felt actively betrayed by unmet promises.

I: Do you think of yourself as being in recovery at the moment?

Ben: Nah [belly laughing] that went right out the window. It just doesn't matter now. They give you all these ambitions to help you when you're out the jail. And they just don't help you out at all. They just [say] 'yeah, have a good time, see you later.' They egg you on. But the help? There's nothing. (High Down).

Further examples of perceived 'unmet promises' can be found in the sections on housing, education and employment.

Other prisoners

As Gresham Sykes noted, one 'pain of imprisonment' is being surrounded by other prisoners:

The individual prisoner is thrown into prolonged intimacy with other men who in many cases have a long history of violent, aggressive behaviour. It is a situation which can prove to be anxiety-provoking even for the hardened recidivist and it is in this light that we can understand the comment of an inmate of New Jersey State Prison who said, "The worst thing about prison is living with other prisoners" (1958:77)

This was a cross-cutting theme for several interviewees, several of whom rejected a 'criminal' label. Nick (High Down) repeatedly clarified 'I'm not a criminal, am I' whilst Bryn (Swansea), Jahan (Brixton) and George (Swansea) offered similar sentiments, sometimes questioning the extent of their own drug or alcohol dependency (and whether or not they were a 'real addict'). This could leave them feeling profoundly uncomfortable in the prisoner communities of Drug Recovery Wings. Bryn (Swansea), for example, felt alienated from the pro-criminal attitudes of his peers; and isolated by the shame he felt about his offending⁴¹:

I wouldn't say I didn't fit in. Well, I didn't really... That wing was, was more. Geared towards. The drug aspect. I have smoked in the past but in a recreational basis. I've never been addicted. Um. And. I don't know. I think. ... a majority of the people there were um. Minded on one thing. One thing only. [Using heroin], and crimes surrounding it. Whereas me, I felt ashamed of being there, personally. Whereas I got the impression that a lot of people there were kind of proud of their. Erm. Indiscretions. It was like they were almost boasting about them whereas I personally. Felt the opposite. (Bryn).

⁴¹ This seemed likely to be related to Bryn's background as a supermarket manager, and the multiple years he had spent living a relatively conformist family life before alcohol dependency, chronic unemployment, and repeat imprisonments for breaching a restraining order took over his life. No other Swansea interviewee had similar roots.

Paul (Holme House) shed a particularly interesting light on the role of other prisoners within his recovery journey. He had been through Holme House's abstinence-focused therapeutic community twice. The first time, he had actively engaged in all groups and programmes. However, this meant engaging with other prisoners; and...

...there was a lot of drugs. There was a lot of. Erm. ... not bullying physically. But people borrowing stuff you had to pay double back.

Paradoxically, the second time round he chose to withdraw from therapeutic activities and from the therapeutic *community* – as engaging with the TC programme meant engaging with drug-involved peers. He attributed his apparent progress prior to and following his release to this social withdrawal, and to the intervention of a therapeutic officer who supported him in stepping back from the wing's usual requirements. Bryn expressed similar frustrations with the limitations of treatment in an intrinsically antisocial environment:

[They're] putting people in a group and everyone is there using, and at the beginning of the session they say you know "confidentiality, what happens in this group stays in the group." Now. Everybody agrees "yes yes yes blah blah blah" but that's not going to happen... No group's gonna be totally safe. Or even half suitable. Because nobody believes that what you say there is going to stay there and obviously you've got to go back onto the wing with these people... Because it was a small wing. And you have to live with these people... Twenty four hours a day... And you can't get out... And I mean if, if somebody takes offence to you, and you're on the wing. You can't go home. You can't avoid them. You know... It's a confrontation waiting to happen. It's a constant mind game (Bryn, Swansea).

In this context, Bryn felt completely disempowered. Disclosures were unsafe, as were any attempts to bring groups (or the broader DRW community) round to pro-social or therapeutic norms.

Paradoxically, a small group of interviewees felt that living alongside more chaotic peers was a positive advantage. Despite the extent to which this rendered group therapy problematic, they felt that looking at desperate cases gave them insights into where their lives could end up:

Do you know what [the DRW] has actually helped me, it helped me by looking at people. Not in the personal aspect because I know what I've done is wrong, I know I'm not going to do that again... [But] because other people in there, they weren't in no good state man. (Jahan, Brixton).

I got to see. How bad things can get. And where you can end up if you're not careful. I didn't take that away so much when I was on the main wing. But it was more so on [the DRW] hearing people talk about it... And [having] their whole mindset on. On life. In prison. Made you kind of think, "god. I don't want to be like that." (George, Swansea).

Mo and Elias – both Brixton prisoners with robust access to recovery resources – expressed similar sentiments.

Physical recovery in prison: tea-total, and physically fit

A description of jail as ‘a poor man’s health club’ came from a Chelmsford interviewee during the rapid assessment, and this was widely reflected in our follow-up interviews. Gains centred on two core themes: gains in physical fitness; and abstinence from drugs and alcohol.

In terms of physical fitness, prison gyms clearly offered widespread benefits:

Row? That’s what we used to do in there, we used to go on the rowing machines. Fucking hate it. That fucking gym we went to. But it wasn’t like a gym to do the weights it was all cardio like. I used to do 5,000 metres on the rowing machine... The other thing, I used to go to the gym to do the weights. (Clive, Manchester).

He used to get heavily involved in the gym because he’s fanatical about keeping fit. He used to get heavy involved in the gym. He’s got more certificates than you could sling a cat at (Monica, Holme House).

Prisoners – and their RSEs – often described leaving prison in peak physical condition (though sustaining this could prove more challenging).

Secondly, a number of interviewees noted that DRWs offered them a chance to spend some time drink- or drug-abstinent. Even if this was not their long-term ambition, they appreciated the break it gave their bodies from heavy and dependent using:

When I was on there when I was on my DRW, for me, it was a period for getting clean and sort of like a detox sort of thing. You know it never does you no harm to do a bit of abstinence now and again. (Matt, Holme House).

It’s a good wing if you want to stay clean. Yeah it’s a good wing if you want to stay off everything. I’d go back there tomorrow, if I had a habit again (Alan, Brixton).

Elias (Brixton) saw both gains as equally important:

When I go into prison my main thing is just to like get fit, that’s my main thing, like I would hate to come out of prison and be unfit sort of thing. It would just seem like there isn’t much point in me going in. But I just asked them if they could get me on the DRW and they got me in there, you get more gym sessions as well. Oh, and you get to stay clean, you know what I’m trying to say so it sort of helps on two different fronts.

These gains might appear to ask relatively little of Drug Recovery Wings: that they have access to physical education, and reduce access to drink and drugs. Nonetheless, they were features of prison that several of our interviewees appreciated.

Recovery Supports

Not one of our recovery support interviewees was aware that our prisoner cohort had been housed in a Drug Recovery Wing. The name meant nothing to any of these interviewees, and only Monica was aware that her son had been in a treatment or support unit of any kind – a therapeutic community⁴².

I: Did you get any sense that he'd received help in prison this time?

Kerry: No, well he wouldn't, would he? He came out off the drugs, but there wasn't no help for him there.

I: Is it news to you that he'd been on a treatment wing?

Gillian: I don't know much about Nick when he's in prison. He phoned me and I sent money in. I went to see him. But I didn't like it. Didn't like the prison. I felt. Awful.

I: Did you hear anything about this sentence? Support he'd received or...

Pen: No he never. He never ever. He always says he's been stitched up. It's not my fault. They've got it all wrong. he doesn't want to talk to me about that. And that's fine too. I'm not going to dig deep if he doesn't want me to know that's fine.

Nonetheless, recovery supports were divided about whether or not they had seen any behavioural change in our cohort of former prisoners. Some clearly felt the DRW had no impact, as they had seen no behavioural changes:

I: Did you see any improvements in him after his last sentence?

Kate: No, no. You can't rely on him for nothing. He got out and he was straight back with his old friends. (Swansea).

Others were more positive. For some, changes were short-lived, and appeared to have little to do with therapeutic change:

I: And when he came out, did you see any improvements or...

Carol: Oh yeah! It's brilliant for the first 2 days because he's had no drugs. It's the first 2 days and then the [lack of] housing kicks in and. And everything else just gets chaotic (Swansea).

Others noted longer-lasting gains, reflecting real progress made in former DRW residents' drug use, mental health, motivation, and physical fitness:

Well when he come out he didn't smoke. He give it up. Even things like roll-ups, he didn't smoke anything. And of course when he moved, got his flat... There was positivity when he come out definitely. He looked well. He'd put on weight you know he was in a good frame of mind. Wanted to get a job. (Maureen, High Down).

⁴² Paul progressed to Holme House's TC after graduating from the DRW. He was one of very few people to do so, though this was the prison's envisioned treatment pathway. Despite having heard that Paul was in a TC, Monica was sceptical of its usefulness: 'he got no support at all in prison'

This last year I've felt as if he's had enough for him. And I think he's just got to that point where he's got to change his life or... You know. I don't think he couldn't quite carry on as he was. And I think he's made more effort. This last year. To sort of pull himself out of it. It's not as quick as I would like. He knows that. But he is definitely in the right direction. (Lil, Swansea).

Strikingly, even these more positive accounts were clear that prison had not been responsible for any change:

I: What is it that prompted that turnaround?

Lil: I don't think it was the sentence because he's so used to going back and forward that you know I didn't think that was making a lot of difference. (Swansea).

Instead, they attributed changes to other personal or lifestyle factors. For example, maturation, or time spent away from deviant peers:

I: Did you see any other differences in his behaviour?

Maureen: Yeah. But he's grown up. I thought that boy, he's actually he's actually gonna you know. Sort himself out. So. (High Down).

I: Is that at all due to the prison sentence?

Sue: I think what it is he's seen sense now and he's staying away from the idiots who he was with, they've all proved what friends they are so. (Brinsford).

The absence of DRWs from recovery supports' accounts seemed remarkable. It may have been that prisoners were cautious of giving their relatives false hope about the future, were expecting to use on release, were embarrassed or ashamed of talking about drug-related needs, or simply that they saw the world beyond prison as an entirely different entity.

Summary

When reflecting back on their experiences of DRWs, some site-specific patterns emerged. In Manchester, these centred on the improved conditions on the wing. In High Down, Brinsford, and Swansea, these centred more on the ready availability of drugs. Holme House interviewees particularly commented on the absence of (anticipated) therapeutic provision on the DRW.

A second substantive theme centred on preparation for release. Interviewees felt they had received little support; but also widely commented on the impossibilities of projecting prison life into the community. The two appeared to be worlds apart, and those with highly ambitious aspirations often found that they had the furthest to fall. The chaos and complexities of life often took over. None identified that they regularly reflected back on life on, or lessons learnt in, their DRWs.

With hindsight, several interviewees also commented on the difficulties of other prisoners. Confidentiality had, they noted, often been limited by the nature of DRWs. Disclosures could be high-risk, and other wing residents could be drug-involved and prone to glorying in their offences.

For some of our more robust interviewees, this provided a tangential benefit. In seeing where their lives could end up, they found themselves more keenly motivated to enact change in their own lives.

On a more positive note, a handful of former prisoners also looked back – with some affection – at the benefits of DRW conditions for their physical health. Going to the gym, and improving their fitness, was an important part of DRW (and, indeed, prison) conditions for some interviewees. Others saw prison as a means of physically recovering from the ravages of heavy and dependent drug use – even if they had every intention of returning to drug use following their release.

Finally, not one recovery support had been told by their relatives that they were on a drug treatment wing. Those who had seen changes in former prisoners' behaviour invariably attributed this to broader life events – none saw prison as a helpful or supportive place.

Education and employment

Interviewees and their recovery supports identified that ex-prisoners had accessed a wide variety of employment opportunities. Perhaps reflecting the relative stability of our follow-up sample of ex-prisoners (who, by definition, had not been re-imprisoned) only eight identified that they had secured no periods of stable employment. Of these, Chris (High Down) expected to begin a cash-in-hand job bricklaying for a friend within days; Frank (Brixton) and Ben (High Down) had each managed to secure some money from occasional cash-in-hand work.

This contrasted with instances where we were only able to interview recovery supports, many of whose relatives were more chaotic and had been re-imprisoned. Here, just two interviewees identified that their partner or son had found work.

Currently employed

Experiences of employment were dominated by short-term and unpredictable contracts. Just five interviewees were currently employed during follow-up interviews, and one of these was on a zero-hours agency contract, working unpredictable hours. Most employed interviewees were thriving. Mark (Brixton) found that full time employment in a paper mill filled his days, and – combined with a daily commute and time spent with his daughter – he found it hard to find the time to be interviewed. Paul (Holme House) had, if anything, taken on too much. Within weeks of his release, he took up an opportunistic post within his local recovery service:

They had a music room and a gym. Sports hall and stuff. I asked if I could do a bit of voluntary with the guy who was running the fitness department because I've done all the gym instructor qualifications, so I was like, "can I help?" And he was like "great, yeah." So I sort of shadowed him. And spiced it up a bit. And he got me a job.

A short while later, more structured opportunities arose:

I was encouraged to go for this interview [for] a 'through the gate' project. Erm. and it's a kind of a 12 month pilot and it's kind of being watched by the rest of the country. So...

These three positions became available for ... coaching people fresh out of prison. So I went for the job and they offered me the job.

By capitalising on both formal and informal opportunities, by the time of his follow-up interview Paul had two part-time jobs 'with full-time hours'. Perhaps more remarkably, he was routinely going into prisons and recruiting prisoners for recovery services, whilst still on license himself.

Work played an equally dominant part in Rob's (Manchester) recovery. Again, his initial pathway into paid work was informal – shortly after his release, a friend had offered him work on a market fruit stall. The nature of his work meant he had to work very long hours, and a telephone interview was only possible on a Saturday afternoon:

Oh it's brutal! But better than no jobs... I sell fruit... I work on a market now. I love it, mate. Because me mate knows the boss so. He was just passing one day. I just started helping out. He said right, you want a job. Sweet. It is a lot of hours... [But] because [of my benefits] it's only 19 hours [that I can be paid for] innit so. It's only 90 quid a week.

An average working day comprised twelve hours, six or seven days each week days. Even though much of this was notionally unpaid he felt that his boss took care of him – he could take days off at will and at Christmas he was gifted a range of high-value goods as untaxed remuneration, including a television and PlayStation.

Nick's (High Down) relationship with employment was more strained. As noted earlier, Nick saw himself as fundamentally non-criminal, though his alcohol dependence and personality disorder had caused significant problems in the past. He began looking for work as soon as he left prison, and soon found a post with a roadwork company; but he found it highly unrewarding:

It's not labour. To be honest with you. You sit on a road. You sit on a road you do nothing. It's just basically uh. Doing nothing all day.

Drink had become Nick's driving priority. The levels of daily consumption that he described meant that he would have rarely been sober at any time of day, even if he had remained tea-total at work. However, Nick's dependence was such that he sought to make use of every opportunity to drink, consuming alcohol 'on the sly' and talking colleagues into supporting his own drinking:

If I'm really having a bad hangover day... I've took people in pubs. Youngsters at 8 o'clock, sorry half ten in the morning, eight, half eight. And I've pulled other people with me to have a drink in the morning. Just so they don't get me in trouble.

That Nick was managing to attend work at all appeared to be quite an achievement.

Previously employed

As noted, for a large group of interviewees experiences of employment were transitory. A small number had found work almost as soon as they were released; but found the pressure unmanageable, and swiftly returned to heroin use. In several cases, contracts simply had not

translated into full-time opportunities, and this could be a real source of frustration both for ex-offenders and their relatives:

Obviously and he got back into the circle, working again. But they went into [production] and he was only working on an agency. So they've given him the boot now. I did keep telling him to try and get on contract with them because it means that the next company that comes would've kept him, you see. But I don't think that the boss he was working for could do it or something (Sheila, High Down).

Poor conditions also led a few to disengage from work. As noted earlier, Mo (Brixton) was unique in being found work by a non-statutory employment agency. Whilst he was willing to give this a try, both pay and working conditions fell short of his expectations, and he left to seek opportunities elsewhere:

I done the first day. Second day I didn't bother going in because for me it was only 7 pound an hour where like you're doing digging and stuff. Hard manual labour for 7 pound. Where you can just earn the same working in Sainsbury's just stocking the shelf.

Though Mo had chosen not to investigate the prospect of shelf-stacking at Sainsbury's, he was under serious pressure from his family to find work and identified that he felt like a 'waster' whilst unemployed. More significantly, he saw work as the only way to a stable future. His girlfriend was in a well-paid position in the service sector; in Mo's worldview, it was unacceptable that he was not looking after her financially, and marriage (let alone fatherhood) was out of the question until he was in a well-paid job. Better-paid opportunities had yet to materialise; though he had high hopes for a £500 railway safety course that he was about to undertake with the financial support of his parents.

A handful of formerly-employed interviewees also described considerable success in securing and retaining posts. It took multiple attempts to contact Jahan (High Down), as his family identified he was in Amsterdam. Initially, it sounded as if this might have involved a return to drug use; however, in interview, it turned out to be the result of a shining success following a plethora of unpaid and informal roles. Again, informal networks of support had proven critical to both securing him an initial post, and progressing through swift promotion:

When I came out I started looking for jobs and that obviously and you get your knockbacks all the time like always. But I was just knocking around and I was helping my uncle around and then waiting and waiting and working for one of my friend's groceries... Cash in hand. Do the odd bits. And then September, started applying for jobs and then one of my friends came, and he was like, "do you know what Jahan I might be able to get you into this apprentice scheme." And I was like "I'm 25. You can't get me in." And he was like, "do you know what just come in for training. They won't pay you but it gets you in." End of October. "Ah Jahan... the guy wants to see you..." I went in for an interview, do you know what, "I'm gonna offer you a role in Amsterdam. Holland. Will you take it?" I was like, "I don't know. What am I doing?" And he goes "Business Development Manager." I'm like, "are you serious?"

Family support was also critical in ensuring he followed up this opportunity. Though Jahan was unsure whether or not to take the post, his mother was emphatic:

When they offered me the job I was like, you know what, I didn't know whether to take it or not... and then I was like "oh mum I don't know" she's like "GET OUTTA HERE! THAT'S IT! THAT'S YOUR CHANCE! GET OUTTA HERE! IT'S GOOD! JUST GO! You need something. And don't come back til you're like settled and shit."

He subsequently spent about three months working in Holland, before resigning for ethical reasons. Jahan explained that he felt exploited in his role, and was unhappy with the way he was being asked to treat his staff.

Joe (High Down), too, appeared to be highly competent at negotiating service sector opportunities offered by the formal job market. In his original interview, he described the historic necessity of being economical with the truth in order to secure employment. This had continued:

When you called me this morning I was literally applying for more positions. Obviously you've always got to explain why there's that little gap in your system on the CV and that. But you can kind of. Veer around it sort of thing. "I was studying" or something like that, or I was just signing on and couldn't find work basically...

The results he had secured, though, appeared robust:

I got out, went back to stay at my mum's. Then I started working. So I've had a couple of jobs since I got released. Contract jobs. And the last one just finished last month... I was working for [a government department] doing customer service. Advising people on how to save energy and stuff like that.

He remained optimistic about his prospects for securing work, and his work history suggested continued success was likely. Indeed, Joe was the only interviewee who could be contacted with a personal email address he gave in prison – and in interview, he described negotiating multiple email accounts and job applications with his smartphone. Joe appeared particularly adept at engaging with employment opportunities offered through the formal job market. His immediate – and repeated – use of such opportunities contrasted with the reliance on good luck and informal networks largely described elsewhere.

Unemployed

A final subgroup of interviewees had been consistently unemployed. For a couple – including George (Swansea), a fully drink and drug abstinent family man – this was not an issue. Work was for later consideration. David (Swansea) was of a similar mindset: 'I just want to relax for a bit, do you know? Take some time before I look for anything.'

For others, the difficulties in accessing work proved a continual frustration. In this, both Ben (High Down) and Jason (Holme House) felt seriously let down.

I wanted to go back to work. [High Down] got me on a course. When I come out Jobcentre laughed at me and didn't put me on a course. [I wanted] to go to college to do this CSCS course. They wouldn't let me go. They didn't have the right letter. (Ben).

Jason, meanwhile, felt let down by a perceived mismatch between the training he had received in prison, and the job opportunities that were available following his release:

In there I was doing a renewable energy course. Aye. And they don't know nowt about it out here. Cannae get nowt. There's no work, like there's no firms, I got the probation to check and they didn't seem to know owt about it. But it's the future, that's the way things have gone. All them turbines that's gone up, all them wind turbines (Jason).

Finally, a subset were desperate to find work but felt they kept hitting barriers. Clive (Manchester) had struggled to find paid employment of any kind but, the day before interview, had attended an interview to become a peer worker in an alcohol project. He was awaiting a call. For Elias (Brixton), his lack of secure housing prevented from making progress in any area:

The fact is I'm trying to sort out my housing situation I can't get into studying I can't get into. I can't get into anything Geoff at the moment.

Desperate to find a way out, he was exploring the Army as one means of accessing a career that could provide him with transferable skills:

I need a *career*, sort of. Like I know work is is is on that on that on on on the same sort of path but in a way I'm just like 25 now and I've just got so much energy that I need to do something. Like. Constructive. So I been thinking about recruiting up and trying to go into mechanical engineering in the army sort of thing.

The Army also had the potential to provide the one thing that Elias felt he most lacked: stable accommodation. He was keen to find out if his criminal record would disbar an application.

Finally, Bryn (Swansea) described the greatest sadness about his unemployment. He had once been a regional manager for a large supermarket chain, until his drinking and growing criminal record made it progressively harder to find work. His main daily activity now centred on going to the jobcentre and taking up any and all training that was offered; yet work remained elusive:

I have tried [to find work] but um. My record has gone against me. I'm actually working with Working Links. And he specifically works around ex offenders. So I'm getting support from him around covering letters, disclosures etcetera etcetera... It does get a little demoralising sometimes. When I think that possibly I'm not getting the jobs purely based on my conviction and not my abilities. That has been demoralising. But understandably obviously. I myself have employed people. And I know it's a biased kind of thing. If you've got somebody with similar qualifications and no criminal record I know which one I'd pick, you know. I have been knocked back. Sometimes I'll see something and think "is there any point?" So there are jobs that I may have gone for but I haven't had the confidence.

Summary

Despite a lack of structured resettlement support, our prisoner interviewees described reasonably robust access to employment. Only eight (of twenty-one) prisoner interviewees had experienced no employment at all – though it was notable that the roles they found often centred on short-term contract (or unpaid) work. This was emphasised by the proportion who were in secure employment at the time of interview – just five people. Whilst there was a lingering sense of ex-prisoners being exploited for their labour (with a couple of unpaid roles failing to result in work, and one interviewee working vastly more hours than he was paid for), others had clearly thrived – with a small number attaining management positions. Particularly in Brixton and High Down, there was also a sense that some former prisoners were highly adept at managing the job market, and applying for (and securing) service sector jobs.

Finally, we interviewed a group of former prisoners who described no success at finding work. Some were relatively unfazed; but there was a real sense that for more motivated interviewees, this was a powerful frustration that was seriously impacting on their sense of self-worth.

Housing

Comments on housing were so prolific that they could have easily filled a chapter of their own. For better or worse, some interviewees spoke of little else. Their lives revolved around the place that was meant to be their home. When this was a safe, warm or supportive place, this allowed them to begin exploring or fulfilling other needs. When this was an unsafe, uncomfortable or unstable place, they often felt unable to progress any further.

In this context, it was striking that not one of our ex-prisoner interviewees identified that they had been offered safe, secure and supportive housing through prison housing services. Often, they attributed this directly to a failure of prison services:

They were supposed to have got me housing, a half way house? Like from jail, probation and that. I would've took that. But they was like, "ummm there's no spaces we can't give you nothing." Hold on hold on. I'd've rather stayed in [prison] for another month. Like I'd've rather stayed in there for the whole sentence... Not like this. Kicking me out. It's like they want to make you relapse (Ben, High Down).

Some qualification should be added here. Whilst the experiences of our interviewees were poor, pre-release interviews, triangulated with recovery supports, identified some success in securing prisoners their preferred form of housing. One person had moved into residential rehab, and two had moved into specialist supported housing with dedicated substance misuse workers. Unfortunately, none could be interviewed; all were reimprisoned within weeks.

Street homeless

At one end of a housing spectrum lay those who had been released street homeless. In some instances, this was due to a complete lack of both structured and informal support. Elias and Alan,

for example, were the subjects of restraining orders preventing them from contacting people they had previously lived with. When support services then failed to find them housing, each left Brixton street homeless:

I told you they was meant to sort out supported housing? ... Nothing. Nothing. I came out with fifty quid in my pocket, street homeless. No hostel, no night shelter, nothing. I was down housing every day looking for a place, but nothing come up. No hostels, no B&B... Turning up on mates' doorsteps, asking if I could sofa surf for a couple of days. Spent a few nights in doorways. Fucking freezing. What can you do? (Alan).

Oh, Geoff, I literally mean street homeless. When I come out I had nowhere to go I was renting a hotel for thirty quid a night for like three months! It was coming out of my own pocket. Because I sorted my benefits out, the benefits managed to forward me like 300 quid. But it literally all went on, went onto hotel (Elias).

As noted earlier, Elias directly attributed the breach of his restraining order and brief reimprisonment to his lack of access to housing. Moreover, his life after prison was consumed by trying to find housing. All of his earnings, both licit and illicit, were funding his hotel place, whilst securing stable work or education was impossible without a fixed address:

It's like literal, literally the money is literally coming out of my pocket. I'm having to work harder every week just for the plain fact of having a housing situation. And I ain't even working sort of thing. It's, it's mad Geoff. The fact is I'm trying to sort out my housing situation I can't get into studying I can't get into. I can't get into anything Geoff at the moment. I've already looked [at work and education] online and looked at a few things and the fact is I want to have the housing situation sorted and until then there's nothing else I can do. It's just so jarring it's been about 6 months now that I've been trying to sort this out (Elias, Brixton).

Alan's situation seemed still more unfortunate, reflecting a serious failure in joined-up provision. Whilst in Brixton, he had been offered access to specialist supported housing, targeted at former drug-dependent ex-offenders. However, this would only be available after a week, during which time Alan was expected to find his own accommodation and stay drink- and drug-free. Further complicating the picture, all of Alan's friends were heavy drug and alcohol users making abstinence highly challenging. On the night of his release, he got drunk:

Housing was shit. I spent all day there, then went and found some mates. And got wasted.

Within a week, he had resumed heroin and crack use. Within a month, he had left London entirely, returning to Newport where he had a stronger local connection, and improved chance of accessing housing. By the time of interview, he was still sofa surfing with local friends; and his recovery support identified that shortly thereafter, he was reimprisoned. A failure in joined-up housing provision thus left him reliant on drug-dependent friends; and this, in turn, seemed to be related to the collapse of his motivation, and his swift return to prison.

Hostels

By far the most common experience described by our interviewees was being released into a hostel, or funded B&B. Only one interviewee aspired to living in hostel accommodation: Elias, who was otherwise street homeless or reliant on his self-funded B&B. None of those who had entered a hostel found it a positive experience. Three said that living in a hostel had been driving them 'mad,' in some cases literally:

I've been hearing voices, seeing things and that. Like it's just been bad. It's been really bad... My mental health's never been this bad. (Chris, High Down).

Others had taken drastic action to escape, with several describing suicidal feelings, and Matt resuming drug dealing in order to fund his escape. Nearly all interviewees felt that living in hostels made a return to prison far more likely:

If I was still in the [hostel] I don't know how I would be now. I don't know how I would have been, it's like I come out with all good intentions and everything... But I don't think I would have stayed in the [default hostel], I wouldn't have stayed there because it was just mad. (Clive, Manchester).

Some hostels had clearly picked up established reputations. Both of our Manchester interviewees described returning to the same hostel after every sentence, and finding it grimly oppressive.

The strength of interviewees' feelings meant that many described hostels as 'worse than jail' (Rob, Manchester) with problems compounded by chaotic living environments and a substantial lack of structure. Conflicts and petty theft were widely described as routine – if not daily – occurrences, whilst the generally difficult living situation made a serious impact on interviewees' mental health:

I told them I can't be in [a hostel] because it's allowing too many people to smoke drugs. I'm off drugs myself now and I can't be around people, like it's driving me mad. It's literally driving me crazy, being in a hotel... I just... all the noise, banging upstairs when I'm trying to sleep, banging downstairs, always kids running around the hotel. And then you've got all people constantly knocking at my door, at fucking early hours in the morning, and shit. (Chris, High Down).

Some of the people... they're quite. You know people coming out of prison. Homeless people. Beggars, prostitutes. You name it... Because it's mixed, male and female, the prostitutes, it'll get to a night time. And they'll do what they're doing. And then they bring all the trouble back to the hostel. They're robbing punters and... so then you get them coming round like you know looking for these prostitutes. And any amount of alcoholics... I'd say the majority of people in there are alcoholics like... Ah honestly Geoff. Nightly. Nightly. I had some sort of confrontation. You know like having to like you know push somebody away from the door or you know have words with people. That was on a nightly basis. It was ridiculous. The lad in the room next door to me. I think he like he took everything like drug wise. He'd been up for like four nights. And he wouldn't think like nothing of knocking on your door at 4 o'clock in the morning and ask for a bin bag or... you

know a cigarette or just you know anything. So you'd have four nights of music on. People coming and going. And then he'd go into a coma for two days when his amphetamine run out. Ah. Honestly. It was driving me mad. It was absolutely driving me mad. (Matt, Holme House).

Staff, too, were seen as problematic – because of their absence, their lack of ability to reinforce discipline, and (in one instance) because of their own criminal behaviour:

There's always staff are there, but they're dodgy as fuck. One of them got arrested the other week for grabbing up a girl. The staff are as dodgy as fuck (Chris, High Down).

There's no discipline. There's no one to do the discipline any more. Or like to keep the order to keep any order. (Mark, Brixton).

Those that found ways out tended to do so through their own initiative. Matt took up dealing, Clive moved to a different city, George moved back in with his dad, and Rob took the initiative to apply for specialist supported housing.

Partners

None of our interviewees returned to live with partners. One (Alan, Brixton) had sought to do so. However, his wife's (Marie) account of their relationship made it somewhat surprising that Alan had identified her as a recovery support. She described their long-since ended relationship as violent, controlling, and abusive:

He was constantly violent very controlling. If I went to the shop he would time me how long it would take me to go to the shop. And he would accuse me, accuse me of doing things I hadn't done and he was getting very violent and when he didn't have drugs I would have to pawn my jewellery to get him money to get his drugs because he would just smash up the house he would beat me up. And then in 2008 I just made a decision that I couldn't deal with it no more between him and the other people outside it was it was either me get up and go or I'd end up taking my own life. Because he started getting quite abusive towards my children as well and. I said enough is enough. I had to think of my children.

And identified that the index offence leading to his imprisonment had been a series of exceptionally violent assaults on her (sometimes in public spaces) followed by repeated breaches of a restraining order. This was not mentioned in Alan's original interview, where he identified he had been imprisoned for 'robbery, and common assault.' She was unwilling to have him in her house again.

Parents

The age of interviewees is included within this section, as it seems particularly relevant to living with parents.

A substantial group of interviewees returned to their parents' homes. Of these, relatively few saw the situation as completely ideal; though Paul (36, Holme House) was an exception. Now fully abstinent, returning to live with his mother (Monica) brought advantages for both. Monica was unwell, with a second kidney transplant failing. Paul escaped hostel accommodation, and was happy to help around the house whilst rebuilding his relationship with her. As Monica noted, this required a degree of mutual accommodation:

Obviously there's a big generation gap. I've been on my own for, for years. It's quite difficult. All of a sudden having a young person in the house who's full of energy. Who doesn't work like you do. He's messy at times and he leaves things laying around and I say to him "this is my space. You have your television, your laptop. Everything you would need is in your space. Keep it in there... It's 2 bedrooms but I had a conservatory built on the back so I had an extra space so I could sit and look at the garden. But it was never really meant for me and Paul.

For Paul, the difficulties that arose were different. The more he worked on 'control issues' with his twelve step sponsor, the more frustrating he found it that Monica was not working on hers.

A substantial cohort of others had also adjusted well to life with their parents. Almost without exception, these were younger interviewees with relatively robust access to recovery capital, and few (if any) previous imprisonments. George (32, Swansea) would have struggled to find housing anywhere other than with his family, due to a conviction for arson. However, living with his dad was working out well. He was supported in making daily contact with his children, and his home environment had become safe, secure and supportive. Others were similarly positioned, with relatively few low-level concerns. Jahan, for example, would have appreciated a bit more privacy:

I'm still living with my parents now. I tried getting with housing but they couldn't get me a place so. Anything. So I wasn't living here for the past 6 months [whilst working abroad], so I came back. It's alright. I don't get the privacy sometimes [laughing] You know what it is, you can't do a lot of things!

Such complaints were low-level, though, and were often tied into broader patterns of support provided by financially solvent parents. Tensions rarely centred on drug use or criminality which, for the most part, were no longer seen as an issue. It also seemed striking that this group included our only two interviewees from first- and second-generation immigrant Asian families. Their family units had played a strong part in their lives, and they described aspirations that remained (broadly) aligned with their parents' social values: marriage, education, and employment.

For other individuals (often older, with longer criminal histories, histories of heroin dependence, and more marginalised families), the relationship was more complex. Jason's (41, Holme House) mum only had a one-bedroomed flat (a common problem for relatives across sites):

[Living] with me mam was alright. But it wasn't practical given she's only got a one bedroomed. It's like a little flat. Like a bungalow kind of thing. One bedroom. So I was on a couch you know what I mean. So. It wasn't ideal...

Danny (23, Swansea) had a long history of being released street homeless, often leading him to sofa surf at his heroin-dependent brother's flat. His mother felt that housing was the one thing that could have slowed down his years of spiralling homelessness, offending and prison:

The issue is that he doesn't have anywhere to live. That is *the* issue (Ann).

Joe (37, High Down) would say nothing more than that things were 'straiiiiiined.' He was spending most of his time at a new girlfriend's flat, whilst Ben (26, High Down) struggled in a family home that had 'druggies, drunk people and drug dealers' coming and going at all hours.

Finally, the behaviour of a subset of ex-prisoners appeared to be clearly responsible for the tensions that arose whilst living with their parents. After two days of sobriety, Nick (28, High Down) got spectacularly drunk, threatened his mother (Paula), and threw her out of her house:

Huh. Fucking hell. Jesus. Turned up [at my mum's], lasted 2 days. Walked in there Thursday. Getting stressed. All my clothes went fucking missing. I had a right go at her. Then um. I don't know. I, I She kicked me [out]... I had a. Had a blazing row. Got absolutely slaughtered... I said "look if you fucking cross me now I'm gonna fucking stab you fucking stay away from me..." The police turned up they wanted to put me in prison again because I was on license.

He threw me out the house. He wouldn't let me get back in so I had to get the police out because I couldn't stand up to him and they came out. And and he slept in his car for the night and then the next night he went (Paula, High Down).

After a few days of living in his car, Nick secured private rented accommodation.

Bill's (50, Swansea) situation was less confrontational. His mother had allowed him to stay with her on numerous previous releases. This time, she had only done so under pressure; a refusal would mean Bill spending longer in prison:

The probation officer, I think, told me... he'd have to stay in longer and he could come out quicker being tagged. So I thought "oohhhh. Alright alright ok. Let's just give him a chance again?" But that didn't work out. He was tagged. For about 4 or 5 nights he was alright. And that was it, then.

Gillian found herself driving around the streets of Swansea, trying to find Bill in order to bring him home before his daily curfew expired. When this failed, she ordered him out. Bill then started begging housing from his daughter (Kate), instead:

He sees [his granddaughter] when he comes up my house. But he only normally comes up when he's got nobody, nowhere to stay. He doesn't really bother otherwise... I feel like I've got to put him up. I feel like I can't leave him out on the streets. If I do tell him that he can't stay then he makes me feel really guilty about it and then he tells me that he's, he's told me loads of times that he's gonna kill himself. He's just a pain really.

Gillian was particularly worried about the impact this was having on her daughter and great-granddaughter, who only saw Nigel when he was desperate, intoxicated, and imposing.

Successes in independent living

A handful of interviewees were happy with their housing situation. All three Brinsford releases had returned to some form of supported housing, which both they and their recovery supports described as effective:

I: Do you have to share with anyone?

Ahmed: Nah, man. It's boss, ya get me? I got my bedroom, I got a little kitchen. It's well tidy, man. Like, twelve quid a week, ya get me?

For Jason (Holme House), accessing supported housing had been the most positive thing to happen to him over multiple releases. After her release from New Hall, his partner had been offered a place in a supported housing unit. She liked it hugely; and this shaped Jason's aspirations. He had been interviewed in prison, before being released to his mother's house:

Well [supported housing providers] come to see us. Like two weeks before I got out and er. just like told them I was homeless and that. Me probation officer wouldn't come. But they come and they asked us loads of questions and that. And they said right we'll come back to us with a decision.

To his surprise, a month or so after his release, things had worked out:

I was like hoping and wishing that I would get that place, a vacancy. There isn't that many. So I was a couple of weeks out, I thought ah I'll be laughing if I got that. You know what I mean. And everything came together. So things are looking bright.

Jason had been given a prize room: up in the eaves, well-appointed and newly-decorated, with a built-in kitchen and bathroom. We interviewed him there. The pride he took in his room was apparent, with cushions and throws decorating the (tidy) bedsit. It also gave him a safe, independent refuge: he could spend his days playing Xbox without getting in anyone's way.

Others had followed a similar path. After a couple of weeks in a hostel that was 'worse than jail', Rob (Manchester) had applied to a supported housing unit on his own initiative:

I done the interview then told Probation. Told them listen, I'm going there. She went "what?!" I went "yeah. Buzzing." So. I love it here, yeah it's brilliant.

The unit was a 'dry house,' with some therapeutic groups. Throughout the interview, Rob frequently described as being like the supported, follow-on phase of many residential rehabs ('stage two'), wherein residents often live together for six months to a year in the community:

Rob: [The groups are] like erm. It's more of an induction to life skills and stuff. With a bit of recovery thrown in.

I: You could probably lead some of those groups.

Rob: Yeah well I do actually you know what I mean.

Staff were flexible, and willing to support Rob in his unusual working hours:

The staff here are amazing. Amazing. They've helped loads. They're great to get on with. They let me work. I know they've bent the rules a bit letting me go out at 3 in the morning and stuff like that but do you know. They're great, they're great.

He was positive about other residents, too. Everyone was 'thriving'; the hostel was 'brilliant'; Rob intended to use his £20 Tesco gift card in order to fund a community meal for all his peers. Overall, his enthusiasm for his housing was only matched by Jason's though, of the two, Rob was involved in a notably more community-oriented, rehabilitative venture.

Clive (Manchester) had also found a warm and positive home. He met Claire when they were both at junctions in their lives. Clive badly wanted to escape the hostel he had been housed in. Claire was unhappy with social services' involvement with her children. They consequently decided to move to another area, closer to Claire's oldest daughter:

I: Did you find it easy to get housing over here?

Claire: Well, yeah.

Clive: Yeah, because it was [Claire's daughter]... it was.

Claire: It was my daughter that come here and it was just easy, she rang up...

Clive: She put the £50 deposit down, we came down two weeks later, got the housing benefit sorted and that's it, we were in. And it was just a matter of getting... because the Social Services in Manchester are a lot different from up here, aren't they?

Their current situation was not perfect: their neighbours could be noisy and unsympathetic; they knew virtually no-one; and they were one of very few white households in a predominantly Pakistani neighbourhood. However, the couple noted that the move had made a world of difference. Bradford's social services took a far more relaxed attitude to supervising Claire's children; they believed they were likely to be removed from their caseload at the next review.

Finally, three interviewees had managed to return to their own flats. As described earlier, Matt (Holme House) talked up the horrors of hostel life, and his escape to private rented accommodation funded by a last-ditch resort to crime. His sister offered a less dramatic account:

His housing? Well he lives in a house that we own. So whenever he comes out of prison, we make sure that there's a house there for him. So his housing's absolutely fine. If he can't get rent, that's fine. And if he can, fine too. He's quite lucky, isn't he?

Irrespective of how he got there, Matt was clear that decent housing had made a world of difference to his life:

I: So how did you find your new place, Matt?

Matt: It was actually through my old landlord. I've landed, I've managed to get the house I had before I went to prison. It was like really lucky. I'm just decorating it all now. And getting it all furnished again. I lost all my furniture when I went into jail like. But I'm.

Getting on with it. Obviously looking. I'm sitting here, it's looking quite nice. It's great, it's very comfortable. Like I've got myself back.

This, again, seemed to highlight the potential benefits of a supportive family.

Frank (Brixton) and Bryn (Swansea) had also found their own homes, with Bryn being the only interviewee across sites to benefit from sustained housing benefit payments. Frank, in contrast, had relied on informal networks of support; a former drug dealing associate had paid his rent for the duration of his prison sentence. For each of these interviewees, housing seemed to provide a real point of stability in otherwise complex lives. Frank's return to drug dealing (and use) had precipitated a good deal of additional life chaos:

It's all gone tits up. I'm just trying to sort it all out. Just trying to hold onto it... Trying to hold onto my flat. Behind with the rent, and it's not gonna be easy.

He had, however, remained housed, in contact with his daughter, and out of prison. Bryn's life was less dramatic, though he was also struggling financially. Unpaid bills and historic debts hung over him; though – again – his housing acted as an anchor. His sustained tenancy also discouraged him from any further offending; his landlord had told him during his previous sentence that any future imprisonments would lead to the loss of his housing.

Summary

The housing situation of our prisoner interviewees was generally poor. Not one of our prisoner interviewees felt that they had been allocated appropriate, safe or supportive housing by prison housing services, and DRWs did little (if anything) to improve this most important area of recovery capital for released prisoners. Those who had robust access to recovery capital when imprisoned generally retained it, along with access to safe and secure housing with family or friends. Those who were imprisoned with nothing generally left to find themselves in an identical situation.

A large proportion of interviewees were released street homeless, causing one to break his restraining order so that he could find a place to sleep. Hostels were seen as not much better than street homelessness. Those who had spent time in them identified that hostel accommodation had exacerbated mental health problems, made sustained abstinence impossible (due to the widespread availability of drugs), and led them into routine conflicts and confrontations. Hostel staff were generally seen as part of the problem, and a few interviewees were clear that a return to prison was preferable to living in a hostel.

One person sought to return to his partner, who was also his recovery support. She identified that this had never been a viable option – as their relationship had been violent and controlling, his most recent sentence had been for abusing her, and any relationship had ended six years ago.

Of the considerable group who returned to live with parents, few had actively chosen to do so. His situation was working out well, though both he and his mother acknowledged that they had to proactively manage tensions as they arose. A handful of other young interviewees (invariably with histories of non-opiate drug use, and few previous sentences) had returned to live with their

parents, and found things were working reasonably well. In other instances, former prisoners identified that living with their parents provided a somewhat strained – but manageable – situation.

Two sets of parents found their sons' returns particularly challenging. Nick had swiftly become drunk, violent and abusive. Bill had made an equally swift return to drinking and drug use, and his mother and daughter now only saw him when he was drunk, desperate, and had nowhere to go.

Finally, interviewees also identified a handful of successes at independent living. Brief telephone interviews identified that three Brinsford residents had managed to access a local supported housing scheme. Two people had also managed to secure their own access to supported housing that they thought was excellent. For Rob, this was a dry house with excellent staff and some therapeutic provision. For Jason, this was a quiet, warm room of his own where he could have his own space and keep away from troublesome associates.

A final group of interviewees had moved into their own flats. For Clive, this involved setting up home in a distant city, with benefits for both him and his new partner. Three other interviewees returned to flats they had lived in before. Despite somewhat discrepant accounts, it seemed likely that Matt's sister had offered him the keys to a flat she owned. Bryn and Frank had managed to retain their tenancies – Bryn because he was only serving a very short sentence and had secured access to sustained housing benefit payments (the only interviewee to benefit from these); Frank because a former drug dealing associate had paid his rent for the duration of his sentence.

Recovery Supports

The narratives of recovery supports were often raw, painful, and filled with emotional pain. Paraphrasing many such accounts seems inappropriate, and risks reducing the emotional force of the damage described by the children, partners and parents of our prisoner interviewees. In consequence, this section has been compiled with a light touch and relies heavily on unfiltered quotations from interviewees.

General experiences

Interviews with recovery supports tended to centre on a single, overriding narrative: one of being progressively ground down by a relentless series of highly painful, emotionally damaging events. Even the most optimistic were clear that, over the course of multiple years, they had been harmed beyond repair. These were often deeply sad narratives, framed by experiences of repeated drug use, failure and disruption:

Well I suppose it's just continuously feeling for years that you're not getting anywhere. And always keep on going in spite of having police in the house and raiding the house and. And all of that. And sort of breaking your heart seeing his life is going by and no changes for him you know. He's ah. Like he's. For anybody of his age I suppose he hasn't got much you know. Not things he's achieved. He's got his family, but he hasn't got his own family. And I think all of this is affected by the life he's had (Lil, Swansea).

Many described experiences of failed ‘rescue attempts,’ offering their relatives housing, funding for residential rehabilitation, or the clearing of their debts. Disrupted home lives were also a common feature, with doors being kicked off by repeated police raids, or bailiffs routinely appearing to demand payment for unpaid fines:

Well I got him out of debt and everything and then he got himself in debt again. And I can’t get him out of it again so. And I said “you only get so many chances in your life and if you choose this track to go down then I can’t have you living with me because I can’t have the bailiffs coming round here again and all this kind of scenario.” And I said I can’t keep on with you keeping me up at all hours of the night and looking at you spaced out and falling about and. (Kerry, High Down).

For a subset of RSEs, their lives with former DRW residents had also been characterised by explicit violence, and escalating victimisation leaving them feeling desperate, unsupported, and alone:

I’ve been hit with boxes I’ve had knives at my throat I’ve been kicked I’ve been punched. And I’ve got no help. Not. A. bit. (Paula, High Down).

As a result, many parents – particularly if their sons had been reimprisoned (yet again) – wanted nothing more to do with their sons:

I’ve had it. It’s his life and I just. I just don’t want nothing to do with him (Gillian, Swansea)

Even for those who remained supportive, it was clear that grievous damage had been done, and that trusting relationships could never be established on the quite same footing again:

He wanted to make amends, first step he wanted to make atonement. And he wanted to try and put the wrongs right. And I said “you can’t do that. You can’t put them right. Some scars go to deep. But we don’t have to go back.” I said, “I never look back.” I wouldn’t be alive today if I kept going back and back and back. We can only look forward (Monica, Holme House).

Kate (Swansea) offered a striking perspective here, separating out her father’s drug use from the person he had once been:

It’s horrible, this bloody addiction. It’s. like I said to him if he didn’t’ve gone in with the people that he was with it wouldn’t’ve come to it and I know he’s killing himself for it now. (Kate, Swansea).

As this brief overview suggests, experiences were diverse; but were nonetheless linked by some prominent themes.

Victimisation

Often, recovery supports had been the victims of our interviewees' offending. In many cases, this involved theft; with such thefts undermining the trust and security that people felt within their own homes:

You know I used to walk around, I used to panic if I'd left a tenner on the fireplace. Or a ring. Or something. Anything of value worth over a tenner, get you a bag. I walked around with my handbag under my arm like an old lady in my home. Permanently. With everything I valued in that bag. And it never left my sight. If by some chance I went into the bathroom and forgot and he was sat let's say there. I would come back in in absolute panic. Didn't bother him at all. Just used to say *bag*. (Monica, Holme House).

Theft had broader impacts, too – undermining relationships between defensive parents and other family members, and triggering further isolation from possible sources of support:

Gill: He's always pinched off me, you know? And I mean. My step. His step father. He's the same. He's pinched off him and you know jewellery and money and you name it. Bill could get a couple of bob for it, it was gone.
I: How's that impacted on your family?
Gill: Oh terrible oh well to be honest I don't show a lot to my family about him you know. (Swansea).

The shame of having a thief for a son could also cause wider ripples. Mel, for example, noted that her son had burglarised multiple houses on their estate after his release from Brixton's DRW. As a result, she never wanted to hear from him again:

He's robbed off us, he's robbed off his own kids. Even that's not bothered him. He's done it too many times. We don't even know where he is, I don't have his prison number. (Mel, Brixton).

Finally, far from all victimisations were limited to financial exploitation and breaches of trust. A subset of RSeS also offered clear descriptions of violent and controlling behaviour from either partners or sons:

When he was smoking [cannabis], when he didn't have it he was just. Just horrible. Horrible than what he was when he, than when he never had it. Bad tempered. Smashed up me house more than once. And he'd find the least little reason to start. And I had you know the two smaller ones and I'd just brung them away from their dad who behaved like that (Maureen, High Down).

Without exception, RSeS had experienced some form of victimisation or betrayal of trust. As noted, the consequences of these could be diverse.

One prominent result was that, after multiple attempts at providing support, many of our recovery supports felt that they could no longer share a house with our interviewees. These decisions were

often described with real pain, and with a full awareness of the consequences of locking their loved ones out of the family home:

I really couldn't have him at the house. I couldn't go back on. On. And to be honest with you. Through the years. I think he's probably forgotten most of the things that's happened. Unfortunately I haven't. It's. Destroyed me as a person. You know. To let my son sleep. On the streets. To have him phone me. At three in the morning and say "right, mum. I'm gonna kill myself." And me not have a car and not know what to do. And I've had to put the phone down and say to him, "well do you know what Chris. I can't be behind you 24/7. If that's what you do, that's what you're gonna do. You should think about your sister and brothers. And me. And I can't. I can't." Because I think Chris wanted me to say, "well come round here then Chris. Come to the house." Because I'd stopped him coming there. And it was like, he'd do everything to try and. Break me. And he must've thought I was hard as anything. And maybe over the years, I am now. I mean it's changed me as a person. I'm not as, as soft. And as easy as I was, as in letting them getting away with everything (Maureen, High Down).

Such decisions could also be motivated by a desire to avoid further pain; and to avoid seeing the deteriorating health and behaviour of children whose lives appeared out of control:

I won't disown him. But I just can't have him living under the roof with me. I just can't handle watching him doing what he's doing to himself. I nearly ended up with a breakdown. I would never sleep. Because I had one ear open one eye open wondering where he's going now coming in all hours blah blah blah you know it's worry worry worry. Especially when... I mean he's not as bad as he was before prison but if you can imagine going into a bathroom and finding him comatose under the water. It was awful. Head in the water. Just absolutely in a coma. (Kerry, High Down).

Even in cases of the most severe alienation, an element of concern still remained, though. Several parents described a lingering fear of a knock at the door, and the sudden news that their relative was dead.

I don't know what's gonna become of him to be honest. I've always said. Many years ago. His life is mapped out. Its either prison all the time or he'll be up in the grave with his brother. A few years now I've said it... It does play on your mind if somebody knocks this door, if a police car stops outside. You know. "Is he dead?" And that may happen. You know I had it with my first son, police knock on my door. And I think I put up with [Bill] so long because of my son dying. His brother dying. He's all I got. And that's always been. I can't turn my back on him if something happened to him. But I got past that now this past year. No. I can't put up with it no more (Gill, Swansea).

Family breakdown

Families were often divided by the stress of managing repeat offenders, too. Monica's marriage had ended, in part because of the continual strain of Paul's offending:

Monica: It was my siblings, my three sisters and my mum. My dad died when I was very young. Erm but were very very close. And I could tell them anything but I couldn't really talk to them about Paul because it made them cross. [And my husband] couldn't deal with it. Because like most parents, when they're little and they come running in with a bloody knee, you wipe it kiss them and make it better. And he couldn't make it better and it made him extremely angry with himself. He just couldn't put it right and make it better and he did try. He tried very hard but what he couldn't do was... just get into the whole thing. There was no grey area and he just sort of gave up on him. Turned his back on him for years... They don't speak at the moment. (Holme House).

Multiple interviewees narrated accounts of fractured relationships (particularly with ex-prisoners' stepfathers) and serious difficulties finding anyone who was able to listen to them without advising straightforward abandonment. Lil and Monica each stood out as exceptions here. Lil had found solace in her church community; Monica had attended a series of self-help parents' and carers' groups (many of whose slogans – such as 'let go with love' – she found infuriating).

Perhaps the deepest physical and emotional scars to be left by recovery supports' victimisation came from Alan's long-term partner. In Brixton, he had told us that he had been imprisoned for burglary and theft. In interview, his ex-wife presented an entirely different account:

He got sent to prison for beating me up. Because what happened at first, they didn't send him to prison. He got probation and erm he had to stay away from me. But then he kept sending me threatening text messages, making threats, because I got involved with somebody else. And he was making threats that he was going to kill me, was going to kill my partner. He was going to set my house on fire. Things like that. And. And. It come to the point that I had enough and I handed it to the police...And it'd been going on for a long time and I think the final straw was when he beat me up in [Town], where we lived, in the train station. And basically he knocked me unconscious. Yeahhhh. And basically it all got caught on CCTV. And that's when he first got took to court on the case and they told him he had to stay away from me and he didn't? And that's when they sent him to prison, afterwards (Marie).

Marie was clear that she wanted to find a way of supporting Alan in continuing to see his children. However, this presented real difficulties in establishing and maintaining boundaries.

I: He was still trying to control you?

Marie: Oh, yeah. Even now he still does. He still keeps ringing me up now telling me how he wants to sort things out and I'm like well I'm with somebody else. I've been with my new partner now nearly 5 years...

The scars, too, ran deep.

It has had an impact on my new relationship? Because like I'm expecting that if my partner raises his voice. He'll see me back away. Because I'm expecting him to lash out on me as well. And it does annoy me, because he'll say "why are you backing off like that what do you think I'm gonna do gonna hit you?" He goes, "I'm not Alan." But those scars have been

left. So it has had, has had an impact on me, that has... And I think it has actually had a big impact on [Alan and Marie's son]. Because [his son] can get quite violent towards his sisters? And I think it's because of what he sees his father do? it's like his older sister, who's 22. He actually attacked her. Yeah.

Marie was now in the process of seeking structured counselling with the hope of beginning to address the harms caused by years of controlling violence.

Compassion and resilience

Despite all the difficulties they had been through, recovery supports still showed strong signs of compassion and resilience. Only one voiced sentiments that could be interpreted as hostility:

We're never having nothing to do with him... You get someone like my oldest daughter can't have kids, and then you've got him and her spurting them out and not bothered at all. (Steph, Brixton).

In nearly all other instances, recovery supports spoke of our prisoner cohort with tenderness and sadness. Albert felt Ollie's life had been shaped by his mother dying when Ollie was a baby:

The whole things' been sad all the way through. There's not a day that goes by. Without you thinking. And certainly every night I go to bed, the last thing I think of before I get to sleep, I try to get to sleep you know. Where he is now and... (Holme House)

Indeed, in most accounts recovery supports went a long way towards minimising the blame that they attributed to our prisoner interviewees. In one prominent narrative, they blamed poor mental health (and unsupportive mental health services) for the condition their partners or relatives found themselves in, even when offenders themselves had downplayed the impact of mental health on their drug use or offending:

He had taken his medication in prison, I think he was there for 6 months. When he come out. You can see a totally different person. Even when he's smoking you can sort of see a different person. But as soon as he stops his medication or he stops smoking that's it. He's back to square one. And I think he's 26 now and I don't think he can ever.. without proper support. Live life. As it should be (Maureen, High Down).

Historically? Eh. Well. Ah. That's a difficult question to answer. Because I took [my son] to the doctor when he was 4 and erm. Told them that I was sure that he had what was then called hyperactivity. Aaaaand she dismissed it as new-fangled nonsense. And by the time he was 6 he was seeing a child psychologist (Monica, Holme House).

And even the people I work with they knew what he was like because he used to work with me before. And even they were coming up to me and saying, can't believe it's the same lad. They said it's awful watching it because he looks depressed all the time. And I think that was the problem to start with but the doctors didn't pick it up. And I think he was

looking at alternatives and then he got in a rat trap because somebody said [heroin] will make you feel alright. And he fell for it (Kelly, High Down).

In other situations, recovery supports presented accounts that held the downplayed the offences their relatives had committed, or emphasised the role the criminal justice system played in criminalising them:

A lot of the time he's gone in it's been his own fault, but not all of the time. And they were just looking to put something on him you know. I've seen myself, I've seen, in the police station, I've seen the sneaky things that they've done (Lil, Swansea).

And what happened was he was up at court the other week and. Er. The laws. That's another thing I've learnt since [my son]'s been inside. The law of this country is a very very strange law you know. If he pleaded guilty, they guarantee you that you'll serve less time. And I mean the number of times he's. he says to me, dad, if you're on drugs you don't know what the hell you're doing. So if they say you've done this... you know. And they say well you'll get so much time for it. He said you just plead guilty. Saves you going to court and everything. (Albert, Holme House).

This last case seemed to highlight a particularly unfortunate dynamic. Local news covered the story of his son's conviction for burglary. It bore no relation at all to the highly exculpatory account his father gave, of his son having clothes stolen from him, resulting in an accidental (though righteous) license recall, and conviction for assault.

Hopes for the future

Contextualised by their evident compassion, it seemed a sad reflection on the state of their hopes that a large proportion of mothers identified that they were happiest when their sons were in prison.

When he's in prison he's fine. He phones me up every day. I send him fifty pound a month. He phones me up every day. He's like "mum, I'm fine." And he sounds genuinely happy. And that's sad. You know that is very sad. (Maureen, High Down).

I'm sometimes relieved when Mike goes to jail because I know he's not on the streets. And I know he's getting fed and he's clean and he's warm and dry. (Paula, High Down).

Given this weight of negative views, it seemed surprising that recovery supports' expectations for the future were mixed. A clear majority held little hope for change:

Maybe he'll always be this way. Maybe one day, and it'll kill me if it happened, maybe he'll do something silly and not mean it, and actually do it. That's what worries me. One day he's gonna kill himself or he's gonna kill someone. (Maureen, High Down).

I think he'll go back to prison. He's definitely not been rehabilitated. In fact. I don't know. It seems to be his um. What he expects of himself. It's his lifestyle now. And I don't know if

part of him not pursuing his daughter. I mean. I know he's trying to go through the right channels to meet up with [her]. But I've actually said to him. I feel he shouldn't push to be in her life if he can't be there constantly. And I don't think he feels he can be there constantly right now. (Jane, Holme House).

I think he'll kill his self. I think that's eventually what'll happen. I think it's just now he's lost everything. And er. I wouldn't have him living here with us (Albert, Holme House).

However, some also felt more optimistic – either believing that their sons had already turned a corner, or that such a turn was imminently feasible:

I: Do you feel that things have turned a corner?

Lil: I do and I don't. I do feel that things are better now than he's been before. But I don't think it would take, like the danger point now is going to be when he's totally off the [OST] medicine. That's when I'm not looking forward to (Swansea).

I: What do you reckon his chances are of staying out of prison, drink and drug free?

Angela: Now I think they're good

I: That's really good to hear... so you think he probably has turned that corner

Angela: I think so, I think he's laid his ghosts (Brinsford).

It is perhaps no coincidence that most such accounts came from RSeS whose relatives remained in the community. Nonetheless, their hope for the future stands out.

Summary

Interviews with recovery supports emphasised the depth, weight and exhaustion of having a son, father or partner who was heavily drug involved. Even the most optimistic offered accounts that identified that they had been ground down and worn out by year upon year of emotional turmoil. Their trust had been savaged by being stolen from, or assaulted. Family units had been broken up by the strain of trying to support a drug-involved offender. Many felt that, after multiple painfully failed attempts, they could no longer let their sons stay in their homes. Given this gruelling context, the love and compassion described by many recovery supports seemed exceptional. Despite being repeatedly assaulted whilst in a controlling relationship, Marie still wanted Alan to have contact with his children. A large group of parents also situated their sons' offending in nuanced contexts – identifying mental health (and a lack of mental health support) as a particular cause for their drug use and offending.

Few recovery supports held any serious hope for the future. Whilst three felt that their sons were likely to stay out of prison, most were more doubtful. Accounts were filled with a sense that former prisoners were destined to live in a perpetual cycle of drug use and imprisonment, often concluding with premature death.

Chapter 8: Outcome Evaluation Findings

Interview Sample of Prisoners Included within the Outcome Evaluation

Our intention was not to draw a selection or sub sample of prisoners from those beginning drug recovery wing treatment but rather to recruit as many prisoners as possible from all of those beginning treatment over a 12-month period and then following those individuals over the study period. Through near continuous contact with all of our participating prisons, and regular visits to each drug recovery wing, we have been able to undertake drug recovery wing reception interviews with 319 male prisoners whose average age was 32.3 across the 5 participating recovery wings. Although the UK does have a drug recovery wing for female offenders -which we have described elsewhere (Grace et al 2015) the particular wing contained too few prisoners to be included within the quantitative element of our outcome evaluation. On the basis of data provided by the prison service on the throughput of prisoner numbers in each of the drug recovery wings operating it was possible to identify those particular recovery wings where the prisoner numbers were sufficient to enable the research team to identify a measurable treatment effect arising from involvement within a recovery wing. In consultation with the commissioning group for the research we agreed to focus the outcome evaluation on five prisons (HMP Swansea, HMP High Down, HMP Holme House, HMP Brixton and YOI Brinsford).

Sample Recruitment

To obtain the sample, researchers visited all five prisons as regularly as was possible to administer our standardised instrument to prisoners beginning their Drug Recovery Wing engagement. With the agreement of prison staff and with a view to minimising the disruptive impact of the research on prison routines, visits by the research team to our participating prisons were confined to two days per month. The exception to this was Swansea where the researcher attended for 3 days on each visit.

Table 8.1: Number of Prison Visits

Prison	Research Team Data Collection Visits
Brinsford	9
Brixton	13
High Down	12
Holme House	9
Swansea	5

There were a number of developments in the operation of certain Drug Recovery Wings that influenced the outcome evaluation. First, there were significant changes in the operation of some DRWs during the period of the research. For example, Swansea prison ceased operating a DRW in September 2014 and it did not resume a recovery wing during the period of the current study. Similarly, Brinsford YOI experienced staffing difficulties amongst the healthcare workers that resulted in fewer research visits to the prison than was intended. In the case of the Drug Recovery Wing within Brixton the functioning and staffing of the unit changed markedly during the period of the fieldwork. Second, although in advance of the evaluation beginning the research team had been provided with data on the numbers of prisoners within each of the Drug Recovery Wings (on the basis of which we estimated the length of time it would take to recruit sufficient numbers of prisoners to identify an effect of Drug Recovery Wing engagement) in fact the actual numbers of prisoners participating within the Drug Recovery Wings during the actual study period was substantially lower than we had been advised would be the case. As a result it was necessary to extend the period of data collection well beyond that which was initially envisaged. Third, in consultation with our participating prisons it was agreed that the research team would be informed both at the time that a new prisoner entered the Drug Recovery Wing, and in advance of each prisoner leaving the Drug Recovery Wing- thereby releasing the research team from having a continuous presence within the Drug Recovery Wing which was regarded as undesirable by prison officer staff. By providing such advance information on prisoner throughput it should have been possible for the research team to schedule their visits to each prison in such a way as to ensure that we were both recruiting our sample and undertaking the appropriate number of interviews with prisoners. In reality this system of being of being provided with advance notice on prisoner throughput proved unworkable and we were frequently aware of prisoners on a Drug Recovery Wing that had begun their time on the Drug Recovery Wing without us having been informed and prisoners whom we had previously interviewed on the Drug Recovery Wing having left without our prior knowledge. In an attempt to minimise the effect of such unplanned shifts into and out of the Drug Recovery Wings we sought to maintain weekly contact by telephone with key staff in each wing. Even with this arrangement in place however there were still occasions when we were unable to interview a prisoner at the start of their Recovery Wing engagement or prior to their departure from the wing.

In total we were able to interview 319 prisoners beginning their Drug Recovery Wing engagement, 203 of whom were interviewed prior to their departure from the wing and 109 of whom were interviewed on a further occasion once they had been living back in the wider community for six months. In table 8.2 below we summarise the numbers of prisoners recruited into our study at each of our participating prisons

Table 8.2: Reception Interviews by Prison

Prison	Nos of Prisoners Interviewed Starting DRW Treatment (n=319)
Brinsford Young Offenders	56
Brixton	69
High Down	48
Holme House	90
Swansea	56

Recruitment

The recruitment criteria for admission to the study were that prisoners had a drug or alcohol problem for which they had been admitted to a DRW, that they were able to comprehend the nature and purpose of the research and able to provide their full informed consent to participate, and that they had 12 months or less left to serve of their sentence.

In the remainder of this report we focus on the following topics. First we provide information on the characteristics of the prisoners included within our research. Following this we look at the progress prisoners were able to make during their journey into, through, and out of the Drug Recovery Wing. To look at this issue of progress through the Drug Recovery Wings and into the community we focus on those prisoners who were interviewed at each of our three time points (at the start of their Drug Recovery Wing engagement, prior to release from the Drug Recovery Wing, and after having been released from prison and living in the community for six months). Following this we focus on each of the Drug Recovery Wings we looked at in terms of the evidence of the extent to which prisoners could be said to be improving in such areas as their self-assessed physical and psychological health in attitudes towards their drug use and criminality and in their expectations of reducing their offending and drug use in the future. We then focus on the views of the Drug Recovery Wings held by the prisoners we were surveying looking at both their positive and negative assessments of the wings. Finally in a concluding section we consider whether it could be said that Drug Recovery Wings were an effective means of meeting the needs of prisoners with a drug or alcohol problem.

Characteristics of the 319 Prisoners interviewed at baseline

85% of the prisoners surveyed in our research were regular smokers. In Table 8.3 below we have summarised the data on the frequency of alcohol and illicit drugs use. 39% of our prisoners reported drinking higher strength beer almost every day over the 12 months prior to custody and 27% reported drinking spirits with the same frequency. With regard to illicit drug use 41% of our prisoners had used heroin within the last six months prior to custody, 46% cocaine, 39% crack cocaine, 68% cannabis and 31% amphetamines (all in the last six months). 37% of the interviewed prisoners reported having injected drugs with an average frequency of 182.25 times (sd=339.03) before custody. With regard to the development of drug using behaviours on average our interviewed prisoners first used glue at age 13 (sd=2.33) cannabis at age 14 (sd=3.38). Average age for first use of crack cocaine was 20.32 (sd=5.48), heroin was 20.06 (sd=6.51).

Table 8.3. Alcohol Frequency and Illegal Drug Use (n=319)

Alcohol Use	Beer N=152 (normal) %	Beer N=138 (strong) %	Spirits N=164 %	Sherry N=65 %	Wine N=76 %	Alcopops N=65 %
Almost every day	34	39	27	3	11	3
5 or 6 days a week	3	1	2	2	1	3
3 or 4 days a week	9	10	13	3	9	2
1 or 2 times a week	18	9	25	3	7	5
Once or twice a month	7	5.1	10	2	1	0
Once every couple of months	1	1	4	2	3	0
Once or twice a year	3	1	2	2	1	2

Drug Use	Heroin %	Cocaine Powder %	Crack Cocaine %	Cannabis %	Speed %	Ecstasy %
Past 48 hours	0.3	0	0	1	0.3	0
Past month	4	0.9	3	7	0.3	1
Past 6 months	41	46	39	68	31	27

In Table 8.4 we have summarised the proportions of prisoners reporting past mental health problems.

Table 8.4: Proportion of respondents (n = 319) who have ever been diagnosed, ever prescribed a drug, or are currently prescribed a drug for these health problems.

	Ever Diagnosed %	Ever Prescribed %	Currently Prescribed %
Major Depressive Disorder	33	30	19
Bipolar Disorder	2	1	1
Acute Stress Disorder	1	1	1
Generalised Anxiety Disorder	6	5	3
Obsessive Compulsive Disorder	1	0.3	0
Panic Disorder	5	1	1
Phobia	0.3	0	0
Posttraumatic Stress Disorder	1	1	1
Brief Psychotic Disorder	2	2	1
Delusional Disorder	0.3	0	0
Schizoaffective Disorder	0.3	0.3	0.3
Schizophrenia	3	3	3
Antisocial Personality Disorder	2	1	1
Borderline Personality Disorder	2	1	1
Narcissistic Personality Disorder	0.3	0.3	0.3
Kleptomania	0.3	0	0
Dissociative Identity	1	0.3	0.3
Sleep Disorder	6	1	0.3
Eating Disorder	1	0.3	0
Sexual Disorder	2	0	0

33% of our prisoners had received a past diagnosis of a major depressive disorder, 30% had received a past prescription for medication in response to a depressive disorder, and 19% were currently receiving such a prescription. Generalised anxiety disorder had been diagnosed in 6% of prisoners, 3% of prisoners were currently receiving prescription medication for this condition.

12% of our sample had reported past emotional abuse and 17% reported past physical abuse by a parent or guardian before age 13. 20% reported having been in receipt of counselling or psychiatric care before age 13. The majority (77%) of the surveyed prisoners had experienced some form of expulsion from school (temporary or permanent), 80% had left school by age 16 (M=4.93 sd=1.42), and 22% said that they had left school by age 14. Only 3 of the prisoners interviewed in our study had a higher education diploma and only two had a post graduate degree.

In Table 8.5 below we summarise the proportion of prisoners reporting that their family members and close friends had committed offences; the proportions that had used illegal drugs; and the proportion that had served time in prison.

Table 8.5. Proportion of drug users reporting that these people had committed offences, served time, or used illegal drugs in the past.

	Committed offences %				Served time %				Used illegal drugs %		
	Yes	No	Don't know		Yes	No	Don't know		Yes	No	Don't know
Spouse / Partner (N = 204)	21	78	2	(N = 199)	9	91	1	(N = 202)	25	75	1
Either parent (N = 293)	29	69	2	(N = 284)	27	72	2	(N = 286)	19	80	1
Either primary caretaker (N = 112)	11	87	3	(N = 115)	10	88	3	(N = 116)	7	91	3
Any siblings (n = 295)	38	61	1	(N = 283)	29	70	1	(N = 290)	35	64	1
Any close friend (n = 302)	78	22	0.3	(N = 299)	72	27	1	(N = 301)	80	19	0.3
Any children (n = 169)	5	95	0	(N = 166)	4	96	1	(N = 158)	3	97	0

What is very clear here is the finding that in a high proportion of cases the prisoners on the drug recovery wing had close friends and or family members who were similarly involved in some level of offending; 21% of prisoners reported that their spouse had committed offences, 29% reported having parents that had committed offences, and 78% having close friends who had committed offences. 44% of prisoners reported having a spouse or a parent that had used illegal drugs 35% had siblings who had used illegal drugs and fully 80% had friends who had used illegal drugs. Nearly one third of prisoners had a sibling who had spent time in prison.

In Table 8.6 below we look at the prisoners attitudes towards crime and being in prison.

Table 8.6. Drug users' attitudes towards crime and prison.

	Strongly agree %	Agree %	Neither agree nor disagree %	Disagree %	Strongly disagree %
In the end, crime does pay (n = 311)	10	9	13	20	48
I've never hurt anyone by what I've done (n = 311)	10	4	5	28	52
I will always get into trouble (n = 309)	7	7	22	27	36
Crime has become a way of life for me (n = 311)	8	17	14	25	36
Crime can be a way of getting what you want (n = 311)	15	32	15	14	24
Live for now; future will take care of itself (n = 311)	8	11	13	33	36
Most would offend if they could get away with it (n = 311)	33	30	14	9	15
I won't get into trouble after my release (n = 311)	29	16	42	7	5
I don't see myself as a real 'criminal' (n = 310)	21	17	17	27	18
Committing crime is quite exciting (n = 310)	14	20	15	25	26
It's hard to resist a chance to commit crime (n = 311)	8	19	17	23	33
Many so-called crimes aren't really wrong (n = 310)	4	8	12	34	42
My crimes have never harmed anyone (n = 311)	4	4	7	33	51
If things go wrong, I might offend again (n = 308)	16	24	25	8	27
I am not really a criminal (n = 311)	16	11	13	32	27
I always seem to give in to temptation (n = 311)	14	27	22	18	20
Poor people can't be blamed for stealing (n = 310)	7	7	14	32	39
There was no victim of my offence(s) (n = 311)	4	2	6	30	58
I wouldn't commit the offences again (n = 308)	32	12	35	11	9
Once a criminal, always a criminal (n = 311)	4	9	13	30	45
I want to avoid offending in the future (n = 308)	65	28	3	1	2
Prison teaches you more about crime (n = 311)	37	34	14	8	6
It's almost impossible to really go straight (n = 311)	9	20	11	27	32
Prison should be hard. It's a punishment (n = 311)	36	29	12	13	11
Prison is risk you must accept if you offend (n = 311)	67	25	4	1	3

34% of our interviewees indicated that they agreed or strongly agreed with the statement that committing crime was quite exciting; 63% agreed or strongly agreed with the statement that most people would offend if they knew they could get away with it; 38% agreed or strongly agreed with the statement that they did not see themselves as a real criminal; and 29% said that they agreed or strongly agreed with the statement that it was almost impossible to go straight. 19% of prisoners said that they agreed or strongly agreed with the statement that 'crime does pay'. On the basis of

these percentages a significant minority of prisoners within our sample had what one might describe as a “pro-crime” attitude to their own offending. However, over half of the sample of prisoners we interviewed stated that they disagreed or strongly disagreed with the statement that in the end crime does pay (68%), 45% disagreed or strongly disagreed with the statement that they were not really a criminal, and 75% disagreed or strongly disagreed with the statement that one a criminal always a criminal.

Within our sample there was a clear division between those prisoners with a strong pro-crime attitude and those who were much less inclined to view their criminality in a positive light. Interestingly, when we looked at the prisoners attitudes towards their drug use (as distinct from other criminal behaviours they had been engaged in) there was much less variation in their views and attitudes.

Table 8.7. Drug users’ attitudes towards drug treatment using ratings from ‘strongly disagree’ to ‘strongly agree’ for each statement.

	Strongly disagree %	Disagree %	Not sure %	Agree %	Strongly agree %
Drug use is a problem (n = 316)	10	5	6	28	51
Drugs are more trouble than they’re worth (n = 315)	5	3	4	24	63
Drug use is causing problems with the law (n = 316)	9	4	3	19	66
Drug use is causing problems with thinking / working (n = 315)	20	13	8	26	34
It is urgent that you find help for drug use (n = 315)	14	9	12	28	37
Drug use is causing problems with family and friends (n = 315)	7	6	4	27	56
Tired of problems caused by drugs (n = 315)	5	4	2	19	71
Problems in finding or keeping a job (n = 314)	12	8	6	24	50
Would give up friends to solve drug problems (n = 314)	5	6	8	22	58
Health problems with drugs (n = 314)	9	9	9	28	45
Your life has gone out of control (n = 315)	16	9	9	23	43
Drug use is making life worse and worse (n = 314)	12	6	5	21	57
Drug use may kill me if I don’t quit soon (n = 315)	15	8	13	20	44
Concerned about legal problems (n = 315)	45	25	7	14	9

As is evident in Table 8.7 more than three quarters (79%) of the prisoners we interviewed indicated that they agreed or strongly agreed with the statement that drug use is a problem; 87% either agreed or strongly agreed with the statement that drugs were more of a problem than they are worth and 90% said that they either agreed or strongly agreed with the statement that they were tired of the problems caused by drugs.

Finally, in Table 8.8 below we look at the prisoners’ motivations for being on the drug recovery wings.

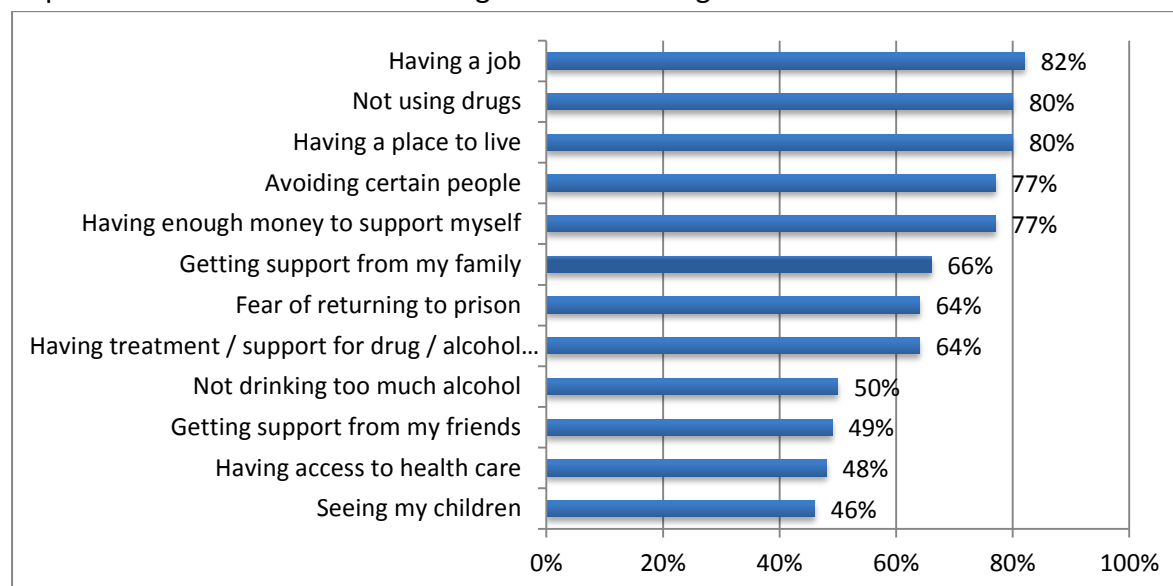
Table 8.8. Drug users' motivations for being on the Drug Recovery Wing.

	Strongly disagree %	Disagree %	Not sure %	Agree %	Strongly agree %
Need help dealing with drug use (n = 316)	7	3	9	34	47
Treatment may be last chance (n = 314)	14	12	13	22	40
You plan to stay in treatment for a while (n = 314)	9	5	5	29	53
Quit without any help (n = 315)	41	29	11	10	10
Someone else made you get treatment (n = 314)	58	23	3	8	8
Treatment programme can really help you (n = 315)	2	2	14	24	58
You want to be in drug treatment (n = 315)	3	3	4	27	63
You want to get your life straightened out (n = 314)	2	0	1	17	81
Family wants you to be in treatment (n = 312)	6	5	6	22	62

There was strong support amongst the prisoners surveyed on the importance of receiving treatment with 81% agreeing or strongly agreeing that they needed help in dealing with drug use 82% agreeing or strongly agreeing that treatment programmes can help them 90% agreeing or strongly agreeing that they wanted to be in treatment and 98% agreeing or strongly agreeing that they wanted to get their life straightened out.

In terms of the prisoners own views as to what they felt would most help their efforts to cease offending on their release, 80% cited having a job, 79% cited ceasing their drug use, and 78% cited having a place to live (see Figure 8.1).

Figure 8.1 Proportion of respondents (N = 319) who rated each of these circumstances as important to their efforts in avoiding future offending



Summary

On the basis of the data presented above there can be no doubt as to the importance of providing treatment and support services for prisoners with a drug or alcohol problem. Equally, there can be no doubt as to the scale of the challenge in meeting the needs of prisoners with a drug or alcohol problem. Other research has similarly identified the strong likelihood that prisoners with a drug or alcohol problem will also have multiple and long standing needs. Maccio et al (2015) have reported that 88.7% of their sample of 300 inmates in Italian prisons had been diagnosed with one or more psychiatric disorders in the past and 58.7% had a current diagnosis; 71% reported a drug or alcohol problem. Recognising the scale of the need identified in their study, and the limited funding for prison based drug and alcohol treatment, Maccio and colleagues note “there is a considerable risk that many prisoners might not receive the appropriate treatment they need” (Maccio et al 2015:529). Within the UK, recent research has similarly identified the extent of the need for treatment and support on the part of prisoners. Williams (2015) for example, has reported on the characteristics of prisoners (n=1435) included in the Surveying Prisoners Crime Reduction (SCPR) longitudinal survey 53% of whom had used Class A drugs in the last year, and 45% had used Class A drugs in the last four weeks. 41% of prisoners reported having committed offences in order to pay for drugs. 24% of prisoners had been in care and 42% had been permanently excluded from school (63% had been temporarily excluded from school). 64% had been on benefits in the twelve months before being in custody and 16% had been homeless or living in temporary accommodation before entering custody. In terms of the factors which prisoners identified as being important with regard to reducing their offending 68% cited having a job 60% cited having a place to stay and 46% cited the importance of stopping using drugs.

The extent of the need for treatment and support amongst prisoners receiving enhanced drug and alcohol treatment within Drug Recovery Wings cannot be in doubt. Similarly, the motivation for treatment on the part of the prisoners surveyed in our study was also substantial with 81% agreeing or strongly agreeing that they needed help in dealing with their substance use. Despite the importance of ensuring drug and alcohol treatment services are available within prison there can be no doubting the scale of the challenge likely to be faced by services seeking to meet the needs of prisoners with a drug or alcohol problem. Whether drug or alcohol problems are the cause of the offending that has resulted in the individual’s custody, or a co-occurring behaviour alongside their offending, what is clear is that effective treatment and support will need to address much more than the individual’s drug and alcohol use. The finding that a high proportion of prisoners receiving Drug Recovery Wing support have family members and friends that have used illegal drugs, that have spent time in prison and that have committed offences powerfully illustrates the importance of treatment and support extending well beyond the individual prisoner and into his or her wider social and family milieu.

The finding that around a third of prisoners on the drug recovery wing has been diagnosed with a major depressive disorder illustrates the importance of providing mental health support to prisoners. Similarly the finding that 38% of prisoners surveyed on the Drug Recovery Wings did not see themselves as being a real criminal, that 66% thought that most people would offend if they felt they could get away with it, and that 47% felt that crime can be a way of getting what you want powerfully demonstrates the pro crime attitudes on the part of many of the prisoners interviewed in this research.

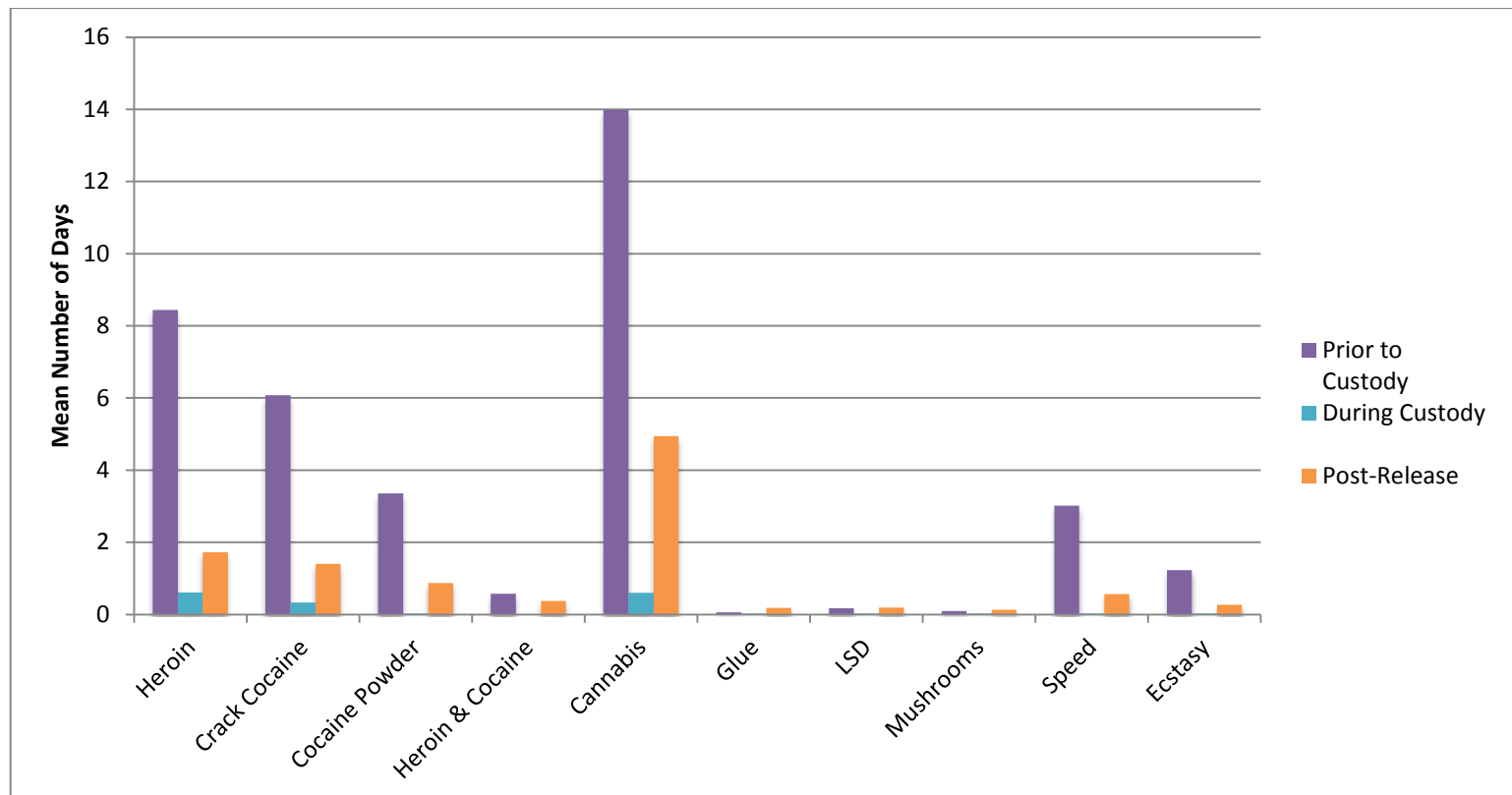
Meeting the needs of prisoners with a drug or alcohol problem will inevitably require moving well beyond the realm of substance use treatment to remedying long standing behavioural, attitudinal, contextual, familial problems in the prisoners lives -many of which will have been deep rooted and long standing. If ever there was a doubt about the importance of meeting those needs, and the consequences of failure in this regard, it should be dispelled by the results of the survey of released prisoners undertaken as part of the Surveying Prisoners Crime Reduction (SCPR) study. In this research 54% of prisoners had used illegal drugs following release, 15% were homeless, 68% had been reconvicted within two years of release, and 73% were on state benefits (Hopkins and Brunton-Smith 2014). These figures underline the importance of not only of ensuring that prisoners receive appropriate treatment whilst in prison but also the importance of maintaining that support following release.

In the next section of this report we look at the progress prisoners were able to make from the point of beginning their Drug Recovery Wing engagement to the point where they had been living within the community for six months following their release from prison. Our focus here then is on the 109 prisoners who were interviewed at each of our three time points (i.e. on reception into the Drug Recovery Wing prior to their release from the Drug Recovery Wing and six months after their release from prison).

Prisoners Progress in, through, and out of the Drug Recovery Wings

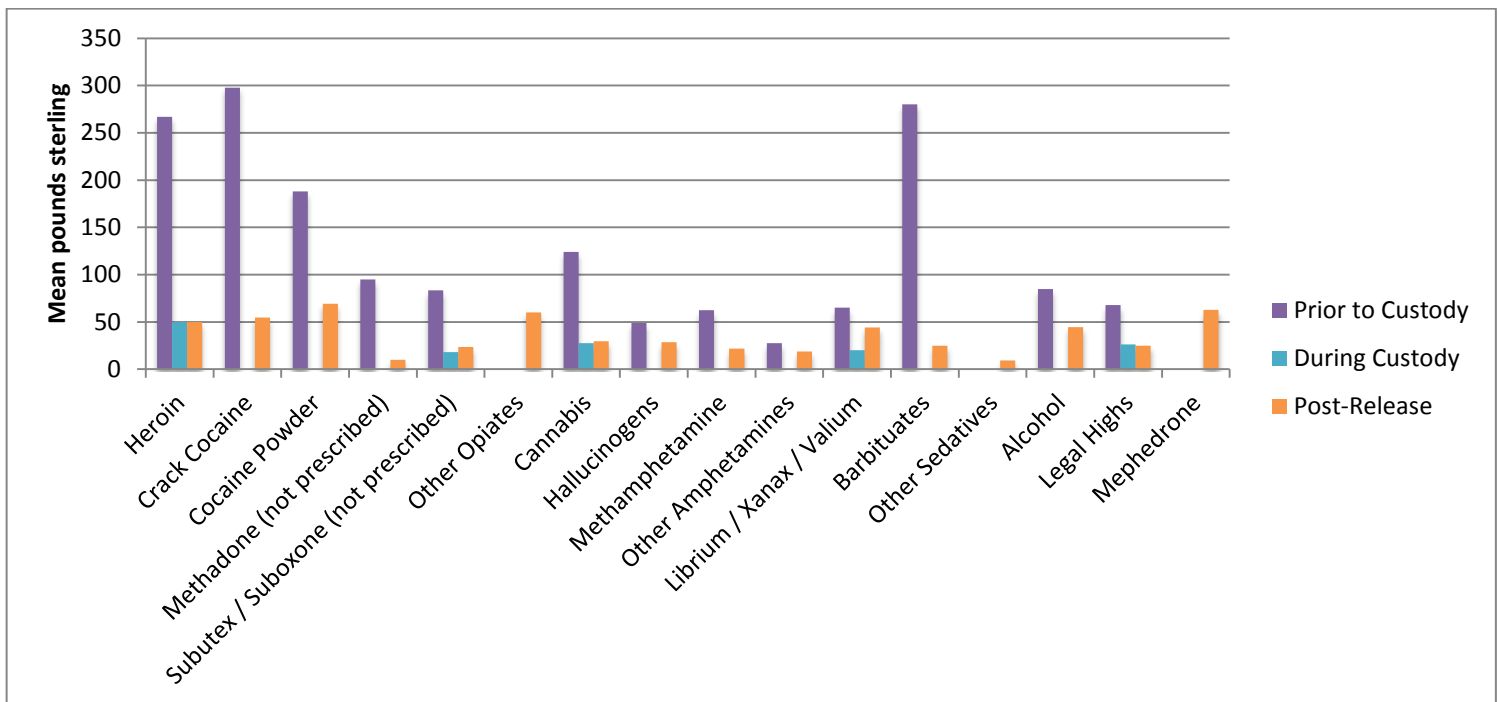
We look first at the changes in drug and alcohol use within our sample of Drug Recovery Wing treated prisoners. Figure 8.2 compares the frequency of drug use in the four week period prior to beginning their Drug Recovery Wing engagement, the four weeks prior to their release from the drug recovery wing and the previous four weeks following the prisoner living within the community for six months.

Figure 8.2: Mean number of days using drugs in the 4 weeks prior to custody, pre-release, and post-release (N = 109)



As can be seen here there were significant reduction in the frequency of heroin use, crack cocaine use, cannabis use, amphetamine use, and ecstasy use, comparing the period prior to custody and after release from their Drug Recovery Wing. What is equally noticeable, however, in the case of heroin, crack cocaine, and cannabis is the pattern of increasing use of these substances from Drug Recovery Wing release to living within the community though the reported levels of use in the community do not match the levels reported prior to Drug Recovery Wing entry. In Figure 8.3 below we look at the amounts prisoners reported weekly spending on drugs comparing the periods in advance of their Drug Recovery Wing treatment when they were living within the community, during their Drug Recovery Wing treatment and six months after prison release.

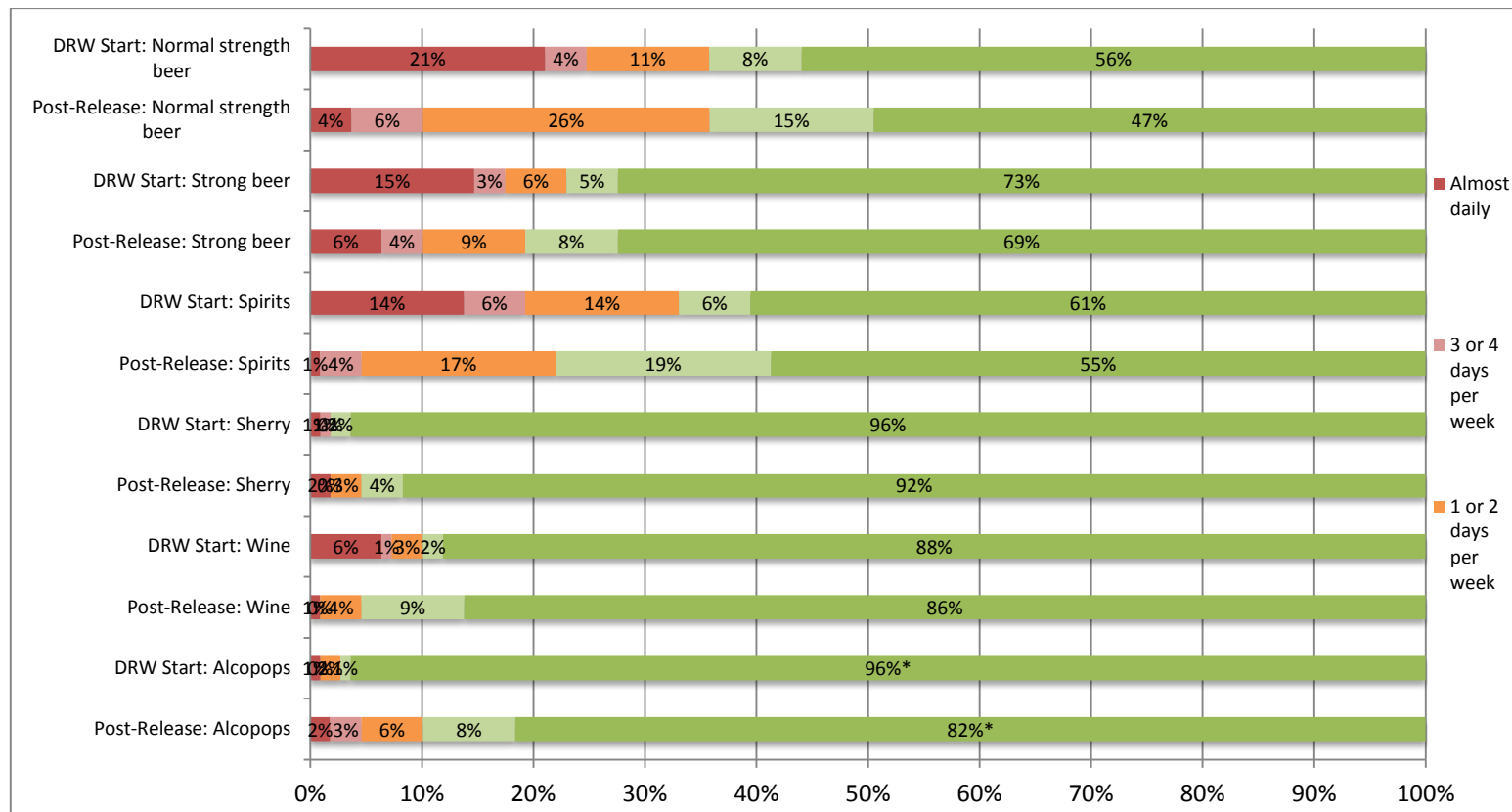
Figure 8.3: Mean in pounds sterling spent per week by those who reported purchasing drugs prior to custody, prior to Drug Recovery Wing release and whilst living within the community



As was evident in Figure 8.3 there was a clear pattern of reduced spending on drugs over the period prior to Drug Recovery Wing engagement to living back in the wider community with significant reductions in spending on heroin crack cocaine cannabis and legal highs.

In Figure 8.4 below we look at changes in prisoners alcohol consumption again comparing the period in advance of their Drug Recovery Wing treatment and following on from their treatment when they had been living within the community for six months.

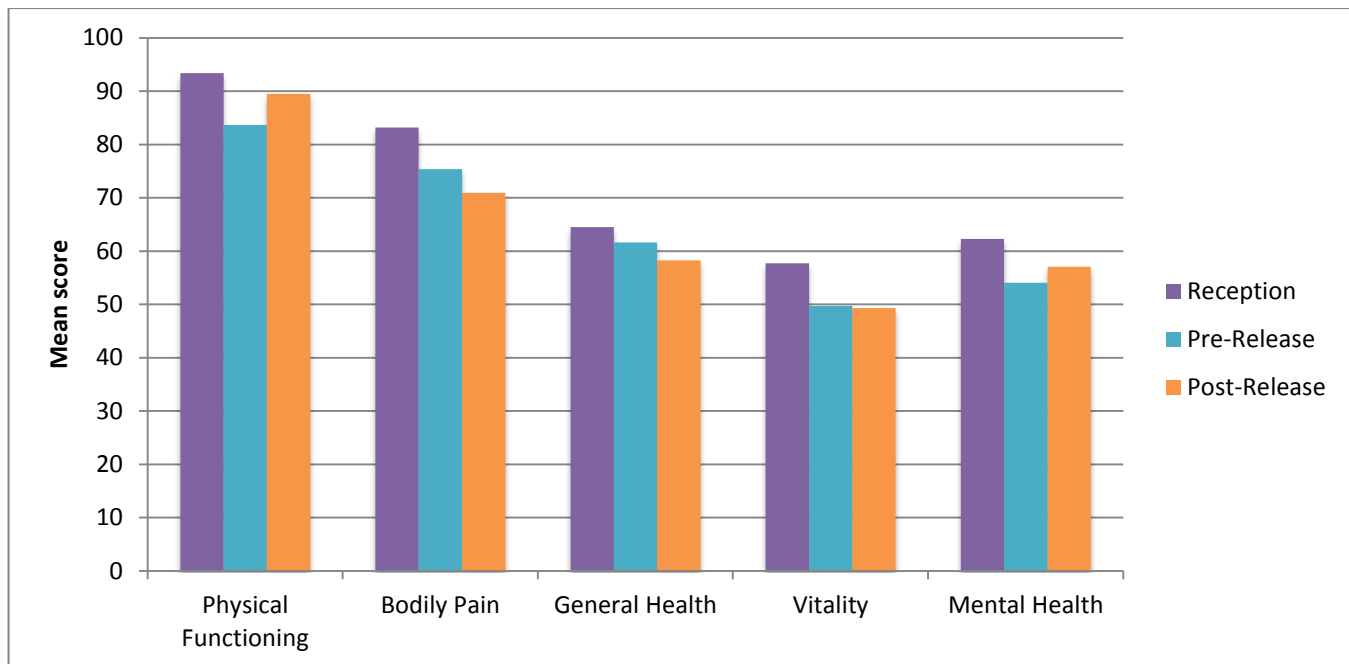
Figure 8.4 Proportion of respondents (N = 109) reporting alcohol consumption according to frequency of use prior to custody and at post-release



In relation to daily consumption of normal strength beer this reduced from 21% of prisoners at the point prior to beginning their Drug Recovery Wing treatment when they were living in the community to 4% of prisoners following their Drug Recovery Wing treatment and living back in the community. In relation to strong beer the reduction was from 15% to 6% whilst for spirits it was from 14% to 1%.

In Figure 8.5 below we look at changes in the health scores for prisoners again comparing the period in advance of their custody the period prior to their release from the Drug Recovery Wing and the period living within the community following prison release. The data here are based on having incorporated the short form SF36 instrument for assessing health status: in all cases, the higher the mean, the better the health.

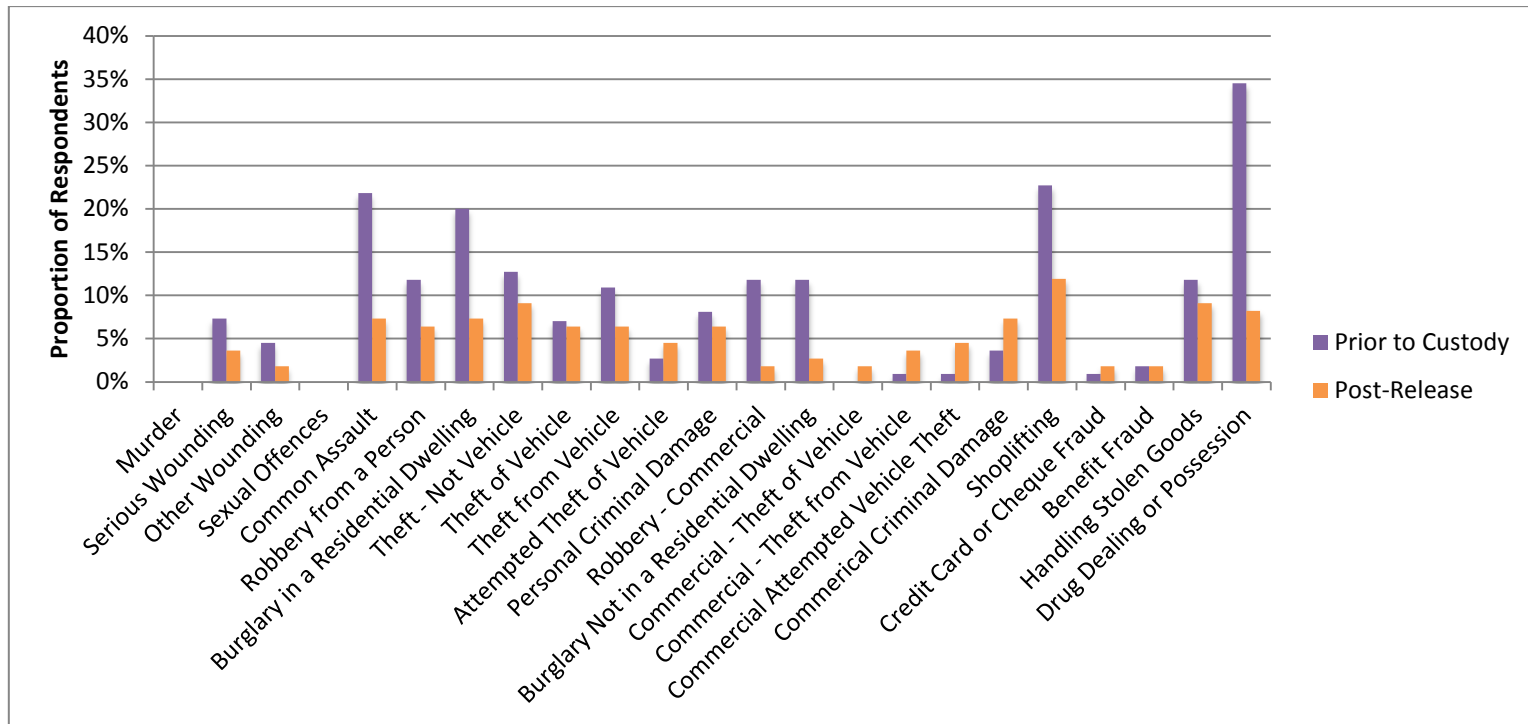
Figure 8.5 . Mean score for each health measure (SF-36) at first interview, pre-release, and post-release



There was a statistically significant deterioration in self-reported physical functioning from the point of starting Drug Recovery Wing treatment to living within the community post prison release. A similar pattern is evident in relation to general health and vitality. In the case of self-reported bodily pain this also reduced to a significant degree over the period from starting Drug Recovery Wing treatment to living within the community.

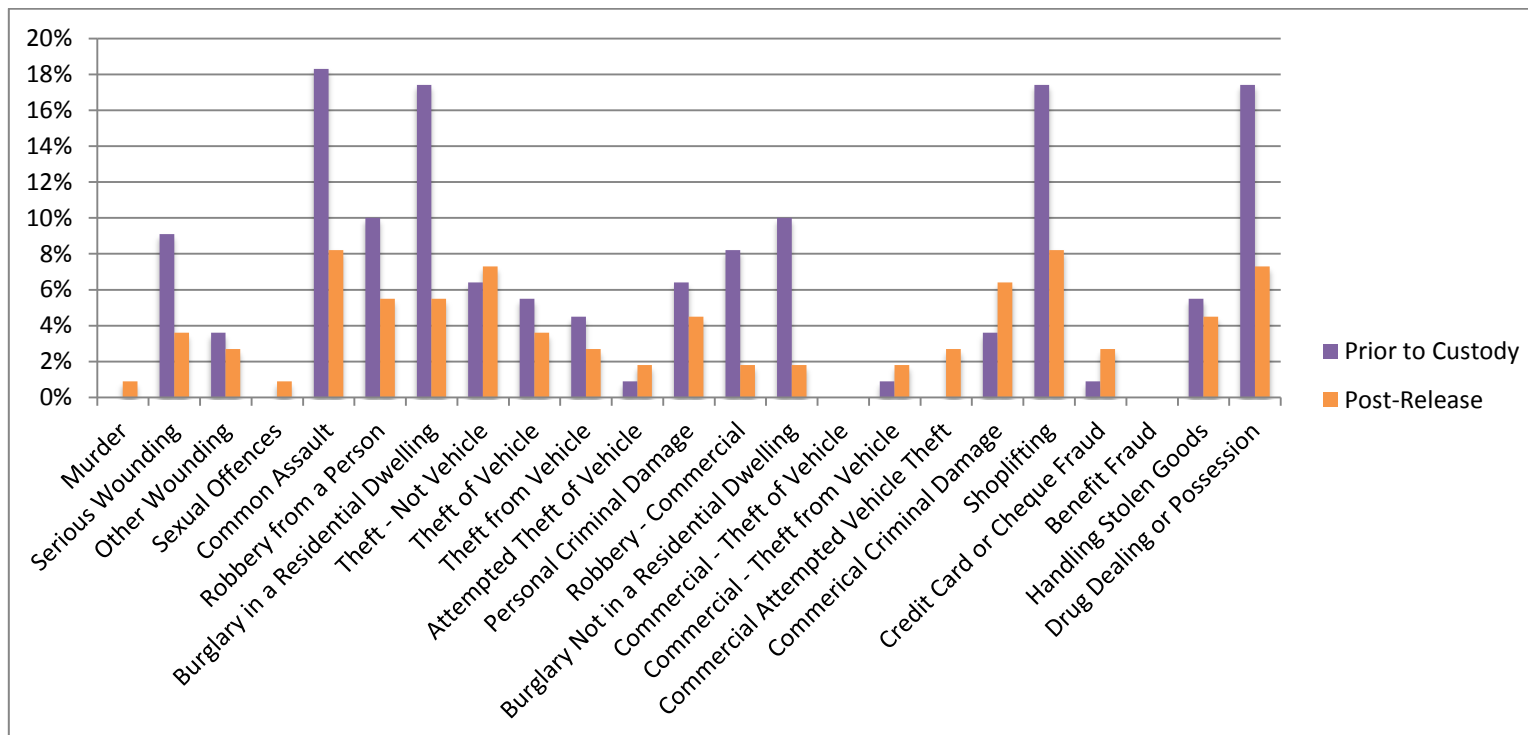
In Figure 8.6 below we look at self-reported crime over the study period. The data here relate to having committed any of a series of offences during the 6 months prior to custody and six months following having been released from prison and living within the community. No data were collected here on the frequency of the various offences over the study period. What is evident here is that there is a clear pattern of reduced offending for each of the crimes listed other than commercial criminal damage, attempted commercial vehicle theft, and theft from a commercial vehicle comparing the period in advance of their custody and following Drug Recovery Wing release when the prisoner had been living within the community for six months.

Figure 8.6. Proportion of respondents (N = 109) reporting crimes committed in the 6 months prior to custody and in the six months following release



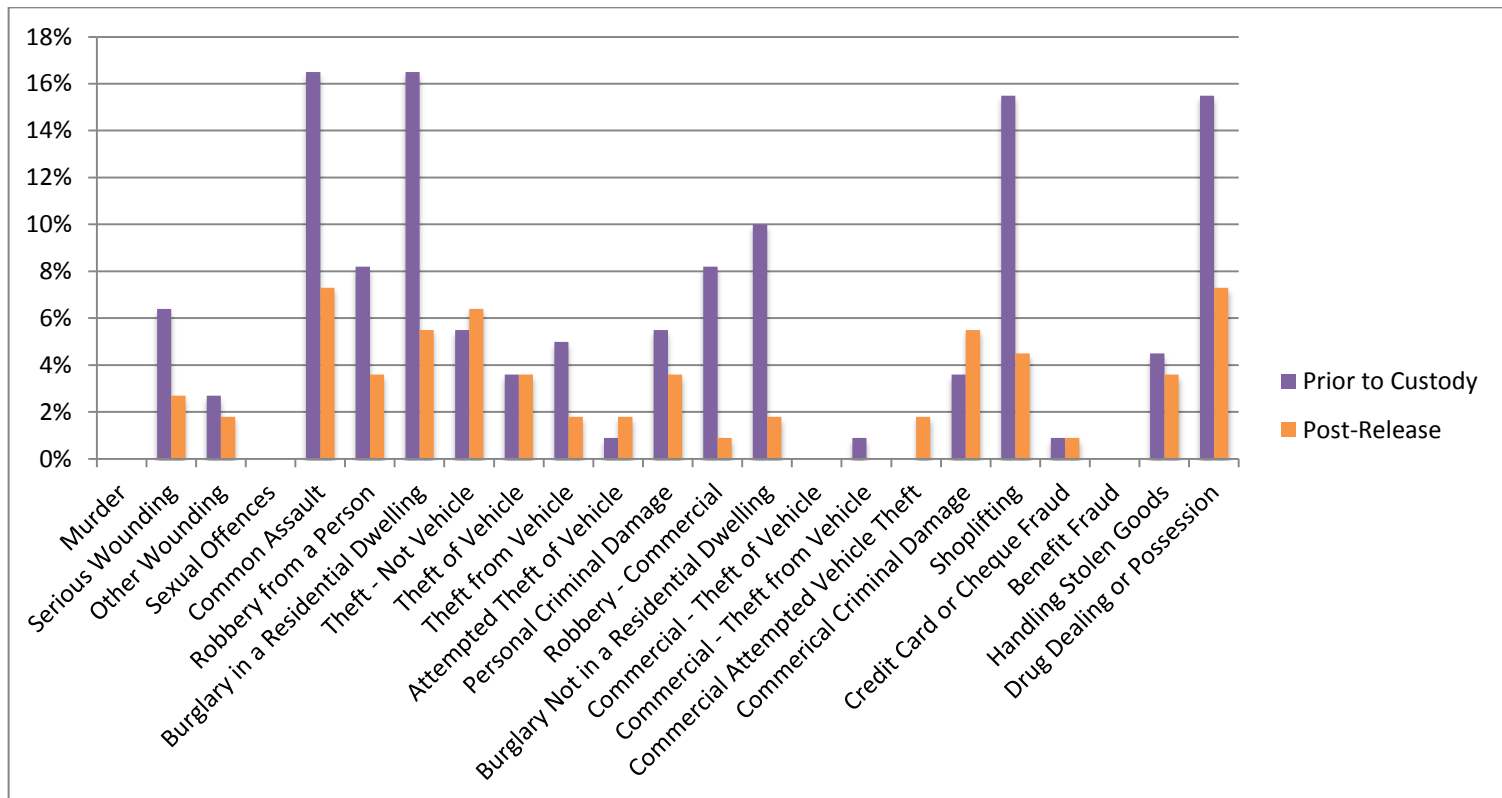
Similar reductions were also evident in relation to arrests for the various crimes listed.

Figure 8.7 Proportion of respondents (N = 109) reporting arrests that occurred in the 6 months prior to custody and 6 months following release



There were substantial reductions in the proportion of prisoners reporting arrests for all offences other than those relating to commercial vehicle theft, commercial criminal damage and credit card or cheque fraud. Finally in relation to criminality there were similar notable reductions in convictions comparing the period prior to custody and following prison release:

Figure 8.8. Proportion of respondents (N = 109) reporting convictions that occurred in the 6 months prior to custody and the 6 months following release



These data show improvements in reduced drug and alcohol use and reduced offending in the period either side of the individual's engagement with the Drug Recovery Wings. However in relation to the health scores there was a clear deterioration at least in terms of the prisoners own self assessed health using a standardised measure. More positively we have recorded a notable reduction in the proportion of prisoners reporting engaging in various forms of criminality post prison release following a period of Drug Recovery Wing treatment.

In the next section we compare individual Drug Recovery Wings in terms of the progress prisoners were able to make in relation to a number of key measures related to individual recovery.

Drug Recovery Wing Results by Individual Prison

Swansea

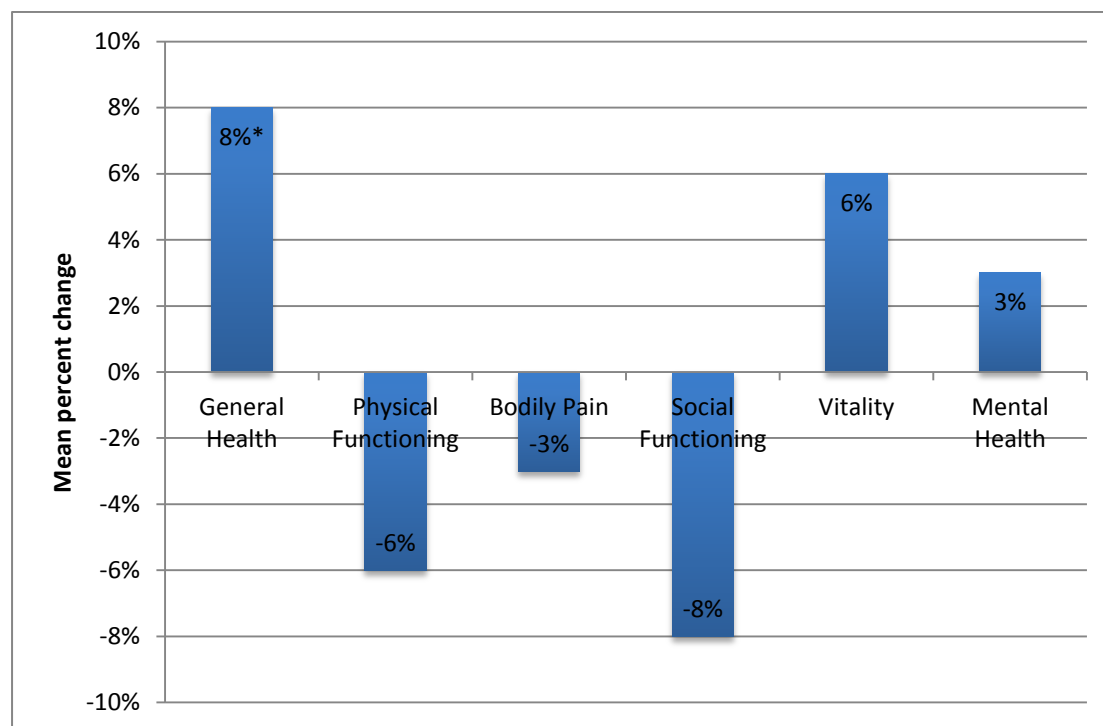
In this section we look at prisoners self-reported recovery comparing their progress from Drug Recovery Wing initiation to graduation. Whilst in the previous section we reported results for the sample of prisoners interviewed at each of our data collection points in this section we focus on the progress prisoners were able to make in each of the five Drug Recovery Wings we focussed upon.

There were 56 respondents from HMP Swansea and 36 of these prisoners responded to the pre-release interview.

Swansea

In Swansea prison we surveyed 56 prisoners beginning their Drug Recovery Wing engagement 36 of whom were re-surveyed at a point just prior to their graduation from the wing. Paired-samples t-tests were used to determine whether there was a significant change in prisoners' physical and mental health between reception and pre-release. This is a parametric test that compares prisoners' mean scores at each time point to identify any differences between the two. General health ($p = 0.03$) showed a significant improvement at pre-release compared to stating treatment. There was no statistically significant change in physical functioning ($p = 0.39$), bodily pain ($p = 0.66$), vitality ($p = 0.29$), social functioning ($p = 0.22$), or mental health ($p = 0.54$) between reception and pre-release.

Figure 8.9: Swansea. Mean percentage of change in self assessed health as measured by the Short Form-36 between start of DRW treatment and Release from Treatment



A paired-samples sign test showed no statistically significant change in symptoms of anxiety and depression ($p = 0.33$) between in initiation into the Drug Recovery Wing and release from the Drug Recovery Wing.

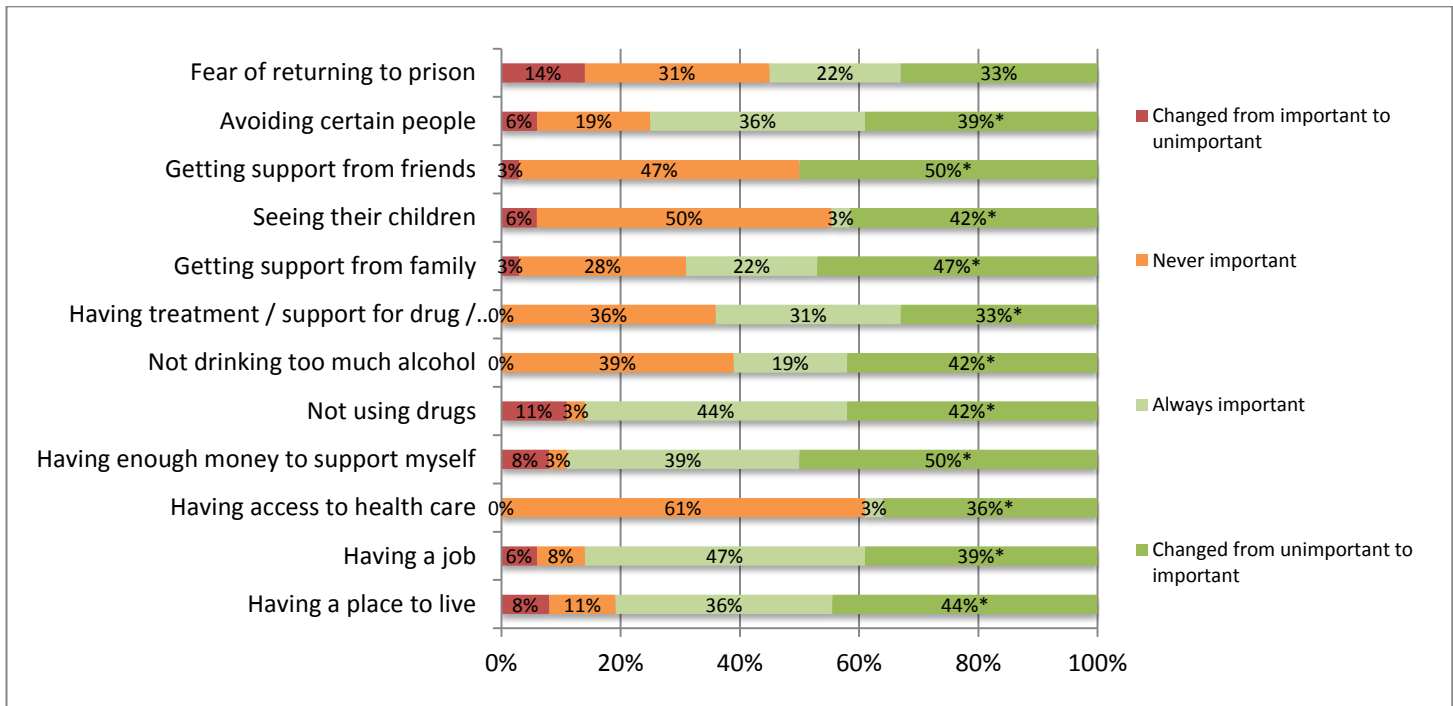
In relation to prisoners attitudes towards criminality, future drug use, and offending exact sign tests showed no statistically significant change in prisoners' perceived likelihood of future drug use ($p = 1.00$) or in their perceived likelihood of reoffending ($p = 0.82$) between the start of the Drug Recovery Wing treatment and their graduation from treatment.

Prisoners were asked to rate their agreement or disagreement with a series of statements about crime and punishment. These attitudes were not found to have changed at a statistically significant level between the start of their treatment and their graduation from the Drug Recovery Wing ($p = .06$), but trended towards an increase in pro-crime sentiment over time ($N = 26$; More pro-crime at pre-release = 65%, Same attitude at pre-release = 8%, Less pro-crime at pre-release = 27%).

Prisoners were asked to identify any circumstances that they felt would help to prevent them from committing crime in the future. McNemar's tests show that prisoners were significantly more likely to rate having a place to live ($p = 0.004$), having a job ($p = 0.004$), having access to healthcare ($p < 0.001$), having enough money to support oneself ($p = 0.001$), not using drugs ($p = 0.02$), not drinking too much alcohol ($p < 0.001$), having treatment and support for drug or alcohol problems ($p < 0.001$), getting support from family ($p < 0.001$), seeing their children ($p = 0.002$), getting support from friends ($p < 0.001$), and avoiding certain people ($p = 0.004$) as important factors in preventing them from offending at pre-release compared with reception. There was no statistically significant change in the proportion of prisoners who rated fear of returning to prison ($p = 0.14$) as important in this way.

Figure 8.10 shows how ratings of importance for these factors changed over time between reception into prison and prior to release from the Drug Recovery Wing.

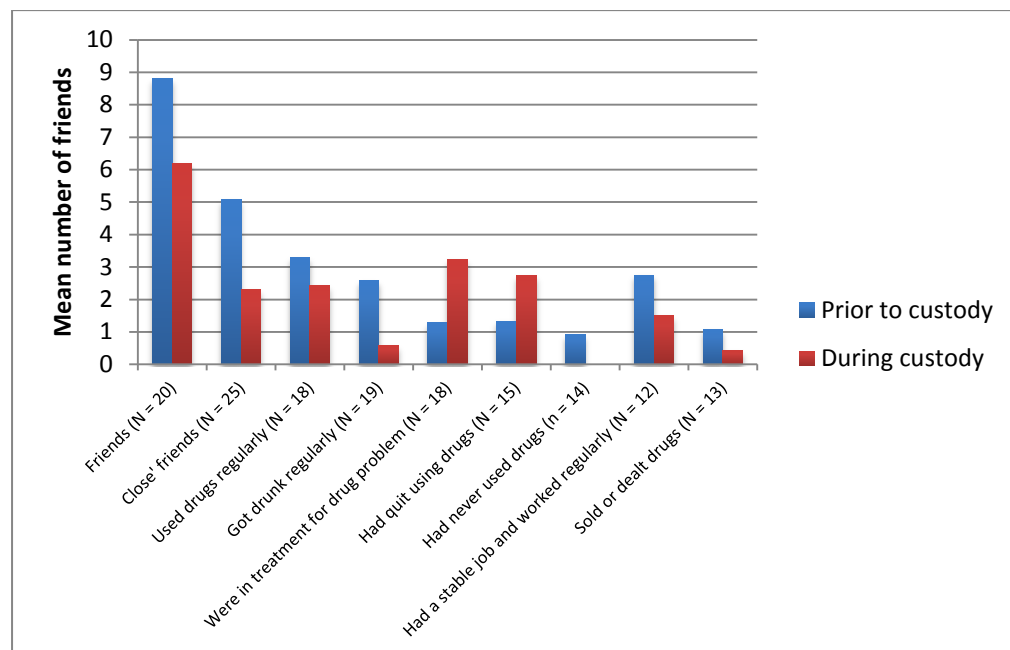
Figure 8.10: Swansea. Proportion of prisoners (N = 36) in HMP Swansea according to change in opinion between reception and pre-release when asked whether each of these 12 factors would be important in preventing future offending



According to paired-samples t-tests, prisoner reported having significantly fewer friends who they considered to be 'close' ($p = 0.009$), who got drunk regularly ($p = 0.004$), or who have never used drugs ($p = 0.05$), but more who had quit using drugs ($p = 0.04$) in prison compared with the friends that they had outside of prison. There was no significant difference between friends before prison and friends inside of prison in terms of the total number of friends ($p = 0.23$), the number who currently used drugs regularly ($p = 0.51$), the number in treatment for a drug problem ($p = 0.11$), the number who had a stable job and worked regularly ($p = 0.33$), or the number who currently sold or dealt drugs ($p = 0.11$).

Figure 8.11 illustrates the average number of friends that prisoners reported having prior to custody and during custody who participated in these various activities.

Figure 8.11: Swansea. Mean number of friends prisoners had prior to and during custody at HMP Swansea who took part in a number of different activities.



Note: * denotes statistical significance

Summary

In terms of the data from Swansea there were indications in terms of the prisoners own assessments of their mental health, general health and vitality as having improved following engagement with the Drug Recovery Wing. However there was little indication of positive improvements in the perceived likelihood of reoffending and prisoners attitudes towards crime. In terms of prisoners own assessments as to the factors that were most likely to impact upon their likelihood of reoffending the key factors identified were having a place to live, a job, finance, getting support from friends and family and having access to health care.

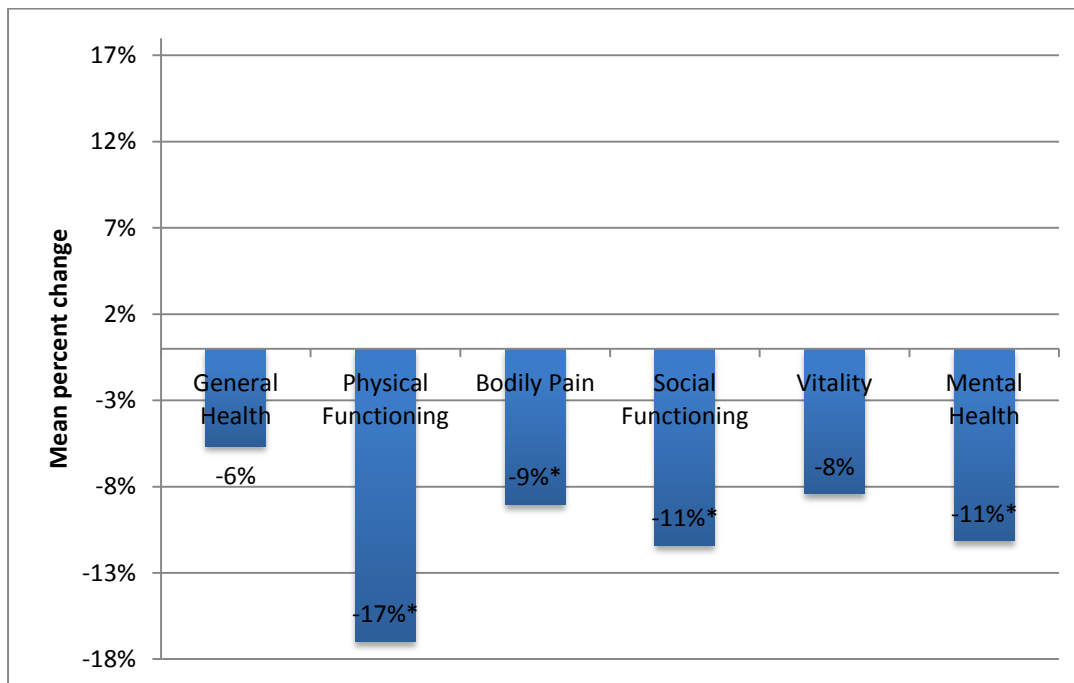
Holme House

There were 90 respondents from HMP Holme House and 58 of these prisoners responded to the pre-release interview.

Paired-samples t-tests were used to determine whether there was a significant change in prisoners' physical and mental health between reception and pre-release. This is a parametric test that compares prisoners' mean scores at each time point to identify any differences between the two.

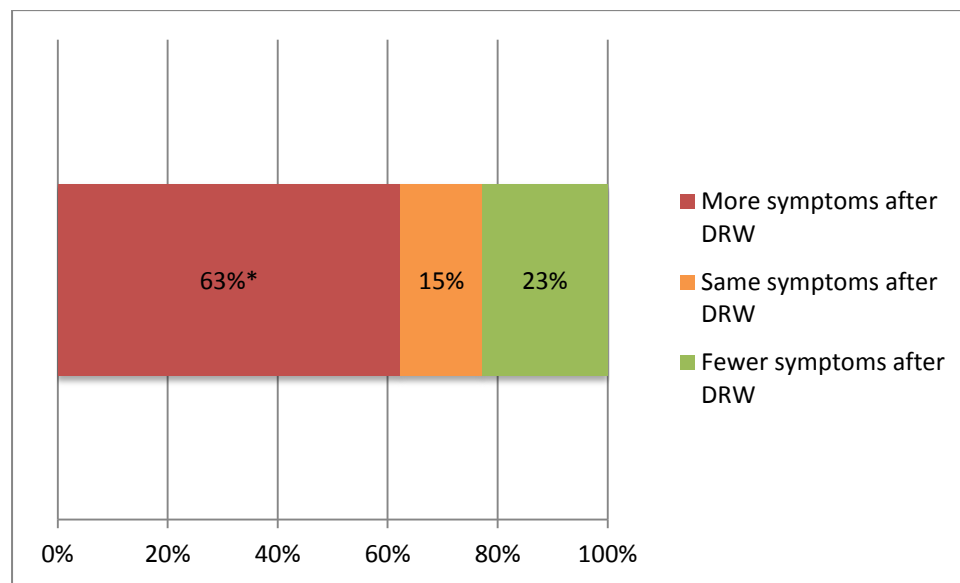
Figure 8.12 shows the mean proportion and direction of change in health over time. Physical functioning ($p = 0.001$), bodily pain ($p = 0.04$), social functioning ($p = 0.03$), and mental health ($p = 0.02$) showed a significant decline between reception and pre-release. There was no statistically significant difference in general health ($p = 0.12$) or vitality ($p = 0.10$) between reception and pre-release.

Figure 8.12: Holme House. Mean percentage of change in health according to general health (N = 49), physical functioning (N = 46), bodily pain (N = 48), social functioning (N = 46), vitality (N = 38), mental health (N = 46) as measured by the Short Form-36 between starting DRW treatment and graduating from treatment



The data here show that according to the prisoners own assessments their general health, physical functioning, social functioning, vitality and mental health all deteriorated over the period of their engagement with the drug recovery wing. Further, a paired-samples sign test suggests that there was a significant increase in symptoms of anxiety and depression ($p = 0.005$) between reception into prison and prior to release from the Drug Recovery Wing. Figure 8.13 below also shows that according to the prisoners surveyed there appeared to be a significant increase in symptoms of anxiety and depression comparing the time period at the start and the conclusion of Drug Recovery Wing treatment.

Figure 8.13: Holme House. Proportion of prisoners (N = 48) according to their change in symptoms of anxiety and depression between the start and the conclusion of Drug Recovery Wing treatment .



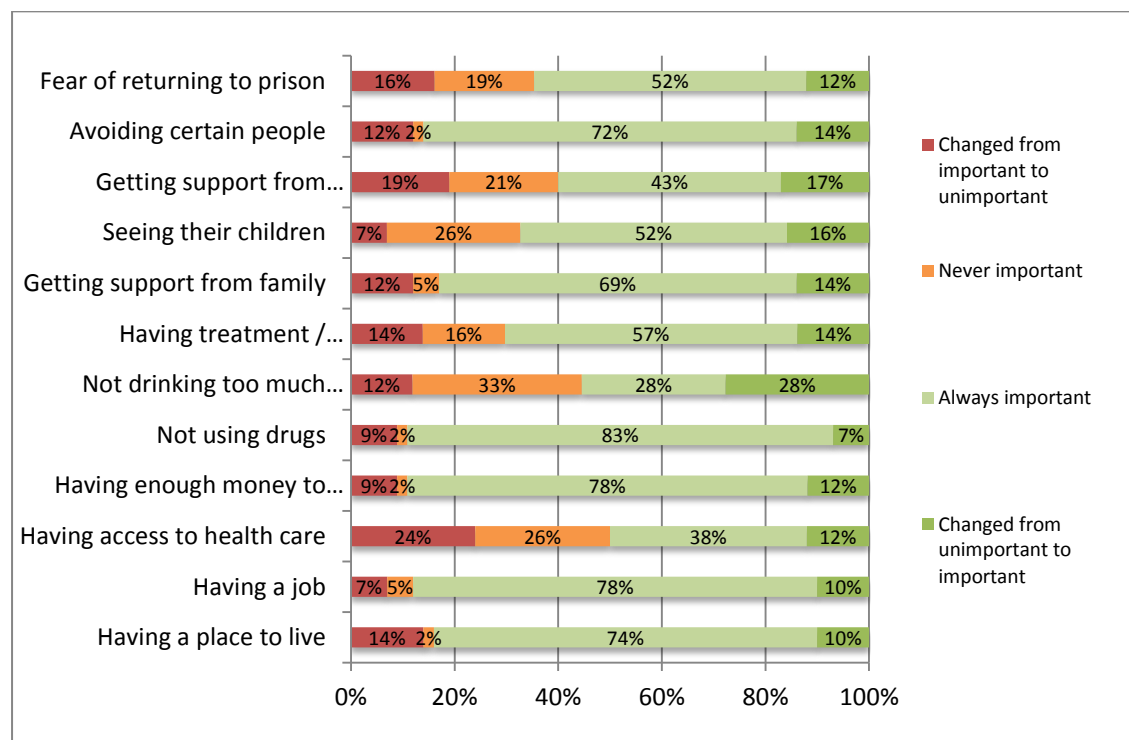
The data show a marked increase in symptoms of anxiety and depression following drug recovery wing engagement compared to the period in advance of their beginning treatment.

With regard to their attitudes towards drug use and offending our data showed little indication of a statistically significant change in prisoners' perceived likelihood of future drug use ($p = 1.00$) or in their perceived likelihood of reoffending ($p = 0.31$) between the start and the conclusion of their Drug Recovery Wing treatment.

Prisoners were asked to rate their agreement or disagreement with a series of statements about crime and punishment. These attitudes were not found to have changed to a statistically significant degree between reception and pre-release ($p = 0.53$), but trended towards an increase in pro-crime sentiment over time (N = 42; More pro-crime at pre-release = 55%, Same attitude at pre-release = 2%, Less pro-crime at pre-release = 43%).

Prisoners were asked to identify any circumstances that they felt would help to prevent them from committing crime in the future. McNemar's tests show no significant changes in these beliefs over time. Figure 8.14 shows how ratings of importance for these circumstances changed over time between the start and the conclusion of the prisoners Drug Recovery Wing engagement.

Figure 8.14: Holme House. Proportion of prisoners (N = 58) in HMP Holme House according to change in opinion between reception and pre-release when asked whether each of these 12 factors would be important in preventing future offending

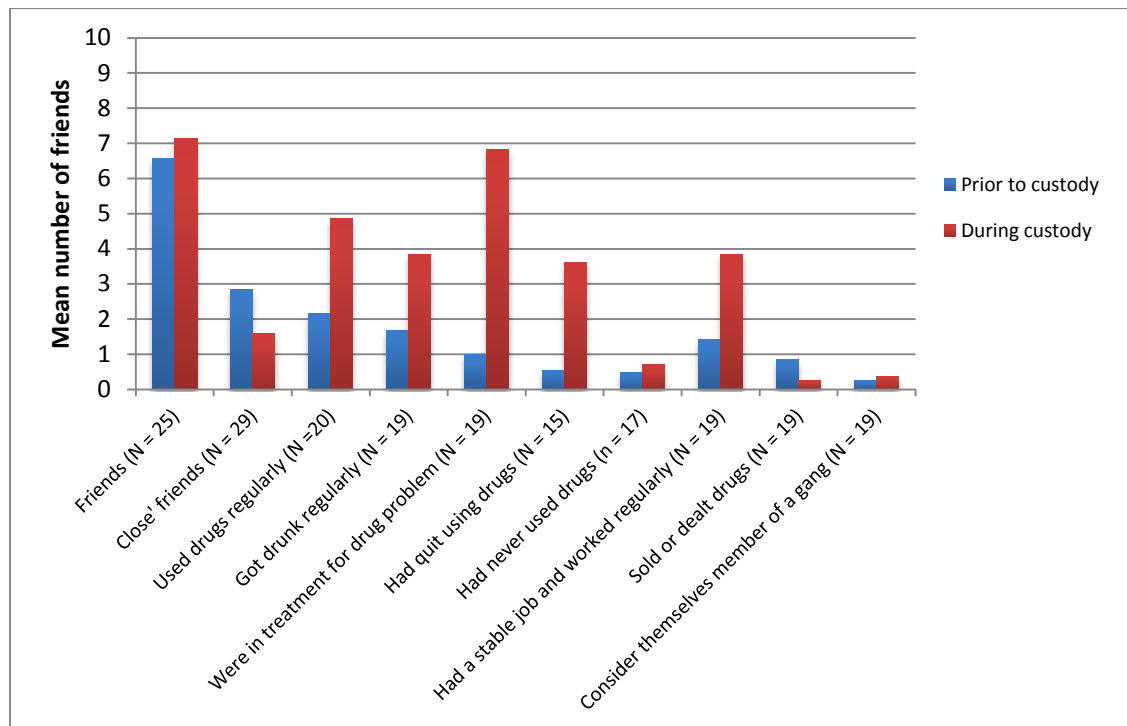


With regard to friendships analysis of our data using paired-samples t-tests, showed prisoners reporting having significantly fewer friends who they considered to be 'close' ($p = 0.02$), or who currently sold or dealt drugs ($p = 0.03$), and significantly more who were in treatment for a drug problem ($p = 0.03$), who had quit using drugs ($p = 0.008$), or had a stable job and worked regularly ($p = 0.06$) in prison compared with the friends that they had outside of prison.

There was no significant difference between friends before prison and friends inside of prison in terms of the total number of friends ($p = 0.82$), the number who currently used drugs regularly ($p = 0.32$), who got drunk regularly ($p = 0.42$), who have never used drugs ($p = 0.57$), or the number who would consider themselves to be a member of a gang ($p = 0.72$).

Figure 8.15 illustrates the average number of friends that prisoners reported having prior to custody and during custody who participated in these various activities.

Figure 8.15: Holme House. Mean number of friends prisoners had at the start and the conclusion of Drug Recovery Wing treatment who took part in a number of different activities.



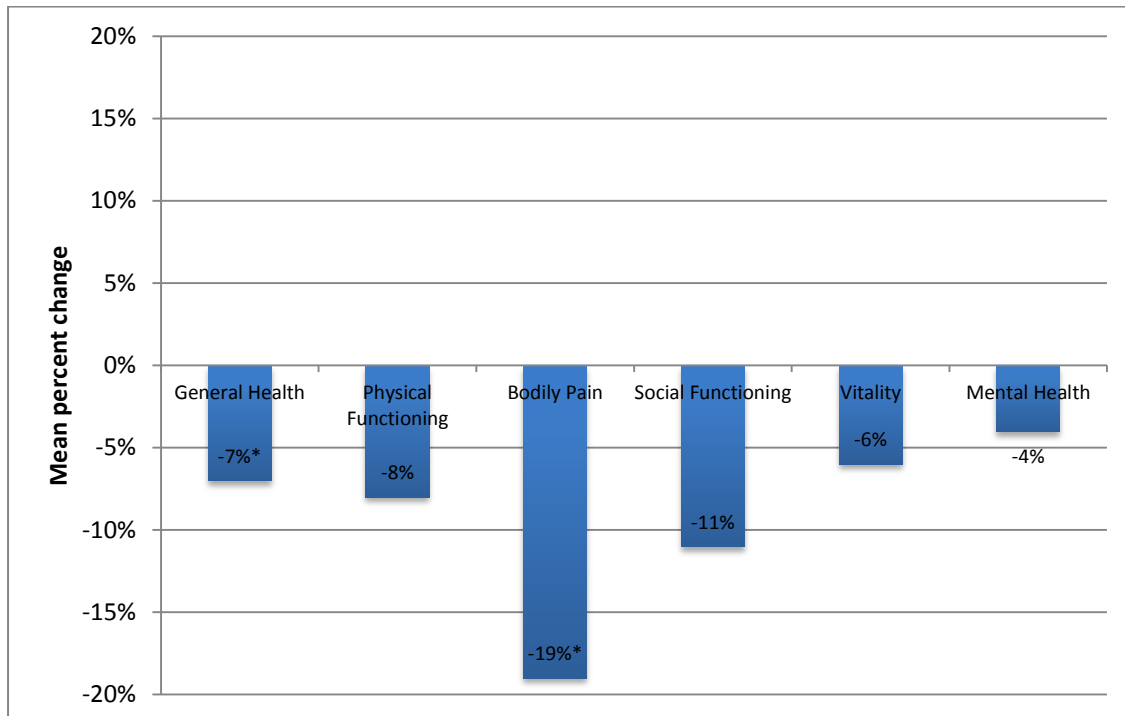
In sum there were indications in terms of the prisoners own assessments of their mental health, physical health, and general health of these dimensions of recovery having deteriorated during the period of their engagement on the drug recovery wing. There was little indication of positive change in attitudes to crime and future offending following engagement on the drug recovery wing although there were indications in some of the prisoners attitudes that they were coming to recognise the importance of certain dimensions of their behaviour and circumstance that might impact upon their future drug use and criminality. Having access to children and getting support were identified by a significant number of prisoners as important with regard to reducing the likelihood of their future drug use and possible further offending.

High Down

There were 48 prisoners in HMP High Down who were interviewed at the start of the Drug Recovery Wing treatment with 27 of these surveyed prior to their graduation from the wing.

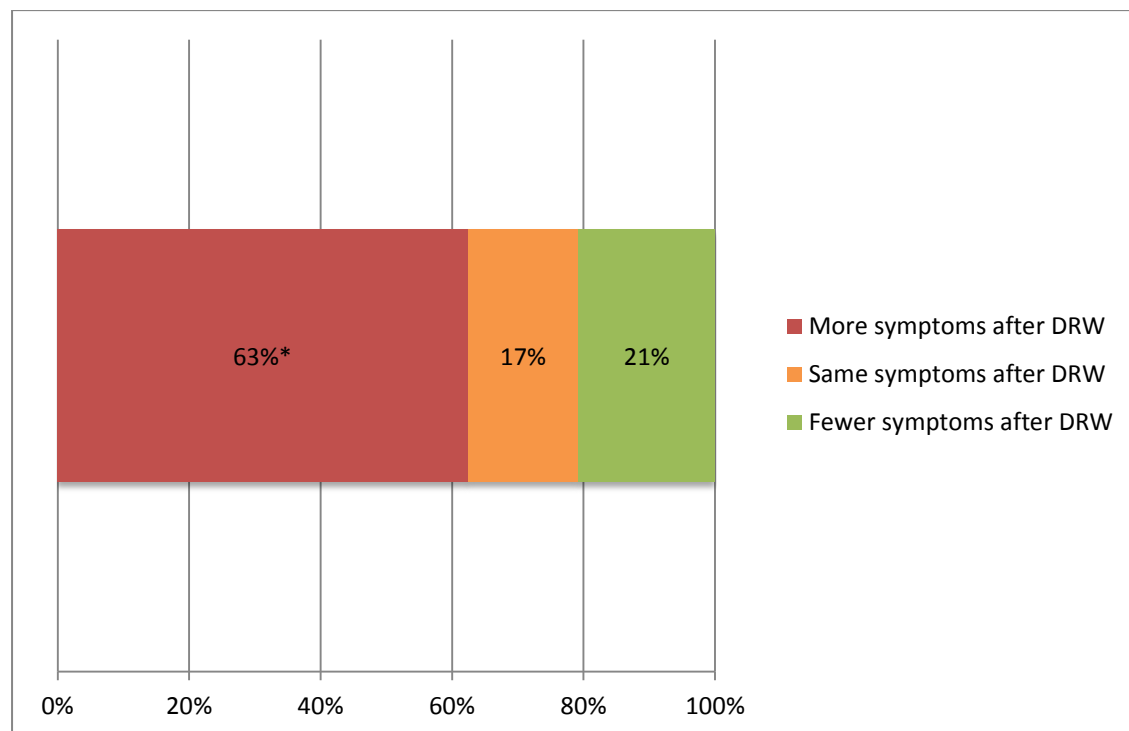
Paired-samples t-tests were used to determine whether there was a significant change in prisoners' physical and mental health between the start and the conclusion of their Drug Recovery Wing treatment. Based on these data prisoners self assessed general health ($p = 0.04$) declined from the start of treatment to the conclusion of treatment. Positively there was also a significant reduction in self reported bodily pain over this period. There was no statistically significant difference in physical functioning ($p = 0.09$), social functioning ($p = 0.09$), mental health ($p = 0.29$), or vitality ($p = 0.29$) between reception and pre-release.

Figure 8.16: High Down. Mean percentage of change in health according to general health (N = 24), physical functioning (N = 24), bodily pain (N = 24), social functioning (N = 25), vitality (N = 21), mental health (N = 24) as measured by the Short Form-36 between the start and the conclusion of DRW treatment.



A paired-samples sign test suggested that there was a significant increase in symptoms of anxiety and depression ($p = 0.04$) between reception and pre-release.

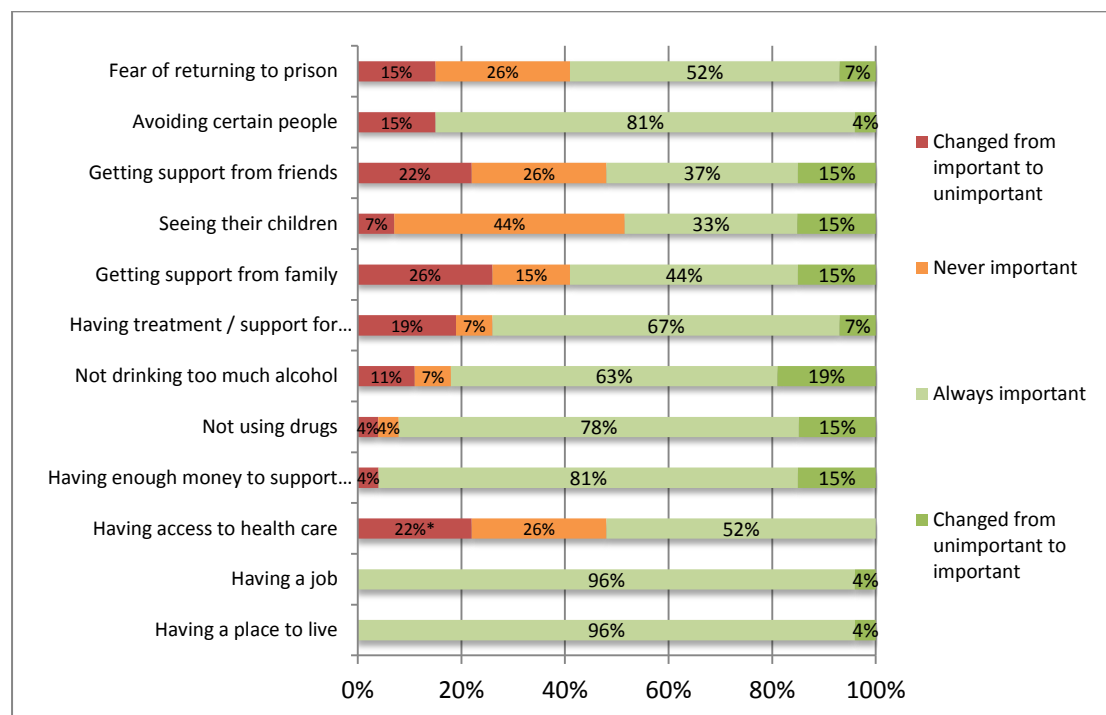
Figure 8.17: High Down. Proportion of prisoners (N = 24) according to their change in symptoms of anxiety and depression at pre-release at HMP High Down



Our data on High Down showed no statistically significant change in prisoners' perceived likelihood of future drug use ($p = 0.08$) or in their perceived likelihood of reoffending ($p = 0.58$) between reception and pre-release. Prisoners were asked to rate their agreement or disagreement with a series of statements about crime and punishment. These attitudes were not found to have changed at a statistically significant level between the start and the conclusion of Drug Recovery Wing treatment ($p = 1.00$), but trended towards an increase in pro-crime sentiment over time ($N = 25$; More pro-crime at T2 = 44%, Same attitude at T2 = 8%, Less pro-crime at T2 = 48%).

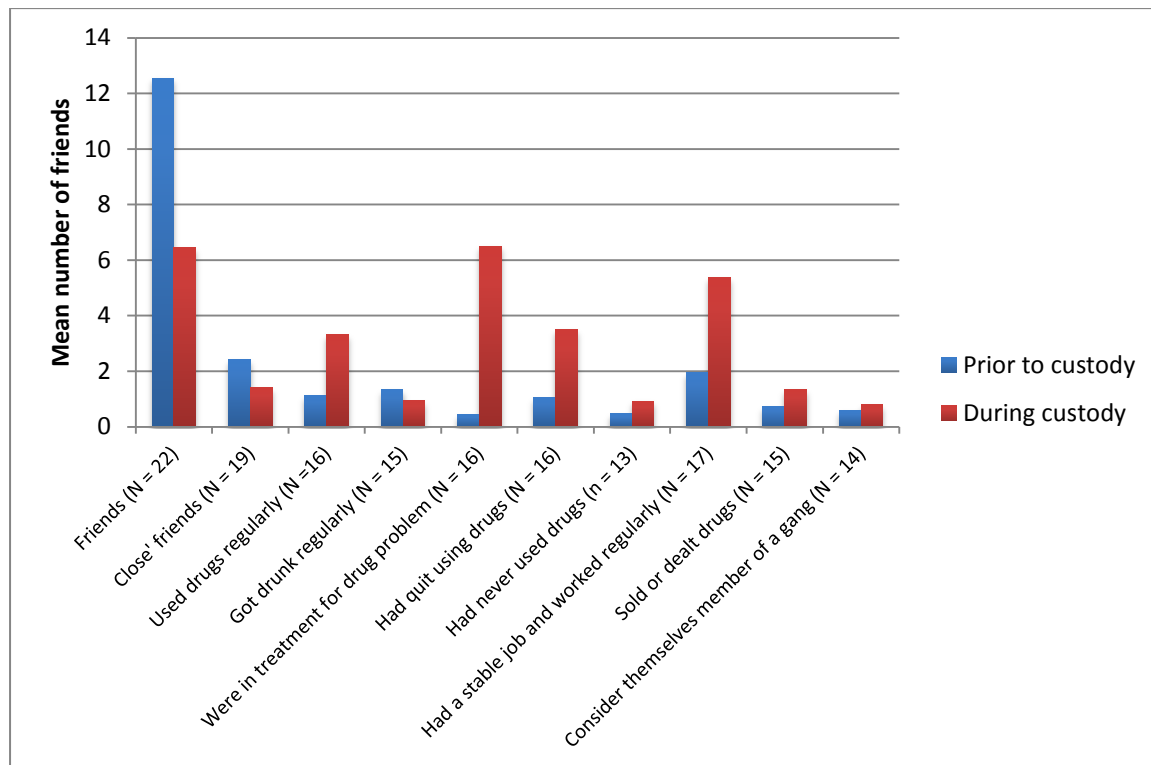
Prisoners were asked to identify any circumstances that they felt would help to prevent them from committing crime in the future. McNemar's tests show that a significant number of prisoners went from believing access to healthcare would be important in preventing them from offending in future to believing that this factor was unimportant ($p = 0.03$). There were no other significant changes in these beliefs over time. Figure 8.18 shows how ratings of importance for these circumstances changed over time between the start and the conclusion of DRW treatment.

Figure 8.18: High Down. Proportion of prisoners (N = 27) in HMP High Down according to change in opinion between the start and the conclusion of DRW treatment when asked whether each of these 12 factors would be important in preventing future offending



According to paired-samples t-tests, prisoners reported having significantly more friends who were in treatment for a drug problem ($p = 0.02$) in prison compared with the friends that they had outside of prison. There was no significant difference between friends before prison and friends inside of prison in terms of the total number of friends ($p = 0.22$), the number of friends who they considered to be 'close' ($p = 0.09$), who currently sold or dealt drugs ($p = 0.42$), who currently used drugs regularly ($p = 0.09$), who got drunk regularly ($p = 0.52$), who have never used drugs ($p = 0.45$), who had quit using drugs ($p = 0.07$), or had a stable job and worked regularly ($p = 0.06$), or the number who would consider themselves to be a member of a gang ($p = 0.76$).

Figure 8.19: High Down. Mean number of friends prisoners had prior to and during custody at HMP High Down who took part in a number of different activities.



Summary

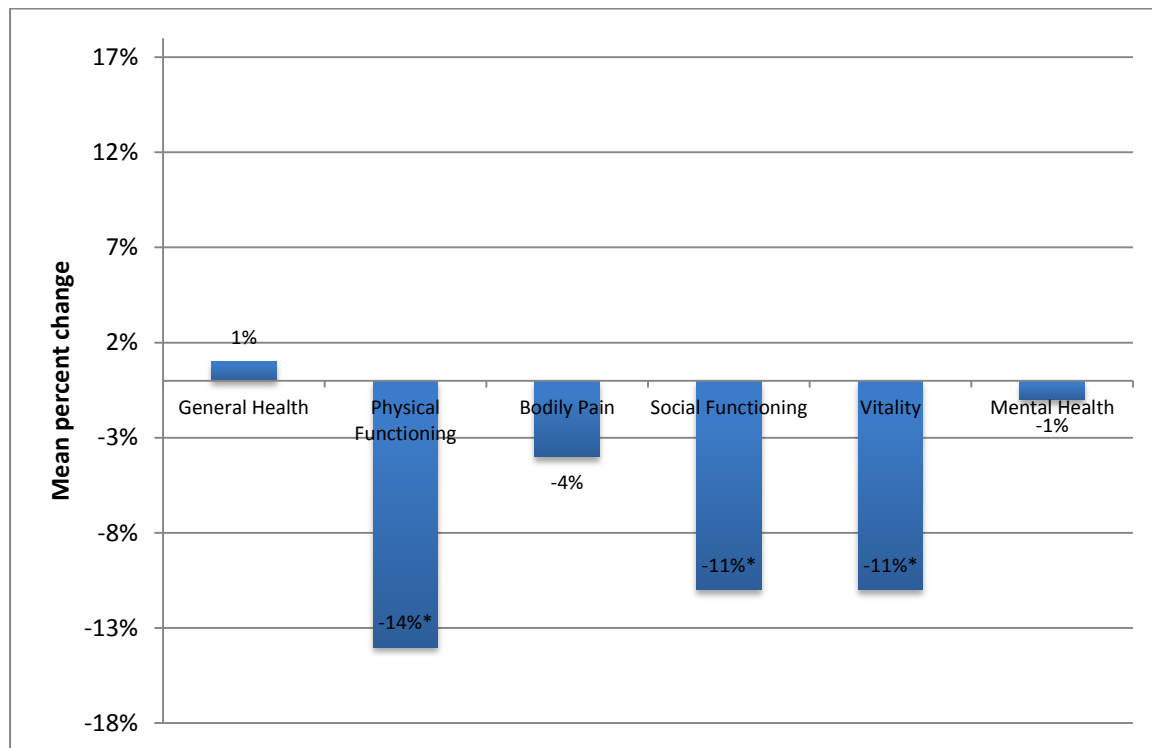
According to prisoners interviewed on the Drug Recovery Wing their self-assessed physical and mental health social and physical functioning vitality declined during the period of their engagement on the Drug Recovery Wing and there was a notable increase in symptoms of depression and anxiety following engagement on the recovery wing. There was little indication of any positive change in attitudes towards drug use and crime with a notable increase in the proportion of prisoners who shifted from believing that access to health care was important to believing that it was unimportant in terms of reducing the likelihood of their future drug use and offending.

Brixton

There were 71 prisoners who were interviewed at the start of their engagement with the Drug Recovery Wing in HMP Brixton 52 of whom were surveyed just prior to the conclusion of their treatment.

Paired-samples t-tests were used to determine whether there was a significant change in prisoners' physical and mental health between the start and the conclusion of their Drug Recovery Wing treatment. This is a parametric test that compares prisoners' mean scores at each time point to identify any differences between the two. Physical functioning ($p = 0.002$), social functioning ($p = 0.002$), and vitality ($p < 0.001$) showed a significant decline between the two points in time. There was no statistically significant difference in general health ($p = 0.72$), bodily pain ($p = 0.28$), or mental health ($p = 0.71$) between reception and pre-release.

Figure 8.20: Brixton. Mean percentage of change in health according to general health (N = 46), physical functioning (N = 45), bodily pain (N = 48), social functioning (N = 48), vitality (N = 46), mental health (N = 47) as measured by the Short Form-36 between the start and the conclusion of DRW treatment



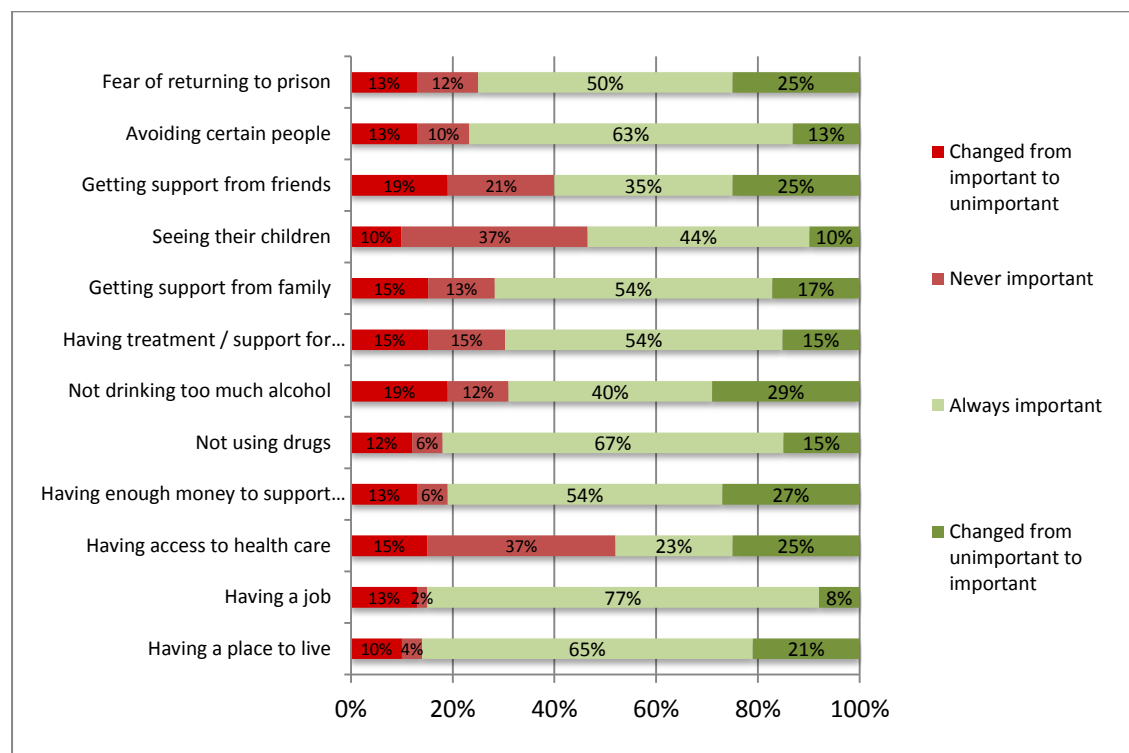
A paired-samples sign test suggests that there was no statistically significant change in prisoners' (N = 48) symptoms of anxiety and depression [$p = 0.75$; 44% symptoms improved, 19% stayed the same, 38% symptoms worsened] between the start and the conclusion of treatment.

In relation to prisoners attitudes towards criminality and future drug use analysis of our data showed that prisoners were significantly less likely to expect to reoffend after release from prison ($p = 0.007$) although was no statistically significant change in perceived likelihood of future drug use ($p = 0.46$) between the start and the conclusion of treatment.

Prisoners were asked to rate their agreement or disagreement with a series of statements about crime and punishment. These attitudes were not found to have changed at a statistically significant level between the start and the conclusion of treatment ($p = 0.50$), but trended towards a decrease in pro-crime sentiment over time (N = 37; More pro-crime at T2 = 41%, Same attitude at T2 = 5%, Less pro-crime at T2 = 54%).

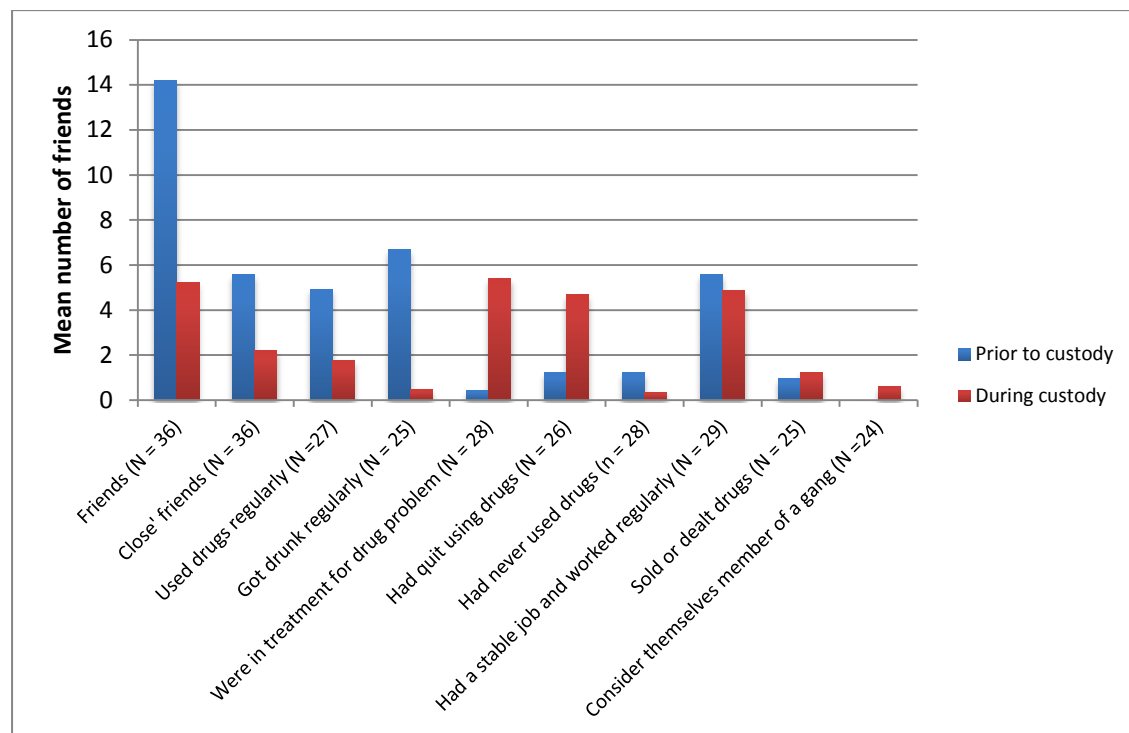
In relation to prisoners views as to the circumstances that in their view might help them to reduce the likelihood of committing offences in the future Figure 8.21 summarises our data with McNemar's tests showing no significant changes in these beliefs over time.

Figure 8.21: Brixton. Proportion of prisoners (N = 52) in HMP Brixton according to change in opinion between the start and the conclusion of DRW treatment when asked whether each of these 12 factors would be important in preventing future offending



According to paired-samples t-tests, prisoners reported having significantly fewer friends who they considered to be 'close' ($p = 0.05$), friends in total ($p = 0.04$), who got drunk regularly ($p = 0.02$), or who have never used drugs ($p = 0.04$) and significantly more who were in treatment for a drug problem ($p < 0.001$) or who had quit using drugs ($p < 0.001$) in prison compared with the friends that they had outside of prison. There was no significant difference between friends before prison and friends inside of prison in terms of the who currently sold or dealt drugs ($p = 0.74$), the number who currently used drugs regularly ($p = 0.18$), who had a stable job and worked regularly ($p = 0.73$), or the number who would consider themselves to be a member of a gang ($p = 0.18$).

Figure 8.22: Brixton. Mean number of friends prisoners had prior to and during custody at HMP Brixton who took part in a number of different activities



Summary

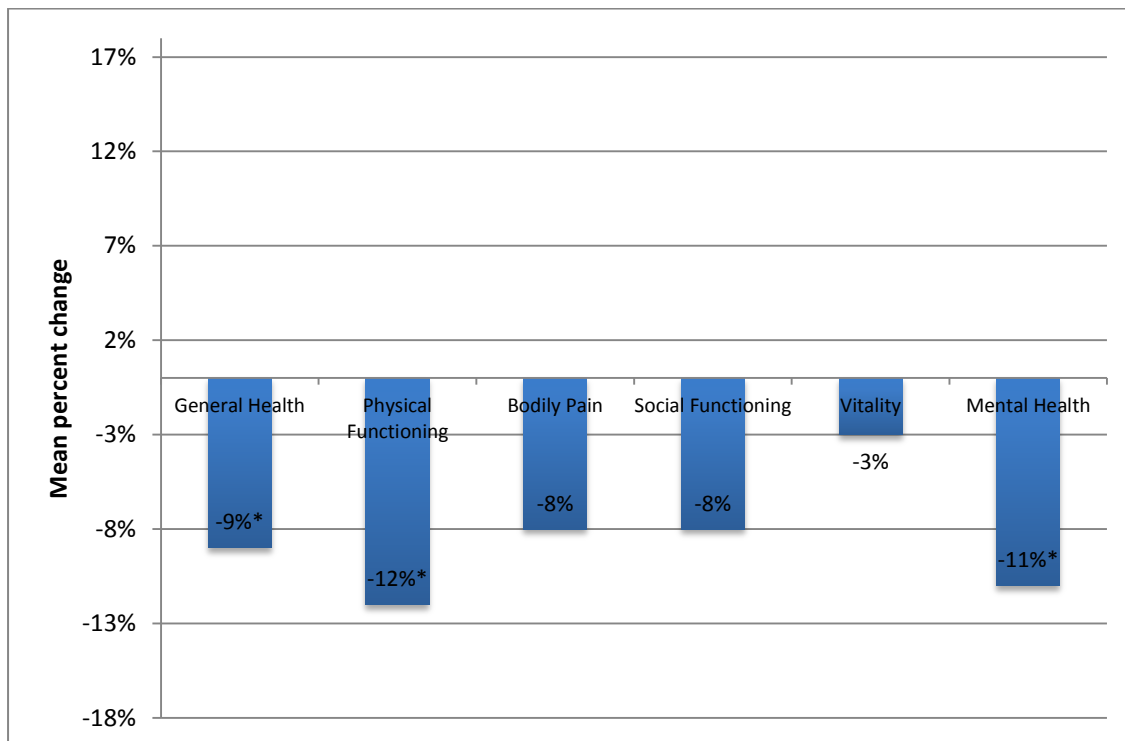
Physical functioning social functioning and reported bodily pain all deteriorated over the period of Drug Recovery Wing engagement. The Drug Recovery Wing was associated with positive improvements in prisoners' assessments of the likelihood of reoffending though not in relation to reducing the likelihood of future drug use.

Brinsford

Within the YOI Brinsford we interviewed 55 prisoners at the start of their DRW treatment 31 of whom were surveyed just prior to the conclusion of their DRW treatment.

Paired-samples t-tests were used to determine whether there was a significant change in prisoners' physical and mental health between reception and pre-release. This is a parametric test that compares prisoners' mean scores at each time point to identify any differences between the two. Physical functioning ($p = 0.01$), general health ($p = 0.04$), and mental health ($p = 0.05$) showed a significant decline between the start and the conclusion of treatment. There was no statistically significant change in bodily pain ($p = 0.15$), vitality ($p = 0.67$), social functioning ($p = 0.23$), or between reception and pre-release.

Figure 8.23: Brinsford. Mean percentage of change in health according to general health (N = 27), physical functioning (N = 26), bodily pain (N = 28), social functioning (N = 26), vitality (N = 23), mental health (N = 27) as measured by the Short Form-36 between the start and the conclusion of DRW treatment.



A paired-samples sign test showed that there was no statistically significant change in prisoners' (N = 27) symptoms of anxiety and depression [$p = 0.06$; 26% symptoms improved, 11% stayed the same, 63% symptoms worsened] between the start and the conclusion of their Drug Recovery Wing treatment.

In relation to attitudes towards future drug use and offending our data showed that there was no statistically significant change in perceived likelihood of future drug use [$p = 0.48$; N = 28; Less likely = 39%, Same = 36%, More likely = 25%] or in perceived likelihood of reoffending [$p = 0.27$; N = 30; Less likely = 30%, Same = 57%, More likely = 13%] between reception and pre-release.

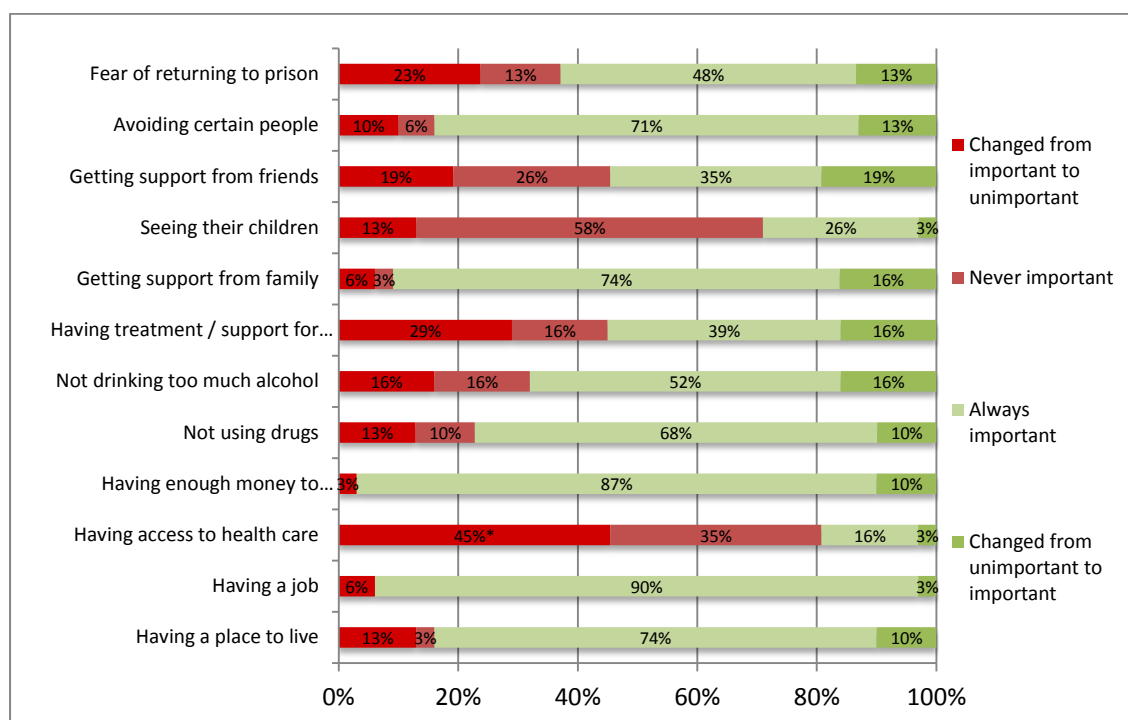
Prisoners were asked to rate their agreement or disagreement with a series of statements about crime and punishment. These attitudes were not found to have changed at a statistically significant level between reception and pre-release ($p = 1.00$), but trended towards a decrease in pro-crime sentiment over time (N = 26; More pro-crime at pre-release = 42%, Same attitude at pre-release = 12%, Less pro-crime at pre-release = 46%).

Prisoners were asked to identify any circumstances that they felt would help to prevent them from committing crime in the future. McNemar's tests show that prisoners were significantly less

likely to rate having access to healthcare ($p = 0.001$) as an important factor in preventing them from offending at pre-release than at reception.

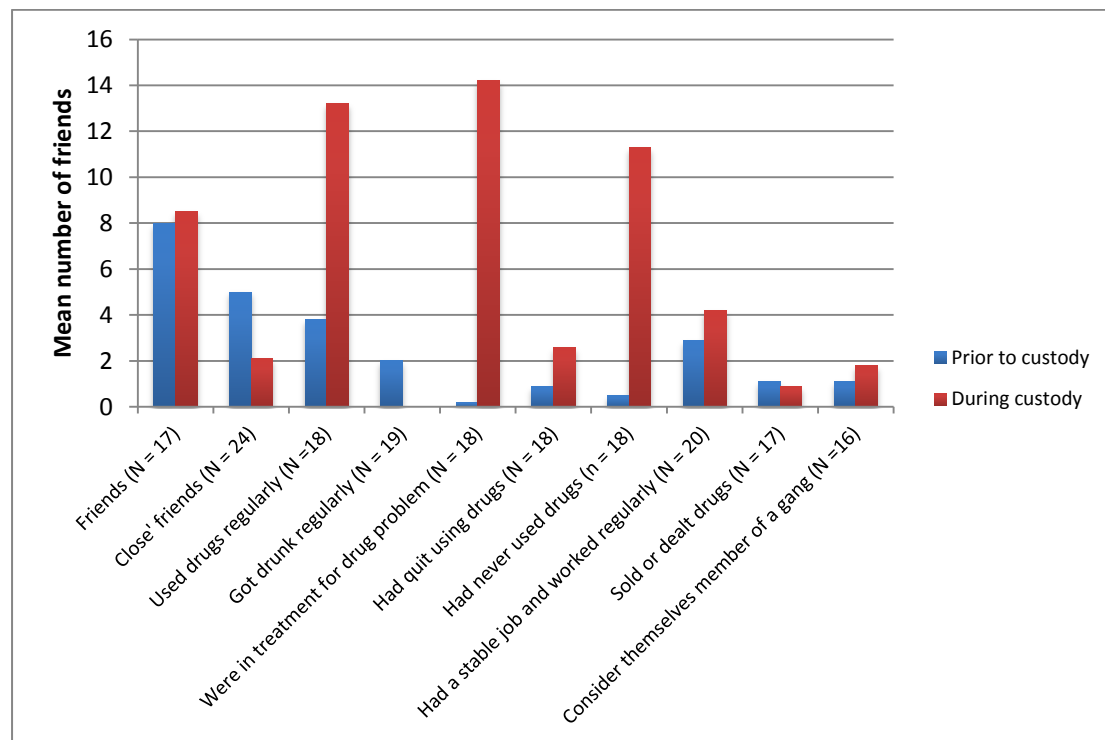
There was no statistically significant change in the proportion of prisoners who rated having a place to live ($p = 1.00$), having a job ($p = 1.00$), fear of returning to prison ($p = 0.55$), having enough money to support oneself ($p = 0.63$), not using drugs ($p = 1.00$), not drinking too much alcohol ($p = 1.00$), having treatment and support for drug or alcohol problems ($p = 0.42$), getting support from family ($p = 0.45$), seeing their children ($p = 0.38$), getting support from friends ($p = 1.00$), and avoiding certain people ($p = 1.00$) as important in this way.

Figure 8.24: Brinsford. Proportion of prisoners (N = 31) in HMP Brinsford according to change in opinion between the start and the conclusion of their DRW treatment regarding whether each of these 12 factors would be important in preventing future offending



With regard to friendships, paired-samples t-tests, showed prisoners having significantly fewer friends who they considered to be 'close' ($p = 0.02$) in prison compared with the friends that they had outside of prison. There was no significant difference between friends before prison and friends inside of prison in terms of the number of friends in total ($p = 0.85$), who got drunk regularly ($p = 0.08$), or who have never used drugs ($p = 0.34$) who currently sold or dealt drugs ($p = 0.69$), the number who currently used drugs regularly ($p = 0.41$), who had a stable job and worked regularly ($p = 0.36$), who were in treatment for a drug problem ($p = 0.22$), who had quit using drugs ($p = 0.07$), or the number who would consider themselves to be a member of a gang ($p = 0.57$).

Figure 8.25: Brinsford. Mean number of friends prisoners had prior to and during custody at HMP Brinsford who took part in a number of different activities



Summary

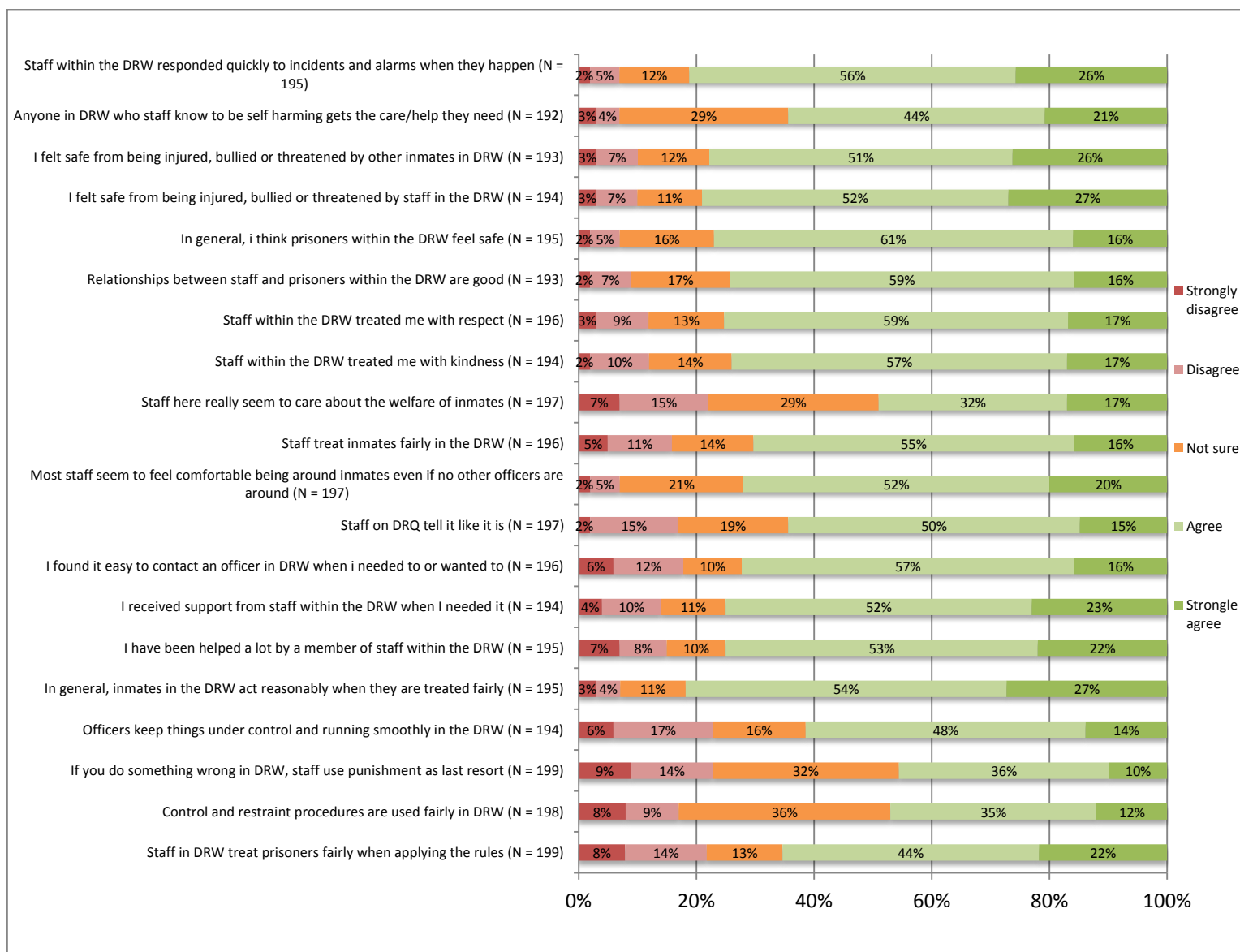
Our data showed that in relation to physical health, general health, and mental health, as these were reported by prisoners themselves, these elements have largely deteriorated not improved in the journey into through and out of the Drug Recovery Wing. Equally there was little evidence of progress in terms of the prisoners' attitudes towards criminality and their self-assessed likelihood of future drug use and future offending.

In the next section of this report we look at what the prisoners we surveyed had to say in terms of their own assessment (both positive and negative) about the Drug Recovery Wings with which they had been engaged.

Prisoners Views of the Drug Recovery Wings.

The data here were obtained using a standard set of questions (extracted from the MQPL instrument developed by Liebling and various colleagues and used elsewhere in this research) provided to prisoners as part of the pre-release assessment. The data here relate only to prisoners interviewed within our study and participating on the Drug Recovery Wing i.e. we are comparing these data to prisoners within the same prisons who were not participating on the Drug Recovery Wing and as a result it is not possible to determine how close these assessment by our Drug Recovery Wing prisoners of the DRW's themselves would correspond to similar assessments made of the wider prisons within which those wings were situated. We look first at the level of prisoners agreement with a range of positive statements about the Drug Recovery Wing they had experienced.

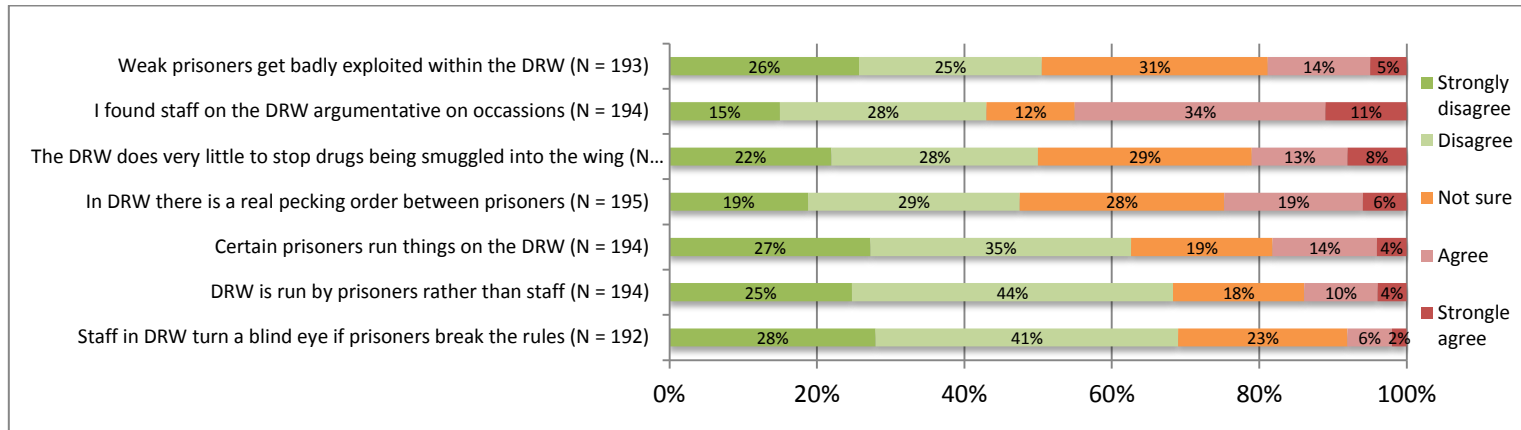
Figure 8.26. Proportion of prisoners according to their agreement or disagreement with positive statements regarding DRW staff



Overall there was a high level of agreement across all of the statements summarising positive views about the Drug Recovery Wings with 79% of prisoners agreeing or strongly agreeing that they felt safe from being injured bullied or threatened by staff, 77% agreeing or strongly agreeing that they felt safe from being injured bullied or threatened by other inmates. 82% of prisoners indicated that they agreed or strongly agreed with the statements that DRW staff responded quickly to incidents and alarms when they happened and 49% of prisoners agreeing or strongly agreeing that staff really cared about the welfare of prisoners. Where there was concern this had to do with the use of control and restraint procedures with 17% of prisoners indicating that they either strongly disagreed or disagreed with the statement that these procedures were used fairly within the DRW and 36% indicating that they were not sure if this was the case.

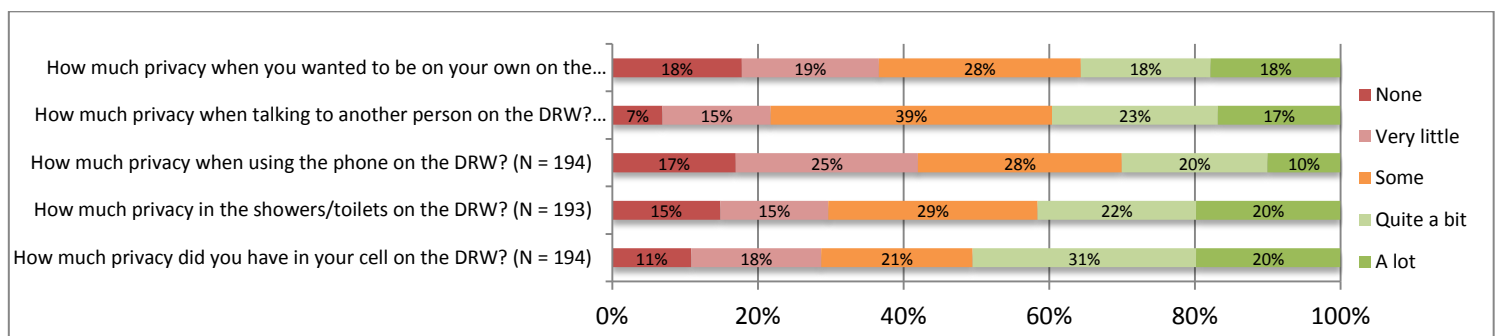
In Figure 8.27 below we look at the level of agreement prisoners had with a range of negative statement about the Drug Recovery Wing.

Figure 8.27. Proportion of prisoners according to their agreement or disagreement with negative statements regarding DRW staff



45% of prisoners indicated that they agreed or strongly agreed with the statement that staff within the DRW were argumentative on occasion, 25% agreed or strongly agreed that there was a real pecking order between prisoners, and 21% felt that staff were doing very little to stop drugs being smuggled onto the Drug Recovery Wing. Nearly a fifth of prisoners surveyed agreed or strongly agreed that weak prisoners were badly exploited on the Drug Recovery Wing. In Figure 8.28 below we look at the issue of privacy on the Drug Recovery Wing.

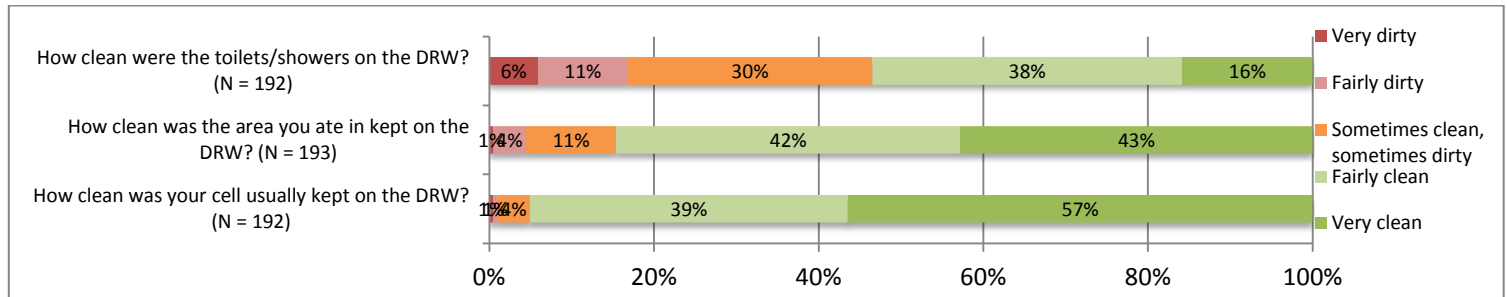
Figure 8.28. Proportion of prisoners according to their ratings regarding the level of privacy on the DRW



37% of prisoners indicated that there was either none or very little privacy when prisoners wanted to be on their own within the Drug Recovery Wing, 42% felt that there was little or no privacy when using the telephone on the Drug Recovery Wing, and 30% felt that there was little or no privacy when using the showers and toilets within the Drug Recovery Wing. These proportions indicate that with regard to the prisoners at least there were strong feelings of insufficient privacy within the Drug Recovery Wing. It is important to recognise however that prisons are by definition institutions that are required to maintain close surveillance of prisoners such that it is perhaps inevitable that

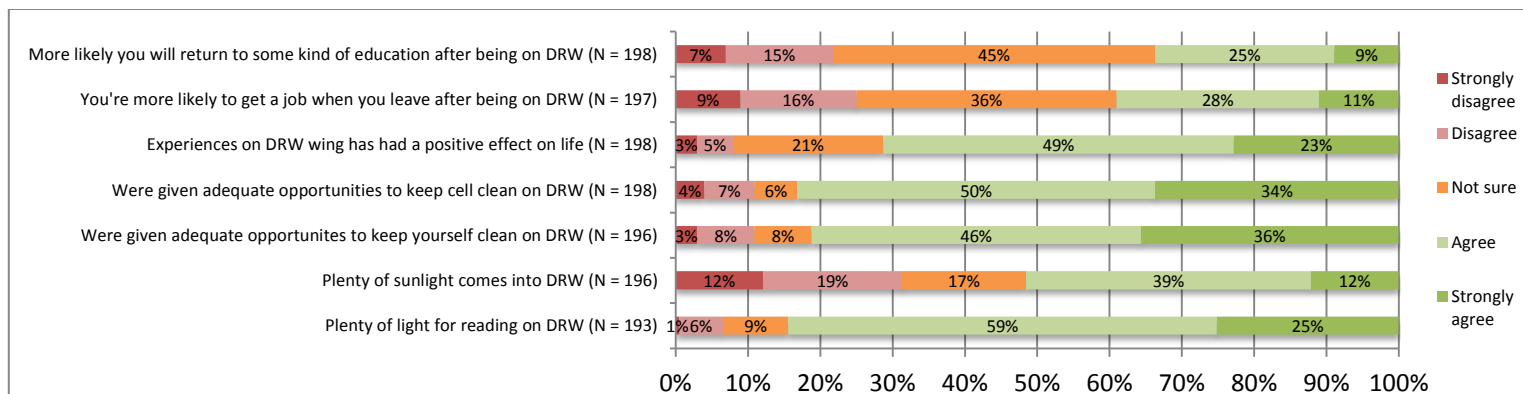
prisoners will feel a marked lack of privacy. However the lack of privacy at least at certain times and in certain situations may militate against effective treatment for drug and alcohol problems.

Figure 8.29. Proportion of prisoners according to their ratings regarding the level of cleanliness on the DRW



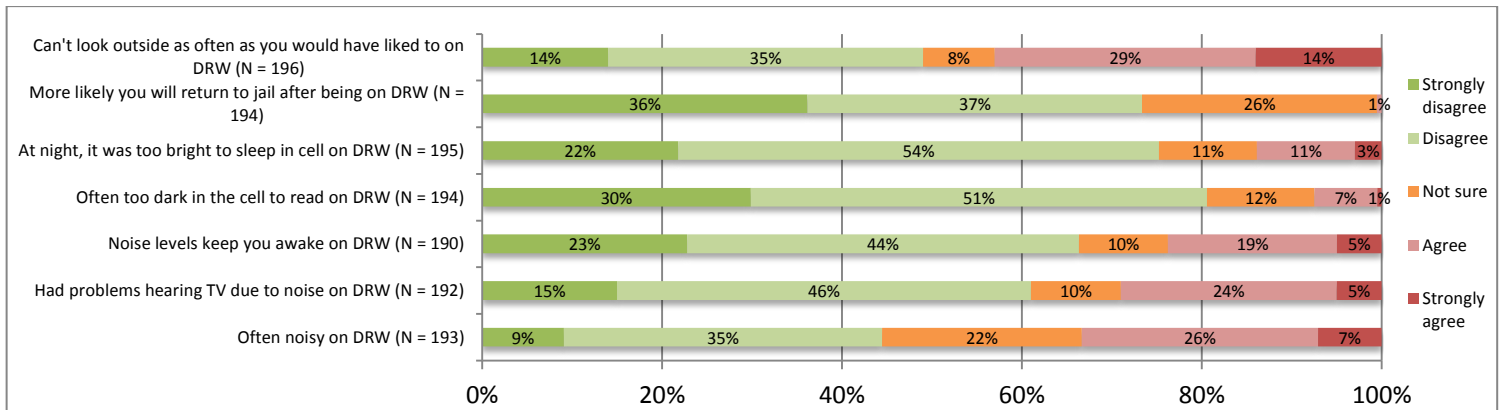
On the basis of the data summarised in Figure 8.29 there were clear indications that prisoners' cells and the areas where they ate were judged to be very clean or fairly clean, whilst the levels of cleanliness of toilets and showers were judged to be less so.

Figure 8.30. Proportion of prisoners according to their agreement or disagreement with positive statements regarding the DRW environment



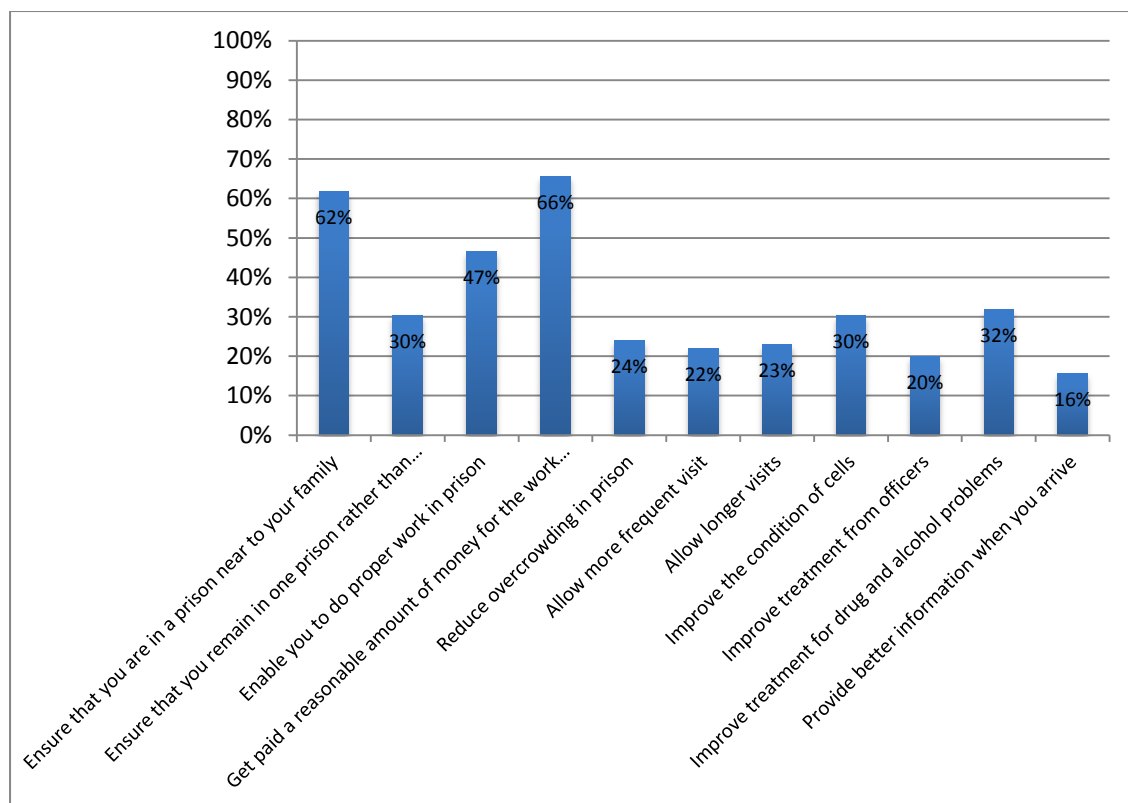
As can be seen here there were high levels of agreement that lighting and sunlight within the Drug Recovery Wing were sufficient, that prisoners were given adequate opportunities to clean themselves and their cells and that the Drug Recovery Wing experienced had had a positive impact on the prisoner's life.

Figure 8.31. Proportion of prisoners according to their agreement or disagreement with negative statements regarding the DRW environment



In relation to Figure 8.31, 33% of prisoners agreed or strongly agreed that the Drug Recovery Wing was often noisy, 24% indicated that they agreed or strongly agreed that noise levels on the Drug Recovery Wing stopped them sleeping on occasion, and 29% indicated that the noise level stopped them hearing the television on occasion. Finally, in Figure 8.32 we have summarised the prisoners' views on a range of possible improvements to the Drug Recovery Wings.

Figure 32. Proportion of prisoners (N = 204) who rated each of a series of potential improvements to the DRW as important



Noticeable here is the level of support for ensuring that prisoners were located near to their family, that prisoners were paid a reasonable amount of money for the work undertaken by them and that they remained in one prison rather than being moved between prisons.

Discussion and Conclusion

The outcome evaluation of the Drug Recovery Wing pilot programme could be said to have focussed on one question, namely; were the wings effective in meeting the needs of prisoners with a drug or alcohol problem? Perhaps the first thing to acknowledge in considering that question is to recognise the significant reductions in drug and alcohol use and criminality that occurred over the period we were looking i.e. prior to custody, to the start and the conclusion of Drug Recovery Wing treatment, to prison release and living within the community for six months. It is important to remember however that we only have data on one third of the prisoners living in the community and on that basis we have no way of knowing about the extent to which the other two thirds of our sample were using drugs drinking excessively or engaging in criminality. Further it may be that there were important differences between the one third of prisoners who were able to retain contact with in the community and those that were lost to follow up. Nevertheless looking at the prisoners who we were able to follow from treatment initiation to graduation to living within the community the fact that many of these individuals were able to reduce the drug and alcohol use and their offending should be seen as a positive outcome.

The question remains however as to the extent to which those positive outcomes were attributable to the Drug Recovery Wing or whether they were an outcome of the prisoners' experience of custody more broadly? In answering this question it is important to recognise that it was not possible in our study for reasons that we have explained to follow a comparison or control sample of prisoners who received only standard prison drug and alcohol treatment. As a result it is not possible for us to determine the extent to which the positive outcomes in reduced criminality and drug and alcohol use within our followed-up sample of prisoners can be attributed specifically to the Drug Recovery Wing provision.

Nevertheless there is a way of addressing this question that can shed some light on the issue of determining whether the Drug Recovery Wing provision may indeed have contributed additionally over and beyond the prison experiences in reducing these harmful behaviours. This is to ask whether there were any indications that other components of recovery were improving as a result of the prisoners Drug Recovery Wing experience? The data here however are much less positive than the data is in relation to reduced drug and alcohol use and offending on prisoner follow up.

Despite the enormous variability in the Drug Recovery Wings we were studying in their size, staffing, treatment programme, prisoner profile, structure in fact what we saw was a very similar picture across the Recovery Wings with regard to the minimal impact on prisoners' self-assessed physical and psychological health, in their attitudes towards criminality, and in their assessment of the likelihood of future drug use. In relation to these various elements, which may bear upon the sustainability of the reductions in drug and alcohol use that we identified post prison release, there was very little indication of a positive effect associated with the Drug Recovery Wing experience.

In the light of that rather gloomy assessment it is perhaps important to consider why Drug Recovery Wings may have had so little positive impact on the various components of recovery even if they

were associated with a marked reduction in drug and alcohol use and offending. In considering that issue it is important to re-iterate the extent of the need amongst the sample of prisoners we were studying. The prisoners within our research were characterised by multiple, serious, and long-standing problems of which their substance abuse was merely one element. In many instances these were individuals for whom offending and drug use had become commonplace elements of their own lives, the lives of their friends and, in many instances, the lives of their family members. This being the case one should perhaps only ever have rather modest expectations as to what any kind of provision or service can achieve by way of enabling these individuals to rebuild their lives, to cease or substantially reduce their substance use and to cease offending. Coupled with the embedded nature of many of the problem behaviours characterised by our sample is the fact that elements of the prison experience itself may well have militated against the effectiveness of the Drug Recovery regimes. For example previous research has shown that sustained recovery from dependent substance use often involves the drug user in constructing a non-addict identity key within which is for the individual to be engaged in positive non drug use related activities whilst building new relationships with individuals who are not connected to the world of drug use and offending (McIntosh and McKeganey 2002). Whilst it is certainly possible for prisoners to be engaged in meaningful activities/work that is unrelated to drug and drug use, it is much harder to build relationships with individuals who are not part of the world of drug use and offending for the simple fact that those individuals are unlikely to be found within the prison environment. It is perhaps for this reason that within our research only Brixton appeared to have seen positive changes in prisoners' friendships in such a way as to increase the proportion of friends who had ceased their drug use. Ideally one might have hoped that participation within the Drug Recovery Wing would have resulted in a much clearer re-organisation of prisoner's friendships such that those who were participating within the Drug Recovery Wings had a greater proportion of individuals within their friendship group who did not have a drug or alcohol problem.

There is a broader debate that is occurring at the present time as to the extent to which prison is an appropriate place to meet the needs of individuals whose offending is driven by their drug and alcohol problems. Resolving that question is as much a political matter as a question of the relative effectiveness of different institutions to meet the needs of individuals with a drug or alcohol problem. However that notwithstanding the possibility remains that the minimal changes in Drug Recovery Wing prisoners' self-assessed physical and mental health, attitudes towards future drug use and offending, may actually be as much a product of the prison experience as any failure of the Drug Recovery Wing provision itself. Whilst the aspiration to foster a recovery culture within the prison environment is legitimate and timely the question remains as to what level of institutional transformation might be needed to truly deliver an effective recovery culture with the prison environment for those with a drug or alcohol problem, and further, whether it is even possible to effectively combine treatment and punishment in this way without undermining one or other of those elements. Indeed it may well be the case that the prison environment, whatever the configuration of any Drug Recovery Wing, is simply the wrong place to meet the needs of individuals whose offending is related to their substance abuse related problem.

In the absence of a shift in political will or government policy offenders with a drug or alcohol problem will continue to need to receive treatment and support within prison. On the basis of the evaluation we have undertaken meeting those needs will require an investment substantially greater

than the pilot Drug Recovery Wing programme and which certainly includes the provision of support to manage the transition from prison release into the community.

Chapter 9: Costs of DRWs

It is important to identify the potential costs involved when public funded programmes are commissioned in order to ensure efficiency and cost-effectiveness. In this study we estimate the costs of providing drug recovery wings on a per patient basis for the five prisons in the impact study.

The study does not use a control and therefore it is not possible to robustly attribute any health or economic outcomes to the patient's attendance in a DRW. Our longer term aim is to address costs and saving to society when comparative reconviction data are obtained. However, in the meantime, by estimating the cost per patient we can identify a threshold cost, with any economic and health benefits over and above this value representing a situation where outcomes outweigh costs and suggest a positive net economic impact.

Few costing studies have been undertaken with regard to providing substance misuse interventions within a prison or other criminal justice setting. One such estimate was made by Brooks et al (2013) which estimated the cost of providing sessions to substance misusers based on data from Youth Offending Teams (YOTs). The cost calculated was £24 per hour, £16 per session or £384 per series of 24 sessions in 2008/9. Inflating these costs to 2014/5 prices gives £29 per hour, £19 per session and £464 per series of 24 sessions.

Costs

A uniform costing methodology was adopted for each of the five prisons in the study. The staff costs were estimated by the proportions of staff time spent on the DRW. 40% was added to staff costs to account for overheads. The study recorded specific costs that were also allocated to the DRW, including set up costs. The capacity of the DRW was calculated by the number of places available and then dividing 52 weeks by the average length of stay to arrive at the number of patients that could be treated in each place in a year.

These costs are incremental costs over and above the costs of providing cell accommodation and security.

Individual DRW costs

We do not present the full cost breakdown of any of the DRWs in this report due to confidentiality as, given the small numbers of staff employed, it would be straightforward to link staff to earnings. The mean cost per DRW attendee was as follows, including staffing costs, overheads and the initial start-up costs for the DRW (£30,000 per DRW). Unit costs

should fall over time as a result of start up costs being spread across a greater number of attendees.

DRW	Cost £s
Brinsford	746
Brixton	1,980
High Down	955
Holme House	438
Swansea	586

Costs in Holme House and Swansea are relatively low, reflecting the low number of staff delivering the regime in the former, and the high throughput of prisoners in the latter. Based on available data and capacity estimates, it is possible to treat approximately 250 patients per annum in the Swansea DRW, based on a 10 week average stay.

Costs of crime

We can look at the unit costs of crime to examine the number of crimes avoided that would need to be achieved as a result of DRW attendance in order for the costs of DRW provision to be recovered. In such cases we would have an approach that would appear to cover its own costs and provide a positive net economic impact.

Table 9.1 below presents the unit costs of crime as published by the Home Office (2011) and inflated to 2014/5 prices using the Retail Prices Index (for a fuller account of how these costs are produced see Appendix 3). The table shows the number of cases of each crime category by which crime would have to be reduced as a consequence of DRW treatment in order for the DRW to in essence pay for itself, in that societal savings would equal the per patient treatment cost. The mean costs of DRW provision and crime rate reductions needed to break even are in the right hand column.

Table 9.1: Rates of crime reduction for each DRW to recover costs

		Costs of DRW (pp)					Mean
		Brinsford	Brixton	High Down	Holme House	Swansea	
Unit cost (2014)		£746	£1,980	£955	£438	£586	£941
Homicide	£2,052,000	0.0004	0.0010	0.0005	0.0002	0.0003	0.00046
Serious wounding	£29,770	0.0251	0.0665	0.0321	0.0147	0.0197	0.03161
Other wounding	£11,320	0.0659	0.1749	0.0844	0.0387	0.0518	0.08313
Sexual offences	£42,726	0.0175	0.0463	0.0224	0.0103	0.0137	0.02202
Common assault	£2,023	0.3687	0.9785	0.4720	0.2165	0.2896	0.46504
Robbery – personal	£10,187	0.0732	0.1944	0.0937	0.0430	0.0575	0.09238
Burglary of dwelling	£4,538	0.1644	0.4363	0.2104	0.0965	0.1291	0.20734
Theft (non-vehicle)	£882	0.8456	2.2443	1.0825	0.4965	0.6642	1.06662
Theft of vehicle	£5,747	0.1298	0.3445	0.1662	0.0762	0.1020	0.16375
Theft from vehicle	£13,914	0.0536	0.1423	0.0686	0.0315	0.0421	0.06763
Attempted vehicle theft	£713	1.0457	2.7754	1.3386	0.6139	0.8214	1.31901
Criminal damage (personal)	£1,218	0.6127	1.6262	0.7844	0.3597	0.4813	0.77287
Commercial robbery	£10,837	0.0688	0.1827	0.0881	0.0404	0.0541	0.08684
Burglary not in a dwelling	£5,328	0.1400	0.3716	0.1792	0.0822	0.1100	0.17661
Commercial theft of vehicle	£11,612	0.3217	0.1705	0.0822	0.0377	0.0505	0.08103
Commercial theft from vehicle	£1,443	2.5890	1.3721	0.6618	0.3035	0.4061	0.65211
Commercial attempted vehicle theft	£713	5.2368	2.7754	1.3386	0.6139	0.8214	1.31901
Shoplifting	£143	26.0572	13.8098	6.6608	3.0549	4.0871	10.73396
Criminal damage (commercial)	£2,125	1.7579	0.9317	0.4494	0.2061	0.2757	0.72416

These costs represent highly conservative estimates, given that they do not allow for criminal history. On rearrest/reconviction, the cohort of released DRW prisoners will have a high chance of reimprisonment, given that many will be on license and will have recently served a prison sentence. The actual costs of reoffending for this group will therefore be substantially higher, given the very high costs of reimprisonment.

Drawing on the impact findings (see Figure 8.6 above), the most common crimes reported by the followed-up DRW prisoners within six months of release were shoplifting; theft; handling stolen goods⁴³; drug dealing/possession¹; theft; common assault; burglary from a residential dwelling; and commercial criminal damage. As can be seen from the table above, the costs associated with such crimes vary considerably and as a result, the threshold levels of crime reduction needed to achieve overall savings also vary greatly. On average across the DRWs, 11 shop-lifting offences would need to be prevented per individual in order for the intervention to pay for itself. By comparison, preventing domestic burglary at the rate of one in five prisoners would reach this savings threshold. Most of the offences typically associated with drug-driven crime to fund opiate addiction such as drug dealing, shoplifting and non-vehicle theft have low costs associated with them. Nevertheless, residential burglary, which was quite commonly reported by the impact sample, has a high associated cost. Problem drinkers tend to be more commonly associated with violent offence profiles (Shepherd 1994; Boreham *et al.*, 2007:21), and common assaults and woundings are associated with quite high costs.

The particular profile of substance users in DRWs may therefore be associated with the potential cost savings. Furthermore, beyond substance use and offence type, age and previous criminal history will be strong determinants of future offending, and variations in DRW intake across these variable will also impact on reoffending and reconvictions.

⁴³ Unit costs for these offences are not available and, in comparison to other offences, are very hard to estimate.

Chapter 10: Synthesis, Discussion and Conclusions

This evaluation of the DRW pilots has consisted of an extensive, mixed methods study across a number of different strands, the findings from which have been individually described in the preceding chapters. In the course of this study we have engaged 130 staff and 160 prisoners in detailed qualitative interviews and undertaken post-release interviews with 21 prisoners in the community (and a further 27 recovery supports). We have undertaken a very detailed survey of a cohort of 319 prisoners and followed up 203 of these prisoners prior to release and 109 in the community. Lastly, we have analysed the data from 1,246 prisoners who took part in the MQPL survey in the DRW prisons. As noted in the methods chapter, it is inevitably something of a challenge to bring findings from a mixed methods study together. This is a central aim of the current chapter, which will attempt to synthesise the results by drawing across the findings from the evaluation as a whole. It will then provide a wider discussion of the implications of these findings and offer some conclusions.

Synthesis

Reflecting on the comparative views of prisoners

The MQPL survey was important because it represents the only study within this evaluation which gave us the opportunity to directly compare DRW prisoners' views with those of prisoners elsewhere in the same prison. If we had simply compared MQPL survey results for prisoners from different DRWs, any resulting differences may have been attributable to differences between prisons rather than DRWs. The MQPL data showed marked differences between the DRWs in terms of their comparative quality of prison life scores (comparing DRW prisoners with other prisoners). Prisoners in Manchester, Styal and Swansea DRWs were markedly more content compared to the rest of their prison populations, reporting a more humane environment, which offered support and scope for personal development. By comparison, there were few differences between DRW and other prisoners in Brixton, Chelmsford, High Down and Holme House. Most concerning, prisoners in Brinsford and New Hall DRWs produced significantly lower scores than the rest of the prison population.

These findings correspond quite well with the extensive qualitative research undertaken within this evaluation. Manchester, Styal and Swansea all seemed to represent promising DRW models, which were popular with motivated prisoners, and clear problems with the DRWs in Brinsford and New Hall had been obvious since the Rapid Assessment. The process evaluation provided the opportunity to explore some of the differences and similarities across seven DRWs and offer potential explanations. One issue appears to be physical separation. The Manchester DRW, located in an old

segregation block on the bottom floor of one wing, was separated from the rest of the prison by a large metal door. This afforded the scope to create an unusually separate, small community and also provided some control over drug availability. Importantly, Manchester was also able to retain its 20 beds solely for the use of DRW prisoners. The considerable popularity of the Swansea DRW has presented something of a puzzle to the process research team: with prisoners facing long periods locked in their cells, limited group work and limited physical separation from the rest of the prison. However, exceptionally good relations between staff and prisoners and robust segregation seemed to ameliorate these 'pains of imprisonment' and, like Manchester, the Swansea DRW appeared to be particularly successful in forming a close-knit community, avoiding the presence of lodgers. Contrasting with these two physically protected sites, the Styal DRW was unable to maintain any significant separation from the rest of the prison, with substantial contact with prisoners from other wings. Moreover, there were also lodgers placed in Fox House. Nevertheless, the TC-style regime that was in place at the time of the MQPL survey and rapid assessment, seemed to foster social protection through a self-policing ethos, with the DRW subgroup supporting and protecting each other.

It is interesting that one of the most separate DRWs, New Hall, was one of the least favoured in the MQPL analysis and the Rapid Assessment. As such, segregated DRWs lay at either end of the DRW spectrum, offering both the best reviewed, and the worst reviewed conditions. In shuttering off wing residents from outside influences and locations, there may therefore be a sense in which separation concentrates and intensifies relationships and dynamics, and thereby becomes a two-edged sword. Close, supportive communities such as those found in Swansea and Manchester might arise from the greater proximity and familiarity that comes with staff and prisoners working and living together in a more secluded DRW; or particular discord might arise from sustained exposure to difficult relationships with people who segregation renders literally inescapable. A key feature here is likely to be the selection of the staff who work in these environments.

Two DRW models identified as promising in the qualitative research showed little difference from the MQPL scores of their parent prisons: Brixton and High Down. In both cases, despite promising therapeutic approaches, accommodation on the DRWs was poor and a substantial proportion of places on the wings were taken up by lodgers. We suspect that concerns surrounding these aspects and the MQPL's core focus on prison conditions and prison staff, may have affected DRW prisoners' responses to questions about the quality of prison life. In any case, a clear and resounding issue for DRWs from the Rapid Assessment onwards is the importance of protecting DRW beds for motivated prisoners who wish to do something about their substance misuse. This may be a particularly significant issue in the current policy climate of outsourcing prison functions to partner organisations, including NHS England (Justice Committee, 2015). Specialist programmes such as DRWs rely on support from within the prison for their successful implementation and maintenance: in terms of being given a suitable location (which appears from this evaluation to be very important), in terms of protecting DRW 'beds' from unmotivated 'lodgers,' and in terms of the day-to-day support provided by discipline officers. Unsympathetic officers can easily undermine such programmes. The Chief Executive of a significant voluntary sector external contractor was interviewed as part of the evaluation. He emphasised the importance of prison support:

Our ideal...of having, you know, named, dedicated staff on our recovery wings who are as committed as our staff are, you know, it's getting harder basically (NGO Chief Executive).

He continued:

Fundamentally, you can't have a successful recovery wing or, indeed any successful treatment intervention, unless there is at least a certain level of commitment from the prison management and staff (NGO Chief Executive).

Other themes from the interviews with prisoners and staff

Abstinence-focused recovery?

There were great differences in the provision of therapy or treatment across the seven DRWs studied in the process evaluation. Despite their name and the policy backdrop to their development, it was clear that DRWs did not universally focus on abstinence-focused recovery. In Brinsford and Holme House, the only input appeared to be harm reduction. Furthermore, the nature and intensity of therapeutic input varied greatly across the seven DRWs and also across time in some of the individual DRWs. Only two DRWs had adopted conventional, well-established treatment models, both run by the third sector: one of these represented the most intensive programme delivered across the pilots and consisted of a 12-step programme delivered at High Down. However, it is interesting that other, apparently well-received programmes were designed in fairly *ad hoc* ways by prison staff: such as the Manchester programme and half of the provision at Swansea. Overall, we were struck by how prisoners tended to put much more emphasis on peer relations and prisoner communities than they did on the type or nature of therapeutic provision. Community dynamics seemed to trump therapeutic content.

Filling time on segregated DRWs

Another key issue for DRWs has been the tension between separation and filling time. Ultimately, therapeutic input is unlikely to fill the whole day. To establish such a timetable would be highly resource intensive and, as several staff interviewees suggested, would most likely be too much for all but the most motivated and capable prisoners to absorb. If DRWs wished to maintain a credible degree of segregation between their own residents and the rest of the prison, they had to decide what to do with the time that prisoners might otherwise spend in employment, workshops or education. Some allowed additional association time, which was received with mixed reviews. Particularly in Holme House, prisoners appeared to find this both uncomfortable and unmanageable, protesting that it made time drag and exposed them to interactions they did not want. In other sites, it was received passively: as a minor advantage of living on a treatment wing. Other DRWs resorted to lock-up: although in Swansea where this routinely comprised twenty-three hours of most working days, prisoners did not seem to mind. Indeed, MQPL results suggested that DRW residents on extensive 'bang up' were more satisfied with their quality of life than prisoners on any other locations in 'main jail.' Looking to the future, there would be worth in taking a more evidence-based approach to the therapeutic content within DRWs, attended by careful regime planning.

Mutual aid

A clear message that came out strongly from the prisoner interviews was the popularity and significance of mutual aid groups. These were often commented on in very positive terms and provided prisoners with powerful examples of alternative ways to live. Particularly influential here was the involvement of ex-prisoners who had managed to move on from their substance misuse and offending. For many interviewees, this was the first time they had encountered such people, and the sense that 'lived experience' offered more powerful incentives to change than 'book learning' came through from prisoners in every site. Thus, while the DRWs appeared to be limited in their ability to identify and develop in-house Recovery Champions or mentors, there was the potential for outside mutual aid groups to provide these models. There seemed to be considerable scope for greater engagement with mutual aid groups, including the potential for bridging the support gap on release (see below).

OST

Another very important theme coming out of the Rapid Assessment and the staff and prisoner DRW interviews is the issue of prisoners on OST (Page *et al.*, 2016). Throughout the study, DRWs have experienced difficulties attracting many prisoners on OST to abstinence-focused programmes, where abstinence was taken to (eventually) preclude OST. While some DRWs (such as High Down) had increased the number of opioid users accessing their programme by the time of the process interviews, identifying motivated OST participants remained a problem. Though the staff delivering intensive treatment programmes often voiced aspirations to have full treatment cohorts of former opiate users, none recruited more than three or four at any one time. Concurrently, between one and three hundred OST recipients dwelt in other locations within each prison. The OST issue reflects the wider prison drug treatment policy and practice environment. As senior officers in Holme House reported, the advent of IDTS, the 2006 DH prescribing guidelines and widespread OST led to a dramatic decline in heroin users coming through their TC, and DRWs have similarly struggled.

Drug availability

A central issue for DRWs was drug availability. The only DRW where this did not appear to be an issue was Manchester: presumably reflecting its exceptionally selective recruitment process, relative isolation from the rest of the prison and the lack of lodgers. In some DRWs cannabis, NPS and diverted medications were reportedly readily available. Where DRW prisoners were rubbing shoulders with regular prisoners on OST, Subutex tended to be easy to access: and in the High Down DRW, Subutex was reportedly much cheaper than elsewhere in the prison. Again, these findings point to the importance of separation and retaining cell accommodation only for motivated prisoners who are engaged with DRW programmes.

Reductions in staff numbers

Finally, a recurrent issue raised by prison staff was the wider problems in the prison system, in particular the low and decreasing numbers of prison officers, which was associated with the Fair and Sustainable agenda and competitive benchmarking. There is no doubt that the situation in prisons at the time of the evaluation made the implementation and maintenance of DRW regimes very challenging. Other relevant trends have been the substantial increases in recorded prison assaults, prisoner self-injury and deaths in custody, despite a relatively stable prison population over this period (MoJ, 2017). It could be argued that these ongoing trends, coupled with the dramatic increase in the use of NPS in prison (Ralphs *et al.*, 2017; User Voice, 2016) have made prisons ever

more difficult places in which to protect spaces for intensive work with prisoners with histories of substance misuse.

Problems in the past and preparations for release

In common with much previous research (e.g. Williams *et al.*, 2012; Light *et al.*, 2013), the impact and process evaluation demonstrates the troubled pasts from which many of the prisoners in DRWs had come. The impact study showed that substantial minorities of these prisoners had histories of mental ill health – in particular histories of depression – and experienced physical and/or emotional abuse as a child. Moreover, the separate analyses of impact baseline and pre-release data for each DRW showed that, for the most part, there had been a general decline in physical and mental health over the course of prisoners' stays and little evidence of improving attitudes or hopes for the future.

The process interviews in prison likewise found that difficult experiences of childhood were the norm, with some harrowing accounts of sexual and physical violence and frequent experiences of parental separation and local authority care. However, these experiences were not universal and small number of interviewees were at pains to stress they had been well-supported by their families. The large majority of the impact sample had been excluded from school and most had close friends and/or family members involved with offending and drug use. Truancy and prematurely curtailed education were also described by the majority of the process sample. However, approximately half the process sample described longstanding employment histories, mostly in manual trades.

As was pointed out in the last chapter, the multiple and complex needs demonstrated by the DRW prisoners argue for interventions that are multiply-focused and move well beyond substance misuse treatment. In some of the DRWs with more intensive therapeutic programmes, past experiences and emotional issues were discussed. However, in the majority of DRWs therapeutic content was limited and what there was, focused explicitly on substance use. With regard to more pragmatic help, prisoners were largely disappointed with the support they had received in preparation for release. Despite resettlement being their primary concern and many prisoners' clear belief that recovery began at the point of release, there had been a paucity of professional help, with none of the interviewees reporting having received a concrete offer of housing. Most prisoners expected to be released into B&Bs, hostels and night shelters; and some voiced concerns that housing would not be made available, with the expectation that they would return to live in strained or harmful contexts with partners or family members.

Outcomes on release

The impact study has shown reductions in drugs and alcohol use and criminality for the DRW cohort as a whole, comparing the period prior to custody with the period following release. As was explained in the last chapter, only a third of the sample could be followed up and it is unclear the extent to which selective attrition could have affected these results. Likewise it is impossible to be confident of the extent to which DRWs impacted on these trends in the absence of a comparison sample. However, it is important to recognise that DRW participants' substance use and offending

declined and this suggests that there is scope to capitalise on these at-least temporary post-release reductions.

The process follow-ups also suffered from attrition but offer some qualitative insights into substance misuse pathways and the very serious problems faced by released prisoners with multiple needs. Only three of the follow up group had completely stopped their drinking and drug use, and each had drawn on different motivations in so doing: one faith, another family and the third, mutual aid. However, all three were also motivated by a similar weariness with their former lives as addicted users. Another group had managed to control their substance use: the majority were drinking but at apparently non-problematic levels. Important factors here appeared to be employment, relationships and for two of the opioid users, OST. For some, these improvements appeared quite precarious and there was the sense in which even fairly minor life events might shift the current status quo towards more damaging use. However, the remaining majority of the qualitative cohort on which follow-up information was available, had made few changes to their substance use. In this regard, the anguish expressed by the recovery support interviewees movingly demonstrated the wider impact of their relapse on those around them.

At least 22 of the total process sample of 58 that we attempted to follow-up were re-imprisoned within six months, most often for burglary offences. Furthermore, the majority of the rest of the follow-up sample appeared to have been involved in unreported offending: some of it drug-related, such as dealing and offences committed while intoxicated.

A central theme of this report, and so many that have preceded it, is the lack of support for prisoners on release. Interviewees most commonly described being met by no-one at the prison gate, and swiftly returning to drink or drug use – sometimes (at least initially) of a celebratory kind. However, it was notable that two ‘success stories’ in terms of abstinence had made a determined decision not to be tempted during that first day of their release. Only six prisoners reported receiving professional support at the prison gates: and none had proved very helpful. However, it should be emphasised that the problems faced by many of these prisoners were very great and there is a dangerous simplicity to the phrase ‘through the gate support’. Problems concerning housing, employment, relationships and money were often monumental, requiring long-term, intensive, expensive interventions. Furthermore, some of these prisoners were in any case, resistant to - or dismissive of - the help that was offered: particularly in the first few hours of liberation.

The released prisoners’ retrospective accounts of their time in DRWs were largely negative: with references to the ready availability of drugs, limited preparation for release and the only positive comments relating to wing conditions, including greater access to the gym. Prisoners’ accounts reaffirmed the chasm that exists between life inside and life outside, and the concomitant challenge of transferring anything in terms of goals or ‘decisions’ hatched within the DRW out into the chaos that greeted them. Given the inherent unpleasantness of imprisonment, many prisoners were anxious to forget as much as possible about their sentence and this seemed to include both lessons learnt and therapeutic insights gained whilst on a DRW.

Housing was the issue that most preoccupied our sample of releasees and seemed to lie at the root of the positive or negative narratives that then unfolded. Having a safe, warm home was clearly a

minimal starting point for creating a good life outside. Unfortunately for a large proportion of the sample, such a minimum requirement was not realised. A significant proportion was released street homeless, often sofa-surfing with friends that gave inevitable access to drugs and alcohol. However, by far the most common experience was being released to a hostel or funded B&B. Not one of the ex-prisoners residing in hostel accommodation had found it a positive experience and nearly all regarded hostels as increasing their chances of being re-incarcerated. The interviewees' accounts of their desperation in finding themselves living in such Dickensian, disordered places raise some fundamental questions about what is actually meant by words like the 'rehabilitation' and 'resettlement' of prisoners. Indeed, few of us might be expected to forge 'successful' pathways through life from these positions.

There were more positive stories concerning employment where, despite a reported lack of any structured support, many interviewees had gained employment through their personal contacts – albeit temporary and sometimes unpaid.

Discussion and conclusions

Too little, too early?

There seems to be significance in the fact that so few of the followed-up process study prisoners could remember much about their time in DRWs, and few could identify significant changes in their lives that had come about through DRW (or statutory) intervention. This evaluation has demonstrated a fundamental imbalance between the level of these prisoners' past and present problems and the structure and content of the support they received. Some gains in prison were apparent: several DRWs offered good treatment environments, with strong relationships between prisoners and committed prison staff (Lloyd *et al.*, 2017), and prisoner interviewees expressing a strong desire to make long-lasting changes to their lives. However, without proper help on release, it is hard to see how such plans could have been realised, and in large part they were not.

In this context, it is important to note that outside events seriously hampered what the DRW pilots were able to deliver. Operational models were developed just as prisons began to enter a considerable period of restructuring (MoJ 2013). The impact of two reviews of staffing, pay and conditions particularly affected the development of DRWs and what they were able to achieve. As experts, politicians and policy-makers had openly recognised at the time of their inception, these were pilots at a time of austerity. The Patel Report warned:

There can be no doubt that developing effective drug treatment interventions in prisons and continuity of care on release in the context of tightening resources will be demanding – drug users' priorities may become low ranking in a difficult economic climate. (Review Group, 2010: p.8).

However, as McKeganey *et al.* note, effectively rehabilitating marginalised prisoners

...must mean expanding the availability of treatments which contain the flexibility and range of skills required to address the diversity and complexity of prisoners' needs... However, all of these have very significant resource implications. All... perform best the more that is invested in them (2008:2).

Thus, it can be questioned whether DRWs were either sufficiently resourced or sufficiently protected, given the highly ambitious task they were expected to take on: promoting recovery within a custodial institution.

Recovery and custody

Granfield and Cloud (1999) point out that:

[A] person's structural location in society and the relationships, networks, and other assets that adhere to one's social position greatly affect one's chances for recovery. In some ways, the intensity of intoxicant use may be less important in overcoming dependency than the contextual factors that surround addiction in a person's life (p.178).

By definition, prisoners' 'structural location' is highly disadvantaged. Moreover, much of what makes up recovery capital is affected by imprisonment. This raises a number of issues in the context of this evaluation. First, drug dependent people often have the most severely depleted resources of recovery capital (Page *et al.*, 2016), and this routinely defines their lives well before they even enter prison. Second, imprisonment has an inevitable tendency to remove what recovery capital such individuals may have: by taking people out of their social contexts (Cloud and Granfield, 2008), and stripping away their access to relational, personal, and pragmatic support. As the Social Exclusion Unit's *Reducing Re-Offending By Ex-Prisoners* report surmised:

Two-thirds [of prisoners] lose their job, over a fifth face increased financial problems and over two-fifths lose contact with their family. There are also real dangers of mental and physical health deteriorating further, of life and thinking skills being eroded, and of prisoners being introduced to drugs (SEU 2002:7).

Third, and relatedly, if meaningful recovery services are required to build up service users' recovery capital – as identified in the current Drug Strategy (HM Government 2010), then prison is inevitably a highly problematic arena in which to attempt to achieve such recovery goals. Prisoners' relationships with family (and friends) tend to be negatively impacted by incarceration (Brunton-Smith and McCarthy 2017), and the opportunities to develop new, supportive, 'pro-social' networks within prison may be limited: none of our process sample built such through-the-gate recovery networks while inside prison. While the provision of work programmes within prison may provide useful skills, obtaining employment on release is hindered by the exclusion of people with criminal records from many job markets, and the difficulties of applying for employment opportunities whilst imprisoned. Many prisoners lose their homes while in prison (SEU 2002) and problems of communicating with housing providers, lack of income, jobs and the stigma of imprisonment impact on prisoners' ability to obtain accommodation on release (Maguire and Nolan, 2007)

Given such considerations, it seems justifiable to ask whether one can actually talk of ‘recovery’ within prison and whether, by the same token, the term ‘Drug Recovery Wing’ is inherently contradictory. This conflict was brought home vividly to members of the evaluation team in one of the DRWs that had motivational slogans on its walls, similar to those frequently seen in recovery services in the community. One read:

Life is not about waiting for the thunderstorm to pass, but about learning to dance in the rain

The incongruity of this sentiment, fixed to a white-washed prison wall, was hard to ignore.

This study suggests that imprisonment should be seen as, at best, a hiatus in the development of DRW residents’ recovery capital. The minority of participants who had robust family units throughout their childhood had, in general, also done reasonably well at school. They had, in turn, progressed to develop reasonably stable employment histories, and had fewer previous prison sentences. They often retained access to warm and supportive family units – who remained willing to provide safe and secure housing (and financial support) on release. Contrastingly, many other interviewees described early lives blighted by violence, bereavement and educational failure. These often transitioned into heavy and dependent drug use at an early age, alongside spirals of repeated drug use and offending that led them to lose the trust of those who might have been able to help. For this group, access to informal support was scarce: they had fewer informal routes of finding housing or employment, and fewer skills with which to navigate the structured housing or employment markets. For each group, DRWs had limited impact on their recovery capital. Those who entered prison with robust access to resources left similarly positioned; those who were imprisoned with nothing returned to precarious housing, marginalisation from employment, and unstructured lives surrounded by the temptation of illicit earnings

Our evaluation therefore suggests that the best DRWs served to *prepare* prisoners for recovery on release: but that the real recovery ‘journey’ started (if, indeed, it started at all) on release from prison. Within their capacities, where DRWs worked best, they were able to provide a protected space, where prisoners could cease using drugs and alcohol, be exposed to less temptation than elsewhere in the prison, feel physically safe, engage in therapeutic programmes and work on their motivation to make real changes in their lives on release. These findings emphasise the wider observation that recovery cannot be cast simply in terms of substance use cessation. While the majority of the prisoners in this evaluation gave up their substance use in prison, and many were free of prescribed drugs, their very frequent relapse on release showed the importance of other factors in their lives: most importantly, accommodation, relationships and employment.

Possible ways forward

One logical response to this conflict between recovery and custody is to reduce the incarceration rate of addicted offenders. While there is a considerable history of attempts to do exactly that, through referral of substance misusing offenders to drug treatment at the arrest and sentencing stage, there may be a need to revisit this agenda and identify integrated treatment approaches that can successfully reduce substance misuse and offending among this group. Nevertheless, however

successful such approaches may be, substantial numbers of substance-misusing offenders will continue to be imprisoned.

For those that are imprisoned, one implication of this evaluation is that prison recovery models might adhere more closely to the principles of their community-based counterparts. Tailoring interventions to service users' recovery capital is an essential part of assessments for, and triage of, drug-related needs in community services. It is highly unlikely, for example, that a community-based drug worker would refer a homeless heroin user with serious mental illness to an ambitious abstinence-focused treatment programme: identifying secure accommodation and achieving a measure of stability in their lives would be the initial aims of low-threshold engagement. However, if this same person is imprisoned, their homelessness can effectively be obscured by their residence in a prison cell. This provides the potential for ambitious, abstinence-focused treatment to be delivered to people who will be released with nothing more than a release grant, and a chance of finding a dry doorstep at night, or a temporary bed in a night hostel: a situation that occurred quite commonly in this study. This argues for prison assessments, triages and interventions which take much greater account of the access individuals have to recovery resources in the outside world, and limiting ambitious abstinence- and detox- focused interventions to those who have robust recovery capital (histories of employment, stable and secure housing, family support, etc.). For those with more depleted recovery capital, there is a need for combining harm reduction approaches with much more ambitious resettlement support.

Whatever the level of support on release, for many, it will remain an abrupt, emotionally intense, and risky moment in their lives. There therefore seems considerable merit in graduating the reintroduction of prisoners with substance misuse histories into the community. Release on Temporary License or ROTL allows prisoners to be released temporarily into the community for specific purposes, such as employment. However, use of ROTL has declined quite dramatically in recent years (Strickland and Allen, 2016) and none of our process sample had been on ROTL when interviewed shortly before release. Looking to the future, the White Paper *Prison Safety and Reform* includes a strong focus on devolving operational policies, such as the use of ROTL, to prison governors. There may therefore be scope for prisoners on DRW-style programmes where prisoners have shown a strong intention to make changes to their lives on release, to be granted ROTL, and begin working in the community prior to release.

While it is clear that recovery capital tends to diminish within prison, there is worth in trying to minimise this. One way to try to reduce damage to relationships with loved ones is to provide frequent family visits. Recent work drawing on the SPCR survey has shown how such visits are associated with improved family relations and a decreased likelihood of reconviction (Brunton-Smith and McCarthy, 2017). Specialist prison units that are explicitly focused on drug recovery will need to consider whether they are able to increase the number of such visits. The Holme House DRW had a strong focus on family contact (Lloyd *et al.*, 2014) and this was reflected in MQPL responses, with DRW residents rating much higher than other prisoners on the 'conditions and family contact' factor (see above Chapter 5, Table 5.4). Another approach operating in HMP Brixton was a Family Support Worker (FSW), who covered the prison as a whole, including the DRW. FSW functions include providing advice about family visit procedures, acting as a conduit for information between families and prisoners, and providing emotional support (Boswell *et al.*, 2010). An evaluation of pilot FSWs in four English prisons found positive results in terms of the number of contacts and views expressed in

interviews with prisoners (Boswell *et al.*, 2010). Elsewhere, specialist family support or recovery workers have been funded by local NHS commissioners to work specifically with prisoners with substance misuse problems. Again, specialist drug treatment units should consider how such provision might be enhanced.

With regard to the nature and structure of drug treatment regimes in prison, the *Prison Safety and Reform* agenda may provide opportunities to experiment with different approaches. One model that we regard as worthy of exploration is a whole-prison approach. Eight prisons operating in England and Wales are now sex offender-only prisons. Some of the issues relating to imprisoned sex offenders, such as high levels of stigmatisation, low self-esteem and the need for therapeutic input, also relate to imprisoned substance misusers. Insofar as DRWs have struggled to maintain their therapeutic regime within a largely unsympathetic prison environment, there seems potential in considering specialist facilities for recovering substance misusing prisoners. The evaluation evidence from the Sheridan Correctional Centre (SCC) in Illinois USA (Olson and Lurigio, 2014, see Chapter 2) is promising. A whole prison approach could allow a full range of interventions to be delivered economically, including end-to-end treatment pathways. There would also be scope for such models to create enhanced positions for peers, providing 'role models' for prisoners situated earlier in the treatment pathway.

Particular issues relate to opioid-using prisoners who choose (or are persuaded) to detoxify in prison. Given the strong evidence for the effectiveness of continuous OST on release in preventing overdose deaths, there are strong arguments in favour of resuming substitute medication prior to release where there is any likelihood of relapse. However, some of the prisoners in our sample expressed a strong desire to detoxify and to leave prison without a prescription: a finding replicated in a recent qualitative study from Australia (Larney *et al.*, 2016). Some of our process sample had simply 'had enough' of their opiate addiction and associated lifestyle, and saw their prison sentence as a chance to cease all use. In such circumstances, there is a strong imperative to provide the sort of intensive treatment and through-care we have discussed above, coupled with the provision of naloxone. For those wishing to detoxify from all opioids, the much higher level of support envisaged in such an environment (and, all importantly, on graduated release), would offer some protection against the real risk of relapse and overdose.

These are all complex and challenging issues that are touched on here with a view to engendering a wider debate. Nevertheless, at a time where there have been renewed calls for prisons to focus on reform, there is a pressing need to develop new ways to foster support for transformational change in substance-dependent prisoners' lives through support and preparation in prison, and most importantly, through intensive support on release. Such an approach would be associated with considerable new costs, but if effective, these should be dwarfed by the savings associated with reductions in reoffending and reimprisonment.

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Appendix 1: Data on DRW regimes

Table A.1.1: Summary data on DRWs

		Beds	No. clients at rapid assessment	% lodgers	Hours of structured intervention per week per prisoner	DRW regime segregated from main jail?
Brinsford	YOI	32	27	16%	<1	No
Bristol	Cat B	140	140	0%	<1	Yes
Brixton	Cat C/D	60	40	33%	5	Yes
Chelmsford	Cat B	132	132	0%	<1	No
High Down						
DRW	Cat B	90	60	33%	<1	Yes
High Down						
Bridge cohort		90	12	87%	36	
Holme House	Cat B	70	50	29%	<1	Yes
Manchester	Cat A	20	20	0%	20	Yes
New Hall	Women's	20	11	45%	9	Yes
Styal	Women's	20	7	65%	10	No
Swansea	Cat B	49	49	0%	6	Yes

Table A.1.2 Throughcare and aftercare provision identified in DRW Pilot Sites during rapid assessment fieldwork

	Provision <i>within</i> DRW	Score	Continuation plans and links	Score
Brinsford	1.5 mutual aid groups per week 1 'relaxation group' per week Psychosocial office based on wing Weekly chats / 1-1s with psychosocial workers	Low	Release plans signpost (rather than refer) No 3-way appointments pre-release No prison gates pick-ups No links with community services	Low
Bristol	Psychosocial 1-1s (optional), no groups running during Rapid Assessment Some employment support (available to all wings) Access to a DRW-specific astroturf pitch Prisoners paid to be on DRW	Low	Well-regarded links with housing services Drug-free wing existed; minimal progression from DRW	Low
Brixton	25 timetabled activities per week 2 mutual aid groups DRW Family Support Worker Yoga and acupuncture sessions Weekly community meeting attended by all staff and prisoners Employment support on-wing	High	7-day release timetable provided for all prisoners, detailing daily actions Protocol being developed with 5 local DIP teams Weekly housing surgery Family support worker available (prison-wide)	High
Chelmsford	Additional gym Psychosocial and clinical team based on wing Morning psychosocial drop-in service 'Recovery worker' post	Low	Strategic links with North Essex drug and alcohol services 'Inside out' psychosocial team, provided some continuity of care	Med
High Down	6-week, full-time, highly praised RAPt programme, capacity 12 prisoners 'Building Skills to Recovery' programme 2 dedicated 'recovery officers' on wing staff Enhanced wing, single cells, 'courtesy keys' to cell doors for prisoners. Ongoing 'aftercare' on wing, with additional time unlocked	High	Key-carrying 'link workers' from 5 local DIP teams, receiving 85% of released prisoners Excellent links with a 6-month move-on RAPt programme at Coldingley (Cat C) St Giles Trust active (and employing prisoners as 'housing peers') Blue Skies employment actively working with DRW clients; some apparent success	High
Holme House	Modelled on Holme House's Therapeutic Community (based on the same houseblock) Rolling 'induction programme': 5 * 1-hour groups	High	Tight links with IOM teams from Holme House's four main release areas DRW identified as, originally, a <i>resettlement-focused initiative</i>	High

	<p>One hour of 'smart recovery' each week</p> <p>Prisoners paid to be on wing, and unlocked during the day if unemployed</p> <p>Weekly recovery-focused one-to-ones with personal officers</p> <p>Dedicated gym sessions</p> <p>6-week DRW-specific healthy-living cookery courses (8 prisoners at one time)</p>		<p>4 IOM 'link worker' officers, working in prison and community.</p> <p>Potential progression to Therapeutic Community (little used during RA)</p>	
Manchester	<p>8-week intensive induction programme, involving 7-14 groups per week</p> <p>2nd stage programme involving approximately 6 groupwork sessions per week</p> <p>Daily diaries submitted weekly to key workers</p> <p>Weekly 1-1s with recovery workers</p> <p>Addaction peer mentoring training, with potential to progress to NVQ L2</p> <p>Victim awareness groups</p> <p>SMART recovery groups</p> <p>Aspirations to Therapeutic Community working model</p> <p>Dedicated gym</p> <p>Dedicated server</p> <p>Partnership with Partners of Prisoners group</p>	High	<p>'Resettlement Through the Gates,' a nationally recognised aftercare initiative</p> <p>13 weeks of aftercare from RTG POs in a dedicated community setting</p> <p>Established partnerships with education and employment initiatives</p> <p>Established partnerships with drug and alcohol services</p> <p>Accompaniment to all 1st appointments offered to released prisoners</p>	High
New Hall	<p>3 groups per week</p> <p>5 'morning meetings,' 1 peer support session per week</p> <p>Detoxification encouraged and supported on-wing</p> <p>Acupuncture</p> <p>Additional gym</p> <p>Cookery sessions</p>	High	<p>No structured release provision or support</p> <p>Askham Grange seen as a possible referral for one woman on DRW</p>	Low
Styal	<p>'Therapeutic community' type environment</p> <p>4 'morning meetings,' 1 'community meeting,' and 2 'community evenings' per week</p> <p>Drug-focused or resettlement activities 5 mornings per week</p> <p>Additional gym</p> <p>Recovery rules' and a 'conflict management system'</p>	High	<p>No exit plan' for women on the wing, leading to 'bed blocking.'</p>	Low
Swansea	<p>Up to four groups led by prison officers each week (capacity 8)</p> <p>Up to two 2-hour groups led by outside drug services each week (capacity 12)</p>	Med	<p>Drug free wing envisaged as move-on point within prison</p> <p>Psychosocial team working in the community, supporting continuity of care</p>	Med

Education or employment off the wing forbidden, leading to many hours' 'bang up'
Prisoners paid for being on DRW



Positive uptake of referrals / attendance noted by community drug team



Appendix 2: MQPL data

The following notation is use in all of the following tables: † < 0.1; * < 0.05; ** < 0.01; *** < 0.001

Brixton MQPL subscale scores

All Subscales	DRW	Other Wing	Difference between means
Entry into custody	2.22	2.51	-0.29
Respect / courtesy	2.83	2.68	0.15
Relationships	2.70	2.55	0.15
Humanity	2.50	2.55	-0.05
Decency	2.53	2.36	0.17
Care for the Vulnerable	3.06	2.87	0.19
Help and Assistance	2.86	2.70	0.16
Staff professionalism	2.55	2.57	-0.02
Bureaucratic legitimacy	2.39	2.27	0.12
Fairness	2.26	2.27	-0.01
Organisation/ consistency	1.94	2.05	-0.11
Policing and security	2.88	2.95	-0.07
Prisoner safety	3.44	3.23	0.21
Prisoner adaptation	3.58	3.37	0.21
Drugs and exploitation	2.77	2.89	-0.12
Conditions	3.28	3.12	0.16
Family contact	2.98	2.96	0.02
Personal development	2.41	2.38	0.03
Personal autonomy	2.72	2.72	0.00
Wellbeing	2.31	2.21	0.10
Distress	3.64	3.43	0.21

Chelmsford MQPL subscale scores

	DRW	Other Wing	Difference between means
Entry into custody	2.90	2.84	0.06
Respect / courtesy	3.56	3.29	0.27
Relationships	3.46	3.22	0.24
Humanity	3.34	3.13	0.21
Decency	2.88	2.88	0.00
Care for the Vulnerable	3.4	3.20	0.20
Help and Assistance	3.48	3.15	0.33*
Staff professionalism	3.60	3.30	0.30**
Bureaucratic legitimacy	2.70	2.63	0.07
Fairness	3.06	2.84	0.22
Organisation/consistency	2.95	2.86	0.09
Policing and security	2.99	3.18	-0.19
Prisoner safety	3.17	3.40	-0.23
Prisoner adaptation	3.04	3.41	-0.37 †
Drugs and exploitation	2.72	2.99	-0.27
Conditions	3.5	3.56	-0.06
Family contact	3.31	3.07	0.24
Personal development	3.19	2.98	0.21
Personal autonomy	3.07	3.00	0.07
Wellbeing	2.89	2.74	0.15
Distress	3.05	3.34	-0.29

High Down

	DRW	Other Wing	Difference between means
Entry into custody	2.16	2.35	-0.19
Respect / courtesy	2.90	2.79	0.11
Relationships	2.78	2.66	0.12
Humanity	2.52	2.55	-0.03
Decency	2.44	2.27	0.17
Care for the Vulnerable	3.00	2.94	0.06
Help and Assistance	2.77	2.74	0.03
Staff professionalism	2.81	2.71	0.10
Bureaucratic legitimacy	2.46	2.32	0.14
Fairness	2.40	2.30	0.10
Organisation/consistency	2.17	2.06	0.11
Policing and security	2.92	3	-0.08
Prisoner safety	3.30	3.27	0.03
Prisoner adaptation	3.11	3.31	-0.20
Drugs and exploitation	2.94	2.93	0.01
Conditions	2.82	2.81	0.01
Family contact	2.92	2.81	0.11
Personal development	2.40	2.22	0.18
Personal autonomy	2.63	2.44	0.19
Wellbeing	2.16	2.37	-0.21
Distress	2.98	3.33	-0.35

Holme House

	DRW	Other Wing	Difference between means
Entry into custody	2.73	2.62	0.11
Respect / courtesy	2.93	3.11	-0.18
Relationships	2.81	2.98	-0.17
Humanity	2.83	2.85	-0.02
Decency	2.67	2.62	0.05
Care for the Vulnerable	3.03	3.17	-0.14
Help and Assistance	3.12	2.93	0.19
Staff professionalism	3.11	3.26	-0.15
Bureaucratic legitimacy	2.66	2.65	0.01
Fairness	2.63	2.69	-0.06
Organisation/consistency	2.7	2.61	0.09
Policing and security	3.1	3.24	-0.14
Prisoner safety	3.23	3.46	-0.23
Prisoner adaptation	2.98	3.26	-0.28
Drugs and exploitation	2.57	2.89	-0.32
Conditions	3.40	3.04	0.36 †
Family contact	3.72	3.07	0.65***
Personal development	2.91	2.78	0.13
Personal autonomy	2.94	2.87	0.07
Wellbeing	2.9	2.58	0.32 †
Distress	3.32	3.47	-0.15

Manchester

	DRW	Other Wing	Difference between means
Entry into custody	3.37	2.93	0.44*
Respect / courtesy	3.59	3.23	0.36
Relationships	3.40	3.15	0.25
Humanity	3.42	3.03	0.39
Decency	3.29	2.73	0.56**
Care for the Vulnerable	3.36	3.23	0.13
Help and Assistance	3.77	3.18	0.59***
Staff professionalism	3.75	3.41	0.34*
Bureaucratic legitimacy	2.94	2.52	0.42*
Fairness	2.95	2.81	0.14
Organisation/consistency	3.30	2.87	0.43 †
Policing and security	3.48	3.47	0.01
Prisoner safety	3.78	3.4	0.38 †
Prisoner adaptation	3.57	3.5	0.07
Drugs and exploitation	2.71	3.07	-0.36
Conditions	4.06	3.48	0.58*
Family contact	3.42	3.2	0.22
Personal development	3.81	2.86	0.95***
Personal autonomy	3.14	2.78	0.36
Wellbeing	2.94	2.62	0.32
Distress	3.31	3.37	-0.06

New Hall

	DRW	Other Wing	Difference between means
Entry into custody	2.8	2.83	-0.03
Respect / courtesy	3.06	3.34	-0.28
Relationships	3.14	3.25	-0.11
Humanity	2.93	3.26	-0.33 †
Decency	2.51	2.87	-0.36
Care for the Vulnerable	3.17	3.26	-0.09
Help and Assistance	2.86	3.21	-0.35
Staff professionalism	3.24	3.30	-0.06
Bureaucratic legitimacy	2.23	2.71	-0.48 †
Fairness	2.71	2.86	-0.15
Organisation/consistency	1.97	2.84	-0.87**
Policing and security	2.81	3.31	-0.50
Prisoner safety	2.69	3.48	-0.79**
Prisoner adaptation	2.76	3.33	-0.57 †
Drugs and exploitation	2.29	2.84	-0.55 †
Conditions	3.61	3.66	-0.05
Family contact	3.67	3.24	0.43
Personal development	2.78	3.02	-0.24
Personal autonomy	2.69	2.97	-0.28
Wellbeing	1.79	2.86	-1.07**
Distress	2.43	3.04	-0.61

	DRW	Other Wing	Difference between means
Entry into custody	2.75	2.78	-0.03
Respect / courtesy	3.50	3.13	0.37
Relationships	3.44	3.15	0.29
Humanity	3.52	2.99	0.53 †
Decency	3.07	2.92	0.15
Care for the Vulnerable	3.62	3.20	0.42 †
Help and Assistance	3.56	3.19	0.37
Staff professionalism	3.42	3.22	0.20
Bureaucratic legitimacy	3.11	2.64	0.47 †
Fairness	3.06	2.77	0.29
Organisation/consistency	2.87	2.73	0.14
Policing and security	3.21	3.17	0.04
Prisoner safety	3.65	3.37	0.28
Prisoner adaptation	3.58	3.52	0.06
Drugs and exploitation	2.78	2.65	0.13
Conditions	3.98	3.53	0.45 †
Family contact	3.39	3.12	0.27
Personal development	3.64	3.07	0.57*
Personal autonomy	3.56	3.04	0.52 †
Wellbeing	3.33	2.64	0.69*
Distress	3.39	3.10	0.29

Swansea

	DRW	Other Wing	Difference between means
Entry into custody	3.01	2.96	0.05
Respect / courtesy	3.75	3.31	0.44**
Relationships	3.68	3.36	0.32*
Humanity	3.41	3.10	0.31*
Decency	3.05	2.89	0.16
Care for the Vulnerable	3.39	3.30	0.09
Help and Assistance	3.66	3.13	0.53***
Staff professionalism	3.80	3.47	0.33*
Bureaucratic legitimacy	2.85	2.80	0.05
Fairness	3.28	2.92	0.36**
Organisation/consistency	3.18	2.85	0.33**
Policing and security	3.16	3.31	-0.15
Prisoner safety	3.62	3.51	0.11
Prisoner adaptation	2.96	3.23	-0.27
Drugs and exploitation	2.98	3.03	-0.05
Conditions	3.62	3.42	0.20
Family contact	3.37	3.19	0.18
Personal development	3.50	2.95	0.55***
Personal autonomy	3.19	3.00	0.19
Wellbeing	2.90	2.88	0.02
Distress	3.32	3.43	-0.11

Brinsford

	DRW	Other Wing	Difference between means
Entry into custody	2.02	2.73	-0.71***
Respect / courtesy	1.48	2.65	-1.17***
Relationships	1.68	2.76	-1.08***
Humanity	1.65	2.61	-0.96***
Decency	1.50	2.46	-0.96***
Care for the Vulnerable	2.35	3.03	-0.68**
Help and Assistance	1.94	2.93	-0.99***
Staff professionalism	1.93	2.77	-0.84*
Bureaucratic legitimacy	1.95	2.51	-0.56**
Fairness	1.88	2.41	-0.53*
Organisation/consistency	1.65	2.33	-0.68**
Policing and security	3.13	2.90	0.23
Prisoner safety	3.03	3.16	-0.13
Prisoner adaptation	3.67	3.18	0.49
Drugs and exploitation	3.33	2.75	0.58†
Conditions	1.89	3.02	-1.13***
Family contact	2.17	3.14	-0.97**
Personal development	1.91	2.73	-0.82**
Personal autonomy	2.03	2.88	-0.85***
Wellbeing	1.88	2.63	-0.75**
Distress	2.67	3.44	-0.77*

Bristol

All Subscales	DRW	Other Wing	Mean Difference
Entry into custody	2.56	2.64	-0.08
Respect / courtesy	3.18	3.10	0.08
Relationships	3.09	2.99	0.10
Humanity	2.89	2.84	0.05
Decency	2.55	2.64	-0.09
Care for the Vulnerable	3.14	2.92	0.18
Help and Assistance	3.01	2.78	0.23
Staff professionalism	3.15	3.06	0.09
Bureaucratic legitimacy	2.74	2.50	0.24
Fairness	2.77	2.59	0.18
Organisation and consistency	2.61	2.36	0.25
Policing and security	3.20	3.03	0.17
Prisoner safety	3.37	3.27	0.10
Prisoner adaptation	3.15	3.06	0.09
Drugs and exploitation	2.77	2.77	0.00
Conditions	3.22	3.13	0.09
Family contact	3.54	3.06	0.48*
Personal development	2.65	2.58	0.07
Personal autonomy	2.79	2.76	0.03
Wellbeing	2.40	2.56	-0.16
Distress	2.84	3.30	-0.46**

Appendix 3: Cost of crime calculations

Home Office Research Study (HORS) 217 (Home Office 2000) uses the terms “economic cost” and “social cost” to mean to full impact of crime on society, to individuals, households, businesses and institutions, and include “financial” impacts of crime and a “notional” value for impacts which are not fully or directly reflected in the financial consequences of crime - such as trauma and physical injury.

Economists often divide crime costs by “economic” and “social” costs. Economic costs are financial costs that can be expressed in monetary values. Social costs are the impacts on society that cannot be immediately expressed in money values.

HORS 217 notes that the distinction creates difficulties with estimation rather than real differences. If we measure the economic cost of crime in terms only of those costs that are already expressed in money terms we would exclude important impacts for example with robbery or violence against the person we would value the crime much less seriously than in reality whilst other crimes would appear relatively more serious.

The values from HORS217 used in this report treat the economic and the social costs of crime as one and the same, as it is argued that by just including costs which are easiest to measure often means excluding some of the most important costs (victim costs)

Crime costs used in the current study include the full impacts of crime. Costs are incurred in anticipation of crimes occurring (such as security expenditure and insurance administration costs), as a consequence of criminal events (such as property stolen and damaged, emotional and physical impacts and health services), and responding to crime and tackling criminals (costs to the criminal justice system).

Costs are derived from surveys of victims, including the British Crime Survey and Commercial Victimization Survey, and industry turnover and cost estimates, such as the security and insurance industries. Resource cost estimates for the CJS are derived from a Home Office model which track flows and costs through the CJS system. Emotional and physical impacts of crime are calculated ted using monetary values derived from individuals’ willingness to pay to avoid road traffic accidents.