Evaluation of the Drug Recovery Wing Pilots: Scoping and Feasibility Report

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Full Site Reports

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Structure of this Report

This report has three main sections.

The first section provides an overview of work carried out to date. Brief synopses of rapid assessment findings are presented thematically, and by site. (More detailed reports of site-specific findings are in Appendices 2-11 – see below).

The second section provides a description of the process and impact evaluations that will be carried out during phase two of this research, along with a considered rationale for phase two site selection.

The third section comprises Appendices 2-11, which hold full site reports arising from rapid assessment fieldwork carried out between March and May 2013.

Introduction

The idea of Drug Recovery Wings was introduced thus by the Green Paper, *Breaking the Cycle* (Ministry of Justice, 2010):

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.

The plan to pilot Drug Recovery Wings (DRWs) was likewise highlighted in the Government's 2010 Drug Strategy (HM Government, 2010):

We will pilot wing-based, abstinence focused, drug recovery services in prisons for adults (drug recovery wings)...'

The DRWs were funded by the Department of Health but reflected a cross-departmental programme of work, involving NOMS and the NTA (as was). The implementation of the pilot DRWs was conducted in two distinct phases: the first tranche DRWs were launched in June 2011 and were intended to focus on short term prisoners (between three and 12 months) within Category A[1] or Category B men's prisons. The second tranche DRWs, launched in April 2012, focused on longer term prisoners and included two women's prisons and a Young Offender Institution (YOI). The criteria for the first tranche were later changed to include remand prisoners and those serving longer sentences but in their last year of sentence.

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 evaluation team comprises researchers from the University of York, Centre for Drug Misuse Research in Glasgow, and the Institute of Criminology at the University of Cambridge. The research comprises a number of component parts. The first stage of the research involved an initial rapid assessment and appraisal of the Drug Recovery Wings participating in the Drug Recovery Wing Pilot Programme. This is to be followed by qualitative research involving one-off interviews with prisoners and staff in selected Drug Recovery Wings. In addition the research team will undertake a small number of repeat qualitative interviews with a cohort of prisoners who will be followed up post their release. Structured interviews will be carried out with a sample of prisoners on their reception into a Drug Recovery Wing. These individuals will be re-interviewed just prior to their departure from the drug recovery wing

[1] The only DRW in a High Security Prison (Manchester) is not located in the high security part of the

and then at six months following their release.[2] Qualitative interviews will also be undertaken with a range of service providers within the communities to which prisoners are being released. The research team will also draw upon data from use of the University of Cambridge "Measurement of the Quality of Prison Life" (MQPL) instrument, which has been widely adopted throughout the prison service, to provide information on the functioning of the five Drug Recovery Wing prisons. Finally, the research team will draw upon data from a range of existing data-bases (National Drug Treatment Monitoring System, P.NOMIS, OASys, and the Police National Computer) to compare the rate of d reoffending of those prisoners participating within a Drug Recovery Wing and those receiving standard prison drug and alcohol treatment.

The aims of the present evaluation are to provide a detailed description of the operation of individual Drug Recovery Wings and to assess the degree to which participation within a Drug Recovery wing facilitates individual prisoner's recovery and rehabilitation during their period within the recovery wing and on release into the wider community. Both the research and the Drug Recovery Wing programme are part of the UK Government's commitment to ensure that prisoners are being helped to recover from their substance dependency as a route to reducing their offending.

The contract for the evaluation was awarded in December 2011. Following appropriate approval from the University of York Ethics Committee and the NOMS National Research Committee, the research team undertook the rapid assessment and appraisal work in all ten pilot DRWs. Alongside this work an ethics application was submitted (and approved in July 2013) from the COREC covering the other elements of the evaluation. The present scoping and feasibility report summarises both the results of the rapid assessment work undertaken and the case for focussing the remaining components of the evaluation on a reduced number of selected Drug Recovery Wings. Our original research proposal suggested focussing the second stage of the evaluation on five prisons; on the basis of the rapid assessment work we have undertaken we are now suggesting a modification to that proposal which would include extending the evaluation to an additional two prisons.

It will be helpful as an introduction to this scoping and feasibility report to recount our reasons for structuring the evaluation in the way that we have. On the face of it the most obvious approach to evaluating the Drug Recovery Wing pilots would have been to carry out a systematic comparison of samples of prisoners randomly allocated to either a Drug Recovery Wing or standard prison drug and alcohol treatment provision. For two key reasons such an approach was judged to not be feasible. First, it was apparent from the tendering documents for the research that there was no single Drug Recovery Wing model

[22] Signed consent will be sought for approach for initial and subsequent interviews at the first point of contact. Regular contact will be maintained with DRW staff to monitor prisoners' progress and release dates. Discussions conducted with DRW staff during the rapid assessment have reassured the research team that this is a realistic strategy.

against which to compare standard prison drug and alcohol provision. Rather, prisons participating within the Drug Recovery Wing pilot programme were encouraged to develop their own model of a Drug Recovery Wing reflecting their own local circumstances and the nature of the wider prison within which the Recovery Wing would be nested. Second, from the background material provided along with the tendering documents it was apparent that selection rates and processes for Drug Recovery Wings were variable, making it impossible to develop a random allocation of prisoners into the wings. As an alternative to the gold standard of a controlled randomised evaluation we developed the approach of combining both quantitative and qualitative methods in evaluating prisoner progress within Drug Recovery Wings and on release from the recovery wings. Through this combination we felt it would be possible to compare and contrast across the recovery wings and generate knowledge and understanding that would assist the further development of Drug Recovery Wings within the wider prison estate. By following prisoners for six months post-release we would also have an opportunity to identify the degree to which progress in recovery achieved during the prisoners participation within the recovery wing was being maintained following release. Progress will be defined here in terms of the goals of each individual DRW, the goals of the individual drug users interviewed and the goals as set out by the Government in announcing the Drug Recovery Wing pilots (these were to reduce drug use and re-offending by offenders, to improve offenders' health/well-being, employment outcomes and housing outcomes). Finally, by drawing upon some of the data within the existing prisoner monitoring systems we felt that it would be possible to compare the recovery and offending behaviour of a sample of prisoners who had received Drug Recovery Wing support with those who had received only standard prison drug and alcohol treatment - thereby providing a dilute comparison group for the evaluation, at least.

In the remainder of this scoping and feasibility report we cover the following areas. First we provide a detailed description of each of the Drug Recovery Wings within which we have been working in the initial rapid assessment phase of the research. This is followed by a discussion of the early and provisional findings from the rapid assessment shedding light on a number of themes that were common across recovery wings. We then focus on the criteria for selecting those Drug Recovery Wings that will form the basis of the more intensive process and impact evaluation within the second stage of our evaluation. On the basis of this discussion we outline our preferred list of recovery wings for this more intensive evaluation. Finally we outline the further qualitative research that will form a component of the second stage of the evaluation.

The Rapid Assessment

While some initial delays were encountered in obtaining security clearance to access pilot site prisons, policy contacts in NOMS Headquarters have been very supportive of the research and fieldwork commenced on the 18 March, representing a very short lead-in time for a prison-based research project of this sort. In order to ensure rapid coverage of the ten pilot DRWs, five researchers worked on this element, including two experienced researchers from outside the core team. Since 18 March, 199 semi-structured, detailed interviews have been undertaken across the ten DRWs[3] (see Table 1). A pragmatic approach was taken to the prisoner interviews: in most cases, staff assessed which prisoners would be on the DRW at the time of the fieldwork and asked them if they were happy to take part. With regard to the staff interviews, those most involved with the DRW were approached for interview and in most cases, the Prison Governor.

Table 1
Interviews conducted in the 10 pilot DRWs

Prison	Prisoners Interviewed	Staff interviewed
Manchester	13	9
Chelmsford	9	13
High Down	15	10
Holme House	11	14
Brixton	9	10
Swansea	9	7
Bristol	10	10
Styal	10	7
New Hall	6	7
Brinsford	10	10
Totals	102	97

Initial Findings

Rapid assessment methodologies have been applied across a wide variety of disciplines and subject areas, including the drug field (Stimson et al., 2006). They are ideal for providing reliable, broadly descriptive accounts of the operation of projects and programmes in a short period of time. This work has yielded a very rich set of data about the DRWs and the

[3] Askham Grange was originally listed as a separate, discrete pilot DRW in the Department of Health's invitation to tender documents but has formed a 'cluster' model with New Hall, offering a recovery pathway for prisoners arriving from New Hall. The Rapid Assessment therefore focused on New Hall. For further information see the New Hall section that follows.

experiences and impressions of the prisoners and staff involved. These interviews have been supplemented with field notes summarising observations of the context and the operation of these programmes, the conditions within the DRWs and the wider prison environments in which they are located. While it had been hoped to draw on data-sets collected by the DRWs as part of the rapid assessment, no standardised data collection appeared to have taken place, with DRWs varying widely in the type of information collected.

Given the recentness of the rapid assessment fieldwork, only an initial, provisional account can be offered here, drawing on field notes and a very brief, thematic analysis of interview data.

Overview of the 10 DRWs

Manchester

The Recovery Through the Gate (RTG) project offers a three-stage recovery programme consisting of the following elements:

1. An intensive, compulsory eight-week programme on entry to the DRW, including life skills, victim awareness, Outcome Star, the SMART (Self Management and Recovery Training) recovery programme, Alcoholics Anonymous, Narcotics Anonymous, Partners of Prisoners and Family Support Group (POPs) and healthy mind and body. A weekly schedule for each prisoner is provided every Monday morning.
2. Attending education or employment; or working as a peer mentor.
3. On release, at least 13 weeks of support in the community.

The RTG is a comparatively small and separate DRW with 22 beds, of which 18 were occupied at the time of the research (including two peer mentors and two cleaners). As well as the intensive initial programme, there are weekly one-to-one meetings with key workers and weekly whole wing 'Our Time' meetings, where issues can be discussed. There is a strong therapeutic community flavour to the RTG, reflected in rules surrounding detoxification, the intensive programme and support, peer mentoring and expectation that prisoners may stay on the wing until release.

A key characteristic of Manchester's DRW is the relative physical isolation of the RTG project on the ground floor of H Wing. Once serving as a segregation wing, H1 has a solid ceiling, preventing communication with upper floors but also limiting natural light, resulting in a somewhat claustrophobic atmosphere. To access the RTG prisoners have to be abstinent or on a reducing programme that will allow them to complete their detoxification prior to release. This appeared to be implemented, in that four of the seven interviewed opiate

users had detoxed and three were on rapidly reducing methadone doses. However, perhaps the defining characteristic of RTG, as its name suggests, was the work done 'through the gate': in preparation for and on release. Interviewed prisoners referred to the importance of the assistance they received with accommodation on release and staff all agreed that this was the strongest part of the programme. On release, ex-prisoners are escorted through the gate by their keyworker either to the Roberts Street drop-in centre or directly into the community. Contacts are made with a range of agencies prior to release, and released prisoners are escorted to their first appointments if requested. This programme of support is continued for a minimum of 13 weeks and includes one to one key-working, advocacy and where necessary accompanying the ex-prisoner to appointments with other agencies involved with the peer support and self-help fellowships.

While the RTG is equipped in a number of respects – including the provision of a highly popular and much-used catering toaster – there was limited scope for exercise, with a small and minimally equipped gym and a small, enmeshed exercise yard, accessed by RTG prisoners for one hour per day. This was one of the very few criticisms made by prisoners, who were otherwise very positive about the programme, including relations with 'recovery staff' working on the wing.

The interviewed sample of prisoners had long histories of problematic substance use ranging from 5 to 33 years. Most were polydrug users, with seven out of ten prisoners[4] on the programme using opiates, four having problems with alcohol and some instances of amphetamine, crack and tranquilliser use. Notably, five of the men had not experienced substance misuse treatment outside the prison environment or engaged with treatment in prison before the RTG:

> I have been into alcohol or substance misuse 25, nearly 30 years. I have been involved with crime or drugs most of my life, me. There's not been any help as such in the past…So I thought this time, rather than just coming in and getting out – same old thing – I'd see what happened [prisoner interview].

> I want to be clean. I have come here to detox myself and get some awareness. I never had no help. I had help I never complied…I want to get off heroin. This is the first time on methadone. [Prisoner interview].

Sentence length varied between three-and-a-half months and two years, with most having between two weeks and seven months left to serve. One prisoner had 13 months left to serve.

[4] A total of 13 men were interviewed, three of which had already been released.

The recovery staff team consisted of five therapeutic staff: four male and one female. The male officers wore a distinctive uniform (polo shirt) and are all keyworkers, working more intensively with the prisoners. Keyworkers delivered group work, one to one sessions and dealt with day-to-day issues. All the officers are employed directly by the prison, had received specialist training, and had previous experience working with substance users.

The RTG was conceived as an intensive programme, run along lines similar to a therapeutic community. With this in mind, a degree of isolation was thought important – hence the eventual siting of the programme in H1 (when first implemented, it had been part of a larger wing within the prison). Staff and prisoners agreed that this improved safety, improved relationships and greatly reduced the availability of drugs on the wing (although involvement in education, employment, visits and other trips off the wing inevitably gave prisoners some opportunities to access drugs).

> There's a degree of safety and support - support from the recovery workers, support from the other prisoners – going with people who are going through the same, they understand. They encourage and support you [prisoner interview].

> You are surrounded by people that want to be clean [prisoner interview].

Prisoners spoke positively about the peer mentors, who attended an accredited programme overseen by Addaction, which they could continue on release to gain a level two or three NVQ.

Brixton

The Brixton DRW is situated within the largest general population wing of the prison, A Wing, and takes up half of each of the top two landings. It is separated from the rest of A Wing by Perspex screens. The DRW has capacity for 60 prisoners but is rarely full of DRW participants, other prisoners being placed on the wing due to accommodation pressures.

The psychosocial programme is delivered by the Rehabilitation for Addicted Prisoners Trust (RAPt) and is wide-ranging, with opportunities to engage in groups in the morning and afternoon on every weekday. The actual programmes delivered appear to have changed since the fieldwork was conducted, with Stepping Stones now being delivered, alongside a range of other sessions such as yoga, Living Safely, Self-Care, Back on Track and acupuncture. Community meetings involving prisoners and staff are also held each week on the wing and were appreciated by interviewees. Indeed, some felt that the sense of *community* was more important than the individual programme components:

> …the real therapy happens in actually being in a community…getting a sense of community on a DRW is important. [Staff interview]

Prisoners also recognised the different atmosphere on the wing:

> …as far as the DRW is concerned I think it is quite different from the rest of the prison…it's a kind of contained, it's a lot more personal to a certain degree, the officers are familiar with the inmates and again it is a nurturing environment… [prisoner interview]

The staff team consists of two dedicated prison officers, who volunteered to work on the DRW and have received training; and a team of six RAPt substance misuse workers. The importance of having dedicated, trained prison officers working on the DRW was emphasised. It was thought to be problematic when other officers were brought onto the wing for cover:

> When we don't have dedicated staff, when we have general Wing staff that doesn't work as well at all, it's really problematic… I think they're not committed to the ethos and the mentality of the Wing really…. [staff interview]

The eight current prisoners interviewed[5] were serving sentences of between 10 months and four years and some had spent long periods on the DRW: up to 13 months. Surprisingly, some of those interviewed did not seem to have had current drug or alcohol problems on admission. Others had had problems with alcohol, cannabis, crack and heroin. However, this group was notable in not including many opiate users. The DRW lead identified that seven (of 53) DRW residents had histories of heroin dependence in July 2013.

Staff and prisoners generally agreed that the DRW should be an isolated and self-contained unit, segregated from the rest of the prison but that this was hard to achieve in Brixton for a number of reasons. First, prisoners can communicate though the Perspex screen separating the DRW from the rest of A wing; second, there is shared access to food, medication and laundry; and third, prisoners had to access work, employment, medical care and other services elsewhere in the prison. According to one member of staff:

> Unless it can be a completely separate unit which has control over its own numbers it will never be as it ought to be, that's a structural issue [staff interview].

Another structural issue was the mix of DRW and non-DRW prisoners on the DRW, which was considered by one member of staff to be its 'Achilles heel'. Prisoners found this frustrating:

[5] Eight prisoners and one ex-prisoner were interviewed in total.

> There's so many people on this Wing that are not on any sort of drug recovery it's a joke... [prisoner interview]

A prisoner suggested that only a third to a half of the DRW was taken up by prisoners committed to drug recovery.

Further challenges to the operation of the DRW at Brixton came from wider changes affecting the prison. In 2012 HMP Brixton was re-roled as a Category C prison, taking Category C and D prisoners. A number of the interviewed prisoners were frustrated with the regime at Brixton:

> I was told I was being moved here from my previous prison on a progressive move, well if this is progressive, it knocks the wind out of me... this is absolutely appalling... If I could go tomorrow I would go [prisoner interview].

Prisoners also spoke about the general conditions within the wing (and the wider prison):

> ....you're living in the toilet basically, you eat in the toilet, you sleep in the toilet [prisoner interview].

These structural issues affected the prisoners on the DRW, as they presumably affected prisoners elsewhere in the prison.

Bristol

The DRW at Bristol comprises C Wing, the largest wing in the prison. There is also a Drug Free Wing (DFW) in Bristol's B Wing. C wing consists of three landings and a ground floor. The top floor, C3, is the highly segregated detoxification and stabilisation unit, with capacity to hold 42 prisoners. Most of the prisoners coming into C wing arrive on C3, having tested positive for drugs at reception. There are no other selection criteria. Some other prisoners arrive on the wing from other areas of the prison, on request or following relapse. During their time on C3, prisoners are kept separate from the rest of C Wing, having its own medication hatch, telephone and servery. Following stabilisation/detoxification, prisoners usually move from C3 to C1, where they are expected to engage with psychosocial support, and from there to C2, from where they are engaged in employment projects around the prison. On completing the programme, prisoners could be released into the community, transfer to the DFW, or transfer to another wing. The DFW took prisoners from all of Bristol's wings.

All prisoners sign a compact, covering drug testing and adherence to the DRW rules. However there is no mandatory attendance at groups or other psychosocial support. Still, group attendance and participation are incentivised: prisoners are paid to be on the DRW, and for the courses they complete.

Prisoner views on the courses and support available were mixed and staff also recognised that psychosocial support on the wing needed to be improved. There were plans afoot at the time of the fieldwork to introduce a new programme. The DRW and DFW had sole access to an Astroturf pitch and a Sports and Games team. The strong focus on physical activity was thought by staff to decrease stress and assaults and increase confidence, self-esteem and bonding between prisoners and some prisoners also referred to the way that this access contributed to a good atmosphere on the wing.

A strong theme in the staff interviews was the provision of opportunities and the motivation of prisoners to take these up. Groups and support were voluntary and it was therefore up to the individual prisoner whether or not he wished to address his drug use and move towards recovery:

> You make of it what you want when you come to prison... if you want to do it, you do it, if not, you don't do it... It's down to the individual at the end of the day... [prisoner interview]

> It's a good wing if people want to recover from drugs and get their head down but it depends if they want to use it to their advantage [prisoner]

However, for the majority, stabilisation and substitute reduction rather than recovery was the goal. Several prisoners were concerned with the prison service policy that prisoners should move to abstinence if serving a sentence of six months or more. Given that treatment was provided by the NHS, they felt that they should be allowed to stay on substitute medication for as long as they wished.

Interviewed prisoners were serving sentences of between 18 months and 4 years. The DRW is staffed by a mixed team comprised of prison service discipline officers, the substance misuse team and the clinical team. The substance misuse team consisted of 15 workers, covering the whole prison, including C wing; and the clinical team consisted of 20 staff, including nurses, healthcare assistants and GP support. Specialist prison officer posts included the relapse team, housing, sports and games and supply reduction. These services cover other areas of the prison but are located on C wing and provide a specific service to C wing.

Prisoners were generally positive about the regime and conditions on the wing. Most thought it was quieter and calmer than elsewhere; and cells were thought to be an adequate size. The large degree of separation from the rest of the prison was also thought of as a positive, in part because one was surrounded by other prisoners with similar problems:

> There are a lot of people in your boat.... [You can] feel more comfortable in your surroundings [prisoner interview].

A specialist relapse team was described as an important part of the DRW integrated team, having won national awards for its work. Relapse on the wing did not necessarily result in dismissal: rather, work was intensified to get prisoners 'back on track'. With regard to through the gate services, a part-time Housing Officer and the links he had made with community services was thought to have increased the likelihood of prisoners finding accommodation on release. However, staff were keen to further improve this service and provide more intensive support on release, similar to Manchester's RTG.

The main aim of the Bristol DRW therefore appeared to be to take on all the prisoners with drug problems, stabilise them, give them the opportunity to move towards recovery, and return them to general accommodation. This prevented other wings having to deal with 'needy' and chaotic prisoners.

> We take everyone with a drug issue. We contain them here, which means their issues aren't spilling out in the other units... When [other officers] receive them on [another] wing, they're getting a better prisoner, he's stable, he's maintained, he's healthier, he's organised now and he can move on... [staff interview].

With regard to the future, there was the feeling that wider changes in the prison system and limited internal support had already undermined the DRW and was likely to further undermine it in the future.

> ...it's a bit of a shame really that you've come at the end of what has always been a really successful pilot site... it's been nationally rewarded and it's just a shame that at the end of it we're struggling a little bit if I'm honest [staff interview].

> They've brought this business development group in to get rid of staff. These people need support. They need IDTS. They need medication and I think it's just going to dwindle out… I can see it going back to the old days [staff interview].

> … I just think it's a shame that it's all going to be risked because of cost.... I think if this disintegrates it will be a disservice for the prison and for the community... I think the prison will become a less safe place and the community will see the impact with regards to an increase in offending [staff interview].

High Down

The DRW at High Down is positioned on the A spur of Houseblock 5. While there are 90 beds on this spur, at the time of fieldwork, 60 were occupied by DRW prisoners, the rest the beds being equally divided between trusted workers and high risk prisoners placed there because of the single cell accommodation. This level of occupancy at the time of our visit was considered by interviewees to be representative.

Following assessment and induction, those prisoners with ongoing need for high dose methadone or Subutex[6] were housed in Houseblock 6, the 'stabilisation wing'. Those referred to the DRW could come straight from induction or from other houseblocks, having been assessed for suitability by a CARAT worker. A defining feature of High Down's DRW is the focus on motivation for change and prisoners' own perception of their drug use as 'problematic' as key criteria governing acceptance on the DRW. As a result, cannabis users who were highly motivated to address their drug use could find a place on the programme.

> So it's irrelevant, their drug use. It could just be cannabis, it could just be alcohol, it could be crack-cocaine-heroin-everything. It's where they're at with the problems it's causing them. Do they want to change? [staff interview].

This marked a profound departure from most other DRWs that followed standard criminal justice policy in focusing, at least in part, on opiate users.

Two main programmes were offered to DRW prisoners: the cognitive-behavioural Building Skills for Recovery (BSR), delivered by two selected and trained recovery prison officers, and the Bridge Programme, delivered by five RAPt workers. BSR consisted of between three and four session per week delivered over a five week period and focused on developing recovering skills to avoid relapse. The Bridge Programme was an intensive, full-time, six week programme consisting of 60 sessions in total. Those prisoners attending the Bridge Programme were also expected to attend fellowship meetings – either AA, NA or CA (Cocaine Anonymous)- of which there appeared to be approximately three groups running a week. Two prison officers had also been trained to deliver the SMART programme but at the time of the rapid assessment, resourcing problems were making this difficult to deliver.

Prisoners and staff were particularly positive about the Bridge Programme:

[6] Reflecting the language used in prisons, 'Subutex' is used in this report rather than buprenorphine.

> It doesn't work for everybody. But in my experience I've seen a lot of people change [staff interview]

> The RAPt programme was absolutely amazing. It changed my outlook on life completely [prisoner interview]

It was clearly an intensive programme that appeared to affect many of the prisoners involved in a positive way. However, having spent six weeks consumed by this programme, working on it full-time, including in-cell homework, there was the danger that prisoners felt bereft when the programme came to an end:

> Researcher: How did it feel when it came to an end
> Prisoner: I felt a bit lost. Yeah I felt a bit lost.

In comparison with other interviewed samples, the High Down prisoners' substance use trajectories were predominantly social and recreational, with the 'rave scene' being referred to by four of 11 DRW interviewees.[7] Problematic cannabis and cocaine use had tended to creep up on them or taken a hold when wider economic and relationship issues had made them vulnerable. Only one had a history of heroin use.

The lack of opiate users in the DRW was evident in terms of previous treatment experience, with only two reporting previous experience of mainstream community services (both residential rehabilitation). It was also evident in terms of rates of previous employment and access to housing and other support on release: the interviewees were clearly very different from the socially excluded, long-term heroin users that had been interviewed elsewhere.

> I thoroughly enjoyed it [crack]. But I weren't plucking for it all the time and I weren't stealing for it. I had money. I had a full time job. I had a mortgage on a flat and I had two cars. I had a partner with two children. I just got greedy. With money: I got really greedy [prisoner interview].

The reasons why opiate users were not on the DRW appeared to be complex. As mentioned above, motivation was described as the primary selection criterion. This appeared to lead to the selection of less damaged prisoners who were determined to reform and, perhaps, readily able to express their determination. Another factor was that there appeared to be few prisoners on substitute prescriptions who were prepared to reduce to the maximum permitted level of 2 mg of Subutex or 20 ml of methadone on the DRW. From prisoner interviews, it appeared possible that the provision of single cell accommodation on the

[7] Eleven DRW prisoners were interviewed and a further four prisoners from the nearby Therapeutic Community wing.

stabilisation wing as well as the DRW may have detracted from the comparative benefits of moving onto the DRW.

Staff and prisoners also suggested that some DRW residents may have had ulterior motives for being there: and this was a theme echoed elsewhere across the pilot sites. One of the Bridge workers estimated that only 'two or three' of the participants in his 12 group sessions were 'really dedicated' to the programme. From prisoner interviews, there were clearly a range of motivations. Prisoners frequently referred to the single cells and time spent out of cells. They also referred to the importance of being seen to address their addiction:

> …but at the end of the day, I'm doing all this off my own initiative just so I can say 'well I've done this and I've done that' [prisoner interview]

However, even where prisoners appeared to be at least partly motivated by sentence plans and parole hearings, interviewees still thought that once they were actually engaged in the programme, it affected them.

Another important motivation for getting on the DRW was prisoners' relationships with their families. While this is echoed in many interviews with prisoners in other DRWs, it appeared to be particularly true of High Down, perhaps because relationships had not yet been completely severed by long period of opiate addiction.

> I need to do it for my kids. What are my kids going to have if I stay an addict forever? They're not going to have anything. They're going to have an addict for a dad and I had an addict for a mum. My mum was an alcoholic. I watched her drink basically, most of her life away… I don't want to put that drama on my children [prisoner interview].

With regard to the team on the DRW, there were a total of approximately 20 officers working on the wing, with around six or seven working at any one point across the two spurs of Houseblock 5. Two of these officers were 'recovery' officers, trained in the delivery of SMART. The other main group of workers on the wing was the five RAPt Bridge Programme workers.

Prison officers involved with the programme spoke about the importance of getting the right mix between discipline and care:

> Well I'm out on the spurs speaking to prisoners all the time, so I'm always interacting with them. Obviously you've got to be professional, stay secure…make sure they don't

> escape [laughs]…But then you've got a duty of care to them as well. To look after them [staff interview].

> The problem is that you go from possibly rolling around the floor with a prisoner you've been fighting with to ten minutes later, talking about the fact that his wife's left him and he feels like using again [staff interview].

While the original plan had been to set up the DRW as separate unit along the lines of a therapeutic community, it quickly became apparent that staffing levels precluded this. Most DRW prisoners went to work or education each day, if not involved in the full time Bridge Programme.

High Down had a comprehensive and well-developed through-the-gate service, seen very positively by interviewees. DIP prisonlink workers from the five 'core areas' to which 80% of prisoners were released came into the prison regularly, and carried prison keys. Nevertheless, employment and accommodation were perennial issues for released prisoners.

Chelmsford

The Chelmsford DRW is housed in E Wing and was described by the majority of interviewees as 'the IDTS Wing' or, most often simply 'E Wing', with few references to the 'DRW'. The wing provided 126 beds, of which 88 were occupied at the time of the rapid assessment. However, a month previously, 121 beds had been filled and cell occupancy varied considerably over time, reflecting the rapid 'churn' in this wing's population of mostly remand and short-term prisoners. Some spare beds were filled with 'lodgers' or non-DRW prisoners: at the time of study, two or three had been placed there from other wings for security issues such as risk of violence.

At the time of the rapid assessment, there appeared to be limited group provision, although plans were in place to introduce a new programme. Nevertheless, a daily 'drop-in' service was provided by psychosocial and clinical workers, which was additional to standard one-to-one provision. An AA meeting was held each week but this appeared to attract quite a small number of prisoners (five were observed at one meeting). While some prisoners were happy with the help they had received, others felt that more needed to be done:

> Everything's stopping. There's no money. [Later:] There is no drug recovery… The only drug recovery there is on this wing at the minute is prescribing methadone and Subutex... [prisoner interview]

The central focus of E Wing appeared to be on the reduction of substitute prescribing.

> Reduction… is what we're about [staff interview]

Reduction was equated with recovery by many members of staff, who used the words interchangeably:

> They can discuss their reduction. And there is… a recovery, reduction worker… And usually people are quite, you know, happy to do their recovery. They're quite focused on reducing. [staff interview]

The focus on recovery-as-reduction seemed to reflect the short time available to work with prisoners on E Wing:

> Literally as soon as people are titrated and stable they'll be shipped out. [staff interview]

Nevertheless, while little could be done to encourage remand prisoners to reduce, there was the expectation that sentenced prisoners would do so, although this could be a challenge:

> While they're on remand it's fine. But yeah, you do come up against some battles with people on high doses, trying to encourage them to start reducing… You have got a lot of people that're happy to stay on what they're on. [staff interview]

The reduction ethos was enshrined in the compact that all prisoners were required to sign on coming to the wing committing them, where they were on opiate substitute medication to start reducing their dose. Few prisoners chose to undergo a full, rapid detoxification: 'one or two per cent' according to one clinical team interviewee. Indeed, prisoners could be actively discouraged from taking this course:

> Yesterday we were talking to somebody on here who wanted to come down and the nurse and I both said it simultaneously: we don't think that's a good idea. Because the guy is getting out Monday and he was trying to rapid detox. Which would not be helpful to him. It would be unsafe. [staff interview]

Prisoners recognised that they would need to go elsewhere to achieve abstinence but some still had a strong commitment to achieving this:

> I won't be able to [achieve abstinence from Subutex] on this wing. But I hope there's a prison within this system that I can go to, to sort of get on that rehab programme... [prisoner interview]

> Being on maintenance, to me, is not doing anything. Being released with a maintenance script, I've still got a drug problem. And back to the same old... [prisoner interview]

While staff spoke about the importance of achieving reduction on E Wing, the prisoner interviews suggested that there had been little pressure on them to achieve this.

> Is there any pressure? I wouldn't say pressure. People just don't want to because they've got it easy. They're getting their medication, they're getting other people's medication... The majority of them, all they're interested in is getting out their nut… [prisoner interview]

> I would say it [reduction]'s optional. I wouldn't say it's that encouraged either… you've got a choice where… you can stay on whatever makes you comfortable or you can choose to reduce… prisoner interview]

Prisoners were generally very positive about E Wing and the support that was available, should they need it. They were given extra access to the gym and this was popular among the prisoners interviewed.

> Going to the gym has turned my thinking around… I want to make myself better and… Your body's a temple... [prisoner interview]

> You can look at [prison] as a poor man's health club really... [prisoner interview]

While speaking positively about E Wing, as with prisoners in other DRWs, interviewed prisoners tended to cite other influences as motivators for achieving change: in particular, partners and children – but also, health:

> I had a bit of a scare last year… I've gotta stop. I'm 37. I won't be here next year if it'd carry on [prisoner interview].

With regard to the availability of drugs on the wing, Subutex was a particular problem. Some prisoners were adept at spiriting away prescribed Subutex despite what appeared to be careful supervision:

> You could watch them like you would a hawk, like you would a magician. And that tablet would disappear. And that person would be able to give it to you completely intact… They're very, very clever. You'll not see it [staff interview].

Relationships between prisoners and staff appeared to be generally good and better than elsewhere in the prison system, with several interviewees referring to individual prison officers who had helped them with personal problems.

Three main professional groups were working with DRW prisoners. The NHS IDTS team employed six full-time equivalent nurses, one 'recovery champion' and three healthcare assistants, providing clinical support for drug dependent prisoners. The Westminster Drug Project (WDP) were contracted to deliver the prison's psychosocial support services, known as *Inside Out*, consisting of four frontline workers and two senior practitioners. The third group consisted of a 'core group of 12' prison officers. Two of these posts consisted of specially selected and trained 'recovery officers', funded by WDP. They provided care and support, undertook assessments, prepared release plans, supervised the medications queue and carried out drug tests: doing, in the words of one of these officers 'exactly the same as the civilian people'. Their relationships with prisoners appeared to be particularly positive.

With regard to through the gate support, some staff reported that this was working well, with prescriptions being effectively transferred to community providers and the psychosocial team drawing up release plans, setting out referrals and signposts to community agencies. While not a representative sample, none of the interviewed prisoners reported having a release plan. Wherever possible, community drug workers were invited into prison to participate in three-way meetings with prisoners and prison staff prior to release. The Inside Out team were also key to making links in the community, working as their name suggests both within and outside the prison. Links within Essex appeared strong but if prisoners were being released elsewhere, this was thought to be more problematic.

While links with external drug agencies were thought to be effective, housing was felt to be a much more problematic issue:

> That is the biggest problem: housing. Mmmm. I mean we can organise their prescribing, we can organise [psychosocial] support in the community... But the only area we don't plan is their housing. And that is usually the major reason they come back to prison [staff interview].

Likewise prisoners:

> I left here [HMP Chelmsford] homeless a year and a half ago and I come back homeless. [prisoner interview]

> When I get released I've got to commit a crime. I've got to. I haven't got an address to go to. [prisoner interview]

Styal

Styal's DRW, which was fully implemented in October 2012, is located in a separate 19-bed building called Fox House. At the time of the research, 11 prisoners were participating in the DRW programme, one 'graduate' was still living there and two were lodgers, placed in the DRW because of population pressure.

The Staff on the DRW were all drug workers apart from one duty prison officer. Between two and four drug workers were available throughout the day out of a total of six staff.

Mornings consisted of recovery programme work; the afternoon, education and employment in the wider prison. Engagement with the programme was compulsory, with a strong emphasis on providing a busy and structured day. During the mornings, after a warm up game, the women were given a recovery trait or skill for the day, such as 'appreciation' (on one of the fieldwork days): a word they are expected to reflect and act on and then discuss at the following day's morning meeting. Each individual prisoner is also encouraged to act on one aspect of their outcome star (Triangle Consulting Social Enterprise Ltd, 2012) – a system for assessing progress across a range of recovery dimensions, such as drug use, accommodation, physical health etc. The rest of the morning is taken up with a number of inputs or activities, such as SMART recovery, education/employability, gym and visits from external agencies. With regard to the latter, presentations from ex-users were popular:

> We've had quite a few ex-offenders and ex-drug addicts… it is [helpful] because you can see how well they've done and think: "oh god, I want to be there" [prisoner interview]

In setting up the Fox House DRW, the aim had been to provide a holistic, recovery-oriented approach along the lines of a therapeutic community and this was reflected in the intense, community-focused environment in which women were expected to 'live and breathe' their recovery. TC language and processes were evident, with reference to women acting 'As If' (behaving in a way that they should do, rather than how they have done), and a set of rules governing the DRW enacted through community meetings. These rules included honest communication and no glorifying of substance misuse. A conflict management system had been introduced, whereby negative behaviour could be challenged by other prisoners. In such circumstances, challenged prisoners were asked to 'refresh': to think about their behaviour and seek to change it. Community meetings were held weekly.

The importance of the sense of *community* at Fox House was emphasised by many interviewees:

> It's a tight-knit community… I know I can go to at least three people in this house and speak to them if I need to [prisoner interview].

> I think one of the things that is working really well is they're actually working as a community and I feel that having the meetings together in the mornings, having activities that they have to do together, there really is a sense of community feel… [staff interview].

This strong sense of community may have been aided by the time that women spent on the DRW: the majority of women had been living in Fox House for between three and six months, and some were serving quite long sentences. The flip side of this situation was the difficulties faced in moving women on from the DRW:

> There's no exit strategy. For example, there are people on the house who aren't due for release who have participated in it… So now they've got quite a lot from the house, they've genuinely developed from the house… and they've still got maybe twelve months of further sentence to complete so what do we do with these people [staff interview]

Given that the DRW had only been operating for seven months, the fact that women had not moved off the wing was not a significant problem: there were still places free in the House. However, staff thought that this would present a problem in the future. While ideally, all the women would be released to the community, in reality, some would need an alternative progression route. Interviewed prisoners voiced concerns about going back to the main prison population, where there would be more temptations.

The interviewed prisoners all had long histories of drug and/or alcohol problems. The longest involvement was 45 years, the shortest eight and the majority had problems with heroin and crack cocaine. They were serving sentences of between 14 months to 4.5 years, with two on remand and one on license recall. Any member of staff could refer a prisoner to the DRW or prisoners could self-refer. A thorough assessment process was in place, including a detailed assessment of substance use needs, whether they are in the 'right place' in their recovery and understood the underlying causes of their problems. The assessments were carried out by one member of DRW staff and applications were then considered at a weekly allocation meeting. Staff reported that the most important issues were how motivated women were to change and their own understanding of their substance use:

> I definitely think people who have a good knowledge around their substance use and it tends to be through doing programmes [in the past]… If they don't really know what

> their areas are that they need to work on, or they've not got a solid foundation, I think somebody would struggle coming onto the house [staff interview].

There was therefore a strong emphasis placed on previous treatment experience and self-awareness.

Prisoners reported being sick of their drug-using lifestyles and the losses that had been associated with them. Loss of children to adoption was a common theme and several described violent, dysfunctional relationships with men who were often drug users and drug dealers.

A large proportion of the interviewed prisoners were on methadone: seven out of the ten, one of whom only had an alcohol problem. There was clear policy of tapered methadone dosage, with two having slowly detoxified on the wing. Those that were still being prescribed mostly had a clear end date by which they were expected to detoxify, apart from one interviewee who was stabilised on 40mls of methadone and had a plan to detoxify on resettlement in the community. While further research would be needed to verify that the prisoners did end up detoxifying, it appears that the Style DRW is like Manchester and New Hall, in taking mainly opiate users and successfully persuading them to detoxify.

The Fox House environment was very different from the other DRWs, described by the researcher as 'bright and cheerful', with colourful pictures on the wall and comfortable, modern furniture. Sleeping accommodation was referred to as 'bedrooms' rather than cells and there was an informal, relaxed atmosphere, with non-officer staff dressed informally. This was appreciated by interviewed prisoners, one of whom described it as 'the posh house'. Relationships with staff appeared to be very good.

The women on Fox lived fairly separately from the rest of the prison in that they ate, slept, exercised and spent their mornings there. However, most went out to work and education in the wider prison and also mixed with other prisoners during association. Interviewees generally thought that this achieved the right balance, pointing out that coping with the wider prison was a good test for the temptations that lay in wait for them on release.

The nine prisoners previously using opiates all said that drugs were readily available in the wider prison but that there was no problem with drugs in Fox House. The main drug in circulation was diverted Subutex, with occasional influxes of heroin brought in by newly admitted prisoners.

Holme House

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.

In the late 1990s, Holme House became one of the first British prisons to house a drug-focused therapeutic community (TC). This was operational during the rapid assessment fieldwork, managed by Phoenix Futures, and identified by interviewees at all levels of seniority as a highly valued resource. Indeed, the existence of the TC supported Holme House's decision to become a pilot DRW site, as senior managers felt they had access to considerable therapeutic expertise. The TC and DRW were situated on spurs a and b of houseblock 6, shared custodial managers, and evidenced some intermixing of frontline staff and prisoners.

Holme House DRW sits within a clear prison-wide recovery framework. On arrival, prisoners are assessed by healthcare workers whilst housed in the prison's reception wing. Where required, methadone prescriptions are titrated over the course of four weeks. Once stable, medicated prisoners may be moved to nearly any other houseblock, as all wings have medication hatches. Those who psychosocial workers believe are well-motivated to reduce their medication may be identified as potential candidates for the DRW.

Whilst Holme House's recovery pathways could move prisoners up to and beyond the point of abstinence, the DRW's role centred primarily on medication reduction and related support. All DRW residents were receiving a methadone script during the rapid assessment, with a perceived willingness to reduce constituting a prerequisite of DRW engagement:

> It's the standard agreement that when you come on here, you will be expected to reduce. You will be expected to take part in groupwork and it's not a case that you can't be bothered today [staff interview]

However, reductions required complex negotiation. Psychosocial practitioners felt that advertising the DRW as a 'reduction wing' could prove actively harmful to recruitment:

> They do have a compact to say that they will reduce on here but again there's no stipulation with [the psychosocial team]. It's difficult because what we don't want to do is tell people that by coming on here you're being forced to reduce [staff interview]

Conversely, prison officer interviewees felt frustrated by their inability to insist on reductions:

> The main thing with drug reduction is it's down to them. I can't sit down one of my lads and say "listen, you're on 20mls you've got to come down to 17, 18." That's down to him and the nurses. So for me it's a Drug Recovery Wing, sometimes there's lads been on here as long as I've been on here. None has been taken off it or has never reduced at all. We can't get involved in that because it's the nurse the healthcare team and him [staff interview]

When prisoners agreed to reduce their medication, reduction schedules could be slow. Staff and prisoners identified that reduction schedules of one millilitre per month were widespread. Four (of seven) DRW interviewees were reducing at rates of between one and three millilitres per month, with one not reducing at all. This context may explain Holme House's apparent struggle to encourage people into abstinence, despite apparent success at initiating reduction regimes:

> Last month we had 90% reduction and 10% in maintenance… We had 5 [obtaining abstinence, out of] 270 in treatment [staff interview]

The DRW offered potential applicants several incentives: greater access to single cells, courtesy keys, additional gym time, a 'relaxed' atmosphere, and regular community meetings.

> We unlock them all get them all get them all out and just sit around and have a discussion about what's happening… Because "I'll get green applications in asking this, that and the other" [is the standard prison way of doing it] and I think it's loads easier to just go and see them, and talk to them face to face. Give them the ideas of what we're trying to achieve and put in place and any new projects… [staff interview]

Each of these elements and incentives was identified as part of an overall drive to foster individual responsibility and a 'community' feel, reflecting the TC's operational model:

> We try and copy the other side… to get them together as a community. And to show, for me, the ways of right living. So making sure your curtains are open. Making sure your bed's made. Which sound like tiny things. But they're huge if you can get somebody into that kind of routine [staff interview]

The DRW stopped short of implementing the TC's full community-led disciplinary system, instead adapting their neighbour's conceptual framework. Whilst the TC had 'wing policemen,' the DRW had three 'expeditors,' who worked in shifts to encourage residents to take greater responsibility for their own behaviour, and for the DRW's community:

> The wing expeditor is like a wing policeman… Not only do they help the residents, they help the staff. Patently the problem on the DRW is that they're used to immediate gratification. And that just annoys everybody involved, including the residents. So the expeditors are a buffer. But also help filling forms and give peer support. Say you've left your TV on but you've come to a meeting. "Think about the greening aspect!" So just that little aide memoire [staff interview]

> If they go to an expeditor and complain [about another prisoner's behaviour]… the expeditor will say "hang on a minute." There's no arguments or scenes going on. It cuts out all the bullying because people know they can get it all off their chest without taking someone in the showers for a fight [staff interview]

This system also allowed prison officers to prioritise therapeutic work.

> It leaves the staff more time to sit down and have meaningful conversations with the prisoners. To key work them. Or if anyone's got a particular issue [staff interview]

Prison officers delivered most therapeutic work within the TC. Personal officer work also constituted the cornerstone of DRW provision, with the prison's drug team transferring case management responsibilities to prison officers when prisoners entered the wing. The wing had ten allocated officers, each carrying a caseload of five clients, meaning 50 of the wing's 66 beds could be filled by 'DRW' clients at any one time. Foreign nationals, older prisoners, and people on the DRW's (substantial) waiting list were given priority for 'lodger' beds. Prisoners interviewees voiced few, trivial concerns about their presence:

> [We got] a toasting machine, and the people who weren't on the DRW could use that. That was meant to be for us, a privilege [prisoner interview]

The experience and localness of DRW officers constituted one of the wing's striking features. Each of our five prison officer interviewees had worked in prisons for over a decade, with the second least experienced having twenty years' service. All were grounded in local communities, and willing to relate to prisoners in a non-authoritarian and supportive manner:

> You're helping them in ways that you've probably never helped a prisoner before. So obviously there's borderlines that you can't cross and they can't cross but you know from a professional point of view you build up quite a good relationship with them [staff interview]

Staff were also quick to acknowledge DRW residents' expertise, and the potential for prison officers and prisoners to learn and grow from each other.

> You get a bit of chat on with the lads. We get to listen to their knowledge. When you actually sit and talk to one of the fellas that's when your knowledge base grows and grows [staff interview]

The quality of staff and their relationship with prisoners was consistently highlighted as one of the wing's strongest features:

> The staff are mint. First name basis right. I kid you not. It sounds bizarre this right. If I was out there in Asda I bumped into any of them I would talk to them I would give any one of them time They're really good folk and these they are they're very clever people [prisoner interview]

> They help ya. They understand. Like we've just has a couple out there, they sit with us. They get involved a lot more [prisoner interview]

> On other houseblocks and that some of them are not bothered about the job. They're just there for the pay. Whereas the officers on this wing, they are concerned. If you've got a problem you can go to them in confidence and you'll know that they'll help ya [prisoner interview]

In addition to key working sessions, DRW officers delivered a rolling induction programme to the wing's new arrivals. This consisted of five groups, delivered over the course of one week. No other officer-led groups were delivered during the rapid assessment, though some were apparently delivered on an ad hoc basis and in response to identified prisoner need.

Additional provision on the DRW suggested wide-ranging model of recovery. Drug-focused support included weekly AA, NA and SMART Recovery groups, each attended by 8-12 people. Wing residents voiced enthusiasm for cookery groups, dedicated 'DRW gym' sessions, and the imminent arrival of a 'DRW garden,' which would produce vegetables for the prison's staff Bistro. DRW residents could also access all groups offered by the prison's psychosocial team, and engaged with the prison's broader regime. Whilst all were unlocked during the day, approximately 70 per cent were in full-time work or education delivered on other wings. This lack of a DRW 'silo' was not identified as a significant problem.

Holme House's focus on prisoners' exit and transfer pathways merits specific comment. Prior to 2012, Holme House TC only accepted clients who were fully abstinent of all medication, with histories of Class A drug use and 12 or more months until release. However, following a recommisioning process and the roll-back of national targets, the TC had refocused on local needs. Selection criteria were adapted so that prisoners with six months left to serve could complete a shorter version of the TC programme. Prisoners

prescribed 10mls or less of methadone could also move to the TC, so long as they agreed to sustain their reduction at a rate of at least one millilitre per week. Both of these measures increased the accessibility of the TC to DRW clients, strengthening the DRW's position as a mid-point of an envisioned drug recovery journey from medicated intake to abstinence and beyond. Three medicated prisoners had transferred prior to our rapid assessment. Staff hoped to increase this substantially in the coming months.

The TC accepted referrals from any prison in the country. In contrast the DRW only accepted referrals from within Holme House, and nearly all DRW residents came from one of four Teesside areas. Managers consequently conceived of the DRW as an emphatically local resource, yielding opportunities for enhancing aftercare provision. With the intention of harnessing only the strongest resettlement networks with the greatest potential for impact, the DRW initially accepted only Prolific and other Priority Offenders (PPOs) engaged with one of four local Integrated Offender Management (IOM) schemes:

> The criteria was PPOs Tees Valley only… because of the follow-up work that was being done [staff interview]

Four prison officers were tasked to act as IOM 'link workers' associated with each IOM area, enabling community workers to come into the prison for release planning meetings, and supporting prisoners following release. Selection criteria had expanded as pressure to fill DRW beds increased: firstly to include PPOs from any area, and latterly include non-PPOs. Still, the benefits Holme House DRW provided to prisoners (in the form of integrated aftercare) and to IOM teams were felt to be one of the wing's key strengths:

> I was at a community partnership meeting last month and the IOM manager for Stockton said they had finances to pick 400 of the most prolific offenders. But the ones that's passed through the DRW are not committing as many crimes as they used to, so they no longer fit the IOM criteria. So now they can concentrate on another batch and work with 600, 700, 800 offenders [staff interview]

Three prisoner interviewees who were within six months of release seemed to be aware of the availability of aftercare preparation and support, particularly for PPOs:

> I do know prior to release there's a meting with all the agencies. Housing, benefits, probation officer… [prisoner interview]

> I'm a PPO so they have to do something for me! [prisoner interview]

Two interviewees had also engaged with the prison's four-week Focus on Resettlement programme. Prisoners' concerns about housing and homelessness were markedly less prominent than in some other pilot DRW sites, with only two voicing specific concerns.

Brinsford YOI

Brinsford is a Young Offender Institution (YOI), housing up to 577 male prisoners aged between 18 and 21. Though most prisoners come from the West Midlands area, the closure of Gloucester's YOI meant that Brinsford was accepting increasing numbers of prisoners from further afield. The drug recovery journey at Brinsford began at reception. A staff interviewee describes:

> A triage document is completed, assessing need and areas of concern. And from there the recovery coordinator has a 10 day window in which to start a comprehensive assessment. And once areas of concern are identified, the recovery coordinator will start a recovery plan stating what the areas of concern are how it's going to be resolved in what kind of timeframe… who's doing what. (staff interview)

Whilst referrals were the initial responsibility of healthcare nurses' thereafter prisoner assessments, recovery planning and all non-clinical treatment fell to the prison's psychosocial team, the Drug and Alcohol Recovery Service (DARS).

During the rapid assessment, DARS' five frontline workers carried a caseload of 160 people. Twenty-seven of these resided in Brinsford's 32-bed DRW, situated on landing 1, H wing, Res 4. Brinsford's DRW offered one of the longest-duration programmes across sites:

> We have got prisoners that are long-term, that probably will be here for 2 years [Staff interview]

DRW-specific exit pathways were still being developed at the time of the rapid assessment. Those serving four or more years, or who turned 21, were transferred to other prisons. Otherwise, prisoners could progress towards release by moving from the DRW to the prison's 'enhanced' houseblock.

For those prisoners released to the community, aftercare appeared to be fairly minimal. Release plans centred on signposting agencies, with few concrete referrals and no means of supporting clients' attendance at community services. Professionals identified that Youth Offending Service although with prisoners being met on release by community based agency staff. In the main prisoners expected to make their own way home.

Brinsford's DRW was clearly in a difficult state of transition at the time of the rapid assessment. Substance misuse services were being recommissioned and staff spoke of significant changes in pay and conditions resulting in a large number of resignations. The successful provider then struggled for some time to recruit permanent staff. Despite plans to develop a full programme of groups, DRW provision was consequently starting from a greatly reduced baseline.

DARS' office was based on H1, and professionals identified this colocation as the DRW's main recovery-oriented benefit. Whether formally or informally, practitioners sought to see DRW clients approximately once each week, contrasting with the monthly one-to-ones offered to clients elsewhere. Prisoners could also attend one of 1.5 mutual aid groups delivered each week (AA held weekly meetings; Recovery Is Out There held fortnightly meetings). These were not open to prisoners on other wings or landings, and professionals identified that they attracted attendances of between 4 and 8 people.

Brinsford's governor was wary of compromising prisoners' choice by bolstering applications to the DRW with pay or incentives. However, some quality-of-life benefits were felt to exist. Both professionals and prisoners identified a 'community' feel to the wing, with virtually no bullying and only occasional fights. The association room held a fish tank, and some interviewees asserted that DRW residents received extra gym.

Managers framed the wing as a means of supporting the choices of prisoners who wished to attain recovery, defined as long-term abstinence:

> The young people on this wing. They've made a choice. It's an option that's available to all that have issues with substances. They've decided on a drug free life. (staff interview)

However, staff interviewees identified no documented or formal selection criteria. Instead, individual workers sought to identify clients on their caseload who they felt were well motivated, or would 'fit in':

> It's very much like somebody who you feel would be good for the DRW. And that are going to fit in and haven't got major issues. You sort of get a feeling for it [staff interview]

> We're sort of in our heads thinking… would you be beneficial to the wing? So we're looking for motivation… You know. Their behaviour. Erm. That they actually want to make steps to address their substance misuse [staff interview]

This approach seemed to have yielded specific challenges and successes. Both prisoner and staff interviewees queried whether all DRW residents had drug problems. Staff felt that the wing sometimes provided safety for vulnerable prisoners who might struggle to engage with structured recovery-oriented provision, but who might be bullied elsewhere. Conversely, prisoners felt that some of the wing's longer-term residents had perhaps been identified as good DRW candidates because of their stabilising potential, rather than any ongoing drug problem.

Working with 18-21 year old males defined several features of DRW provision. Firstly, opiate use was an extreme rarity amongst DRW clients with only two of DARS' 160 clients receiving opiate substitute medication prison-wide. Both were housed in the prison's healthcare wing. Professionals identified that drug finds and throw-overs (drugs thrown over the perimeter fence) most frequently involved cannabis and steroids:

> Surprisingly cannabis use is quite high. It comes in on visits. It comes over the fence. They're all using mobile phones and steroids… They can walk straight up from the main road to the fence and lob it over [staff interview]

> We're seeing… a lot of legal highs [staff interview]

Prisoner interviewees broadly supported this depiction. Whilst none acknowledged using steroids, seven (of nine) named cannabis as a preferred intoxicant; five identified cocaine; and two named alcohol. Despite the lack of heroin and crack users on the DRW, with surprising consistency professional and prisoner interviewees noted that the DRW had something of a reputation as the 'baghead' or 'smackhead' wing on other houseblocks.

Secondly, connected to the young age range of the prisoners within Brinsford, violence appeared to be a much more prevalent occurrence within this DRW than elsewhere:

> If you put a lot of young testosterone fuelled personalities into a cage they're going to start fighting [Prisoner interview]

Despite the DRW's acknowledged success at reducing violence and bullying, four prisoners described being involved in fights since their arrival. One prisoner had just returned from segregation, following an assault on education staff:

> I trod on his foot deliberately. I looked up and [stamp!] [prisoner interview]

Index offences tended to involve violence, too. Two interviewees had been involved for non-violent offences (burglary of a dwelling and driving offences). Two had been imprisoned for straightforward violent offences:

> I thought he was getting the better of me so I've pulled out this knife and started straddling him… I just remembered this vision of me going to get off that bus and him sitting down on a chair, blood dripping down his face. It wasn't a good sight. [prisoner interview]

The other five had been imprisoned for violent acquisitive offences:

> Totally didn't care about who was in the property. However we get hurt or they get hurt. Didn't care at all. It was a matter of life and death really. If you live you live if you don't you don't. We went that far [prisoner interview]

Thirdly, and relatedly, DRW interviewees were serving long sentences. One interviewee was on remand; one had received an indeterminate sentence for public protection; the mean sentence length for our other seven interviewees was 5 years (60.7 months).

Fourthly, family work in the youth estate took on a different meaning to family work in the adult estate:

> In the adult estate it's around utilising partners. We'll be utilising parents. The issue wit that is we are dealing with 2nd 3rd generation drug users. So it's giving families support as well. [Staff interview]

Whilst professionals tended to raise prisoners' parents as a priority for structured work, it also seemed noteworthy that three prisoners talked of their children as providing an incentive for ceasing their drug use and offending behaviours.

Fifthly, professionals identified a need to tailor groups to young people's needs and attention spans.

> Lots of them have not finished education. So pictures. Bright colours. Activities to get them involved. Rather than sitting and talking. Keep writing to short sections [staff interview]

> You've got to keep groups light and airy with lots of breaks because otherwise you'd find attention wandering [staff interview]

> They are more unruly. They're more restless. It takes them more time to settle [staff interview]

> I'm conscious of the fact that they're children. So I'm adding pictures. Cartoons. Cars. If there's a definition of something and they've just got the writing, that's gonna bore the pants off them. But if you if you associate it with a cartoon they can remember that cartoon and associate it with that definition. So it's just being conscious of the age level. [staff interview]

Finally, expectations needed to be realistic. Working with young men, four professionals identified that abstinence might represent an unrealistic goal. Four of our prisoner interviewees stated an intention to continue smoking cannabis or drinking alcohol post-release.

Swansea

Swansea is a Category B men's local prison, housing approximately 445 prisoners from South and West Wales. With the intention of establishing a full and integrated recovery pathway, Swansea's senior management team decided to establish Drug Free and Drug Recovery Wings at the same time, and the units were opened on Wings B and C (respectively) in July 2012. These two wings share a complement of 16 full-time prison officers selected on the basis of their expressed interest in therapeutic work:

> I don't want to just open and close doors, I liked the idea of working in a wing where the ethos was completely different. If I could get just one person through their recovery I'd be happy [staff interview]

Interviews with prisoners suggested this process had helped to shape a positive atmosphere on the wing, strengthening staff / prisoner relations:

> They give you the time of day, they'll help you in any way they can [prisoner interview]

> On the other wings, they don't really talk to you. In here… they talk to you if you've got any problems, they're really helpful … they're the best staff in the prison [prisoner interview]

Psychosocial and clinical workers also worked with DRW clients, though their caseloads were spread across all prison wings.

Prisoners' envisioned recovery journeys begin in Swansea's induction block. Here, the healthcare team conduct initial assessments and prisoners with an identified need for opiate-related medication are titrated up to a stable dose of methadone. Following induction, prisoners may be dispersed to any one of Swansea's wings. Those who are willing

to move towards abstinence, and who are receiving 30mls (or less) of methadone per day, may be considered for the DRW. Subutex had been intentionally excluded from the DRW:

> The DRW couldn't work, didn't work when we had subutex on the wing. The temptation was too much [staff interview]

Swansea seemed to represent a departure from the DRW operational models implemented by several other prisons, insofar as it engaged prisoners with eclectic drug histories. Three (of nine) prisoner interviewees had histories of opiate dependence. Other preferred drugs included cannabis (N=2), alcohol (N=3) and cocaine (N=2). On entry to the wing, prisoners were required to sign a compact agreeing to engage with psychosocial courses and provide voluntary drug tests on a weekly basis. At the time of the rapid assessment, Swansea's DRW had filled its 49 beds and was operating a waiting list system.

Separation constituted one of the cornerstones of Swansea's operational model. Though DRW residents might encounter prisoners from other wings in healthcare, the visitors centre, or whilst working in the prison servery, they spent most of their time as a discrete population. DRW residents were prevented from accessing off-wing work or education:

> Their recovery is their work [staff interview]

However, from a staff perspective, benefits clearly outweighed any negatives:

> We've created an environment where they can relax a little bit without that peer pressure… it's huge… To avoid that pressure we decided from the offset really that to try and create a little bit of isolation would enable them to focus much more on their own recovery [Staff interview]

Prisoners, too, noted that the DRW was 'calmer' than other wings, with lower levels of violence, bullying and drug availability. Prisoners were paid £5 per week for attending courses, providing them with a better wage than 'unemployed' prisoners. Some jobs were also available within the DRW, accompanied by wing-specific benefits. Wing cleaners were paid an additional £1 per week, and could stay on the wing indefinitely.

For residents other than wing cleaners, the DRW's recovery-oriented programming was expected to last 8-10 weeks. During this time, they could access a rolling programme of groups. A community drugs agency, West Glamorgan Council on Alcohol and Drug Abuse (WGCADA), delivered one two-hour 'personal development' group, and one two-hour 'IDTS group' each week. Up to twelve prisoners (approximately one-quarter of the DRW's residents) could attend each, and prisoner interviewees particularly appreciated the role of ex-offenders in delivering these groups. Prison officers also sought to deliver hour-long life

skills and SMART Recovery groups on an ad hoc basis, as staffing levels allowed. Two such groups were being delivered each week during the rapid assessment, to groups of up to eight prisoners (approximately one-sixth of the DRW's residents).

Prisoners were positive about the DRW programme, and general levels of support:

> It's helped me to get in touch with my emotions and be able to talk about things with my mum and dad and realise what I was doing didn't just affect me, it's affected everyone else [prisoner interview]

> I've really changed in myself, before I couldn't hold a conversation down… now I'm getting on better with my family members, talk about stuff when I didn't used to. I used to hold everything in [prisoner interview]

> It's given me a kickstart to think about things before I get out [prisoner interview]

Whilst group attendance was entirely voluntary, registers were kept for each resident. If they wished to transfer to the DFW on completion of the DRW programme, prison officers would first clarify that they had engaged with a prerequisite menu of courses and groups.

Additional recovery-focused provision included weekly AA groups (capacity 12) and chaplaincy information sessions (capacity 12). DRW residents were also unlocked for one hour of association every Monday to Thursday evening, had twenty minutes in the exercise yard each morning (in the absence of staffing shortfalls or inclement weather), were sequentially unlocked for showers and phone calls, and could apply to attend up to four one-hour gym sessions each week.

Each activity seemed to take on particular weight and significance in Swansea's siloed DRW, as prisoners were locked behind their cell door at all other times. With optimal staffing levels, the DRW offered just over one WGCADA or prison officer-led sessions per prisoner per week. Many DRW residents consequently spent a very considerable amount of time behind their cell door. Some thought there could be more for prisoners to do during the day, commenting on how much time they spent in their cells:

> I've come over here for recovery. Where's the help? [Prisoner interview]

The arrival of a second WGCADA group was heralded as a substantial improvement by one prisoner interviewee, due to the potential it offered for more out-of-cell time.

Professional perspectives on prisoners' in-cell time were both qualified and pragmatic. One staff member felt that additional provision might 'overwhelm' DRW residents. However, as

a practical response, staff had developed in-cell SMART Recovery packs which prisoners could complete whilst locked up.

After completing the DRW's 8-10 week programme, prisoners' recovery journeys could head in one of three directions. Firstly, prisoners might be transferred elsewhere in the prison estate to serve the rest of their sentence. Five DRW interviewees were serving sentences of 16 to 54 months, increasing their susceptibility to external transfer. Secondly, Swansea's Drug Free Wing held 40 beds, offering DRW residents one means of taking their recovery journey forward whilst staying within the same establishment.

Finally, prisoners might be returned to the community. One DRW prisoner was within three months of release; three more were on remand (though all were awaiting sentence). At the point of release, WGCADA's position as a community drug service offered the DRW particularly enhanced provision. When Swansea's CARAT drew up prisoners' release plans, WGCADA workers were involved. Moreover, the same workers who delivered groups within the DRW often held roles in the community. Referrals to both clinical and psychosocial provision were streamlined, with appointments assured. Though no precise numbers were available, WGCADA workers noted that they were pleased with ex-prisoners' levels of attendance. Throughcare was consequently felt to be a real strongpoint of Swansea's DRW provision:

> There's no gap in service. We're capturing people at a far better time because of this link [staff interview]

Although WGCADA's remit lay primarily in delivering drug- and alcohol-related work, the agency had a firm and established network of links with resettlement agencies. Consequently, WGCADA could act as a springboard for prisoners to access education or day treatment, secure qualifications, and engage in diversionary and time-filling activities such as walking, cooking, art and crafts, and music.

New Hall

New Hall's DRW is entitled Project Recovery Empowering Women (PREW) and is located on Rowan House. It consists of a traditional wing in a building shared with a juvenile wing. All of the 21 cells are single bedded with a toilet and a shower, of which one was reserved for a 'listener' and one a 'recovery champion.' Out of the remaining 19 cells, nine were taken up by women on the programme at the time of the research.

The PREW was the most isolated, separate regime that we saw. In the morning, a meeting was held which dealt with administrative issues and gave women the chance to air any grievances. Three mornings a week the women then do group work, delivered by Turning

Point staff. At the time of the research, the focus was on Mindfulness. Most afternoons are free time, with gym sessions on Tuesdays and Thursdays. Women do not work and virtually all their time is spent on the wing. Where women have appointments elsewhere in the prison, they are escorted by an officer wherever they go.

Once assessed, women coming into New Hall with drug problems are usually placed on the 45-bed Oak 1 Wing for stabilisation and can then be moved to Oak 2 for detoxification. Referrals to the PREW came from prison staff or through prisoners self-referring. Any prisoners applying to the PREW had to be engaging with Turning Point staff in the prison and were assessed either through an interview with Turning Point staff or a written application. A weekly meeting was held to consider applications.

Five out of the six prisoners interviewed had a long history of problems with drugs and/or alcohol: the longest 19 years and the shortest 12. The majority had problems with opiates and/or crack cocaine. They were serving sentences of between five months and four years. In order to gain access to the PREW, women need to be either drug free or down to 20 ml of Methadone or 2 mg of Subutex. Women frequently started detoxification in Oak House and then moved on to the DRW to complete the process. There was a strong expectation that on arrival on the PREW women would undergo a rapid detoxification, and none of the five interviewed opiate users were receiving methadone or Subutex at time of interview: all having detoxified on the wing. While numbers are small, this suggests a particularly strong abstinence culture on the PREW.

There were some issues with the quality and quantity of recovery work being delivered in the PREW. Group work was delivered on Monday, Thursday and Friday mornings, usually by a Turning Point worker. There were mixed feelings about how beneficial these sessions were:

> It's been really good. A lot of us have really enjoyed it… and come back feeling a lot better [prisoner interview].

> To be quite honest, the group sessions I don't get… It's all about breathing in and breathing out… I thought when I came up here it'd be drug courses and awareness of how to prevent yourself properly when you got out… [Prisoner interview].

> I think she does try to fill our time but the things she comes out with goes over my head… [Prisoner interview].

Other components mentioned were peer support sessions, acupressure, self-tanning and manicure, arts and craft and jigsaws. However, for a number of interviewees there was not enough to do:

> To be honest we are sat around a lot doing nothing… I'm finding myself wandering from room to room [prisoner interview]

> Sometimes it's proper boring though with nothing to do [prisoner interview]

A significant amount of time in the afternoon was spent in small groups chatting in cells.

On the positive side, the segregated regime largely kept drugs out of the PREW. The drug problem elsewhere in the prison was described by staff as 'horrendous', with the familiar problems of new arrivals coming into prison 'packed' with drugs and diversion of Subutex.

Relations between prisoners and staff appeared to be strained at the time of the research as a result of a recent incident involving the cooking and eating of two cheesecakes. It should be emphasised that a rapid assessment provides a snapshot, and is thereby affected by the events and atmosphere prevalent at that particular time. However, it is interesting that this disagreement had occurred in the most segregated of all the DRWs, suggesting perhaps that there is a potential for a pressure-cooker atmosphere in small, isolated groups of prisoners and staff. Some prisoners were generally positive:

> Most of them are alright. There's a few staff that are… but the majority are sound… They're totally different to what they are in the main jail [prisoner interview].

Others were more negative:

> They've got a proper bad attitude… It's like they hate drug users… They say that these officers are handpicked, well I'm sorry but whoever handpicked them don't know nothing about doing a detox… They treat us like children [prisoner interview].

Some women felt that there should be more input from Turning Point staff and less from discipline staff, suggesting that the latter did not do enough:

> They sit on their arses all day basically [prisoner interview].

For their part, staff were generally positive about the programme and the support it provided to the prisoners.

The staff team consisted of eight prison staff plus the drugs strategy manager and the Turning Point drug worker. The discipline staff were handpicked to work on the wing, with considerable previous drug treatment work in prison.

The expected stay on the PREW was six to eight weeks but prisoners could stay longer and this was assessed on an individual basis. On leaving the PREW, women are released into the community, transferred to another prison (such as Askham Grange) or moved onto the Drug Free Wing: a more open wing, with 40 beds and voluntary testing. Of the interviewed women, only one was going to be released straight back into the community, one was moving to Askham Grange, one was moving to the Mother and Baby Unit and the remaining three were going back to the main prison and hoping to go on the Drug Free Wing.

With regard to through-care, most staff thought that far more could be done to make good contacts with outside agencies that might be able to help the women on release.

Discussion

Before discussing some of the issues that have arisen through this rapid assessment of the 10 DRWs, it should be reiterated that these are offered only as tentative and preliminary observations rather than firm findings.

- Change

One clear point is that many of these projects were going through a process of significant change. To begin with, it needs to be recognised that all ten DRWs are recently-implemented pilot projects. They were not set up as permanent services according to some detailed blueprint and they have, quite rightly, adapted and changed direction as they have developed. The second tranche DRWs became fully operational in the latter stages of 2012 and were therefore in their first few months of their operation when the research team visited. Empty beds at these establishments may well therefore reflect the early stages of recruitment.

The DRWs have also, inevitably, been affected by policies and strategies at the local and national level. At the time of the research, a number of the prisons had either received a visit from the Competition Benchmarking team or were shortly to receive such a visit. Concerns were frequently expressed by staff, including governors, that this process carried the potential to undermine DRWs, given its focus on delivering efficiency savings through identifying minimum staffing levels. The idea of a standard prison officer: prisoner ratio was thought to make the sort of intensive work witnessed in DRWs impossible to deliver.

It seemed that as a consequence, some Senior Management Teams appeared to be rethinking DRW staffing, or were planning to relocate DRWs on other wings, or develop more sustainable operational models. One factor raised in some interviews was whether prisons could continue to afford to have prison officers acting as recovery workers. While

any wing will require a minimum level of officer supervision for discipline and security, programmes of work can be (and often are) delivered by voluntary sector drug treatment agencies. The role of the specialist 'recovery' officer therefore appeared to be in some danger.

Other significant changes included the retendering of services delivered within DRWs and the re-roling of Brixton as a Category C establishment, which was clearly having a significant impact on that prison, and the DRW within it.

It seemed that a key determinant of the likely impact of all such changes was the level of support DRWs received from SMTs, including the governing governor. While missing from the above accounts because of ease of identification, a range of views were expressed by senior staff from wholehearted support to considerable scepticism. It is unsurprising that the level of support that optional extras like DRWs receive from senior staff will vary according to their individual strategic perspectives and priorities. Without dedicated funding from central government, this was always likely to be the case.

- Recovery or reduction

When they worked with significant numbers of opiate users, one way in which the DRWs seemed to differ fundamentally was in their expectations with regard to detoxification. While at one end, some DRWs seemed simply to aim at reducing methadone and Subutex medication, at the other, there were strongly-enforced expectations with regard to detoxification. Much depended here on the length of time prisoners spent on the DRW, the size of its population and the related inclusion criteria. Where large numbers of opiate users on substitute medication were passing rapidly through a wing, there was a limit to what could be done. In such environments, those prisoners wanting to detoxify often planned to move elsewhere or attempt this on release. Careful selection, intensive support and a limited number of beds appeared to be the most successful way to ensure that prisoners on substitute prescriptions moved on to detoxification. Identifying genuinely motivated prisoners and having clearly enacted rules appeared to be important here, given the potential for endless prevarication on the part of prisoners teetering on the brink of abstinence and the fact that, ultimately, prison staff were powerless to do anything other than persuade or exclude from the DRW.

- Nice work if you can get it

It was clear that DRWs offer a range of attractions: they do not simply and solely offer a space for recovery. Better accommodation, greater safety and less time locked in cells all acted as additional hooks and this seemed justified if prisoners were to be persuaded to address their addictions. However, the concomitant problem became one of distinguishing

the genuinely committed from those feigning commitment in order to move to a better environment or regime. This was a perennial issue across the DRWs, although the view was frequently expressed that, where the DRW was small and the programme intensive, dissemblers were unlikely to be able to maintain their pretence.

- The continuum between TCs and 'standard care'

DRWs are clearly not the only specialised approach to drug and alcohol in prison. Some of the pilot sites had Therapeutic Communities (TCs) and some had Drug Free Wings. Operationally, DRWs were clearly positioned somewhere on the continuum between TCs and normal provision. A number of DRWs appeared to be set up with the TC philosophy and approach in mind but had migrated away from this end of the spectrum as the practicalities of segregation and the level of staffing required became difficult to maintain. Two of the DRWs appeared to have always been designed as a single wing for all the substance users in the prison and as a result, were closer to the 'standard care' end of the continuum.

- Segregation

Those DRWs imbued with the TC philosophy tended to set their sights on segregation, at least early in their development, in order to give prisoners committed to recovery a safe space to focus on their goal. However, the staffing and practical resources required to deliver true segregation were very great and only New Hall appeared to manage this successfully. Aside from the practical issues, complete segregation demands a very high level of programmatic input if prisoners are not to spend long periods locked up in their cells (as in Swansea) or, if unlocked, wandering aimlessly around the wing.

Resourcing aside, arguments for limited segregation appeared to be twofold. First, prisoners often appeared to appreciate work and education, even if they were paid for being on the DRW. Moreover, there should be some recovery potential realised through engaging in work and education, although this was rarely referred to. Second, many staff interviewees referred to the importance of testing prisoners' resolve. Contact with prisoners in the general population was thought to represent one step on the road to the more complete temptation they would be exposed to on their release. Complete segregation was equated with wrapping prisoners in cotton wool.

- Availability of drugs

Where a high level of segregation is delivered in therapeutic communities, drug free wings and DRWs, the availability of drugs can be kept to a minimum. However, another factor that appeared to considerably affect the comparative availability of drugs across DRWs was the

prescribing of Subutex within the prison. Where Subutex was prescribed, however rigorous the preparation and supervision, the drug was diverted and appeared to fuel drug use in that prison.

- Not just about the programmes

Interviewees in the smaller DRWs frequently spoke about the wider impact of living in a community of recovering substance users. Prisoners often spoke about the support provided by their peers – especially, where they had engaged in intensive group work. DRWs were sometimes clearly more than the sum of their parts: they were approximating the sort of holistic, 'recovery communities' found outside prison.

- Recovery vs discipline

There was a clear tension between the recovery agenda and the security/discipline agenda revolving around interactions between staff and prisoners in all the DRWs. This was evident in terms of the language used ('prisoners,' 'patients,' or 'clients'?), the empowerment of prisoners in recovery programmes and the roles of prison officers as carers or custodians. The language of recovery – including posters proclaiming that 'LIFE is not about WAITING FOR THE THUNDERSTORM TO PASS, but about LEARNING TO DANCE IN THE RAIN' – also seemed to jar in the context of a custodial setting.

Second Stage Evaluation: Assessing Impact

Identifying Sites

Aims

The primary aims of the impact evaluation are to inform the extent to which five selected Drug Recovery Wings in England and Wales are progressing as measured against their own goals, to inform the extent to which recipients of these DRW programs are progressing as measured against their own goals, and to identify the factors that are most strongly associated with positive and negative offender outcomes at each DRW.

Outcomes

Five high-level, long-term offender outcomes (i.e. beyond the offender's release from custody) were identified by the Government at the outset of the DRW pilot program in 2010: to reduce drug use and re-offending by offenders, and to improve offenders' health/well-being, employment outcomes and housing outcomes. Service providers at each pilot DRW were then tasked to identify and draft targeted short-, medium, and long-term outcomes for the recipients of the DRW program and the wider prison environment into a mission statement, and given freedom to locally develop a formulary of services by which these outcomes – e.g. increased motivation to work towards abstinence from illicit and licit drugs -, increased engagement with staff and treatment services, improved staff-offender relationships, acquisition of skills for securing housing and employment post-release – could be engendered in their treatment population. Finally, offenders who are eligible and volunteer to participate in DRW programs will have their own aspirations about what they consider to be priority outcomes of their DRW experience – e.g. repairing fractured relationships, brushing up on numeracy and literacy skills – and conceptions about the intermediate outcomes that would represent progress towards these personalised endpoints. This evaluation will examine the extent to which five DRWs have been successful in producing these stakeholders' targeted outcomes.

Scientific Case for Site Selection: Statistical Power Occupancy and Envisaged Analysis

Analytic Plan and Research Questions

A series of statistical analyses, described in greater detail below, will be conducted to investigate (i) the extent to which outcomes targeted by the Government, DRW staff, and recipients of DRW programs are being realised within and across five DRWs, and (ii) the likelihood that success and failure to achieve these goals is attributable to those who provided DRW services, those who received DRW services, the quality and quantity of DRW service provision, and the settings in which DRW services and skills are learned and enacted. Specifically, three research questions will be investigated:

1) Adjusting for differences in treatment population, to what extent are five examined DRWs effective in producing targeted long-term health, social, and offending outcomes in offenders, and to what extent do the examined five DRWs vary in their effectiveness?
2) To what extent are positive and negative health, social and offending outcomes in each DRW sample predicted by characteristics of the offenders, DRW staff, and wider prison culture and environment?
3) Adjusting for differences on a number of empirically-supported predictors of reoffending, are offenders who receive treatment for drug misuse within DRWs less likely to reoffend up to 12 months post-release compared to a matched sample of offenders who received non-DRW prison-based treatment for drug misuse?

The following sections describe (i) the statistical methods to be used to test three research questions about the clinical, social, and economic impact of five DRW programs on its recipients, (ii) the sample size required from each DRW to sufficiently power the planned analyses to detect meaningful effects, (iii) the likelihood that the required sample size can be recruited from each DRW within the allotted timeframe, and (iv) recommendations as to which five of the ten candidate 10 DRWs should be selected for further study purely on the basis of afforded statistical power.

Question 1: To what extent are DRWs effective in producing targeted long-term health, social, and offending outcomes in offenders?

Analytic Plan

The comparative effectiveness of five DRWs in producing targeted long-term outcomes in offenders will be tested within three types of regression equation, each of which handles different types of outcome data: linear regression (where the outcome is a value on a

continuous scale, e.g. number of previous offences committed), binary logistic regression (where the outcome data are recorded as one of two values, e.g. violent-type index offence, yes/no), and multinomial logistic regression (also called 'categorical', where the outcome data are recorded as one of at least three values, e.g. index offence = burglary vs. assault vs. criminal damage vs. auto theft, etc.). Very broadly, each of these regression equations uses actual data to estimate the magnitude of change in an outcome variable (e.g. did offender commit a violent-type offence within 12 months of release?) that one may expect to result from a unit change in each predictor variable (e.g. level of drug use, employment status, housing status), thereby steering researchers and policy makers towards the people, settings, and conditions that are empirically most likely to engender positive and negative outcomes. Knowledge of the cumulative and independent effects of predictor variables on outcomes-of interest can in turn be used to prioritise attention towards the people, settings and conditions characterised by the strongest, immediate, and most costly antecedents of negative outcomes at the expense of those characterised by weaker, less urgent and less costly antecedents.

The rapid assessment yielded preliminary evidence to reinforce the general conclusion drawn by the authors of the tranche 1 and 2 DRW pilot reports and the independent evaluation of DRWs conducted by the Policy and Innovation Research Unit (PIRU): due to their localised tailored development, there exists considerable heterogeneity across the ten pilot DRWs in terms of their inclusion/exclusion criteria, target population, quantity and type of interventions offered, and how staff conceptualise drug dependence, recovery and the functions of prison-based drug treatment. Significant heterogeneity on these potential explanatory variables across DRWs offers an ideal opportunity to assess which interactions of treatment provision X treatment population are most effective for improving offenders' status on the five targeted high-level, long-term outcomes of drug use, reoffending, mental and physical health, employment and housing, adjusting for pre-treatment differences on these outcome variables.

An example logistic regression model of the comparative crime benefits of five DRW models is shown in table 2. In this model, 'commission of a violent-type offence in the 12 months post-release' (yes/no) will be entered as the criterion variable. Data will be obtained from offenders on 10 empirically supported predictors of reoffending and drug use upon their entry and exit from a DRW and up to six months after their release from prison: drug use, alcohol use, offending, employment, employability, housing, finance, relationships, past drug treatment, and treatment motivation. The severity of offenders' difficulties in each of these life areas will be assess by summing the item scores which address each life area to produce 10 factor scores. These factor scores will be entered as covariates in step 1 of the regression model. DRW Model (x5) will be entered as the sole predictor variable in step 2. To assess any moderation of the effect of DRW model by the factor scores in step 1, interaction terms for DRW X step 1 covariates will be entered in step 3. To avoid over-fitting,

two-way interaction terms (with dummy coding on the DRW Model variable) will only be added where there is a strong theoretical and/or empirical rationale for their inclusion.

Table 2. Example logistic regression model of the covariate-adjusted effect of DRW model on the likelihood of offenders' commission of a violent-type offence within 12 months of release.

Criterion variable	Actual 12-month violent-type reoffending (yes/no)
Step 1	Drug use
	Alcohol use
	Offending
	Employment
	Employability
	Housing
	Finance
	Relationships
	Past drug treatment
	Treatment motivation
Step 2	DRW Model (x5)
Step 3	DRW Model X Step 1 Covariates

Question 2: To what extent are positive and negative health, social and offending outcomes in each DRW sample predicted by characteristics of the offenders, DRW staff, and wider prison culture and environment?

Analytic Plan

The importance of a number of putative antecedents for producing targeted outcomes within each DRW sample will be examined within the three types of regression equation described above. Though this question is technically informed by the significance of the interaction terms for DRW model X step 1 covariates in step 3 of the above model, any moderation of the effect of DRW model by the above listed covariates will be better understood by deconstructing these interaction effects into five separate regression models, one per DRW, and assessing the effects of the above listed covariates as main effects.

Testing these predictors as main effects within each prison also improves power relative to when these predictors are tested as part of an interaction effect with the prison variable. Testing the effects of these factors on outcomes separately for each DRW, and discussing the findings for each DRW in turn, should therefore give the reader a clearer understanding of the characteristics of offenders that are most strongly associated with positive outcomes in each sample, and of the types of staff and interventions that are most strongly associated with each sample's positive outcomes. An example linear regression model of the comparative drug use benefits of each DRW is shown in table 3. In this model, 'days of heroin use in the past four weeks' among offenders at DRW A will be entered as the criterion variable. Scores on 10 empirically supported predictors of heroin use will be entered as covariates in step 1. This model will be separately run for each of the five DRWs that are selected for study. Additional models which test staff-related variables, environmental variables (cultural and physical) and interactions of offender, staff and environmental variables as predictors of outcomes in each DRW sample will also be run.

Table 3. Example linear regression model of the predictive importance of 10 drug use-related factors for the past-four week point prevalence of heroin use (recorded at six-months post-release) of offenders who received treatment at *DRW A*.

Criterion variable	Days of heroin use in the past four weeks
Step 1	Drug use
	Alcohol use
	Offending
	Employment
	Employability
	Housing
	Finance
	Relationships
	Past drug treatment
	Treatment motivation

Question 3: To what extent are DRW graduates less likely to reoffend up to 12 months post-release compared to graduates of non-DRW prison-based drug treatment?

Analytic Plan

Comparing rates of offending among DRW graduates and a matched counterfactual sample of offenders treated for their drug problems out-with DRWs will inform judgements about the incremental social benefits of treating offenders' drug misuse within as opposed to out-with DRWs. Ideally, this comparison would be made by randomising DRW-eligible offenders to receive either treatment within a DRW or elsewhere in the same prison, comparing outcomes between these groups, and assessing the proportion of variance in outcomes explained by participation in a DRW, adjusting for other possible explanatory variables. However, a randomised controlled test of this hypothesis was found not to be feasible for the reasons that most DRWs were undersubscribed and so all offenders who were eligible and volunteered were accommodated on DRWs, and initial discussions with key DRW staff revealed ethical concerns about withholding a treatment package which they presumed to be the superior available option for the sake of a research study. In the absence of a comparison/control group of offenders in receipt of drug treatment out-with the DRW but within the same prison, comparing the rates of reoffending of DRW graduates versus a matched counterfactual sample of non-DRW treatment recipients is proposed as an alternative method of assessing the predictive significance of DRW participation for offenders' risk of reoffending within 12 months of release.

In this alternative method, each DRW graduate will be matched to an ex-offender who formerly received treatment for drug problems out-with DRWs on the basis of the four static risk factors and 32 dynamic risk factors that together create the OASys Violence Predictor (OVP); the OASys General Reoffending; date of release from custody, and time in treatment. Several previous logistic regression analyses of the OASys database have shown the OVP and OGP to be significant independent predictors of offenders' actual 12- and 24-months commission of violent-type and non-violent type offences, respectively. Therefore, scores on the OVP and OGP will be entered as covariates at step one of a logistic regression model (table X below) along with date of release and time in treatment scores, with actual 'violent-type offending' and 'non-violent-type offending' at six months follow-up and 12 months follow-up entered as the criterion (i.e. outcome) variables in separate analyses. Treatment type (within a DRW vs. out-with DRW) and prison (x5) will be entered as predictor variables in step two. To assess any moderation of the effect of treatment type, two-way interaction terms for treatment type X prison and treatment type X step one covariates will be entered at step three of the model. Three-way interaction terms for treatment type X prison X step 1 covariates will be added in step 4. To avoid over-fitting, three-way interaction terms will only be added where there is a strong theoretical and/or empirical rationale for their inclusion, e.g. to further explore any significant two-way interactions in step 3.

Table 4. Example logistic regression model of the covariate-adjusted effect of treatment type on the likelihood of offenders' commission of a violent-type offence within 12 months of release.

Criterion variable	Actual 12-month violent-type reoffending (yes/no)
Step 1	OVP
	OGP
	Date of release
	Weeks in treatment
Step 2	Treatment type (DRW vs. non-DRW)
	Prison (x5)
Step 3	Treatment type X Prison
	Treatment type X Step 1 Covariates
Step 4	Treatment type X Prison X Step 1 Covariates

Data Matching

Vast quantities of historical offender data on offending history and offending-related factors are known to be stored in the OASys, PNC, NDTMS P-NOMIS and System One databases. In order to construct a matched counterfactual sample of offenders not treated within DRWs, data-sharing agreements between the research team and the relevant database managers which specify the conditions on which the research team may extract and link offender data across databases for the purposes of research and reporting are required. Several database managers have been identified and a brief written description of the research aims and what and when requests will be made to them throughout the study period. Initial feedback to this notice of future requests for access and assistance have been positive and informative of the procedures by which such sharing agreements have been established in the past, as well as common roadblocks to establishing agreements. Though these discussions are in their infancy given that this analysis will not take place within the next 12 months, positive feedback relating to both the value of constructing a matched counterfactual comparison sample in this way and the feasibility of linking data across databases to produce this sample.

Calculation of the Required Sample Size for Each Planned Analysis

Sample size analysis is intended to calculate the minimum number of data that would be required to detect a statistically significant effect of an independent variable on a dependent variable where one exists. Convention in null-hypothesis significance testing (NHST) is to allow a 20% chance for a Type II error; that is, to design a study which gives an 80% probability, or power, of finding a statistically significant relationship between an observed event and its putative causes at p = 0.05, where such a relationship exists. Achieving 80% power in studies of psychosocial health behaviour change interventions is a notoriously challenging feat, compounded by the perils of conducting following up assessments with participants out-with the treatment/intervention setting and the perils of maintaining contact with individuals, many of whom have in the past lived chaotic lives as a result of their problems with drug use, and many of whom experience peaks and troughs in their willingness to stay engaged with researchers and treatment services. Therefore, the sample size requirements to achieve both 60% and 80% power of detection with each analysis are reported.

The statistical power of a study to detect meaningful effects is determined by five factors: number of predictor variables tested (more predictor variables = increased power), effect size (larger effect = increased power), sample size (larger sample = increased power), significance level (higher alpha = increased power), and nature of the hypothesis (one-tailed = increased power, two-tailed = decreased power). The goal standard in study design is to conduct a power analysis prior to beginning a study in order to calculate (i) how many participants a study needs to draw reliable conclusions about the relationships between observed phenomena and their possible causes, (ii) how many additional participants should be recruited to offset any anticipated loss of participants to follow-up for whatever reason in order to maintain a satisfactory level of power, and (iii) how feasible it will be to recruit the target sample size.

On an important side-note about null-hypothesis significance testing (NHST), Cohen (1990) argues that an observed difference for which $p > 0.05$ should not be discarded as clinically meaningless solely on the basis of dichotomous statistical decision-making because "p = 0.05 is not a cliff but a convenient reference point along the possibility-probability continuum. There is no ontological basis for dichotomous decision making in psychological inquiry" (p.1311). Wagenmakers (2007) goes as far as to argue that *p* values which approach 0.05 in small samples may have similar or greater evidential value than *p* values that are slightly lower 0.05 in large samples. Additionally, health behaviour change research in the past 20 years has increasingly adopted Cohen's argument that *p* values should be invoked as a more or less helpful descriptor of more informative effect sizes when inferring the clinical significance of an intervention. Taking these statistical arguments into account, discussion about the clinical

significance of effects arising from analyses that were based on small samples will be informed primarily by effect sizes and secondarily by their associated p values.

Question 1: Calculation of the Required Sample Size

Continuous Outcomes

With a sample of 61 per DRW, a linear multiple regression model testing up to 11 predictor variables has 80% power to detect a medium size effect difference ($f^2 = 0.15$ for R^2 increase) in outcomes at p = 0.05. In anticipation of a 30% loss-to-follow-up rate, 87 offenders should be recruited per DRW to attain a final sample of 61 per DRW. With a sample of 44 per DRW, power to detect the same effect is reduced to 60%. Anticipating attrition, 63 offenders should be recruited to attain a final sample of 44 per DRW.

Binary Categorical Outcomes

With a sample of 104 per DRW, a logistic regression model has 80% power to detect an unadjusted odds ratio = 1.5 in outcomes at p = 0.05 (two-tailed). In anticipation of a 30% loss-to-follow-up rate, 148 offenders should be recruited per DRW to attain a final sample of 148 per DRW. With a sample of 66 per DRW, power to detect the same effect is reduced to 60%. Anticipating attrition, 93 offenders should be recruited to attain a final sample of 66 per DRW. A two-tailed test is specified because the wish is to test for the possibility that any given DRW is both more and less effective than any other examined DRW.

Question 2: Calculation of the Required Sample Size

Continuous outcomes

A linear multiple regression model testing up to five predictor variables has 80% power at p = 0.05 (one-tailed) to detect a medium sized effect difference ($f^2 = 0.15$ for 'R^2 deviation from zero') in outcomes in a sample of 46 per DRW. A one-tailed test is specified as it is believed that positive outcomes will be more strongly associated with fewer problems, not more problems, in each of the examined life areas. Table 5 below shows how the sample size requirements increase as predictor variables are added to the model. These are the final sample sizes that a study would require in order to have an 80% chance of finding a significant relationship between a tested model of predictor variables and an outcome variable, where one exists.

Table 5. Sample size requirements for the planned multiple linear regression analyses.

Number of Predictors	1 – β err prob	Required N Per DRW	Expected Attrition	Recruitment Target N
5	0.80	46	0.30	67
6	0.80	49	0.30	70
7	0.80	52	0.30	74
8	0.80	55	0.30	78
9	0.80	57	0.30	82
10	0.80	59	0.30	85

Accounting for an anticipated loss of 30% of offenders up to the six months after release from prison, a linear regression model containing up to 10 predictor variables would require 85 offenders per DRW to retain an 80% chance of detecting a medium-sized effect difference in outcomes. Assuming a worst-case scenario in which only 43 offers (50% of the target) can be recruited per DRW, power to detect this same effect would be reduced to 61%.

Question 3: Calculation of the Required Sample Size

Binary Categorical Reoffending Variables

With a sample of 104 per DRW, a logistic regression model has 80% power to detect an unadjusted odds ratio = 1.5 in outcomes at p = 0.05 (two-tailed). In anticipation of a 30% loss-to-follow-up rate, 148 offenders should be recruited per DRW to attain a final sample of 148 per DRW. With a sample of 66 per DRW, power to detect the same effect is reduced to 60%. Anticipating attrition, 93 offenders should be recruited to attain a final sample of 66 per DRW. A two-tailed test is specified in this case because the wish is to test for the possibility that DRW treatment is both more and less effective than non-DRW prison-based treatment.

Likelihood that the Required Sample Sizes Can Be Recruited at Each DRW

All of the planned analyses described above would be powered at or above 80% to detect medium size effects in outcomes at p = 0.05 with a sample of 104 per DRW (148 data*0.30 attrition), and powered at or above 60% with a sample of 66 per DRW (93 data*0.30 attrition). The next step was to estimate the likelihood that **a minimum of 93 offenders** can

be recruited from each DRW. These estimates were based on three factors: (i) the time allotted by the research team for offender recruitment, (ii) the actual utilisation of beds within the ten candidate DRWs, and (iii) the number of offenders who graduate/discharge/transfer out of each DRW within the timeframe allotted for offender recruitment.

Recruitment Time

On the assumption that recruitment of the first offender to this study will take place on or before October 1st, 2013, we propose to cease recruitment of new DRW entrants by September 30th, 2014, cease collection of data upon offenders' exit from a DRW/release from prison at September 2014 in order to cease collection of six-month community follow-up data at March, 2015. This schedule would give 10-12 months for offender recruitment, followed by the final four contracted months to undertake final analyses and produce the final report.

Bed Utilisation

Table 6 below shows the sample sizes that are hypothesised to be attainable from each of the ten candidate DRWs. These sample sizes were estimated on the bases of information about the number of beds in use at each DRW, assuming different lengths of an offender's stay in the DRW before transfer or release, a recruitment period of 12 months, and an anticipated maximum loss-to-follow-up rate of 30%. These estimates will however vary as a function of the fluid local development of DRWs and will be subject to variable policy change pertaining to the structure and population of DRWs. It is also important to note that the number of beds in use at the time of the rapid assessment are snapshots of bed usage and may not accurately reflect peak-and-trough trends in the normal uptake and turnover of DRW beds. To account for potential variability in DRW bed availability, utilisation and turnover over the 12-month recruitment period, upper and lower bounds estimates were constructed around these mean estimates by multiplying the number of beds in use by 0.7 and 1.3 (i.e. less or plus 30% of mean estimate).

Table 6. Attrition-adjusted estimates of potential sample sizes at ten DRWs.

DRW	Beds in Use	Recruitment Time (months)	Offender Months in DRW: Two	Three	Four	Five	Six
Brixton	40	12	168	112	84	67	56
High Down	66	12	277	185	139	111	92
Holme House	60	12	252	168	126	101	84
Manchester	17	12	71	48	36	29	24
Styal	11	12	46	31	23	18	15
Brinsford	27	12	113	76	57	45	38
Bristol	140	12	588	392	294	235	196
Chelmsford	132	12	554	370	277	222	185
New Hall	9	12	38	25	19	15	13
Swansea	49	12	206	137	103	82	69

Green = Potential sample size estimated to be ≥ 93.

Red = Potential sample size estimated to be ≤l 93.

Assuming a turnover of DRW cohorts occurs every three months, on average, table X shows that achieving a final offender sample size which gives 80% power to a linear regression model containing 5-10 predictor variables to detect a medium effect size at p = 0.05 is predicted to be feasible at six DRWs: Brixton, High Down, Holme House, Bristol, Chelmsford and Swansea. Reducing the acceptable power threshold to 60% would include a further two DRWs: Brixton and Brinsford. On the basis of bed utilisation data alone, the required sample size is not predicted to be achievable at the remaining three DRWs: Manchester, New Hall and Styal.

Rate of Throughput

Requests were made to the 10 DRWs for data on the number of offenders released from their DRW directly into the community within the past 12 months. Actual or estimated past 12-month throughput data were reported by five DRWs: Brinsford (n = 93), Holme House (n = 110), New Hall (n = 60 in past ten months), Swansea (n = 80-90), and Manchester (n = 50-60). No throughput data were received from the DRWs at Bristol, Chelmsford, Brixton, Styal and High Down.

Conclusion

Taking available DRW bed utilisation and throughput data together, it is estimated that the DRWs operating at HMP's Brixton, Brinsford, Bristol, Chelmsford, High Down, Holme House, and Swansea offer the greatest potential to recruit a sample size ≥ 93 within 12 months as required to give at least 60% power to all planned regression models to detect a medium effect size difference in outcomes. The estimates of potential sample size that confer this conclusion are based on the bed capacity of DRWs, uptake of beds, and rate and speed of offender throughput at the time of assessment and therefore the reliability of these estimates are sensitive to changes in these factors. Substantial changes to factors that affect the capacity and uptake of DRW beds, and the speed and rate of graduation from DRWs during the study period should reduce confidence in these estimates of potential sample size.

Second Stage Evaluation: Process Evaluation

The process evaluation will proceed broadly as described in our proposal in the prisons listed above. It will provide contextualised accounts of the development and functioning of the DRWs and the experiences of prisoners and staff on these wings. It will consist of the following elements:

i. A Measurement of Quality of Prison Life (MQPL) survey
ii. MQPL qualitative element
iii. Further interviews with prison staff in each prison
iv. A qualitative cohort study
v. Recovery process interviews in the community
vi. Interviews with local commissioners and through-care staff
i. MQPL survey

Alison Liebling will lead on this component. To obtain these data prisoners' quality of life will be assessed using Liebling's (2004) Measurement of Quality of Prison Life (MQPL). The MQPL is a tickbox instrument which measures the dimensions of "staff-prisoner relationships", "fairness", "professionalism", "security", "personal development" and "wellbeing". There is a standardised methodology for its administration, involving multiple groups of up to twelve inmates, in which literacy problems can be addressed and queries answered. These surveys are currently being undertaken in a number of prisons by NOMS, who have agreed to oversample prisoners in the DRWs, to allow a comparison of quality of life within and without the DRWs. The research team will work with NOMS in collecting MQPL data in those prisons where surveys are due to take place in the study period. Should

there be prisons in the study where such surveys are not taking place, the team will be responsible for undertaking this work.

ii. MQPL qualitative element

The team will also be responsible for the qualitative element of the MQPL, which is embedded within the quantitative element. This will consist of interviews with inmates and staff. Ten inmates identified for interview through their participation in the survey will be interviewed. These interviews will address a range of issues relating to their involvement with the DRW, services provided and the quality of life dimensions referred to above. Interviews will also be conducted with 15 members of staff drawn mainly from the DRW but also from elsewhere in the prison. These interviews will address their involvement in the DRW, their views on its effectiveness and further exploration of the quality of life dimensions. These elements will be undertaken wherever the opportunity arises either where the survey is undertaken by the research team or by NOMS.

iii. Further interviews with staff

Building on the rapid assessment, further interviews will be undertaken with staff to update the earlier findings and clarify any outstanding issues. We will undertake between five and ten interviews with staff in each prison, drawing both on key staff involved in the delivery of the DRW programme and, where pertinent, members of staff from elsewhere in the prison. [Total = c. 35-70]

iv. A qualitative cohort study

At each of the DRWs, a qualitative, longitudinal cohort of 10 to 15 prisoners will be interviewed shortly before exit from the wing and at six-month follow-up on release. This additional longitudinal element will provide a qualitative, 'three-dimensional' account of prisoners' experiences on the DRW and on release and the degree to which the DRW has prepared them for recovery. This element will constitute a separate sample from the quantitative cohort. There will, inevitably, be some attrition in this sample (Total = c.150).

v. Recovery process interviews in the community

With the permission of prisoners in the qualitative cohort, we will interview key people involved in recovery support to individual prisoners (as identified by these prisoners). These may include friends, family, workers from a range of different agencies etc. The number of interviews achieved here will depend on follow-up rate but we aim to interview one or two people for each prisoner successfully followed up. (Total = c.80)

vi. Interviews with local commissioners and through-care staff

We aim to undertake three interviews with drug and alcohol service commissioners and senior staff within key drug and alcohol agencies in each prison area. We will also undertake

interviews with the two workers most involved in each DRW's through-care provision. From previous experience, some such participants may prefer to take part in telephone interviews and we therefore anticipate that there will be a mixture of face-to-face and telephone interviews (Total = 35 interviews).

Sampling

Prisoners and staff will self-select to some degree, in that only those that elect to take part in the qualitative element of the MQPL will take part. However the further interviews with staff and prisoners will give the research team the opportunity to invite individuals whose voices have not yet been heard. Local commissioners and through-care staff in the areas served by the case-study DRWs will be selected for interview. We will purposively sample workers who have a high level of involvement and workers who have a low level of involvement with released prisoners, to explore obstacles and facilitators to linking up with the DRW.

Scientific Case for Site Selection: Delivery of Recovery Focussed Work

Alongside our analysis of possible site selection based upon occupancy numbers we have also drawn upon information on the nature of the therapeutic programme within each of our Drug Recovery Wings obtained on the basis of our rapid assessment. This information provides additional material contributing to selecting the Drug Recovery Wings to be included within second stage of our evaluation assessing the impact of Drug Recovery Wings.

Following Liebling *et al*. (1999), principle of 'appreciative inquiry'[8] all of the DRWs will have encountered challenges during their initial setup, and in their ongoing work and routine. On that basis there is a strong case for 'focus[ing] on the best aspects of [DRWs'] work and role, and the conditions in which they function especially well',[9] Stage 2 of the research can offer prisons and policymakers insights into working styles and operational models that are particularly promising, without avoiding difficult issues or challenges. There is an argument then for focussing upon those particular prisons that have the strongest forms of Drug Recovery Wing in operation. To this end we have drawn upon data from our rapid assessment work to identify those Drug Recovery Wings which appear to have made the greatest investment in developing recovery oriented work and which appeared to be providing the greatest support for prisoners following release. We have summarised the information on these domains across each of the Drug Recovery Wings in table seven.

[8] Liebling, Price and Elliott 1999
[9] Liebling, Price and Elliott 1999:71

Table 7. Throughcare and aftercare provision identified in DRW Pilot Sites during rapid assessment fieldwork

	Provision *within* 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 details available regarding groups 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 (awaiting clarification re: current delivery) 2 additional mutual aid groups Additional family visits, dedicated DRW Family Support Worker sessions 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
Chelms-ford	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 St Giles Trust active (and employing prisoners as 'housing peers') Blue Skies employment working with DRW clients; some apparent success	High
Holme House	Modelled on Holme House's Therapeutic Community (on same houseblock) Rolling 'induction programme': 5 * 1-hour groups One hour of 'smart recovery' each week Prisoners paid to be on wing Prisoners not in education or employment unlocked during the day Weekly recovery-focused one-to-ones with personal officers Wing-based 'expeditors' (trusted prisoners: reinforce rules, mediate requests) Dedicated gym sessions 6-week DRW-specific healthy-living cookery courses (cohorts of eight) DRW vegetable garden (training and education opportunities)	High	Tight links with IOM teams from Holme House's four main release areas DRW identified as, originally, a *resettlement-focused initiative* 4 'link worker' officers, working in prison and community. Therapeutic community exists as within-prison progression pathway	High

Manch-ester	8-week intensive induction programme, involving 7-14 groups per week 2nd stage programme involving approximately 6 groupwork sessions per week Aspirations to Therapeutic Community working model Daily diaries submitted weekly to key workers Weekly 1-1s with recovery workers Established peer mentoring programme Addaction peer mentoring training, with potential to progress to NVQ L2 accreditation Victim awareness groups SMART recovery groups 2 Fellowship meetings each week Dedicated gym Dedicated server Partnership with Partners of Prisoners group	High	'Resettlement Through the Gates,' a nationally recognised aftercare initiative 13 weeks of aftercare (often more) delivered to prisoners, by prison staff, in a dedicated community setting Established partnerships with education and employment initiatives Established partnerships with drug and alcohol services Accompaniment to all 1st appointments offered to released prisoners	High
New Hall	3 groups per week 5 'morning meetings' per week Detoxification encouraged and supported on-wing 1 peer support session per week Acupuncture Additional gym Cookery sessions	High	No structured release provision or support Askham Grange seen as a possible referral for one woman on DRW	Low
Styal	'Therapeutic community' type environment 4 'morning meetings' per week 1 'community meeting' per week Drug-focused or resettlement activities 5 mornings per week Additional gym Compulsory community activity' two evenings per week Recovery rules' and a 'conflict management system'	High	No exit plan' for women on the wing, leading to 'bed blocking.'	Low
Swansea	Up to four groups led by prison officers each week (capacity 8) Up to two 2-hour groups led by outside drug services each week (capacity 12) No education or employment off the wing, leading to many hours' 'bang up' Prisoners paid for being on DRW	Med	Drug free wing envisaged as move-on point within prison Psychosocial team working in the community, supporting continuity of care Positive uptake of referrals / attendance noted by community drug team	Med

*As a YOI, Brinsford's release provision is further complicated by its very wide catchment area. We spoke to prisoners who lived over 80 miles away

Our analysis of DRWs' recovery-oriented provision highlighted four sites with high-intensity, recovery-oriented provision at all stages of prisoners' journey: Brixton, High Down, Holme House and Manchester. Table 5 would lead us to exclude three sites which on the basis of the rapid assessment appeared to be delivering minimal recovery-oriented support within the wing: Brinsford, Bristol and Chelmsford. Two of these also appeared to have minimal recovery-oriented aftercare and transfer pathways. Finally, although three prisons lacked *high*-intensity provision at all stages of the DRW, they nonetheless evidenced sufficient provision to act as viable Stage 2 case study sites. Swansea evidenced mid-intensity throughcare and aftercare, whilst New Hall and Styal followed high-intensity throughcare with low-intensity aftercare.

Heterogeneous Provision

Having established which wings may be appropriate for intensive evaluation, we proceeded to review prisons' and DRWs' characteristics. The scientific rationale for this process was predicated on the perceived benefits of securing a heterogeneous case study sample, focusing on prisons with differing models of provision and target populations. Heterogeneity is scientifically desirable for two reasons.

Firstly, it allows the evaluation to focus on a wide variety of interpretations of 'recovery.' The Recovery Agenda[10] has embraced variations in regional provision. As the Policy Innovation Research Unit initial report on the DRWs notes, a similar philosophy has underpinned the DRW model:

> The pilot sites were given the flexibility to design DRW models appropriate to their context and offender population (PIRU 2012:1)

Focusing on heterogeneous DRW models thus reflects the original policy intentions underpinning DRWs, whilst allowing lessons to be learnt about DRW operational models whose diversity reflects national 'recovery' provision.

Secondly, selecting a diverse group of DRWs bolsters the applicability of the evaluation, supporting the potential for adaptation, adoption and roll-out for multiple client groups in many prisons.

Table 8 presents data relating to prison type and DRW population. Cells are shaded on the basis of the rankings from Stage 2 of the selection process. Green prisons are those with high intensity recovery-oriented throughcare and aftercare. Red prisons are those which appear to be providing insufficient recovery-oriented support to justify intensive evaluation.

[10] E.g. HM Government 2010:20; HM Government 2012

Amber prisons are those which fall short of delivering consistently intensive provision, but still evidence evaluation potential.

Table 8: Prison type and main DRW population

Prison	Category or Type	Main DRW population
Brinsford	YOI	Non-opiate
Bristol	Cat B local	Opiate (and alcohol detox)
Brixton	Cat C	Non-opiate
Chelmsford	Cat B local	Opiate (and alcohol detox)
High Down	Cat B local	Non-opiate
Holme House	Cat B local	Opiate
Manchester	Cat A	Opiate and non-opiate
New Hall	Women's	Opiate
Styal	Women's	Opiate
Swansea	Cat B local	Opiate AND non-opiate

The four sites delivering the most recovery-oriented throughcare and aftercare are all men's prisons. Two are Category B local prisons, working with different client groups (primarily opiate; and primarily non-opiate). One is a Category A prison working with a wide variety of drug and alcohol dependent prisoners. The final intensive recovery-oriented site is the only Category C DRW, working primarily with prisoners without histories of opiate dependence. The four top-ranked DRWs to emerge from stage one of the selection process thus satisfy our heterogeneity criteria: they are all working with different populations or within a different kind of institution, and consequently offer findings that are applicable to a large proportion of the prison estate. One men's Category B prison (Swansea) is also included in the second tier of our recovery-oriented ranking. As Swansea is delivering mid-intensity throughcare and aftercare, and as we already have two Category B men's prisons in our preferred four prisons, the case for including Swansea in these terms becomes less than it might otherwise be the case.

The other two prisons are women's establishments. Women's prisons are not categorised in the same way as men's. Women prisoners also have different profiles to male prisoners, and present with more hard drug use, drug dependence, and drug-related risk behaviours (e.g. Singleton *et al* 1998:20-21; Boreham *et al.* 2007:48;61-2). There is consequently a scientific justification for including a women's prison within stage 2 of the research, to inform policy and provision in England's other 14 women's prisons. Both Styal and New Hall were delivering highly intensive programmes *within* their regime, but evidenced shortfalls in established aftercare provision and release planning.

Three factors provide a justification for prioritising Styal. Firstly, despite both women's prisons delivering highly intensive recovery-oriented support when compared with the full range of DRWs, Styal was delivering between two and four additional recovery-oriented groups per week *and* was striving to model provision on the principles of a therapeutic community. Features of the community-oriented model included the accepted presence of a conflict management system, enacted by the women themselves; and 'recovery rules.'

Secondly, predicated on three days of fieldwork and 18 interviews, Styal's rapid assessment report indicates that working relationships between prisoners and professionals were particularly well-developed, with a highly supportive team being warmly praised by prisoners. The principles of appreciative inquiry thus suggest that Styal might be expected to yield more positive learning points for other establishments.

Thirdly, prisons in the North West of England are expected to trial a new resettlement programme in the near future. This is likely to improve Styal's access to resettlement funding, and concomitant resettlement provision. No such measures are expected with regard to New Hall's resettlement provision.

On the basis of this rationale Styal would be included as one of the preferred prisons for inclusion in Stage 2 of the Drug Recovery Wing Pilot evaluation.

Patient and Public Involvement

We have had one meeting with the chair of our Patient and Public Involvement group which comprises prison staff, former prisoners, and service commissioners and at which we discussed the progress of the research to date. It is our intention to circulate to this group the reports of the rapid assessment work and our plans for the second stage of the research. It would have been premature to have done this in advance of the rapid assessment reports having been approved by the participating prisons and the government departments involved within the research. In addition we will also be circulating our prison questionnaire to be used in the impact assessment to the chair of the PPI group for discussion and where appropriate amendment. In connection with referees suggestion of contacting community groups and family support groups we anticipate that this is likely to be maximally useful in the second stage of the research where we are following up prisoners post release. We will explore the feasibility of making such contacts at the relevant time.

Proposed Site Selection for Second Stage Impact and Process Evaluation

Having considered the various options for the second stage of the research, we propose focusing the process and outcome evaluations at the following five prisons: Brinsford, Brixton, High Down, Holme House and Swansea. Additionally, we propose undertaking process evaluations at Manchester and Styal, given the high intensity recovery work within these two DRWs. However because neither Manchester nor Styal have sufficient numbers to meet our sample size requirements they will not be included within the impact evaluation element of the second stage of the research.

Next Stage: Research and Development Approval

Now that ethical approval has been provided for the research the next component part of the approval process is to obtain approval from the Governors of each of the prisons focused on in the second stage.

Appendix 1: References

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Appendix 2: Brinsford

Rapid Assessment

Help's just there if you want it (P)

I don't think we are delivering as much as we hoped to (S)

Starting note: interview identifiers

Throughout this report, staff (of all kinds) are identified with an S. Prisoners are identified with a P. Thus (P) after a quotation indicates that it is drawn from a prisoner's interview. (S) indicates that it is drawn from an interview with a member of staff.

Basic prison information

Situated on the edge of rolling Staffordshire countryside, six miles from both Cannock and Wolverhampton, 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 shares its location with two other prisons. HMP Featherstone is a Category C closed men's prison. Established in 1976, it has an operational capacity of approximately 690 prisoners. HMP Oakwood is a privately-operated Category C men's prison, originally commissioned as part of New Labour's Titan prison building scheme. When Titan prisons were abandoned the construction of Oakwood continued, but its planned operational capacity fell from 2,500 to 1,605 beds.

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.

During fieldwork, prisoners' recovery journeys began in reception. Clinical and psychosocial practitioners conducted triage assessments, and all prisoners with identified drug problems were taken onto the psychosocial Drug and Alcohol Recovery Service's (DARS') caseload. Prisoners with additional clinical needs were rare. Brinsford held two opiate dependent prisoners during fieldwork. Each expected to serve their full sentence on the prison's 24-hour, 12-bed healthcare unit. All other DARS clients followed one of two recovery pathways. Approximately 83% lived on general population wings, receiving psychosocial one-to-ones on a once-monthly basis. Up to 32 young prisoners with drug-related needs could also be housed on the DRW, benefiting from improved access to the DARS team, and some groups.

At the time of our visit, the DRW was in an early stage of development. Difficulties arising from a region-wide recommisioning of prisons' psychosocial services led to a hiatus in full provision, beginning in October 2012. For several months, clients had access to limited keyworking and no structured groups. A week before fieldwork the first professionally-led group had been delivered, and plans for a full programme of provision were in place. That there were good reasons for the DRW's reduced condition, and clear and credible plans for the near future, should be borne in mind when reading this report.

A typical day on the DRW

> I: Are there any differences in the regime between the DRW and the other wings?
> S: No. They try to keep it the same.

During fieldwork, the DRW offered a sum total of 1.5 hours of timetabled therapeutic provision each week, consisting entirely of mutual aid groups. Each group had a maximum capacity of 12 people, yielding an average of 18 group attendances (at most) each week[1]. As the wing had 27 full beds, this equated to (on average) 40 minutes of mutual aid support per person per week. Informal (or formal) one-to-ones might add between five minutes and one hour to this figure, yielding (optimistically) 100 minutes of therapeutic support per prisoner per week. In this context, therapeutic work could not act as the mainstay of prisoners' days, or of the DRW's regime.

Thus, prisoners' days took one of two routes. Most engaged with purposeful activity (work or education), often on other wings. Five (of nine) of our prisoner interviewees were engaged with purposeful activity, with the busiest holding three jobs and earning £13 each week. 'Only a couple of lads' (S) were unemployed and out of education. We interviewed four such prisoners, each of whom described repetitive and boring days with 23 (or more) hours spent behind their cell door:

> If you've got no sosh[2]… 23 hours a day [bang up]? Sometimes more. Get me dinner, get my tea. Fifteen minutes exercise on the morning. And that's it (P)

These interviewees described spending their days watching television, or writing letters to family and friends. It should perhaps be noted that for reasons of time and resources, we interviewed a 'convenience sample[3]' of prisoners during this rapid assessment. Prisoners who were unemployed and out of education were particularly likely to be available. It seems plausible that they were consequently over-represented in our interview sample.

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[1] In practice, one mutual aid group ran on a weekly basis, and one on a fortnightly basis. Thus, presuming both groups were running, there would be 12 and 24 group attendances available on alternating weeks.
[2] Association periods were spread throughout the week: Tuesdays, Thursdays, Fridays. Saturdays and Sundays
[3] Blaikie describes: 'a typical convenience sample is obtained when an interviewer stands on a street and selects people accidentally as they pass. Such respondents are representative of no particular population, nor even of people who passed that spot during a particular period of a particular day… it is likely to produce very unrepresentative results' (2000:204). With only 2-3 days to carry out 20 interviews in each rapid assessment site, and mindful of the resources already being asked of prisons supporting this research, we sought to interview those prisoners who were already available on a given DRW. Sometimes, staff also played a role in selecting our interviewees. Each of these processes – our reliance on convenience, and on staff selection – mean that all findings must be heavily qualified, as our interviewees cannot be assumed to represent all DRW residents.

Rules, requirements, and the DRW compact

We were unsure whether Brinsford's original DRW compact was developed by the DARS team, or by the CARAT team who preceded them. However, DARS staff were clear that once the DRW had begun to find a solid footing, they found the compact difficult to police. Few prisoners were aware of its contents:

> Although young people had signed it, when I asked them what the compact covered, none of them had a clue. And that was a concern because we're asking them to follow the conditions of something they don't understand (S)

A chance encounter then led wing staff to consider a different approach:

> I went to Dovegate [therapeutic community]. It was run by the prisoners. And I said "we're having a little bit of trouble with the compact. They're not sticking to it. And not understanding it." And [a prisoner] said to me "go down there, get them all out, and get them to write their own compact. That way they know what's on it. They're gonna be reasonable, and they may adhere to it more." So that's what we did (S)

In the course of a two-hour consultation, staff and prisoners drew up a new compact (see Appendix A). Whilst prisoners' contribution to the new compact had been limited by security and staff pre-requisites, wing residents contributed to at least three points.

In a further bid to ensure that prisoners were fully apprised of the compact's contents, each wing resident was given their own copy, and a copy was on open display in the DRW's association room. Notwithstanding these considerable efforts, only a third of the prisoners we interviewed indicated that they had any understanding of the compact. Three described it in broad terms, with one specifying that it prohibited 'fighting and that,' and one noting that you have to 'behave or you will be kicked off'. Of all disciplinary issues, violence seemed to be the most prominent[4]. Two of our interviewees had fought other offenders, one had 'kicked off' when he gained a 'dirty' padmate, and a fourth had assaulted a member of staff. Though two had lost their positions in education or employment, none had been threatened with removal from the DRW[5].

It seemed likely that wing residents were also be reasonably unsure of the compact's precise role and status. Some apparently non-negotiable requirements were routinely breached[6], whilst some areas of apparent flexibility were policed with a hard line[7].

Observations on the physical and social environment

> I wouldn't go on any other wing. The staff here are good. I'll threaten them, say "nah I'll fucking hit ya" but I wouldn't do that. Because I've got that bond with them (P)

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[4] Of 34 prisoner interviewees in three adult DRWs, just one had been in a fight whilst on the DRW.
[5] It bears mention that two 'lodgers' had been removed shortly before fieldwork, for destroying a double cell.
[6] e.g. the compact states 'I will… attend at least one mutual aid group on a weekly basis.' This was impossible, as there were insufficient mutual aid groups for every resident to attend once each week. Staff added that clients need not go if they found them boring, or got little benefit from them.
[7] The DRW compact states that, even with regards to bullying and drug use, "the DRW will not be run as a zero tolerance unit.' Staff were clear that this was not the case: "S: We have zero tolerance on bullying [I: And positive test results are zero tolerance?] S: Yeah"; "[If] there is bullying…. we will move them straight away" (S)

Brinsford is the only YOI we visited. We visited no direct comparators, and all comparisons are with adult prisons. This should be borne in mind throughout this report.

Security measures were more visible in Brinsford than in our sample of adult prisons, largely due to the YOI's residential structure. Landings' staircases were topped and tailed by security gates, as were the entrances to wings and houseblocks. From many standpoints, three or four sets of gates could easily be seen. The DRW's central corridor was lit by fluorescent strips, with natural light limited to the association room (and, presumably, the cells which lined the wing's outer walls). In other respects, staff felt H1 offered some material advantages over other wings. These included increased access to single cells, renovated and refurbished windows, and some additional decorations:

> We put plants [in the association room]. And the buzz that that created. Just over some plants. And they've kept them alive. And they've proved that they can look after things to the point that we've said "right, we'll give you the fish tank that you want." Alright, there's no fish in it, but that's a teething problem. That's the next step (S)

Prisoners tended to be less confident that the DRW represented an improvement over other wings. Whilst one interviewee praised H1's association room, two felt the wing was under-resourced:

> It's a mess down there. H1 don't get as much stuff as other wings. F wing, they've got loads of paint, loads of new clean brushes, mops. Downstairs we've got one mop. One dirty broom. And half a tin of paint. Just you don't get as much stuff. Like the washing machine. That's been reported around [huffffff….] three, four months ago (P)

The theme of the washing machine was particularly recognised by staff.

Both prisoners and professionals presented the DRW's relational environs in positive terms, supported by the attitudes of both staff:

> We have good relationships with the lads down there. We try to instil that sense of community and that ownership of that wing. Because… the staff are familiar. And [prisoners] have our support Monday to Friday (S)

> It's good man. It's a good wing to be on… Because the staff do care, ya get me (P)

And by the attitude of residents, some of whom described looking out for vulnerable peers:

> Some of them. You *feel* for them, because some of them commit suicide because of the drugs and their mum don't want them. I speak to a few of them and just tell them. "Yo. Ya get me. There's more to life than this." Ya get me. (P)

> I like the vibe down there, the people. I've got people who I like to and relate to (P)

The presence of both potential peer supporters and their beneficiaries on the wing raised several interrelated issues and tensions. **Firstly,** the DRW was widely felt to provide a safer environment. Three psychosocial interviewees identified that they would sometimes prioritise applicants for DRW beds on the basis of their perceived vulnerability to bullying or exploitation on other wings. **Secondly,** this was thought to have an impact on the work that

could be delivered. Whilst vulnerable individuals might benefit from the wing's more supportive environs, they might struggle to engage with structured interventions:

> I think that the people that….. struggle to cope most have quite a lot on their plate to just get through the day. And to really focus on making changes is quite difficult (S)

Two vulnerable prisoners saw this rather differently, querying whether or not the wing's more 'stable' prisoners had ongoing drug problems or rehabilitative needs. **Thirdly,** the DRW's 'stable' residents had no formal accountability, official position or defined role, leaving their remit open to both interpretation and potential exploitation. Staff described several such residents as valued sources of stability and peer support. Two 'stable' prisoners offered a similar view, presenting themselves as benevolent and supportive patriarchs:

> There's only four main people on the wing. Me, [and three others]. If people need people to talk to they'll come to us. If people are starting to bully them, they'll come to us. We don't let that happen (P)

Vulnerable interviewees were more hesitant. Two identified the wing's more stable prisoners as particularly troublesome, naming one as the 'main dickhead' behind exploitation and bullying on the wing. Those holding trusted jobs on the wing were identified as troublemakers too, using unmonitored time out of their cells to eavesdrop on confidential discussions, gather information on other wing residents, and bully those still locked in their cells by slamming observation hatches, turning cell lights off, and kicking cell doors.

It is possible that these concerns were partly the result of wing politics or resentment, and future studies would certainly benefit from exploring the relationships between 'needy' and 'less needy' prisoners more closely, particularly in the context of a YOI. Perhaps more importantly, even vulnerable prisoners unfailingly identified that the DRW represented a weighty improvement over the relational conditions on other wings. An officer surmised, 'I know a lot of these lads would go backwards on normal wings.'

Profile of DRW residents

> Heroin's an old man's drug. [We're seeing] a lot of legal highs and things like that (S)

> There're some people down there who have mental health issues. That are poor copers. Others that are so far the other way, that they can't actually bring themselves down (S)

All interviewees were between the ages of 18 and 21. Our sample (including one remandee) had served a mean of 13.8 months in prison, with a range of four months to four years. Two were serving their first sentence (though each had previously been detained once on remand). Three had been imprisoned once before, and three were on their third sentence. Only our remandee was a frequent flier, imprisoned for the 15th time. Despite their lack of previous prison sentences, our sample had been convicted of some very serious or prolific offending sprees. One had 28 offences taken into consideration; one had been imprisoned for a series of "dwelling, aggravated and normal" burglaries; and a third had been convicted of two burglaries and a series of violent street robberies. Consequently, sentence lengths were long. Discounting one prisoner's indeterminate sentence, our sample's *mean* sentence length was 6.3 years with a range of 14 months to 10 years.

In the adult DRWs we visited, interviewees tended to have been imprisoned for violent *or* acquisitive offences. In this respect, Brinsford interviewees stood out: five (of nine) had been imprisoned for *violent acquisitive* offences such as aggravated burglary or street robbery, often characterised by real recklessness for the safety of both themselves and their victims:

> It was stupid. We'd rob people on the streets, rob people in their homes. I've been charged yesterday with another 8 burglaries. It's how many houses we can do in one day. Totally didn't care about who was in the property. However we get hurt or they get hurt. Didn't care at all. If you live you live, if you don't you don't (P)

> Doing these crimes, the robberies and stuff, I used to always carry a weapon with me. I've always had a weapon, whether it's knives, nunchuckas, knuckledusters, anything (P)

In addition to our violent acquisitive offenders, two interviewees had been convicted of non-acquisitive violence, and one of non-violent acquisitive offences. Our final interviewee had been convicted of driving offences.

The family backgrounds of our interviewees were complex and varied. Five described supportive families, with three briefly employed by fathers' or uncles' businesses until each was sacked for not turning up to work. For several interviewees, decisions to disengage from work reflected a broader disengagement from family, education, and other supports and services as intoxication took an increasingly central role:

> First time I took any [intoxicants] was when I was 11 years old. I robbed it off a member of family. Just carried on getting worse and worse and then ended up getting kicked out of three schools. My habits begun getting bigger and bigger. My mum tried to keep me out of prison. But she just couldn't control me. I was drinking and taking drugs all the time. I'd go out and come back two weeks later. I was homeless for about 2 and a half years, a year and a half I was on the streets (P)

Three of our sample had fewer starting chances: two had been brought up in care, and one had no living family members.

Two DRW residents faced particular challenges. Following the closure of HMP Gloucester in March 2013, Brinsford had begun taking in young offenders from further afield. One interviewee's parents, partner and unborn child lived 'about four and a half hours away[8]' by public transport. He had stopped asking them to visit. A second interviewee had autism and severe, diagnosed learning difficulties. The description he provided of his time in prison and (brief) release on license suggested that he had experienced multiple, compounded difficulties. During his (unsupported) release, he had failed to comply with 'a lot of curfews which I didn't understand about.' He identified that serial experiences of bullying and victimisation had contributed heavily to his eventual recall, and to his experiences of prison.

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[8] From the centre of this prisoner's closest home town, google maps indicates that the journey to Brinsford via public transport would take approximately three hours. However, this includes one bus, three train connections, and a taxi to cover the final five miles. If his family were not located in his closest town's centre, were reliant on bus for the final five miles instead of a taxi, were reliant on buses instead of trains, or had any difficulties with connections, then his 4.5 hour estimate becomes very credible.

Lodgers

During fieldwork, H1 offered up to 32 beds, in a mixture of single and double cells. Twenty-seven were filled with DRW clients, with one double cell unoccupied and awaiting refurbishment. This left three beds occupied by 'lodgers,' prisoners placed on the DRW by prison authorities. Though staff spoke of historic difficulties with lodgers (and drug dealers in particular), they were now identified primarily as a minor, bed-blocking frustration. If DRW applicants were housed on specialist wings[9], or security concerns prevented a DRW lodger being moved elsewhere, then it might be impossible to move desired or desirable applicants to the DRW. Whilst lodgers could sometimes become 'converts,' applying to officially join the DRW programme, staff were concerned that such applications might be motivated by a desire to avoid transfer. As a result, they were particularly hesitant about the authenticity of lodgers' conversions.

Prisoners' drug, alcohol and treatment histories

Our interviewees mostly liked similar drugs. Seven identified cannabis as one of their two most favoured drugs. Five named cocaine, with all but one clarifying that they only used powder cocaine. The fifth identified that he had used crack; but acknowledged that such admissions could be stigmatised by other DRW residents:

> If they asked I'd say I take coke… it's just it's got a bad name for itself. If you say crack you automatically think… crackhead. You know. Dirty crackhead. Like I know I ain't dirty. I'm a crack smoker not a crackhad. And I smoke crack. Ya get me (P)

In this context, some interviewees may have chosen not to identify themselves as crack users. Three of our interviewees identified alcohol as a drug of choice, three named 'MCAT,' and one benzodiazepines. Just one identified himself as an all-out polydrug user, consuming 'everything except for crack and heroin.' Indeed, no interviewees acknowledged past or present opiate use of any kind.

Though three prisoners had begun to see their drug use as problematic following their imprisonment, not all were similarly convinced. Three clearly stated that they 'weren't addicted' or that their drug use was 'not a problem,' and four had no aspirations towards abstinence. Perhaps building on this picture, only two prisoners had previously accessed treatment. Both were coerced; neither identified treatment as having a significant impact on their drug use or offending.

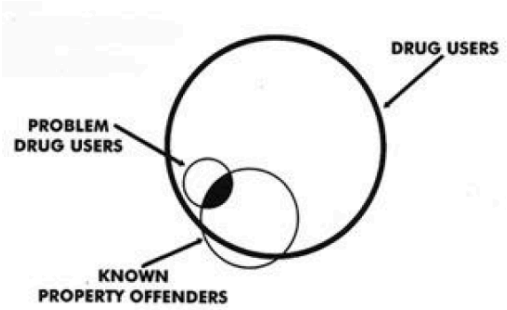
Prisoners' offending: drug related?

The relationship between drug use and crime is complex, varied, and heavily mediated. Possible indicators of a causal link include arrestee and treatment data. High proportions of acquisitive arrestees have historically been identified as heroin or crack cocaine users, whilst a high proportion of people arrested for violent offences have used alcohol (Holloway and Bennett 2004; Boreham *et al* 2006). Moreover, engaging with structured drug treatment has been associated with substantial reductions in acquisitive offending. This does not, however, equate to a straightforward causal link from drug use to crime. In Mike Hough's excellent and comprehensive review of the literature on drug misuse and crime (1996), he summarises

[9] For example, the enhanced wing, healthcare block, or induction wing.

the relationship between drugs and acquisitive offending thus, suggesting that *problem* drug users represent a minority of both known property offenders, and drug users:

Figure 1: The relationships between drug misuse and property crime



Further complicating claims for a straightforward causal connection, Pudney drew on 3,900 interviews to identify that most young people began using drugs some years *after* they began offending:

> The average age of onset for truancy and crime are 13.8 and 14.5 years respectively, compared with 16.2 for drugs generally and 19.9 years for hard drugs. Thus crime tends to precede drug use rather than vice versa (Pudney 2002:v).

In a small study of 26 heroin and crack cocaine users in Manchester, Allen found that offending preceded substance misuse for 23 of his interviewees; 22 had begun offending three or more years before they started using drugs (Allen 2005:358). If offending behaviour precedes drug use, it clearly cannot be fully caused by it.

The causal association between non-opiate drug use and non-acquisitive offending represents an additional degree of uncertainty, as there have been few large-scale studies exploring the impact of intensive / residential non-opiate drug treatment on non-acquisitive offending. This does not mean that there is not a causal link; but makes it more important that potential associations are explored in populations such as Brinsford DRW's.

Each of the seven prisoners who touched on a potential link identified that their offending *was* drug-related:

> I can turn quite violent when I drink sometimes. I got released on a community order. And I was OK for a week and it was the day that I had a drink… I did one. And come back. I was [back] out in two weeks. Stayed clean for a week. But then I drank. Got in a fight. Then I stayed out for three weeks that time, came back in… (P)

> I never thought I'd go back. And this is where the drugs come back into it again (P)

> I was smoking cannabis. And drinking a lot that day. I had a different mentality that was probably more violent, it made me more… paranoid mixed with aggression, violence (P)

> If I didn't take drugs I reckon I'd be at college. Not robbing people, burgling houses (P)

> If I ain't got drugs in my system I will go out and commit a crime to get them drugs. If I stop [using drugs] there is no point in me doing crime, is there? (P)

Though no conclusions could be ventured from so small a sample, these data certainly suggest that reducing their drug use might be expected to reduce our interviewees' offending.

Prisoners on the DRW: selection, ingress and egress

After completing Brinsford's prison-wide induction programme, all prisoners with identified drug needs underwent an initial triage assessment with a DARS worker. Over the next ten days, a DARS 'recovery co-ordinator' then conducted a comprehensive assessment, leading to the construction of a 'recovery plan' identifying 'areas of concern, and how they're going to be resolved in what kind of timeframe' (S). DARS staff presented these assessments as collaborative processes, often giving offenders ITEP maps to fill out or complete themselves.

> And my patter is "there you go. Have that." And then they start writing what changes they need to make (S)

Whilst all DARS clients went through this process, a very small proportion (under 20%) progressed to the DRW. Whilst this implied a very *exclusive* process, selection was uncodified, and predicated entirely on professional discretion. As one staff member reflected,

> There isn't really a criteria, and if there was a criteria… for… the idea of actual recovery I don't know whether there'd be enough people to fill that (S)

Criteria that were applied on other DRWs – such as sentence length, engagement with a local PPO team, remand status, drug of choice, medication need, or recent episodes of self-harm – were not mentioned by Brinsford staff. Instead, they named one dominant desirable feature: perceived client motivation:

> For me, that wing's gotta be a luxury. For the lads. They've gotta work to get on there. they've got to prove the motivation to want to go on there, and want to help theirselves achieve their goals. That they want to achieve (S)

> I look for a genuine motivation. To make some changes (S)

Even this criterion seemed to be negotiable if prisoners were particularly vulnerable or disordered. Staff discussed potential applicants at a team meeting before offering them a place, giving the full psychosocial team an opportunity to express an opinion. Despite its lack of codification, selection was widely felt to be working well.

Those prisoners who were not returned directly to the community might leave the DRW as graduates, or for disciplinary reasons. Graduation routes had yet to be established. Prisoners could stay on the wing for 'up to two years,' with three staff describing an intention to develop an exit pathway through Brinsford's enhanced wing towards release on temporary license. Prison authorities were supportive of attempts to remove prisoners for disciplinary reasons, though psychosocial staff felt the process still needed some ironing out:

> When the prisoner says "I don't want to move," they put in an IEP. "You have to move." "Oh, I don't want to move." "Ok, we'll put another IEP in." And *then* you have to go. That process is taking weeks. We need results [in] a couple of days (S)

Due to the risk bullies presented to residents of any wing, moving them off the DRW presented additional security challenges.

Mirroring professionals' accounts, several DRW prisoners described informal assessment and selection processes:

> It's easy to get on the wing. It's basically a tick list… "How much are you using. How long've you been using for." And you say "eight pints a day six grams a week" (P)

> I was on the induction wing and then [worker] come and see me and said "are you taking drugs or what…?" I went "yeah." She said "you've got to sign a compact, and then you can come down here" (P)

Whilst four prisoners described applying to the DRW out of enthusiasm or motivation, three followed less conventional routes. One had applied after being ejected from the enhanced unit for a series of minor breaches. A second claimed to have been moved onto the DRW after being caught smoking cannabis:

> We were banging a bit because it was new years eve. And the boss was saying that we had hooch. We was smoking cannabis. Come and spun our pad in the morning. And they moved us [to the DRW] (P)

A third had been moved to the DRW following a 'nasty fight' on the healthcare unit.

Prisoners views about other DRW residents

Prisoners described their wingmates in one of three broad ways: as useful and positive supports; as immature and disruptive bullies; and as vulnerable, fragile and prone to self-harm. Positive descriptions presented other residents as 'chilled,' 'relaxed,' and supportive:

> It's not like other wings. Everyone's chilled out. So. It's a different atmosphere (P)

> Everyone's chilled on here… Because everyone's in the same position ain't they (P)

Negative takes centred either on bullying, or denial and disruption in mutual aid groups:

> They don't like to admit they've got a problem. They don't like to admit they've taken drugs. They'll tell you what they have taken, [but] in a group they wouldn't say nowt because they think they'd get called a baghead or a smackhead or something (P)

> Most lads in the groups are just fooling around. They don't care. They're just going "you were sitting on the street drinking white lightning and you've drunk piss!" (P)

Finally, three interviewees commented on the vulnerability of some DRW residents:

> A lot of the lads on there are vulnerable. Vulnerable as in… they self harm. And. They're not really confident…

> They slash up innit mate. It's like the other day we've opened the door and was literally blood everywhere. I've seen some things man but this was nasty. This kid was slashing up his arm and that. It's not nice

Detoxification and reduction

Detoxification and reduction were not issues for prisoners or professionals on Brinsford's DRW due to prisoners' very low levels of opiate and alcohol dependence and withdrawal. One prisoner noted that he had been detoxified from legal highs, without providing additional details. This may merit more detailed exploration in future work.

Motivation and incentives

Managers were keen that Brinsford's DRW should be based on client choice, arising from authentic motivation. They were consequently wary of creating conditions that presented so strong an incentive that 'it's removing a choice, actually, because it's almost like bribery.' Beyond limited improvements to physical conditions and the wing's positively-received relational environs, incentivisation was consequently limited to a small number of therapeutic benefits. DRW residents had access to the wing's 1.5 weekly mutual aid meetings, occasional community 'briefings,' and would be the first beneficiaries of professional groups once they began to run. Prisoners also saw their keyworkers more often, as the DARS' office was based on the periphery of H2.

Motivations: Best bits

Two professionals identified 'best bits' of the DRW, with each highlighting psychosocial workers' availability to DRW residents:

> Best features…… The availability. To us as a team (S)

Prisoners tended to emphasise the support they gained from peers or professionals:

> The best thing is having good people on here. That's the best part on here (P)

> Staff are alright. If you see yourself letting yourself down. The drug recovery is just there so you can come talk to them (P)

> The one to ones I think. [My worker] is good man. I like him a lot (P)

One prisoner named the wing's first professional-led group as the wing's best feature:

> The relaxation [group]. That's the first time I've relaxed in ten months, ya get me. I thought it'd be bullshit. But I've never been so relaxed. It's madstuff (P)

Finally, two prisoners saw the wing's physical conditions as its best feature, particularly emphasising the beanbags and fishtank in the 'sosh room,' and improved access to the gym.

External motivators: family

Commenting on prisoners' family support networks, a staff interviewee stated:

In the adult estate it's around utilising partners. We'll be utilising parents (S)

Though parents were certainly mentioned by our DRW interviewees, their *children* seemed to act as a far more potent driver for change. Each of the four who stated that they were fathers placed their children at the centre of their recovery:

> I want to get a job when I get out because I've got a daughter, I want to support her. If I don't do that I'll be straight back in here… (P)

> I need to be a dad. I need to get out. Fix up. Don't want to come back here… (P)

> I've got a daughter on the way. And that changed my state of mind (P)

The prevalence of parenthood and the role of children in young offenders' drug treatment journeys and post-release resettlement may merit closer attention in future studies.

DRW provision

> I: So three groups a week?
> S: Well no, because RIOT only come every 2nd week. And they don't turn up regularly.
> I: So about three-quarters of an hour per week, per person, maybe?
> S: Well if you was to sort of write it down factually, it probably wouldn't be. Somebody could say "yes, we do a, b, c." Which you might not get.

Not including one-to-ones, approximately 40 minutes of intervention were available per prisoner per week, in the form of mutual aid groups. Both professionals and prisoners were particularly enthusiastic about the work delivered by Recovery Is Out There (RIOT):

> RIOT, we do cram them into RIOT, because they love RIOT. So you'd find that a lot of lads, "oh miss let me sit in. Oh, miss, let me sit in." And "oh, right, we can"… because we know they'll sit and they will listen so we will have bigger groups… I think that may be may be down to the mentors, the lads can relate to them a lot more. (S)

> RIOT yeah I like RIOT, RIOT's really good. They tell you what they were like when they were our age they had our problems. It sounds… like my life. I listen to someone like that because I know they've been through the same thing as I have. If they haven't done it themselves you cant really take it from them (P)

Interviewees were also positive about the wing's first professionally-led relaxation group. Three prisoners described relaxing for the first time since being imprisoned. A professional facilitator described seeing real progress during the hour the group had taken:

> I just said, after they'd opened their little peepers, "just shake the person's hand next to you. From your heart, look in their eyes and say "I wish you well. I really do."" And they did! And it was people that they wouldn't necessarily shake hands with (S)

The final component of group engagement involved fortnightly briefings, in which the psychosocial team informed prisoners of forthcoming developments, and gave them a chance to air any grievances.

One-to-one support was enhanced by the DRW's proximity to the DARS office. Whilst DARS clients across Brinsford's estate received monthly structured one-to-ones, psychosocial practitioners described informal contacts with DRW residents roughly once each week. Three prisoners were effusively positive about one-to-ones, identifying them as strong loci of support and encouragement:

> "Why are you taking drugs? What's the effect? And. If you keep taking drugs what's the effect later in life? Is it affecting your family? Is it going to affect your daughter? When she's older?" Things like that. And it does make you think. Because my daughter. She ain't properly going to see me until she's three. Nearly four. That just makes me think. "Yo. Nah man. I just don't want to do it no more." Tsssss (P)

Two were less engaged with their keyworkers. One felt he had already recovered, so needed little (if any) ongoing support. A second stated that he had been told that he was unsuitable for one-to-ones. We were not sure if this was a full and fair representation of his situation, as this prisoner had some difficulties with comprehension. However, it was certainly his belief. This issue may benefit from further exploration.

Violence and Bullying on the Wing

Brinsford is a YOI. As one prisoner drily noted,

> If you put a lot of young testosterone fuelled personalities into a cage they're going to start fighting (P)

Four interviewees had been in fights or other violent incidents. All staff acknowledged that violence – and, perhaps, bullying – were inevitable:

> You're always going to get some incidents. We're dealing with lads who are aggressive, volatile, reactionary. They haven't got the thinking processes what adults have got (S)

> There's a lot of intimidation that goes on the wings. (S)

Nonetheless, with one exception staff felt that the DRW had reduced levels of violence. Professionals also believed that bullying was scarce. However, *should* bullies be identified, specific difficulties attended their removal:

> The difficulty is, once you've alerted the prison it has to be recorded. It's really difficult to move a bully off a wing to another wing to potentially bully other people (S)

This had, in one instance, led to a delay of six weeks in getting two young people removed.

Eight DRW prisoners felt that levels of violence and bullying were between minimal and non-existent:

> There's hardly any down here. Not that I've seen, anyway (P)

> Violence. You don't get it. You don't get it on the DRW. There's no bullying (P)

> There is fights, but not every day. Every couple of weeks, every couple of months (P)

A ninth, more vulnerable interviewee provided a rather different account.

> Lads started switching my night light on. Kicking my doors. Slamming like my hatch. So I then press the bell. I've gone on IEP for that now….They come to your door like slamming, kicking your door. You press your button and then you get IEPs and you lose your TV and you start smashing your obs glass and all that (P)

This interviewee felt doubly punished: bullied by wing residents, and sanctioned by wing staff for trying to do something about it. Even within this context, he felt that levels of bullying on the DRW were significantly lower than on other wings.

Drug availability on the wing

Non-seasonal hooch was not felt to be a problem on Brinsford's DRW[10], though drugs were thought to be widely available. Drug finds tended to be of cannabis and steroids:

> A lot of it come through throwovers and visits… We've got over 40 prisoners who can be out and about unsupervised. That gives you an element of things coming in (S)

> Cannabis use is quite high It comes in on visits. It comes over the fence. They're all using mobile phones and steroids… (S)

Insofar as professionals felt able to compare levels of drug availability on the DRW and elsewhere, they offered mixed accounts. Three prison employees felt that the DRW had reduced levels of drug availability:

> I think it's far better. It's not perfect but I think we've got lads who want to be there and that for me is key. They do feel safe in that environment and feel supported (S)

> Looking at other units, I think it is better (S)

Three staff felt it had made little difference:

> It's all about the same. You usually know when they've had what we call *a good visit*. Because the officers sat in here are as stoned as the lads (S)

> It'd be nice to say "oh there's not…" But there is. You've got a lot of cannabis throughout the prison (S)

Staff also reported that dynamic security had been proving effective, with one major recent success in catching a drug dealer.

The picture presented by DRW residents resonated with that provided by professionals. Drugs were either *as* available, or *less* available, than on other wings:

> There is a lot of drugs around I'll tell you the truth… I've been offered cannabis, steroids. Loads of it. And I was like nah nah nah (P)

---

[10] We don't have brewing particularly. We do at Christmas time we have hooch being made but we try to keep on top of that because it makes people aggressive alcohol does whereas… the cannabis is a constant battle (S)

I'd say there's less. If you wanted it, yeah. But you'll have to get it off wing (P)

None of our interviewees felt that drugs were *more* available on the DRW than elsewhere.

Additional services DRW interviewees would like to see

This question was only routinely asked of prisoners. Two staff nonetheless offered answers. One wanted to improve continuity of care, with DARS workers keyworking individual clients from the point of reception through to (potentially) beyond release. A second wanted to locate two 'duty' DARS workers in the DRW, making them available full-time.

Prisoners' desirables varied. Whilst three were entirely happy with current levels of provision, six had more idiosyncratic desires including protein shakes and a wing library. Three wing residents wanted additional time unlocked and more groups, suggesting an increased focus on support for 'relationships and that' and self-harm. Finally, one young person had a history of sexual victimisation, and was deeply uncomfortable using the wing's communal showers. Other wing residents had apparently picked up on his discomfort, and were bullying him about it. Whilst he was in the process of attempting to access Brinsford's enhanced unit because of their *en suite* facilities, he also yearned to be able to shower in his DRW cell.

Prisoner / staff relationships

Prison officers were slightly peripheral to the main business of the DRW, as they delivered no structured drug work. Officers were also moved into the DRW on rotation, without necessarily expressing any interest or preference for drug-focused or supportive work. Nonetheless, psychosocial staff identified DRW officers as positive, open, and trustworthy:

> [A previously misbehaving prisoner] said "miss, I have been good and I've been buckling down because of that officer there." She'd invested loads of time sitting and chatting with him for hours. He said "miss, I love her. But not in that in that way. She put she put her trust in me, her faith in me." And he's totally turned around (S)

Prisoners' accounts were more mixed: some officers were good, responsive, and caring; others were mostly there to turn a key in the door:

> I do get on with the officers man, like if I see them on the street I would shake them by the hand. Do you get me. Some I would. Some I would slap them… (P)

> Tssss. I like the staff on res 4. I like them all but some of them do more than others. You ask them to do something, some of them will get it done, some won't. [Some] will do anything any time for anyone. Everyone always asks [one officer] because he's the one that gets it done. So he's overloaded. But most of the time most of the staff are ok (P)

Prisoners were particularly concerned about two recent incidents, in which they felt that officers' unresponsiveness had nearly led to serious harm:

> The bells were going for like an hour. And they were stringing up. So we was kicking our doors and everything. And they come down and they were like "get off your bells, IEP." And when they've gone to his bell they've realised he's stringing up (P)

> They need to answer the bells quicker at night. The other day. My opposite. Think he was self-harming himself. He. Pressed his bell. Took about. At least. Twenty minutes or probably more. To get to that bell. So that's a joke (P)

It seems likely that our reliance on officers' willingness to volunteer for interview, and the limited time available for rapid assessments, meant that we sampled particularly motivated and committed officers. Certainly, their accounts suggested that they were understanding and empathetic to prisoners on the wing:

> Nearly all of them I know really well down there. They do open up to you, and then the trust [comes]. After a while you can begin a relationship, they just divulge things a little more, a little more. If you just make that little bit of time [for] that lad, perhaps he hasn't had a visit for a few weeks and he's in that cell a lot of the time (S)

Relationships with the DARS team were unfailingly identified by both staff and prisoners as real strongpoints of Brinsford's DRW. Professionals described their working styles in terms of respect, empathy and trust-building:

> They're human and it's about treating them just how you'd like to be treated yourself. That's the key to everything (S)

> I think that because of [our working relationship] they trust us. Not entirely. They're not going to snitch. But they do let slip things perhaps that they wouldn't elsewhere (S)

One psychosocial worker also felt that being a *civilian* without direct responsibility for security greatly assisted the relationship-building process.

The DRW's reputation among *staff* in the wider prison

Three interviewees noted that, despite efforts to educate officers about the DRW prison-wide, few understood it.

> No prison staff I can think of have ever said anything to me. So I'm not sure it's thought of much of at all (S)

> You never hear anybody else mention it (S)

A fourth staff member had formed good personal relationships with officers on the induction wing, improving and streamlining referrals. Finally, a manager felt that prison officers were generally supportive, encouraging prisoners on all wings to apply if they might benefit from the DRW regime.

The DRW's reputation among *prisoners* in the wider prison

Despite the DRW's lack of acknowledged crack or heroin users, by far the most common message to emerge was that the wing was seen as a stigmatised, heroin and crack users' wing.

> You get "it's a smackhead wing, a baghead wing" from this age group (S)

> Initially it was… "oh yeah. I don't want to come over there it's full of bagheads it's full of crackheads"… but slowly bit by bit there hasn't been that feeling about it (S)

> I mentioned [the DRW] to a lad, "I'm not going to the smackhead wing" (S)

> Particularly prisoners who've already been in a few times and are moved to a normal location will say "I'm not going there, it's the crackhead wing" or whatever. (S)

> If you live in H1 you are just known as a baghead, as a baghead and people don't like that. I get that but I don't care (P)

> Some people call it the crackhead wing. But… everyone's done drugs ain't they (P)

> Other prisoners think that we're all bagheads … (P)

> People call you crackheads and things like that (P)

Mirroring a theme raised in other sites, two professionals also noted that the DRW had developed a reputation as a refuge for sex offenders. Both prisoners and professionals identified that this reputation had historically deterred people from applying to the DRW, though psychosocial staff felt that the wing's reputation was improving.

Four professionals also gave voice to more positive accounts. One felt that people who had not been in Brinsford before were more open-minded about the DRW. A second noted that the prisoner grapevine was beginning to identify the DRW as a positive place to be:

> If you've got a lad who's coming down to IDTS or a lad who's coming through reception and you say "well, where do you want to be?" "Well actually I want to be on 4." There's some peer knowledge going around that actually it's a good place to be (S)

Finally, two psychosocial interviewees felt that H1 was developing a solid reputation as an 'easy' or 'relaxed' wing with improved physical environs. Whilst this was encouraging applications, there were some concerns that not all were driven by authentic motivations:

> What you get a lot of the time is "oh miss, miss I've got a drug problem! Oh honest miss, I've got a drug problem, I need to go to H1!" But they haven't got any issues (S)

These positive perspectives should perhaps be read in context; no prisoner interviewees felt that the wing was seen positively by residents on other wings.

In recovery? Professional perspectives.

Without exception, Brinsford's psychosocial team identified recovery as a personal (and personalised) journey. Staff unanimously agreed that individual recovery journeys could embrace continued usage and harm reduction. However, posters on the walls of the association room emphasised that DRW residents must be working towards 'abstinence from all drugs and alcohol.' This tension between *prescribed* and *client-led* recovery journeys seemed both significant, and unresolved. A manager made the clearest attempt to align the DRW's client-led and directive interpretations of 'recovery':

> The DRW is very much about abstinence. It's about making, like, a career choice. The young people on this wing. They've made a choice. They've decided on a drug free life. The rest of the prison haven't come on that recovery journey to complete abstinence (S)

Thus, DRW clients had individually chosen to engage with a programme based on a unilateral, abstinence-based model of 'recovery'. This seemed like a pragmatic interpretation; but such tensions may benefit from further exploration in all DRW pilot sites.

In recovery? Prisoner perspectives

Three (of nine) prisoners described recovery as being on 'the right path,' using that precise phrase without prompting:

> Getting on the right path, yeah. And trying to keep recovering from your drug life, ya get me. That's what I think (P)

Two intimated that being on 'the right path' meant instigating broader life changes than just stopping drug use.

Four prisoners situated their families at the centre of their future lives, though not in an explicit context of 'recovery.' Two mentioned employment, with one seeking to open a tattoo parlour and a second aspiring to start his own gym. The three other prisoners who sought to define recovery framed it in terms of reduced drug use, total abstinence, or improvements to general wellbeing:

> To be free from drink, drugs. Drink and drugs. And to be living a normal healthy lifestyle. That's good for me and everyone around me (P)

> Like recovering from something. Trying to help yourself trying to get better (P)

It should perhaps be noted that few prisoners seemed to have reflected on the word 'recovery' in depth, perhaps because of transitional nature of treatment on the wing.

With each prisoner free to define 'recovery' as they saw fit, so they were free to own (or disown) it. Three interviewees felt fully recovered:

> I'm fully recovered, right at this minute, right now. I am fully re-covered. I was going to say rehabilitated. But that's more what I think the prison thinks it does for you. Which I don't think it does. But the DRW. I've recovered from being on drugs (P)

Our other six Brinsford interviewees felt that they were still in recovery. An addendum should perhaps be noted here. 'Recovery' certainly meant something other than abstinence for some DRW residents. As previously noted, four (including one who had 'recovered') fully intended to return to using one or more drugs following their release.

Interviews with staff: staff characteristics

We interviewed four prison employees, two of whom were in managerial positions. Three had relatively straightforward prison careers, and two had prior experience of supportive work with young people and / or drug users. We also interviewed the full psychosocial team:

five frontline workers, and one manager. Five had extensive prior experience of working in housing and drug agencies, or children's services, and one had come to drugs work as a graduate.

Description and development of the DRW

Following the recommisioning of Brinsford's psychosocial services, just one worker stayed in post. Shortly thereafter, a second worker was transferred from the prison's programmes unit, where she had been delivering accredited drug treatment programmes. With two professionals case managing 160 clients, work was effectively restricted to delivering triage assessments and filling out release plans:

> They were pretty much chasing their tail. Literally all we had time to do were inductions, release plans. And [you were] having ten people come in per day. On the Monday you had people coming in from Friday, Saturday and Sunday, all waiting to have an initial induction (S)

Even following the arrival of new staff and a permanent manager between December and January, provision was limited by the need to train up new employees. By May, staff were getting to a point where comprehensive assessments and therapeutic work could be delivered. This process had clearly been extremely difficult for all involved, and still defined the DRW during fieldwork.

Working with Young Offenders: challenges, rewards and responses

Lots of them have not finished education. So pictures. Bright colours. Activities to get them involved. Rather than sitting and talking. Keep writing to short sections, not long pages (S)

It's not a strange age, an age of extremes. Emotions. Physical development, the break away, all of that's happening at once, and in a custodial setting. And that's difficult (S)

Insofar as staff identified positive features of working with young people, they tended to relate to the youthfulness and lability of YOIs, and the hope such characteristics engendered.

> Their zest for life, I love it, it's just phenomenal, and there's something undiscovered as well in latent talents and allsorts… (S)

> They've got a lot of love in them. They're fun. And I hope that if you plant a seed now. That even if in 10 years time someone turns round and says "oh yeah I remember [worker] said something about that…" It's frustrating at times. But you can leave here having had a really good day. It can be quite life affirming (S)

However, as one staff member noted, 'it's much easier to talk about the challenges than the rewards.' These challenges broadly fell into two themes: temperamental; and processual.

Issues of *temperament* related to the same 'sparkiness' of character that fuelled Brinsford's levels of violence:

> They are reactionary. They are volatile. We have a lot more incidents than… a Cat C adult jail. It's the nature of the beast that that we're dealing with (S)

> They're not so stable. The behaviour is completely different. Adults behave like adults. Young offenders are more… unruly. They're restless. It takes them more time to settle (S)

> Their attention span wanes very easily (S)

This led to differences in *process*: Brinsford's psychosocial team described adapting groups by making them friendlier, livelier, more interactive, and more accessible:

> They're children. So I deliver it in a different way. I'm just in a process of bastardising [adult] group [templates]. If there's a definition of something. And they've just got the writing. That's gonna *bore* the pants off them. But if you if you associate it with a cartoon they can remember that cartoon and associate it with that definition (S)

> You've got to keep the interested with things. You've got to keep [courses] light and airy with lots of breaks where they can go off and roll a cigarette, take a cup of tea (S)

> The paperwork. Good grief. Sometimes you're reading it out… [It's] ridiculous. And then they've got ADHD [and] start swinging from the chairs… (S)

One frontline interviewee also suggested that expectations of 'recovery' also had to be realistic, and responsive to the needs and desires of YOIs:

> How can you expect a 19 year old to give up drinking for life? It's like the end of the world for them (S)

Others noted that, because of their lack of life experience, YOIs also needed a fuller explanation of the potential benefits of work and education.

Ongoing developments: future plans for provision

Psychosocial staff saw the future of DRW provision in positive terms. Plans for future provision on the wing were multifaceted and wide-ranging. Workers were adapting a series of 18 groups for young offenders:

> We've all got our own section. I've got legal highs. [Worker]'s got anger management. Then alcohol awareness, cocaine. We also want to offer them some different things (S)

One staff member intended to begin delivering auricular acupuncture, and the team hoped to establish weekly Narcotics Anonymous and Families Anonymous groups, too. Once additional *ad hoc* relaxation and meditation groups were taken into account, the intention was to deliver daily groups on the DRW, with additional groups being delivered prison-wide.

Three professionals also noted intentions to develop release plans. Aftercare provision within the DRW was minimal during fieldwork, and staff spoke of improving partnerships with community drug services, DIP teams and families. Pre-release three-way meetings provided a particular focus:

> The plan is to involve families in release planning, and bring DIP teams in so young people have a name to the face (S)

Across the board, professionals identified that DRW provision was at the start of a long journey. Four interviewees spoke with warmth and enthusiasm of anticipated developments:

> It's really exciting. There is a lot of potential. And I'm really happy that I get the opportunity to give it a go, and be part of that (S)

> I think it could be really good when we're all sorted and up and running. For those lads that are ready, I think it could work really well for them. Really good (S)

Level of separation / siloisation

I wanted to stay small. But they needed to be able to socialise with other people, and not just be in that bubble and then we throw them to the lions afterwards (S)

Brinsford DRW was not a silo. Indeed, attending work and education (often on other wings) was required by the DRW compact. Seven people voiced thoughts on whether or not siloisation was a good idea. Two professionals felt it would be beneficial, with one officer suggesting it would improve the wing's distinct 'persona.' Two prisoners were also keen on increased separation, as it could reduce the accessibility of the wing to 'dickheads', whilst increasing the safety of vulnerable individuals.

One prisoner was *against* increased separation for related reasons, feeling that siloisation would increase DRW residents' susceptibility to being labelled sex offenders or cowards:

> It's working well, man. If we were proper closed off then they are gonna think, "why are they closed off?" It might get a reputation. "Oh, they're scared…" (P)

Two professionals also felt that mixing with prisoners from other wings increased DRW residents' resettlement options, whilst avoiding the creation of an artificial 'bubble':

> What I want is for these lads to be supported but to be able to go to the gym, go to education, go to classes, go to church, so [when they graduate from the DRW] they can say "I'll go on res 5 and go and get ROTL and go and work out in the community." What I didn't want is the creation of a unit that then closed doors (S)

> [Segregation] would give them this false sense of security. Away from the big bad world. Being wrapped up in cotton wool rather than being exposed to… other lads (S)

Concerns about engendering a 'false sense of security' were widely cited across DRW sites.

Drug testing, and positive tests

The steroids don't come up on the MDT (S)

Brinsford's DRW delivered two kinds of tests Mandatory Drug Tests (MDTs) involved urinalysis, and sampled a random 10% of the prison population each month. The consequences of testing positive were in the prison's hands: all were placed on Governor's adjudication, the results of which could include 'extra days' (loss of remission). which can include Voluntary drug tests were exclusive to the DRW, with each prisoner tested approximately every two weeks. Psychosocial staff were particularly concerned that these tests involved mouth swabs of questionable accuracy:

> The voluntary drug tests *don't work* (S)

> Some [prisoners] will say "I don't know how it tested negative because I had cannabis yesterday." I think the relationship can be tarnished [by] the systems we're using (S)

Though informal monitoring suggested that 'dud' VDTs were less common than 'successful' tests, staff remained concerned. However, the team had a large supply of the £7 kits waiting to be used, throwing away unused tests was considered unjustifiable, and alternative kits were thought to be more expensive. For these reasons, there was no realistic prospect of the tests being changed. Even if new tests were commissioned, there was no apparent prospect of securing oral swabs or urine tests that would screen for a full range of steroids. This presented a particular concern to a small number of frontline prison and psychosocial staff.

Staff offered differing accounts of the official response to positive tests, suggesting a 'three strikes' approach, a 'zero tolerance' approach, or a flexible response determined by a multi-agency panel. These differing understandings may have reflected a policy that was still in development; as one interviewee surmised, 'we haven't got set protocols for things.'

Relationships between prison agencies

We interviewed no clinical staff, so can offer no insights into clinical understandings of prison officers and psychosocial staff, the DRW's two other professional groups.

Our two prison officers described psychosocial workers in positive terms, presenting them as friendly, responsive, and helpful:

> Obviously they're in the next office from us. Constantly back and forth. Any slight problem dealt with straight away (S)

Psychosocial interviewees were equally positive about *most* DRW officers, describing them as the best staff in the prison.

> We have the best staff at the moment on this res. They are the most helpful. They are the most friendly. I can go to the senior officer and go "can you go and get such and such out" and they'll do it… (S)

Good communications were sustained through both formal and informal means, with psychosocial and prison staff attending each others' meetings, and sharing comestibles. It perhaps bears mention that relationships with officers on other wings were not described in equally glowing terms, with psychosocial staff often finding it difficult to access clients.

Healthcare occupied a wing some distance down a covered walkway. It housed the prison's opiate-dependent clients. As such, it was *rare* for DARS workers to have many clients in healthcare (though all healthcare clients were on DARS' caseload). Key interagency difficulties centred on sharing information and processes:

> Mental health don't feed back to us. Only if I phone them. And it depends who you talk to they can be quite… closed in what information they'll give you (S)

Interviewees also stated that clinical staff sometimes failed to update clients' recovery files, meaning that psychosocial staff might duplicate work that had already been delivered.

Relationship with external agencies (through the gates support): professional perspectives

Three weeks before a prisoner's likely release date, their keyworker would draw up a release plan:

> The release plan is to ensure that harm minimisation, harm reduction is looked at. Part of that is about information giving. Part of that is establishing a meeting with DIP teams. Also things like family mediation services. If a young person's lived here for 6 months the transition back to the family home can be fraught with difficulties (S)

During fieldwork, release plans were sparsely populated with appointments. Prisoners might be given a referral to DIP, but other support services were more likely to be signposted:

> As far as I know a young person is given a list of the local services to them. So at least they can tap into them if they so wish because again it's a personal choice (S)

Few processes were in place that might encourage prisoners to engage with community providers. Pre-release three-ways with DIP, a cornerstone of release planning in other establishments, were apparently non-existent:

> DIP never come in. We're not organised enough. We haven't got enough staff (S)

Pickups at the prison gate – again, a standard feature of DIP provision in many areas – were described as equally rare. In this context, DARS workers believed that prisoners' attendance at community services was…

> …very rare. Very rare. A rarity. A rarity. If I'm honest it's a rarity for these lads to attend DIP appointments. Very rare (S)

Still, some areas of aftercare were seen as particularly strong. Two psychosocial practitioners identified that housing agencies and the Jobcentre were very good at following up young people pre-release, even without DARS prompting or input. Few prisoners were released with no fixed abode; housing was seen as less of a concern in Brinsford than in other sites.

A final note. Release planning was further complicated by Brinsford's status as the only YOI in the West Midlands, with the closure of HMP Gloucester leading to the arrival of young offenders from up to 100 miles away. Developing good relationships, let alone securing prison-gate pickups, was thought to present a real challenge when potential resettlement partners were so far afield.

Relationship with external agencies (through the gates support): prisoner perspectives

Few prisoner interviewees spoke of release planning, perhaps because only three had any chance of returning to the community within the next year. One of these was held on remand, rendering his future uncertain. A second was expecting release in the next four weeks, but had no idea whether or not anything had been (or would be) set up for him. The third was expecting to be released in five months' time. Again, he had no idea what preparations might be made for his release. Others had vague ideas of what might be prepared for them on release, though none of the accounts contained any precise details:

> Drug recovery are sorting out the release bit. Because they're good at that. So I don't think I've got that to worry about. I'll just keep going and hope they sort me out (P)

For our one remandee, awaiting trial in two weeks, the lack of clear housing support presented a particular concern:

> If I get found not guilty [probation] won't help me with housing or nothing, they just throw you straight on the street. And that's rough. Say I was getting out today, if I don't get housing sorted I'm just going to be straight back to [crime and drug use] (P)

Housing presented an equally big concern to a second interviewee, who was unwilling to live in a hostel. He was consequently willing to breach any related license conditions, and considered a swift return to prison a real possibility. Despite these two prisoners' worries, it should be noted that housing presented a far greater concern in the adult DRWs we visited.

Perceived likely impact on future offending and drug use: professional perspectives

> I kept on saying how are we going to evidence this? Reoffending rates? I'm [also] thinking "if I can get a lad from injecting to smoking, that itself is success" (S)

All professionals were unsure of the DRW's impact:

> I would literally be sticking my finger in the air and saying yes or no (S)

> It's hard to measure. The only thing we can evidence is when they return (S)

> Not a clue (S)

Notwithstanding this uncertainty post-release, one officer added that he could see prisoners making substantial improvements in their communication skills *whilst* on the wing.

> Some of these lads I know from other wings, and they've really struggled. The improvement is tenfold since they've been down there. it's been a great help… A lot more confidence. You can see how it's developed the personality in them (S)

He felt this improved prisoners' chances of making and sustaining changes following release.

Perceived likely impact on future offending and drug use: prisoner perspectives

Prisoners described the impact the DRW had on them in one of three ways. Three suggested that they were going to stay out of prison or stay off drugs in future, though they were wary of attributing these changes specifically to the DRW:

> I won't come back to jail… I might come back to cannabis and drink. I wouldn't do the sniff again. I'm off it now, there's no point in going back (P)

> If I do get a second chance back out on license I'm going to go and do this probation course. And it's 10 % they'll be bringing me back (P)

Four framed the DRW's benefits primarily in terms of insights they had gained, or improved levels of self-understanding:

> When you meet your drug worker. And then she talks to you and makes you realise. Like she has the same conversation like we've done. And it just makes you realise. When I'm in my cell I think to myself… ahhhh. If I didn't have a spliff. I wouldn't (P)

> When I've got a worker and she says "what did you do?" She'll go into the ways and the things that I wouldn't necessarily think of myself, but she'll help me think, so next time is different to this time so. And I'm out longer. So it's going to help me a lot (P)

> It's helped me think, like think, think differently… Because if I hadn't've come on here then I wouldn't've spoken to people, like they're treating me with respect I treat them with respect like… like I'll go to them and tell [the prison officers] things and like when I'm on another wing I wouldn't have that chance you know. They'd be all like [smacking sound] "just get in your cell!" (P)

> It's made me think a lot. It's like the AA groups. Ex alcoholics. They'd come in. and they'd say about their life. And you're thinking. "Yo. One day that could be me," if I don't stop it. I could be in the gutter. You know what I'm saying (P)

One prisoner framed the DRW's impact primarily in terms of the education, factual knowledge and tools he had picked up:

> It's learnt me all the facts about drugs and that. I mean I thought I knew some fucking shit about drugs, you know what I mean, but then I come to here and these people asked about drugs and that… [And] that relaxation thing. I could take that on board for when I'm feeling down. When I want a spliff or a pipe I could just go back to the DRW and think I know how to relax without any drugs in me (P)

Finally, one prisoner felt that his chances of staying clean depended on whether or not he could access a gym immediately after re-entering the community.

If you could change one thing…

Staff interviewees offered a very wide, and rarely overlapping, selection of thoughts on what they would most like to change. Suggestions included peer mentoring:

> People who'd changed their lives, ex offenders, could come back and take part. And I think that would be really significant… To show people "I'm normalised. I'm a family man. Life's good." I think that's a really powerful message (S)

One professional wanted a staff / prisoner forum to steer the development of the DRW, whilst four others desired some form of additional resourcing to support more intensive intervention:

> I'd like to go more intense. Get a bit more knowledge. Perhaps professional training (S)

> To have more of [prisoners'] time. To have more time to work with more groups (S)

> I'd say more. More free time. And more staff to facilitate more groupwork (S)

Finally, one staff member desired a general improvement in 'organisation,' whilst a second sought to align the DRW with the operating principles of therapeutic communities (beginning with a holistic refurbishment programme).

One prisoner agreed with this last account, prioritising 'a nice bit of a clean' and 'fresh paint' for the DRW's cells and communal spaces. A second prisoner acted as a lone voice, calling for lodgers to be removed and selection processes to be tightened:

> Make sure that the right people are on the wing. It's not fair that [lodgers] get what we should have because it's our wing (P)

Three wing residents voiced preferences on a shared theme, desiring more time out of their cells and increased exercise periods.

> More time out the cell. More freedom. More groups and that. Because if you've not got a job or anything and you're stuck in there your head goes man. Madness. And I haven't had one exercise since I've been on here. Four months and not once has someone knocked on my door to say exercise (P)

Finally, one of our interviewees concluded with an highly positive take on DRW provision:

> Nothing to be fair. It's good as it is. it's dealing with like problems (P)

The wing, in his eyes, was supremely fit for purpose.

Appendix A: the DRW Compact

Drug and Alcohol Recovery Compact
Residential Unit 4 Drug Recovery Wing

Full Name: .....
Prison Number: .....

To reside on the Drug Recovery wing (DRW) I understand that I need to be working towards my recovery.
Whilst on the DRW I will:

- Seek to gain employment or attend education
- Be actively working with the Drug and Alcohol Recovery Service to address my substance misuse behaviour
- Attend at least one mutual aid group on a weekly basis
- Engage with the Compact Based Drug Testing on the wing
- Continue to participate in any treatment or program that that you are currently engaging with in order to promote recovery
- Attend and fully participate in recovery reviews and case management boards, which will take place prior to release
- Not press my bell unless I am in need of emergency assistance
- I will keep shower room as I found it clean and tidy
- Treat others the way I like to be treated with respect

I have read through and fully understand the following:

- The Drug Recovery Wing will not run as a zero tolerance unit, on areas such as bullying, drugs if I am caught in possession of non prescribed medication I will be challenged and a decision will be made which may result in my removal from the wing.
- If my behaviour does not meet the standards expected of me , I am still liable to be placed on report and receive IEP warnings
- Any deselection from the program whether you choose or are asked to leave will result in relocation from the Drug Recovery Wing
- I fully understand that I must abide by all wing and prison rules
- I understand that first and foremost the Drug Recovery Wing will run as a discipline wing
- I will be ready and prepared to attend groups, interviews, assessment and any other activities when required

By signing this compact I agree to the conditions set out above, declining to sign this form will result in not being accepted onto the Drug Recovery Wing

Prisoner's signature: ..... Date: .....
Witnessed by:..... Date: .....

A copy of this form to be given to the prisoner and the original will be located in the client's Drug and Alcohol Recovery Service file.

Appendix B: References

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Appendix 3: Bristol

Fieldwork

Fieldwork was undertaken over two days in March 2013. A total of 21 interviews were completed. In addition, an initial visit was made to the prison (also in March 2013) to meet with the main contact at the prison for the research and to be shown around the DRW. A further visit was made to the prison in early May 2013 to conduct the final staff interview and on this visit there was an opportunity to have another look round the DRW.

Interviews with Prisoners

1. Ten male prisoners aged between 22 and 41 years old, with a mean age of 34.
2. All 10 prisoners had been to HMP Bristol at least once before (some numerous times). Many had been to C Wing (the DRW) before. One identified that C wing was where he had first used heroin, in the days before it housed the DRW.
3. Two prisoners were detained on remand, and two had been recalled on license. The remaining six were serving straightforward sentences.
4. Six of eight prisoners with an expected release date were anticipating a return to the community within a year. Four of these expected to be released within six months.
5. Seven interviewees had been convicted of acquisitive offences, including two offences of possession with intent to supply. Two had also been convicted of violent offences. The final interviewee had been convicted of offences unrelated to acquisition or violence.
6. Nine prisoners gave information about their drug use. One of these had no drug problem, and accessed the DRW 'because one of the officers said they do sports and that.'
7. Of the other eight, four identified heroin as their main drug of choice, with two apiece naming alcohol and crack. Three primary heroin users named crack as their second drug of choice, whilst two primary crack users named heroin as theirs. Two prisoners stated that their second drug of choice was 'anything'. Finally, one interviewee named alcohol as his second preference.
8. Six interviewees were prescribed opiate substitute medication. Two were keen to emphasise that, apart from such medication, they had been drug-free at the point of arrest.

Interviews with Staff

1. Eleven interviews with C Wing staff, many of whom had been at HMP Bristol for multiple years.
2. The 11 staff included 5 direct prison employees, 3 clinical workers, two third sector employees, and one prison employee who was funded by the DAAT. Seven worked in frontline posts, and four held managerial responsibilities.

HMP Bristol

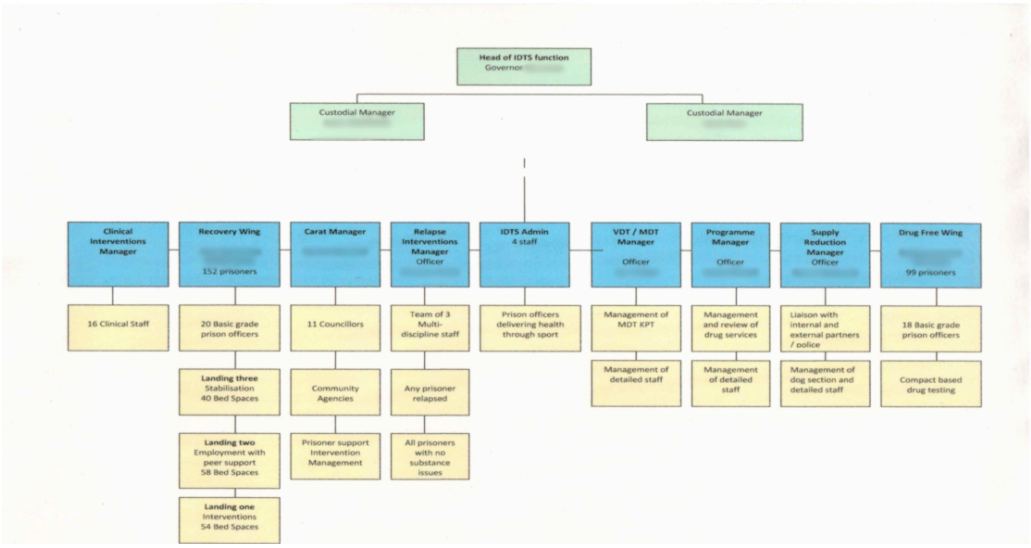
1. HMP Bristol is a Victorian prison situated in a built up area about 1-2 miles from Bristol city centre. It is a Category B male local prison for sentenced and remand prisoners (including some YOs). HMP Bristol holds about 600 prisoners.

2. The prison is feeling the effects of the closure of other local prisons in the area (e.g. Gloucestershire and Shepton Mallet) in terms of the number of prisoners and pressure on staff. Currently Bristol is taking more remand prisoners, and 'moving on' sentenced prisoners more quickly as a result. This is having an impact on the DRW, and is discussed in some of the interviews. There have been some major staff changes and challenges at HMP Bristol and, according to many of the staff interviewees, these have had a significant negative impact on the DRW, particularly over the last year or so. This includes a change in Wing Governor (a temporary replacement came in to post but not until a few months after the departure of the previous Wing Governor), and several other significant staff changes within both the prison and the externally commissioned clinical and substance misuse teams (this includes changes at a senior level and has included the loss of several highly experienced clinical and other staff). This, combined with uncertainties about funding (and its impact on the staffing of some posts), and further changes coming in to effect (also linked to staffing as a result of the national 'benchmarking' agenda), came up in several of the interviews.

The Drug Recovery Wing

1. C Wing is the DRW and is also the largest Wing at the prison. It is a first phase DRW pilot. There is also a Drug Free Wing (DFW) which is B Wing (in another building adjacent to C Wing).
2. All prisoners are screened when they come in to the prison. Those who screen positive for drugs are taken from reception to the separate IDTS suite, removing them from the chaos of the intake environment. In the IDTS suite there is space for prisoners to sit, rest, watch TV, have a cup of tea etc. They are then seen by a doctor and/or nurse, who prescribe substitute (and other) medication as required. Many prisoners are already on scripts and they will receive a standard dose of whatever medication they need while their scripts are checked with the doctor who they are registered with (this may mean that some prisoners are temporarily receiving a different (often lower) dose of substitute (or other) medication.
3. As appropriate prisoners are then taken to C Wing (the DRW). There are no specific selection criteria for the DRW, other than screening positive for drugs on arrival at the prison. Prisoners housed on other wings may also access the DRW following induction if, for example, they have relapsed or see the DRW as a desirable environment.
4. The DRW is housed in its own building and consists of four landings (the top three house the prisoners). Overall, the DRW allows a fully integrated service, involving multiple providers, to be provided in one Wing 'under one roof'. The team is a mixture of Prison Service Discipline Officers, the psychosocial team (previously the CARAT team) and the Clinical Team. There is also external funding for a number of commissioned posts which are mainly Officers who take on a specific role. These posts are intended to cover various supportive remits: relapse, housing, sports & games, and supply reduction (these posts may cover the whole prison but they are housed on the DRW and offer a specific service there). Figure 1 gives a visual overview of the DRW staff structure and profile, though it should be noted that current numbers and roles may have changed slightly in the time since fieldwork.

Figure 1: Overview of Drug Recovery Wing at HMP Bristol



5. The psychosocial team (still called CARAT by many) has recently been awarded a new contract and so has taken on new staff. The team currently has 15 members of staff, including a Band 7 Team Manager, three Band 5 practitioners, eight Band 4 recovery support workers and three prison officers. The team is based on C Wing but will cover the whole prison. The team aims to see everyone with identified drug needs on their first day in the prison. It is a voluntary service but the team will try to engage with anyone who needs support.
6. The clinical team has approximately 20 staff. This includes 10-11 nurses (including night duty nurses), 6-7 healthcare assistants, a manager, reception staff, and GP support (RCGP trained in substance misuse).
7. The DRW has three landings (C1, C2 and C3) and a ground floor landing with other facilities (described below), with a total capacity of about 140 prisoners. The top floor is C3; this is the detox and stabilisation unit and it houses up to 42 prisoners. This is where (most) prisoners come when they are first sent to the DRW following a positive screen for drugs. Hence, C3 also serves as first night centre for these prisoners (as opposed to these prisoners going to the usual first night centre).
8. C3 is essentially a contained wing within the DRW. There are three corridors off the central entrance area, with one corridor including offices for the meds hatch (which is for C3 prisoners only) and the clinical staff. C3 also has its own 'phone and servery. All cells are equipped for double occupancy, though for health or security reasons some house only one prisoner. Each has its own observation hatch so prisoners can be monitored at all times.
9. Prisoners on C3 have round the clock access to medical care and will usually remain on C3 for up to about 10 days. The Clinical Opiate Withdrawal Score (and versions thereof for other substances) is used to determine levels of withdrawal and appropriate medication. There is also a five day review with each prisoner, and prisoners are asked for their consent for information to be shared with other professionals as appropriate. Those who require detox because of alcohol problems are at increased risk of serious adverse events including seizures, hypertension, tachycardia and hallucinations, and are consequently more closely monitored.
10. When a prisoner is ready to leave C3 they will usually move downstairs to C1, later progressing to C2. C1 and C2 have a similar layout to C3 – three corridors off a central area. There is also a phone and servery for each of these two landings.
11. C1 residents usually engage with psychosocial support, while progression to C2 usually means that a prisoner is engaged with prison employment. Monitoring by the clinical team continues when prisoners move to C1 and C2. There is round the clock nursing care available and good links between the clinical and psychosocial teams. In addition to the 5-day review, further reviews are completed at about 4 and 12 weeks for prisoners who remain on the DRW.
12. In theory, prisoners spend around 28 days on the DRW before moving elsewhere (which may include the DFW). In practice, prisoners generally spend longer than 28 days on the DRW and recent staffing and regime changes arising from budget cuts mean that progression through the DRW is less well-defined, and wing residents are more likely to spend more time in their cells.
13. All prisoners who engage with the DRW sign a compact to cover things like drug testing, and adherence to the DRW regime and rules, although there is no mandatory

attendance at groups or other psychosocial support. Prisoners are paid to be on the DRW and for the courses that they complete.

14. It is hard to describe a typical day on the DRW because there are three landings and all are rather different. A typical day on C1/C2 starts about 8am. Prisoners are given their meds and breakfast. If a prisoner is working then they start work around 9am. Prisoners return to the DRW and are locked in their cells for lunch, which is at about 12 noon. Prisoners then work again between about 2-4.30pm, following which they return to the Wing for food (at about 5pm) and time in cells. On a few days a week there is association time on the Wing when prisoners can have more time out of their cells (between about 5-6.30pm). Prisoners can also access the gym, and additional sports and games facilities on the AstroTurf (see below).
15. C Wing felt very much like a 'normal' prison environment although its location and layout mean that it is possible to maximise its segregation from the rest of the prison. Each landing seemed clean and fresh and had many of the facilities required to maximise segregation (like a phone and servery). On the stairwells there was information about DRW programmes, rules and so on. On the bottom floor of C Wing are many of the other facilities for the DRW. This includes a large room which has pool tables, table tennis and table football. At the far end of this room is the meds hatch (for C1 and C2 prisoners only), individual rooms for staff to see prisoners, the laundry, and a corridor with the classroom for groups (although this has not been used for several months due to asbestos and subsidence problems). From the entrance to the DRW on this floor are two gates: one to the offices for DRW Discipline Staff, which includes a general office with boards which contain details about all DRW prisoners; and another to offices for the psychosocial team.
16. DRW prisoners do not have their own exercise yard. Prisoners from C1 and C2 have set hours for use of the main exercise yard (this time is shared with the DFW). Prisoners from C3 also have their own set hours for use of the main exercise yard. Additionally, there is a two-year old AstroTurf pitch [which is shared by the DFW and] can be used for a range of sports. Prisoners on C3 (the detox landing) cannot participate in sports but they are taken outside to watch if they want. This facility cost about £30-40,000 and was funded by a number of external services. There is also a room which house sports equipment and a small number of prisoners have jobs as sport orderlies. Some of the interviewees (prisoners and staff) talked about the additional benefits to the DRW of having this facility. On one visit to HMP Bristol it was warm and sunny, and there were about 30 prisoners using the pitch to play cricket.
17. The DFW hols up to 100 prisoners. Prisoners have to sign a compact to be on this Wing (to include things like regular urine testing - a positive drug test means instant dismissal from the Wing). The DFW offers single cell accommodation, and prisoners are allowed their own clothes, bedding and cutlery, and are given a lanyard which says (something like) 'say no to drugs'. DFW residents can engage with counselling and other services, and peer and mentor support is available on the Wing. On the ground floor there is a snooker/pool table and three old fashioned (green not red) 'phone boxes.
18. Aspects of what is now the DRW were highlighted as good practice in the most recent HMIP report (HMIP, 2010). This includes the IDTS suite, the relapse intervention team (a service now provided by one Officer) and partnership working between the prison and a range of statutory and non-statutory partners.

Summary of interview findings

The interview findings are discussed following nine broad themes. These are: the Wing and general conditions; the role of C3 and medication; psychosocial programme; wraparound and through-the-gate services; staff and relationships; challenges and gaps; impact on wider HMP Bristol environment; impact on prisoners; and the future.

The Wing and general conditions

- The prisoners gave their views on the general conditions of the DRW. There were many positive comments, with some prisoners finding the DRW clean and quiet. Some of the interviewees thought that the contained nature of the DRW led to an overall calmer environment with staff highlighting a notably low level of assaults and aggravation (compared to other Wings). Some interviewees thought that the AstroTurf and the increased access to sports and games contributed positively to the overall atmosphere of the DRW.
- One prisoner thought that the cells were a good size for sharing, and appreciated their separate toilet areas. Another prisoner thought that the DRW was better than other prison wings because it is smaller in size (e.g. the corridors which house the cells are shorter). Some prisoners commented on the increased freedom for prisoners on the DRW, for example by having more time out of their cells. One prisoner liked the routine and ease of access to medication. However, one prisoner said that because of his mental health needs he would prefer single cell accommodation on the DRW.
- There were many positive comments from interviewees about the importance of having the DRW as a self-contained Wing that is largely separate from the rest of HMP Bristol. Some prisoners added that being housed on a Wing which housed drug misusers only was beneficial. At least one staff interviewee felt that the specific support and structure available on the DRW was to a prisoner's advantage if they chose to engage with the DRW.

  > "there are a lot more people in your boat……[you can] feel more comfortable in your surroundings" [prisoner]
  >
  > "[prisoners] can come here and get well, they can be supported....it's all about grasping the support that's there and applying themselves….a lot of our clients, they're incapable of making their structure or keeping to their own boundaries outside but they can do it in here because [we] provide that" [staff]

- However, some prisoners compared the DRW with other Wings at HMP Bristol, finding the DRW to be noisier, less relaxed, more chaotic and more cramped. One prisoner explained that the DRW seemed more chaotic because of prisoner turnover and it being the area of the prison where drug misusers are housed straight from reception.
- There were other negative comments about the DRW. Some prisoners thought that the cells were of a poor standard with one describing them as "diabolical". Other comments included the DRW being basic, cold, "bearable", and having low quality furniture. Several prisoners criticised the food (although some said that this was not necessarily unique to HMP Bristol), saying that there is not enough of it, it is poor quality and prisoners often have to subsidise by buying more food from the canteen. There is only one hot meal a day and one prisoner said, "….we're always basically hungry". One prisoner, who because of his job interacts regularly with kitchen staff, said that kitchen

staff try and respond to feedback but can only do so much with the resources available to them.

* Some prisoners thought that they spent too long each day in their cells and would rather have more opportunity to engage with employment. One prisoner found the time in his cell "....stressful [and] irritating" while another said it makes the days drag.
* The DRW at HMP Bristol was the first DRW to pay prisoners to engage with prescribing and drug treatment interventions. A staff interviewee explained the rationale behind this move, and the importance of this aspect to the DRW.

> "I wanted to contain it here and keep them available for appointments….so I removed them from labour but we paid them the same rate....we couldn't be seen to be taking them out of employment and deprive them of earning potential so we paid them for being on IDTS, we still do....we allow them certain bits of work but we don't want to remove them from what we're trying to do" [staff]

The role of C3 and medication

* Having C3 as a contained part of DRW, with dedicated time for detox and access to medication, was generally viewed by staff interviewees positively, and as a strength of the DRW at HMP Bristol. The presence of clinical staff who can monitor and support prisoners at all times was also felt by staff to be an advantage.
* One interviewee explained the wider impact that C3 has on the wider prison environment, saying that it allows the rest of the prison to operate a full and normal regime because other Wings do not have to structure their days around medication. One interviewee thought that it was safer for prisoners to have medication managed separately on C3.

> "....it is a lot safer to have everyone....cos everyone's in the same boat whereas if you're just thrown into general population on any wing I think a lot more bullying comes in to play I'd say with the drugs, getting the Subutex away and things like that" [prisoner]

* Some interviewees felt that the contained nature of C3 reduced the spread of drugs throughout the rest of the DRW. Furthermore, one prisoner thought that there were less 'hard' drugs around the DRW because prisoners are on substitute medication. Officers are present on each occasion when meds are dispensed to prisoners (this is also the case for C1/C2) with one staff interviewee describing this work by Officers as "diligent". The supply reduction Officer developed a best practice guide for staff who are involved in giving and supervising the dispensing of medication.
* Some of the staff interviewees talked about the challenges which the DRW faces with detox and prescribing. One interviewee explained that the clinical team recognised that, partly because of staffing and other difficulties faced by the clinical team, ideal prescribing and reduction regimes could not always be followed. This interviewee particularly felt that prisoners, rather than the clinical team, were sometimes given too much say in their prescribing regime, adding that there are active efforts to redress this.

> "....we're actually making a conscious decision now to try and get back a bit to how it was to be honest....we're trying to tighten things up again" [staff]

* Another interviewee talked about the challenges resulting from the introduction of a new prescribing protocol (which had been in place for less than a month at the time of

fieldwork) whereby, on release, any client of probation's prolific offenders service must get their scripts from the rapid prescribing service at the local statutory drug service, as opposed to being able to re-engage with and receive scripts from their GP. The interviewee said that the new protocol is not being well received by some prisoners who would prefer to engage with their GP rather than shift to the rapid prescribing service.

* Another issue, debated by many staff and prisoner interviewees, focused on the extent to which prisoners should be maintained on medication, or encouraged to reduce and become abstinent. Several prisoners expressed real concerns with Prison Service directives that prisoners should move to abstinence if they are in prison for six or more months. At least one interviewee was of the opinion that this area came under the remit of the NHS rather than the Prison Service, and that prisoners should be able to stay on substitute medication for as long as they wished. One staff interviewee said that the changes which would be required to develop a more abstinence focused model were just not possible for the DRW in its current format and within current resources.
* Some interviewees commented on the role of sports and games in encouraging prisoners to consider alternatives to drugs and substitute medication, while another staff interviewee talked about how prisoner anxiety around abstinence could be tackled.

  "I think it's maybe just identifying as well that maybe small changes for them are huge, so even if they look at reducing slowly that may be slower to other people for them that's a massive step and maybe that once they reduce slightly they might think actually this doesn't feel too bad and then be encouraged to reduce again. And just giving them all the support that they need really and appreciating that maybe they aren't ready" [staff]
* One staff interviewee held particularly strong views in favour of abstinence, supported by treatment coercion and strict treatment regimes. This person also highlighted inconsistencies within the treatment system which negatively affect abstinence models – e.g. the response to a prisoner who is using drugs on top of his meds is to increase his script; and clients will still get their scripts even if they DNA from an appointment with a community treatment service. This interviewee also thought that remand prisoners should be detoxed rather than stabilised.

  "you're overweight so I'm going to help you stop eating Mars Bars. You are currently eating 4 each day – to help you stop I'm going to let you have one Mars Bar a day" (not a verbatim quote) [staff]

  "...in my mind everyone should be detoxed, there shouldn't be a stabilisation period....surely we're colluding with them if we stabilise an individual…." [staff]

Psychosocial programme

* Many of the prisoners did not talk in detail about the psychosocial support available on the DRW (which is not compulsory), although they offered insights into what they found helpful and unhelpful about this aspect of provision. Positive comments centred on group support (which was thought to be well facilitated), informative courses, and more personalised support using mapping interventions. One prisoner said that the courses he has attended have helped change his attitude and increase his motivation.
* However, on the other hand, some prisoners thought that the courses did not offer anything new (particularly to prisoners who had done such courses before), were at too

low a level (e.g. 11-Plus level said one prisoner), and that some were "....to be honest…. pretty crap....a bit pointless". One prisoner felt strongly that he needed more 1:1 support. However, one prisoner, who did not find the group courses so helpful because he has done them before added that he still found them a useful refresher. He added: "the more that goes in your head the more you think about staying clean."

* There was some acknowledgement from staff interviewees that the psychosocial support available on the DRW needs to be improved. One interviewee explained that the psychosocial team will be introducing a new recovery-oriented groupwork programme in May, as they have recognised that the current programme is "stagnant" and less useful to many prisoners. The new programme will involve daily orientation groups for prisoners on the DRW alongside a rolling two week programme for the whole prison. It is hoped that the new programme will encourage abstinence and further strengthen links with through-the-gate services.

  "[we will be]...having an orientation group as soon as people come on to the wing and saying look we're not going to maintain people on medication any more, we want to look at you getting clean, getting abstinent" [staff]

* There were some comments that psychosocial support which is more intensive over a longer period of time would be helpful. Comparisons were made with the previous short drug programme (SDP) and with intensive 12-Step programmes in other prisons.

  "that's where the failing is, there needs to be some sort of intervention [or] drug programme in a local prison" [staff]

Wraparound and through-the-gate services

Six issues are discussed under this heading: housing, relapse, sports & games, progression to the DFW, through-the-gate services and resettlement, and mental health services.

* The part-time **Housing Officer** is seen to be an important part of the DRW integrated team, with the post developed in recognition of the link between a lack of accommodation on release and reoffending. The work of the Housing Officer, and the extensive links with a wide range of community services that he has made, has increased the likelihood of a prisoner having some form of accommodation on release. One staff interviewee identified that up to 90% of DRW prisoners were now found housing. The Council housing officer now comes to the prison twice a week (previously this was once a week). Improvements with the through-the-gate service supports the work of the Housing Officer, although this aspect of a prisoner's journey could be further strengthened. One interviewee said that they would like a full-time Housing Officer like they have at HMP Manchester.

* The **Relapse Team** is another important part of the DRW integrated team, and has won national awards for its work. The work of the relapse team ensures a more positive and constructive response to relapse. A relapse does not mean dismissal from the DRW; on the contrary support is likely to be intensified.

  "....before when they relapsed they didn't have anywhere else to go, they just relapsed and that was it, so now he's giving them the support that they need to get back on track" [staff]

* However, the original relapse team (which consisted of a dedicated Officer plus support from the clinical and psychosocial teams and administrative support) now consists of

only one Officer, and staff felt that changes within the Prison Service are placing the relapse service at risk. One staff interviewee highlighted a particular challenge for the relapse team, which had the potential to affect the credibility and confidentiality of the service. An external agency had apparently placed pressure on the prison to disclose to them when a prisoner had relapsed; this affected the trusting relationship between a prisoner and prison staff on the DRW.

* The **AstroTurf**, along with the **Sports & Games** team (both of which are only available to the DRW and the DFW), are seen to bring particular added value to the DRW. This is for a number of reasons – including reducing isolation through time out of cells, improving health through physical activity (links to the poor health and body image of drug misusers), a calmer environment within the DRW because of the increased availability of physical activity, and encouraging team work and bonding between prisoners which can improve confidence and self-esteem. It is also important because efforts are made to engage all prisoners, with those who do not want to actually engage in the activities encouraged to go outside and spectate.

Staff views on Sports and Games

"....with us it's not about sport, sport's the vehicle to engaging people because drug users can become quite insular….[we try to] get them out of that mindset and show them other ways of enjoying themselves"

"....it's to go up there and talk to everybody and encourage everyone out, in my eyes it's the person that isn't the first person to put their hands up when gym's shouted, that's the person they should be mentoring and getting outside, that's out target audience really"

"....it's been really positive....a lot more time out of their cells, they're out doing team sports, they're doing motivational stuff, self-esteem work, they're getting physically better, physically healthier, using up a bit of energy during the day, we've had a reduction in the general alarms….when the prisoners are around the wing all day and they're not getting out, they're more pent up….it's a lot calmer, the wing's a bit calmer"

"....it gets them out their cells and it does de-stress them and tire them out....when we first opened C Wing there was quite a few assaults and the atmosphere was quite edgy but now the sports and games has come in you can feel the atmosphere isn't half as bad, the prisoners get on a little bit better"

"...to see an AstroTurf at a Cat B prison that was only designated to substance misuse prisoners, they loved it"

* The opportunity to progress from the DRW to the **Drug Free Wing** is seen to be beneficial. However, several prisoner and staff interviewees felt that there were ways in which the DFW could be better used. The size of the DFW, and the fact that prisoners from other Wings can also move to the DFW, means that prisoners from the DRW cannot always move to the DFW or are not prioritised. This can impact upon prisoners who are less likely to see the DFW as an incentive. One prisoner said that he did not want to move to the DFW because he would lose the status and privileges which he has

on the DRW, while another prisoner said that his need for medication (for general health issues) meant that he could not go to the DFW. One staff interviewee thought that DRW prisoners should be prioritised for the DFW while another thought that there needed to be much more psychosocial support available to prisoners on the DFW so that they could continue with their recovery. One interviewee held the view that the progression from the DRW to the DFW is much less clear than it used to be because of other changes which have taken place.

> "...now we're missing a stage and they're saying you come off your detox and you're into the normal regime of the prison, and I think there's a massive confidence building stage that we're missing....that's managerial decisions that have been made....[and] it's not been communicated very well" [staff]

* It was widely acknowledged that HMP Bristol and the DRW have excellent links with a wide range of drug treatment and other resettlement services both within Bristol and further afield, partly as a result of taking prisoners from other Courts because of the closure of other local prisons. Some improvements in **through-the-gate services** were noted (partly associated with the role of the Housing Officer as noted above), including closer links with Criminal Justice Integrated Teams (CJITs) and Bristol's prolific offenders service. However, it was also noted by some that further improvements are needed in this area. One staff interviewee would like to see further improvements to the through-the-gate service for prisoners on release, with officers potentially escorting them to appointments with housing, drug and other resettlement services. A comparison was made with HMP Manchester where there is a dedicated 'through the gate centre' to prepare and support prisoners before and on release.
* Some prisoners highlighted how hard it is to adjust from the structure and routine of prison life to being back out in the community, suggesting that more help is needed in this area (one felt particularly strongly about this).

> "the prison is doing nothing to me….my problem starts when I'm outside"

* It was recognised that DRW prisoners commonly have co-existing mental health problems and that not enough is done to support them. These prisoners can also affect the capacity of the DRW because they are often deemed high risk and so have a cell to themselves. There were generally negative views about **prison mental health services**, although it should be acknowledged that only a small number of interviewees discussed this.

> "there are no links with us and mental health….we're not allowed to make a referral to mental health for the first week cos we can't tell if it's mental health or detox issues" [staff]

* One prisoner said that he disengaged with the prison mental health team because he was not finding it helpful, while another said that he has been unable to engage with the team because officers had not been available to escort him to appointments. Staff interviewees highlighted several things which prevented swifter access to, and closer engagement with prison mental health services. Firstly, unless a prisoner is already engaged with community mental health services, the prison mental health team will not engage with them for 28 days. Secondly, referrals to the prison mental health team can only be made by a Doctor. Thirdly, the prison mental health team will not see a prisoner until they have completed their Valium detox (which can take 20-28 days). Fourthly, the prison mental health team use their own computer system, which makes it difficult for

professionals in different roles to share information about prisoners effectively. Finally, when the prison mental health team discharge a client there is no ongoing care plan. One interviewee said that efforts were being made to improve partnership with the prison mental health team. There are plans to introduce a comorbidity clinic to try and offer an improved and more joined up package of care to prisoners with dual diagnosis.

* Although not a significant theme to come out of the interviews, there was recognition that **the response to prisoners with alcohol problems is insufficient**. One staff interviewee made comparisons between community based alcohol and drug treatment, favouring the rapid reduction and abstinence-based approach of alcohol treatment. On the other hand a second staff interviewee suggested that alcohol dependent prisoners receive additional resourcing, stating that prisoners who are receiving an alcohol detox are very closely monitored because of the increased risks associated with withdrawal and detox. The HMIP report on HMP Bristol said that there should be specific support available for prisoners with alcohol problems (HMIP, 2010).

Staff and relationships

* Staff and prisoner interviewees were overwhelmingly positive about relationships between prisoners, among the integrated staff team, and between staff (Officers and other DRW staff) and prisoners. There was a general view that prisoners are supportive of each other, and that there is less aggression and bullying than on other Wings.
* DRW Officers and other staff were described as responsive (and not fobbing off prisoners), approachable, understanding, knowledgeable and expert. In many cases staff and prisoners are known to each other and this can positively influence relationships. Two staff interviewees commented on how they thought relationships between Officers and prisoners have changed over the years, largely due to Officers' changing attitudes and understandings around prisoners with drug problems.

  "things have changed, attitudes have changed, staff are more approachable now……if you've genuinely got a problem, as long as you're not taking the piss out of them all the time....they'll go out of their way to do something for you and sort things out" [staff]

  "....those barriers are coming down....prisoners are speaking openly about their drug use and their problems in front of prison officers....that's new….they're talking about their use in prison to a prison officer, now those things before were unheard of, why on earth would you tell a screw that you're using drugs in prison, you'd get in trouble you know….you have them and us, but now there's a lot of meeting in the middle....I think that's been a real positive for us" [staff]
* Having an integrated staff team, who are all located on the DRW, was generally seen to be one of the strengths of the DRW. However, staffing resources (and the presence of Officers who are not dedicated to the DRW) can be problematic, affecting relationships with prisoners and disrupting the regime (for example, because a lack of staff means that there can be not association time, or access to sports and games). The DRW team felt well supported by Senior Officers and the Custodial Manager, although higher level support was viewed with greater hesitancy. The staff interviewees expressed serious concerns about staffing changes (those which have occurred over the last 12-18 months, and those which are forthcoming under wider Prison Service changes) and the potential

risks for the integrated staff team. There used to be a weekly IDTS management meeting and one interviewee thinks that this should be reinstated.

Staff views on the DRW Integrated Staff Team

"It's good, I like the integration, I like the integrated working, it makes it a bit more interesting than just dealing with day to day prison life"

"the way everyone works together is really really positive"

"you can make a big difference...you've actually got the opportunity to affect these people's lives for the better"

"everyone that works on here really believes in...the service....everyone's working to the same goal really, everyone believes in drug recovery and in wanting to help people as much as possible"

".... the staff are really motivated....most of us have been here a few years, we're quite a close knit team, we all work for each other....and everyone's committed really"

Views on Staff-Prisoner Relationships

"they do keep a good eye on you which is better to get clean" [prisoner]

"[they are] good as gold" (more than one prisoner used this phrase)

"....[the staff] are always there if you want the help but if you're not willing to have the help you're not going to get anywhere" [prisoner]

"they are always in view or nearby" [prisoner]

"generally some of best I've seen" [staff]

"….prisoner-staff relationships, not just with the substance use team, but with the discipline staff is very good….and I think you can see when you walk around the landings there's a much better rapport, much more shall we say relaxed atmosphere than sometimes when you go on other Wings" [staff]

Challenges and gaps

Two issues will be discussed here - the availability and use of drugs and alcohol, and the impact of repeat offenders.

* Little was said about alcohol on the wings. There were generally mixed views about the availability and use of drugs on the DRW when compared to rest of prison. There appeared to be a more common view that prescribed medication (particularly Subutex) was a major problem for the DRW along with the greater concentration of prisoners with drug problems and/or on substitute medication on the DRW.

  "....it's going to be anywhere, if you wanted to you could find it, but it's not as in your face, I think it's a lot more behind closed doors in this wing now whereas I remember on A Wing you could smell it as you were walking down the landing....it was always about" [prisoner]

  "that accumulation does cause a problem" [prisoner]

* It is generally recognised that drugs are a major problem at HMP Bristol; for example there was a significant spike in positive drug tests around the time this rapid assessment was undertaken. Prisoners on licence recall, many of whom go straight to the DRW when they are brought back to prison, are believed to pose a particular problem. While staff recognised that strenuous efforts are made to minimise drugs coming into the prison and their movement around the prison (including the work of the Supply Reduction Officer), they identified operational challenges which greatly affect the kinds of drugs that prisoners use, and the availability of professional responses. Staff felt that drugs had become more prevalent in the absence of a dog and handler at the prison. One interviewee also felt that introducing routine drug testing had created an incentive for prisoners to use heroin, as it stayed in prisoners' oral fluids and urine for much less time than cannabis.

    "....a major failing of the drug recovery wing, I think if we had a bit more technology we could be on top more of prisoners using on top of their medication" [staff]

    "that's the biggest mistake prison's ever made, bringing [different testing procedures] in" [staff]

* Another challenge for the DRW is keeping it full with prisoners with drug-related needs. Population pressures often mean that other prisoners are housed on the DRW. The number of high risk prisoners on the DRW also affects capacity because many of them need to be in a cell in their own.

* As already noted the number of repeat offenders is also an issue. HMP Bristol is not unusual as a local prison in having high numbers of repeat offenders, many of whom are prolific offenders serving short sentences. Many DRW interviewees (particularly staff) highlighted a number of challenges presented by this group. Some prisoners will deliberately offend to be able to return to what they see as a safer prison environment where they can access detox and other help. One interviewee thought that short sentences and the focus on substitute medication were not the best response for repeat offenders.

    "....you're not going to get effective drug treatment and change a person or change even their point of view on a short sentence….. [Substitute medication] is all they're interested in….they've got absolutely no intention of coming off the drugs....Sentencing is a major issue for substance misuse...you've got too short a period when you can't change a person's lifestyle" [staff]

Impact on wider HMP Bristol environment

* There was a general feeling that being able to contain drug misusers within one Wing of HMP Bristol was beneficial to the rest of the prison environment. However, the presence of a dedicated DRW means that it can be viewed negatively by other prisoners and staff. There were several comments that other prisoners see the DRW as the 'junkie wing' and do not want to be housed on the DRW, while Officers on other wings can lack understanding of the DRW and DRW Officers' different working styles. There were some suggestions that staff in the wider prison can be envious of what they see to be additional resources given to the DRW, such as access to sports, games, and the AstroTurf pitch. Interviewees also spoke of a 'them and us' mentality from some other Officers. One interviewee thought that prisoners with alcohol problems did not want to mix with drug misusers on the DRW.

Views on the DRW across the prison, and the perceived impact of the DRW on the wider prison environment

"the environment we have here, it can be a bit chaotic at times because of the nature of the prisoner….their lifestyle outside is the lifestyle they bring in with them, but we kind of contain that here, it is a strict regime but the routine suits....these individuals need a routine....it's structured"

"we take everyone with a drug issue, we contain them here, which means their issues aren't spilling out in to the other units…...when [other officers] receive them on [another] Wing, they're getting a better prisoner, he's stable, he's maintained, he's healthier, he's organised now and he can move on, those wings aren't used to receiving what we get upstairs which is a chaotic, crazy prisoner running around cos he's got nothing"

"I suppose this is more of a contained wing in the sense of maybe more of a community I guess so there's a lot more that happens on this wing rather than them having to be moved elsewhere"

"we're actually giving them a less chaotic, more stable prisoner than what they would have had....I think that it [the DRW] is a vital stage….they need somewhere to sort themselves out for want of a better phrase and get level before they then engage in the normal prison population and that's where C Wing fits in....if we took C Wing's function out of the prison and these chaotic individuals were then dotted around everywhere people would realise what C Wing had done for the prison"

"....when they're on the other wings I think they just get shoved to the side and people didn't really want to deal with them because they are quite needy...."

"I think the ethos of this wing is better than the rest of the prison. The rest of the prison....just want to come to work, do what they've got to do and get off, whereas the ethos of C Wing's always been you do as much as you can rather than just turn up for an easy day....but a lot of the rest of the prison don't understand what actually happens over here"

"....the [other] wings general attitude is when they get beat [in sport] by C Wing, I can't believe we got beat by a load of crackheads and other druggies, stuff like that, so their perception of them is quite low"

"...but I don't think they really appreciate it's only an easy life on here because the officers work really hard to make it work well"

Impact on prisoners

* Prisoners were generally positive about the idea of DRWs within prisons, with some interviewees thinking that there should be a DRW in every (local) prison. However, it was hard for interviewees to articulate and quantify how they thought a DRW benefits prisoners. Some interviewees said that prison is a false environment, a controlled reality, and felt that it is hard to assess the impact of something like a DRW until after release.
* Because HMP Bristol is a short-stay, remand, prison this can affect the work which it is possible to do with prisoners and the change which it is possible to effect. The closure of other local prisons has had an impact because HMP Bristol is taking prisoners from six

other local courts. This affects the time prisoners are spending at HMP Bristol and the amount of work it is possible to do with them.

* While not discussed in detail it seemed from the interviews that very little specific data are collected about DRW prisoners. Furthermore, the prison, the psychosocial team and the clinical team all use different IT systems and this affects the data collected and available on DRW prisoners.
* A couple of staff interviewees said that there was anecdotal evidence supporting the work of the DRW. For example, one interviewee talked about prisoners who are working, and/or back in touch with their families/children etc. and who are doing well. This interviewee added that good links with community projects, and the role of local champions (involving prisoners through peer support), can offer prisoners some of the additional support that they need. One interviewee thought that the IDTS had contributed to a drop in the suicide rate at HMP Bristol.
* Several interviewees commented that a central factor associated with the success of something like a DRW was prisoner motivation. A small number of the staff interviewees thought that initiatives like DRWs need to ensure that prisoners are given as much responsibility as possible for their recovery, thinking that perhaps the prison did too much for prisoners.

  "....because the responsibility has been taken from the client, it's our responsibility now….prisoners see that, they utilise that to great effect I feel" [staff]

  "….I think that's what's lacking at the moment, putting the responsibility back on to the client" [staff[

  "a smaller more dedicated unit….we take every detox prisoner that comes through the prison….and I'd like to work with just the people [who] are actually dedicated to change and they want to address their issues, not the ones who just come in....not interested in the help....working with people motivated and [who] want help rather than trying to force people into help" [staff]

The importance of prisoner motivation to change

"you make [of it] what you want when you come to prison….if you want to do it you do it, it not you don't do it....if you do do them you're out of your cell more often and you do get paid for doing the courses as well, it's down to the individual at the end of the day, to make of [it] what you can while you're in prison" [prisoner]

"it's a good wing if people want to recover from drugs and get their head down but it depends if they want to use it to their advantage" [prisoner]

"I was ready to give up drugs anyway, now was my time and being in this environment has helped me still think like that….having an environment where it's [i.e. heroin and the like] not readily available does help a lot" [prisoner]

"it's given me time to get my head together [and] put things in to perspective….[the DRW will not affect my future]....I will affect my future" [prisoner]

"....it's the prisoners mentality and whether they want to be helped a lot of the time…..if they're not ready to tackle their own issues….there's plenty here for them if they need it....and whether they want it or not is another question" [staff]

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* Views on the future of the DRW came mainly from the staff interviewees. In the light of recent staffing changes, expected staff reductions, associated concerns about funding,

and the impact of the closure of local prisons, the future was viewed negatively by this group of interviewees and there were real concerns about the risk to the DRW. Overall, all the interviewees thought that such real-world limitations may have impacted on strategic support for the DRW's future. One interviewee thought it was a shame that this rapid assessment had not come at the best time for HMP Bristol given the impact of such factors, while another interviewee was pessimistic about the future of the DRW.

> "....it's a bit of a shame really that you've come at the end of what has always been a really successful pilot site...it's been nationally rewarded and it's just a shame that at the end of it we're struggling a little bit if I'm honest"

> "I've visited every pilot site and to see the support, the ideas that we took back, the ideas that we gave to people that we spoke to, I can't see why things are changing within the prison service.…These people need support, they need IDTS, they need medication and I think it's just going to dwindle out and it's going to be hard for staff to get involved because you're not going to have the resources any more....I'm less optimistic, I can see it going back to the old days"

* Staff changes in several areas were of great concern to the staff interviewee. In addition to the change in Wing Governor, and to the clinical team, changes in shift patterns and the Officers who will be on the DRW are about to be introduced. These changes will also affect the prison's core day and potentially also the prisoner:staff ratio: this will impact upon the programme on the DRW. Further changes will see the prison with a core staff team of 200 Officers, with an impact on the ten externally commissioned posts (who are not included in this core group of 200). Overall, there were concerns expressed by staff interviewees that impending changes to Bristol's staffing structure, service commissioning arrangements, and prisoner:staff ratio will break up a well established and experienced integrated staff team, with a potential knock-on impact on relationships with prisoners and the ethos of the DRW.
* Despite these concerns for the future, many of the staff interviewees believed in the DRW model and hoped it would continue.

> "....I think what you've got to do is not have a fixed model and you should adapt it to the environment that you're working in....you should be flexible anyway because things are always changing and you should move with those changes otherwise it's just too rigid and becomes unworkable"

> "I hope that something stays in place, we really need drug treatment in prison....a structured drug treatment programme for prisoners".

> "I wholeheartedly believe in what we're trying to do here....[but] part of me thinks that a more Draconian style might work, but another bit of me thinks it wouldn't work....but what we're doing to, for these prisoners is positive and right and proper but we're still seeing them back time and time again"

> "...medication is only probably 10% of what, why they're here and the rest has come from the staff, integration from the clinical, what the Government's proposed....and I would hate to see that change sort of flitter out really which I think we can see is going to happen"

Staff views on the future of the DRW at HMP Bristol

"....the weaknesses are from outside of this Wing"

"....we haven't been robustly ringfenced"

"I don't think we've got that [direction] any more....[and] it's not working as well at the moment"

"....ultimately I don't know where they want us to go with this if I'm honest, it's all a bit up in the air, there's no real, no-one getting a grip of it and saying...[before there was] passion and drive….I don't know if that's there at the moment""....the fears are the funding gets cut to be honest....without some key funded positions I think a lot of it would just fall apart"

"....if that [external funding] were to ever go, which I dare say in this climate it will, I think that a lot of the work that goes on here will cease"

"....with this I feel at least we're doing some quality work, we have a different engagement and interaction with the prisoners and I just think it's a shame that it's all going to be risked because of cost"

"....with this I feel at least we're doing some quality work, we have a different engagement and interaction with the prisoners and I just think it's a shame that it's all going to be risked because of cost....I think if this disintegrates it will be a disservice for the prison and for the community....if this goes because of changes in cost and philosophy I think the prison will become a less safe place and the community will see the impact with regards to an increase in offending"

"At the moment on this Wing there's a group of staff that have worked together for a long time, they know each other well, they have excellent relationships with each other.... so we will go away from the ethos of people coming to C Wing cos they believe in IDTS...[but] cos I'm on a shift pattern or whatever, that's where I've got to work....that's a difficulty for me....new staff is good don't get me wrong, but do the new staff believe in IDTS?"

"....I think it's just obviously staff rotation, those who came on before were so knowledgeable as to what these sort of guys, you're dealing with, you had your RCGP trained staff, you had your alcohol worker, you had your substance misuse workers, now it's just the rotation of staff....there's probably 3 staff who are RCGP trained....it is a big impact"

* The staff interviewees also had ideas on how the DRW could continue to develop.

  i. Having a DRW which is contained within a larger Wing (e.g. HMP Manchester) rather than being a separate building as it is at HMP Bristol.
  ii. A full-time Housing Officer.
  iii. A separate through-the-gate centre (like at HMP Manchester)
  iv. Getting prisoners free from medication "so it gives them a better starting point, I don't think there's enough effort put in to getting [prisoners] meds free and I think that's a big starting point for them". A fully abstinent model, "a harsh backward step" is needed.

v. Increasing prisoner access to employment for when they are stable in relation to medication/drug use.
vi. More resources to provide, for example, a proper classroom and better sports facilities (e.g. a changing room area to make it a bit more professional).
vii. Improving the overall physical environment of the DRW.
viii. A smaller unit which is more selective with prisoners it accepts.
ix. A renewed, clear statement of purpose and strategic direction for the DRW.

Conclusion

This rapid assessment indicates that there are several successful elements to the DRW at HMP Bristol. These include: the contained nature of the DRW (and C3, the detox unit, within it); the large multi-provider integrated team housed on the DRW (with the added value of externally commissioned posts and of the IDTS suite); the extent of partnerships with external agencies; improvements to through-the-gate and resettlement services; and the dedicated sports and games Officer supported by the AstroTurf facility. However, there are a number of issues which need to be addressed for the DRW to continue to develop. These include: revamping the psychosocial group programme and other support; tightening up prescribing protocols; developing an operational framework which is more strongly guided by reduction and abstinence; continuing to develop through-the-gate and resettlement services; establishing a clear pathway between the DRW and the DFW; and assessing the impact of the DRW on prisoners during their stay at HMP Bristol and post release. It also seems that some staff and prisoners view the DRW negatively and lack understanding about the DRW, indicating the need for a programme of work to address this. There was also little mention of family support, either in terms of supporting families of prisoners in their own right, or in terms of supporting prisoners and families together. Overall, the lack of family support may represent a missed opportunity for the DRW and its wider understanding of recovery.

However, the greatest risks to the future of the DRW come from broader issues faced by both HMP Bristol and the Prison Service, as a result of changes to staffing levels and organisation, and regime changes. Uncertainties about funding and the impact of the closure of other local prisons also present specific challenges to the DRW at HMP Bristol.

Appendix 4: Brixton

Fieldwork

Fieldwork was undertaken over two days in April 2013. A total of 19 interviews were completed. Some of the interviews were conducted in an office on the DRW itself which provided a further opportunity to walk through, observe and spend time on the Wing (and the larger general population Wing of which the DRW is part).

Interviews with Prisoners

1. Eight male prisoners with a mean age of 35 years old, and a range of between 22 and 51 years old.
2. One male ex-prisoner was interviewed. Due to concerns about confidentiality, identifiable data from his interview has not been used in this report.
3. Because ethnic diversity is a prominent characteristic of HMP Brixton and its DRW, seven prisoner interviewees were asked how they would describe their ethnic status. Three are White British, one British Pakistani, two Black British, one Black British Caribbean, and one multi-ethnic.
4. All eight prisoners had been sentenced. None were on remand, or recalled on license.
5. Six interviewees had been sentenced for acquisitive offences (including one for possession with intent to supply). Two had been sentenced for violent offences.
6. Prisoner interviewees had been sentenced to a mean of 29 months, with a range of 10 to 48 months.
7. Release information was unavailable for one interviewee. The remaining seven prisoners had a mean of seven months until they were eligible for release. Six expected to be released within a year, with five of these anticipating release within the next six months.
8. For five prisoners, it was their first time in prison (although not necessarily their first offence).
9. Some interviewees had recently transferred to Brixton from other prisons. There was variation as to whether the prisoners would complete their sentences at Brixton or be transferred to another prison.
10. Two interviewees identified that they had not been using any drugs problematically at the time of (or for some time preceding) their arrest. The remaining six collectively identified nine drugs of choice.
11. Alcohol and cannabis acted as interviewees' main drugs of choice, with three prisoners naming each. One interviewee identified himself as a primary crack cocaine and heroin user. One final interviewee identified himself as a polydrug user.
12. Perhaps unsurprisingly given the low levels of opiate use in the interview sample, only one interviewee was receiving opiate substitute medication.

Interviews with Staff

1. Eleven interviews with four psychosocial, three clinical and four prison staff, and one employee of an external third sector agency. Seven interviewees held frontline roles, whilst four were in management positions.

Description of HMP Brixton

1. HMP Brixton is a Victorian prison. It was previously a Category B male local prison but in the last couple of years has re-rolled and is now a Category C-D male local prison with a total capacity of about 800 prisoners.

The Drug Recovery Wing

1. The DRW is within A Wing. A Wing has four landings, and is the prison's largest general population wing. The DRW takes up half of each of the top two landings. It has its own gated entrance on the lower landing and is separated from the rest of A Wing by this gate and large floor-to-ceiling Perspex screens.
2. The capacity of the DRW is about 60 prisoners but it is rarely full to capacity with DRW participants. It seems that this is closely linked with the re-rolling of the prison (and limited capacity elsewhere in the prison) and so it has recently been decided that the DRW will roughly halve in capacity. This is intended to ensure that the DRW maximises participation by prisoners who are eligible for the DRW.
3. The DRW is a voluntary Wing. There are a number of routes by which a prisoner can end up on the DRW, with recognition from staff that related application and selection processes need to be streamlined. Some of these revisions are needed as a result of Brixton's re-rolling.
4. Staff aim to maximise the segregation of the DRW from the rest of the prison. However, this is hard given that not all DRW residents are engaged with the DRW programme, and the unit itself is nested within a larger, general population Wing. The meds hatch is on one of the lower landings of A Wing, which is one of several times when DRW prisoners mix with those from other units.
5. The staff team is mixed. It includes a small number of prison officers (including two dedicated DRW officers), a team of psychosocial substance misuse workers from an external provider (about six staff), and clinical input from the substance use team (delivered by an NHS Trust). There is also a Family Support Worker at HMP Brixton (employed by the same external provider as the psychosocial team) and their work covers the DRW. The DRW Discipline Officers were recruited to work on the Wing following an expression of interest.
6. The programme delivered by the psychosocial team is broad-ranging with groups running every weekday morning and afternoon. An example group timetable is presented in Figure 1. The afternoon groups run parallel with association time, and all groups are held in a classroom within the DRW. The psychosocial team also offer one-to-one support to DRW clients, and deliver programmes for the wider prison. Nursing staff are available seven days per week so this allows coverage at weekends when staff from the substance use team are not working. There are also 12 Step fellowship meetings.
7. Prisoners who are eligible for the DRW programme, and who wish to fully join it, sign a compact and are paid for their attendance and completion of courses. Prisoners can also engage with education or employment. If a prisoner is engaged with, for example,

the DRW and employment then they receive whichever of the two payments is the greater. There do not appear to be any time limits to engagement with the DRW.

Figure 1: HMP Brixton DRW. Sample Psychosocial Timetable

Weekly Programme w/c – 08/07/2013

Monday	Tuesday	Wednesday	Thursday	Friday
Stepping Stones	Stepping Stones	Stepping Stones	Stepping Stones	Stepping Stones
Morning				
Yoga	Living Safely	Introduction To Recovery	Self Care	Back on Track
Afternoon				
Check In	Acupuncture	Community Meeting	Recovery Meeting	Check Out
Evening				
CA				

8. There are communal spaces on the lower of the two DRW landings containing fixed tables and chairs, a pool table, and a table tennis table. On the top landing there is a small fitness suite, with several items (e.g. a treadmill, exercise bike, rowing machine, elliptical trainer) which have been donated by an external company. There were a few leaflets and posters on the walls but overall the DRW was quite bare and seemed very much like a 'normal' prison wing.
9. The prisoners were generally critical of the living conditions and prison regime on the DRW, largely because they felt it was not in line with the prison's re-rolling to a Category C establishment. The DRW prisoners have their own time in the exercise yard and their association time is in the afternoon. This is deliberate, as the rest of A Wing have their association time in the morning. DRW prisoners are also eligible for four family visits each month: one more than those not engaged with the DRW programme. The DRW has its own showers but lacks some other facilities (for example, it does not have its own laundry facilities).
10. In terms of a typical day on the DRW, prisoners attend courses every morning, or can engage with education or employment. Then prisoners are banged up between about 11am and 2pm, with lunch served at 11.30am. In the afternoon prisoners can attend courses again which run parallel to association time, then dinner is at 4.30pm before prisoners are banged up for the day. There is additional association time two evenings a week.
11. There is no drug-free Wing at HMP Brixton.

12. The most recent HMIP report on HMP Brixton (HMIP, 2010) was published at a time when drug treatment within the prison was delivered by a different provider. The report highlighted both positive features and challenges which this service faced. The report also highlighted that the most commonly identified safety issue at the prison was the availability of drugs, something which was frequently mentioned during the interviews for this DRW evaluation. A lack of sufficient support for those with alcohol problems was also identified. The role of the externally-provided Family Worker was recognised in terms of the contribution it made to resettlement. This role was praised by both staff and prisoners and was highlighted as good practice in the HMIP report,

Summary of interview findings

The interview findings are discussed under six broad themes. These are: the DRW environment, the DRW programme, supporting services, relationships on the DRW, how the DRW benefits prisoners, and general thoughts on the DRW.

The DRW environment

* The prisoners were generally positive about the DRW and its environment, and thought that it was better or safer than other areas of the prison. However, prisoners and staff interviewees had three main criticisms of the DRW, and these will be discussed throughout this report; namely, the location of the DRW within a large general population Wing, the disparity between the conditions and regime on the Wing compared with what is expected from a Category C prison, and the difficulties of housing prisoners on the DRW who are not engaged with the recovery programme.
* The prisoners had come to the DRW through a variety of routes. This included some who did not know how they had ended up on the DRW, or who thought they had been housed there because it was the only area of the prison which had space, as well as some who had requested or been invited to be housed on the DRW. While there was consensus among the prisoners that the DRW was a better environment than the rest of the prison, there were also strong views that the work of the DRW was hampered by the number of prisoners who should not be on the DRW. One prisoner suggested that only about one-third to one-half of the DRW capacity is currently taken up with prisoners who are on the Wing for drug recovery. One staff interviewee described this problem as the 'Achilles heel' of the DRW, while another said that the presence of these other prisoners can "demotivate" those who do want to be on the DRW.

    > "I think [DRWs] are a good idea but you need to have people up here who want the help and are not coming just because it's a little bit easier up here and you get the extra association and you need to keep it away from the drugs that are available on that part of the Wing but on the whole, yeah, it is a good idea" [staff]

* Some of the prisoners were critical that the prison or the DRW were not like the Category C establishment that they were expecting. One prisoner said that he had been told that moving to HMP Brixton was a progressive move for him, but disagreed that this was the case, while another prisoner found coming to HMP Brixton a shock because of "the state of the place". One prisoner said that prisoners on the DRW were banged up for the four day Easter weekend, which he said should not happen at a Category C prison. At least one prisoner thought that, given it was supposed to be a Category C prison, Officers should treat prisoners more leniently.

General prisoner views on the DRW

"...there's so many people on this Wing that are not on any sort of drug recovery it's a joke, it's not a drug recovery Wing, it's just a normal Wing".

"they're not committed to recovery"

"I thought it would be a more safer environment, totally drug free, abstinent place so I would rather be around that than anywhere else and be tempted…..it's a nurturing environment, an organic environment, I think it's a lot better than any other part of the prison"

"[it's] a haven away from the rest of the prison"

"you feel a lot more safe on this Wing"

"I just find the regime and Brixton, I was told I was being moved here from my previous prison on a progressive move, well if this is progressive it knocks the wind out of me because....this is absolutely appalling, it's run as a B Cat prison, it's run as an A Cat prison, it's just you know, if I could go tomorrow I would go"

* There was general agreement from prisoners and staff that the DRW should be an isolated and self-contained unit that is largely segregated from the rest of the prison, but that this was hard to achieve at HMP Brixton for two main reasons. First, the DRW is situated as a 'Wing within a Wing', with its location meaning that DRW and A Wing prisoners can communicate with each other through the Perspex screen which separates the two; and that DRW prisoners have to move through A Wing to access (for example) food, the meds hatch, the laundry, and all other areas of the prison. Second, as noted above, the presence of a number of non-DRW prisoners on the Wing also means that the DRW cannot operate as a contained and sterile environment. Overall, the historical infrastructure of HMP Brixton as a Victorian jail in a built-up location poses challenges in setting up something like a DRW.

  "I think in hindsight a different location would have been better cos it's a Wing within a Wing" [staff]

  "unless it can be a completely separate unit which has control over its own numbers it will never be as it ought to be, that's a structural issue" [staff]

* The prisoners had strong opinions on the general conditions of the DRW, which were described by some as abysmal, illegal, inhumane and grim. Overall, prisoners did not feel that the DRW was as it should be for a Category C prison. In particular, prisoners felt that they should have their own cells and that toilets should be screened off. The prisoners commented on the level of hygiene on the Wing, particularly in relation to the showers and the toilets in the cells and the lack of laundry facilities.

  "....you're living in the toilet basically, you eat in the toilet, you sleep in the toilet" [prisoner]

  "[the showers are] not healthy [or] hygienic" [prisoner]

* Several prisoners were very critical of the food, saying that it was horrible and that the portions were small, like 'war rations'. However, one prisoner said that the food was fine

(although he said that the portions are small) while another said that attempts are made to cater for diversity in terms of dietary needs (e.g. providing Halal or Kosher meals). One prisoner said that he cooked extra food in his cell (using his kettle to boil water) while others said that they topped up their food by buying more from the canteen. However, one prisoner who did this said that the canteen food was mainly junk food while another said that spending money on food meant that there was less available for other things like telephone credit. Some prisoners also thought that meal times (lunch at 11.30am and tea at 4.30pm) are far too early.

"I wouldn't even call [the food] edible" [prisoner]

"....[the portions are] an absolute joke, I wouldn't give my...[teenage] sister the portions they give here" [prisoner]

* The prisoners also commented on other aspects of the DRW. Prisoners are able to use the exercise yard but this does not happen every day as it is dependent on staff availability and the weather. Some of the prisoners appreciated the fitness suite that is available on the DRW. There were also comments on the amount of time that prisoners spend in their cells; this will be discussed further below.
* There was general agreement that HMP Brixton has a serious problem with the amount of drugs that are available across the prison; this is a problem which appears to have worsened with the re-rolling of the prison. There were mixed views as to whether the DRW fared any better than the rest of the prison in this regard. Some prisoners and officers said that cannabis (and in one case, heroin) can be smelled on the DRW, and two prisoners said that they had used cannabis and hooch while on the DRW. It was acknowledged that drugs (and hooch) are available on the DRW but that the problem is probably less serious than it is in the rest of the prison. One staff interviewee thought that the problem was probably the same as the rest of the prison but that it was focused more towards cannabis and alcohol, rather than Class A drugs. Overall, the prisoners did feel that the DRW did offer a less intense environment in terms of the amount of drugs available, and in the behaviour of prisoners dealing and moving drugs around. Some interviewees made suggestions about how the situation could be further improved on the DRW; including the DRW having its own meds hatch, having more drug testing, and reducing the number of prisoners on the DRW who are not engaged with the DRW programme (because they are the ones most likely to bring drugs and/or deal substances).

"all you've got to do is walk on that Wing and you'll smell it" [prisoner]

"out there you can smell it, you can see it" [prisoner]

"[the rest of A Wing is a] lion's den" [prisoner]

"we're asking for the help, you've got to owe it really to the people that are helping you to stay drugs free do you know what I mean" [prisoner]

The DRW programme

* Staff described the DRW programme as flexible and holistic, with one interviewee having the view that this model worked better than one which was more rigidly structured. Several staff interviewees also highlighted the importance of service user involvement within the DRW's inclusive and responsive operational model. Prisoners' views were considered in a number of ways, including at the weekly community meetings which are

described later in this report. Ultimately, staff emphasised that the DRW ethos is about trying to maximise the ownership by prisoners of their own recovery.

> "we are listening to what people want on the Wing" [staff]

> "….we have a bit of an open door policy....that's the ethos we're trying to have....you have to have people engaged in the process so they are signed up and there are expectations of what they need to do but we're quite flexible in that I think....we are quite intuitive to the guys' needs, trying to give them more of a sense of responsibility over their own recovery, to reinstill that they have the power over their own recovery and that their needs are met by us" [staff]

- The prisoners were generally positive about the DRW programme, the groups that are available and the way groups are run. One prisoner, who said he has never really had an alcohol or drug problem, still found the DRW programme useful. Another prisoner, who also did not think he had much of a problem with drugs or alcohol, was surprised and said that he has taken something from every group that he has been to: "this has done me the world of good".
- Some prisoners valued the range of groups available, including things like yoga, poetry and creative writing. However, at least one prisoner felt that these were irrelevant to recovery.
- One prisoner said that the groups did not run so well when they were attended by prisoners who were housed on the DRW but who were not part of the DRW programme. Given the problem of the Wing housing non-DRW prisoners, one prisoner commented that it is important to share a cell with another prisoner who is a compacted DRW client.
- Some of the prisoners gave their views on gaps in the DRW programme and how they thought it could continue to develop. One prisoner said that outside of the groups there appears to be little structure to the DRW programme and that prisoners are not doing enough work on their own recovery (for example, there are no assignments or course work), making comparisons with a programme that he completed at another prison. Another prisoner thought that some of the information given in the groups was out-of-date, again making comparisons to groups he attended at another prison. A prisoner thought that the group programme could be better structured to help prisoners plan what courses they want to do, with staff perhaps giving some advanced notice of the group sessions timetable. This prisoner also acknowledged that there have been some recent changes in this regard. At least one prisoner and one staff interviewee hoped that by starting to pay prisoners to go to (and complete) groups that attendance and engagement would improve further. Another prisoner listed some of the suggestions that he had made about additions to the DRW programme – for example, arts & crafts, a book club, and amateur dramatics.
- One prisoner said that Officers seem to be quick to lock up prisoners again after group sessions and that some flexibility after groups may be of benefit to prisoners in providing an opportunity to talk to others about the group.

> "....we've just come out of a group, it was a very intense, open group and it's like the officers couldn't shut people away fast enough, [we] didn't even get time to breathe....and interact with whoever was in the group and say 'what did you think of that group', as soon as they came out of the door the officers were on you and in your cell…." [prisoner]

- Several of the prisoners also received one-to-one support from the psychosocial team, with all saying that they found this very helpful. At least one prisoner said that he found this more helpful than the groups, and all thought that more one-to-one support should be available. One prisoner said that he only found out that regular one-to-one sessions were available because he asked, adding that he does not think that many prisoners are aware that such support is available and that more could be done to raise awareness about this.
- A key characteristic of the DRW programme is service user involvement and this is achieved in a number of ways. One of the most important is the weekly community meetings which are held on the DRW and which bring together prisoners and staff (including Discipline Officer and other Prison staff, and representatives from the Psychosocial and substance misuse teams), so that prisoner views on the DRW can be heard and issues discussed. Several prisoners and staff interviewees thought that these meetings were very helpful and an important aspect of the ethos of the DRW model. Some staff interviewees talked of plans to develop service user involvement on the DRW further. For example by introducing SMART Recovery, regular client (prisoner) reviews, and the greater involvement of ex-prisoners to support the work on the DRW.
- Several staff interviewees commented on the limitations to the ongoing development of the DRW programme, and expressed concerns about how the programme will integrate within the prison's broader resettlement agenda following its re-rolling. One staff interviewee wondered if, because of the increased focus on education and employment under the new regime, DRW prisoners will be penalised if they attend DRW groups rather than education or employment. This interviewee talked about the importance of recognising the DRW programme as a 'purposeful activity' akin to other education courses or employment, meaning that prisoners will not penalised for non attendance. Another staff interviewee confirmed that prisoners will not be penalised for not attending education sessions for so long as they are engaged with the DRW programme.

  > "I am a firm believer, if you don't treat the cause or the root of the problem all we're going to have is some well educated addicts, as great as education and vocational courses are you can't do that to people....it seems there is some understanding of what we're trying to do and where we're trying to go....if it's classed as purposeful activity the prison is more accommodating to us" [staff]

- Some staff interviewees said that it is hard to develop the DRW programme without access to more classrooms, while some said that it is hard to integrate the programme with other aspects of the prison regime because, for example, groups clash with education, association time or gym time.
- One prisoner explained that he had tried to find help for his cannabis problem in the community but had not been able to find any help from services which he felt were mainly oriented towards those with problems with Class A drugs. This prisoner said he had found the DRW programme helpful and that staff had supported him to find services which he could engage with on release.
- One prisoner expressed strong views that the physical and nutritional aspects of recovery are very neglected, talking about diet, the food and access to exercise. For example, while prisoners can purchase food from the canteen this tends to be junk food and "there should be healthier options available".

"....I think also in terms of recovery for me personally I think the physical and nutritional side of it is neglected, as they say 'you are what you eat', it's really really important….[for] a lot of these guys diet is non-existent to them on the outside, they're fuelled on drugs and alcohol and so on and I think that side of it is neglected" [prisoner]

Supporting services

- Some of the prisoners were also attending education classes (mainly Maths) and said that they found this helpful. One prisoner explained that he hopes such courses will help him to engage with his sons by, for example, helping them with their school work. However, some prisoners thought that the education programme seemed to be largely restricted to English and Maths and that it could be much broader, with some prisoners also commenting on the lack of access to the library and the poor range of materials available in the library. One prisoner wondered if education courses could be accredited by an external professional organisation

  "we don't want our brains to be turned to mush watching TV all day" [prisoner]

- Interviewees commented on the importance of support for prisoners to prepare for release, and to support them on release. Staff interviewees recognised that release and resettlement had become more important with the re-rolling of the prison, and highlighted the strength of the DRW programme in forging links with services in the local communities. It was nonetheless acknowledged that further work is needed in this area.

  "you've got to have something to go out to, some kind of job or some kind of training to go out to and help with your addiction, there's no point in just kicking you out and expecting you to do it all on your own" [prisoner]

  "….I think the thing that probably makes this a little bit different is we're starting to bring the walls down of the prison, I know prison walls keep people in but they also keep people out and what we try to do with our DRW is drop them walls down, not physically....but get the community in and introduce them....they're going to be coming back to their communities, they're not our people, they're on sort of loan to us really and it's communities that they're going to go back to so the better we can plug people in to that whatever that looks like is better and I think the guys benefit from that" [staff]

- Several of the prisoners were unsure of their accommodation arrangements on release, with some saying that because such support is only offered a number of weeks before prisoners' expected release dates, it is often unavailable if a prisoner is released early on tag. One of the psychosocial team interviewees explained that a new initiative will hopefully increase the support which is available to prisoners around release and resettlement. A new protocol with the five local DIP teams will strengthen co-working between the psychosocial prison team and the DIPs, whereby a DIP worker will engage with a prisoner from three months before their release date. Additionally, the psychosocial team in the prison will follow up with the DIP to see if a prisoner kept their first appointment on release. One worker added that they will help a prisoner to put together a seven day plan to give structure to their first week on release.

- None of the prisoners mentioned whether they had talked to the Family Support Worker, and how this may have helped them. However, some prisoners said that their time on the DRW had helped them to think about the impact of their behaviour on their family. One prisoner said that he is about to start a course which includes content on fathering

and being a better father. Another example was given above by a prison who was attending Maths courses so he could help his children with their school work.

* The Family Support Worker thinks that there is real benefit in working with both the prisoner and their family (together and separately), and that this work can bring added value to the DRW because "families tend to get forgotten". If family support is in place and goes well then it can increase the likelihood of a prisoner having a home to return to on release rather than being released with no fixed abode or to other unstable accommodation. Family support may also assist prisoners' reintegration with their families when they do return to the family home. The presence of the Family Support Worker at HMP Brixton appears to bring added value to the DRW, its prisoners and their families. The role could be developed to increase the family support which is available to prisoners, to family members in their own right, and to family units. Some of the staff interviewees acknowledged the value of the Family Support Worker.

  "[it's] massive....I've learned the value of family involvement, whatever that means, if that's the immediate family or the secondary family or whatever that looks like....if you can put somebody in to a healthier support network the outcomes improve massively and I know that's not always possible and I know that in certain situations that's completely broken down and we have to try and find different ways of looking for that but it's right up there for me to try and have as much family involvement as possible" [staff]

* The addition of a Clinical Psychologist to the substance use team also seems to be beneficial to the prison and the DRW and there is scope for this to develop further as the post has been extended. To date the role has been largely strategic, looking to improve work with prisoners with drug and alcohol problems across the whole prison. In the future it is hoped that the role may widen and have a greater impact on the DRW, for example, through the Psychologist providing supervision to staff, running groups, and delivering staff training and other clinical work. The Psychologist also expressed a hope that the continuation of the role will improve joint working between substance use and mental health saying, "they're not necessarily distinct, there is such an overlap....helping the staff to be more confident in recognising it and how to manage it".

Relationships on the DRW

* The prisoners generally viewed staff, including DRW Officers, positively. However, some prisoners said that some Officers were better than others. Overall, prisoners found the Officers helpful and thought that relationships between prisoners and staff were generally good – although some prisoners commented that some Officers are lazy and dismissive, with one stating that that some Officers are quick to lock prisoners up but then stay on the DRW and play table tennis. As noted above, a few prisoners thought that Officers should act more leniently because it is a Category C establishment, with one saying, "they could ease up a little bit I suppose." Another prisoner thought that the DRW should have a more disciplined regime like, "....a boot camp regime".
* The DRW has two dedicated Officers and it seems beneficial to have this consistency with staff (although it is not always possible). There was general agreement that staff levels need to be appropriate and consistent, with at least one prisoner saying that there needs to be more specialist Officers on the DRW. One staff interviewee said that

Discipline Officers should receive specialist training for working on the DRW, and that things are in motion to action this.

> "when we don't have dedicated staff, when we have general Wing staff that doesn't work as well at all, it's really problematic I find....I think they're not committed to the ethos and the mentality of the Wing really....traditionally some Officers, I'm not going to label them all with the same brush, some Officers are negative about what we try to do and unfortunately negativity breeds a lot more than positivity" [staff]
>
> "I fully believe that continuity in all areas of staffing never mind just discipline is important and it's frustrating when it doesn't happen" [staff]

* Several interviewees highlighted the importance of relationships between prisoners and staff on the DRW. As noted above the consistency with the Discipline Officers who work on the DRW is an important part of this. Some interviewees also highlighted the importance of building a therapeutic alliance between all staff and DRW prisoners, with one viewing this as critical to what the DRW is trying to do.

The importance of relationships on the DRW

"...as far as the DRW is concerned I think it is quite different from the rest of the prison….I've been on A Wing and I know what goes on....as far as the DRW it's kind of contained, it's a lot more personal to a certain degree, the officers are familiar with the inmates and again it is a nurturing environment, we're offered help whenever we want it more or less" [prisoner]

"....the real therapy happens in actually being in a community....getting a sense of community on a DRW is important" [staff]

"....I don't see many fights or aggravation up here....because of the philosophy of looking after people and treating people with respect....I think it spreads out and I think it has a domino effect on the rest of the prisoners....it is a calmer environment than the rest of the prison" [staff]

"...there tends to be a fellowship type of dynamic on the Wing.... we look out for each other....we look after each other....which is quite encouraging to see, I've seen that here more than I've seen it in other parts of the jail definitely....the dedicated officers....we do look after them....what I'm trying to say is….that I think we're doing a good job" [staff]

"…..that therapeutic side of building relationships with people and then everything else....can then weave in, it makes that easier, that's my vision, that's my view" [staff]

"there's that feeling of friendship….you definitely get a feeling of a family atmosphere up here which I thought was going to really hard at Brixton prison to do that" [staff]

"I think the sense of community, although it's a 60 bed unit and not everybody up there is signed up to the DRW, there is a sense of community that grows up there and it's a bit like a, the best way I can explain it, it's a bit like a kibbutz really, people come up there for lots of different reasons but they're together, they have a common thing that holds them together....and that for me is one of the main ingredients, there is a collective community, a therapeutic community....which in all the research I've looked at improves outcomes of success" [staff]

* There was also agreement that prisoners generally get on very well, although a couple of prisoners said that it was not much different to other prison settings. The DRW has both a peer supporter and a Listener. One prisoner described the DRW as being like a family. One prisoner thought that prisoners could be given more time out of their cells to have more opportunities to connect with and support each other, and that there could be structured activities for prisoners.

  "it's a pretty safe environment….[but] I like to compare it to a tinder box so to speak, it can go off at any time"[prisoner]

  "when we had the right lads in there who wanted to change, who wanted to be on that Wing it was brilliant" [prisoner]

  "people are more willing to talk to you than what they would be downstairs" [prisoner]

* The weekly community meetings were viewed as an important part of building a DRW community, although at least one prisoner said that these meetings worked less well when attended by prisoners who are housed on the DRW but who are not engaged with the programme.

Benefits of the DRW for prisoners

* Although not discussed at great length, there appeared to a range of ways in which the DRW benefits prisoners. This includes supporting prisoners to be more positive and honest, to open up and talk about themselves and their feelings, to recognise the impact of the behaviour on their family and others, and to facilitate connections with local services.

  "I welcome being evaluated, I think it's good, I welcome any kind of reflection and feedback from that....I've been around it long enough to know that it does make a difference from someone being on a normal location to someone having a drug recovery Wing can sometimes be the difference between someone succeeding and someone failing" [staff]

Impact of the DRW on prisoners

"the Wing is doing well for the drug recovery because I haven't relapsed really since I've come, I had a minor relapse since I first came, I first first came and that was it and since then I haven't relapsed at all and I credit that to this Wing....I don't feel I needed it like I needed it before, I still want it....I still have those urges but they're not as intense because when I've got problems I've some way to vent it on this Wing….100% it will definitely help [in the future]" [prisoner]

"I haven't even thought about drugs, it hasn't crossed [my] mind which I thought was quite strange cos for like 20 years I've been a drug user....I don't hide behind the drugs no more....I am actually happy" [prisoner]

"initially I would have said it hasn't ruined my family life but it has" [prisoner]

"it's fantastic, his journey has just been incredible" [staff]

"you definitely see them start to take more responsibility for themselves" [staff[

"...get them to take responsibility of their surroundings, get them to take ownership of their own community because it is where they live….if they're not coming with you then it's not going to work" [staff]

- One staff interviewee said that it is a shame that Officers rarely get to find out how something like the DRW impacts upon prisoners because this is not truly known until after release. However, one interviewee said that there have been prisoners who have approached him in the street to say how they are doing and to thank him (and others) for what was done for them while in prison. Another staff interviewee cited the example of an ex-prisoner in demonstrating the success of the DRW. This interviewee said that he does not think that this prisoner would have 'made it' if he had remained on a general Wing rather than having the opportunity to engage with the DRW.
- There was acknowledgement from some staff interviewees (it was not discussed with all interviewees) that work is needed to develop ways of measuring the outcomes and impact of the DRW. One interviewee said that they are starting to develop a spreadsheet to capture data about DRW prisoners and enable the production of quantitative outcome reports. The work of the Clinical Psychologist is making a contribution in this area also; for example, by introducing a prison-wide 'satisfaction survey'. Another interviewee said that they do collect quite a wealth of data specifically with regards to DRW prisoners – this includes assessment, care plan, four week DRW review, further four- to six-weekly reviews, a Drug and Alcohol Outcomes Star (Triangle Consulting Social Enterprise Ltd, 2013), data on group attendance, and National Drug Treatment Monitoring System data (although the interviewee was critical of this saying, "it's a complete and utter nightmare"). Data are also collected as part of the collaboration with DIP teams.

General thoughts on the DRW

- Overall, both prisoners and staff viewed the DRW positively, believing that it brought added value to HMP Brixton and to those who engage with the programme. One staff interviewee thought that the DRW model was better suited to a Category C rather than a Category B prison.

  > "we're actually being allowed to do this....that's our opportunity" [staff]
  >
  > "I think it's a really innovative way of trying to address...substance misuse issues. I think it is important that people have a[n] area, again going back to my kibbutz analogy, you know that there is somewhere where they can be together for a common goal...I believe that increases peoples' ability to not only address and stop using or move towards stop using drugs in prison but also if you can continue to build on that and create that in the wider community....then the outcomes of them resettling and reducing reoffending will improve" [staff]

- Many interviewees recognised that the DRW is a work in progress, particularly in light of the re-rolling of HMP Brixton. One staff interviewee commented that they have almost had to start the DRW again because of the changes which have been required, and which are still needed, as a result of the re-categorisation of the prison. The staff interviewees acknowledged that there were several key issues which need to be addressed; most notably the location and size of the DRW and, as a knock-on from this, the recruitment process and the implementation of measures designed to minimise the number of prisoners on the DRW who are not engaged with the programme. One interviewee said that they were jealous of the DRW at HMP Manchester because it is a self-contained unit.

"....we haven't seen changes quick enough so as long as this Wing does fulfil its promises of the things it will change and the things it will do....as long as it picks up on stuff that we've voiced that will change then I'm sure this Wing will be a great place for anyone that comes on with a drug problem or an alcohol problem….it's still a great place with all the problems they've got....but it could be better" [prisoner]

"what transcends for me, what transcends all those difficulties is, is the belief that change is possible and change does happen" [staff]

Positive views about the DRW

"it has grown and developed a significant amount...there's a lot going on up there that does make it very different from the rest of the prison population, the range of activities that are on offer is much greater, the amount of activities and the fact that they have dedicated staff, and in terms of creating a therapeutic environment that's really key that there are set staff that work there [who] clients can build a really good relationship with"[staff]

"it's the community, it's the type of things that are on offer, the range of things that are on offer, the ease of accessibility and I think also more intensive in terms of reviews and keeping clients in mind as a team....it really is a good resource [and] of real value to Brixton prison" [staff]

"prisoners feel more valued here....and it must boost their confidence that....the Prison Service....this is genuine what they're offering and what they're doing" [staff]

"everyone seems comfortable to be there….they're easy to work with, I never feel threatened in any way....I like the feel of the Wing" [staff]

"....I'm happy with the direction of travel, I think there's more to be done but overall I'm happy that it's moving in a positive direction....I very much support it and endorse it" [staff]

"I think it has its benefits, definitely it has its benefits....initially I was totally against it because I didn't want my Wing disrupted but it's definitely proved me wrong and you can see positive things coming out of it" [staff]

"what we've created is something along the lines of a unit....which has provided prisoners who want to do something a bit different to go and do it....the DRW as far as I'm concerned will have a place here….I'm well aware of its limitations, I think it's got a lot of potential, I think we're halfway there, I'd like us to keep the DRW as a tool in our armoury" [staff]

"we are moving in the right direction through some very difficult times" "quite rosy....there's a lot of foundation work been put in....I just see it going from strength to strength really" [staff]

* Some interviewees commented that the DRW was viewed negatively by non-DRW prisoners and staff, although some also expressed the view that this had improved over time. One interviewee said that staff at HMP Brixton, some of whom were described as 'old school', were unsupportive generally of wider changes at the prison.

"this Wing is viewed as extra work [by some Officers]" [staff]

"....it's slowly getting better, I wouldn't say everybody's in love with the DRW, and that's taken a long while but it is slowly starting to come on board....it's probably still there but it's not as loud as it was and I think we have started to turn a few people on to our side" [staff]

- Many of the staff interviewees talked about their hopes and fears for the future of the DRW. One interviewee said that calling it a pilot meant that some people thought it would just 'fizzle out' and so offered less support to the DRW. The staff interviewees also expressed mixed views about how extensively the DRW model was supported at a strategic level.
- One interviewee said that they wanted senior staff to offer specific support to the DRW, for example, by stating that only prisoners who fulfil the DRW criteria should go to the DRW, and that there should be consistency with the Discipline Officers who are on the DRW. Some interviewees also felt that senior health partners had initially been reluctant to support the DRW but that this had changed over time; for example, the Primary Care Trust (PCT) has given some funding to the DRW which has, for example, funded the extra association time which DRW prisoners receive. Some staff interviewees said that one challenge in garnering strategic support for the DRW had been the lack of funding for the Wing and the requirement to run it at nil cost. Two interviewees said that because there was no funding for the external services who supported the DRW (such as Fellowship Groups or DIPs) it was difficult to challenge the reliability of these services when they were not able to attend or run meetings, for example.
- The staff interviewees did not discuss in detail the potential impact on the DRW of wider Prison Service agendas and changes. As had been seen throughout this report there are far greater challenges for the DRW at HMP Brixton, largely as a result of the re-rolling of the prison. One staff interviewee said that the national agendas would not have significantly negative impact on the DRW while another thought that the specific needs of the DRW had been recognised.

  "we are being heard that special dispensation needs to be made for drug recovery wings and I think that it being heard" [staff]

Conclusion

Interviewees identified several strengths to the DRW at HMP Brixton. These include: the multi-disciplinary team, including input from the Family Support Worker and the Clinical Psychologist; the range and depth of the DRW psychosocial programme, focusing on the release and resettlement of prisoners and of forging strong community links to support this; the weekly community meetings that are held on the DRW, and the involvement of a range of staff in these; and the efforts to develop a model which actively considers service user (i.e. prisoner) involvement.

There were few criticisms of the DRW itself; rather obstacles to the DRW were associated with wider issues such as the location of the DRW and the impact of the re-categorisation of HMP Brixton from a Category B to a Category C-D establishment. Issues associated with Brixton's re-rolling were also raised, including the size of the DRW, the conditions and regime on the Wing, and the presence of prisoners who are not engaged with the DRW programme. Overall, the DRW is viewed positively, although more work is needed to develop ways of monitoring the impact of the DRW on prisoner outcomes, and to bring

added value to HMP Brixton particularly as it continues to develop as a resettlement and training establishment. It is important that the DRW is fully integrated within this new regime.

Appendix 5: Chelmsford

Rapid Assessment

This is what we're all about… A reduction programme (Staff)

Starting note: interview identifiers

Throughout this report, staff (of all kinds) are identified either as (staff), or with an S. Prisoners are identified as (prisoner), or with a (P). Thus (P) after a quotation indicates that it is drawn from a prisoner's interview. (S) indicates that it is drawn from an interview with a member of staff.

Basic prison information

Chelmsford is a Category B local men's prison. With the closure of Bullwood Hall in March 2013, Chelmsford became the only active prison in Essex. Interviewees described the prison's accommodation in terms of 'wings' and 'spurs' (rather than 'houseblocks'), with prisoners being housed in one of two types of accommodation. The 'old' part of the prison was built in 1830 as a local jail, and was referred to by our interviewees as 'the centre.' An open, three-storeyed atrium acted as a hub with wings A, B, C and D[1] radiating from its semi-circular front in a Panopticon-style arrangement. Each wing held 3 balconies, referred to as the 'ones,' 'twos,' and 'threes,' with upper balconies on B, C and D wings being prioritised for prisoners on Enhanced IEP regimes. Prisoners could access other balconies via staircases, but the central spaces of the wings were closed off by solid floors and ceilings. Some medication could be dispensed from a medication hatch within the centre to the (apparently few) prisoners receiving methadone or subutex without being housed on Chelmsford's DRW. For the most part, these were apparently 'those people who can't mix with these [on the DRW] because they want to kill them' (Staff). At full capacity, and without any cells acting as office space, wings B, C and D could house approximately 132 prisoners each, mostly in double cells.

The new part of the prison was built in 1996, comprising three wings. Each wing had two spurs emanating from opposite sides of a central office space, with each spur holding two landings. During fieldwork, G wing housed 'enhanced,' foreign national and older prisoners: low risk groups who were unlocked during the day with open access to an exercise yard. F Wing housed the prison's first night centre and induction wing. All prisoners, including those who were drug or alcohol dependent in the community, spent their first night in F Wing, where they would be greeted by a Samaritans-trained Listener and an experienced prisoner known as an 'insider.'

E Wing housed the Drug Recovery Wing, It was predominantly described by interviewees as 'the IDTS Wing' or E Wing, with scant few unprompted references to the 'DRW'. E Wing's two spurs had originally been designated 'red spur' and 'blue spur,' representing initial and move-on stages of treatment. This distinction had been dropped as few practical differences in treatment or client characteristics existed between the two spurs.

[1] Wing A acted as the prison's segregation unit. Wings B and C held a mixture of adult and young adult offenders. Wing B was in a process of being 'mothballed': during the rapid assessment, fewer than ten prisoners were still housed there. Wing D acted as the prison's vulnerable prisoners wing.

Prisoners' recovery journeys began in Chelmsford's first night and induction centre. After spending a few days on F Wing, all prisoners identified by the prison's clinical team as having an ongoing need for medication related to drug or alcohol dependency were moved to the DRW. From here, they could choose whether or not they wished to remain. Those choosing to access the DRW were required to sign a compact, agreeing to engage with psychosocial and clinical practitioners and to reduce their medication after 26 weeks. Those choosing not to access the DRW were, in theory, housed elsewhere but placed on a rapid medication reduction programme with some prescribing of BritLofex[2] for symptom management[3]. Uptake of this latter option was seemingly non-existent. The DRW thus became the prison's default residence for drug- and alcohol-dependent prisoners with ongoing medication needs.

During the rapid assessment, 88 of E Wing's 126 beds were occupied though, reflecting Chelmsford's high churn, 121 beds had been filled one month before. Of the 38 'spare' beds, Chelmsford's clinical lead identified that relatively few were filled with 'lodgers'[4]

Four main professional groups were working with DRW clients. One third-sector agency was contracted to run the prison's 12-bed healthcare unit, and also delivered initial healthcare screens and first-night assessments. The NHS IDTS team employed six full-time equivalent nurses, one 'recovery champion,' and three healthcare assistants, delivering all ongoing clinical support for drug dependence. A second third-sector agency delivered psychosocial support through a team of four frontline and two senior drug workers. Finally, the wing had a 'core group of 12' (Staff) prison officers. The psychosocial team funded two of these posts[5] using Essex DAT money, and were seeking to recruit a further two.

Interviewees identified two defining features of Chelmsford's DRW. **Firstly**, high levels of population churn meant prisoners spent an average of 12 weeks in Chelmsford. Focusing on abstinence was considered unrealistic in this timeframe. **Secondly**, two processes had recently cut Chelmsford's budget. The prison had been downgraded from a 'complex' to a 'standard' prison with the mothballing of its B wing, thereby losing capacity, funding and several management grades. Chelmsford was also one of the first English prisons to undergo a 'benchmarking' process. This had led to cuts in staffing levels and prison funding. Whilst the DRW was in the process of developing a new low-cost 'roll-on, roll-off' series of interventions, during fieldwork no group programme was in place.

In this context, during fieldwork 'recovery' was operationalized as one-to-one support and medication reduction for clients receiving subutex, methadone or alcohol detoxification.

A typical day on E wing

> At the moment? Well now it's waking up half past 7, getting ready, waiting for the door to open. Door will open, wake up cigarette, cup of coffee. Out into the meds queue. Get my

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[2] A brand name for Lofexidine. 'Lofexidine is used for the alleviation of symptoms in patients undergoing opioid withdrawal. Like clonidine it appears to act centrally to produce a reduction in sympathetic tone but reduction in blood pressure is less marked' (BMA and Royal Pharmaceutical Society of Great Britain 1999:236)
[3] Very few prisoners opted for this latter route. Indeed, we were uncertain as to how realistic this option was.
[4] A term widely invoked across our four prisons, referring to 'non-DRW' prisoners housed in a DRW cell.
[5] Recovery officers were effectively carrying out the work of a prison officer *and* a drug worker: "I'm a prison officer… [but] I have been working for [the psychosocial contractor]… So I do exactly the same as the civilian people. The assessments and all the release plans and things like that… But I also do prison work." Additional Recovery Officer duties included supervising the medication queue and carrying out drug testing.

medication. When they open the door they'll tell you if you've got to go anywhere in the wing, in the prison… I done [my prison induction] today so it'll be… out on mass move to wherever I've got to go. If I'm not out on mass move then I'll just be in the cell, cleaning the cell, watching TV, drinking coffee, smoking cigarettes. Writing letters. Obviously lunchtime I will be out getting my lunch. Same thing, mingling, just talking to people. Getting my applications. Putting my letters in and whatnot. And then bang up in the afternoons. I've already done my gym induction. So for the last 2 days I've been going out and playing football in the afternoons. So after that… on mass move… bang up for a bit, out on dinner, association, and then bang up at about quarter to 7 and then that's it for the night. TV, come 10, 11 o'clock I'll go to sleep. And then, you know, the next day starts. (Prisoner)

The only thing that is obviously different [from other wings] is the medication (Staff)

As the opening quotes for this section suggest, a 'typical day' on E Wing was not very different from a typical day on any other wing in Chelmsford (see **Appendix A** for E Wing's full, daily regime). Prisoners engaged in work and education alongside prisoners housed in the rest of the prison, and the sole *timetabled* difference in regime centred on approximately 75 minutes each day allocated to dispensing DRW residents' medication. Managers expressed intentions to establish a new set of timetabled group programmes, matched to the prison's resourcing and role. Until these programmes were fully rolled out, there was no group provision *to* be timetabled.

Pragmatic justifications for a prison-wide regime were supported by principled ones. Interviewees talked of parallel regimes 'normalising' prisoners' experience in two senses. **Firstly**, as a route to recovering 'normal' life through social reintegration:

> We encourage [DRW prisoners] to try and do what we all do – get up in the morning, go to work, do an activity… It's all about getting that mindset that you've got to get up and go do something to earn some money…. (Staff)

Secondly, as a normalisation of exposure to real-world, community risks. Creating a protective silo for drug users could, interviewees felt, prove harmful following release:

> If you make it specialist, you put them in a false environment… I feel it would be wrong to wrap them and say "ok, you've got separate education, separate gym… you don't mix with the other prisoners." I could lock them up and throw away the key and say you're now on recovery and you're not going to have [access to] any drugs… That's not real. (Staff)

Psychosocial and clinical interviewees noted that an increased risk of overdose might also attend substantially discrete regimes, or overly-'protective' abstinence-focused environments.

The mainstay of DRW provision was one-to-ones. Psychosocial staff offered all DRW residents up to six structured interventions, guided by a recovery plan. Alcohol workers were more restricted, funded only to work with North Essex residents[6]. E Wing also provided a

[6] Two staff interviewees raised broader concerns about the paucity of provision for alcohol dependent clients. One noted a total absence of psychosocial support from anyone who was not an Essex resident. A second commented 'To be fair, they get a bum deal. They really do get a poor, poor service.'

daily 'drop-in,' staffed by psychosocial and clinical workers. DRW residents could access drop-ins irrespective of the number of structured interventions they had received.

Finally, E Wing offered weekly Alcoholics Anonymous meetings. Staff noted that this was run during prisoners' association time, thereby curtailing attendance. On the week we were there, a quick and informal head count suggested that about 5 prisoners were attending.

Prisoners' reaction to Chelmsford's retrenchment of provision seemed to fall into two broad categories. One self-motivated, independently-minded remand prisoner had chosen to reduce his methadone with the intention of being abstinent by the time he appeared in court. He felt that treatment on the wing was comprehensive, and well-suited to his needs:

> I think everything's on offer. Whatever you need, there's support. There's all the drug support. There's the [psychosocial] team. Everything I've asked for has been supplied.

Two further prisoners presented pictures of equally satisfactory provision.

A subset of interviewees seemed to be struggling rather more. One 'frequent flier' felt particularly troubled by the prison's lack of structured drug treatment and support:

> P: There's no drug courses now… Everything's stopping. They're sending us to prison but there's no help in prison because there's no money… I would say within the next year. We're just going to be behind a door constantly.
> I: So this is now called a drug recovery wing…
> P: There is no drug recovery… The only drug recovery… is prescribing methadone and subutex… There is not one drug course that they run in this jail

For two prisoners with histories of abuse, the prospect of a reduced regime was particularly worrying, as 'bang-up' triggered persistent and intrusive memories.

Rules and Requirements: the DRW Compact

On entering the DRW, each prisoner was required to sign a compact (see **Appendix B**). In essence, this specified that prisoners on the DRW agreed to engage with the DRW's psychosocial and clinical teams, and to comply with drug testing.

Interviewees saw the compact as fulfilling both principled and practical purposes. In principle, it tied prisoners to a 'recovery agenda.' Two managers and three frontline staff surmised that the compact had effectively instilled a reduction culture within the DRW[7]. In practice the compact also enacted a second, pragmatic, disciplinary function:

> Some of [the compact] is very *prison* because it's covering that person for when he may be nicked. Adjudicated. The guy says "I didn't know, no-one's told me" and somebody says "have a look at that! It was read through to you. You did sign it…" I wouldn't say the compact pushes recovery. It's for a different need (Staff)

A quick analysis of the compact certainly suggested a strong disciplinary function. Ten (of twelve) points of the methadone compact and fifteen (of seventeen) points on the subutex

[7] See pp.13-14 for further details on reduction and recovery

compact specified precise elements of required behavioural compliance. For example, 'to drink 200mls of water, following your Methadone consumption and hand the cup back to the pharmacy tech,' or 'sit down with your hands under your bottom.' One point related to general behaviour ('respect and dignity'), one to information sharing, and a final point[8] specified consequences for non-compliance.

Effectively communicating the contents of the compact to new wing residents was recognised as a challenge. A staff interviewee noted

> When they first come in they're quite all over the place… They're a bit *needy*. And they're quite, not all there, until their meds get settled and it evens it out (Staff)

Three prisoners concurred.

> It's only presented when you first come into prison. And there's a lot of people that are withdrawing. So they will sign anything. They can't really see properly or whatever. They should wait until they're stable (Prisoner)

> It was shown to me when I entered the prison. And you sign it. … You're just given it. They went "there you are, that's that, that's that" and I signed, it was about half past 10 when I got here so it was like there's another 6 blokes the fellow's got to see so it was like oh, here you go, crash. As quick as possible. I've not even read it properly. But it's standard. "Yeah, sign that, no problem." (Prisoner)

> You get someone coming in, they're all over, they'll sign anything. "Yeah just get me through." So they don't really read what they sign and later on they go "ohhh we got your signature here." And you're like "oh bloody hell, did I sign that?"

A fourth prisoner raised concerns about the complexity of language used in the compact[9]. In this context, three staff described a tight process, designed to ensure that prisoners fully understood what they had signed:

> It's gone over again after 5 days by IDTS. Word by word, line by line, paragraph by paragraph. And then [the psychosocial team] go over it again with them (Staff)

Nonetheless, none of our prisoner interviewees seemed to have a full grasp of DRW's compact and its requirements. Two thought that the compact was exclusively about voluntary drug testing,[10]. Two others offered more detailed (and at least partially accurate) accounts:

> It just says don't use, don't sell your medication, don't use other people's medication.

> There's the compact like, erm, violence, gangs, passing drugs, so forth…

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[8] One point specified a required behaviour *and* established disciplinary consequences; hence the mismatch between the number of points stated, and the number of points described.
[9] "They use long words, titration and all of this. I say well what does titration mean? Help me out here."
[10] Drug testing comprised point two (out of 12 or 17 points) on the subutex & methadone compacts.

A large proportion of our interview sample were on detained on remand, and most were relatively new arrivals. However, if our interviewees' comments represented the experiences of other prisoners on E Wing, then the familiarisation process might benefit from being revisited.

Rules and requirements: violence, indiscipline, and self-harm

One of the policy objectives underpinning DRWs was the establishment of safer wings. With one notable exception[11], prisoners and prison officers described violence and bullying on the DRW in moderated, positive, terms. Lower levels of violence between prisoners seemed to be indicated by the wing's 'more relaxed' atmosphere, the presence of 'less complaints,' and the use of 'less control and restraint' techniques by prison officers (staff interviews).

Five professional interviewees acknowledged that bullying existed to some extent, with four highlighting strong anti-bullying measures. Perpetrators were placed on Chelmsford's 'basic' IEP regime, lost any trusted positions, and were subjected to intensive surveillance and monitoring. Despite professionals' confidence in anti-bullying processes, two prisoners raised concerns that such measures could be invoked as a response to (threats of) *self*-harm[12]. Staff confirmed that threats of self-harm, particularly when made in an attempt to gain access to medication, were seen primarily as a problem of *order*[13].

Violence and bullying aside, discussions about discipline tended to focus on breaches of compact: predominantly illicit drug use, and responses to positive drug tests[14]. Frontline workers offered varying estimates of the frequency of disciplinary action. One had seen disciplinary measures invoked twice in four months. A second considered this a substantial overestimate:

> S: I've [seen] 4 reviews, 3 prisoners each time, over 2 years… I've known a couple of prisoners been put on report. And I've known a handful moved off the wing.
> I: And the rest?
> S: They're still on the wing

Follow-up studies may benefit from further exploring the frequency of such actions.

Observations on the Physical and Social Environment

> This is the best you're gonna get. I mean I've been on one prison in 2003-4, it was like Butlins. It was amazing. But this, it's really good. You've got clean cells. You've got access to people 24 hours with the buzzer. So you're not alone. You've got TV. I mean people say prisoners have it lucky. This is the kind of wing where it is (Prisoner)

We saw relatively little of E Wing's accommodation or fittings, as we spent the majority of our time in the central office space. From our limited observation, the spurs seemed relaxed,

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[11] Single, notable exceptions seemed to be quite a common feature in
[12] One prisoner identified that he had been placed on anti-bullying measures for telling a member of the clinical team that he would harm himself if his community prescription for subutex was replaced by methadone
[13] S: We have people who will cut up to say "you haven't given me my meds" or "if you don't give me *more* meds I will do these things." [I: So people self harm to put pressure on [staff]?] S: They can do, yeah.
[14] See pp.24-5 for more details of responses to positive tests…

sociable, and well lit with a substantial open association space on the lower floor. Though one prisoner felt E Wing's cells could do with repainting, as a whole the wing was tidy and well-presented with little rubbish in the prison grounds. Prisoners seemed free to flow into the office space (and between wings) whilst unlocked, particularly on the lower floor. We were approached by several inquisitive prisoners. They clearly felt free and able to do so.

Though we directly observed few interactions between prisoners and professionals, interviews allow us to venture some tentative thoughts about the DRW's relational environs.

Firstly, of the four DRWs we assessed, Chelmsford's seemed to be most clearly framed by security concerns. Therapeutic staff noted that prison rules were always ascendant:

> Even though I work for [the psychosocial contractor], I work for the prison service first. We're run by their rules, then [the contractor's], so I'll always check that I can always do it within the prison because we are under obviously stricter guidelines (Staff)

> Ultimately, your boss is the prison (Staff)

In three other DRWs, therapeutic staff could (and often would) keep prisoners' disclosures of drug use confidential. Contrastingly, Chelmsford staff were clear that a wide variety of information constituted a 'security risk,' so should be passed to prison authorities:

> I: Self-harm you'd pass on?
> S: Yep, or if they're breaking prison rules. I'm not their friend… I do know people on the team that have… worked with someone smoking cannabis. [Who] told them. And then really got disgruntled. And the worker's like "well, you told me that you're using.

Few prisoners commented on this directly, so this may not have felt like a pressing issue for them. However, this stood out as a feature of Chelmsford's DRW when juxtaposed with practice in our other three rapid assessment sites.

Secondly, the psychosocial contractor employed two 'recovery officers' (or 'blue shirts'), funded by the DAT. These staff were felt to hold particularly positive attitudes towards the DRW and its residents:

> I: Do you think that the prison officers are sympathetic? By and large?
> S**:** Towards… the service users? On the whole no. [But] the [psychosocial team] prison officers… see [prisoners'] issues as differently to the white shirts. Definitely… The officers that wear the white shirts, they've got no understanding of drugs and alcohol. It takes a little while for service users to trust a new [psychosocial team] officer. Because they used to see him in a white shirt … but that trust does come…

As a manager surmised, for 'white shirts' working on the DRW was 'not greatly popular… We're not inundated with people desperate to work on here.' Therapeutic staff felt that 'white shirts' were particularly likely to hold negative views about drug users, and to be unsupportive of therapeutic work.

Thirdly, each staff group seemed particularly aware of the significance of language. DRW residents were variously described as prisoners, clients, patients, or service users.

> They're service users in here. Or prisoners. But to me they're still clients (Staff)

> It all depends who I'm talking to and how I'm talking to them. I'm an officer… They know they're prisoners. To *you* they're my clients. But they are prisoners. … I could be talking to a group of volunteers … And if I say "prisoner this, prisoner that" they get the hump straight away… So I just change tacks slightly so that I'm on the same level. But I would say to them, "at the end of the day they're a prisoner" (Staff)

> To us they're patients (Staff)

> I usually say client. Or patient. They're still someone that you're helping. Treating. And it's hard to say prisoner… Obviously to the officers they're always going to be a prisoner or an inmate. So you've gotta switch between the two, haven't you? (Staff)

White-shirted prison officers tended to refer to 'prisoners' or 'inmates'. Clinical practitioners tended to use 'patient' or 'client,' whilst psychosocial staff referred to 'clients' or 'service users.' Several interviewees noted that they tailored their language to their audience.

Profile of E Wing Residents

As Gresham Sykes noted, one of the main 'pains 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)

In gathering all medicated clients together, the DRW shaped how such 'pains' manifested:

> I have to have a single cell. A lot of people on this wing, they're needy. They're needy, needy people. They can't just get on with it… There's a lot of, how can I put it, *attention* seekers… A lot of them are, erm, idiots. They're selling their medication. They're swapping it for tobacco … A lot of them have got mental problems. They don't know what drugs they're taking… It's a very very needy place. (Prisoner)

'Neediness' was a word used by each prison officer we interviewed, and five prisoners held their wing-mates in low regard, distancing themselves from them during association periods and on mass move.

E wing's prisoners were mostly local offenders, on remand or serving short-term sentences for drug-related acquisitive offences:

> I would say 90% of our client group are from Essex (Staff)

> Most clients actually come in and are released from this particular prison. It's the nature of the offending. It's theft. It's, it's normally theft. Drug related… I would say something like 60 to 70% will be released within 1-3 months (Staff)

More detailed information was available about our nine prisoner interviewees, though without broader comparative information[15] it is impossible to assess whether or not they were representative of the wing's broader population. Our interviewees had a relatively high average age, with a mean of 40 and a median of 41 years old. None were in prison for the first time. One had served three, long-term sentences in different jails, and five were 'frequent fliers': well acquainted with Chelmsford's regime, and (in some cases) the DRW and its staff. Seven were on remand, and neither of our two sentenced interviewees had more than four months left to serve.

Six interviewees were charged with explicitly acquisitive offences and all but two clearly stated that their offending was primarily drug-related, often to fund drug use. All described long histories of drug dependency and multiple imprisonments. Eight were expecting to be transferred to other prisons, or awaiting imminent appearances in court[16]. One prisoner was approaching release, but anticipated swift reimprisonment.

Prisoners on E Wing: Ingress and Egress

Staff felt that prisoners routinely manipulated the system to gain access to the DRW. This might be because 'they know their little comforts and… come back to where they're comfortable,' or because they were 'plugged up' with drugs and saw the DRW as an excellent target market[17]. Prisoners might also try to avoid being identified as drug- or alcohol-dependent. A clinical interviewee surmised:

> They don't want to be on this wing if they've got issues with other guys that're on here… If you get travellers coming in they're very keen to get detoxed because obviously it's a… stigma in their culture and their community. (Staff)

The stigma of being a drug user housed on the drug users' wing was certainly identified by our prisoners as one major downside of accessing the DRW[18].

In order to minimise manipulation, healthcare nurses delivered initial screening assessment. The two prisoners who spoke of this process felt it was effective, and well-run:

> She can sense if you're playing a game or if you're actually serious. On the wing you get a lot of people who think this is a ticket away from the normal population. And… she was really good at actually sussing you out (Prisoner)

> They do a good job here. They get on to people quickly, and suss out where they're at.

Though small-scale, this prisoner feedback seemed promising.

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[15] At the time of writing, we are awaiting data from the DRW which may provide some broader context.
[16] If found guilty, which all those on remand considered either likely or inevitable.
[17] See pp.17-18 for more details of Chelmsford's identification of, and responses to, this problem.
[18] Two had previously avoided the DRW, choosing to undergo a self-managed detox. However, it might be expected that any large-scale avoidance of the DRW would come to the prison's attention. As interviewees from other prisons surmised, a lack of fits, seizures and soiled bedding throughout the prison might be taken as a good indication that relatively few people were in severe withdrawals.

Induction assessments were also used to identify prisoners' initial medication and detoxification needs. This process evoked mixed reactions. Three prisoners described well-managed responses to drug or alcohol withdrawal. Others were frustrated:

> I come in ready to be on 2 mil of Subutex. I still had Subutex in my system. Told the doctor the situation, 2 mil of subutex. He went "you're going on 40 mil of methadone. [You'll] probably be ill for a couple of days…" I couldn't believe what I was hearing. I literally couldn't (Prisoner)

> [I'm having] troubles sleeping… because I'm withdrawing from methadone. And I'm not. I'm not on enough methadone (Prisoner)

Of greater concern, two prisoners identified that they had been unable to secure initial prescriptions for health conditions unrelated to drug dependence.

> I'm epileptic and it's took me 6 weeks to get my medication. And it's not a medication that would give you any pleasant feeling (Prisoner)

> I'm still awaiting my antidepressants (Prisoner)

These issues may merit more detailed exploration in further studies.

Psychosocial practitioners were required to deliver initial assessments within three to five days of prisoners entering the DRW. First assessments consisted of the 'outcomes star' (Triangle Consulting Social Enterprise Ltd, 2012; see **Appendix C**) and three ITEP maps exploring prisoners' drug use and offending. Assessed needs were then matched to future interventions, in a document known as a 'recovery plan'.

Staff identified that prisoners most often followed one of two exit pathways from the DRW. Approximately 70% returned directly to the community, with most others transferred to another prison to continue serving their sentence.

A small number of prisoners were also transferred to one of Chelmsford's other wings for one of three reasons. **Firstly**, for breaching the DRW compact, particularly if they were felt to be a threat to the wing[19]. **Secondly,** for failing to engage with psychosocial or clinical staff[20]. **Thirdly,** prisoners who attained abstinence from prescribed medication became eligible for transfer. Some requested transfer; others were moved because the DRW was in need of beds. Clinical staff stated that prisoners undergoing alcohol detoxification were particularly likely to be moved, as full detoxification took approximately eight days.

Prisoners' Drug, Alcohol and Treatment Histories

With one exception, our interviewees narrated long and difficult life stories. Two had been introduced to hard drugs by family members, and associated the development of their dependencies with long-term physical and sexual abuse. Two had grown up in 'care':

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[19] "If they're caught diverting their medication then they'll be on a rapid regime, reduction on another wing"
[20] "People that aren't wanting to engage… get moved to another wing within this establishment"

> I was in a children's home with 8 kids, 4 of them [are now] dead and the other 3 are in the prison system. All of us ended up on drugs. There was a lot of abuse going on

A fifth stated that multiple family bereavements triggered the development of his drug problems.

Our interviewees' age of first use was also markedly low. Two prisoners began using drugs and alcohol at the age of eleven or twelve. Five began using drugs or alcohol between thirteen and fifteen, and all began using heroin at or before the age of 19. Only our 26-year old had been heroin dependent for fewer than ten years, with four describing dependencies of 20 to 30 years, and one being heroin dependent since 1980. This long-term user's treatment history seemed truly remarkable, as he had never previously accessed any form of drug treatment. Five of our prisoners named heroin of their drug of choice[21], with two primary crack users[22], and two all-out polydrug users.

Seven prisoner interviewees described long-term engagement with community treatment providers, consisting of substitute medication and some psychosocial support. Two had *completed* residential treatment programmes in the past, with both giving glowing reports of their experiences. Residential rehabilitation provided one prisoner with his first in-depth support for serious childhood trauma. A second account of residential rehabilitation was equally positive:

> I didn't offend for 10 years. That's what I'm trying to get back to now

Most of our interviewees described periods of abstinence of between two months and ten years, though the drivers for these could be diametrically opposed[23]. A third of our prisoner interviewees volunteered that they had accessed AA and / or NA in the community.

Detoxification

> If you've got a drug problem and you're committing crime for it, when you come in here I think personally it should be [about] getting… off it as quick as you can (Prisoner)

> I won't be able to [achieve abstinence from subutex] on this wing. But I hope there's a prison within this system that I can go to, to sort of get on a rehab programme (Prisoner)

Professionals noted that 'one or two per cent' of prisoners sought full, supported detoxification on entering prison. We interviewed only two abstinent prisoners, but as the quotations leading this section imply, interviewees often *aspired* to abstinence. A recently abstinent prisoner offered a particularly blunt perspective:

> Being on maintenance, to me, is not doing anything. Being released with a maintenance script, I've still got a drug problem. And back to the same old (Prisoner)

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[21] Three of these identified crack as their second drug of choice. Two identified themselves as heroin-only.
[22] Both of these identified heroin as their second drug of choice, or dependency
[23] One particularly clear example lay in the effect of prison in supporting or deterring abstinence. One prisoner felt utterly unable to attain abstinence in prison, but had achieved abstinence in the community with the support of his partner. Two others felt prison supported their abstinence, though they found it very difficult to do the same in the community.

The relationship prisoners posited between prison and abstinence was complex and nuanced. Two could only obtain abstinence in the community; others found this impossible, describing prison as an active choice, and a part of their move towards abstinence:

> This was my fast track, my own personal choice, I knew that I wanted to get off it and change, this was my way of doing it. I can detox myself completely while I'm here. And then… they accept me for funding for rehab or I get an naltrexone implant (P)

> I knew I was coming to prison. I was like, "I'll get on E Wing, I'll get my nut down, I'll get my medication, I'll get well, use the gym, go out clean" (P)

Two further prisoners added that they found it difficult to sustain the gains they made in prison following release, particularly after short-term sentences.

Prisoners also talked about detoxification from non-opiate drugs. One was glowing with praise for the comprehensive support he had received when detoxifying from mephedrone and crack cocaine. A second had been detoxified from Zopiclone. Following some years of community prescribing, Chelmsford's clinical team only offered short-term diazepam as a replacement. Despite feeling some initial rage, this worked out well:

> I've got myself into a routine…. And I don't have no problems with sleeping. It seems [if] I wasn't getting the tablets I could've dealt with it a long time ago (Prisoner)

Thus, prison prescribing seemed to have presented a considerable boon to this individual's progress.

The relatively small numbers attaining abstinence seemed to be related to the core focus of Chelmsford's DRW. In a local prison working with a population defined by a high degree of churn, abstinence could put released prisoners at increased risk of overdose. Contrastingly, reduction regimes were felt to leave prisoners well-prepared for transfer to other prisons or to the community, where more intensive resourcing and longer-term engagement made abstinence a more realistic goal. Professionals thus clarified that *reduction* rather than *abstinence* was 'what we're about'. Several described talking clients out of very swift abstinence-focused reductions:

> The nurse and I both said it simultaneously, "we don't think [abstinence] is a good idea. Because the guy is getting out Monday. It would be unsafe (Staff)

> Why don't we look at being safe. And going out on something. Going in the community and swapping over to subutex. Or let's get you physically checked out, go on Naltrexone. You can't actually say you've got to go out clean. That's unrealistic.

For nearly all, the move towards prison prescribing had been extremely positive, with mandated abstinence framed as unrealistic, purposeless and harmful:

> We really used to muck people up when they were on methadone outside, came in for four weeks, two months. We'd detox them and then chuck them back out (Staff)

Perhaps surprisingly, prisoners were more keen on enforced reductions than staff.

Reduction

> I: Have you signed something to say there'll be a reduction?
> P: Not as yet. I think what'll happen is they'll want to maintain me for so long, and then obviously it will be my choice when I want to start reducing. I believe that they will leave me alone to let me deal with that.

This section begins with a substantial qualifier. Our sample consisted of nine interviewees, seven of whom were on remand. Four had been in Chelmsford for less than two months. Their experiences may not be representative of prisoners' experiences throughout the DRW.

Eight prisoners had been prescribed subutex or methadone on entering Chelmsford. We had no information about whether or not one prisoner was reducing. Of the remaining seven, five were being maintained. Three of these wanted to increase their dose, and no interviewees apparently felt any pressure to reduce:

> Is there any pressure? I wouldn't say pressure. People don't want to [reduce] because they've got it so easy. They're getting their medication they're getting other people's medication… The majority of them, all they're interested in is getting out their nut.

> I: Are you feeling any pressure to reduce your medication?
> P: No… Whilst I'm on remand they can't pressurise you to reduce.

> It's optional. I wouldn't say it's that encouraged either… you've got a choice… You can stay on whatever makes you comfortable or choose to reduce.

Within our small sample, there was little sense of reduction being encouraged.

This differed markedly from professionals' accounts. Here, it is hard to escape from the power of one manager's statement: 'reduction … is what we're about'. Recovery and reduction seemed to be so closely associated in many practitioners' minds that they used the words interchangeably, switching between them in contiguous sentences:

> They can discuss their reduction, and there is a recovery, reduction worker. And usually people are quite happy to do their recovery. They're quite focused on reducing (Staff)

In some respects, recovery-as-reduction presented the prison with a particular subset of challenges. Prisoners on remand could not be compelled to reduce. Even once sentenced, *required* reduction only came after six months, and it was exceedingly rare for prisoners to stay on the DRW for that long. Consequently, the main push for reduction came through encouragement, support and advice. In this context, it was perhaps unsurprising that staff responded to *self-motivated* prisoners with particular warmth and enthusiasm:

> It's lovely, it is rewarding when you see someone want to reduce, and they do it, they do it well. And. I get a feeling of satisfaction from it. It's nice to see someone want to do it for themselves. Not be told to do it. I think that's the biggest part for me. (Staff)

Such prisoners seemed to be a comparative rarity, and staff sought to highlight the real difficulties of changing the behaviour of *very* long-term drug using offenders. Responses

centred on chiselling away at intransigence, with the intention of acquainting prisoners with the idea of reduction through incremental decreases in dose:

> Even reducing by only 1 mil per month, you're heading in the right direction (Staff)

Senior staff felt that this had encouraged a substantial proportion of prisoners to reduce:

> At our height, 67% of our population on IDTS were on a reduction. And for a local prison that's quite impressive. We were held nationally as best practice for that (Staff)

Moreover, *individuals'* positive experiences were felt to be inextricable from the wing's *group* effect. Professionals described what might be seen as a DRW 'reduction ripple effect':

> [Reducers] are talking about reduction… [And] it's not "oh we'll wait til we get to 26 weeks." They're more inclined to volunteer to reduce. They'll say, "Bob says it's not that bad to reduce. I want to be clean before I go out." (Staff)

Insofar as staff identified ongoing resistance, it came from a small number of long-term 'frequent fliers… clients who've been in the system for years and years ' (Staff)

Considering E Wing's success at moving people into reduction, staff expressed concerns that such regimes might not be continued elsewhere:

> We move them to another jail and… all of a sudden they're maybe thinking, "I don't need to reduce…" I might say "I need to be maintained. Oh, I need to be increased" (Staff).

Governors were responding strategically, establishing good information sharing partnerships with local establishments to ensure the continuation of reduction regimes. In line with this, some very small-scale follow-up work had recently been carried out:

> We've tracked about 9 or 10 [prisoners following transfer[… 3, 4, 5 are still on reduction. Two are being maintained. And a couple have completed their reduction. … The good thing there is that none of them are increasing their dosage. (Staff)

Whilst recognising the limitations of these findings, staff felt they were encouraging.

Professionals: Programmes, Provision and Perspectives on E Wing

Living on Chelmsford's E Wing gave prisoners access to medication. This, clearly, represented a particularly potent incentive for opiate-dependent individuals. Other incentives covered a broad array of recovery-oriented options:

> We use the [PE instructors] to offer healthy lifestyle, sessions on healthy living and eating, and benefits of staying off drugs. As well as extra gym sessions. And some will get hot chocolate and biscuits when they're starting to withdraw. They have [instant] access to the clinical team and the GP… There's auricular acupuncture, yoga… (Staff).

Incentives such as hot chocolate and biscuits might seem relatively small. However, interviewees across rapid assessment sites noted that small rewards could have a major impact on prisoners who started with virtually nothing.

E Wing residents also benefited from additional access to staff. A Recovery Worker had been introduced as the DRW developed. He delivered daily drop-in sessions, and was identified by colleagues as a valuable reduction / recovery resource:

> Since he started… you can definitely see a lot more people wanting to reduce *and* reducing. I think they feel they've got someone they can go to now. (Staff)

Prisoners also had ready access to the prison's psychosocial and clinical teams, whose offices were between E Wing's two spurs. Both staff and prisoners felt this supported the development of stronger staff / prisoner relationships:

> The prisoners that go straight to [other wings], we won't have such a good relationship with them… because we're always here. The throughcare team live on the wing. We're easily accessible here. We wouldn't be on other wings (Staff)

> When [DRW residents] are unlocked they can just come and knock on our door… You have to make sure that you remember to go down to the other end of the prison and talk to the others (Staff)

E Wing thus offered potential residents some material and relational benefits.

Prisoners: Perspectives on E Wing Motivators and Incentives

Notwithstanding one or two specific concerns, all prisoners framed the DRW in a *generally* positive light. The support on offer and the feel of the wing were routinely identified as a real motivator for change:

> It's what they're offering and the environment you're in… The environment, because your ability to go and do things is restricted because you're in prison. That, combined with having the opportunity to take medication and reduce further, makes dealing with the drug problem easier for me… I find it easier to do it in prison (Prisoner)

> I've been in situations outside where I've been under extreme pressure. And drugs have seemed like the only way to alleviate that pressure. In prison I'm not accessible to drug dealers. I'm not accessible to go and get money. (Prisoner)

Three prisoners highlighted wing staff as available, helpful, responsive, and supportive:

> You can ring your bell and you can go "right you know what, I'm really feeling [withdrawals]. I'm not good. And whether it's… or a member of staff or prisoner, someone will come and chat to you. It's like they do actually care. (Prisoner)

> There's 24/7 staff available. Every morning we get up and there's one of them sitting there, they're there to ask questions. There's notices up all around the wing, if you've got any problems come and talk to us (Prisoner)

> They're always floating about… for a quick 2, 3, minute chat or whatever (Prisoner)

Prisoners also voiced appreciation of the DRW's additional gym:

> Going to the gym has turned my thinking around. Your body's a temple (Prisoner).

> You can look at [prison] as a poor man's health club, really (Prisoner)

Finally, one prisoner valorised what he described as the feeling of *safety* he got as soon as he arrived. These specific accounts did not stand alone; some interviewees made more general comments, such as 'for me, it's been a positive experience.'

Access to the psychosocial team boosted prisoners' chances of securing referrals to specialist support, such as one-to-one counselling and the chapel's bereavement programme:

> It wasn't until I went to Living with Loss, [that] what I was feeling…. Actually made sense. Instead of dealing with it, coming to terms with it, I was drinking (Prisoner)

Two interviewees noted that the wing had specific relational benefits for them. One was imprisoned alongside a close relative; a second had access to a supportive network of peers.

> Everyone that I know from Chelmsford, all of my friends are on here… If I can't go talk to the officers about something I can talk to people that I know. If I was on another wing. I might know no-one. Start to feel isolated, more depressed. (Prisoner)

External Motivators

Several interviewees were motivated to change for reasons outside the DRW's control. Health problems featured prominently, with one third describing life-threatening conditions:

> I had a bit of a scare last year… I won't be here next year if it'd carry on... When you're in a situation like I've found myself in you realise how important [support] is, and how it can change your life (Prisoner)

> I've had 2 heart attacks already. And I really want to stop (Prisoner)

> I'm getting myself off drugs because healthways I'm not a well man. I've had 2 stents fitted in my heart. And I've had a couple of heart attacks. I really need to be taking responsibility for my own health. (Prisoner)

Six interviewees named partners or children as supportive drivers for change, too.

> I've got a strong partner. She's backed me 100% and her sister's a mentor and she's been clean for 7 years. I'm going to be going with her to [meetings] (Prisoner)

> I feel I'll succeed this time. I've got a 10 month old… in a few days time she's one year old… If I don't change then history's going to repeat. She's going to go to school and people are going to be going "your dad's a junkie." I've got to change. (Prisoner)

> I've got a beautiful partner out there I'm married to. I've got a degree to finish. A daughter to bring up. I've got a house. I've got a job waiting for me. I've got a great life there. I've gotta choose. Do I want selfish addiction or do I want life? (Prisoner)

We rarely specifically asked prisoners about family or children. That so many prisoners volunteered this information consequently suggests the strength of family both as a driver for change, and as a source of resettlement support.

Drug availability and violence

All interviewees were asked about drug availability. Most presented a similar picture: drugs were available throughout the prison, though sustaining a habit would be difficult:

> Unless you are a multi millionaire. You couldn't get a habit in here. You couldn't use heroin or crack and smoke cannabis every day. You get about a third of the amount of drugs for about 5 times the price of what you would pay for on the road (Prisoner)

Drugs could be brought in by visitors, staff, or returning prisoners:

> Officers bring drugs in. Drugs get thrown over the wall. Drugs come in on visits (Prisoner)

> We know that some people get rearrested for license recall because they know they can only do a certain amount of time. And they come loaded with drugs or phones (Staff)

> I would say 40% [of releases] are recidivists. I would say about 10% of those, 5% of come in packed up to sell. (Staff)

During reception and induction screening, any prisoners suspected of coming in with illicit goods would consequently be moved to the segregation unit and kept under tight observation 'until we recover those items' (Staff).

In addition to illicit supplies, very substantial quantities of Subutex and methadone were dispensed each day. Diverting medication held particular appeal to a cohort who, even within prison, were defined by poverty and isolation:

> They've spent most of their money on drugs… they've lost touch with most of the family. People aren't likely to send money in (Prisoner)

Skilfully secreted medication offered a source of income and intoxication:

> I could get you some guys up here. You could watch them like a hawk, like a magician. That tablet would disappear. That person would be able to give it to you completely intact without any saliva come off it… They're very clever. You'll not see it (Staff)

Subutex had thus attained a prominent position within Chelmsford's DRW, in a variety of semi-ingested and cellophane-wrapped forms.

Drug availability and violence were widely seen as partially overlapping phenomena, with medication contextually related to both violence *and* pacification:

> I've seen a little bit of violence. On my first day I had a little tussle… That was about jumping into the [medication] queue. We shook hands afterwards. (Prisoner)

> I haven't seen no trouble. Most people are on their medication so they're… more likely to collapse [laughter] (Prisoner)

Nearly all prisoners were keen to emphasise that bullying on the wing was minimal:

> P: People on this wing are quite vulnerable when they come in
> I: Do other people on the wing take advantage of that?
> P: No! No no there's no bullying you don't get bullying
> I: Really?!
> P: No, no.

> No-one's being bullied. If people notice bullying they're prepared to step in, sort it out.

However, two discrepant accounts merit further attention. One prisoner suggested that people might be bullied to satisfy others' drug debts:

> Say him over there was weak and had his canteen. This man here wanted some drugs but didn't have the money to pay for it, he'd go and beat him up and take his canteen to go and buy the drugs. A lot of that goes on in here. A lot of it goes on. (Prisoner)

A member of clinical staff also felt that some prisoners were being bullied for their medication. As victimisation almost inevitably took place out of sight, it was very hard to quantify or police.

Perspectives on the efficacy of control measures varied. Two third sector employees stated that E Wing's officers were sometimes unresponsive to apparent drug use on the wing:

> I smelt cannabis on the wing this morning. The officer just said "oh well I don't know where it's coming from." I said "definitely that door." But they ignored me (Staff)

Two prisoners felt that incentives for providing information were poorly handled, potentially exposing them to victimisation and abuse:

> A lot of officers say "I'll offer you twenty quid's canteen if you tell me who it is." And if you do things like that you end up getting into fights and getting bullied (Prisoner).

Prisoners, psychosocial staff, and clinical staff thus felt that security procedures on the wing could be tightened.

Additional Services E Wing Residents would Like to See

DRW residents voiced a desire for four main types of additional service. **Firstly**, two wanted more mutual aid groups:

> I've approached them several times about it and said "can we get an NA meeting going." I've had a couple of officers just… laugh it off. (Prisoner)

Secondly, three wanted elements of aftercare to be improved:

> I think it'd be a great idea to give… some heroin addicts naltrexone. Before they leave this prison, they're clean, there's your naltrexone. (Prisoner)

> The link with the outside. Working with… my team outside, CDAS and my worker. So I could work on issues that I've been working with [in prison] for so long. And not have to start over with someone that you don't know (Prisoner)

Thirdly, one prisoner wanted enhanced access to education:

> Education is the way forward. Education is knowledge. And knowledge is power.

Fourthly, one interviewee wanted enhanced drug treatment on E Wing:

> Definitely a few more different courses… on recovery. There's too much of… "you'll look like a prune, you'll lose your liver, blah blah blah, you'll look old"… We need stuff which is going to really shock people and get to the nitty gritty. (Prisoner)

Prisoners' Attitudes to Staff

Prisoners accounts of almost all staff were positive. E Wing's officers were described in muted, positive terms:

> They're pretty good people (Prisoner)

> The staff have always treated me alright since I've been here. I've got no complaints

Two prisoners also offered ringing endorsements of their *personal* officers:

> I've known him for years… If I've got any problems I can talk to him and he helps me out. If I'm feeling low or if, things that have happened in my childhood, I'm getting really down, I can talk to him. Which I couldn't talk to other officers about. (Prisoner)

> You link to one person… I've got someone who I talk to. He's been through it himself. Not addiction, but he's been through something where he had to get his life back together again. And he's been really, he's been there for me this last week. You know really, really strong (Prisoner)

Added levels of personal officer involvement, and their willingness to relate to the people in their charge, seemed to add greatly to how prisoners related to and perceived them.

Attitudes to E Wing from the Wider Prison

Chelmsford housed nearly all medicated prisoners on E Wing. This apparently gave rise to considerable stigma:

> "Dirty scumbags. Smackheads…" If you're out say you're at work and someone says "ah, what wing you off? Ah you're off E wing. Ah you're a smackhead a dirty scumbag. Fucking rob your nan" and all that. You do get. You do get that (Prisoner)

> People say "oh, junkies, fucking all that, that's the no teeth wing,". There's always that bit of banter from, from staff and whatnot… (Prisoner)

Three of our interviewees consequently sought to distance themselves from any suggestion that they 'belonged' to the DRW:

> I'm not blowing my own trumpet, when you're on the way to work, I get a lot of people saying "why don't you get off that wing? You ain't like them lot" (Prisoner)

Perhaps relatedly, this interviewee was one of the strongest critics of his cohabitees, describing them variously as 'idiots' and 'needy… attention seekers.'

The attitudes of staff in the broader prison were described in one of three ways. **Firstly,** they might have little idea of the DRW's existence:

> I would imagine if you were to ask some of the officers what DRW means they wouldn't have a clue (Staff)

Secondly, they might see the wing in extremely positive terms (it should, perhaps, be noted that only one interviewee offered this perspective):

> S: It's called the happy wing!
> I: Is it called the happy wing or the *happy wing?*
> S: It's called the Happy Wing!
> I: With no sarcasm?
> S: I don't think so!

Thirdly, E Wing might be seen in negative terms. Clinical, psychosocial and prison staff all surmised that officers on other wings often saw drug users in negative terms:

> They usually call them crackheads and things like that… A lot of officers will look at it that way (Staff)

E Wing was consequently thought to be an unpopular place to work.

Our interview schedule focused predominantly on prisoners' experiences of the attitudes of prisoners on other wings, and professionals' experiences of their own wing. The attitudes of officers on other wings may merit further exploration in future studies.

E Wing's Residents: 'In Recovery?'

Prisoner interviewees framed recovery in three ways: as personal change; as reducing or stopping drug use; or as broader social reintegration (e.g. securing a job or housing, rebuilding family relationships, etc). Only one defined 'recovery' with explicit reference to offending[24]. Five interviewees felt that they were 'in recovery,' though their understandings of this word and its relation to them varied considerably. One offered a precise, considered, technical description:

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[24] [I'm] kind of in recovery. Because I'm thinking about the crimes that I'm doing. And I want to recover from not doing those crimes. And I want to work also. (Prisoner)

> Do I see myself in recovery…? [On] the cycle of change I am between action and maintenance (Prisoner)

Two other interviewees suggested recovery involved a lifelong commitment to change, whilst one gave the most effusive definition we encountered across multiple sites:

> Recovery looks like, it looks like…… *Everything*. It's like a fucking great big sunshine tropical island release. Life. Options (Prisoner)

The two who had made the greatest reductions in their medication stood out as particularly motivated by the features of 'recovery,' as they defined it.

Of the four interviewees who felt they were not 'in recovery,' one felt he needed an entire 'change of mindset,' one saw himself as 'maintained on a script really, just hanging around,' and one felt entirely unable to understand the word in a drug- or alcohol-related context:

> Recovery to me would feel like having an accident and getting over it… But I'd never determine a drug problem as recovery. Or an addiction. … If you were asking me what recovery means in terms of a drug problem… honestly, I couldn't. (Prisoner)

One of our interviewees also felt unable to own 'recovery' because of the perceived desperation of his situation:

> What I'm doing. I wouldn't call that recovery… I've got no qualifications. I'm 51. I'm not going to retrain. I'm not a computer allitreate [sic], me spelling's not all that. And it's going to be hard, for 32 years, [heroin] has been a big part of me life (Prisoner)

Finally, two prisoners saw 'recovery' as part of a longer journey, noting that the state of their recovery depended on securing transfer to a rehabilitative prison or community programme.

A final note. Several interviewees commented on other prisoners' attitudes towards recovery. It is impossible to draw any firm conclusions from these perspectives. However, it bears mention that none of our interviewees felt that recovery or reduction were widespread:

> It's quite a small per cent. It seems to be the same faces time and time again (Staff)

> I don't know that many wanting to achieve recovery (Prisoner)

> I wouldn't've thought there'd be many detoxing… Some people come on these places just to maintain drug addiction. Just to go outside and continue taking drugs (Prisoner)

These perspectives may reflect how interviewees *experienced* Chelmsford's DRW, if not objective reduction rates.

Interviews with Staff: Staff Characteristics

Staff interviewees held one of three roles[25]: clinical, psychosocial, or discipline (prison officers). We secured interviews with five prison employees, four clinical workers, and four

[25]Recovery officers' remit spanned two of these roles.

members of the psychosocial team. All prison officers had spent in excess of ten years working in the prison system, with differences in motivation driving their move to the DRW: two volunteered, and two *were* volunteered. Our clinical interviewees all had extensive experience of nursing in a variety of community and prison settings, with one drawing a striking analogy between working in prisons and secure psychiatric wards. Psychosocial practitioners had heterogeneous backgrounds. All had at least 3 years' relevant experience, though only two had long-term experience of working with drugs and alcohol, or in prison.

Description and Development of the DRW

It was clear from interviews that the DRW represented the latest stage of Chelmsford's drug wing's evolution, beginning with the arrival of prescribing (and IDTS) in 2009. This evolution seemed fluid; some staff were unsure what distinguished the 'DRW' from 'IDTS,' or what either entailed:

> I: IDTS and the DRW… those are… running separately? Together?
> S: If I'm right, IDTS is us, the nursing staff. The DRW is E wing… The DRW umbrellas a bit of everything. I think.

> Downstairs IDTS, upstairs we're [the psychosocial team]. But we're all IDTS (Staff)

Despite these apparent confusions, interviewees suggested that the DRW's arrival brought an increased sense of a shared professional identity, and a new focus on recovery / reduction:

> The word recovery is fairly new. We've always worked on the basis of a care plan. But I think the word care maybe is not specific or targeted or focused enough…. Care can be perceived as a bit wussy. So I like the idea of recovery. (Staff)

> There's been much more emphasis and focus on reduction and recovery. (Staff)

As noted earlier, interviewees commented that two particular features of the DRW (the introduction of new compacts and the drug recovery worker) may have played particularly strong roles in supporting change.

Ongoing Developments: Benchmarking

Over the last two years, English prisons have undergone two major reviews of staffing, pay and conditions. Fair and Sustainable was developed in discussion with the Prison Officers Association, and sought to implement new working structures throughout the prison estate:

> In the current economic climate, the POA cannot allow public sector prisons to be easy targets … We must have a public sector service which has the ability to compete with private sector companies. These proposals go a long way in achieving this aim, by providing a long term. sustainable workforce (POA 2012:5)

Within a year of Fair and Sustainable being rolled out, 'competition benchmarking' was introduced to make prisons even *more* competition-proof. The POA surmise:

> The Public Sector benchmark involves using the Zero-based Resource Approach based on a core day established for competition and an optimum staffing complement

> of all grades. It also involves providing a regime by identifying the best possible response to the commissioning intentions document through the blend of work, learning and skills and resettlement services with the constraints of each prison's build environment and facilities and in response to its prisoner profile (POA Circular 1 / 03.01.2013)

By the time of fieldwork, Chelmsford prison had been fully benchmarked and had received the benchmarking team's report. The core impact was likely to be on staffing levels, determined by inflexible formulae and ratios. Staff felt this was likely to impact on non-'core' activities, including unlocking prisoners for psychosocial appointments:

> They said we will start at zero. So you've got 126 prisoners. Do you need an officer? Yes. Do you need 2? Of course. 3? Yeah. 4? Yes. 5? Hmmm, maybe not. Because what they say is you need about 30 prisoners to *a* member of staff.… It's extremely difficult to see how we're going to manage the regime… (Staff)

Across rapid assessment sites, practitioners and managers who had undergone benchmarking shared a belief that the requirements of DRW pilots had not been taken into consideration.

Staff also had concerns specific to their population. The staffing of the medication queue did not seem to have been taken into account:

> Benchmarking came in and looked at [medication]. Benchmarking did it on a computer. And they said we should be able to do everybody's meds in 15 minutes… Let's say we could do it in 30 seconds each. Which we can't. Because some of them are on multi-meds. Some of them are on subutex [which] in some cases takes 10 minutes [to dissolve]. But anyway, 112 people. That don't fit into 15 minutes, does it? (Staff)

Amidst interviewees' general frustration at the benchmarking process sounded some notes of cautious optimism. One interviewee felt that the almost complete irreconcilability of the DRW's regime and the benchmarking report might even open up new possibilities:

> I know that some of the things they've recommended have been absolutely ludicrous. So it might be that, because of that, it will get to the stage where we have our own standalone regime. Which will be brilliant for us (Staff)

Difficulties were thus reimagined as an opportunity for change.

Level of Separation

The vast majority of medicated prisoners were 'siloed' in Chelmsford's DRW, a situation which prison officers (in particular) saw as positive:

> Everyone's on here together. And the drugs are on here. When you start going to other wings you've got the risk of drugs spreading out. A lot of them… obviously… like to sell them. So it's bad I guess when they have to go up that end (Staff)

However, Chelmsford was performance managed on the basis of numbers in work and education. Prisoners thus intermingled with those from other wings, and *total* siloisation was felt to be harmful to prisoners' broader resettlement journeys.

Of the two processes, siloisation and intermingling, intermingling *tended* to be seen as the more problematic. Mass move was seen as an effective opportunity to secure or sell drugs:

> A lot of [the drugs] come off of this wing. The walkway out there is called the M1. When you're on the way to work you meet every other wing. That's where all the exchanges go on (Prisoner)

Three interviewees consequently aspired to develop more siloed provision, in which DRW clients would be kept on the wing for several weeks of intensive drug treatment before progressing to work or education.

> If they didn't do work for the first couple of weeks, we would have total access to them to address these problems, get everything done, put a plan together… It's no good teaching someone to read and write if they've not sorted out their drug problem. Or send somebody off to do brickwork when they're still drug dependent. (Staff)

> If this had a standalone regime, they wouldn't have to go off to education, off to here, off to there. They would stay on here. And then maybe we'd have more attendance to the rolling group programme because they'd be here and it's not about affecting the KPT figures for the establishment… (Staff)

One manager developed this suggestion further, noting that the DRW's work would be greatly eased if drug treatment was paid and rewarded like other purposeful activities.

Drug Testing, and Positive Tests

> We try to hit about 150 tests a month. So some prisoners may get tested a couple of times in a month's period at different times of the day (Staff)

Chelmsford's DRW operated two kinds of testing. Mandatory drug testing (MDT) operated throughout the prison, with positive MDTs resulting in disciplinary charges:

> You'll go to an outside adjudication, that's an outside offence, to have the drugs in the prison. The first time is normally a suspended sentence. Second time would be loss of canteen, basic regime, or 14 days, 21 days or whatever. The 3rd time could be extra days. Anything from 21 days up to, well depending on how many drugs (Prisoner)

Compact based testing (CBT) was notionally voluntary. Prisoners could sign up for CBTs, which constituted one element of the DRW compact.

Formal wing policy set out a succinct and robust response to positive tests, centring on 'two-strikes' followed by an enforced rapid reduction on a non-DRW wing. The DRW compact (see **Appendix B**) clearly defines the rapid reduction process in these terms. Rapid reductions might be *seen* as punitive:

> S: There needs to be control and there needs to be penalties, and [rapid reduction] is it
> C: So rapid reduction is a penalty for repeat [using]?
> S: Yeah. Because to my mind a reduction… can be [seen as a penalty] I suppose.

However, managers and clinical staff framed the process in terms of safety and support:

> It's never done punitively (Staff)

> If they've taken something particularly dangerous then the doctor in conjunction with the clinical lead for IDTS and myself will make a decision whether to rapidly reduce for *safety's* sake. Because if they've been taking illicitly on what they've already been taking then that could lead to a fatality. (Staff)

'First strike' positive tests consequently received a supportive multi-disciplinary response:

> Instead of having a really hard approach, in the first instance we look at how we can support them further. Discuss what their reasoning is behind what they do and then give them another go… (Staff)

Psychosocial practitioners employed a 'Why Did I Use' ITEP map in prisoners' next one-to-one session. The second strike notionally invoked a more hardline response, though frontline interviewees were unsure how often rapid reductions were actually used.

Relationships between Prison Agencies

> I think the joint working between ourselves [The psychosocial team] and IDTS clinical can be, can be very impressive (Staff)

> Everything knits together and makes it work. You need a bit of [clinical] and you need a bit of [the psychosocial team]. You need a bit of everything combined to get the result (Staff)

> Nurses and prison officers have worked together for years. [The psychosocial contractor] is an agency, isn't it. Nurses and prison officers instinctively click together (Staff)

As these quotations suggest, a wide variety of interviewees felt that relationships between agencies were working very well. Without exception, The psychosocial team and Clinical workers described good joint working relationships, strongly supported by jointly conducting prisoners' 5 day, 28 day and 13 week reviews. Information sharing was felt to be good, with practitioners feeling able to present clients with a unified front. Despite *some* hesitancy from the clinical team about the professional boundaries of psychosocial workers, the relationship was seen to be positive, effective, and widely beneficial.

Whilst relationships with recovery officers were widely felt to be excellent, relationships between 'white shirt' prison officers and other staff groups seemed more complex. Psychosocial team workers felt relatively excluded, and could struggle to secure officers' required support:

> As drug workers. I think we've come a long way from where we were. But… I still think there is a little bit of reluctance. You know, "we can't get them out if the count's wrong." Well actually, the governor says we can. We have a letter saying we can keep them out if the count's wrong. Sometimes you feel like you're being ignored. But it works a lot better than it did (Staff)

Interviews with prison officers suggested that Psychosocial perspectives might be grounded in fact:

> When [psychosocial workers] come onto a wing, it's another task [an officer has] to do. They're constantly coming down for their clients. Constantly. It breaks into the prison officer's role quite a lot … it interferes with the officer's day (Staff)

Clinical staff also voiced a sense of arriving in Chelmsford as unwanted outsiders, delivering unnecessary provision to an undeserving client group:

> Some of the attitudes are, why can't we just get on with it? Why do they need these meds? Why do we need these outsiders here?... It's threatening [to officers]. And… I think they would prefer to go back to the old BritLofex or cold turkey days. There's a little bit, well there's a lot of animosity between certain staff. I've been told by a senior officer that they didn't want us here. They've said it in a jovial, cutting way (Staff)

These challenges notwithstanding, all therapeutic interviewees acknowledged that relations with prison officers had improved significantly since the IDTS Wing's inception.

Through the Gates: Professional Perspectives

Two to three weeks before release, the psychosocial team sought to draw up 'release plans' for all DRW residents, setting out referrals and signposts to community agencies[26]. Clinical throughcare was felt to be working well, with prescriptions effectively transferred to community providers. Chelmsford's clinical lead identified that relationships with North Essex community drug services were on a particularly solid footing, supported by strong management ties, routine meetings, and shared commissioning arrangements. Community drug workers could be invited into the prison to participate in three-way meetings in the time leading up to prisoners' release. This was identified as a real strong point of Chelmsford's provision. Essex DIP teams could also provide Psychosocial workers with feedback on clients' progress. Expanding this resource beyond Essex was considered desirable.

Irrespective of the efficacy of clinical throughcare, staff felt that DRW residents' chances of staying drug- and crime-free were heavily undermined by their housing situation on release:

> That is the biggest problem. Housing. We can organise their prescribing, we can organise [psychosocial] support in the community… the only area we don't plan is housing. And that is usually the major reason they come back to prison. (Staff)

> Some people are coming in because they're homeless and they've got nothing there. And they shoplift just to come back here (Staff)

This resonated strongly with the accounts of our prisoner interviewees.

Through the Gates: Prisoner Perspectives

Offenders widely described prison as an artificial environment, with meaningful gains to be made and sustained *independently* in the community

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[26] Unfortunately, none of our prisoner interviewees had received a release plan at the time of interview. This section consequently focuses primarily on professional interviewees.

> It's when you get out. And when you get out unfortunately the prison system fails people. The minute you're in the community no-one's got a duty of care. (Prisoner)

The most prominent resettlement issue for prisoner interviewees was housing. We asked no questions about housing. Still, five volunteered that dire housing provision had proved a great problem for them, often leading them to return to drug use or offending:

> I left here homeless a year and a half ago and I come back homeless (Prisoner)

> NACRO… said all we can do is release you with a letter saying you're homeless and need housing … Every time I've been in here they've released me homeless (Prisoner)

> NACRO… can't help you. I have got to commit crime to get a deposit to get a roof over me head. Because I will not go in a shelter with a load of drunks (Prisoner)

> I'd been on the council list for over 2 years something like that… And I'd just suffered another heart attack. They refused to house me but they were obligated, because of my health conditions, to find me accommodation. So they put me in an emergency night shelter … Every day you had to leave at 9 o'clock and you weren't allowed back until half past 7 in the evening. You had to pay £3 to stay there. If you can't provide them £3 a day they'll ask you to leave. So everything's on top. It's pressure (Prisoner)

Homelessness has been identified as one of the main criminogenic risks contributing to reoffending nationwide. Despite some efforts to address drug using offenders' housing situation (e.g. Home Office 2004), our interviewees' accounts suggest that it may still need considerable attention.

Perceived Likely Impact on Future Offending and Drug Use

Irrespective of DRW provision, several prisoners saw their *own* actions, particularly following release, as the key determinant of their future behaviour:

> I've said [I'd stay abstinent] before and every time… if you stuck me in front of a lie detector chair whilst I was in prison I'd pass it. With flying colours. (Prisoner))

> I wouldn't say I'm worried about [relapsing post-release]. A couple of times, I've got out, I've made a success of it for a period of time. But for whatever reasons it's gone wrong in the end… I hope not [to use]. I don't plan to. But I didn't plan to last time I was released. And I did. (Prisoner)

Prisoners' beliefs about the impact of Chelmsford's services covered every possible angle. One felt that prescribing services made his future offending and drug use *more* likely:

> All it does is maintain your script. All it does is make prison easier. A lot easier. You don't mind getting arrested now. Because you've got everything here. (Prisoner)

At the other extreme, an interviewee was semi-evangelical about the DRW's impact:

> People on this wing are changing their lives around. You can watch it happen. People here are coming back from death's door to life again. The system is working (Prisoner)

Other prisoners felt impact rested on factors beyond the prison's control, such as the quality of aftercare support, and continued contact with partners and children.

This tallied with managers' conception of Chelmsford's high-churn DRW as the *initiator* of recovery journeys, 'the start of their intervention, the start of their reduction' (Staff). Whilst two staff interviewees thought the DRW was having little impact, the majority sought to offer a balanced opinion, framing estimates in terms of their own, small-scale and anecdotal experiences. Such assessments tended to contain at least some positive elements:

> We try and sow a seed here that lets those that are ready, give up. We give them an avenue. To try and give up properly. I know some successes, I've met them in town and they look great. And when I see them healthy, I'm really pleased. However the ones I see outside charity shops or, or laid out on the street outnumber those (Staff)

> I've not had any that have come back in… I'm sure some of them will, but if you can one positive change to their life. Then I think that we're doing good (Staff)

> A lot of people haven't come back. And you hope that they are…carrying on with their programme. Their reduction or maintenance. (Staff)

Finally, one staff member situated Chelmsford's impact in broader terms, noting that if the wing positively impacted on individuals' willingness to ask for help, then it put them in a stronger position in future.

If you could change one thing…

A handful of professional interviewees were the only people to voice a desire for certain changes within Chelmsford's DRW. There were individual calls for 'a pay rise … then [introduce] a second meds hatch', 'a national direction and a local direction', and for closer working relationships with healthcare nurses, specifically around mental health.

Other priorities garnered slightly more support. Two interviewees were frustrated by the ubiquity of methadone. One favoured a blunt response:

> I would go harsher. I often say I would go back to letting them go cold turkey. A lot of these people haven't got any boundaries and… they do like it when the boundaries are put in place, and you're firm but fair with them. They do like that. (Staff)

The second was in favour of a moderate response, informed by a substantive review.

Five staff in all roles, at all levels of seniority, supported the most popular priority for change: an increase the intensity of DRW provision. Some staff suggested that this might involve the introduction of a siloed regime:

> I'd like to hold prisoners on here for a period of 6-8 weeks before we start integrating them into other areas of the jail for other activities. I'd like some more psychosocial work, interventions, marrying with the clinical team. So we can do some proper productive work and then say right, and get paid for it. (Staff)

Others suggested that the intensity of provision could be increased by allowing workers to treat clients *unequally*. Instead of offering equal access to equal levels of treatment to all

prisoners, these practitioners yearned to be able to give more time and attention to those who they believed needed or wanted it:

> [I would like to] get a chance to work with them a bit more. More than I do. The ones that need it. The ones that need it, it shouldn't be so rigid. We should be able to see them as many times as we want (Staff)

> We've not been radical enough [We should] treat people differently. I mean, they say "if you don't work with [the psychosocial team] you *will* get reduced." I'm not sure that's right. Because if that person's not going to give up you haven't achieved anything… I get upset when the same people come through the door all the time. And we just try and do the same things with them. And I think "that didn't work the 7th or 8th time. Why am I doing it?" Why not just say "look, mate. Come to me when you are ready. And be truthful. Because I'll be truthful with you." And I'll spend my time on the guy that does want the help. (Staff)

This subset of professional interviewees seemed to be calling for the more selective (and intensive) models of DRW that have been piloted elsewhere.

Appendix A: E Wing's Regime

E Wing Regime

HMP & YOI Chelmsford, 200 Springfield Road, Chelmsford, Essex, CM2 6LQ

HM PRISON SERVICE
Public Sector Prisons

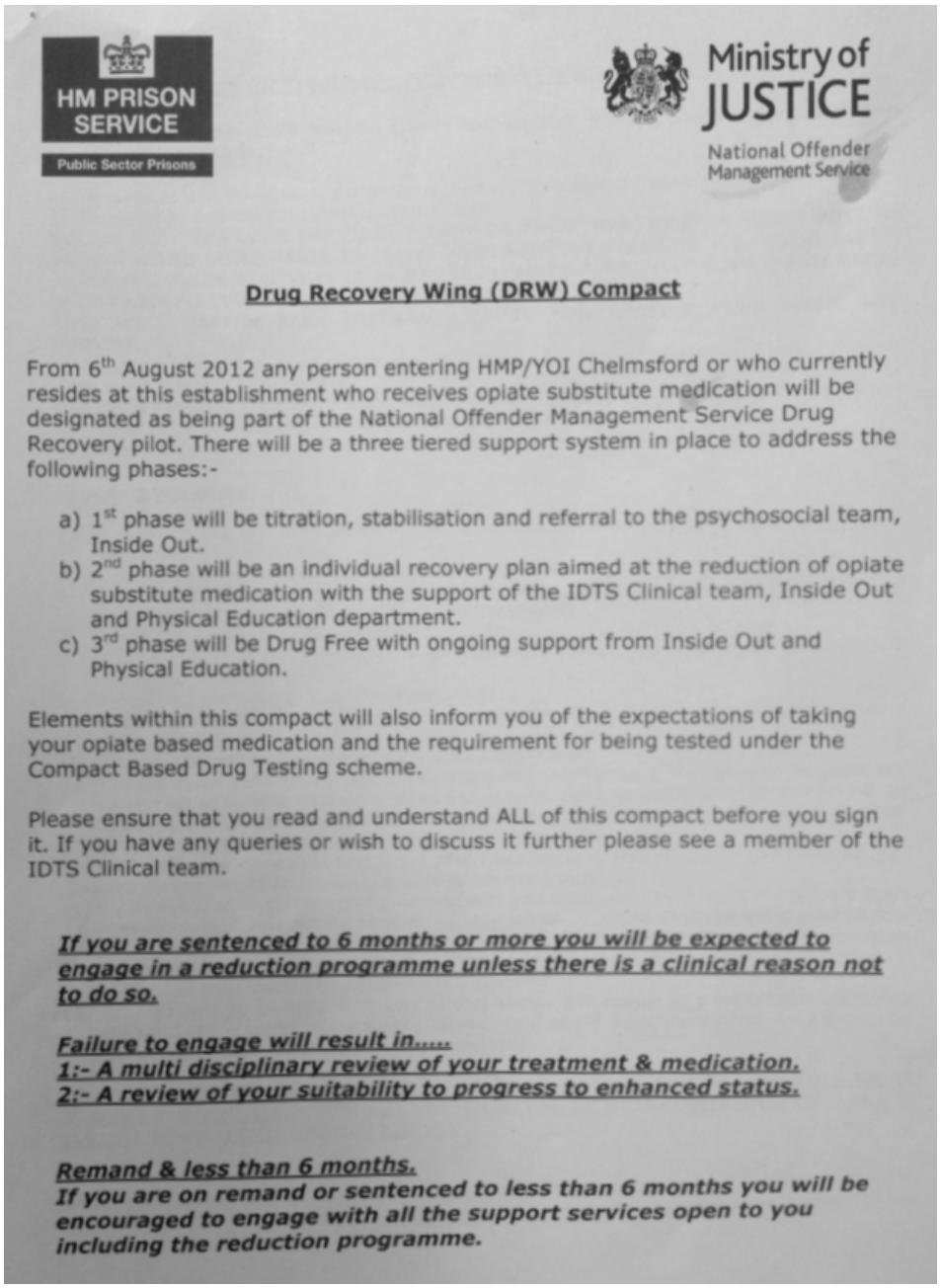
TIME	MONDAY
7:30	STAFF ON DUTY, UNLOCK FOR MEDICATE KITCHEN WORKERS FOR MOVEMENT STAFF
7:45	UNLOCK FOR DOMESTICS (This includes Breakfast, Applications, Phone calls, Meal choice, and Showers)
8:00	IDTS ASSESSMENTS FOR NEW RECEPTIONS
8:30	LOCK UP PRIOR TO MASS MOVEMENT
8:45	MASS MOVE
9:10	MASS MOVE ROUTE CLOSED
9:15	MEDICATIONS
10:15	UNLOCK / COMMENCE EXERCISE
11:15	EXERCISE RETURNS
11:30	MASS MOVE RETURNS, SERVE LUNCH AND MEDICATION
12:15	LOCK UP FOR ROLL CHECK
13:35	UNLOCK FOR MASS MOVE, MEDICATIONS
13:45	MASS MOVE
14:10	MASS MOVE ROUTE CLOSED
14:15	COMMENCE IDTS CLINIC / REVIEWS AND WING ROUTINES
14:30	INDUCTION TALK WITH E WING INSIDERS
16:10	CLINIC FINISHES
16:15	MASS MOVE RETURN, SERVE DINNER, MEDICATION AND BLOOD PRESSURES
17:00	LOCK UP

TIME	FRIDAY
7:30	STAFF ON DUTY, UNLOCK FOR MEDICATE KITCHEN WORKERS FOR MOVEMENT STAFF
7:45	UNLOCK FOR DOMESTICS (This includes Breakfast, Applications, Phone calls, Meal choice, and Showers)
7:45	IDTS ASSESSMENTS FOR NEW RECEPTIONS
8:20	LOCK UP PRIOR TO MASS MOVEMENT
8:30	MASS MOVE
8:50	MASS MOVE ROUTE CLOSED
9:00	MEDICATIONS
10:00	UNLOCK / COMMENCE EXERCISE
11:00	EXERCISE RETURNS
11:00	MASS MOVE RETURNS, SERVE LUNCH AND MEDICATION
11:30	LOCK UP FOR ROLL CHECK
12:50	MUSLIM PRAYERS
13:00	CANTEEN, KIT CHANGE
14:00	GYM INDUCTION
14:30	MUSLIM PRAYERS RETURN
15:00	GYM INDUCTION RETURN
15:30	ENHANCED ASSOCIATION ON BLUE SPUR
16:00	ENHANCED ASSOCIATION ENDS
16:00	SERVE DINNER, BLOOD PRESSURES AND MEDICATION
17:00	LOCK UP FOR ROLL CHECK

TIME	TUESDAY / WEDNESDAY / THURSDAY
7:30	STAFF ON DUTY. UNLOCK / MEDICATE KITCHEN WORKERS FOR MOVEMENT STAFF
7:45	UNLOCK FOR DOMESTICS (This includes Breakfast, Applications, Phone calls, Meal choice, and Showers)
8:00	IDTS ASSESSMENTS FOR NEW RECEPTIONS
8:30	LOCK UP PRIOR TO MASS MOVEMENT
8:45	MASS MOVE
9:10	MASS MOVE ROUTE CLOSED
9:15	MEDICATIONS
10:15	UNLOCK / COMMENCE EXERCISE
11:15	EXERCISE RETURNS
11:30	MASS MOVE RETURNS, SERVE LUNCH AND MEDICATION
12:15	LOCK UP FOR ROLL CHECK
13:35	UNLOCK FOR MASS MOVE, MEDICATIONS
13:45	MASS MOVE
14:10	MASS MOVE ROUTE CLOSE
14:15	COMMENCE IDTS CLINIC / REVIEWS AND WING ROUTINES
14:30	INDUCTION TALK WITH E WING INSIDERS
16:10	CLINIC FINISHES
16:15	MASS MOVE RETURN
16:45	SERVE DINNER, MEDICATION AND BLOOD PRESSURES
17:00	ASSOCIATION
18:30	LAST CALL FOR SHOWERS
18:45	ASSOCIATION ENDS. LOCK UP FOR ROLL CHECK

TIME	SATURDAY / SUNDAY
8:30	STAFF ON DUTY
8:35	UNLOCK FOR MEDICATE FOR CHAPEL, VISITS, KITCHEN, GYM (SUNDAY ONLY)
8:40	ISSUE BREAKFAST PACKS (USE CLEANERS TO ASSIST)
9:00	CHAPEL SERVICE
9:00	ASSOCIATION, MEDICATION, BLOOD PRESSURES
10:00	CHAPEL RETURNS
10:15	ASSOCIATION AND MEDICATION ENDS
10:30	EXERCISE OR LOCK UP
11:30	EXERCISE RETURNS. SERVE LUNCH
12:15	LOCK UP FOR ROLL CHECK
13:30	UNLOCK VISITS AND MEDICATIONS
15:30	ENHANCED ASSOCIATION ON BLUE SPUR
16:10	ENHANCED ASSOCIATION ENDS
16:15	SERVE DINNER. BLOOD PRESSURES AND MEDICATION
16:50	LOCK UP FOR ROLL CHECK

Appendix B: the DRW Compact



HM PRISON SERVICE
Public Sector Prisons

Ministry of JUSTICE
National Offender Management Service

Drug Recovery Wing (DRW) Compact

From 6th August 2012 any person entering HMP/YOI Chelmsford or who currently resides at this establishment who receives opiate substitute medication will be designated as being part of the National Offender Management Service Drug Recovery pilot. There will be a three tiered support system in place to address the following phases:-

a) 1st phase will be titration, stabilisation and referral to the psychosocial team, Inside Out.
b) 2nd phase will be an individual recovery plan aimed at the reduction of opiate substitute medication with the support of the IDTS Clinical team, Inside Out and Physical Education department.
c) 3rd phase will be Drug Free with ongoing support from Inside Out and Physical Education.

Elements within this compact will also inform you of the expectations of taking your opiate based medication and the requirement for being tested under the Compact Based Drug Testing scheme.

Please ensure that you read and understand ALL of this compact before you sign it. If you have any queries or wish to discuss it further please see a member of the IDTS Clinical team.

If you are sentenced to 6 months or more you will be expected to engage in a reduction programme unless there is a clinical reason not to do so.

Failure to engage will result in.....
1:- A multi disciplinary review of your treatment & medication.
2:- A review of your suitability to progress to enhanced status.

Remand & less than 6 months.
If you are on remand or sentenced to less than 6 months you will be encouraged to engage with all the support services open to you including the reduction programme.

Five-Way Agreement for Treatment Programme - Methadone

On our part, we, (your IDTS worker, Inside Out worker, Doctor, pharmacist and prison establishment), agree to;

1) Help you to address your substance misuse issues, to promote recovery and abstinence.
2) Prescribe and administer substitute medication.
PLEASE NOTE THAT FOR THE FIRST 5 DAYS OF YOUR TREATMENT, A NURSE WILL BE UNDERTAKING SOME BASIC PHYSICAL OBSERVATIONS ON YOU E.G. YOUR BLOOD PRESSURE, PULSE ETC. THIS IS IN ORDER TO MAKE SURE THAT YOUR MEDICATION IS CORRECT FOR YOU AND TO KEEP YOU CLINICALLY SAFE.
THIS WILL HAPPEN EACH MORNING BEFORE YOU RECEIVE YOUR MEDS AND EVENING.
3) Provide a referral to other community drug work agencies, counsellors and other services within the prison as necessary.
4) Offer full information about treatment options and informal involvement in making decisions concerning treatment and reduction planning.
5) Respect privacy, dignity and confidentiality as far as it is possible within the prison.

On your part you agree;

1) To enrol on the IRIS recognition system to ensure accurate and safe dispensing of your medication.
2) To provide a urine sample for routine/random screening when requested.
3) To have your clinical observations done BEFORE you receive your medication in the morning for the first 5 days of your treatment and in the evening.
4) To take your Methadone as prescribed.
5) To drink 200mls of water, following your Methadone consumption and hand the empty cup back to the pharmacy tech.
6) To sign your prescription chart once consumed.
7) To attend and actively take part with any on-going assessment and appropriate psycho social interventions.
8) To treat other prisoners and staff with dignity and respect.
9) That we, (your IDTS worker and pharmacist) can communicate with each other regarding issues such as current treatment plans and options, but that additional information will be discussed with you, the client, before it is shared between the above (unless you are at risk of harming yourself and others).
10) Not to take any medication that is not prescribed by us to you. If you choose to do so, you run a serious risk of accidental overdose which could be FATAL.
11) Any evidence of diversion activity will result in you being seen by a multi disciplinary team immediately and your **Methadone** being stopped and a **rapid Methadone detox** regime being commenced. There will not be any warning or negotiation. You will be placed on **report** by the supervising IDTS officer. The incident will be documented in your medical records and your Inside Out worker will be informed.
12) Failure to comply with any of the above will result in your treatment being reviewed by a multi disciplinary team. You could also be placed on report, be subject to an IEP review or SAFE procedures.

PLEASE NOTE THAT IF YOU ARE SENTENCED FOR 26 WEEKS OR MORE, YOU WILL WORK TOWARDS REDUCING YOUR CURRENT PRESCRIPTION OF METHADONE UNLESS THERE IS A CLINICAL REASON THIS CANNOT HAPPEN.

I have read and fully understood the above, about **Methadone** treatment and I agree to adhere to **all of this** while I am on the treatment. I have had the opportunity to discuss the agreement and its meaning with the IDTS Team.

. Five –way Agreement for Buprenorphine (Subutex) Treatment Regime

On our part, we, (your IDTS worker, Inside Out worker, Doctor, pharmacist and prison establishment), agree to;

1) Help you to address your substance misuse issues, to promote recovery and abstinence.
2) Prescribe and administer substitute medication.
PLEASE NOTE THAT FOR THE FIRST 5 DAYS OF YOUR TREATMENT, A NURSE WILL BE UNDERTAKING SOME BASIC PHYSICAL OBSERVATIONS ON YOU E.G. YOUR BLOOD PRESSURE, PULSE ETC. THIS IS IN ORDER TO MAKE SURE THAT YOUR MEDICATION IS CORRECT FOR YOU AND TO KEEP YOU CLINICALLY SAFE.
THIS WILL HAPPEN EACH MORNING BEFORE YOU RECEIVE YOUR MEDS AND EVENING.
3) Provide a referral to other community drug work agencies, counsellors and other services within the prison as necessary.
4) Offer full information about treatment options and informal involvement in making decisions concerning treatment and reduction planning.
5) Respect privacy, dignity and confidentiality as far as it is possible within the prison.

On your part you agree;

1) To enrol on the IRIS recognition system to ensure accurate and safe dispensing of your medication.
2) To provide a urine sample for routine/random screening when requested.
3) To have your clinical observations done BEFORE you receive your medication in the morning for the first 5 days of your treatment and in the evening.
4) To take your Buprenorphine as prescribed.
5) **Crushed Buprenorphine** must be taken under your tongue. Administering staff will give you a full cup of water (200mls) before and after administration of Buprenorphine which you must drink. Then hand the empty cup back to the pharmacy tech.
6) Always show the administering staff that the **Buprenorphine** is under your tongue before sitting down or moving away from the hatch.
7) Sit down with your hands under your bottom. (For Centre ONLY- stand with your hands behind your back). **At no point should your hands be anywhere near your face.**
8) You are not allowed to talk to colleagues or supervising staff while your **Buprenorphine** is under your tongue.
9) You are not allowed to bring anything in your hand while taking your medication.
10) Your mouth will be checked by the IDTS officer during the process.
11) To sign your prescription chart once consumed.
12) To attend and actively take part with any on-going assessment and appropriate psycho social interventions.
13) To treat other prisoners and staff with dignity and respect.
14) That we, (your IDTS worker and pharmacist) can communicate with each other regarding issues such as current treatment plans and options, but that additional information will be discussed with you, the client, before it is shared between the above (unless you are at risk of harming yourself and others).
15) Not to take any medication that is not prescribed by us to you. If you choose to do so, you run a serious risk of accidental overdose which could be FATAL.
16) Any evidence of any diversion activity will result in you being seen by a multi disciplinary team immediately and your **Buprenorphine** being stopped and a **rapid Buprenorphine detox** regime being commenced. There will not be any warning or negotiation. You will be placed on **report** by the supervising IDTS officer. The incident will be documented in your medical records and your Inside Out worker will be informed.
17) **Failure to comply with any of the above will result in your treatment being reviewed by a multi disciplinary team. You could also be placed on report, be subject to an IEP review or SAFE procedures.**

PLEASE NOTE THAT IF YOU ARE SENTENCED FOR 26 WEEKS OR MORE, YOU WILL WORK TOWARDS REDUCING YOUR CURRENT PRESCRIPTION OF SUBUTEX UNLESS THERE IS A CLINICAL REASON THIS CANNOT HAPPEN.

I have read and fully understood the above, about **Buprenorphine** treatment and I agree to adhere to **all of this** while I am on the treatment. I have had the opportunity to discuss the agreement and its meaning with the IDTS Team.

HM PRISON SERVICE

Public Sector Prisons

Ministry of JUSTICE

National Offender Management Service

Recovery Voluntary Based Drug Testing Compact

Prisoner's name: _____ Prison Number: _____

Date of birth: _____

This Compact is made between the Governor of HMP Chelmsford and the above named. It sets out their commitment to remain drug free and contains agreement to be subject to a programme of drug testing. In return the prison will provide support and assistance to the above named to help them remain drug free.

Prisoner's Obligations

1. I agree that the use or supply of all controlled drugs, alcohol, mood altering substances and all medicinal products unless prescribed is prohibited. I will refrain from bringing drugs into the prison and agree not to deliver or supply any illicit item to any other prisoner or behave in a way that contravenes security requirements or general levels expected; any such behaviour will be treated as a failure to comply with this Compact and lead to a review of my circumstances, possible removal from the programme and may be considered a disciplinary offence under prison rules.

2. If I am found in possession of any illegal drugs, mood altering substances, alcohol or any equipment used for the taking of illicit substances, this will result in adjudication.

3. I agree to provide fresh, unadulterated urine samples when required and give my consent to, at minimum a rub down and on occasion a full search prior to providing the sample, and to indirect observation of the sample provision. I understand that refusal to provide a sample or consistently providing diluted samples, unless there are clear medical reasons for doing so, constitutes' a serious and immediate breach of compact and provides grounds for removal from the programme, review of medication and a possible relocation move.

4. I understand that I may be held in confinement for up to 1 hour if unable to provide a sample when requested.

5. I understand that tests will be carried out according to the national contracted supplier's instructions in order to provide an indicative screening test result and that tests are not subject to confirmation testing.

6. I understand that testing positive or refusing to provide a fresh, unadulterated sample will not result in disciplinary proceedings but will lead to a review of my circumstances and eligibility to remain on the programme and Drug Recovery Unit.

Positive test results will be treated as follows:

First Positive: Review by board consisting of Head of Drug & Alcohol Services, IDTS Clinical Nurse Manager, Inside Out Manager, Unit Manager or nominated representatives of the multi disciplinary team. Referral to an Inside Out worker for a structured intervention. Review of the following, commitment to the programme, any trusted work position and suitability to remain the unit. If appropriate a rapid detox being commenced in consultation with the IDTS G.P.

Second Positive: Review by Board consisting of Head of Drug & Alcohol Services, IDTS Clinical Nurse Manager, Inside Out Manager, Unit Manager or nominated representatives of the multi disciplinary team. Removal from the CBDT programme and unit. Loss of trusted work position. If appropriate a rapid detox being commenced in consultation with the IDTS G.P.

7. I understand that, if the review board consider my removal from the programme to be warranted, they can implement this at any of the above stages. I also understand that if there are reasonable grounds for a review this can occur at any time as required by the Drug Strategy Team. I also understand that if I am employed as an orderly or any other trusted position on the wing this will be terminated.

8. I understand that I remain subject at all times to MDT and will be liable to be placed on report under Prison Rules for committing any disciplinary offence including drug related offences. Mandatory drug testing (MDT) positives or refusals will be treated as voluntary drug testing (VDT) Positives. In exceptional circumstances, the overriding importance of public safety could result in a risk assessment MDT following a positive CBDT test.

9. I give my consent to the CBDT staff confirming details of my prescribed medication for the past three months, following a positive result only, to enable them to ascertain if the medication has potentially affected the outcome of my test, and to obtain details of pre-existing conditions that may cause my samples to be dilute or stop me from providing samples. A review may then take place to ascertain the best way to proceed.

10. I also consent to CBDT staff sharing the test results within the wider Drug Strategy Team, including Inside Out and Healthcare. Passing this information to other Departments or Agencies, other than the Residential Manager or Employer, will only occur when I provide my informed and written consent or when in the opinion of the Governor, the Security of the Prison may be compromised.

11. I understand that the frequency of testing I will be subject to is agreed as a minimum on average of 2 tests per month at irregular intervals.

12. I understand that violence, verbal or racial abuse, threatening or anti-social behaviour will not be tolerated and may result in disciplinary procedures including being placed on report, be subject to an IEP review, SAFE procedures or my removal from the programme / unit following a multi disciplinary review.

13. I confirm that the terms and conditions of this compact have been fully explained and understood by myself and by signing this compact I am demonstrating a commitment to comply with the terms of this compact.

Prison's Obligations

1. To promote and encourage a drug recovery and drug free ethos throughout the prison.

2. To provide services such as Inside Out, IDTS Clinical, Physical Education, Recovery workers/ Mentors and Mutual Aid to encourage, aid and maintain the commitment to remain drug free.

3. To provide CBDT in line with Prison Service guidelines.

4. To provide test result certificates to prisoners if required.

5. To provide the opportunity to complain or appeal against decisions made in connection with this Compact, either informally or formally. This process should begin with an informal discussion with either the Drug Services Team or Residential Management; if the issue cannot be resolved it may continue formally via the Complaints procedures outlined in PSO2510.

Signed..... Print Name.....

Date..... Number.....

Witnessed by:

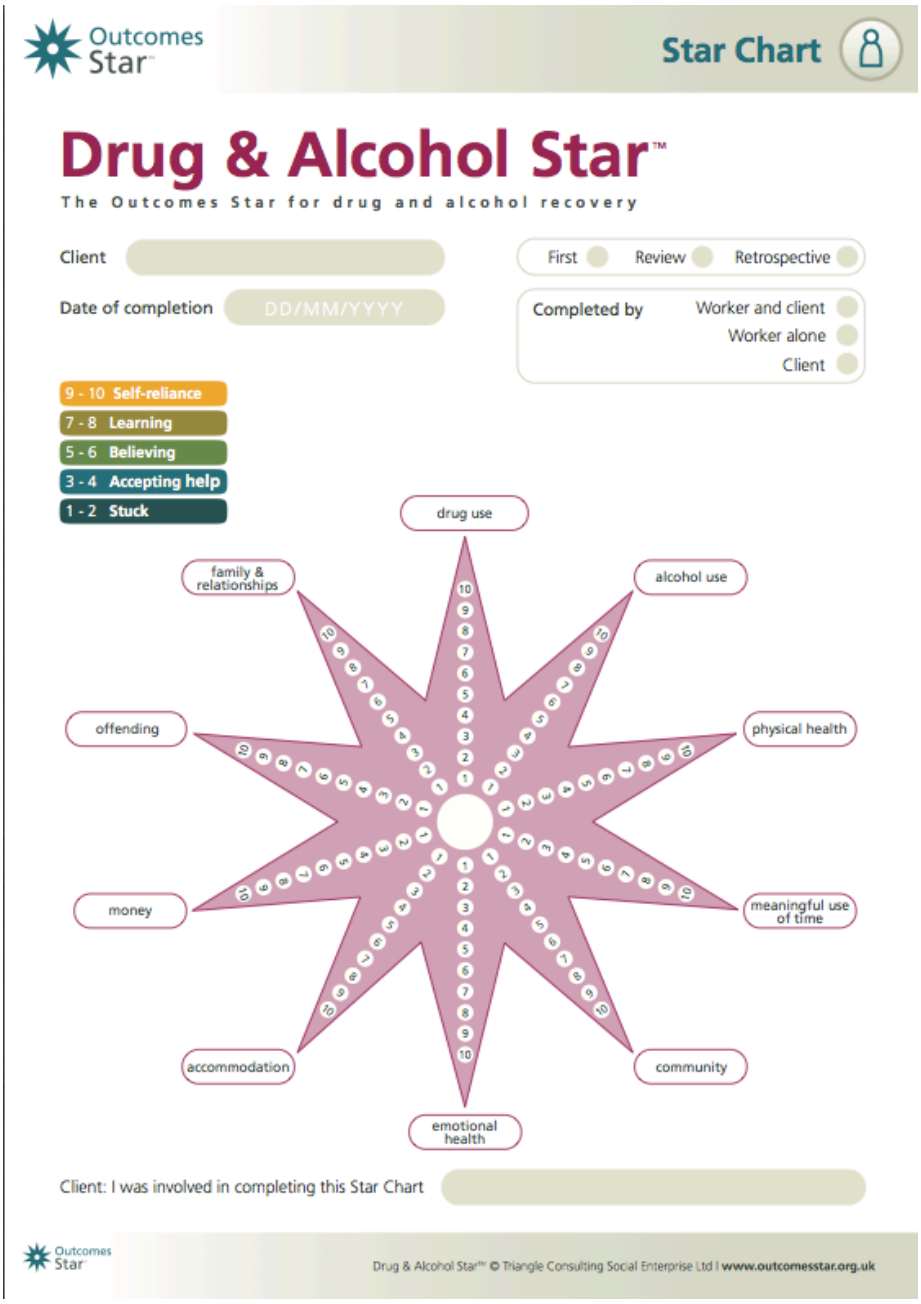
IDTS Clinical team Name.....

Date..... Signature.....

IDTS G.P Name.....

Date..... Signature.....

Appendix C: the Drug and Alcohol Outcomes Star



Star Notes

1 Drug use

2 Alcohol use

3 Physical health

4 Meaningful use of time

5 Community

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Star Notes

6 Emotional health

7 Accommodation

8 Money

9 Offending

10 Family and relationships

Action Plan

Priority area from Star	Current score	Next steps	By who?	By when? (date)	Completed (date)

Signatures:

Service user _____ **Date** DD/MM/YY **Staff** _____ **Date** DD/MM/YY

Outcomes Star

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Appendix D: References

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Appendix 6: High Down

Rapid Assessment

I tend not to look at offending behaviour. I look at where they are in their recovery (Staff)

High Down is not about having a lie down. It's about actually improving, progressing, looking at you as a person. Not your substance misuse, not your offending, but *you. Who are you?* And actually getting them to, to start looking at them (Staff)

Starting note: interview identifiers

Throughout this report, staff (of all kinds) are identified either as (staff), or with an S. Prisoners are identified as (prisoner), or with a (P). Thus (P) after a quotation indicates that it is drawn from a prisoner's interview. (S) indicates that it is drawn from an interview with a member of staff.

Basic prison information

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 primarily double cells. In 2009, High Down gained houseblocks 5 and 6. Each new houseblock has two spurs, with each spur holding up to 90 prisoners. Prisoners' recovery journey begins on houseblock 2, the induction and reception centre. New arrivals are screened by healthcare workers. All prisoners with identified drug or alcohol needs are referred to the prison's psychosocial team. Where required, prisoners' methadone and subutex prescriptions are titrated over two to three weeks. Opiate dependent individuals are then moved to houseblock 6, High Down's 180-bed 'stabilisation wing.' Prisoners with drug problems can also apply to High Down's Drug Recovery Wing (DRW), situated on houseblock 5, spur A. During our rapid assessment, 60 of 5A's beds housed drug dependent prisoners. The remaining beds were filled with a mixture of trusted workers, and high-risk prisoners who could not be housed elsewhere.

The DRW offered two main programmes. Building Skills for Recovery (BSR) was a relatively low-intensity, four-week, cognitive behavioural programme delivered by prison officers. The Intensive Programme[1] offered a more intensive six-week, full-time, abstinence-focused course delivered by a third sector agency. New cohorts (of twelve prisoners) were accepted onto the Intensive Programme every eight weeks.

[1] To avoid breaching sensitivities, we have made an editorial decision to avoid using contractors' and contractors' programmes' proprietorial names. As such, High Down's intensive programme is referred to as the Intensive Programme throughout this document.

A typical day on the DRW: DRW Regime

> Wake up about seven, make myself a cup of tea, make me bed. The door might be opened quarter to eight or something. I get straight in the shower, get back from the shower, get ready, get dressed. I might pop in next door, have a few games of cards. Nine o'clock I go off to the Clink[2], and work down there until half three. Come back here. Usually lock us up at about half four til about half five when we get let out for dinner. Do dinner, have association until seven and then it's lockup (Prisoner)

This account provides a full description of the DRW's regime, with one qualifier. Only Clink employees spent lunchtime off-wing. Other prisoners were locked in their cells. Further specifics of prisoners' daily lives varied according to the activities they were undertaking. The Intensive Programme filled both mornings and afternoons with recovery-oriented groups, beginning with prisoner-led check-in sessions, and progressing to professionally facilitated groups. Other purposeful activities occupied about six hours each day.

Two subgroups of interviewees described less fulfilling days. We interviewed three residents of High Down's stabilisation wing, none of whom were in education or employment. All spent most of each day behind their cell door. Graduates of the Intensive Programme could also find themselves in limbo. Many came onto the DRW with highly-prized prison jobs, but had to give them up in order to attend full-time treatment. Replacement jobs were not immediately available when they completed the programme, leading to a very substantial drop-off in the structure of their day, and the intensity of support:

> For me personally, doing the [Intensive Programme] course was the worst thing I could've done. Because it's really fucked me over workwise. It pisses me off. And there's a few of us who had jobs when we went into the [Intensive Programme]. We're all sitting around all day now (Prisoner)

> It's quite a shock when you finish. Going from a situation where you're let out every day, having support, learning about yourself, really progressing to the next day locked behind the door all day. I need to go and find something. I'm quite stressed (Prisoner)

Rules and Requirements: the DRW Compact

> Obviously when you come onto this houseblock you sign this compact to say you're not going to take drugs. That you will take a voluntary urine sample at any time. You will keep yourself clean. Blahblahblahblahblahblahblah (Prisoner)

In order to access the DRW, potential residents were required to sign a '[Psychosocial Contractor] / HMP Highdown Residential Compact Houseblock 5A' (Appendix A). The terms of the compact covered a broad range of recovery-oriented expectations including requirements for prisoners to seek purposeful activity, accept a referral to the gym, submit to voluntary drug testing, and engage with fellowship meetings, personal officers, and psychosocial workers.

To ensure compliance with these provisions, professionals described a loose, recovery-based disciplinary system. Interpretations of clients' engagement with recovery was broad, requiring little more than perceived willingness and *some* contact with services:

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[2] The Clink is an on-site fine dining restaurant, catering to members of the public and offering prisoners training and qualifications.

> You could be attending tackling drugs through PE, doing some 1-1 work, [or] accessing fellowship meetings. As long as a client is, in one way or another, doing something directly related to their substance misuse, they can be on the wing (Staff)

To be disciplined for non-engagement, staff suggested that prisoners needed to be 'on the wing for months' and 'flagged up as not doing anything *at all*'. In such situations, staff described strikingly collegiate disciplinary responses:

> We did an email to the CARAT worker, drug recovery volunteer, personal officers. All [senior officers], [three managers], the Intensive Programme. And said "what do you think? Any feedback? If you've got any information, we've got to discuss it." (Staff)

We also found indicators of a responsive and nuanced disciplinary system. One prisoner was caught brewing hooch, and felt he had been allowed to stay on the unit 'because I do stand at that door asking for help'. Conversely, staff stated that 'lodgers' received no leniency at all.

Three prisoners spoke of DRW rules, noting that friends or acquaintances had been removed from 5A after being found in possession of drugs. If prisoner interviewees understood the wing's broad, recovery-oriented and engagement-focused discipline system, they made no mention of it. Due to the very limited nature of our sample, and our lack of questions focused on the compact, future studies might explore this question more fully.

Observations on the Physical and Social Environment

> This is the best prison I've been to (Prisoner)

> It's almost like I would think a super-enhanced wing would be (Staff)

> There is a sense of people wanting to change, wanting to do something different… Fellowship meetings is on the wing. There's a sense of recovery. There's a calmness. I think there is. Some. Respect. For. Themselves. And others (Staff)

Each prisoner had been housed in High Down's older houseblocks at some point. Experiences were universally bleak. Five interviewees described being beaten up, bullied, or systematically robbed.

> Some inmates decided to come in and jump me in my cell (Prisoner)

> I went from houseblock 3 to houseblock 4, which was horrible. It was all run down. A lot of gangbangers in there, a lot of trouble. I found out that I was gonna get mugged and… sorted out. Basically. And stripped of all my stuff. By a few heads (Prisoner)

Both staff and prisoners described these older houseblocks as violent and unpleasant environments in poor condition, with minimal natural light. Moving to the newer drug recovery and stabilisation wings was consequently a positive experience:

> Have you been to the old bit of the prison? Its depressing. It's really not nice. Here, it's like a breath of fresh air. It's much better than the rest of this prison (Prisoner)

Benefits came in several forms. **Firstly,** most[3] houseblock 5 residents had single cells. Prisoners described these as a substantial boon; so strong a boon that staff felt they might be actively harmful. One narrated an encounter with a prisoner who claimed to have taken opiates, in order to falsify a drug test, purely to access a single cell:

> I did say this to him, "would you really put yourself at risk to get a single cell? By taking a drug a) that's not prescribed for you, b) that you're telling me that you only use cannabis on the outside anyway?" He said, "needs must." (Staff)

Staff had additional concerns about access to 5A's single cells. As the DRW worked primarily with abstinent prisoners, mendacious applicants need not even forge a drug test.

As the DRW worked primarily with drug-abstinent prisoners, securing access to its single cells was more straightforward: prisoners did not need to provide a positive drug test.

Secondly, prisoners in the newer houseblocks were given 'courtesy keys,' which allowed them to lock (and reopen) their cell doors at times when it would otherwise have been open. From prisoners' perspective this was a real boon, providing added privacy and safety:

> I: You really prefer it on here?
> P: I've got a *key* to my *cell* [both laugh]. That's it!
> I: And that means a lot to you?
> P: Yeah it does. It's nice. You've got your own time

One prisoner used the privacy of single accommodation to carry out physiotherapy exercises uninterrupted. A second felt able to put up pictures of his children, believing that his courtesy key prevented them from being used for sex offenders' 'own purposes.'

Thirdly, the process of selecting motivated or recovery-oriented prisoners for the DRW was felt to create a positive atmosphere:

> When I come over here it was like coming to a different prison. It's a lot more relaxed, the people are a lot friendlier. Everyone's willing to help (Prisoner)

> I think they choose people suitable for this wing. They won't grab any troublemaker because they know it's not good for the atmosphere, for recovery (Prisoner)

> You're not on edge all the time… I don't lock my door. I get me lunch, come back to me cell, no-one's been in it. Everybody seems more trustworthy (Prisoner)

Four prisoners described a further level of trust between graduates of the Intensive Programme in general, and Intensive Programme cohorts in particular. Relationships between prisoners were thus presented as one of the DRW's prominent strengths, emphasised by the contrast with relations on the (equally new) stabilisation unit.

Fourthly, interviewees identified relationships between staff and prisoners as a major strength. Interviewees filling a plethora of professional roles described the DRW as a 'relaxed' or 'laid back' environment. This may have been partially attributable to managers' efforts to establish a regime predicated on engagement and support, with DRW wing staff going through an

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[3] The wing had a couple of double rooms for prisoners who needed cellmates for (e.g.) medical reasons.

interview, selection and training process. One officer interviewee bought into the recovery agenda so strongly that he distinguished 5A's 'clients' from its 'prisoners':

> The guys that are in recovery I class as clients… If someone has made a long term commitment to work towards abstinence, made a transition from being maintained to going into recovery then they deserve the dignity of being classed as a client rather than a prisoner (Staff)

Concomitantly, wing staff described wing policing predicated on the careful deployment of discretion, incentives and (most prominently) relationships[4]:

> When they speak to prisoners on other houseblocks it's a bit too… authoritarian. "*You* need to go there *NOW"* whereas if somebody's smoking a cigarette on a landing for instance, I'm more likely to look at them just say… *hmmm*. And "sorry, guvnor" back they go back they go. And it's relaxed. Because it's got to be (Staff)

> It's like dangling a carrot. They see what privileges they've got up here and… you've gotta try and work with that. And hopefully [they] end up being well behaved (Staff)

Whilst one interviewee expressed concerns that discipline might be unduly lax[5], measures of drug use, violence and bullying seemed to indicate that DRW processes were effective.

The degree of trust that existed between prisoners and wing staff seemed to have knock-on benefits. Senior officers felt able to unlock prisoners even when they theoretically had too few wing staff to do so, giving prisoners more time out of their cells. Officers also described a relatively free flow of drug-related information coming from wing residents.

Profile of DRW Residents

Our small and non-representative sample of DRW prisoner interviewees had served a mean of 10 months and a median of 9 months each. Three (of 11) had been imprisoned for less than half a year, two had been recalled for breaching license conditions, and only one was on remand. The mean age of our High Down interviewees was 33 years old, with a median age of 30. Prisoner interviewees were particularly fond of cocaine. Four identified it as their main drug of choice[6], with a further four naming it as a second preference[7]. Our interviewees' second most prevalent drug of choice was alcohol. Four identified themselves as primarily or exclusively alcohol dependent, with one naming it as his second drug of choice. We also spoke to two people who identified themselves as cannabis dependent (with three people naming cannabis as their second drug of choice), and one who ascribed his offending to benzodiazepine dependence:

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[4] Crewe describes this form of prison policing as the use of 'soft power,' contrasting with the rule-bound, inflexible and confrontational deployment of 'hard power'.

[5] 'It feels very much as if the staff have almost retreated from… the discipline side of our business. So whereas I would go onto a normal wing or a normal houseblock in any other prisoner and I would expect to see quite a lot of staff interaction with the prisoners and that in itself would generate conflict because prisoners aren't getting what they want out of staff and vice versa, that doesn't seem to exist. There seems to've been created, whether deliberately or by accident, an environment where prisoners feel in control' (Staff)

[6] One identified a preference for powder cocaine, one preferred crack cocaine, and two were equally keen on both salt and freebase forms.

[7] One identified an indiscriminate preference for either salt or freebase form, two used powder cocaine, and one explicitly preferred crack.

> Every [time] I get put on the benzos something happens… and then I go to prison. We call them charge sheets. Anyone who mixes alcohol and Valium ends up in prison (Prisoner)

Two interviewees mentioned opiates: one had previously used both cocaine and heroin, but was receiving no medication. The second had had developed a dependence on codeine whilst in the community, receiving 'a low dose of methadone' on entry to High Down. One prisoner was also receiving low-dose anti-depressants. The other seven were fully abstinent.

We gathered information on offending and prison histories for nine DRW interviewees. Sentences were relatively long, with one serving an indeterminate sentence. The mean length of determinate sentences was 41 months, with a median of 37. Index offences were heterogeneous: three had been imprisoned for burglary, three for violence, two for robbery, and two for possession with intent to supply (one cocaine and heroin, one cannabis). Only one prisoner could be clearly identified as a prolific offender, with 'about ten' previous prison sentences. Two others were on their third sentence, one was serving his second sentence, and our remaining five DRW interviewees were in prison for the first time.

Our DRW interviewees described pathways into drug misuse and offending that were very different from those of the opiate users we spoke to in other DRWs. None had histories of total unemployment; even our most prolific and long-term offender described picking up drugs following a failed relationship in his early twenties. He had sustained his drug use with legitimate earnings for some time before resorting to crime. Other interviewees described notable financial (and even relational) success:

> I thoroughly enjoyed [crack]. For definite. But I weren't plucking for it and I weren't stealing for it. I had money, I had a full time job. I had a mortgage on a flat and I had two cars. I had a partner with 2 children. Just with money I got really greedy (Prisoner)

Our sample included self-employed builders, bricklayers and company owners. Two had attended private schools. Though one prisoner described a difficult *family* background, not one interviewee described the pervasive histories of homelessness and unemployment that defined opiate-dependent prisoners' experiences in other DRWs.

Comparison with Stabilisation Wing Residents

With only three of our interviewees drawn from the Stabilisation Wing, it is impossible to make firm or meaningful comparisons. However, it may be valuable to moot some tentative thoughts. Some differences were apparent from spending time on the wing. In the DRW, nearly all offenders wore their own clothes. In houseblock 6, prison uniforms were ubiquitous, apparently reflecting prisoners' more desperate situation:

> I: I feel as if I've seen more prison uniforms on this wing. Is that my imagination?
> P: No, you're fully right. That's people that don't have visits or haven't got people sending their own clothes in. Drug users in this wing shit on all their family. They have no-one. When they end up in places like this, no-one wants to help them

> These lot… they wouldn't let a bloody half ounce [of tobacco] go out their hands. None of them have got nothing. No-one outside (Prisoner)

Some striking differences appeared within our small sample, too. Two (of three) interviewees were on remand: already double the number we found in our eleven DRW interviewees. One

remandee had served at least ten sentences in 'all the London prisons,' beginning a life of shoplifting and petty theft when his parents effectively abandoned him at the age of seven. His opiate using career began with a violent and abusive stepfather, progressing through twenty years of constant methadone maintenance, to abusing fentanyl patches before his most recent imprisonment. The second remandee had been repeatedly imprisoned over the previous thirteen years, cycling through homelessness and imprisonment:

> I was released from prison last year. … got out, didn't get no help, no housing or anything, went straight back out on the street. Begged probation, literally begged probation for somewhere to stay. They wouldn't help me so I told them, I said "listen, I'll start committing crime again." They virtually told me "go on then" (Prisoner)

Our third stabilisation wing interviewee perhaps fit rather more neatly with the profile of our DRW interviewees. He was in his mid-fifties, with a long history of self-employment and sustained good relationships with his family. His only previous imprisonment was 22 years earlier, for offences entirely unrelated to drug use, and he attributed the onset of his heroin and crack use to the tragic death of his son. His family had remained supportive throughout his sentence, and he was hoping to re-establish a small business upon his release.

Lodgers

We've got single cells. High risk prisoners need to be in single cells. So we do have to take in high risk prisoners (Staff)

There's no point me concentrating on my recovery if you're bringing someone over here that's not in recovery. I don't want people over here judging me, putting a hinder on me getting myself better (Prisoner)

High Down's DRW had approximately 90 beds. Professionals estimated that approximately 30 beds were non-DRW at any one time, with 15 occupied by 'high risk' offenders, and 15 housing a 'stabilising population' of trusted workers. Professionals felt that high-risk lodgers presented a particular challenge to the ethos and operation of the DRW:

> If you've got a prisoner that leaves our segregation and re-entry unit [for the DRW] that undermines the ethos of the wing. And it gives them an opportunity to really manipulate some potentially vulnerable clients (Staff)

Two prison employees further suggested that groups of violent drug dealers had occasionally gathered in houseblock 5. However, not all staff saw high-risk groups as equally problematic. Two suggested the DRW offered an ideal context for managing difficult behaviour:

> We've had very disruptive prisoners, people with really, really awful records. They've come on here and 6 weeks later down the line they're working, doing wing jobs, and getting on with things. Other houseblock workers are saying "how did you do that? he's a real bastard. Awful! Really, really, really bad." (Staff)

Prisoners' perspectives on houseblock 5's lodgers were equally mixed. Six DRW residents were explicitly asked about, or referred to, lodgers. One of these seemed entirely unaware of their existence[8]. One voiced very strong concerns, feeling that they were judgmental, and 'put a

[8] 'everyone's got a drug problem or an alcohol problem' (Prisoner). This prisoner was a relatively new arrival to the wing, which may explain this belief.

downer on it.' The final four were either neutral, or warmly welcomed lodgers. Two felt the wing would remain calm, irrespective of prisoners' index offence, recovery orientation or treatment engagement:

> It's. It's calm. Doesn't matter who's on there, it's calm… I think they come here and they think "wow, this isn't like any other wing I've been on. This is calm." (Prisoner)

The other two identified peripheral or personal benefits arising from lodgers' presence. One had formed a good friendship with a Samaritans-trained Listener, whilst the second drew extensively on the 'grey market' goods that 'gangbangers' offered:

> I've got respect for people like that. If they're going to help you out I'm not going to take anything off them and do the dirty on them because then that brings trouble to my door… If there is a problem it normally can be sorted at the next canteen. And they'll make sure of that. (Prisoner)

Prisoners on DRW: Ingress, and Egress

At reception, healthcare nurses took responsibility for *all* assessments, and for referrals to CARATs. Whilst this reduced duplication, some difficulties seemed to exist. Two (of three) stabilisation wing interviewees had not been referred, though one of them had been in High Down for three months, and the other was prescribed 90mls of methadone. In the absence of prison security concerns, CARATs then had a full and final say over who was referred to the DRW. A note of caution should be sounded here: we interviewed very few frontline psychosocial practitioners. Insights into CARATs' referral process are concomitantly limited.

DRW referrals were predicated on an assessment of 'problematic' drug use. Perhaps surprisingly, given the prison context, 'problematicness' was by no means defined by offending:

> I: Is problematic [drug use] always explicitly tied to offending?
> S: No. Could be family. Could be themselves. Could be anything.

In and of itself, this seemed to be a critical factor shaping High Down's DRW, whose psychosocial team seemed more intimately aligned with a *client-led* than *offence-led* perspective. Heroin and crack, both strongly associated with acquisitive offending, became incidental to client selection:

> We get *some* opiate users but it's mostly crack. Some heroin. And alcohol. (Staff)

> We've got cannabis, alcohol, crack cocaine. We've got ecstasy users. And interestingly, this morning we only had one heroin user (Staff)

Senior interviewees identified a clear preference for prioritising recovery-oriented resources for those felt to have the greatest *motivation* for change. For frontline referrers, rather diffuse measures of recovery-orientation and client motivation seemingly became key[9]. Thus, *motivated* cannabis users became viable candidates for intensive drug treatment resourcing:

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[9] "I look at the individuals [and] where they want to go in their recovery. It may be just attending meetings… so there's more availability for that [on the DRW]. It may be that they want to do a 12 step programme. They've got that option there. It may be interest in being around like-minded people achieving recovery… Depends where they

> It's irrelevant, their drug choice. It could just be cannabis, it could just be alcohol, it could be crack-cocaine-heroin-everything. It's where they're at with the problems it's causing them. Do they want to change? (Staff)

Opening up work with clients on the basis of *drug-related* need, in a criminal justice context, represents a departure from UK policy between 1997 and 2011[10].

Powder cocaine, cannabis and alcohol users were highly prevalent in High Down's DRW, with few crack or opiate users. Whilst the DRW could notionally house prisoners prescribed 2mg of subutex or 20mls of methadone, just one DRW resident was receiving substitute medication during fieldwork. Contrastingly, virtually all stabilisation wing residents had histories of opiate dependence and ongoing methadone or subutex prescriptions. Thus, the stabilisation and recovery wings seemed to have virtually no established throughput. This presented a particular frustration for Intensive Programme workers, who felt their intensive treatment programme was best-suited to 'hardcore' opiate users:

> I would like to see more hardcore people coming through. The last group, I think we had 3 that were primarily cannabis users. Now I have nothing against that. But… (Staff)

Three additional factors suggested that the lack of 'hardcore opiate users' warrants further exploration. **Firstly**, filling 5A presented a perennial problem; one-third of residents were 'lodgers,' with no identified drug needs. The stabilisation wing housed 180 drug-dependent prisoners, some of whom may have benefited from the DRW's environment and treatment programmes. **Secondly**, Intensive Programme staff felt that some of their current (largely non-opiate) clients were receiving unduly intensive interventions, and might benefit equally from harm reduction advice. **Thirdly**, staff felt that some current clients had over-stated their levels of need, and were actively manipulating the DRW referral process to access a single cell, to comply with a sentence plan, or because they had friends on the wing. Insofar as client need, client motivation and bed occupancy were seen as important, these factors may suggest that DRW selection processes *over*-sampled non-opiate users; and *under*-sampled opiate users.

Prisoners applied for varying reasons. Three represented practitioners' self-motivated ideal:

> I thought "do you know what, I've got to do something about my addiction." So I writ a letter to my probation officer. I found myself wanting to change (Prisoner)

> I just started thinking "yeah, I've gotta change. I've gotta sort myself out." Started putting in for the CARATs courses and then had a friend who done the [Intensive Programme] Programme, and he said how good it was, and I said "right, I'm gonna have a go at that." I just went for every drug and alcohol programme available. I thought "well, I haven't got anything to lose, I've only got something to gain" (Prisoner)

Two prisoners applied primarily to look good for their sentence plan or future parole dates:

> Everyone's come over here to find a way to get out of here quickly [laughing] that's the bottom line (Prisoner)

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wanna go. I would look at what their motivation is and… whether it would make a difference, being on drug recovery, whether that would help that." (Staff)

[10] The 2009 *Drug Interventions Programme Operational Handbook*, for example, clearly states that DIP's remit is to work with *Class A* drug users who are actively involved in offending.

One interviewee qualified this; he had become an ardent enthusiast once he began attending the Intensive Programme, and was an psychosocial peer at the time of interview. A sixth interviewee applied after being threatened with violence on other houseblocks, and hearing good things about the DRW from friends. Violent mood swings following a period of abstinence led a final interviewee to see his cannabis use as a problem, and seek help.

Prisoners' descriptions of the applications process were relatively brief and nondescript[11]. Several mentioned seeing nurses at reception, and follow-up assessments with CARAT workers. Prisoners who arrived after the DRW had been introduced described putting in applications for transfer between 14 days and four months after arrival, and being transferred to the DRW between two and eight months into their sentences.

Anticipated egress from the wing came in a number of forms, though many of our prisoner interviewees had little or no idea where they might be going. Given two were awaiting sentence plans, two had been recalled on license, and six expected to serve at least six more months, this is perhaps not entirely surprising. Nonetheless, three were anticipating transfer to HMP Coldingley's 6-month Intensive Programme course. A fourth was expecting to access a community residential rehabilitation unit in Bournemouth, whilst a fifth hoped to slowly rebuild his life whilst working with racehorses on his brother's farm. The High Down DRW was thus presented as the *start* of a rehabilitative journey for five of our interviewees.

Prisoners' Drug, Alcohol and Treatment Histories

Two DRW interviewees gave indications that they may have started using drugs or alcohol at an early age. One began drinking when he was 'very young,' whilst the other grew up in a pub. Two further interviewees began using a variety of drugs at the age of 14; the rest described picking up drugs or alcohol for the first time aged 15 or older. Only one person situated the roots of his drug use in a difficult childhood:

> I just never got a chance to settle with my life really, and then being away from my home, and my mother divorcing and having a schizophrenic dad… Splitting up from my brothers when I was 17. My mother… had a drug problem. [I] got a job, worked for ten years and just lived by myself. Really depressed (Prisoner)

Perhaps reflecting their non-opiate drugs of choice, interviewees' trajectories into drug and alcohol dependence seemed to be strikingly *social* and, initially, recreational. The rave scene kickstarted the using careers of four interviewees.

Moreover, some DRW residents continued to conceptualise their drug and alcohol use in recreational terms. One interviewee identified primarily as a binge drinker:

> I can go for a week without a drink… but when I do drink I'll drink massive (Prisoner)

A second felt he had been pressured by Intensive Programme workers to own an 'addict' label:

> "Oh, *come on,* admit…" they made me admit I'm an alcoholic. And I'm not really. [laughing] Fucking I'm not. It was one of my assessors, I said well I could go in a pub and

[11] One prisoner's description of his CARAT assessment seemed to ascribe some supernatural powers to his worker: 'Did they do any tests? Any urine tests or anything as part of that assessment?' 'No they take it on sort of a glance. The CARAT workers are there they know just by looking at you what drugs you're on. They're not silly. They're not silly people. They've been around…' (Prisoner)

> have a half and leave… he wouldn't have it. I said "no, I can, you know"… They'll try and brainwash you… But it goes too far sometimes (Prisoner)

Three other interviewees described drug use steadily growing, until they found themselves using heavily and often on a daily basis.

Four interviewees had no prior experience of drug treatment. This included our two primary cannabis users, one of whom reflected on his reasons for not seeking help:

> I was always afraid that [help-seeking] was a weakness. I didn't want to expose myself (Prisoner)

Perhaps more surprisingly, our only DRW interviewee with any history of heroin use had no experience of treatment. Indeed, the only community services voluntarily accessed by our interview cohort was residential rehabilitation, for alcohol (twice) and crack cocaine (once). Otherwise, our cohort's experiences were limited to criminal justice intervention. One primary crack user, and one alcohol and cocaine user, had attended a veritable bevy of criminal justice initiatives, completing 'all the courses' in prison whilst receiving multiple DRRs. Each contrasted their previous efforts to manipulate drug tests and treatment requirements with their authentic engagement with the DRW's regime. Finally, one interviewee described multiple bouts of sobriety, relapse and alcohol detoxification, and multiple stays in psychiatric hospitals. We were unclear whether or not he had attended dedicated drug and alcohol treatment services.

Comparison with the Stabilisation Wing

We interviewed only three people on the stabilisation wing, so are limited to venturing some tentative thoughts. However, three features stood out. **Firstly,** all situated the origins of their drug dependence in difficult situations or troubled home lives:

> My mum started having an affair with this bloke who was a heroin addict. And I used to find needles and all that under the pillows of the sofa and chairs with no lids on them. I still can't get a why I did it, I started taking cocaine, crack. And then I said let me try a bit of that heroin, see what it does. And I liked it. If I'm honest (Prisoner)

Our more 'conventional' stabilisation wing interviewee had begun using opiates and crack cocaine following a bereavement. **Secondly,** two (of three) interviewees had long histories of engaging with treatment services. **Thirdly,** the *nature* of stabilisation wing interviewees' engagement was qualitatively different to that of DRW residents. DRW residents engaged primarily with psychosocial treatment, and stood to lose little but support (and attendant privileges) if they disengaged. Stabilisation wing interviewees were literally dependent on treatment services for continued medication.

Detoxification and Reduction

> I'm seeing men maintaining a drug habit to maintain single cell accommodation. We've got circa 120 men that are taking 2 mils or less of methadone to keep themselves on a script.

High Down's DRW housed virtually no opiate dependent individuals. Our interviewees consequently had scant few experiences of detoxification. The experiences of our stabilisation clients were mixed. Two felt they had to fight to secure a reduction or detoxification regime

> Have I felt any pressure to reduce? Aaaww no, man. I've felt pressure to keep taking it (Prisoner)

Though detoxification and reduction were relatively absent from our prisoner interviewees' accounts, they played a prominent role in those of our professionals. From the top levels of High Down's management structure, there was a strong drive for full detoxification as part of prisons' *moral* agenda, particularly for repeat offenders:

> Very personally, I want people off drugs… Should we be giving people a choice in custody about whether they want to stay on drugs or not? Morally, I think not. Morally I don't think that's right. Morally, I think taxpayers would expect me to be getting people off drugs not keep them on it (Staff)

> We should be working towards getting people clean. It's pointless just maintaining people. We're reducing people then we retoxify back into the community (Staff)

Despite this enthusiasm, very few prisoners on opiate substitute medication were apparently achieving total abstinence.

A lack of full detoxification was felt by several staff to be *the* main reason that the DRW acted as an anything-but-opiate treatment unit. Prisoners' reasons for *not* detoxing were framed in one of three contexts. **Firstly**, as blunt and wilful intransigence:

> They're quite happy with their comfort blankets on the stabilisation unit, and see that moving to a DRW means they have to take responsibility and look at a reduction plan

> Clients on methadone and subutex aren't challenged, aren't… open to engagement… and motivated to address any issues, but just want to come in, get their 2 mils a day, sit in their cells, not go to work, not get in employment, nothing (Staff)

Secondly, because of the prison's residential structure. The only way of *guaranteeing* single cell accommodation was to be in receipt of methadone or subutex, thereby securing access to the stabilisation wing. For those who started with an opiate substitute prescription, detoxifying and moving to the DRW offered a more precarious existence. Abstinent individuals could be moved to any of the older houseblocks if they completed the six-week Intensive Programme, or breached the DRW's rules. **Thirdly,** because of the lack of detox-focused psychosocial support. Two interviewees felt that intensive, targeted detox groups might significantly increase the number of prisoners attaining abstinence.

Motivations

> It doesn't matter why people come to recovery, as long as they come here they can see the benefits… I've always believed if the person *stays* for the right reason then that's a result (Staff)

> One of the reasons he joined is because it would look good on his sentence plan. But it's like the penny dropped for him. This is actually going to help me (Staff)

Prisoners' motivations for coming onto the wing came in three main forms. **Firstly**, there were the conditions of the wing, as previously described. **Secondly**, prisoners might be motivated by a desire to perform for the parole board. As the lead quotations for this section suggest, this was not necessarily seen as a bad thing by staff.

Thirdly, there were *external* motivators: factors outside the prison's control. Contrasting with other pilot DRWs where such justifications were the norm, only one High Down prisoner cited 'maturation,' emphasising that he was 'sick and tired' of the stresses of daily heavy or dependent drug use:

> I'm 29, I was sick and tired of coming back to prison… the buzz of doing the drugs has gone for me now. It's not fun no more (Prisoner)

Perhaps because of their *relative* social conformity (for drug dependent prisoners, at least) many interviewees described wanting to sustain or develop family ties which had not been severed, even if they were painful, complicated and confused:

> I want to do everything in my power, it's my time, I can't keep doing this, I've got children that are coming of age. They're able to distinguish between dad who is a pisshead or not. So it's about time that I pulled up my socks and sorted it out (Prisoner)

> Drugs. I made a point to be abstinent when I came here because I've got kids. I need to do it for my kids. I'm missing two years of my children's life. Because of twenty minutes of pure stupidity. I'll never, never, never, never make that mistake again (Prisoner)

> It was the hurt about what I've done with my wife and my kids and… [indicating a picture on a lanyard] they're my grandkids. I thought of them as my higher power. I've let my own kids down in a lot of ways but I'm not going to fail *them* (Prisoner)

Family (and children in particular) powerfully grounded many DRW residents. For several, partners also offered vital emotional and pragmatic aftercare support.

Provision

I think it's just being able to offer the clients as many support bases, treatment programmes, available choice, as you possibly can. If I can have BSR, SMART, [the Intensive Programme], NA, AA and CA meetings up there, great. We had deep tissue massage therapists, yoga, acupuncture… (Staff)

We had a philosopher come in… Not everybody wants to be a painter, decorator, whatever. We get them to do other things, use their brain more, think about long term goals (Staff)

As these quotes suggest, High Down sought to offer DRW residents a wide and eclectic range of treatment options. BSR and the Intensive Programme formed the mainstay of drug-focused provision. Each had very different entry requirements. BSR operated prison-wide[12], working with clients on any level of medication. The Intensive Programme operated exclusively on the DRW, working only with people who were fully drug abstinent. The programmes also varied considerably in intensity, and required client commitment:

> The Intensive Programme is very rigid and very structured. The building skills for recovery… it's very structured in the way that it has to be delivered, and there's core elements. But. It's not as intense. The Intensive Programme is 60 sessions over 6 weeks.

[12] We received conflicting reports about BSR. Some interviewees were clear that it was available to prisoners housed on any wing. Others were clear that this had originally been the case, but that access to BSR had been restricted to the DRW in order to offer a cognitive-behavioural DRW treatment option.

> It's mornings and afternoons Monday to Friday. Building skills to recovery is a minimum of 3 sessions per week, maximum of 4 and is delivered over 5 weeks (Staff)

In addition to these structured programmes, two DRW officers had received SMART training, and hoped to develop a programme of SMART groups for DRW residents.

Whilst two prisoner interviewees mentioned BSR, they spoke far more volubly of attending 12-step fellowship groups, and of their experiences of applying to or completing the 12-step Intensive Programme. This may have reflected a degree of selection bias; whilst BSR was available throughout the prison, the Intensive Programme constituted *the* main additional treatment offered on the DRW. People applying to the DRW might thus be reasonably expected to be keen about 12-step treatment.

Contrastingly, staff were keen to emphasise that no intervention could work for everyone, describing a wide range of treatment options matched to a wide range of needs. Though many professionals took a neutral stance, three voiced preferences for specific modalities:

> [CBT] skims the surface. It's very much "ok, yes, we've got 90 through there, excellent." Whereby 12 step is looking at the emotional side, really looking at the heart, and giving them the tools to actually survive out there. And the network and follow-up (Staff)

> [12-step groups] think about a higher power, cling onto something to help them through. SMART recovery is non-secular. It's purely, like, "I'll do a cost benefit analysis. How much do you drink, durdurdur," and then right, "what are the outcomes of this? Right, drink, financial, less money, loss of memory, whatever it is. How does this impact on you, the people around you?" And it's more a nuts and bolts things where a lot of people can say "ah, ok, it's that." A logical progression (Staff)

That staff voice preferences for *different* treatment modalities may have reflected the health and diversity of High Down DRW's treatment environment.

The Intensive Programme

This section is split into four subsections, detailing interviewees' perspectives on the Intensive Programme's selection criteria, provision, challenges faced, and outcomes.

Selection was relatively straightforward. CARATs referred clients with identified drug problems, who might then become part of a 12-person treatment cohort. Abstinence from all drugs and related medication constituted a *sine qua non* of Intensive engagement:

> First thing is that they're abstinent. Then they can look at what role they want to take, and over the 6 weeks we link in drug use, crime, all sort of different factors (Staff)

As noted earlier, Intensive staff expressed some concerns that selection processes should be adapted, to ensure that more 'hardcore' heroin users and fewer cannabis users were referred.

The **process** of the Intensive Programme can be subdivided into structural and relational processes. Structurally, the programme consisted of six weeks of full-time groups with an additional requirement to attend fellowship meetings (NA, CA or AA). In Intensive Programme

groups, clients were taken through Steps 1 and 2 of the twelve-step process[13]. Two prisoners were particularly appreciative of the insights this gave them into their using:

> The first step… that's the hardest step. Meeting your powerlessness. Unmanageability. And then you look at your life, and it's like… yeah, that's right, really (Prisoner)

Prisoners were also appreciative of the programme's coverage of childhood and adult relationships, and the genesis of their dependencies:

> I loved it. I see it as a life saving thing… I really can't express how much it's done for me. I said it on my review. I said I felt like it'd pulled me brain out washed it and put it back in. It's changed my way of thinking about life. A lot of guilt. And I found it very hard because a lot of it is very emotional, digging deep inside yourself, ain't ya? (Prisoner)

> It's certain situations, like I've always felt resentment for my mum. Because where my older brother wanted to live with her when my parents split up when I was give I wanted to go and live with my dad. And I always felt that my mum resented me for that. And yet I didn't see it like that until doing the [Intensive Programme] (Prisoner)

In any context, exploring issues such as childhood abuse puts a weighty onus on practitioners to ensure that they are acting ethically and keeping clients safe. In a prison context, such issues are intensified. Strikingly, none of our interviewees described anything but feelings of admiration and safety for the running of the group. Despite initial reservations, one manager also described the psychosocial contractor's training and supervision programme as 'excellent' and 'intense'.

Prisoners were particularly effusive about two further aspects of Intensive Programme delivery. **Firstly**, the treatment was delivered *by people with histories of drug dependence*:

> Listen. Shall I tell you why the Intensive Programme, for me, works? Because it's run by drug addicts. At the core of [Psychosocial Contractor] is experience in going from a crack addict who is kicking down his mum's front door to steal her jewellery so he can spend it on crack, or someone who's been whoring themselves out for a ten pound rock. They have engaged within the 12 step process. Experienced a complete paradigm shift in their own thinking… they're talking from experience that an academic can never understand (Prisoner)

Secondly, treatment cohorts came to trust one other, offering a source of ongoing support.

> I've met a few good people on here that truly I class as my friends, from being on the course. Because… how honest they were about sharing, how they manipulate people and basically, excuse me, take the piss out of people. And it made me realise, you're not this different. Their honesty has made me be honest. Which is a good thing. And now if I've got a problem I ask, I ask for help (Prisoner)

Excellent peer and professional support were thus seen as mainstays of Intensive provision.

One professional voiced some hesitancy about Intensive Programme **outcomes.** Even his account had strong positive features:

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[13] Step 1: we realised that we were powerless over our addiction, that our lives had become unmanageable; Step 2: we came to believe that only a power greater than ourselves could restore us to sanity.

> I'm not going to tell you the Intensive Programme is an unqualified success. It doesn't work for everybody. But in my experience I've seen a lot of people change (Staff)

Other professionals were unwaveringly positive, though the most powerful descriptions came from prisoners themselves:

> My idea was once I finished there I would be promoting it, I would be going around shouting it to the rooftops. Because it really worked for me (Prisoner)

> The [Psychosocial Contractor] programme is the first programme for alcohol and drug abuse that I've seen and've thought "wow, this is excellent." The [Psychosocial Contractor's] programme was absolutely amazing. It changed my outlook on life completely (Prisoner)

> Ah it's brilliant, brilliant, absolutely brilliant… one of the facilitators challenged me, because I never used to identify my emotions… But if you do start feeling like you're gonna cry be a man and cry you know? Can't credit it enough to be honest (Prisoner)

> I never used to talk about things, I always used to bottle things up and go "ah, yeah, I can do it by myself." But being on the [Psychosocial Contractor's] programme has helped me be able to talk about things, not bottle things up. It's been a big weight off my shoulders (Prisoner)

Two **problems** were noted by our interviewees. Firstly, two staff seemed hesitant about the reliance of twelve-step treatment on the word 'God':

> The thing that these guys struggle with, is the initial thing of surrendering to a higher power. But that's the nature of the 12 step… it's religious based. I think maybe if they updated some of the terminology then it would be more appealing (Staff)

Though selection bias should be borne in mind (i.e., few prisoners who *did* have a problem would have applied to the DRW), no prisoners raised 'the God word' as a concern. Several described using their 'group' as a non-metaphysical higher power.

Secondly, prisoners were concerned that they were required to give up paid employment to attend the Intensive Programme, with no assurances of work when treatment concluded:

> I'm supposed to give up work [but] I wanna keep hold of my job. I've spent 12 weeks behind a door. I want something to do once I'm out (Prisoner)

A second interviewee had already given up his employment, and was awaiting a space on the Intensive Programme. He described feeling powerfully frustrated by the lack of gainful activities available to him.

Life After The Intensive Programme: post-programme aftercare support

> Endings are always very difficult, lots of people can't and either try to end it or having to eff it off. We try to see whether people can end with love. Very difficult. You try to finish with your wife and you're, like, "I love you goodbye," it don't happen that often. It's like, "you bitch…" So we talk about endings, but it's difficult because I do recognise that there's not a lot that we can do. They get quite attached to the structure [and] to us. They bond with the group and

when that finishes they're often left on their own. Although we talk about it, it still don't stop them from feeling it (Staff)

For six weeks, prisoners' daily lives would be consumed by treatment programmes and in-cell homework. When this ended, it seemed uncertain what prisoners would progress *to*. The structure of this section reflects two possible answers: the official response; and prisoners' lived experiences.

A 'recovery officer,' described official post-Intensive Programme aftercare thus:

> Once they actually finish the course they have 6 weeks where they can stay open, they can attend cocaine anonymous, narcotics anonymous. They can also speak to the [Intensive Programme] peers… We sit down with a group of 6 to 8 people and talk to them. There's no point, "right you've done a course, now on to the next one." I think people need time to sit down, talk to other people who share the same experiences (Staff)

We were unclear whether or not *all* Intensive Programme completers were unlocked during the day, or if this had been a discretionary response implemented by a couple of willing officers. Certainly, one prisoner interviewee seemed to think that he had been unlocked for discretionary, rather than policy, reasons.

Irrespective of how widely spread this open door policy was, the end of the Intensive programme constituted a very radical drop-off in activity and support. In this light, prisoners' *experiences* of aftercare seemed particularly important. These were diverse. We spoke to one evangelistic psychosocial peer, who could not have been more positive about the depth and intensity of aftercare. Three further prisoners felt that aftercare had been ample:

> Even though the course has stopped the help hasn't. I still see the facilitators on the wing on a day to day basis. If I do feel down I can go and approach them (Prisoner)

> I finished the [Psychosocial Contractor's] course 2 weeks ago, I've had aftercare… with my CARAT worker and [Intensive Programme] facilitator. It's been quite good (Prisoner)

However, two others described more difficult experiences:

> They don't give you the aftercare they claim to. When you ask for help I think they're going through the motions. Their own world. They're not as helpful as they make out (Prisoner)

> I: How did it feel when it came to an end?
> P: I felt a bit lost. Yeah, I felt a bit lost. I missed it straight away.

It might be most appropriately surmised that prisoners with different needs had different experiences of Intensive Programme aftercare. This may merit further exploration in later studies.

Mutual Aid / Peer Recovery / Fellowship Meetings

All people attending the Intensive Programme were required to attend fellowship meetings. The DRW held three each week: cocaine anonymous (CA), narcotics anonymous (NA) and alcoholics anonymous (AA). We found it difficult to identify how widely attended these groups were. Seven DRW interviewees described regularly attending two or three fellowship meetings

each week. If this was the case, then we may have interviewed a particularly motivated subset of DRW clients, given one prisoner's estimate of (at most) 36 fellowship attendances per week:

> I would say that there is a minimum of 6, a maximum of 12 people in each group (Prisoner)

A second interviewee suggested up to fifteen people attended NA and CA each week. Even this suggests that we interviewed about half of all Fellowship attenders, and a very small proportion of fellowship non-attenders.

I asked all prisoners who identified themselves as regular twelve-step attenders whether or not meetings were truly confidential. All trusted the process; none knew of any breaches of confidentiality; all felt willing to share even intimate and personal information:

> I: And what's said in the room stay in the room?
> P: Yes [emphatic]
> I: And that really does work?
> P: That really does work

As fellowship meetings were chaired by visitors from the community, they also offered enhanced 'through the gates' support. Four prisoners were seeking community NA sponsors, for post-release support. Seven stated an intention to continue attending meetings.

Violence

DRW is safest. For assaults, things like that. Stabilisation unit is second safest (Staff)

You have that [relaxed] atmosphere on a wing. You don't have as many fights [or] thefts (Staff)

The last time we had [a violent incident] here was probably 2, 3 months ago (Staff)

There's no problem with bullying. That's all for the baby wings or the little young offenders (Prisoner)

Bullying on the DRW, the amount of self-harm, the amount of assaults, is a lot lower than the rest of the prison. There's a much more supportive environment on there (Staff)

As these quotes suggest, both prisoners and professionals felt that bullying was close to non-existent, with prison officers' relaxed style reducing the prevalence of control incidents.

Drug Availability

It's a standing joke, there's more drugs on the DRW than there is on the other wings. But I don't know how true that is (Prisoner)

Of course they get in. You are always aware that it could be got if you wanted it (Prisoner)

I heard about it a while ago but it's elusive. Whether anyone's ever got any is another thing (Prisoner)

Five prisoners felt that drugs were as available or more available on the DRW than on other wings[14], though only one identified that they had seen or used an illicit substance (cannabis, sourced whilst on houseblock 4). One had also resorted to brewing his own hooch, being caught in the week before fieldwork. Far more common were rumours, hints, and intimated supplies. Three interviewees felt that they would be able to find drugs with relative ease; but none had tried.

Professionals' accounts contrasted with those of prisoners, identifying that the DRW consistently had the lowest levels of drug finds and violence prison-wide. Each of the prison officers we spoke to emphasised the role of dynamic security in limiting drug availability: gathering information informally by engaging with and relating to prisoners. The wing's recovery focus was also thought to help, as prisoners were willing to engage with prison officers and to divulge information about potential threats to the wing's recovery ethos.

> I can't say that I'm running a group of informers because that would be against Home Office protocol. But snippets of information comes to our light (Staff)

Insofar as there were any positive tests and drug finds on the DRW, they tended to be for cannabis. One officer felt that the DRW's main supply route came from other wings, with prisoners exchanging drugs whilst passing one another on 'free flow.'

Additional Services DRW Residents would Like to See

> I: So is there anything else that could've been useful, that hasn't been on offer?
> P: Not that I can think of. Because I can't really criticise anything

DRW residents were strikingly content with levels of provision and support on the DRW. Our most critical prisoner felt that access to expert counselling and mental health services could be improved, as could access to prison jobs[15]. Employment was a prominent theme for a second interviewee, too, though specifically in the run-up to release:

> I would like more help with employment. When I leave, I want a job (Prisoner)

Two prisoners expressed a desire for more association time, particularly over holidays and weekends. One wanted a widescreen TV.

Prisoners' Attitudes to Staff

At the inception of the DRW, officers were selected on the basis of their enthusiasm for and commitment to drug work, and their willingness to engage in education and training. Since then, several officers had moved on and their posts had been filled with uninterviewed staff:

> We've now got [some] new officers that have no understanding of substance misuse, aren't particularly interested in substance misuse. Don't want training… they're not

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[14] For example, 'the people who run this they're just gonna have to accept that there's gonna be drugs in prison and that's all there is to it. You know. It's just not gonna stop. But how people deal with their drug addiction can be changed. I would, I would have a system whereby you know the majority of the wing if not everyone is committed to drug recovery' (Prisoner); 'it doesn't matter where you go. It doesn't matter where you go. You could be on houseblock 1, 2, 3 4, 5, 6 wherever you are. This is pirson. People are going to break the rules unfortunately. It just depends on who you are and what you want to do' (Prisoner)

[15] This sentiment was shared by CLARIFY, who found themselves unemployed after completing the Intensive Programme. See PAGE NUMBERS

> interested in the reasons for the clients' offending [or substance use]. And don't have an awful lot of understanding or empathy (Staff)

Whilst staff noted such variations in officer motivation, prisoners were less qualified in their praise. Wing officers were characterised as respectful, helpful, friendly and responsive:

> They seem to do a lot more for you. I've asked officers for a load of different things and it happens. Whereas I've asked for it when I was on houseblock 6 and you've got to keep on and on and on (Prisoner)

> A coupla days ago we all sat down and had a game of Trivial Pursuit with the officers. You can talk to them all over here. Which is a good thing (Prisoner)

> Respect, they give you respect. They don't fob you off. If they can't do something they'll tell you. They've got a good respect and understanding as well towards the addiction side. And the officers come in to graduation and that. It shows they care (Prisoner)

Four interviewees also appreciated not being treated like 'criminals' or 'addicts.'

Fewer prisoners commented on their relationships with other professional groups. However, nearly all such comments were positive. CARAT workers 'put a lot of effort in,' 'talk to you properly', and were generally liked and appreciated by their DRW clients. Intensive Programme Staff were greatly appreciated, as were staff delivering work and education. Our prisoner interviewees' only reservations involved two complaints about non-responsiveness: one relating to 'national careers,' and one relating to mental health inreach. In each case, prisoners felt as if promises had been made that professionals had then failed to deliver.

DRW: Reputation in the Wider Prison

Staff

Staff who commented on professional attitudes towards the DRW in the wider prison tended to be sceptical. One staff member noted that it was seen as an 'easy wing' for prisoners; two others felt most prison officers were wary of the DRW's agenda.

> [It's a] daily struggle. If I'm honest if you ask around the jail it's probably just seen as the junkie unit along with houseblock 6 (Staff)

These are limited and tentative thoughts, drawn from a subset of interviewees who felt sufficiently strongly about the issue to venture a comment upon it. However, it seems striking that two messages, officers' ignorance of and hostility towards DRWs, resonated across our fieldwork sites. They may merit further exploration.

Prisoners

> It was renowned for being a better wing. Cleaner. Better environment. Wing to be on (Prisoner)

> They all want to get in here (Staff)

In several other prisons, DRWs were deeply stigmatised, with labels such as 'smackhead' or 'baghead' attached to residents irrespective of their drug of choice. The message from High Down could not have been more different. One interviewee referred to the DRW as 'the

enhanced wing,' whilst a second was clear that '*I* don't feel any stigma'. Insofar as there were any difficulties, they seemed to centre on a lack of awareness of the DRW and its role. Interviewees on the Stabilisation Wing, in particular, seemed to have little understanding of the DRW's role (or even of its existence).

Houseblock 5's single cells, increased hours unlocked, and generally improved living conditions were identified as key factors shaping the wing's reputation. Perhaps more importantly, stigma seemed to follow (medicated) heroin users, and consequently seemed to be attached primarily to the stabilisation wing. Three stabilisation wing interviewees surmise:

> If people ask me what houseblock I'm on, I do say 6. As soon as you say 6, there's a… they're like fffuuuu. Houseblock 6 is the junkie wing… You're a smackhead (Prisoner)

> They look at you like you're a druggie. Because it's true, ennit. It says stabilisation bloody wing outside. Fucking. On the wall there (Prisoner)

> It's smackheads. Dirty scum. You're junkies (Prisoner)

These accounts could have been drawn almost *verbatim* from interviewees in medication-focused DRWs elsewhere.

DRW Residents: 'In Recovery?'

Understandings of 'recovery' came in two forms: professionals' perspectives on whether the DRW *as a whole* was 'in recovery'; and individual interviewees' accounts of whether or not they were in recovery.

Professionals referred to 'recovery' as engagement, abstinence, and as a journey. They tended to divide the DRW into recoverers and non-recoverers, often predicated on the measure that was most visible to them: engagement. Given approximately two-thirds of the wing were not engaged with treatment at any one time, this tended to lead to cautious estimates of overall levels of recovery. Governors, in particular, were keen for more drug testing; whilst psychosocial interviewees voiced concerns about the proportion of wing residents who they felt were 'in denial'. One officer felt this mixture of recoverers and non-recoverers was particularly difficult for those who were making an effort, as they could find themselves surrounded by people who were 'openly using.'

We asked eight DRW interviewees if they were 'in recovery.' All felt that they were in recovery, with one exception:

> Would I say that I'm in recovery? No, I'd say I'm recovered (Prisoner)

Five operationalized 'recovery' first and foremost in terms of drug and alcohol use:

> Recovery means being drug and alcohol free for myself (Prisoner)

> Drugs is where it starts. And then it becomes other things. So if you get rid of the things that started it… you'll get clearer and you'll sort it out (Prisoner)

Sometimes building on this, six interviewees situated recovery in terms of broader themes.

> It means I'm trying to make an effort about doing something with my life (Prisoner)

> I sort of see [recovery] as putting me old life behind me. I feel like I've started again. I'm just looking forward to my new life. I really am. I'm enjoying my recovery (Prisoner)

For two other prisoners, recovery meant 'carrying the message to others,' and never returning to prison.

Interviews with Staff: Staff Characteristics

In the course of our three-day rapid assessment, we interviewed ten staff. Prison staff were very well represented in this sample, with one frontline officer, two recovery officers, one supervisory officer, one custodial officer, and two governor grades. Only one officer had served under ten years, with four identifying historic interests in drug dependence and treatment. We also interviewed three people with roles in psychosocial services. Each had delivered drug treatment for at least eight years.

The DRW Officer's Role

> We want people to do well. Not because it's going to be a key performance indicator, but because that's the way that it is (Staff)

> What my staff do is exactly what prison staff should be doing. They can do the control bit they can be approachable, they can do it all. You wear many hats during the day, and the hats are interchangeable depending on the way somebody's behaving (Staff)

Identified differences between DRW and other officers centred on three main characteristics: a 'soft power' approach to control; the need for flexibility; and the need for authentic relationships, underpinned by a genuine motivation for recovery-oriented work.

In terms of 'soft power,' officers were aware that they were managing the wing in an unusually non-confrontational way. They presented this as a means of securing control.

> It's the way you use your authority. You say. You explain. In prison there's so many people that have some sort of a learning difficulty, the numbers are something ridiculous like 60%. So you've got to try different tacks. Shouting in people's faces, that's probably what they've been used to all their life. But when you sit them down and speak to them, say, you know "I've told you shouldn't smoke on here. Because…" You're trying to give them the idea that, look, if you cant get disciplined in a prison how're you going to succeed outside? (Staff)

Time and time again, prison staff spoke about the key importance of relating, communicating, and making time for prisoners in difficult situations. This, in turn, was seen to be associated with low levels of violence on the wing, and improved intelligence gathering.

This perhaps related to the second characteristic: flexibility. Officers might have to switch between roles very quickly, as a recovery officer described:

> You go from rolling around the floor with a prisoner you've been fighting with, to 10 minutes later talking about the fact that his wife's left him and he feels like using again (Staff)

Officers' flexibility was supported by a shared motivation, even passion, for DRW work:

When you join a job like this you join it for a reason… to make a difference (Staff)

I believe in what I'm trying to achieve. I didn't just want to be a turnkey I wanted to do something in additional to normal residential duties… I feel passionate about it (Staff)

I wanted to make a difference… I do like trying to, trying to mould people [laughs] (Staff)

Each was consequently willing to invest *emotionally* in DRW clients, and to offer emotionally astute responses to difficult and challenging situations.

Description and Development of the DRW

We almost got criticised for setting up a 12 step unit. Very heavily criticised (Staff)

When the DRW idea first arrived in High Down, the governing governor asked managers to develop an operational model that fit well with High Down's extant regime. In consultation with the SMT, a possible framework for provision began to emerge. Initial calls asked for DRWs to focus on prolific offenders serving sentences of under 12 months. However, problems with fulfilling these criteria led to alternative suggestions:

We didn't have the *population* to focus on those types of people. I don't think we could even fill up *half* the wing. So what we went for in the end was 30 prisoners on there as a stabilising population. Cleaners, full-time workers, more trusted people than the average prisoner. And then 60 people who were… on the road to recovery (Staff)

The arrival of the DRW was also seen as a means of opening up treatment options to new populations of prisoners, particularly those who did not use heroin nor crack. Clients' own understandings of *problematic* came to define the DRW's selection process, with levels of medication (less than 20mls of methadone or 2mg of subutex) constituting the only formal selection criterion. As described earlier, this had (perhaps inadvertently) created a DRW that held very few opiate dependent prisoners.

Managers were keen to ensure that the DRW offered additional 'recovery' provision despite the DRW pilots' 'zero resourcing' focus. The solution involved re-negotiating the prison's psychosocial contract to support a new, DRW-only day-treatment programme. Five full-time CARAT posts were dropped through natural wastage, with five full-time Intensive Programme workers employed in their place. Once the Intensive Programme was established, it acted as the mainstay of DRW provision. The wing thus effectively developed a 12-step orientation, to the concern of some managers and staff. Managers consequently sought to rebalance the wing with an additional, wing-specific cognitive behavioural option:

One of the things we did was build it in… that if they wanted to access building skills for recover they would move onto the DRW (Staff)

This had, one manager thought, created a 'more balanced [treatment] dynamic on the wing.'

Ongoing developments: benchmarking

The process is very algorithmic. They turn around and go "you've got 181 prisoners in there. Supervision in a Cat B prison is 1 to 30, divide 181 by 30 gives you 6 and a little bit" (Staff)

People will lose their jobs along the way. Let's not be shy about that (Staff)

We're waiting for the fallout. Of a thing called ZEBRA (Staff)

Over the last two years, English prisons have undergone two major reviews of staffing, pay and conditions. Fair and Sustainable was developed in discussion with the Prison Officers Association, and sought to implement new working structures throughout the prison estate. The POA identified that, from their perspective, the main rationale for supporting Fair and Sustainable lay in its potential to reduce contestability:

> In the current economic climate, the POA cannot allow public sector prisons to be easy targets for the Coalition Government and its Competition Strategy for Offender Services, which was announced by the Secretary of State for Justice in July 2011. As a responsible Trade Union, we must give ourselves the best opportunity to protect and promote the interests of our members. The lessons learned from the privatisation of HMP Birmingham must not be lost on this Union. We must have a public sector service which has the ability to compete with private sector companies. These proposals go a long way in achieving this aim, by providing a long term. sustainable workforce (POA 2012:5)

Fair and Sustainable was originally envisaged as a long-term working model. However, within a year of its rollout, 'competition benchmarking' was introduced with the intention of making prisons even *more* competition-proof. The POA surmise:

> The Public Sector benchmark involves using the Zero-based Resource Approach (ZeBRA) based on a core day established for competition and an optimum staffing complement of all grades. It also involves providing a regime by identifying the best possible response to the commissioning intentions document through the blend of work, learning and skills and resettlement services with the constraints of each prison's build environment and facilities and in response to its prisoner profile (POA Circular 1 / 03.01.2013)

High Down was one of the earlier prisons to undergo competition benchmarking. By the time of fieldwork, the prison had been fully benchmarked and had received the benchmarking team's report. This had not been a positive experience for the DRW; managers described feeling as if their input and the wing's needs were had been substantially ignored. Prison-wide, large-scale redundancies were expeccted. In order to make efficiency savings, BSR would cease to be delivered and officers' relational work would be curtailed:

> [Benchmarking] will be based around a group of staff that just…. Follow prisoners basically. There won't be any great personal officer work that goes on. There won't be any great interaction with the prisoners on the DRW. I can see all the SMART stuff, discussion groups... ppppwwwwwwoooo. Thing of the past. I reckon (Staff)

High Down staff were in the process of submitting a list of concerns to the benchmarking team, with the hope of securing changes that might allow continued delivery of services. How the process played out remained to be seen.

Ongoing Developments: the move to houseblock 4

My mum always used to say "if you put people in a pig pen, they'll act like pigs." So that concerns me about houseblock 4. They need to spend money on it. Make it habitable (Staff)

Plans were afoot to move *all* prison drug-related provision to a single houseblock. Houseblock 4 held three spurs:

> If you require some form of detoxification or stabilisation you'll go onto A spur. Once you're off that you will then go onto B spur where you'll undertake your Intensive Programme type work. And we'll use the guys that're now drugs free on C spur to support the others (Staff)

The greatest *apparent* obstacle to this plan lay in the number of drug-dependent prisoners housed in High Down during fieldwork. Houseblock 6, the stabilisation wing, held two wings of 90 people. Houseblock 5 held approximately 60 DRW residents. Houseblock 4's spurs held 60 people each. High Down's extant operational *need* thus equated to 240 beds, whilst the new unit offered only 180. The solution to this was felt to lie in the conditions of houseblock 4. Whilst some prisoners were thought stay on houseblocks 5 or 6 because of their enhanced conditions, houseblock 4 was widely described as grotty, unpleasant, and in serious need of refurbishment. Prisoners were reasonably expected to seek an escape from houseblock 4 as soon as possible, motivating opiate users to progress through the drug recovery system:

> We've got people [on houseblock 6] that are sort of maintaining themselves on small doses to be able to stay there. So very soon that's going to move to houseblock 4. Not so nice. Which will encourage people to detox quicker and not maintain themselves for a period of time because they'll want to progress to a nicer houseblock… It gives them an incentive to move towards putting it down (Staff)

> We anticipate that a lot of them will come off their medication (Staff)

It should, perhaps, be noted that the DRW's *current* non-opiate clientele seemed to have little role within this new system. Staff were also concerned that people might be deterred from applying to High Down's envisioned DRW. As one prisoner noted,

> I'll take meself off recovery if it means I can stay here (Prisoner)

Level of Separation

At the time of fieldwork, the DRW was emphatically not a silo. High Down acted as a working prison; most DRW residents went out to work or education each day. Three professionals were against siloisation, for both pragmatic and principled reasons:

> I think it's important that… they experience what their life will be outside. In the real world your next door neighbour may be out front having a drink or smoking cannabis. And I think you have to try and create that inside the prison as well (Staff)

> We wanted a unit that would be completely self-contained… separate exercise, staff escorting prisoners to visits, a separate aisle in the visits hall. It's not sustainable (Staff)

Three professionals were equally *for* the DRW becoming a discrete unit.

> If you want to help facilitate change, a part of that is making the environment safe and making the individual feel safe. Even out in society, if you're trying to get somebody off of drugs the last place that you want to take them is a drugs den… (Staff)

> I would like to see the drug recovery unit be a discrete unit. While people are still vulnerable and we're allowing them to mix with drug dealers and people that are openly using, we're setting them up to fail. Why wouldn't they use? (Staff)

Across pilot sites, the issue of siloisation evoked considerable professional passion.

Drug Testing, and Positive Tests

Across the prison, a random selection of prisoners were mandatorily drug tested each month, with positive tests being sent for outside adjudication. Possible outcomes included loss of privileges, and extra days.

Prisoners on the DRW were also subjected to monthly (or, for Intensive Programme clients, weekly) voluntary drug tests. Professionals were positive about VDTs as a motivating factor driving clients' recoveries, but the *frequency* of testing presented some concerns. Although monthly testing was slightly unpredictable, following a test prisoners knew they would not be tested *again* until next month. They were consequently still able to identify safe times to use. Three prison managers thus queried whether anything particularly meaningful could be inferred from the DRW's testing regime[16].

Prisoners held varying views about what might happen should they provide a positive VDT:

> They either throw you off the wing or they give you a warning (Prisoner)

> If you mess around you're off the wing. But recently... they're letting them stay (Prisoner)

> I suppose if you took 10 and you were dirty on all 10 I suppose obviously they've got to bring some sort of thing in. I don't know (Prisoner)

None of our interviewees had failed a VDT. One had failed an MDT whilst on another houseblock, shortly before his transfer to the DRW.

The DRW compact notes that the DRW does *not* operate on zero-tolerance principles, a message that was important to both professionals and prisoners. Responses to first positive VDTs were consequently framed in supportive terms. CARATs would deliver 1-1 sessions and harm reduction advice. At the same time, a multi-agency case management board would agglomerate, sharing information to assess the client's levels of engagement and recovery orientation. Those who were thought to be working well would be given another chance; those whose case files evidenced consistent disengagement would be moved to another wing, with the potential to reapply to the DRW in several weeks' time. One group was excepted from this process. DRW 'lodgers' were given no strikes; any positive tests resulted in their immediate removal from the wing.

Relationships between Prison Agencies

> In order for people to get into recovery… people have to work together… It was really amazing to see that prison officers *aren't* just here to turn a key. There are some genuine officers here that really wanted to help (Staff)

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[16] e.g. 'For a client to say that he's drug free and to give me a certificate to say that he's produced 6 tests in 6 months doesn't really tell me anything. If you're going to use it properly you need to be testing every 3-4 days.'

We just have a very good working relationship with everybody (Staff)

All following comments are circumscribed by the limits of our interview sample. We spoke to just three psychosocial workers, and no clinical staff.

Relationships between prison agencies were *generally* presented as outstanding. As one manager surmised, the 'most impressive element' of the DRW was 'the integration between all of the staff'. Healthcare and psychosocial workers were felt to work superbly together, though two staff desired slightly improved information flows from healthcare to CARATs. Relationships with the psychosocial contractor were mostly described as excellent, too, though again interviewees pointed to two possible areas for improvement. Intensive Programme staff felt that CARATS could be better-informed of the programme's remit, to bolster referrals of 'hardcore' heroin users. One officer also described shortfalls in communication: 'The [Psychosocial Contractor] never really tell us anything about [the Intensive Programme] or how the group's going.'

Relationships with prison officers on the DRW tended to be seen as good. The most consistent narrative about officers on other wings was one of variation. Some officers were responsive and engaging, others were 'anti-therapeutic,' harsh, or controlling:

> Drug using behaviour and drug seeking behaviour on a wing is something that officers can identify and want to flag up and take… punitive action… (Staff)

> For a lot of officers and their whole way of looking at things the whole way of thinking about things is about control… I can name a couple of officers who don't believe prisoners are capable of change, they're just not capable of it (Staff)

> The majority of the officers we have a good rapport with. But there are some officers that seem to see us as like I say as do-gooders. And they're their ethos their main concern at times is about security (Staff)

These concerns seemed noteworthy; however, it may be worth bearing in mind that for the most part, they centred on officers who were not based on the DRW.

Relationships with External Agencies (Through the Gates Support)

Through the Gates: Professional Perspectives

> You've got The [Psychosocial Contractor], you've got SMART recovery, you've got Lighthouse [mentoring]. You've got DIPs… But nine times out of ten it's house, money, isn't it (Staff)

High Down had one of the most well-developed and comprehensively integrated throughcare and aftercare systems we saw in any of the four DRWs we visited. At the core of this model lay a 'High Down directory,' detailing every available element of throughcare and aftercare support that prisoners might need whilst in the establishment. The directory was divided into sections focused on discrete resettlement pathways:

> Accommodation, attitudes, children and families, drugs and alcohol, education, faith, finance, foreign national issues, physical and mental health. It's an amazing bible (Staff)

DIP prisonlink workers provided a second mainstay of throughcare and aftercare provision:

> Prisonlink workers come in one day a week, they can have whatever they want. If they want access to the CARAT files, if they want to photocopy care plans… if they want to sit in on release planning meetings they can. Because although I've got procedures we've got to follow… it's the clients' continuity that is most important (Staff)

Between them, the five prisonlink DIP teams accepted 85% of the prisoners released from High Down. Three-way pre-release meetings and at-the-gate pickups constituted standard elements of care, with DIP workers ensuring comprehensive referral packages were in place.

Links with DIP teams were supported by strong strategic links with DATs. Managers sat on an assortment of DAT meetings and joint commissioning groups. Managers clearly felt that they welcomed by their community counterparts, and had good levels of input into commissioning processes and decisions. Throughcare and aftercare for drug-related needs was thus seen as cohesive, well-developed, and well integrated.

High Down seemed to evidence particularly strong support in other areas, too. Driven by a clear moral agenda, one of the DRW's Supervisory Officers had initiated a voluntary mentoring programme working primarily with DRW clients:

> I've been running that for four years. What we do is find a mentor for a prisoner in the last three months of their sentence, then work with them in the community for the six months after release. I currently have 14 mentors and 14 clients (Staff)

The Lighthouse mentoring scheme was warmly endorsed by interviewees at every level of the prison's hierarchy, seen by the Governing Governor as a means of delivering peer support alongside holistic recovery-oriented provision. Because of the extent to which mentoring married with the recovery agenda, the programme's lead envisioned a point at which he could provide a mentor for every single released prisoner.

Two further areas of need were consistently raised by professional interviewees:

> I: So you might get the services right, drug services and so on but accommodation
> S: Massive
> I: Employment
> S: Massive. Huge issues. If they go out without any accommodation it's almost setting them up to fail. Because if you ain't got no residence, what are you, basically?

Housing and employment support were available, with two interviewees volunteered that they had been *promised* jobs on release[17]. Every time we visited a wing, orange-shirted housing peers were active, too. Still, housing was felt to be 'luck of the draw'. Many prisoners were released to hostels or night shelters.

Finally, professionals noted that, whilst the psychosocial contractor ensured pathways into residential rehabilitation were reasonably well-developed, problems remained as 'a lot of them still see [residential rehab] as being in prison,' and consequently left soon after arriving.

Through the Gates: Prisoner Perspectives

[17] Our interviewees certainly believed they had been promised employment. We were uncertain whether this reflected Blue Skies employees' actual statements, or prisoners' optimistic interpretation of them.

Three factors complicate High Down prisoners' experiences of through-the-gates support. **Firstly**, they were mostly serving long sentences. Only two expected to be released within two months. **Secondly,** they had fewer previous experiences of *previous* releases: only one had experienced repeated short-term imprisonments. **Thirdly,** they were – as a group - socially embedded, and relatively unreliant on state provision. For example, one interviewee (with three years to serve) anticipated being housed and employed by his family:

> Now my family are like "when you come out we need you to be sitting here in the office, we need you there. Just to bloody sit down and do your shifts" (Prisoner)

Several others expected to return to reasonably stable family homes. We found it noteworthy that none of our DRW prisoners raised housing as a prominent release issue. This stood in contrast to two of our three stabilisation wing interviewees; and nearly all prisoners interviewed in the first DRW we assessed.

The two prisoners who were approaching release described differing experiences. One would become eligible for parole on the day after interview, and had already established links with education and employment:

> I've applied to college. And they've sent the things through for starting on the 22nd of this month… [And] because of the work I've been doing in jail, these blue sky people, they've sorted me out a job for when I get out… They've told me they'll be able to get me a job when I know what area I'm going to (Prisoner)

The second prisoner approaching release had a rather more difficult experience. He had been recalled on license, rendering him ineligible for prison courses:

> I can't put in to do courses. Normally you have to have a year left on your sentence, and obviously I can't do that because obviously from now til 2015 you don't know if I'm getting released or not. It's the parole system, which is a buggery (Prisoner)

Perceived Likely Impact on Future Offending and Drug Use

Professional Perspectives

I do think a good percentage of them become really aware of what they are and… they get ideas about how they can change their lives (Staff)

Ahhhhh. I really really don't know… I want feedback. I want feedback. I want a central recording system that tells me that we released John Smith six months ago. His DIP officer picked him up at the gate, took him to his accommodation, took him to a job interview, and he's been employed for six months. Or Joe Bloggs left the prison and reoffended (Staff)

I'm seeing people who are doing the Intensive Programme for the 2nd or 3rd time. You then have to question, a) is it working, and b) if it is working, why are people coming back to then do their 2nd or 3rd time? The cynic within me says is this because people want to maintain themselves in that environment because of the selfishness (Staff)

Professionals held very different ideas about the DRW and its efficacy, loosely aligning with their role. Governors and managers wavered between scepticism and caution, often keen to improve their own understandings through enhanced feedback mechanisms. One manager took

a particularly striking approach, framing efficacy not only in terms of defined outcomes, but also in terms of public perception:

> It's the biggest thing for me. I don't know if me and my team are doing the right stuff. The measure I always use is what would the average…… [laughs] not Sun reader, not Mail reader… What would the average normal person think? (Staff)

Frontline officers were less cautious. All three believed that the DRW was having a strong and measurable impact on offenders' rates of recidivism and drug use.

> I do think it is working. We're not seeing the same faces coming back (Staff)

> If they've got the determination to do it, it can make an impact on them. It does work (Staff)

The reservations of our most cautious officer were predicated on shortfalls in aftercare provision, rather than provision on the DRW itself.

Our psychosocial interviewees defined impact in terms of *soft* outcomes and small gains.

> They are reoffending. But they're still alive. And may've changed their drug use slightly. So they're going in the right direction (Staff)

> I like to think it gives people hope that they can have a better life. They can do something better with themselves. I think that's what we are about (Staff)

> If they want to carry on using, do you know what, that's their choice. As long as we can ensure they do it *safely*. Because it's choices. It's not for us to judge how anybody lives their lifestyle. If a client goes out of here and is still alive… (Staff)

A final point should be noted, emerging from professional interviews. Three people commented that, irrespective of how well provision was working at the moment, funding cuts were likely to make current levels of provision difficult to sustain.

Prisoner Perspectives

Well [I'm serving] about 10 years, probably. But that doesn't have to be negative. These tools that I'm learning along the way are actually making me a happier man. It's not all about getting out of prison. It's about living a life that I find fulfilling.

It's going to be hard but with [the Intensive Programme] and me going to meetings… it's really gonna help me. I'm never gonna forget it. It's [the] first step in my recovery

Some prisoners referred to drug use or reoffending, when specifically asked. One interviewee felt that the Intensive Programme had helped him 'definitely 100%' stay out of prison in future. Six interviewees also emphasised the importance of keeping up recovery-oriented work post-release: five through attending fellowship meetings, and one through utilising probation and CARAT support.

However, it was striking how often prisoners framed impact in insight-focused terms, and with reference to all-encompassing, positive life change. Several of these are described in the section on the Intensive Programme, but even amongst these one account stood out. Despite

potentially being imprisoned for life, he felt the Intensive Programme had offered him new insight, and a new life. Prison was immaterial; life had become fulfilling and meaningful because of the support he had been offered:

> Drugs are symptomatic of a bigger problem. The crime is the consequence of the drugs. So really. When I talk about a paradigm shift. It's a completely new way of living your life. And for me, that is one day at a time. I plan ahead in the practical way of things. But in terms of how I'm going to cope with my addiction today, it's the 24 hours as I'm living it. And it's a willingness to accept, I I in truth all I can tell you is that the 12 step programme and I'm not talking about religion, I'm talking about, there is something in all of us as human beings that addicts seem to suffer with especially, is the need to… fill a void within us that we run from in the form of drugs, alcohol. It's taken me over, you know (Prisoner)

A second prisoner attributed his all-encompassing experience of change to the *tailored* nature of DRW support, whilst a third felt he had been given tools that he would continue to use in daily life. Indeed, this fed into a substantial theme for our interviewees: six prisoners felt that their ability to sustain change was largely dependent on the (predominantly drug-related) support that was offered, and which they accepted, in the community.

If you could change one thing…

Staff interviewees desired change in one of two main forms.

Firstly, four prison staff aspired to move the DRW towards siloed provision. For three, this involved making the unit a *complete* silo, with little or no contact with other prisoners:

> If I had the funding and I had whatever I was ggoing to do I would make the DRW completely independent of any other wing in the prison… make it completely by itself with no crossing over from any other houseblock of workers. Or from agency staff that're run by prisoners. None of them. It'd be completely insular (Staff)

Two others preferred qualified silos. One would have liked the DRW to intensify provision, with new residents being unable to leave the wing for at least the first fortnight:. A second preferred the idea of a smaller wing with tighter selection criteria, designed to exclude any possibility of there being lodgers on the wing. **Secondly,** two interviewees desired increased prison officer involvement with DRW clients, and with the delivery of programmes:

> I would want it to be staffed properly and staff involvement within the actual programmes. I think that is so important. If I had four members of staff during the core part of the day, two could go away and run groups (Staff)

The looming impact of benchmarking made this seem an unlikely possibility.

Prisoners were not explicitly asked if there was any one thing they would like to change about the DRW. However, two volunteered suggestions, requesting the removal of lodgers, improved access to (higher) education, and enhanced mental health provision and support.

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Residential Compact

Houseblock 5A

1. To reside on Houseblock 5A in the Drug Recovery Wing (DRW) I understand that I need to be working towards my recovery
2. I understand that refusing to sign this compact I will not be allowed onto the DRW.
3. Whilst on the DRW I will:
   a. Seek to gain employment or attend education (complete an employment application form)
   b. Be actively working with CARATs to address substance using behaviour
   c. Attend at least one mutual aid meeting on a weekly basis
   d. Be referred to attend the Tackling Drug Through Physical education programme
   e. Be referred to the voluntary drugs testing programme on the wing
   f. Attend any groups run on the wing to aid recovery
   g. Attend my case management board, which will be set up 6 weeks prior to release, to ensure continuity of care from being released from prison back into the community.
   h. Be actively engaging with Personal officer to address substance using behaviour
4. Access to deep therapy massage and acupuncture will be made available to me, but a referral from my CARAT worker must be made for me to be able to access these services.
5. I understand that every effort will be made to ensure that I remain on Houseblock 5A spur for up to a maximum period of 6 months. If I complete the "Intensive" programme I may be considered to remain on the wing as a trusted graduate of the programme. This will be a decision, made at the discretion of the DRW management team. Houseblock 5A will **not** be run as a zero tolerance unit, however anybody caught with hooch/drugs/un-prescribed medication etc, will be challenged and a democratic decision made which may mean you lose your place on the DRW. I also understand that I am still liable to be placed on report or receive IEP warnings if my behaviour makes this appropriate.
6. At the end of the six months, and due to operational requirements, I may be required to return to the main wings to ensure facilities are available for more DRW clients.
7. Any de-selection from the programme whether self-discharge/exclusion or imposed, will be discussed and may result in my removal from the DRW.
8. If I am to be considered as a trusted graduate the following areas will be taken into consideration: overall participation and behaviour during treatment and continued action towards my recovery whilst on the wing. Compliance with the wing compact is essential, i.e. role modelling, attending min of 2 fellowship meetings per week, respect and courtesy for others, actively helping the newcomer, working the steps etc.
9. I will comply with the DRW testing procedures as outlined in the DRW expectations.
10. I understand that whilst I reside in my cell, I will not damage it anyway. If I do I will be placed on report for damage to prison property.
11. I understand that the DRW/Houseblock 5A will be run as a discipline wing first and foremost. During breaks and prior to groups starting, I will be ready and available to start groups/interviews/assessments when required.
12. Removal or withdrawal from the voluntary testing programme will not in its self result in a changed IEP level.

By signing this agreement, I agree to the conditions set out above.

Signature: ……..…… Date: ……

Name (Print): …… Number: ……

Appendix B: References

British Medical Association and Royal Pharmaceutical Society of Great Britain (1999) *British National Formulary*. William Clowes: Beccles

Prison Officers Association (2012) *Fair and Sustainable. Protecting the Long Term Future of Public Sector Prisons*. POA: London

Prison Officers Association (2013) *Circular 1 / 03.01.2013. Competition Benchmarking Update*. POA: London

Appendix 7: Holme House

Rapid Assessment

Starting note: Interview identifiers

Throughout this report, staff (of all kinds) are identified with an S. Prisoners are identified with a P. Thus (P) after a quotation indicates that it is drawn from a prisoner's interview. (S) indicates that it is drawn from an interview with a member of staff.

Basic prison information

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).

Prisoners' recovery journeys begin in reception. New entrants live on houseblock 4 for up to 28 days, undergoing a process of assessment and induction. Prisoners with identified drug needs are referred to psychosocial and / or clinical support services, where methadone prescriptions are titrated to stabilising doses by the clinical team. Non-clinical needs are addressed by Holme House's psychosocial Drug and Alcohol Recovery Team (DART). Once prisoners have been stabilised and inducted, they are transferred to other wings.

Prisoners with drug-related needs *can* be referred to Holme House's (abstinence-based[1]) TC or (medication-oriented) DRW. The two wings' prisoners share an exercise yard and some gym time, whilst their officers share an office and intermingle extensively. A small number of prisoners have transferred from the DRW to the TC, and a small number of TC residents have acted as occasional peer mentors, organisers, and 'wing policemen' for the DRW. However, whilst interviewees presented the long-established TC as a core referent for the DRW's operational model, six integral differences exist. **Firstly**, the TC is a national resource, accepting referrals from any prison in the country[2]. All DRW referrals come from within Holme House. **Secondly,** in order to access the TC, prisoners need to be sentenced, with at least 6-12 months left to serve. DRW residents might be on remand, or serving short sentences. **Thirdly,** after completing the TC programme, many residents anticipate a transfer to open conditions in preparation for release. Most DRW residents are returned directly to the community. **Fourthly,** prisoners' drug of choice plays no role in the TC's selection process. TC residents may have been problematic cocaine, heroin, alcohol (etc) users. The DRW is medication-focused, so primarily targets prisoners with opiate dependencies.

[1] The therapeutic community had originally *only* worked with prisoners who were fully abstinent of all drug use
[2] In practice, interviewees identified that about 70% of TC referrals came from within Holme House.

Fifthly, the TC benefits from dedicated, ringfenced, NHS funding. TC officers are DAAT employees, and cannot be moved to other wings to cover staffing shortfalls. They were not thought to be vulnerable to impending prison budget cuts. As prison employees, DRW officers are regularly required to work on other wings, and were thought to be vulnerable to forthcoming cuts. **Fifthly,** because of the nascent state of many DRW residents' recovery, and its zero-resourcing operational model, it offers few(er) groups, and is considerably less reliant than the TC on a hierarchical prisoner community as a site of challenge and change.

At full operational capacity, houseblock 6a holds 78 beds. However, during fieldwork people were only accepted onto the DRW *programme* if they could be allocated a keyworker. Ten DRW officers keyworked five clients each, yielding a 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 our rapid assessment. Every houseblock in the Holme House had its own medication hatch, meaning that methadone-prescribed prisoners were dispersed throughout the prison.

A typical day on the DRW

> We wake up on a morning, we get let out for methadone. The lads are banged up while cleaning's getting done. Start sweeping me landings. Mop the floors. Have a cup of coffee. If I need to see anyone [or] need owt doing I'll go to the office. My door's open 'til half past 11. Then it's dinner. There's a special DRW gym fitness wing where you can go for an hour and a half after dinner. Work out. Shower. Banged up for tea. Out for tea. Then sosh. (P)

This quotation provides a full account of the regime experienced by our interviewees, none of whom were attending full-time work or education on other wings. Though therapeutic groups were far from full-time, unlocking cell doors was presented as a means of strengthening relationships between prisoners, and between prisoners and staff:

> You're open a lot more. You've got a key to your pad[3]. When you're on association if you just want to sit in your pad with your friend, you can lock yourself in, it's good. On the other wings, when you're open, you're open, and that's it. And if you want to go behind your door, you're banged up behind your door. It's like a different jail (P)

One subgroup of DRW residents did not benefit from extensive time unlocked. New arrivals first had to complete the DRW's five induction groups, provoking some resentment.

> They never said "when you're going over the DRW you don't get straight out of your pad, you're banged up all day for god knows how long." Everyone else had a key, I was behind the door. And I was thinking it wasn't right (P)

Still, staff sought to ensure some purposeful activities were available for all, holding 'entertainments and quizzes' (with chocolate prizes) to further develop a community feel.

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[3] Prisoners on the DRW had courtesy keys for their cell doors.

Rules and Requirements: the DRW Compact

I think it's a lot more focused here. Because it's that standard agreement that when you come on here, you will be expected to reduce. You will be expected to take part in groupwork, and it's not a case that you can't be bothered today (S)

Holme House had three compacts, covering compact-based drug testing, key work, and general behavioural standards (see Appendices A, B and C). Compact-based drug testing was not in operation during our rapid assessment visit, and consequently was not commented upon. The only other references made by our interviewees in relation to compacts centred on the role of medication reduction. This seemed to provoke some confusion, with one interviewee firmly believing that medication *was* a compacted requirement, and a second clearly stating that it was not. This latter interviewee was correct; medication reduction was *not* required by any DRW compact, though 'offenders who choose reduction in substitute prescribing' constituted a priority element in the wing's eligibility criteria (Appendix D). Moreover, irrespective of its absence from the compact, reduction was recognised by both prisoners and professionals as a requirement of remaining on the wing.

One lad went this morning, he's never reduced… (S)

I: So what are the requirements of being on the wing?
P: Nowt, just show your willingness to change, by coming down off your methadone.

Staff referenced one further requirement: engagement. Prisoners receiving substitute prescribing were 'not given the option not to work with us.' Additionally, violence, drug use and drug dealing were given as the main reasons people were removed from the wing.

Observations on the Physical and Social Environment

I: How does it feel when you come on here?
S: It is a community. It is a community

Everybody likes a bit of easy jail. Jail's jail wherever you go. But it is a bit easier over here (P)

Most prisoners were housed in double cells, spread over two balconies. Prisoners could put their names on a waiting list for single cells, though these were prioritised for high-risk offenders and those with specific medical needs. Each of houseblock 6's two spurs had a number of pot plants dotted around the main staircase, with comfy chairs, a television, and table tennis and pool tables in the central spaces of the ground floor. The walls of each wing were covered in large *applique* motivational quotations, written in an effusive variety of colours and fonts:

Life is not about *waiting for the thunderstorm to pass*, but about *learning to dance in the rain.*

Yesterday is the *past.* Tomorrow is the *future.* But today is a *gift.* That's why they call it the *present.*

Life is not measured by the number of breaths we take, but by the number of moments that take our breath away

Be the change that you want to see in the world

> When it rains, look for rainbows. When it's dark, look for stars.

Other decals included pictures of a caged bird, and a great number of seagulls flying free. These covered most wall spaces, and undoubtedly added colour and interest to the wing's walls. We were curious about prisoners' responses to these messages.

DRW prisoner and professional comments on the wing's social environment were positive, describing the wing in two main ways. **Firstly**, as 'a much more relaxed regime' (Staff). Four residents identified that they particularly appreciated prison officers calling them by their first name or preferred nickname. Other prisoners were also felt to contribute positively:

> There's no kicking about, no bullying. You're not having to turn the other cheek. You just breeze through it laughing your tits off all the way with a big grin on your face (P)

Two other residents made similar points, emphasising that 'there's no bad people here' and that 'the environment provides a safety net for some people.'

Secondly, several prisoners compared life on the DRW favourably with life on other wings:

> You're not involved in the mainstream madness of the rest of the prison (P)

> It's mint. It's better than the normal wings, like from houseblock 2 where I come (P)

> Obviously there's drug use on here but it's a minimum. It's not like other houseblocks when everyone's running about like headless chickens trying to get summat (P)

Professionals agreed that the DRW was more relaxed *and* more structured than other wings, particularly emphasising the roles of peer support and well-trained, well-motivated staff.

Time and time again, prisoners and professionals referred to the DRW as a *community:*

> They do feel that there's a bit of a community feel about it (S)

> It's more open. And I see a lot more prisoners just on the landing, on stairs, talking to the staff. It's nice to see. They try to get that community together (S)

> We try and copy our entertainments on the other side by using quizzes and things to get them together as a community. And to show, for me, the ways of right living (S)

Three *processes* seemed to shape this community feel. **Firstly**, we were struck by the extent to which the prison officers we met were emphatically local, and exceptionally experienced. Deverell and Sharma (2002) have drawn a distinction between *paper* and *personal* qualifications, noting that an open, relaxed and humane approach based on building strong affective ties can often provide the most effective means of engaging marginalised groups. The prison officers we interviewed seemed to reflect this, emphasising their own 'soft' or relational qualities, and the time and respect they had for wing residents:

> I think it's endless, the relationship you can have with [prisoners]… As long as you keep it professional. I'll mention personal experiences… Even part of my experiences of seeing somebody with substance problems and how far I've gone with it (S)

> Be prepared to listen to the prisoners. Drugwise, streetwise, they know a lot more than I'll ever know. But being able to deliver the groups… And if they're coming to release doing that little bit extra for them (S)

> [They value] the fact that someone's sat down and spoken to them. They've never had that before. Taken an interest that they've got 2 kids in care… Taken an interest in why they're imprisoned, and why they've taken drugs, and what help you need (S)

Secondly, professionals described trying to foster a sense of community through *groups*. Foremost amongst these was the DRW's weekly community meeting, which all wing residents were asked to attend. The Custodial Manager would explain any forthcoming developments and invite prisoners to air any grievances, with the *face to face* element of such meetings seen as particularly important. Prisoners welcomed these meetings, referring to the custodial manager by his first name as they described the information he passed on.

Thirdly, the DRW implemented a system community management based on the TC's 'wing policemen' (prisoners with disciplinary and organisational responsibilities). Three 'expeditors' worked in shifts, encouraging DRW residents to resolve the problems they encountered. Prison officers particularly welcomed expeditors' work:

> If prisoners want the basic things, like a toilet roll, they just go and see the expeditor. And it leaves the staff more time to sit down and have meaningful conversations with the prisoners. Just doing that sort of thing gives a community feel to the prisoners (S)

> Not only do [expeditors] help the residents, they help the staff. Patently the problem on the DRW, one of them, is the fact that they're used to that immediate gratification. And that just annoys everybody involved. So the expeditors are a buffer (S)

Prisoners were less vocal about expeditors. Their views may merit attention in later studies.

Profile of DRW Residents

> He'd get out, he'd come back in, he'd get out, he'd come back. These are not on a long bit of string. They're only on about 500 yards of string. Or a bungee (P)

We begin this section with a brief profile of the offence-related characteristics of our interview sample. Drug-related behaviours are explored more fully in the next section, *Prisoners' Drug, Alcohol and Treatment Histories,* though it should be noted that many (if not all) features of the DRW's residents seemed to reflect their histories of opiate dependence.

Our seven DRW interviewees were relatively young, with a mean of 32 and a median of 33 years old. Perhaps surprisingly, we only had a range of ten years; our youngest interviewee was 27, and our oldest 37.

One (of seven) DRW interviewees was detained on remand. The other six had been imprisoned for acquisitive offences: five burglaries, and one theft. Each had received a mid-term sentence, the shortest being 2.5 years, and the longest four. The mean and median sentence lengths were 37 and 36 months, respectively. Professionals noted that the DRW was intended to act, in part, as a release-focused initiative. This contention was supported by our interviewees' sentence profiles, with five expecting parole within half a year. The range was 1-19 months until release; the mean and median were six and four months respectively.

None of our DRW interviewees was serving their first sentence. Several gave imprecise reckonings of the number of times they had been imprisoned: for example, 'a few times', 'a lot of sentences' and 'must be double figures.' Based on the precise data we had, and a cautious approximation of other interviewees' prison histories derived from their qualitative accounts, we found that of our DRW interviewees had served between four and 15 sentences, with an estimated average of 10 (mean) and 8 (median) apiece.

Our interviewees described multiple experiences of abuse, long-term marginalisation, financial hardship, and desperation. None described offending or drug use careers that began in an uncomplicated or recreational manner, with few describing positive life chances:

> I was in a care first, and then I went to a residential school. Everybody – and I mean everybody – I was in school with, they're in jail or dead. It's mad (P)

Reflecting ongoing disadvantage, professionals' comments suggested that new DRW arrivals were often in a parlous state:

> They tend to have a lot of wounds that have been just left. Their general health, physically, is just poor. They're malnourished, they've got dental hygiene problems (S)

The offending and drug use careers of our sample began between the ages of 11 and 13, with one being *opiate* dependent by the age of eleven. Experiences of imprisonment were extensive: three had not been in the community for more than a few days or weeks in the previous ten years, with one imprisoned so extensively that he felt 'when you've done it as long as I have, [prison] does become a need.'

The depth of DRW residents' disadvantage is highlighted by a tentative comparison with our four TC interviewees. These were, on average, six years older than our DRW sample. Three described solid histories of (self-)employment, rooting their drug use in emphatically recreational and social contexts. Three had partners or families that they aspired to reunite with, and who they identified as core motivators driving their recovery. Three were sentenced for crimes of violence or 'high gain' acquisitive crimes, and the *shortest* sentence being served by our TC interviewees was equivalent to the *longest* sentence length being served by our DRW interviewees. Indeed, two TC interviewees were serving nine-year sentences; more than twice as long as any sentence received by our DRW sample. Finally, two TC interviewees were in prison for the first time. Whilst it is impossible to infer anything about the wings' full characteristics from our very small, non-random sample, we were certainly interviewing subsets of prisoners with very different profiles.

Lodgers

Holme House DRW suffered from a surfeit of capacity. 'Spare' beds were filled with lodgers. Neither professionals nor prisoners expressed particularly passionate views about lodgers or their potential removal, though four prisoners expressed mild irritation or annoyance. Two voiced fears that lodgers might be sex offenders, or judgmental towards drug users. Two were also concerned about the broader impact of lodgers, suggesting that they occupied a bed that might otherwise be filled by someone seeking recovery, and had access to privileges (gym sessions and a DRW toaster) that were 'meant' for DRW residents.

Prisoners' Drug, Alcohol and Treatment Histories

Five (of seven) DRW interviewees volunteered age of first use information relating to *any* drug. Three of these began using drugs or alcohol at the age of eleven, whilst the other two began at the age of thirteen. Other prisoners offered information on specific drugs: one began using opiates whilst 11, with four picking up opiates at the ages of 14, 15, 18 and 30:

> I've been a drug addict since I was 11. But I've been a heroin addict since I was 14. It's just been downhill and burning bridges ever since (P)

No DRW interviewees were in treatment for the first time, and four had been accessing community drug treatment for over ten years. Of the other three, one began using illicit subutex whilst in prison, following 17 years of abstinence. He then began using heroin in the community, leading him to engage with treatment services. A second had been opiate dependent for over twenty years without engaging with community or criminal justice treatment services. Having 'found love' in the community, he sought treatment. However, when difficulties with his prescribing service led to his prescription being stopped, he returned to heroin use and acquisitive offending.

The third had been alcohol dependent until, at the age of 30, his doctor told him that drinking would kill him within a year. He then began using heroin instead. Of our remaining six interviewees, five identified as primarily heroin dependent, with the sixth switching from heroin and crack to alcohol. Three named second drugs of choice: one apiece opted for subutex, benzodiazepines (up to 300mg of 'snide blues' per day), and crack cocaine.

Five interviewees described periods of abstinence. Three had historically stopped using when (regularly) imprisoned, and two had attained abstinence when offered well-paid and rewarding employment by family members. Two had sustained abstinence for over ten years.

Prisoners on DRW: Ingress and Egress

Prisoners' entry to Holme House involved an initial reception screening, followed by a move to the prison's 28-day stabilisation unit on houseblock 4. From here, prisoners could be moved to any other houseblock, including the DRW. Prisoners described varying routes into the DRW. One had enthusiastically applied, whilst a second seemed to have been rather swept along by an enthusiastic (and persistent) DART recruiter. Two more had been moved following succinct ultimata from prison authorities:

> There was trouble on the wing and I got taken to the block. When they looked at the camera it wasn't me. So they come down and they said "right we're going to let you out the block with no charges. We're not letting you go back to the houseblock." So I said "ahhh well I'll come over to 6." And I come over here and it's mint. It's class (P)

> Do you know what it was, I didn't want to come on, right, I was on houseblock 1. I'd finished my 4 year [sentence] and then I wanted to stay on there, and they wouldn't let me. And they went "you can go in 6 or you can get nick" so I come over here (P)

Perhaps importantly, no prisoners felt that selection was working *badly*. Despite a small group of suboptimal residents[4], the DRW was felt to have a well-selected community feel.

Though the DRW was mostly run by prison officers, the DART team was responsible for selecting and recruiting clients. Reflecting a common theme across pilot DRW sites, DART interviewees were particular concerned about the authenticity of applicants' motivation:

> We've had a cohort of people come in recently for conspiracy to supply. And all of them want to come either onto the DRW or the TC. I've questioned that and said "is it because a lot of the people over here are easy targets to sell drugs to?" (S)

> You will get somebody who sounds absolutely sincere but is really wanting to peddle drugs. Especially from induction. If there's people coming in [who] don't even know what drug recovery is but "I want to go on drug recovery," you get suspicious (S)

Interviewees noted that courtesy keys and conditions on the wing might also encourage inauthentic clients to apply. Psychosocial workers' main response centred on deploying keen judgment, potentially delaying referrals until they were satisfied of applicants' authenticity.

Means of egress depended on whether or not DRW residents were behaviourally compliant. Data on 112 DRW completions in 2012-13 indicates that release was by far the most prevalent exit pathway for behaviourally compliant prisoners, followed by 109 prisoners. Three were transferred to the TC, and none were transferred to another prison. Over the same period, 23 prisoners were also moved off the wing for behavioural non-compliance:

> If we found someone dealing… they would be removed from the wing. And if someone was bullying or there was a racist incident, we would move them off the wing (S)

Five 2012-13 residents were removed from the wing for 'concealing,' four for bullying or fighting, and two for suspicions of dealing. Each of these actions invoked a zero-tolerance response. For less serious infractions, clients' levels of engagement were felt to be an important factor in determining whether or not they could stay.

Detoxification and Reduction

> I've never known them to not be happy with someone who's not reducing (P)

> We can drop from one mil to five mil to ten mil. As long as we show we're willing (P)

During our rapid assessment visit, detoxification did not present as much of an issue for Holme House's DRW clients. The only abstinent prisoners we interviewed were from the TC. However, two themes were raised. **Firstly**, following a 2012 recommissioning process, the TC had begun to accept people prescribed 10mls or less of methadone per day. These prisoners were not 'on' the TC programme; but were housed in TC cells, awaiting full entry to the wing's structured therapeutic regime. To date, few people had transferred:

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[4] P: About 90% are the right people [I: And the other 10%?] P: Scumbags. And grasses

> I can count on one hand how many manage to come off it and come over to the TC. It's not as easy as what they first thought. To get them completely off it (P)

However, for those who *were* keen to escape the DRW, or to progress with their own recovery, the potential to move to the TC provided a potent incentive:

> From being on the DRW I've got right down from 40 mil, and I come right down because they said "when you get down to 10 mil [you can move to the TC]…" (P)

Professionals further noted that being surrounded by fully abstinent TC members presented prisoners with a powerful incentive for moving through the final stages of opiate withdrawal. **Secondly,** three (of seven) DRW residents stated that the perceived strength or efficacy of the DRW's 'rattle packs' discouraged them from detoxing:

> I want. To do a proper detox in here… but not with the rattle pack that they give you. Coupla paracetamol! And that's no good for no one. We said "listen, ay, you need proper sleeping tablets and something that's going to stop you rattling for 2 weeks." Because nobody will come off their methadone with just a few paracetamol (P)

Professionals also recognised that rattle packs presented a persistent concern. Though the wing's doctor had apparently agreed to negotiate rattle packs with clients on a 1-1 basis, prisoners voiced concerns about his reputed willingness to provide adequate medication, even for prisoners with long histories of community prescribing for evident physical injuries.

Reduction presented a different picture. All DRW residents were prescribed methadone during the rapid assessment, with a perceived willingness to reduce constituting a core dimension of DRW selection. However, reductions required complex negotiation. Psychosocial practitioners felt that over-emphasising reduction could deter applications. Conversely, prison officers felt frustrated by their inability to insist on reductions:

> The main thing with drug reduction is it's down to them. I can't sit down one of my lads and say "listen, you're on 20mls you've got to come down to 17." That's down to him and the nurses. [Although] it's a drug recovery wing, there's lads been on here as long as I've been on here. None has been tooked off it or has never reduced at all. We can't get involved because it's the nurse the healthcare team and him (S)

Still, something of a reduction culture seemed apparent. A clinical interviewee commented that, prison-wide, 'last month we had 90% reduction and 10% in maintenance.' All but one of our DRW interviewees identified that they were on some form of reducing dose, with two suggesting that the DRW's support had been integral to their decision:

> I've always tried to blag it to stay on the same dose, but this wing I'm coming off the methadone. There's support. Where the other wings, there's not the support (P)

In addition to the *direction* of travel, the *pace* of travel seemed relevant. Many DRW interviewees were very afraid of withdrawals, with one wanting to establish a peer support group specifically so he could ask about the physical impact of reducing from 55 to 50mls of methadone. Staff and prisoners identified that reduction schedules of one millilitre per month were widespread, with one TC interviewee suggesting that 'reductions' of one milliletre per *quarter* were commonplace. Four DRW interviewees were reducing at rates of

1-3 millilitres per month. Another had been reducing at a rate of 2mls per month, but now intended to level off. Perhaps relatedly, attaining *total* abstinence was a rarity prisonwide:

> Last month we had 5 [obtaining abstinence, out of] 270 in treatment (S)

Motivations

Six Holme House interviewees identified that their main motivation for change came from maturation: growing up, or being 'sick and tired' of drug dependence and its consequences:

> At 34 year old… [I've experienced] homelessness. Losing jobs. Me family. Just everything. And now is the time. I've had it. Maybe it's age (P)

> It's got to that stage now where you open a book and you just say "right, that's it, bang." I don't want to be doing it no more. I've had enough. I've got to that stage (P)

> Doesn't really interest me any more. Sick of it, really. It's rubbish. It's pointless (P)

> I'm getting old now and my son's 11… It's a disgrace because I'm 37 and I've done nothing with my life. If I died now I'd have a wardrobe full of clothes and that's it. I just think you stop when you've had enough. And I think I have had enough (P)

Alongside residents' accounts of their own motivation lay others' more cynical accounts. One DRW graduate (and current TC resident) felt that most were motivated by material incentives:

> Everyone that I know that I've spoken to on this subject has said "I'm only here because it's a single pad and I'm unlocked all day" (P)

A highly-motivated DRW interviewee concurred:

> I think sometimes people are only over here because you get a key to your door. You're allowed out more. Where to me, I'd rather be here to get off me addiction! (P)

These accounts sat ill-at-ease with those of our DRW interviewees, only one of whom acknowledged material or quality-of-life incentives as a reason for applying to the DRW.

Professional accounts of prisoners' motivation were sparse. However, staff all noted that DRW residents varied in the extent of their motivation:

> There are people who are more visible because they put their hands up, because they want to get involved in every activity. You've got others that you've really got to try and engage and motivate because they are quite withdrawn and disengaged (S)

> I think the problem is sometimes they obviously don't want to be here (S)

Given disengagement could lead to prisoners being moved off the DRW, one interviewee was particularly keen to distinguish between quiet clients, who could be drawn out and encouraged; and uninterested clients, who might be most suitably transferred elsewhere.

External Motivations: Family

Perhaps because of our interview sample's extensive history of opiate dependence, repeated imprisonment, and repeated offending, only two Holme House interviewees presented their families as supportive forces, driving them towards enacting change:

> My life's completely changed for me in that 2 years I was out. [laughs] Sounds soppy this but I fell in love. Fell in love, had a baby. My first (P)

It is impossible to know how representative our interviewees were of the DRW's full population. However, the ubiquity and power of family as a motivator in other DRWs suggests that its relative absence in our Holme House interview sample may merit further exploration.

Motivations: Best Bits

Prisoners' accounts of the *best bits* of the DRW followed several paths. **Firstly**, several identified that the responsiveness and help of staff stood out as the wing's best feature.

> Me personally it's just like the support of the staff. Like I said you couldn't get that on other houseblocks (P)

> On this wing, you can go and talk to an officer without thinking he's not bothered. You know they're ok. And just that little bit of support. I think it helps you a lot (P)

> If I need to somebody I can go and ask the staff and they seem to do it. On another houseblock it would be mebbes said "[I've got] too many people to look after" (P)

Secondly, three interviewees identified that elements of the prisoner community represented the wing's 'best bits':

> More relaxed. And there's not as many drugs as there'd be on another wing (P)

> With like most of the lads detoxing, you're not just the one. You're all in it together. Like our own community (P)

Thirdly, three prisoners identified that material and quality-of-life incentives represented the wing's most positive features (though these were not identified as reasons for applying):

> You get extra activities like the cookery class and gardening, the veg plot… (P)

> Best bits on the wing. Eh. The gym. Ehh. Getting my job. Ehhhh. Staying drug free (P)

For three staff interviewees, witnessing prisoners progress through the DRW represented both the wing's best, and its most emotionally rewarding, feature:

> Hope. Because I think we get a lot of hopeless prisoners. They've never had anything. It's definitely that hope where somebody comes in and they're chaotic and they're stabilised through medication. And given hope that they can have a brighter future (S)

> When they come to us they're at their worst. Obviously their drug use is chaotic. So the DRW to me is massive as part of their recovery, of the recovery agenda… It helps, [it's] marvellous with the work and things that they do… It works really, really well (S)

For other professionals, the *drivers* of these changes represented the wing's strongest features. One felt that the *containment* and *focus* of prison lay at the heart of engendering change:

> Within the community you deal with the same kind of clients [but] the prison is more contained. [There's] nowhere to go. Outside there's too many things to focus on (S)

Two more felt the wing's environment and community represented the wing's best feature:

> The environment… like the single cells. They've got more time out of their cells, they've got the benefits of here, they are really well looked after, they're well supported. The staff are really good, there's a lot of support in places (S)

> I think probably the support that the lads get from each other. The peer support that goes on. I think that on its own… You don't get on a normal houseblock (S)

Finally, one interviewee highlighted release planning and support.

> It's an it's an option they've never had. Now they've got things in place before they leave instead of "there's your discharge grant, off you go." They've got people and contacts and support and treatment, a seamless link straight out (S)

DRW Provision

At the outset of this section, it should perhaps be noted that Holme House DRW did not stand out from other DRWs in the intensity of drug work being delivered. What *did* stand out was the wide-ranging and eclectic menu of support options. As one prisoner noted,

> Dave's putting all sorts out for us. It's like a selection box. He's putting a greenhouse out there. He's forever doing things for us. You get gym *every single day* (P)

DRW provision began shortly after arrival, with cohorts of 8-10 prisoners undergoing a five-group, week-long induction programme. Following induction, prisoners would be allocated a keyworker. Keyworkers then used the Outcomes Star (Triangle Consulting Social Enterprise Ltd 2013; Appendix E) to draw up a 'recovery plan', requiring prisoners to attend a series of groups matched to their assessed needs whilst participating in the prison's full regime:

> It's bespoke. If someone hasn't got a parenting issue then we won't stick them through a parenting group. But it's about as well giving them access to the wider regime as well. Going out to work. Going to the gym. Going to education (S)

Officers estimated that approximately two-thirds of the wing were in education or employment, leaving 15 to 20 prisoners unlocked and in the DRW at any one time.

Groups came in two forms. Two dedicated 'DRW officers' were tasked with delivering groups to DRW residents. These were presented as excellent opportunities for relationship-building, and for prisoners and officers to learn from each other. DRW residents also had

access to groups delivered on other wings, led by DART workers, available to DART clients prison-wide, and covering a wide variety of additional themes:

> Debt, money management, motivation. Physical health problems. Mental health problems. Self-confidence building. AIP? Alcohol intervention project, which is a 3 week structured programme. Alcohol awareness, which is a 2 day course. Drugs and you which is a 2 day course. Drug awareness is a 1 day course. Recovery groups… (S)

Group attendance ran alongside keyworking sessions with prison officers. Each officer submitted keywork reports for their clients every 14-28 days, and consequently sought to hold one-to-ones with their clients on an approximately once-monthly basis.

With regard to specifically drug-focused provision, the DRW also offered three mutual aid groups each week, with each attended by 6-12 prisoners. None of our interviewees commented on, suggesting they may merit further exploration in future research. A TC psychosocial worker also delivered SMART Recovery groups every Friday.

Staff also identified three forms of support that were not specifically drug-focused. **Firstly**, each psychosocial interviewee spoke warmly of family visits:

> The visits are done differently. Dad can take his child to the shop within the visits hall and ask the kid what it wants. They can push them around in the pushchair. Play with them in the play areas. Make crafts with them. And honestly it's been the most…. Welcomed and long-time coming experience for every single person that's been involved in it. We get to meet the kids that they've been talking about. And it's just much more personal now (S)

Secondly, the DRW's custodial manager had secured funding for a DRW garden. Prisoners spoke of this as a sign that they were *cared* for. Staff presented it as an opportunity for education and employment, and as a source of food for the prison's Bistro. **Thirdly,** staff commented on about the broad benefits offered by 'DRW gym':

> [There's] basic healthy life style courses with a YMCA gym instructor level 1, so they get a qualification. They'll do a first aid course. We give them the rolling DRW gym sessions. We have a really nice gymnasium facility. [And] it was about getting lads down the gym who have never done nothing. Might just go down and walk on the treadmill for half an hour. Or they might just go down to change their minds and get them off the wing (S)

Provision was thus felt to be responsive to a wide variety of preferences and needs.

The activities that prisoners particularly valued included an eight-week cookery course (with a capacity of 8 prisoners) led by an external Probation provider. Prisoners were walked through a menu of sweet and savoury dishes, to support independent living on release:

> Fairy cakes they cooked last week. Chicken parmesans the week before, a local delicacy (S)

A full roast dinner celebrated the course's finale. Prisoners were also keen on Holme House's resettlement support. One had completed an array of professional training courses:

> I've just done me solar panel fitters course. I've passed the mobile scaffolding tower. And I've just passed me CSCS card test (P)

Two DRW residents talked of 'focus to resettlement' (a four-week accredited programme), and two praised a pre-release 'marketplace' attended by external providers:

> And that's for housing, that's for all the different agencies. You can actually get on the phone to the jobcentre and set your benefits up, so it's already in place (P)

Holme House's links with IOM schemes seemed to be bringing in additional initiatives, too. We encountered a Restorative Justice practitioner in the process of recruiting DRW residents for RJ conferences. One of our interviewees was enthusiastic about the potential this offered for something approaching amends:

> Because who am I to take someone's stuff when they've worked for it? I'll say "my actions haven't just affected you. They've affected my family in a massive way because they *hate* what I do. They don't want me to do it, because they're all like "why should you nick it, you should work for it." My dad always says to me "why are you like this?" I just wanna put it across to them like I didn't pick him out, it's just his car was there, I done it. It's not right is it. Because I wouldn't like someone to pinch my son's stuff (P)

DRW residents also mentioned mentoring courses and DRW gym as strong positive points.

Violence and Bullying

Insofar as there was *any* violence on the wing, prisoners were keen to assert that it was less prevalent than it was on other wings and only took place between approximate equals:

> The lads wouldn't stand for bullying on here (P)

One prisoner's account was hard to reconcile with this picture. He provided an account of routine serious threats, violence, bullying and theft. The stark contrast between his account and those of other wing interviewees is difficult to explain away. It is tempting to suggest that he may have been disordered, playing his audience (me) or making up stories for dramatic effect. However, he presented as someone who was coherent, genuine, and who had a powerful belief in his own account.

Staff perspectives aligned with the majority of prisoners, suggesting violence and bullying were rare:

> I've not seen violence. I've been here since august and I haven't seen no violence (S)

> We've had a couple of fights, that's it, since I've been on here (S)

> Oh we've had bits of indiscipline and bad behaviour. But violence? No (S)

A psychosocial interviewee detailed a comprehensive, intelligence-led anti-bullying programme predicated on proactive staff measures:

> If somebody's not buying any canteen but they're earning a wage and their cell is full of products, that's got to come from somewhere. And that's why we do daily cell

> checks. To make sure their curtains are open, their beds are made. But also for security reasons (S)

In this context, it seemed *unlikely* that our concerned prisoner's account was entirely representative or, perhaps, truthful. This may merit further exploration in future research.

Drug availability

Subutex is notionally incompatible with methadone, and all DRW residents were prescribed methadone. Still, insofar prisoners identified any drug as available, it was Subutex:

> If you were to just score on this wing? Not a lot. Mebbes. *Mebbes* a bit of illicit subutex (P)

> The main thing, the main thing, is subutex. That's the main thing (P)

No other DRW residents named specific, available drugs. Indeed, the DRW was generally thought to have had a positive impact on the availability of drugs:

> There are bits all over, but it's not like the other houseblocks where it's rife (S)

Both professionals and prisoners described the availability of hooch as nil.

Professional interviewees also identified Subutex as the DRW's main drug of choice:

> If you're testing for cannabis you'll not get any hits. But if you're testing on buprenorphine, which is the main one in here, then you might get some [positive tests] (S)

Staff tended to fight shy of making strong comparisons of drug availability between various wings. One professional noted this was because 'there's not a great deal of feedback in terms of [availability comparisons between wings].' Instead, professionals described an ebb and flow of drugs, with high levels of availability one month potentially turning into a non-existent drug problem the next.

> It fluctuates from wing to wing. We hear things like "there's none on houseblock 1 at the moment." "I think the TC's got a huge problem with drugs. But the DRW side not mebbes so much" whereas it might've been the other way round last week… (S)

Professionals detailed two further points relating to drug availability. **Firstly**, DRW residents were seen as a good, and unusually willing, source of security information:

> A thing that really surprises me on houseblock 6 is the amount of prisoners that'll come up to you as a staff member and tell you information. About keeping their environment safe. "I think you should know…" or "you should look at… on a visit." And then we'll put an SIR in and they'll be targeted on that table. We're one of the highest rated in the prison for putting in accurate SIRs because prisoners are quite forthcoming with that information (S)

Secondly, staff saw suspicion-based drug testing as a highly valuable resource.

> I had a lad coming on a couple of weeks ago who was dealing subutex and cannabis. We just put him through mandatory drug testing, so it's found out straight away (S)

Additional Services DRW Interviewees would Like to See

Requests for additional services were few and far between. As one prisoner commented:

> To be truthful, me, I don't think they could do any more for you. Me personally, I don't think they could… Just an extra couple of groups? That's it (P)

Other interviewees expressed an eclectic range of preferences. Two yearned for additional support from ex-offenders, or people with histories of drug use:

> I went into an office with a counsellor. And the first thing I said to them is. "Have. You. Ever. Been. On. Heroin." When they said no I shook their hand and walked out. Because you can read up on it, but until you've actually experienced it… [You need] someone who's *been on them*. Someone who's *been on the drugs*. Someone who can say "look, I know what you're going through" (P)

Other suggestions volunteered by individual interviewees included acupuncture, an 'external' drug worker, a dedicated dual diagnosis nurse, and a 'staged' programme of groups for people who had been on the DRW for different lengths of time.

Prisoner / Staff Relationships

DRW interviewees were unanimously positive about the officers on the DRW. They compared them favourably with officers from other wings whilst praising them as helpful, caring, responsive and understanding:

> Well the officers are better. They help ya. They just they understand and that. We've just has a couple out there, they sit with us. They get involved a lot more (P)

> If you've got a problem you can go to them in confidence and know they'll help ya (P)

> If I've got a problem with my money I'll say "boss, I've got a problem with me money. Please will you look at the computer and see what's come in and gone out." "Yeah, I'll do that for you, give me 5 minutes I'll sort it out." If I was on another wing, "listen you, there's 20 different heads asking me questions, you're gonna have to wait" (P)

Wing residents particularly praised officers' willingness to have an informal chat, and identified high-quality officer-led one-to-ones as sites of positive relationship-building.

For professionals, relationships seemed to be equally important. Strikingly, not only were prison officers calling prisoners by their first names; prisoners referred to the DRW's prison officers, custodial manager and governor by their first names or nicknames. Two officers even described positive interactions that were sustained following release:

> Ex-prisoners coming up to staff, it'd normally be abuse. But I've always had positive experiences. It's surprised me family because they're with me and the last thing that you want is to be walking through the supermarket with your family and getting abuse

> or… you know. I've had handshakes and offers of you know drinks and allsorts. And it's nice to see. "It's good to see you I'm pleased you're doing well" (S)

These strong and positive relationships were presented as resting on a variation of 'do unto others…' ('treat them like shit and you'll be tret like shit yourself' (S)), underscored by core principles of decency, empathy and respect. These principles seemed to be manifested in three key operational processes. **Firstly**, in day-to-day prisoner-staff interactions, which were all the more frequent because of the DRW's extensive hours unlocked. **Secondly**, in the DRW's 'expeditors,' who smoothed nuts-and-bolts wing processes and enabled staff to focus more on relating. **Thirdly,** in the wing's 'community meetings,' which were identified as effective means of fostering positive communications *and* developing the DRW's community feel. Each of these processes supported DRW staff in building stronger, closer, more informal relationships than were thought to be viable on other wings.

> You walk off this wing and go to [general population] houseblock 5. Big massive difference. [General population] houseblock 1, you'd just be seen as a white shirt. You might have a name if you're lucky. Walk on houseblock 6 and go on b wing. All prisoners know their staff and who to go to. They know [who to go to] if they want this or this. We're very lucky with the staff on here. Good personal skills (S)

Professional interviewees noted that not *every* new recruit bought into the DRW's ethos so readily. However, those who were not committed soon sought relocation.

The DRW's reputation amongst *staff* in the wider prison

Only professionals provided any data on the reputation of the DRW amongst *staff* in the wider prison. Perspectives accumulated on three themes. **Firstly**, of ignorance. Four interviewees felt that prison officers working on other wings had little or no idea of what the TC and DRW did. **Secondly** (and relatedly), two staff interviewees noted that TC and DRW training days had been established to inform officers on all wings about their work. Officers who had been in post for some time were consequently likely to have a reasonably good understanding of the TC (at least), and its workings. **Thirdly,** five officers noted that, insofar as the DRW had developed a reputation, it centred on a relatively harmless stereotyping of wing staff as 'fluffy' or 'care bears':

> You might get one or two *oohhhhh do-gooders* but in general [it's a minority] (S)

> Well the only label I'll ever get called is care bear… Because you've taken ownership of somebody's treatment. To help them or support them. Or empathise with a prisoner. And straight away you are… "are you a prison officer any more?" (S)

The DRW's reputation amongst *prisoners* in the wider prison

At this point, it must be acknowledged that our interview sample is likely to yield an unrepresentative impression of the DRW's reputation in the wider prison. The only non-DRW prisoners we spoke to were from the TC. All were, to some extent, critical of the motivation and medication of the DRW's residents, who were less stable, less socially embedded, and at a considerably earlier stage of their recoveries. DRW interviewees also noted that the wing's reputation was far from unequivocally positive. Two noted that the DRW was seen as a refuge for sex offenders, whilst one surmised that the it had a reputation

as a general 'protection wing' that was 'full of grasses'. These negative accounts aside, one prisoner offered an unqualified positive account:

> From what I've heard everyone wants to be on the DRW (S)

This lone account seemed to be difficult to square with those of other prisoner interviewees.

DRW Residents: 'In Recovery?'

In Recovery: Professional Perspectives

> To me recovery means reduction. I don't think it means abstinence because I'm not sure how realistic [that is]. But it definitely means reducing your level of substance misuse medication. To a point where you can function (S)

Given the ubiquity of methadone in Holme House's DRW, and universal awareness of *some* pressure to reduce, it seemed striking that only two professionals defined 'recovery' primarily (let alone exclusively) in terms of medication reduction. Other interviewees cited models of recovery that reflected the eclectic and wide-ranging nature of the DRW's provision. For these interviewees, recovery was individualised and client-led, perhaps encompassing abstinence, but also embracing improvements across multiple domains:

> I take recovery as an individual basis… if somebody's on maintenance, and they're not injecting, and they're not getting DVTs, and they're not getting hospital admissions, I'm keeping them safe. I've given them, I suppose, a better lifestyle and a longer life (S)

> I think it's what works for the individual. Some people choose to still use alcohol or smoke cannabis when they're released. Some people give up absolutely everything (S)

Staff offered varying estimates of levels of recovery on the wing. At one end, an officer noted a subset of prisoners who engaged as little as possible:

> If they think the wing's alright they'll just like do enough to get by… Just attend the groups [during the first week], do the keywork sessions (S)

At the other end, a psychosocial interviewee felt that '90 per cent' of wing residents were taking their recovery seriously.

'In Recovery': Prisoner Perspectives

Across pilot DRW sites, a very high proportion of interviewees identified that they were 'in recovery.' Holme House was no exception. Just one of our seven interviewees felt they were not 'in recovery'. We also found some indications of just how flexible 'recovery' could be. One interviewee who had been housed on the TC for approaching a year stated that he felt unable to own the word recovery 'until I'm… staying off it. It'll be, like, how I can deal with staying off it' following release. Others who were heavily medicated felt both willing and able to own the word.

Within our DRW sample, the one interviewee who expressed doubts about his own current 'recovery' framed it primarily in terms of drug (and methadone) use:

> [Recovery is] if I was gonna come off me methadone altogether. To do your rattle and then mebbes change the way you're looking at drugs, and not want to take drugs (P)

Three further DRW residents offered very similar, drug-focused interpretations of 'recovery':

> Recovery mean to me getting clean off drugs. Totally completely. Once you've been an addict I think you'll always be in recovery. Because it takes so many years (P)

For our other interviewees, recovery took on a more holistic meaning, encompassing full life change, family, relationships, and employment:

> It means snapping out of this stupid 20 year rut I'm in. All I've done is think about what I want for my future and for my kidses future. Five years time I'm gonna be in the tattoo studio. I want me kids to have all the best, I don't want them to have to wake up on a morning and have to slap me round the face to wake me out of me self-induced smack coma (P)

> Recovery's getting your life back. All the people you've hurt. Getting the trust back. But then you just don't do it again and again and again because I've done it loads of times. Got the trust back and then just gone like fffsssswwww. Got it all back and then messed it up again. But it's time to change. Because nobody gives you chances forever (P)

Prisoner interviewees offered very different assessments of the levels of recovery on the wing. TC interviewees were particularly sceptical about whether or not methadone could ever be compatible with recovery. Those housed on the DRW offered assessments ranging from 20% to 'most of' the wing's residents.

> Mebbes 2 [in ten]. The ones that are here for the right reason are few and far between (P)

> I think it's fifty-fifty (P)

> Most of them do want to change. There was the odd couple on here because you were open all day, but you soon found out who they were and they got shot of them (P)

Future studies may benefit from unpicking the understandings of 'recovery' wing residents applied to other prisoners, and the rationales underpinning their varying assessments.

Interviews with Staff: Staff Characteristics

We interviewed 14 Holme House professionals. Eight were directly employed by the prison: three frontline DRW prison officers, two frontline TC officers, and three managers. We also interviewed six drug workers: two managers, and four frontline. Perhaps the most striking feature of our DRW professionals was the breadth and depth of their experience. DRW and TC drugs workers evidenced considerable experience, and the 'newcomer' in our sample of prison officers had been in Holme House for seven years *after* working in three other prisons. The *second* least experienced frontline prison officer had twenty years of operational experience. Three had been in Holme House since it had opened (in 1992) with one laying claim to being the first person through the prison's doors. Each officer we interviewed aspired to stay in post (and preferably on the DRW) until their retirement.

The DRW officer's Role

I know that when you come in [and] you've got to go to another unit, it's a bit like talking to prisoners, "hey, don't do that!" And it's like, "well, that's just the way I am" (S)

The officers on here are all trained for addiction. They're not normal prison officers on normal houseblocks. They're dedicated officers working with structured interventions (S)

In the community you don't know who's a drug worker and who's a client. In here you can because the uniform's on. But you often see staff talking to clients. It could be a 10 minute chat. "How's your weekend been?" You don't see that on normal wings (S)

The – seemingly outstanding – reputation of officers on the DRW amongst prisoners and non-officer staff had been formed through a process of erosion and natural wastage. At the DRW's inception, houseblock 6a's staff were kept in post. Over time, those who felt ill-suited to the role sought positions elsewhere, whilst those who were drawn to DRW work were interviewed and brought in. Authenticity, openness, and availability were all described as key characteristics for officers working on a wing that relied on solid prisoner / staff relationships, and therapeutic officer-led groups:

> Facilitating groups takes a lot out of you. You can't fake wanting to be involved in drug treatment. And you'll soon find the people who come on thinking they want to do it, but then their eyes are opened and they're like *no* (S)

'Good' DRW officers were also seen as team-oriented, and good listeners:

> Well there *is* a team. That's the difference [compared to other wings]. There is teamwork. We have a common aim. Do something different (S)

> Where some of your old school might not be prepared to listen, or they just bang a door and that's that, a lot of the staff on here are prepared to listen to prisoners (S)

Because of their commitment to the DRW's ethos, two officers described working flexibly to develop their professional skill base and the wing's treatment programme:

> As a goodwill, we give a lot of time up. For instance, this morning I'm supposed to be a half one start. I came in at half seven because they were running a group that I hadn't seen, alcohol awareness, and I sat in on that. I will get them hours paid back, but there's things that I could've done at home this morning. That sort of good will (S)

As suggested by some of these excerpts, all interviewees were clear that the requirements of being a DRW officer were different from those of being an officer on most other wings.

Insofar as changes to the DRW officer's role were felt to be desirable, they lay in one direction. TC officers benefited from NHS funding, and protected roles. They were not subject to the varying fortunes of the prison regime, and – as NHS employees – could not be moved to other wings to cover staff shortages. As direct prison employees, DRW officers had no such benefits, compromising therapeutic provision and continuity of care:

> Unfortunately the regime has to come first. The safety of the prisoners and the prison staff is much more important than whether we deliver a relapse prevention group (S)

> When they're pulled [off to other wings] it's the lads that miss out. It's alright saying "we've got dedicated staff on the DRW." But they are expected first and foremost to be prison officers, and if you're needed elsewhere you will go elsewhere (S)

Equally, when the DRW was short-staffed, officers from other wings might be brought in. This, again, was felt to be less than ideal:

> [They] don't understand the ethos of the wing. [They] don't understand working with prisoners with these sort of issues. They just treat them like any other prisoners (S)

Interviewees consequently desired protection for officers, ensuring that trained staff could stay on the wing delivering therapeutic work.

Description and Development of the DRW

The TC had been well-established for well over a decade when the NOMS invitation to tender for pilot Drug Recovery Wings came out:

> We already had good established practices on the TC. So in some respects, we were quite ahead of the game. It was already there. And tried and tested (S)

The development of the DRW was consequently seen as a means of developing a full recovery pathway within the prison, and working with prolific offenders and opiate users from induction to the point of release. Additional benefits came in four forms. **Firstly**, the TC was largely abstinence-based[5]. The DRW could offer community-oriented support to prisoners receiving substitute medication. **Secondly**, the TC was a national resource. *All* DRW clients would be referred from within Holme House. **Thirdly**, the TC required prisoners to have at least 12 months left to serve[6]. The DRW could work with short-term prisoners, and (latterly) remandees. **Fourthly**, many TC residents progressed to open conditions before release. The localness and short-term sentences of DRW clients offered an outstanding opportunity to develop release-focused and through-the-gates provision.

Building on strong, pre-existing partnership arrangements, Holme House's DRW consequently focused exclusively on Prolific and other Priority Offenders (PPOs) who were engaged with IOM teams in the four areas that provided 80% of the prison's population. Potential recruits were required to have 6-18 months left to serve, to ensure that prisoners could benefit from both throughcare and aftercare work.

This founding model soon ran into problems:

> S: It was specifically for PPOs, from the Tees Valley area…
> I: Could you get a full wing of Tees Valley PPOs?
> S: No. Hence it was empty. It wasn't working.

Selection criteria were revised, eventually including prisoners irrespective of their PPO status, or area of release. Sentence length was also revised to accept people on remand, and those serving 3-18 months. Prisoners who had experienced both regimes seemed positive

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[5] Later changes meant that people could move to the TC whilst prescribed 10mls of methadone.
[6] Later changes meant that people with at least 6 months left to serve could be transferred to the TC.

about these developments, suggesting that the changes led to a fuller wing, an improved sense of community, and the chance for more prisoners to benefit from treatment.

A final addendum. Three further factors were identified as important. **Firstly,** the DRW came in as a zero-resourcing initiative. All the gains described in this report effectively came in at zero cost. **Secondly,** staff in a range of positions felt that the DRW's resettlement-oriented, local work offered a substantial boon to the prison. Partnerships were built with a plethora of community organisations who now supported prisoners released from any wing. TC officers identified that they now had access to agencies as diverse as Christians Against Poverty, Barnados and housing services. **Thirdly,** managers consistently emphasised the role of committed psychosocial and prison staff in shaping and delivering the DRW:

> Staff were allowed to take ownership of it. Ticking a box doesn't mean nothing to me. It's talking to these lads when they're getting released and saying, they've been coming in and out of jail for 15 year, or 20 year, for the first time an officer's sat down, half an hour out of their time and said "right, tell us a bit about yourself. How long've you been taking drugs…" When you get that sort of feedback at their pre-discharge meeting. It's something they've never had before… (S)

The initiative and commitment of frontline staff was identified as integral to developing humane, caring, and creative responses to complex difficulties.

Ongoing Developments: Benchmarking

> They've produced a staffing profile which doesn't really fit, doesn't really work. When you add it up the way they've done it, it's crazy. And then when you challenge them, it's a case of "oh well, that's a local issue." In other words, "do your own profile. We're going to take so many millions of pounds this many staff. Get on with it" (S)

Over the last two years, English prisons have undergone two major reviews of staffing, pay and conditions. Fair and Sustainable was developed in discussion with the Prison Officers Association, and sought to implement new working structures throughout the prison estate. The POA identified that, from their perspective, the main rationale for supporting Fair and Sustainable lay in its potential to reduce contestability:

> In the current economic climate, the POA cannot allow public sector prisons to be easy targets for the Coalition Government and its Competition Strategy for Offender Services, which was announced by the Secretary of State for Justice in July 2011. As a responsible Trade Union, we must give ourselves the best opportunity to protect and promote the interests of our members. The lessons learned from the privatisation of HMP Birmingham must not be lost on this Union. We must have a public sector service which has the ability to compete with private sector companies. These proposals go a long way in achieving this aim, by providing a long term. sustainable workforce (POA 2012:5)

Fair and Sustainable was originally envisaged as a long-term working model. However, within a year of its rollout, 'competition benchmarking' was introduced with the intention of making prisons even *more* competition-proof. The POA surmise:

> The Public Sector benchmark involves using the Zero-based Resource Approach (ZeBRA) based on a core day established for competition and an optimum staffing

> complement of all grades. It also involves providing a regime by identifying the best possible response to the commissioning intentions document through the blend of work, learning and skills and resettlement services with the constraints of each prison's build environment and facilities and in response to its prisoner profile (POA Circular 1 / 03.01.2013)

By the time of fieldwork, Holme House had received the benchmarking team's report. Reflecting a familiar theme across sites, managers felt that it did little but apply an undifferentiated 'one officer to 30 prisoners template' to each and every wing, and consequently failed to recognise the unique role and staffing requirements of the DRW. As a result, a frontline interviewee noted that 'when [the custodial manager] showed us what they come up with there was no DRW.' Holme House consequently sought to mount a vigorous defence of the DRW and the wider regime:

> This prison has undergone our own profiling year in, year out, for the last ten years. So there's probably more expertise in terms of profiling and benchmarking than there is on the benchmarking team. Most prisons they've been to have submitted three to five contentious issues. We've submitted over two hundred. So it's a case of challenging the benchmarking team, saying… "the response you sent us is actually incorrect. You've mixed [central offender management] staff up with [DRW staff]" (S)

By the time fieldwork ended, Holme House were awaiting the benchmarking team's response to their concerns.

Level of Separation

Holme House DRW was not separated from the rest of the prison, with full-time work and education on other wings constituting standard elements of DRW provision. Staff presented this as a practical necessity, noting the resettlement benefits of work and education, and the risk of 'burning out' DRW clients if therapeutic provision was overly intense:

> I: Is [non-siloisation] an issue?
> S: I don't think so. They need a bit of downtime where they can do their literacy or maths skills that can help them when they get out. They can't just do drug work all the time. It'd be too much. They'd be battered. They'd say "I've had enough, I'm off…"

None of our interviewees saw the DRW's lack of separation as an issue, though three staff acknowledged that drug finds often originated on other wings. One also ventured that intermingling with other prisoners allowed DRW residents to 'spread the word' about the wing, thereby encouraging applications.

Drug Testing, and Positive Tests

Following the discontinuation of compact-based drug testing (due to a lack of funding), all testing on the DRW was part of the prison's Mandatory Drug Testing (MDT) programme. Whilst the TC delivered approximately 100 voluntary drug tests per month to its 60 residents, the DRW tested a randomly selected 10% of its population. Within this context, the DRW was easily meeting its performance targets:

> We have a performance target of 15% [positive MDTs] and our end of year rate is 7.3%, so our MDT rate is half of what it should be. When you break it down into

> houseblocks, the DRW's way down the list. We might get…. One positive test every couple of months (S)

Professional responses to positive tests were tailored and flexible. Both prisoners and professionals seemed to share a broad understanding of what this process entailed:

> They'd say "well, we'll have a keywork session. And then they'll help you. They'll look at your star again to see how and why you've relapsed. On the other wings, if they went to an officer they'd refer them to a [CARAT] keyworker. Whereas on here you can speak to them and they'll talk it through yourself. (P)

> We'd have a word with them. Sit down and have a chat with them and just see what went wrong. Because it might be just something at home, a lapse (P)

Some MDTs were also carried out on the basis of suspicion, and if someone produced repeated positive MDTs they might be ejected from the wing. As one officer surmised, testing was sufficiently infrequent for this to be 'very very rare'.

Relationships between Prison Agencies, and between the DRW and TC

In theory, the DRW and TC were envisioned as two parts of a recovery continuum. Whilst many areas of Holme House's processes and communications seemed to be working extremely well, this notional linkage seemed to be something that might benefit from additional attention. Three people had transferred from the DRW to the TC in the ten months before fieldwork, suggesting that the two spurs were largely operating as discrete units. Prisoner interviewees painted a consistent picture of two separate wings, containing residents who had little to do with each other. From the TC side, perspectives were complicated by an evident distaste of the DRW's methadone-prescribed clientele.

> They're sweet and sour. Totally opposites. There's a lot of genuine decent lads on the TC, where you can actually approach them if you have a problem. Whereas. The, the. The general people that you have on the DRW. The calibre of people is quite low (P)

Equally, no DRW interviewees voiced any clear understanding of the TC's role or function:

> I've talked to a couple of the lads about it now and again. But I don't really know what goes on there… They've asked me to go on there, but it's pointless. I've only got 7 month left, and people go on there to go to the open jails and stuff… I don't know (P)

Yet other accounts suggested little intermixing of prisoners. Despite spending well over a year on the TC, one interviewee summarised his involvement with DRW clients as 'nothing, to be totally honest with you,' continuing 'it is a separate unit, definitely.'

Relationships between prison agencies were characterised consistently by professionals in all roles. Accounts of working relationships between psychosocial workers and prison officers were universally positive:

> The prison officers are absolutely fantastic up here. [Custodial manager] is a really good manager. [Governor] is. Like. Fabulous. We work really closely with them (S)

> I do smart recovery for drug recovery. And the staff are just the same as me. Same attitudes and beliefs, don't use derogatory terms and just know their client group (S)

> [Relationships are] absolutely amazing with the team that I work on here. Because it's a group of like-minded people that specifically applied for the jobs (S)

Psychosocial staff were keen to emphasise the difference this marked when compared to relationships with officers on other wings.

> Sometimes you go [to non-DRW houseblocks] and you feel you feel unwanted from prison officers. I've got a better rapport with the staff on the TC and DRW (S)

Despite these excellent links, professionals in each role felt that relationships with the prison's healthcare team needed some work.

> The difficult bits I would say are the fact that the medical team are the medical team. So they, in a hierarchical approach, they take the top pin really (S)

> [Healthcare are] completely off on their own. But that's come together in the last year (S)

> Clinical come on, they do the treatments of a morning. Bit of a chat. but that's as far as it goes with us. Whether they talk to the management more I don't know… (S)

Relationships with External Agencies (Through the Gates Support)

Through the Gates: Professional Perspectives

> When the document first came out that described the criteria we were thinking "well the guys aren't coming in here for long enough for us to do anything for them. So we must be there to sow the seeds and pass them on." And we wanted to do more than that (S)

Prison officers described having very little involvement in release planning. Case management responsibility switched to DART, who began release planning six weeks before release. A series of multi-agency meetings were set up for offenders:

> We would invite Probation, the DIP team, the keyworker from the DRW, the DART worker, the prisoner and any immediate family or friends. Anyone who will be directly involved in their care in the community. And we'll say "right, this is the things they have achieved while being on the DRW, these are the plans for his release" (S)

Professionals at all levels of seniority described strong and sustained strategic and frontline links with criminal justice and generic community services. Managers described excellent partnership arrangements, and a willingness to tailor prison processes and documents to meet the needs of community services.

One main benefit was felt to have arisen from improved information flows. Staff noted that prisoners used to be able to substantially increase their medication when they returned community services. Improved information sharing now ensured community services were fully apprised of the medication status of all released prisoners..

One ongoing challenge was also noted. Feedback from some agencies was felt to be lacking:

> There's that many people working with a client. Mental health. Other healthcare. Benefits. Jobcentre plus. You don't hear once a person's left… did you get housing sorted out…? (S)

Prison officers were largely felt their work stopped at the prison gates. However, drug workers were keen to hear more about prisoners' onwards journey.

Professionals: Housing

Shortfalls in housing provision post-release presented a significant concern for staff in three of the four pilot DRW sites we assessed. Holme House was no exception:

> Accommodation is always gonna be an absolute nightmare. It is quite difficult to get housed in anything other than emergency accommodation (S)

> Housing seems to be, at the moment, a barrier. A big barrier. A lot of issues come with drug abuse. Like lack of money, lack of housing. They can't afford the bonds. Can't afford their houses where they've been before (S)

Poor housing was a particular concern, due to its potential to undermine prisoners' ability to sustain life changes following release. These concerns notwithstanding, it merits note that housing presented far more of an issue in other pilot DRW sites.

Through the Gates: Prisoner Perspectives

Resettlement highlighted a social divide between our DRW and TC interviewees. Three (of four) TC interviewees had no concerns about their eventual release. They had histories of business ownership, few concerns about starting up new businesses, supportive families, and fully-owned homes that they could return to. One found his Probation officer's insistence that he return to a hostel in order to learn how to claim benefits and cross roads passably insulting. Our DRW interviewees were more reliant on state provision, and seemed to have benefited from Holme House's efforts to tighten up resettlement provision. Nearly all were aware of release planning, with many offering high praise for previous or ongoing support:

> Probation was brilliant last time I done a sentence. Probation was brilliant. Absolutely brilliant. I got her a card saying thank you… She was mint. She was lovely (P)

> Middlesbrough PPO are pretty good. If there's anything you need they'll help you (P)

> I do know prior to release there's a meeting. With all the agencies. Say, 2 weeks before you're released. I will see my probation officer and housing. They're the main two (P)

> I know the DRW is trying to sort things out for me prior to release (P)

Additionally, two of our interviewees had been referred to a four-week OMU programme, Focus To Release, delivered to prisoners from any and all houseblocks.

Prisoners: Housing

Four prisoners spoke about their housing situation. One of these was content, having been reassured that supported housing had been secured and was waiting for him:

> Yeah housing. They got me a place. Self-contained flats. It's got a staff on 24 hours. They got me in that straight away. They're good, they do help you (P)

Three others were more hesitant:

> They tell you that they'll only implement housing in the last 28 days… Very too last minute. Especially when they see my file and realise that I'm not allowed in any of the places in my entire area. I don't know what they're fucking gonna do with me (P)

> [8 weeks to release] I feel alright. I'm just worried about finding somewhere to go. The last time I got out, probation had put me in a bedsit and there were people in there that were selling heroin, so it didn't help (P)

It again bears note that housing concerns were less evident in Holme House than they were in other DRW sites.

Perceived Likely Impact on Future Offending and Drug Use

Perceived Likely Impact on Future Offending and Drug Use: Professional Perspectives

I believe in it. I believe. I know you can be cynical but I believe. Some of them will get something out of it, eventually. If it's their first time, second time, whatever. Most of their life's been negative. It takes time to change (S)

A senior interviewee framed the wing's impact in some of the most clearly enumerated and positive terms we encountered:

> I was at a community partnership meeting last month and the IOM manager for Stockton said they had finances to pick, for example, 400 of the most prolific offenders. But the ones that's passed through the DRW who are now abstinent, they're not committing as many crimes. So they no longer fit the IOM criteria. So now they can concentrate on a new generation. And because the ones that are still on the books don't need that much resource they can now start looking at 600, 700, 800 (S)

A second senior interviewee was uncertain about how impact could be evidenced, but had considerable faith in the wing's management team, and a positive 'gut instinct':

> I think it's gone really well… I've worked with offenders for many years now. Much of it is anecdotal, is gut feeling. I don't think you know how much you've impacted on somebody's life, often for a long time. And I think we are having an impact (S)

Frontline interviewees also embraced an anecdotal approach. One identified impact…

> …just by behaviour. And the way lads interact. We get some lads on there who, you can just see the aggression, the way that they don't interact with anyone. And we *make* interact with other people. Unlocked all day. You're with other prisoners (S)

Two others believed the wing was having an impact because 'revolving door' clients were no longer appearing:

> We're seeing less people coming back through the door. That speaks volumes (S)

Finally, three interviewees noted that they lived in the same communities as many of their clients. As such, they were often able to see how prisoners were doing following release.

Perceived Likely Impact on Future Offending and Drug Use: Prisoner Perspectives

Five DRW residents offered opinions on the perceived impact of the DRW on their levels of offending and drug use in future. One of these felt unable to venture any thoughts until he was 'living it' in the community. A second offered a very positive take on the DRW's shorter *and* longer-term impact:

> Me head's the clearest it's ever been. The last time I was out I wasn't bothered. I knew what I was going to do… I was going to go and take drugs. Where this this time being on the DRW has made me think. I don't want the life no more (P)

Two interviewees offered positive, short-term accounts, noting that the DRW had helped them reduce their levels of methadone whilst imprisoned:

> Being on there, it has changed me mindset because you're not hanging about as you would on other wings with people who are still in the mindset of taking drugs. I don't like being in that group when I'm in there. It's not in my head to go out and use. On another wing, you're seeing people come in and out all the time. And talking about drugs and taking drugs. Then it's a bit harder to change your mindset (P)

> If I'd been on any other houseblock I wouldn't've been able to reduce and stay reduced, and once I reduced stay clean. I wouldn't've been able to meet that goal (P)

Finally, one prisoner was entirely sceptical about the benefits of the DRW:

> If I said "yeah" I'd be lying. It's good and that. But it hasn't had an impact on me. I've done all the courses. A bit'll stick, but you change when you've had enough (P)

These qualified or cautious accounts seem particularly curious when juxtaposed with DRW residents' glowing accounts of the positive conditions on the wing, the DRW's supportive officers, and their own levels of recovery.

If you could change one thing…

All interviewees were asked what they would like to change about the DRW, if anything. Reflecting considerable levels of contentment with the wing's provision, just four DRW

prisoners (and one non-DRW prisoner) offered any thoughts. Each came up with a separate answer, though two were related to clinical or psychosocial provision:

> Rattle packs….. I would have a ten mil valium on a morning one on a night. And something there to help you sleep (P)

> To have drug counsellors come in to speak to the lads. It gets very stagnant on there sometimes with a lot of time and little to do (P)

One prisoner was keen to reduce the numbers of lodgers on the wing

> Just to get more DRW lads instead of people who's not on the course (P)

A fourth offered a pragmatic, process-oriented concern.

> Not having to wait for your canteen. The lads coming off other houseblocks are having to wait two weeks to get their canteen (P)

Across sites, interviewees noted the extreme significance of apparently trivial concerns within a prison context. Prison wages and canteen sheets thus took on particular gravitas.

Staff interviewees cohered around a small set of themes. For prison officers, there was one standout theme: the ringfencing or protecting of DRW officers' positions:

> To get more time on it really… for us to run it. There's 16 of us on the detail. And one day you might be working the DRW and the next day you could be working in the centre (S)

> Ringfenced staff would be a good one for the continuity, and to know that all the things that are planned, that you're selling to prisoners and staff, are going to take place and it's not going to be cancelled at the last minute (S)

> Always have DRW staff on [the DRW]. Like you have TC officers. Deputed care officers who are dedicated to that place and that's the only place they'll work (S)

Two prison officers wanted more involvement in the DRW's selection and assessment process, whilst one wanted to expand the DRW so that it could cover three landings. Finally, one officer wanted to find a way to enforce or insist on medication reductions:

> They have to reduce. They have to come up with a plan. And stick to the plan. You give them a grid and say I'm on 45 mil, this time next time month I'll be on 40 mil. You don't have to come all the way, down but make an effort…Because then we could have the space and the time for a lad that's committed (S)

Psychosocial interviewees centred on a related set of themes. Three (of five) wanted more clinical or DART staff:

> The only thing I would mebbes change is mebbes have a substance misuse nurse mebbes up here to support the non-clinical side. And if you've got any questions, have them there. And to have continuity for them to build the relationships because if you see a different nurse every day, sometimes that's quite difficult for them (S)

> I think to have some dedicated DART workers based on that wing full time would be a major boost. They'd be there for the lads to talk to constantly instead of for a surgery on a Friday (S)

> More DART workers. Dedicated to just here. So we could deliver more groups (S)

Speaking from a managerial perspective, one interviewee aspired to have secure funding for the DRW, whilst a second aspired to have a fully interviewed and highly selected group of officers staffing the wing.

Appendix A: DRW Prisoner Compact

PROTECT

DRUG RECOVERY WING (DRW)

PRISONER COMPACT

This is an agreement signed by you, the DRW staff and all residents engaging in the DRW programme

PRISONERS ON THE PROGRAMME MUST AGREE TO THE FOLLOWING:

- To participate in voluntary drug testing (VDT) in addition to mandatory testing (the establishment VDT compact should be signed in addition to this compact).
- To allow the sharing of information between DRW Management Team, Healthcare Department, IOM Team and Community drug treatment organisations and take part in reviews between the DRW and Healthcare in relation to any medical issues which may affect your participation in the DRW programme.
- To participate fully in all aspects of the DRW programme identified in your recovery and care plan, including the structure, key-work, PE activities and group sessions.
- To refrain from violent, threatening or Anti Social behaviour, and from harassment or verbal abuse towards staff or other prisoners.
- To refrain from discriminating against any group or individual on the grounds of ethnicity, religious belief, faith, gender, sexual orientation, disability or other difference.
- All DRW programme rules, which will be explained by your key worker at the start of the DRW programme, must be adhered to.
- To actively seek and attend work/education or employment training.

THE DRW PROGRAMME MANAGER AND STAFF WILL PROVIDE THE FOLLOWING:

- A safe, decent and stable environment free from violence, Anti social behaviour and drug abuse.
- Each resident on the DRW will be allocated a personal "Key Worker".
- Each resident will be provided with an individual and agreed Recovery Plan.
- Each resident will be provided with support and ongoing treatment in the community upon release with the Integrated Offender Management teams and community Drug Support Teams.

I have read and fully understand this compact and I accept the conditions.

Prison Number …… Name……

Signature …… Date ……

Appendix B: CBDT Compact

PROTECT

HMP Holme House
Drug Recovery Wing

Compact Based Drug Testing Compact

Name		**Number**	

Key Worker	**Officer -**

HMP Holme House is committed to reducing drug misuse. It is our intention to support those who wish to be drug free and in signing this compact you are entering into an agreement that requires your active cooperation.

Your Obligation

- I agree not to use or supply to anyone else or be in possession of a controlled drug, alcohol or other mood altering substances unless prescribed to me personally by a Doctor.
- I agree to be frequently tested and fully understand that while a "positive" test outcome will not result in me being placed on report it mat result in my compact being suspended or terminated.
- I am aware that if I fail to provide a urine sample within a 1 hour period it will be recorded as a "positive" test result. I understand that refusal to provide a urine sample or any attempt by me to tamper with the sample will be recorded as a "positive" test result. I am also aware that a referral to the Carats service is made on my behalf after all "positive" test results.
- I understand that I will be subject to mandatory Drug Testing and normal sanctions will apply following a "positive" test result.
- I am also aware that breaching any other terms of the compact, for example, standards of general behaviour may result in the suspension or termination of this compact; it may also amount to a disciplinary offence under Prison rules.
- I understand that if I receive three "positive" tests within a six month period my compact may be suspended or terminated and I will have to re-apply within three months.

Our Obligation

- We will offer you support by giving you access to a Carat worker and provide you with useful practical advice and help with resettlement and drug misuse issues.
- Your continued cooperation with this compact will be reflected in your Incentives and Earned Privileges review although will not alone determine the outcome.

- If you do not comply with this compact an evaluation panel has the right to suspend or terminate it. However you will be involved in this process and your representations will be taken into consideration. If you are still dissatisfied after this you can appeal using the Complaints procedure.

The Process

- You will be selected regularly for random testing.
- You will be required to wait in a holding area or cell until such times that you are ready to produce a urine sample; a maximum of one hour is allocated for this.
- You will be provided with up to a third of a pint of drinking water if required.
- You will be subject to a rub down search before entering the holding area and again before taken to the sample collection site.
- You will be asked to wash your hands, without soap before providing a sample.
- The test will be conducted in your presence and you will be provided with a written confirmation of the test result.

Declaration

I have read or have had read to me the details outlined in this compact and the CBDT information leaflet. I understand that if the evaluation panel decides to suspend or terminate this compact I can not reapply for three months.

Resident Signature ……
Date……

Officer Signature ……
Date……

Appendix C: Key Work Compact

PROTECT

HMP Holme House

Drug Recovery Wing

Key Work Compact

Name		**Number**	

Key Worker	**Officer -**

Drug Recovery Wing residents must agree to the following:

- I agree to participate in Key work sessions while on the DRW.
- I understand that the main purpose of the Key work sessions is to collaborate and review my Care plan targets.
- I understand my progress and development on the DRW will be discussed during these sessions.
- I understand any behavioural issues will be addressed during Key work sessions.
- I agree to plan for these sessions by bringing with me work, queries and issues etc.
- I agree to read and sign Key work session notes after every session if all content and objectives set/reviewed are agreed.
- I agree that Key work sessions will be carried out twice per month and will be time bound to one hour.

I agree to comply with all aspects of this compact. Which I have read or had explained to me and I fully understand.

Resident Signature ……
Date……

Officer Signature ……
Date……

Appendix D: DRW eligibility criteria

PROTECT

DRUG RECOVERY WING (DRW)
ELIGIBILITY CRITERIA

HMP Holme House Drug Recovery Wing (DRW) pilot scheme has been designed to focus on those offenders who are drug dependant and who are serving sentences of less than 18 months in custody where there is limited time to complete treatment interventions. The pilot scheme will be located on house block 6 "B" wing and will provide residential accommodation for 50 residents. The scheme will also ensure effective joined up working and continuity between the establishment and the local community drug services and local Integrated Offender Management Schemes within the identified boroughs of Teesside.

The initial core group of participants must fit the following criteria.

- Offenders with drug treatment needs who are engaged with one of the following Integrated Offender management Schemes:
  Stockton on Tees
  Middlesbrough
  Redcar and Cleveland
  Hartlepool
- Offenders who are serving sentences of 1 -18 months in custody.
- Offenders who have been stabilised and participated in identified IDTS groupwork or 1:1 sessions and completed the 28 day IDTS programme.
- Offenders who agree to actively engage with the Carat's team, and are motivated to achieve their sentence plan targets.
- Offenders who choose reduction in substitute prescribing to achieve abstinence.
- Will complete screening and initial assessment questionnaires that will measure different aspects of their drug use, social and psychological functioning. (All or some of these questionnaires may be repeated at regular intervals throughout their stay on the Drug Recovery Wing)
- Agree to participate in the Drug Recovery Wing evaluation process (Exit Interview) prior to their return to the community.

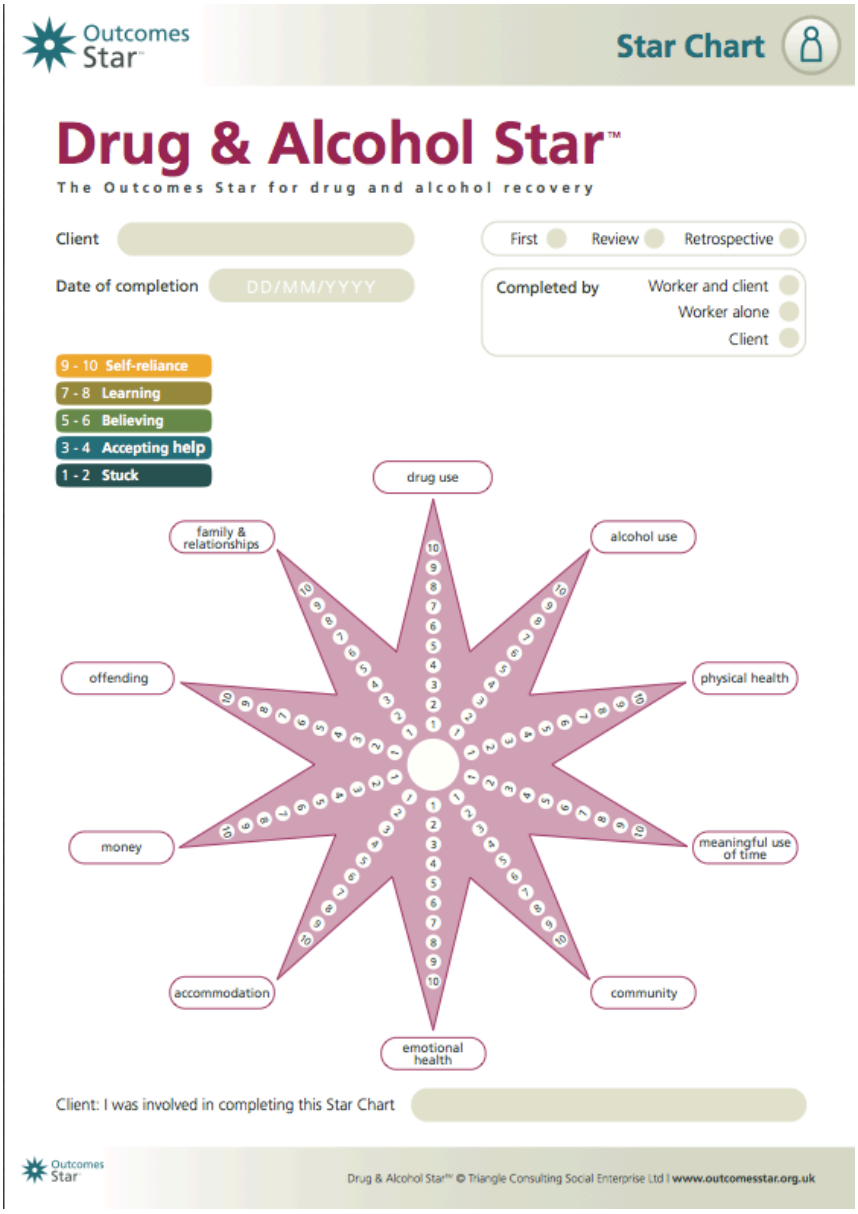
The Drug Recovery Wing will consider any application received from any prisoner who fits the eligibility criteria. Our goal is to create an inclusive supportive recovery community which adheres to the requirements of current equality legislation & will not discriminate on grounds of Age, Disability, Gender Reassignment, Race, Religion or Belief, Sex or Sexual Orientation.

For those offenders with drug treatment needs that fall outside the above criteria for the Drug Recovery Wing the following drug interventions will still be available.

- Carat's intervention
- Integrated Drug Treatment Services (IDTS)
- Short Duration Programme (SDP)
- Therapeutic Community (TC)
- Health Care & Mental Health Team

I Snaith
Group manager
DRW
27th January 2012

Appendix E: The Drug and Alcohol Outcomes Star



Star Notes

1 Drug use

2 Alcohol use

3 Physical health

4 Meaningful use of time

5 Community

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Star Notes

6 Emotional health

7 Accommodation

8 Money

9 Offending

10 Family and relationships

Action Plan

Priority area from Star	Current score	Next steps	By who?	By when? (date)	Completed (date)

Signatures:

Service user _____ **Date** DD/MM/YY **Staff** _____ **Date** DD/MM/YY

Outcomes Star

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Appendix 8: Manchester

Key Points:

- The drug recovery programme is known as Recovery Through the Gate (RTG).
- The drug recovery wing is located on H1 wing. This wing is situated so those on the wing are isolated from the other prisoners with the exception of when they attend education, workshops, visits, library or the chapel.
- There are three stages to the recovery programme.
  1st Stage: The intensive 8 week programme where a time schedule is set and presented weekly. This schedule must be followed by all participants. This first stage introduces them to life skills, victim awareness, SMART recovery, other recovery skills, etc.
  2nd Stage: Prisoners stay on the H1 wing until their release either:
    a) as a peer mentor
    b) attending an education programme or
    c) working in any of the prison industries.
  3rd Stage: Upon their release they are escorted through the gate by their keyworker to the Roberts Street drop-in centre and/or straight on back into the community. They are introduced to the various agencies prior to release and escorted if desired to their first appointments following release. They continue on the programme of support for up to 13 more weeks. In practice however, some clients are still being supported long after 13 weeks.
- Those with histories of opiate dependency who are accepted in RTG must be either abstinent from opiate substitution or on a reducing dose programme that allows them to complete their opiate detox prior to release.
- Those in recovery do not participate in education or workshops for the eight weeks they are on the intensive recovery course. (1st Stage).
- RTG has 22 beds on the wing in twin bedded cells. There is an average of 10 clients on each stage 1 course. However there are currently 18 prisoners on the wing, with 2 of them working as peer mentors and 2 working as cleaners.
- RTG provides continuation of service and support. Prisoners completing the stage 1 course will remain on the wing until release – this then becomes the 2nd Stage of the recovery wing programme.
- The prisoners said that they feel the staff are very supportive and that all prisoners on the wing work as a team to mutually maintain motivation to remain in recovery.
- RTG is not a pre-release initiative *per se* but an intense recovery programme assisting in reaching abstinence prior to release with follow-through support for resettlement within the community.
- The Manchester City Drug and Alcohol Strategy Team (DAST) commission all the RTG services in HMP Manchester and in the community.
- RTG has outstanding working relationships with all drug and alcohol services within the Greater Manchester area.
- The Governor and Deputy Governor enthusiastically support the RTG / DRW programmes.

Basic Prison Information about HMP Manchester

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.

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.

Following a major disturbance in 1990, the prison was re-built, and the running and management of the prison was put out to tender. The Prison Service won the contract and re-opened the prison in 1994. The prison was again put out to tender and the Prison Service won the contract in 2001. In early 2003 HMP Manchester became part of the High Security Estate.

HMP Manchester went out for tender again in 2011 and went on to secure the contract for a further 15 years as preferred bidder. This was announced by the Right Hon. Kenneth Clarke in the House of Commons. The new contract commenced on 1st April 2012.

Address:
1 Southall Street
Manchester
M60 9AH

Tel: 0161 817 5600
Fax: 0161 817 5601

Acting Governor: Hannah Lane

Accommodation: 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.

Operational capacity: 1238 as of 1st April 2013.

Education
The Education provider is Manchester College. Classes that are offered include Skills for life, IT, ESOL, Flexible learning, Numeracy, Life skills and Parent craft. Some classes are based in the education department, however there are also wing based classes for those who are unable to attend and education support for prisoners who work in the workshops on a full time basis. Victim Awareness courses are also offered through the education department.

Training Courses
Training courses are offered in IT, Industrial cleaning and Bakery. All courses offer national recognised qualifications and are linked to employment opportunities. There is also an opportunity for prisoners to gain an NVQ in catering.

Industries
There are workshops in Textiles, Printing and a large well equipped laundry. All areas offer training and have embedded skills for life support.

PE
There is a large well equipped sports hall and gymnasium. Recreational gym is offered Evenings Monday – Thursday and Mornings and Afternoons Saturday and Sunday. Accredited courses are delivered in the mornings and afternoons; these include FOCUS gym instructor, CSLA level 2 and First Aid at Work. There are also 2 courses accredited by the Open College Network, these are Get Fit for Life and Weight Training Theory. Also, there are cardio vascular gyms on some of the wings.

Programmes
The Psychology department offers the following programmes, Thinking Skills Programme (TSP), Healthy Relationships High and Moderate intensity Programmes and RESOLVE. Prisoners can be referred for these programmes but are only offered a place after an in depth assessment as to their suitability.

Services and Interventions
Interventions and Services are offered to reduce re-offending. These focus investment where it will achieve better outcomes. Services include: Accommodation advice, Job Centre Plus, Pro Social Modelling, Medication which includes Healthcare and Mental Health In Reach Team (MHIT), Substance Treatment and Recovery Team (STAR), Peer Mentoring and Building Skills for Recovery (BSR), in addition to the specialist care given on the Recovery Wing.

Visitors

There is a staffed Visitor's Centre outside the main gate, with a canteen and children's play area.

A typical day Manchester, Recovery Through the Gate (Summary)

Each Monday morning the men are given their weekly schedule for activities, groups and courses. Participation in all components is compulsory. After completing Stage 1 of the RTG programme, the men participate daily in education or workshops in the wider prison. However, it is anticipated participation in workshops will soon be discontinued. The men meet with their key worker weekly. The men also attend a weekly group meeting named 'Our Time'. If there are any problems or situations they are brought up at this group. The peer mentors may then take issues to the staff for resolution. Prisoners meet with their peer mentors in groups and support is given by the peer mentors to the men on a regular basis. Peer mentors can call meetings during association times if necessary.

Typical day for someone on the course in the Recovery Through the Gate programme is:

07.30 – 08.15	UNLOCK	– wake up, breakfast, medication, cleaning etc.
08.30 – 09.15*	UNLOCK	**– wake up on Saturday and Sunday** – not locked up again until 12:00 – education, workshops, groups, course work, or association with groups called by peer mentors if needed.
12.00 – 13.30	LOCK UP	
13:30 – 16.30	UNLOCK	– education, workshops, group work, course work groups called by peer mentors if needed.
16.30 – 18.00	LOCK UP	
18.00 – 20.15	UNLOCK	– association, phone calls
20.00 – morning	LOCK UP	
16.30 – morning	LOCK UP	*** Friday, Saturday and Sunday evening**

Table 1: A Typical day in H1

Day of the Week	Morning	Afternoon	Evening
Monday - Thursday Schedule given to participants on Monday morning for the courses or activities they would attend that week.	**WIDER PRISON:** *Medication, education, workshop* **PROGRAMME:** *Course work, activities or group, gym*	**WIDER PRISON:** *Education, workshop* **PROGRAMME:** *Course work, activities or group* *Association, gym*	*Association, library, phone calls, visits*
Friday, Saturday and Sunday	Wake up and hour later, Group work on wing	Group work on wing	Lock up at 16.30
There are scheduled weekly meetings with their recovery worker. Meetings with peer mentors as needed.			

Observation of the physical and social environment of the DRW

The DRW is located on H1 wing, a ground floor landing with a solid ceiling. This means that the unit is entirely self-contained, and prisoners housed in H1 cannot see or communicate with those housed in H2, 3 or 4. The landing was designed originally as a segregation wing.

The wing contains 16 usable cells with in-cell sanitation, but no showers.

At the time of the rapid assessment, 11 cells were occupied, housing a total of 19 prisoners. Eight cells housed 2 prisoners each and 3 cells contained a single prisoner each. The wing cleaners are normally given a single cell, unless there is insufficient space.

The walls have recently been painted with a two tone light- and dark-blue colour scheme. Motivational recovery-focussed posters adorn the walls throughout the public areas of the wing.

In the main association area near the entrance to the wing, there is a pool table and a mini 'library'. This is a single bookcase containing recovery materials, prison information, leaflets from community services and other helpful literature.

An 'information hub' has been installed on the DRW. Resembling an ATM, the hub has a touch-screen interface. This system has largely taken the place of much of the paper-based application processes in the jail – for healthcare appointments, visiting orders and weekly chapel applications etc. The hub also serves as an information point to tell prisoners about services and activities around the jail. It has proved popular, but with prisoners who need to learn inter-personal communication skills it has been seen by some as a barrier to that. Staff commented that under the new NOMS 'Fair and Sustainable' workforce re-structuring process, the information hubs would take the place of several administrative officers across the jail.

A single small classroom doubles as a minimally equipped gym room. However, within a few days of my visit, a new, fully equipped cardio exercise suite on an adjacent wing was due to be made available to the DRW prisoners. The classroom is barely large enough to hold all those on the programme when in a group meeting. The room also contains 3 large applications and complaints boxes attached to the wall, which reduces the available space.

The wing has its own, unusually well-equipped food servery, which has recently been awarded a food hygiene rating of 5 from Manchester City Council. (This is rare in a prison!) Prisoners can complete a certificate in Basic Food Hygiene while in HMP Manchester (regardless of location). One very important perk of being on the DRW is access to the commercial grade toaster, which kept in the servery. Several prisoners cited this as one of the top benefits of engaging with the programme! Staff see this as an important pro-social modelling device – having to queue up and wait your turn for toast while socializing at the same time.

The servery also had up-to-date Halal certificates on display. Staff said that they could not remember any Muslim prisoners engaging with the DRW.

The shower room contains one shower cubicle and a separate changing cubicle. Also, in the same area, are the laundry washing machine and dryer, along with the mops and brushes for the wing cleaners. All these facilities are relatively new and in very good condition. Unusually too, the wing cleaners said that they has no problem getting a full range of cleaning materials (including toilet cleaner) which are traditionally hard or impossible to come by in most jails.

The DRW has its own exercise yard, which is still configured as a segregation unit exercise yard i.e. totally enclosed by wire mesh on the sides and top. The Tarmac ground area is around 6.5 metres square. Two benches, each for three men, are the only other features in the yard. Prisoners on the DRW get one hour of exercise in this yard daily, with no restrictions for inclement weather unless there is snow or ice.

Overall, this is not a spacious wing. In fact it feels quite claustrophobic as there is virtually no natural lighting in the central corridor and association areas. Prisoners were, however, mostly resigned to the conditions on the wing, stating that the safety aspect (i.e. freedom from drugs and bullying) far outweighed any and all other environmental considerations.

The wing is kept very clean and tidy, and has a friendly and relaxed atmosphere. I was particularly struck by the readiness with which prisoners greeted me when I first entered the wing and by how willing they were to talk to me.

Profile of prisoner interviewees in Through the Gate, Manchester Prison.

Thirteen men were interviewed. Ten were prisoners currently on the programme and three had already been released. The oldest was 50; the youngest was 27 with an average age of 41. Prisoners had been convicted of a range of offences: four for violence and disorder (including three for domestic violence), nine for acquisitive offences (including one for possession with intent to supply), and one for violent *and* acquisitive offences.

The longest sentence being served was 3 years 6 months. The shortest sentence was 3½ months. The average sentence was 15.5 months.

The ten current DRW residents had between two weeks and 13 months until their anticipated release, with an average of 3.7 months. All but two were within six months of release, and only one had more than a year left to serve. It is worth noting that the prisoners on the wing who have more than six months to serve are generally either wing cleaners or peer mentors. The model is designed to support prisoners in their final stages of sentence, therefore anyone assessed as suitable for the RTG project would need to be nearing sentence completion.

Those who had already released had been in the community for three months, one month and six months respectively.

The men participating in the *Recovery through the Gate* programme had spent varying lengths of time on H1 wing; the range was from 17 months to a little as one week. (Again, it is worth noting that anyone spending 17 months on the wing would either be a cleaner or a mentor.) Prisoners would arrive at HMP Manchester, complete induction, be placed on detox or the stabilization unit (I wing) if necessary, be scheduled for a selection interview by RTG recovery officers, and upon approval, transfer to H1 wing. There was one man who had entered H1 wing directly from a community rehabilitation centre.

Most of the men were certain they would remain on H1 Wing until their release into the community with the exception of one. This interviewee (who had transferred to RTG from community rehabilitation) felt that on graduation from RTG he would request transfer either to another wing, or to another prison.

With one exception, the men stated they would most likely live in the Manchester or greater Manchester area when released from prison.

Drug and Alcohol history and treatment experiences of interviewees

The longest alcohol and drug using history among the interviewees was 33 years. The shortest history of problematic substance use was 5 years.

The history of substance use by the men was mostly poly-drug use with cocktails of available substances being used. Two exceptions were men who had been dependent upon alcohol only and one with dependency only on heroin. Three of the 13 interviewees arrived in prison with benzodiazepine dependencies, running alongside problems with other substances.

Five of the men had not experienced substance misuse treatment in the community, and had previously avoided engaging with treatment in prison. They explained that they had previously been non-compliant, uninterested, or unready. Three had received treatment, but had returned to illicit drug use. One had been placed on buprenorphine (Subutex) with no aftercare, so had returned to illicit drug use. Three had been placed on methadone prior to arrival in prison and continued a reduction programme in prison. One had received 'every treatment under the sun' but had always previously returned to drinking.

All men stated they had had enough of drink and drugs and felt the time was ready to change their lives. The ages of the men just beginning recovery reflects the recent trend in increased age of those entering recovery.

Detoxifications

All three post-release interviewees had been fully detoxified from any substitute medication whilst engaged with RTG. All were still in receipt of medication for mental health problems.

Seven current DRW interviewees had fully detoxified from methadone. Five of these had also completed detoxification for alcohol dependence, and two had detoxified from benzodiazepines. Three had ongoing anti-depressant prescriptions.

Three current DRW interviewees were reducing their medication, and were in receipt of between 2 and 30mls of methadone per day.

Motivations, advantages and disadvantages

All the men participating on the programme felt they had come to the time and were 'ready' to be clean. Each had specific reasons: children, tired of being sick or needing drugs to live, etc. All, except one (aged 27), said they were just too old to continue. A lot of the men stressed the importance of feeling 'ready' to go through recovery citing numerous attempts and returns to substance use as examples of non-compliance because they were not 'ready'. Additionally, many prisoners stated a recovery programme such as *Recovery Through the Gate* had not previously been available.

The men stated several key advantages of the *Recovery Through the Gate* programme. Firstly, they highlighted high levels of mutual support from other men on the programme. Secondly, they felt that recovery was being delivered in a way that fostered team work and a team identity, with the segregation from other wings seen a positive factor in helping them maintain a drug free environment on the wing. Thirdly, interviewees felt that it was important that some RTG participants were allowed to come off methadone at a slow pace if necessary. Fourthly, the men stated they felt more settled on H1 wing, without having to be concerned about being moved about or being subject to random 'pad mate' changes. Fifthly, the men said it was a safer environment on the wing. Each said they felt safer being there: safer from temptation to use, from distraction, and from possible bullying.

The men also stated that the recovery workers had helped to motivate them to begin recovery. The men said the courses on the programme taught them how to address the issues. Some stated with everyone going through the same stage of recovery they understood how to support each other and would talk with each other during association, providing mutual encouragement. Those on the programme felt having staff that were easily accessible helped resolve problems; and peer mentors were always there to assist when needed.

Several stated that one of the main advantages of RTG was the staff support, which extended throughout the programme and even continued following release. They presented this as one of the main reasons they were able to remain drink and drug free.

Additionally, an important advantage to the men was the assistance being received with accommodation once released from prison.

The only disadvantages mentioned were: more physical activity would be beneficial with more activity space, buprenorphine not being available on the programme, and more 'on the out' focus courses should be incorporated in the courses to help the men face situations once they have been released.

The men viewed the quality of life on the wing as better than elsewhere in the prison, even though there were two to a cell. The relationship with the recovery staff was considered excellent and the discipline staff were generally more respectful than elsewhere in the prison.

The majority of men felt the amount of segregation from the rest of the prison was a good balance. A couple wanted total separation.

Elements of recovery that the men stated had helped them the most were: the groups, Outcome Star, SMART recovery programme, Victim Awareness, healthy mind and body courses, AA, NA, Partners of Prisoners (POPS), Addaction input, Life skills and the peer mentor support.

Most men stated they enjoyed keeping their journals/diaries because it helped them to look back and see how much they had changed. They complete their diaries and/or journals and hand them in each Monday morning. Their key worker reads them and adds comments to their entries.

Availability of drugs in the prison more widely

The men described no availability of drugs on the recovery wing. However, they painted a much bleaker picture of diverted medication, bullying and drug availability and use on the other wings. A couple of men said someone had thrown lines down from the landings above in an effort to deliver drugs to their wing. They stated the times other drugs were available was whenever they were participating in activities out-with the recovery wing i.e. education, medication administration, visits, library and chapel. The men felt the use of drugs out-with the recovery wing even on B Wing, the so-called 'drug-support wing', was widespread.

Additional treatment/services the interviewees would like to see

The majority of the men felt more physical activity should be included on the programme. (It should be noted that this will be rectified imminently – see note on the 'Observation of the physical and social environment of the DRW' – page 3).

Courses which included planning a schedule, banking and more life skills were requested.

A request was made that buprenorphine be allowed on the recovery wing.

Refresher courses or follow-up courses were requested for those that remained on the recovery wing once they completed the current course.

Attitudes to staff

Those interviewed all had good things to say about the staff on the recovery wing. They felt the staff supported them and would do whatever possible to help them resolve any issues that came along. The prisoners stated there were scheduled weekly meetings with their key worker but, if needed, they could ask to talk with a key worker at any time or other (discipline) staff if their key worker was not available. The prisoners felt the understanding and support of the staff was paramount to their recovery.

Attitudes to DRW from the wider prison

Those interviewed on the DRW mentioned situations where they were looked upon by other prisoners as having an easy ride whilst living in a 'soft' prison atmosphere. They stated that attitudes were gradually changing and things were quietening down. There were fewer shouts from the upper landings to those on H1 wing.

The staff felt as though the DRW was being accepted more than it was in its earlier days. They felt that attempts to change staff attitudes needed to recognise that they were based more on awareness than negativity, and that as other prison officers knew and understood what the DRW was about, the attitude would become more positive. Some felt that those who believed the wing was an easy rehabilitation location had not been informed of the true purpose of the wing.

Being in recovery

Each man felt he was in recovery and one said that he had already recovered. Many stated they would be in some stage of recovery for the rest of their lives.

Those interviewed all felt there would be positive impacts upon their behaviour, lasting long after their release. All of the interviewees felt remaining in recovery would have an impact on, or stop, their future offending. Most interviewed stated their offences had been committed either as acquisitive offenses (to fund drug use), or whilst under the influence of mind altering substances.

What do you understand by the word 'recovery'?

All those interviewed described themselves as being in some form of recovery. Many felt recovery was not just recovery from what they were addicted to but recovery from those issues that made them use in the first place. Some felt that recovery was a process which needed life time support and interventions. Many felt recovery meant getting back to normal. Some felt recovery was recovery from what was affecting your life and making you do those things that resulted in offending. Some felt recovery meant not looking back and learning how to cope without substances. Some felt recovery was a change of thinking.

Interviews with staff

The Deputy Governor for HMP Manchester is responsible for the Recovery Through the Gate programme. There are currently five members of staff involved in running the DRW. All the keyworker staff are directly employed by the prison service – mostly uniformed, with the exception of the one female keyworker. Prior to coming to the DRW, most of the staff had previous experience either working in recovery or rehabilitation in other prisons, in the community or on B wing. [B wing is the voluntary testing wing and is a designated a drug-support wing.] Most of the staff had attended numerous recovery-related and/or rehabilitation training courses.

Senior staff raised concerns about the future sustainability of the DRW and, in particular, whether or not Manchester will be able to bid for the delivery of services.

Brief history of the development of the DRW

HMP Manchester has long operated a drug-support wing, situated on wing B. This is intended to provide a more supportive environment for prisoners seeking recovery, backed up by a programme of compact-based drug testing. When the government opened the door for development of DRWs, HMP Manchester was already in the process of developing an intensive recovery programme which was able support prisoners following release. This is the purpose of RTG.

When local commissioners heard of the plans for the recovery programme they supported it fully and began ensuring commissioning of services to initiate and support the programme.

HM Prison Service received its SLA tender for an additional 15 years of prison delivery at HMP Manchester and then tendered to be one of the pilots of the DRW. The DRW was moved from the designated drug support wing (B wing) of 160 prisoners, to H1 wing (which has 22 beds). None of the B wing residential staff

moved, though staff working on the RTG project had previously been located on B wing with the RTG clients. These RTG staff moved location with the project but were always part of the STAR (Substance, Treatment and Recovery) team not residential / B wing officers.

The Drug Strategy/Healthcare Manager was instrumental in the setting up of the methodology of the DRW and the move to a more isolated wing to allow the intensity of the programme to be more effective for the prisoners. The Governor openly and vigorously supports the RTG, making it clear to all the senior management team (SMT) that the project is to be afforded every consideration possible.

Healthcare and the IDTS work closely to ensure that those on the RTG programme or any detox programme can receive support and treatment as necessary in all areas of the prison including the segregation wing.

What distinguishes the DRW? strengths and weaknesses

The staff aspire to continue the development of H1 wing, with the hope of fostering a 'therapeutic community' style environment. Support by the recovery staff is available on the DRW for 12 hours each day during the week, thereby improving access to informal support and psychosocial interventions. Staff identified this as a distinguishing factor and a key strength of the RTG programme. Staff also felt the overall environment of progressive recovery, in which prisoners' needs were dynamically assessed and continually matched to tailored interventions, set the RTG apart from other prison-based programmes.

All of the prisoners and staff agreed the safety factor of an isolated wing was a strength. They also agreed that the supportive environment greatly bolstered the success of the recovery programme. The staff felt the relationships with prisoners on the wing was more relaxed, and that prisoners on the programme felt the freedom to approach them to discuss issues and problems.

The prisoners felt the peer mentors were a benefit of the programme and that everyone on the programme worked as a team to support each other and keep the wing drug free. Prisoner interviewees felt the support given them by staff and others on the programme could not be delivered on any other wing. They felt the structure and interventions were intense and increased motivation to remain in recovery.

A distinguishing part of the DRW was for those prisoners chosen to be peer mentors: they attend an accredited programme which they can continue upon release to NQV level two- overseen by an external provider. They can also progress to NVQ level three through the Back-on-Track community programme.

The staff felt since the programme was continually developing and improving that any potential weaknesses would be addressed. They felt the quality of life was improved and safer on H1 wing.

One member of staff felt that the change in staff detailing (i.e different duty rotas, and officers from other wings being brought in to fill staff shortages) was a weakness. This effectively meant that some discipline officers were detailed to the wing that are not fully in agreement with its ethos. To remedy this it was felt that a set number of staff and specific discipline officers should be assigned to the DRW. Another weakness mentioned was the effect of recent difficulties caused by changes in NOMS security vetting procedures. Visiting facilitators from AA, NA or other training within a Category A prison are now subject to much greater scrutiny which has caused some to decline to apply for renewed clearance.

All agreed the strongest part of the programme was the continued support thirteen weeks after release.

Choosing individuals for the programme

A specially designed assessment process is used to select suitable participants for the RTG programme. The prisoner is assessed initially upon arrival and, if necessary, sent to the detox unit for 5 days stabilisation. After which time, a referral will be made for appropriate prisoners to go to the DRW.

Prisoners' length of the sentence, assessed motivation, willingness to move toward, drive towards abstinence and reasons why, are determining factors for selecting participants on the programme. Prisoners' drug of choice does not play a role in selection. Other considerations include security information, and risk factors associated with each prisoner.

Those typically not accepted on the DRW have high risks and / or extreme violence associated with their offences. The risks to the staff and other prisoners are always considered, as well as the ability to provide the protection for the prisoner themselves on the wing. Cell-sharing risk assessments will be repeated for those applying to the RTG programme.

Extending the programme more widely

There is no plan to extend the programme any wider within the prison at the time. However, there will be a location outside the gate beginning May 2013 for the continued support of prisoners once released. This will be known as the 3rd Stage of the RTG programme.

Attitude to the DRW and its impact on the wider prison

All those interviewed felt that non-RTG staff had a somewhat negative view of the DRW. Staff believed there was some jealousy and un-informed views about RTG's operational model. Some interviewed had received negative comments pertaining to the wing. Some staff felt some prison officers had a 'did not want to know attitude' and just wouldn't accept the intensity of support given to those in recovery. Both prisoners and staff felt the wing was now more accepted and many more understood the purpose and intensity of the recovery programme than was previously the case.

The staff interviewed felt the isolation of the DRW kept it from having any negative impact on the wider prison.

Level of separation from the rest of the prison

Most of the staff and those on the RTG programme felt the level of separation from the rest of the prison was at the correct level. There were 2 prisoners and one member of staff that felt there should be total isolation from the wider prison.

Most felt the risk and severity of contamination / temptation for drug use was appropriate. RTG residents had some, limited contact with those housed in other wings. Interviewees felt this was appropriate, as each of those in recovery needed to undergo temptations to help them build better coping skills for when they were released into the community.

Availability of drugs

The staff and prisoners on H1 wing believed there could never be a completely drug free environment within a prison. They all agreed that the availability of drugs on the DRW wing was as low as possible, and substantially lower than in the rest of the prison.

Drug testing and the consequences of a positive test

HMP Manchester had an average random MDT positive rate of 5% for the previous year 2012.

Each participant in the recovery programme signs a compact agreeing to additional compact-based drug testing (CBDT) that, unlike MDT, does not carry with it any prison-based disciplinary procedures. The RTG recently received commissioner's funding for mouth-swab testing that will be conducted randomly on the DRW by staff on that wing. The swab test consists of both instant results testing as well as sending off to Concertano (medical labs) for the detection of buprenorphine.

The consequences of a positive test are handled on an individual basis. If a peer mentor tests positive they suffer automatic removal from the unit. If a DRW client has gone to their key worker prior to the test and discussed their drug use, they may not be removed from the programme. Each case is reviewed on its own merits.

Relationships with external agencies

The prisoners, staff and members of agencies working with HMP Manchester and the RTG all expounded on the outstanding relationship, feedback and communication with external agencies. The staff of RTG are continually seeking further agencies with which to work.

Regular feedback flows from the external agencies to RTG and back to the external agencies.

Likely impact on prisoners' futures

Each member of staff and those from external agencies were of the view that the impact would be positive for prisoners participating in RTG. They all felt that prisoners' future use of drugs and alcohol would be reduced and that offending would hopefully be removed from the equation, especially those that had only committed offences while under the influence of substances.

If you could change one thing

Three of the staff did not feel there should be any significant change within the RTG/DRW.

One member of staff suggested that prisoners should be able cook their own meals.

One member of staff suggested complete isolation for the first stage of the recovery programme.

Researcher's Conclusions

Overall, I was impressed by the ethos and outworking of the RTG concept. There is, to my knowledge, no other similar programme in any other prison in England or Wales. The notion that the prison's resettlement and rehabilitation work continues post release is a powerful and revolutionary one. It is, of course made considerably easier in a metropolitan city like Manchester where the prisoners from HMP Manchester will, in the main, be released back into the Greater Manchester area. For Category C establishments, that ironically should be more focussed on the resettlement of albeit medium and longer tariff prisoners, there are increasingly problems due to the fact that most release nationally rather than locally.

The focus of the HMP Manchester DRW/RTG programme being on the repeat, shorter-term prisoner is clearly a concomitant strength given its locality and release area.

As a consideration to future research involving released prisoners, the RTG will of course have ready access to many ex-prisoners still receiving support: an important bonus for the research study.

The extent to which the Probation service is involved in the post-release support is an area that I also feel should be explored in greater depth. My initial impression is that it is currently at a level that is not optimum for the best chance of reduced re-offending especially for those ex-prisoners on licence or HDC.

In response to this point, Manchester added further detailed information:

> Probation input, at the time of assessment all clients on the project who were part of the Integrated Offender Management model were jointly managed by RTG and the Choose Change project. However, this does not apply to high numbers of clients. Additionally, the majority of clients would not have been released on licence and would not be afforded Offender Management support by virtue of being sentenced to less than 12 months. However, our team do engage in the Integrated Offender Surgery jointly reviewing PPO cases. As a prison we are engaging with the Through the Gate and Transforming Rehabilitation initiatives, which will of course increase the availability of rehabilitation services to prisoners serving under 12 months, a move we welcome.

Appendix 9: New Hall

Rapid Assessment of HMP New Hall – Drug Recovery Wing (PREW)

Key points

- **A rapid clinical detoxification is the first stage of treatment on PREW and all the women have go through it – usually in the first 2/3 weeks on the wing. They are not allowed to come on to PREW until they are down to 20mls of Methadone/2mls of Subutex.**
- **At the time of the visit, PREW was less than half full.**
- **There is insufficient one to one and/or group work being carried out. The women complained of being bored and of needing more recovery and relapse prevention programmes.**
- **There is little or no direct connection between PREW and external agencies.**
- **The women are totally isolated from the rest of the prison population. They do not work or go to education and they are escorted at all times when off the wing.**
- **Women are at different stages in their sentence, but there is a planned exit strategy of moving on to the drug free wing or, when appropriate, to open conditions at Askham Grange.**
- **There has been a recent breakdown in relationships between the present cohort and discipline staff which is causing a considerable degree of friction – there was some suggestion that a greater understanding of the detox process on the part of the discipline officers might help with this.**
- **The programme will revert from a rolling programme to a cohort from the beginning of June 2013.**

Basic prison information

New Hall is a closed women's facility[1] in Flockton, Near Wakefield. It comprises traditional cellular accommodation and there is no longer any dormitory accommodation. Prisoners coming into New Hall start on Apple wing – which is the first night centre. Once assessed, they are normally placed on Oak 1 wing to be stabilised. This is a 45 bed wing where a more standard IDTS psycho-social intervention programme is run. It is possible to detox whilst still living on Oak wing by moving to Oak 2 (again with around 45 beds) where women work within the prison but receive additional interventions such as group work. The idea is that recovery is possible on Oak 2 for any woman and so there are no restrictions in terms of sentence length, level of risk or mental health needs.

What the prison term 'enhanced recovery' is supplied by their DRW – known as PREW (Project Recovery Empowering Women). This is housed in Rowan wing (which also houses the juvenile offenders[2]) and is an isolated/segregated unit where the women are taken out of the normal prison environment. It is a 21 bed unit, with an expectation that two beds will be occupied by a listener and a recovery champion, leaving 19 beds for women on the PREW programme. All the accommodation is single cell. Women are escorted everywhere they go throughout the prison and so the isolation and protection from the wider prison environment is very comprehensive.

[1] Women's prisons are not categorised in the same way as men's. They are either open or closed and so cater for a wide range of prisoners/offences.
[2] At the time of my visit there were 3 young offenders housed in a separate spur known as Rivendale.

In order to 'qualify' for PREW women have to be either drug free but requiring additional interventions or down to 20ml of Methadone/2ml of Subutex in their methadone reduction treatment. Once on PREW they are expected to complete a rapid medical detoxification whilst being offered holistic psychosocial interventions within a Therapeutic Community-type environment. The minimum stay is six to eight weeks but there is scope to stay longer and this is assessed on an individual basis. Once they have completed their programme on PREW the expectation is that women who are not being released or transferred to another prison move onto the drug free wing housed on Larch – which is a semi-open, smaller unit of 40 beds, with voluntary drug testing and alcohol compliance testing once a month or on suspicion; and which offers 'outreach' support and a community environment which is supportive of continuing recovery. Alternatively, women coming to the end of their sentence may be moved to open facilities at Askham Grange prison in York. For those who are released into the community from PREW, the aim is to link them to a recovery community/supported accommodation.

At the time of my visit there were nine women living on PREW so it was less than half full. The project started in August 2012. On the 1st April 2013, the current Drugs Strategy Manager, Alison Laycock, leaves her post to go to work in NOMS. She will not be replaced by someone with the same level of seniority and her replacement will be simply responsible for delivery of PREW, not its management, which will fall under the remit of a governor.

A typical day on PREW

The women are woken and get up between 7 and 7.30am and breakfast is served at 8.15am on the wing. At 9.00am there is the morning meeting which deals with administration issues for the day and is an opportunity for the women to air any grievances. Three mornings a week the women do group work. The content of this has varied over time, but during my visit it was focused on Mindfulness and was being delivered by a Turning Point staff member. The women eat their lunch on the wing and are then locked in their cells for an hour while the prison officers eat. Most afternoons are free time with gym sessions on a Tuesday and Thursday. As the women are isolated from the rest of the prison, they do not work, and so this time is simply spent on the wing, unless the woman has appointments with other services around the prison. If she does so, she is escorted by an officer wherever she goes. At 6.30 the women are locked in for the night.

Referrals to PREW

Referrals to PREW can come from the women themselves or from a member of discipline staff, Turning Point or the health team. The women must be engaging with Turning Point and all referrals initially come through them and they will see every woman who is referred. A weekly meeting is then held where applications are considered by a multi-disciplinary PREW panel involving OMU, mental and physical health services, Turning Point, PREW staff and sometimes wing staff. The woman has to demonstrate her motivation through an interview with Turning Point or by doing a piece of written work. If the woman is not seen as suitable at this point, she will be given some work to do or goals to reach before being considered again.

Observations on physical and social environment

PREW is housed on a traditional wing in a building which is shared with the juvenile wing. This accommodation is of a higher standard than the larger, general wings. I was shown around the prison and the larger wings are pretty depressing spaces in comparison, though Larch wing – the Drug Free wing – was smaller and had a more relaxed open feel. The women on PREW have a toilet and a shower in their cells all of which are single accommodation. Attempts have been made to 'soften' the environment with paintings and soft furnishings. Because it is a segregated wing, the

women spend all their time in and around their cells (when not in group work or on appointments) and on my visit were sitting in small groups in various cells chatting. They are only locked up during normal times – ie at lunch and in the evening. The temperature was warm and the lighting was strip. Locked doors are evident – this is clearly a wing – but there was a fairly relaxed atmosphere. The discipline officers seemed to spend a lot of their time hanging around in their office/hub and there did seem to be a lot on duty at once. I saw one officer doing a jigsaw in the communal space – but at the time no prisoner had come to join in in this activity. The women didn't complain about the quality of the food but there were some complaints about the quantity – in particular the amount of bread they were allowed. As is the norm in women's prisons, they all wore their own clothing and officers wore a 'softer' uniform of navy polo shirt and trousers/skirt as opposed to the usual 'black and white'.

Profile of the women on PREW

I interviewed six of the nine women currently on PREW. They ranged in age from 47 to 19 years with an average age of 31.5 years. The longest sentence being served was four years, the shortest five months with an average sentence length of just under three years. All the women were sentenced – there was no one on remand.

Time on PREW and where to afterwards

The standard length of stay on PREW is six to eight weeks but there was some flexibility in this at the moment because the unit wasn't full and/or if it was felt that the woman would benefit from a longer stay. The longest serving prisoner on PREW had been there for five months[3] but most had been on the unit for between four and twelve weeks. Most of the women had come from Oak wing where they had started their detoxification – this is important to bear in mind as the women are not allowed to come on to PREW until they are down to 20mls Methadone/2mls Subutex – so for most this means that a substantial proportion of their detox will take place elsewhere.

There was considerable variety in where the women were going onto after PREW. Only one was going to be released straight back into the community and she was currently debating whether or not to go into some kind of therapeutic environment. Another had a release plan which involved a move to open conditions at Askham Grange to complete her sentence. Yet another was waiting for a move to the Mother and Baby Unit at New Hall as she was expecting a baby in two months. The other two women faced a return to the main prison population – though both hoped for a place on Laurel wing – the Drug Free Wing.

Drug and Alcohol history and treatment experiences

All but one of the women had a long history of problems with drugs and/or alcohol. The longest time involved with drugs was 19 years and the shortest one year with an average problem lasting 12 years. The majority had had their main problem with heroin and/or crack cocaine, one had an additional problem with diazepam; another with drinking. Worryingly, the woman with the most recent problem over the last year had developed a dependency on Subutex whilst in prison – and had not had a drug problem before entering custody when she had been placed on 40mls of methadone. Several of the women had a long relationship with methadone – one having been 'stabilised' on it for 15 years before detoxing on PREW.

[3] This prisoner was now working as an orderly on the unit as well as attending the PREW programme. Having this job allowed her to stay more permanently on the wing.

All but one (the youngest) had accessed treatment both inside and outside of prison and experienced a range of interventions including SDP *(*for one woman '*at least three times');* SMART recovery, pre-recovery and abstinence programmes and drug free wings; community projects; 12 Steps and *'every alcohol awareness course going'*.

Detoxification

As explained above, a rapid clinical detoxification was the first stage of the programme on PREW and most of the women interviewed had been through this process on PREW. However, this was not always the case and most had at least partially detoxed elsewhere in the prison before arriving on PREW. Four of the women were on anti-depressants and two on sleeping tablets (to help with sleep disturbance during withdrawal). It was routine for the women to take Britlofex (lofexidine) to help them during their detoxification.

Motivations, advantages and disadvantages

Most of the women had been through several cycles of relapse and stability on methadone throughout their lives – both in and out of prison - and due to this perhaps, the commonest motivation centred around doing something to finally get themselves off substitute medication before leaving prison. One woman suggested that the only way she could get that help was to go to prison *'I needed to do something drastic to get the help I needed'.* Another said that going back to prison this time *'hit me really hard and I thought if I didn't do something drastic then my life is never going to change'.* Others mentioned the motivation of wanting to start a family or for the sake of the children they already had. Others highlighted that they now had a more supportive partner who was also getting clean (or was never a user) and so they could see a drug-free future with these more positive people in their lives. Repairing relationships with family more generally was also clearly important.

Two key advantages of being on PREW were raised by the women. First was being protected from drugs in the prison:

> '*It's easy to get your hand on Subutex in normal prison if you go to work and everything'*.

Second was the support they received from (and were able to give to) the other women:

> *'We all know what each other's going through and on a normal wing they say you are stupid for coming off methadone'.*

It was clear that living with other women going through the same process really helped – particularly in those early stages of detoxification. The key disadvantage appeared to be boredom:

> *'To be honest we are sat around a lot doing nothing…. I'm finding myself wondering from room to room'.*
>
> *'Sometimes its proper boring though with nothing to do'.*
>
> *'We have too much time on our hands to kill*'.

One woman mentioned being in single cell accommodation when detoxing as being a real bonus as her sleep patterns had been very disturbed but on PREW she could watch a DVD, shower etc without disturbing her cell mate.

The extreme form of separation experienced by the women living on PREW was, perhaps not surprisingly, met with mixed reactions from the women. Whilst they often found it difficult, most thought it has been a good thing, especially during the process of detoxification when *'if it's shoved under their nose and they are feeling bad enough they will take it'*. The women found it particularly difficult at first: *'it doesn't feel like it… I hated it when detoxing'* but were generally aware that it had been essential *'That's the one thing I'm grateful for'* and that without it they might have been tempted into using drugs. Because of this in particular all the women said that they felt safe on PREW. One woman felt that whilst it was really important at the beginning the level of separation might be lessened as they progress:

> *'In some ways yeah, in others no. This is voluntary, we come up here of our own accord. I understand why they escort us everywhere… but after a certain period of time we should earn some trust back and be able to go to chapel or to the gym on our own'.*

The women were far more positive about the facilities and living conditions available on PREW and appreciated the fact that their accommodation was far superior to that elsewhere in the prison. They were particularly appreciate of the single cell accommodation *'you can lock your door and get some privacy' 'it's like your own little flat, your own little space'*; and the integral sanitation and having a shower in their cell – particularly during detox when they are unwell and sleeping badly. Each woman also had a DVD player in her room which again helped with sleepless nights.

Availability of drugs in the prison more widely

It was clear that the women felt that there was a *'massive'* problem with drugs in wider prison environment:

> *'There's more drugs on here than there is on the streets'.*
>
> *'It's easier to get drugs in here than it is out there'.*

A lot of the drugs were substitute, traded medication – particularly subutex – but one woman said that she was also aware of diazepam, crack and heroin being available *'at Christmas'*. One woman pointed out that some prisoners developed problems with drugs whilst in prison[4] and that a subutex habit developed inside can lead to heroin use once released when subutex was harder to get hold of. All agreed that PREW had been very successful at keeping drugs away on their wing though – and that this had been essential as they were conscious that there would have been times when they would have used if they had still been in the main population. There had been a number of incidents where women had brought drugs onto PREW but this had been swiftly dealt with and the women had been removed. The interviewees thought this fair as they had put everyone at risk by bringing drugs in.

A typical day on PREW and treatments/services available

The structure of the day and week is described above but there were clearly issues with the quality and quantity of what was on offer that are worth exploring further here. Group work took place on Monday, Thursday and Friday mornings. This has varied in content during the time PREW has been running but is normally provided by a Turning Point worker and might focus on relapse prevention or more general skills such as mindfulness. At the time of my visit, the sessions were focused on mindfulness. There was mixed feelings about how beneficial these sessions were. Some of the women enjoyed them:

[4] This was NOT the woman who had been through this experience herself.

'It's been really good, a lot of us have really enjoyed it… and come back feeling a lot better'.

'*Monday – group work, which I love …. I'm getting the mindfulness now'.*

Others were more critical:

'To be quite honest, the group sessions I don't get…it's all about breathing in and breathing out …I've not quite got that…I thought when I came up here it'd be drug courses and awareness of how to prevent yourself properly when you got out … you're not going to go out are you and if someone's got drugs and go one minute let me sit and think and breath about it… when I asked about that they're saying no it's all the same old shit that you've heard… but some people might have heard it the first time and not got it… I feel more ready to do it now'.

Sessions were also criticised for being repetitive and confusing and not sufficiently focused on recovery or relapse prevention.

'I think she does try to fill our time but the things she comes out with goes over my head – it's unbelievable, I don't know where it's coming from… surely if this is a recovery unit... it doesn't have to be all about recovery, cos I can get bogged down with that as well, thinking when's this going to end… but you need to have an understanding, you need to be working round your issues of your mind, the way your mind works'.

In addition to the group work and the gym sessions, one woman mentioned peer support sessions on a Wednesday and several mentioned acupressure sessions – delivered by a Turning Point worker. There had also been some self-tanning and manicure sessions and arts and crafts and jigsaws are available on the wing. There was some cooking sessions but these were currently in abatement following a disagreement between the staff and the women which will be discussed in detail later.

Additional treatments/services the women would like to see

When asked what other services or treatments they would like to see, the women came up with a variety of ideas. Key to these was more drug focused work – relapse prevention and recovery work - which could be individually tailored to meet different needs: *'different groups for different people'*. One woman suggested some educational videos about ex-users' stories to provide encouragement, another that there should be visits from outside agencies. Others mentioned more variety in activities – painting and a pool table were suggested. Another mentioned work that helped with confidence-building. There were several who suggested that there could be fewer discipline staff on the wing and more input from Turning Point workers and that the wing could be split into two – one side for the women who were detoxing and the other for those who had been through this process and were ready to be gradually introduced to therapeutic group and one-to-one work.

Attitudes to staff

At the time of my visit, there had clearly been at least to some extent a breakdown in relationships between some of the women and some of the discipline staff on PREW. This appears to have stemmed from a row over two cheesecakes that had been made during a cookery lesson. Some of the women were upset that the discipline staff had taken one of the cheesecakes to eat on their own rather than sit with the women and eat the cakes communally. There had clearly been an argument and tempers had flared and as a result cooking had now been stopped. However, it is hard to know how representative this situation is of problems more generally. Certainly the comments about staff from the women who had lived on the wing for longer indicated that they were far happier about their treatment:

'Some of the girls up here find some of the staff up there a bit … off with them – but me personally, I've had all the support from everybody up there… It's the girls that are up here at the moment the personalities clash… because the group I was on… we all got on great… At the minute there's a lot of big personalities up there … and you're not always going to get a perfect group… Maybe some things could be dealt with differently but everybody's irate… but personally myself I've had no bad experience with them at all… I get on fantastic with all the officers up there and they've all gone out to help me in each one of their own way.'

'Most of them are alright, there's a few staff that are… but the majority are sound… you work more closely with them so you see a different side to them… They're more supportive…. They're totally different to what they are in the main jail…'

However, even those women who were generally positive commented on what they saw as staff lacking an understanding and an awareness of the detox process[5].

'Most of them are really supportive… I personally, I think they are all brilliant in their own different ways they've all got their different strengths and their different ways of dealing with things. A lot of girls have had quite a few problems with different members of staff – they're not supportive, they don't do nowt for you, they don't understand detox, and to an extent I think that's true'.

Several others were more vitriolic:

'They've got a proper bad attitude… it's like they hate drug users… some of them are alright… … they say that these officers were handpicked, well I'm sorry but whoever handpicked them don't know nothing about doing a detox…. they treat us like children'.

'They don't understand detox… here it's closed off, it's us and them… now for this unit to work…they have to have an understanding, it can't work and it's not working with staff up here… for me they either get taken away from it and get some training …'

Some women felt there was an imbalance between the input from Turning Point staff and discipline staff and that they would like to see a greater contribution from Turning Point and less from discipline. This was linked with an idea that there were too many discipline staff and they did not have enough to do:

'They don't do much up here...all they really do is lock us in our rooms, open us up and serve lunch'.

'They sit on their arses all day basically'.

Attitudes to PREW from the wider prison

The women described a considerable degree of negativity toward PREW from both staff and prisoners in the wider community:

'Some staff will blatantly say it's a waste of time and money'.

'*Staff working on F wing wouldn't come up here for all the money in the world*'.

'All the girls on the wing were saying don't go up there'.

[5] This was echoed in the interview with the TP staff member who felt that discipline staff required enhanced training to work most effectively and more therapeutically with the women on PREW.

There had clearly been a lot of rumours about what was happening on PREW:

> *'A lot of the girls who have been moved off… a lot of people bad-mouth it. Before I came up here I heard a lot of bad things about PREW…. You can't smoke in your room, you're locked behind your door all day long… you're bored all the time'.*

Over time, most thought that this was dissipating to some extent as women leaving PREW successfully were a more positive role model for what was on offer. Others thought that some of the negativity came from jealousy *'some people say you think you're better than us'* or a lack of understanding or willingness to engage in the recovery process:

> *'Some kinda diss the place cos they're jealous cos they can't do it, they don't want to do it… girls proper slagging the place off, because they don't understand what's going on'.*

Being in recovery

All the women described themselves as being in recovery but were acutely aware that this would be an on-going situation:

> *'I will always be in recovery, because I have to be, I have to be aware'*.

> *'You'll always be in recovery – you're never a fully recovered addict … whether its ten years down the line, whether it's ten months, there's always going to be struggles'.*

Others discussed what they thought recovery meant for them and what they needed to maintain recovery. These centred around: having support; strength; surrounding yourself with positive people who want the same thing and avoiding negative influences; and keeping busy and active. Most were confident that this time was different and that their time in PREW would have an impact on their future offending and drug use though one woman felt that she wouldn't be fully tested until she was out in the community once again. The women clearly felt that they had achieved something very concrete in detoxing and staying clean – regardless of any negative views they might have had about other aspects of PREW.

Interviews with Staff

There are currently eight members of prison staff working on PREW plus the drugs strategy manager and the Turning Point (TP) drug worker. Four of the discipline staff were interviewed in addition to the manager and the TP worker. TP had only come into service in November 2012 and their role with the PREW women was still evolving. The drug strategy manager was the key person behind the development of PREW and she has personally hand-picked the eight discipline staff that worked on the wing. All but one of the uniformed staff had been on PREW since it began – the other joining in January 2013. Between them they had many years of experience of working in prison – from 12 to 23 years and most had had some experience of working with drug users before – most commonly by working on one of the wings where detox took place.

The discipline staff saw their key roles as keeping the women busy when they were not involved in group work; offering general support to them; and trying to teach them some basic life skills along the way:

> *'We've all got different jobs. The main thing is trying to keep the women occupied… we try to give them a few skills as well… some of the women don't know how to look after*

themselves… they've got no home skills… if you are going to send them out into the wicked wide world they've got to be able to cope'.

'Our role is to support them through every day. We do cooking with them, we do gardening with them, we do arts and crafts with them…. We would like to get some more education for them – in respect of reading, writing and arithmetic…. We interact with them a lot'.

The officers were also responsible for escorting the women to any appointments they had around the prison and to the gym. Some mentioned a key worker system, but there was little evidence of this from any other interview. As explained above the TP worker was filling in temporarily for an absent colleague. She was currently running three group sessions a week centred on mindfulness which she described a clinical psychological approach which is:

'A subtle way of perhaps not necessarily going on the past and what caused them to actually use substances…. It's about re-wiring the brain, to strip things back to basics… for example… teaching your mind to wander when you hear things … to focus on what your thoughts are'.

She also offered the women auriculotherapy – a type of acupuncture using beads in the ear rather than needles which also gives her a chance to talk to the women one to one but she accepted that there was no other psycho-social intervention currently available to the women on PREW.

What distinguishes PREW and strengths and weaknesses

Staff were fully aware that what was happening on PREW was a new approach to dealing with detoxification and recovery from drug use and that for some women *'it's more or less kind of a last chance for them'.* Most felt it was entirely different to anything that had been attempted before and that that was what distinguished PREW from other approaches.

'Everything because basically they haven't had anything like this before… there's been nothing like this… it didn't have all the interaction with the outside agencies… it's far more intense than anything else we've ever done'.

There was also awareness that this was a more holistic approach to problem drug use which required a different attitude from them:

'We are trying to do it in a holistic way, it's not a fixed regime, we don't want to say, you've got to do this and you've got to do that'.'[It's a] *different approach to getting women clean from drugs or alcohol. We teach them how to look after themselves, giving them a bit of self pride in themselves, it's not a clinical thing...'.*

The drugs strategy manager was the most clear about the attempt to create a type of therapeutic community on PREW – with a focus on peer support and an *'intensive nutured environment*'. Whilst the discipline staff might not have used that language, they too were generally aware that the creation of a supportive community was important to the work they were doing:

'We are here as a community. It's getting their trust and showing that we are actually interested. We can prioritise each woman for their own needs'.

Having the time and staff resources to focus on the women as individuals was key to what PREW could offer:

'You've got more one to one support with us. We've got more time for them to get to the core of their problems'.

For most this meant they had developed different relationships with the women within the community they had created:

> *'It makes them human… they lose that 'them and us' after a few days…they have lost their inhibitions to communicate with us… it's a happier unit'.*

The discipline staff described being more lenient with the women because of the need to build a rapport and a degree of trust, so that the community could comprise both the women and the officers. Others were aware of this but also conscious that they were still discipline officers working within a prison. Officers felt that the women were generally supportive of each other, particularly once they had been through their own detox and could appreciate what the women currently going through it were experiencing: *'they can tell them there is light at the end of the tunnel'.* Several interviewees mentioned the rolling programme as being beneficial to this process as women further down the line could support the women who were newer to PREW[6].

Other officers were more focused on the support they were able to offer the women during their detoxification as being central to what distinguished PREW:

> *'We are spending time with them… we are not just getting them off the methadone or controlling the methadone… we are not just getting them to a level… they are coming off it and we are trying to help them come off it and helping them to cope with getting off it'.*

Again, a degree of flexibility and a gentler approach was identified as significant in this process:

> *'We know if they're looking a bit under the weather, they can go back to their room, whereas in the main prison a refusal to go to work would result in an adjudication'.*

The most commonly cited weakness highlighted by the discipline staff was the poor working relationships with other agencies in the prison. One officer highlighted problems with the nursing staff whose role it was to support the women's clinical detoxification. He said that at the beginning (of PREW) two nurses attended their morning meetings and one was available on the wing for most of the day but *'now we're lucky if we get them up for ten minutes and it's usually a different nurse every day*'. The officer was fully aware that this might be down to staff cuts but felt that this was a loss to the service they were trying to provide.

Several of the other officers clearly felt resentful about the limitations that they felt had been placed on their role by other agencies with a more central role in drug work. It was almost as though they felt they were isolated on PREW as much as the women.

> *'I don't like the fact that once they come off here we have nothing to do with them… It's as though we only play a small part. Turning Point don't always see us as part of the team… they think we tread on their toes'.*

These issues were exemplified by a publicity drive that the discipline officers had done in order to raise awareness of PREW and increase the number of referrals on to the wing. They had produced a flyer and circulated it around the detox wing. In their view, Turning Point had not taken kindly to this:

> *'We were told it was nothing to do with us… we have no say in the matter… we got our hands slapped'.*

[6] From the 3rd of June 2013 PREW is reverting to a cohort style programme having decided that the rolling programme did not work as well for the women on their recovery journey. The last 'rolling' programme on PREW will end on the 24/05/13.

'We struggle to get the women up here. We wanted to publicise what we were doing and I got told that I needed to know what my place was and that place was on the wing. Turning Point said it was their job to get the women onto PREW but Turning Point don't always know the women like we know the women – particularly those who have been in a lot…. Three different agencies, Turning Point, NHS and us – at some point all three has to link like the Olympic rings does'.

The discipline staff also felt that the input from the prison substance misuse team towards PREW had been somewhat sporadic and unreliable although in fact most acknowledged that this had been before TP had taken on the contract in November 2012 and most were hopeful that this situation would improve. The TP worker also acknowledged that it would be helpful for TP to be more involved in delivering one-to-one psycho-social interventions in addition to the group work but was unsure as to whether the resources were available to make this happen.

In contrast, the TP worker expressed her own concerns about the discipline staff and in particular their relationships and interactions with the women on PREW. She was concerned that without better training and clinical supervision for the staff, problematic dynamics developed on the wing – which she likened to a dysfunctional family - and that officers needed to be more aware of these dynamics in order to support the women as effectively as possible.

The Drugs Strategy manager had some concerns about the long term impact of the level of isolation on the PREW in that she was concerned that this might create a degree of dependency and a *'false blanket of support'* that might be difficult to replicate when the women are released back into the community. She was aware that she was asking a lot of her staff to work in a radically new way on PREW by asking them to *'act outside the box… to take on board criticism from the women… to be part of the community'.* She felt that this was essential so that the women were able to tell the officers when they were struggling.

Most of the staff felt that the women had a better quality of life whilst they lived on PREW in comparison to the rest of the jail in terms of having internal sanitation and a shower in their cell; having DVDS, a WII and a variety of other activities available to them; and having the staff more available and more numerous to offer support and to *'go the extra mile'.* The level of support the women were able to offer one another was seen as important, though most staff said that this took a few weeks to develop – during their detox women often struggled more *'week one and two can be horrific'* – but by weeks three or four *'they settle in and understand*'. There was an awareness of a tendency on the women's part to develop cliques but it was generally agreed that they were supportive and respectful of one another:

'Very supportive, particularly given the difficult environment and situations they are in...'.

'They still form their own individual friendships… [we] *tend to try to break down cliques and make them more of a community. They are forced to be friends with people they wouldn't choose to be. In a small community you've got to get on. As they start to feel better they are more open to being friends. After the first initial week or so they are more supportive with each other'.*

Choosing the women for the programme

The process for how women were chosen to come on to PREW is described above and staff were aware of the multi-agency referral and assessment process that took place and that women had to be down to 20mls of methadone or 2mls of Subutex to come onto the wing. Staff knew that the minimum stay on PREW was six to eight weeks but that if the woman did not feel ready to leave there was some flexibility on length of stay. In terms of what women were most suitable for PREW

most interviewees emphasised the importance of motivation and the futility of working with someone who wasn't ready:

> *'They need to be motivated. They need to show that they want to come off and detox themselves and be clean and ready for change. It's pointless them coming on here if they're not ready to make that change... cos it's unfair on them'.*

There was perhaps a degree of cynicism amongst some officers about some women's motivations particularly those who knew the system very well. This might be cause for concern given it is often just these kinds of prisoners trapped in a revolving door of drug use, offending and prison, that might be the most motivated to make the change:

> '[you] *usually find a lot aren't suitable, cos you usually know the people that are constantly coming in and out of prison and their lifestyle they lead and what they're doing whilst they're in prison and you think no, they're not ready and they'd be a bad combination in a group dynamic'.*

> *'Those that are first time in prison or new to using drugs, are not as jail-wise, cos they feel a little bit more protected being up here and they are more willing to accept the help. Those who have been through it before are a bit more jaded… harder to reach and therefore there's not enough trust there. The old ways of detoxing hasn't worked for them and they'd rather do it themselves their way'.*

> *'Preferably the ones that want to do it, not the one that come up and know they're gonna get a room with a shower and that's all they're bothered about'.*

There had to be some restrictions in terms of the offence the woman had committed because the unit shared a building with the juvenile section – so sexual offenders were not permitted and anyone with a history of serious violence might also be excluded. Other than that most staff thought that if a woman was ready, then they should be given the chance. The only other concern appeared to be if the woman had a serious mental health problem which might make it more difficult for her to engage with the programme.

Again, the Drug Strategy manager had a slightly different take, focusing on the length of time the women had left to serve as being important. She thought those women who had a few months to go until their release were ideal because they had the six to eight weeks to stay on PREW but did not have to go back to the main jail afterwards: *'The idea of going back into that environment is problematic'.*

Extending the programme more widely

Whilst most staff were keen to see the ideas behind PREW expanded, they were equally concerned that the unit remained a separate contained entity from the rest of the prison and were worried that if it was made much bigger they would lose touch with the women, and not be able to support them as effectively; and risk the women being exposed to drug use more frequently. However, most could envisage a time when PREW took over the whole wing (31 beds) with one wing for the detox process and the other for the women to move onto and continue to get support for sustained recovery beyond eight weeks – with a gradual reintroduction to the main prison, work etc. The main target of the Drug Strategy manager was to get PREW full before considering expanding wider than that.

Attitude to PREW and its impact on the wider prison

Staff were fully aware that there had been a considerable degree of hostility towards PREW when it started from both the prisoners and the staff. Some of this was caused by one or two women who were removed from the first cohort on PREW and spread rumours about it when back in the main population. Compounding this was a problem with some prison officers discouraging women from going onto PREW: *'we did more fighting against staff myths'*. However, over time all felt that the situation had improved as women returned more successfully to the main population and told more positive stories about their time on PREW and officers started to understand more about what PREW was all about and encouraged women on their wing to give it a go.

Level of separation from the rest of the prison

All the interviewees were supportive of the level of separation that PREW has from the rest of the prison, but most also acknowledged that this presented a significant challenge to the women too:

> *'It affects us and we go home at night so if it affects staff how does it affect people who are here 24/7 for a length of time?'*

Most felt that attempting recovery in the main prison would be extremely difficult and that taking away temptation to use drugs, particularly during the early stages of detox was crucial to the success of PREW. However, most also thought that going back into the main prison once they have completed their time on PREW was a useful challenge to the women and a chance to put their refusal skills into practice – albeit perhaps on the Drug Free Wing or at Askham Grange where the challenge might not as great.

Availability of drugs

The support for such an isolated unit is perhaps an acknowledgement of a significant drug problem within the main prison population and most interviewees accepted that this was *'horrendous'*. Key seemed to be women coming into the prison 'packed', or getting hold of drugs during visits; and trading in medication – predominantly Subutex. There had been a number of incidents of drugs getting onto PREW in the early days but these had been handled swiftly and there was no evidence of any problems at the moment.

Drug testing and the consequences of a positive test

Most staff agreed that a positive drug test would not result in an immediate removal from PREW and that the only time someone had been removed under these circumstances the woman had had a stock of drugs in their cell and had more than 2 positive tests. A positive test normally would mean a referral to the weekly PREW panel for discussion with all multi-agency partners. Several officers mentioned that removal could potentially be dangerous for the woman, depending upon where she was with her detox, as she risked overdose if she used again back in the main population. All the women on PREW have to sign a VDT but there was some evidence that these were not currently being done as there was insufficient funds to carry out VDTs on both Larch (the drug free wing) and PREW.

Relationships with external agencies

Although one officer did not see external agencies as that relevant at this stage of the women's recovery journey and another viewed this work as best done by the ACORN house in the prison where the women can go for meeting with agencies; the rest thought that far more could be done to make good contacts with outside agencies who might be able to help the women on release. More effective throughcare and aftercare was acknowledged by most as essential to a successful resettlement and most agreed that what was on offer currently was less than satisfactory. The Drug

Strategy manager had clearly spent a great deal of time forging links with outside agencies involved in recovery and had attended many recovery cafes, seminars and community-based groups. However, whilst this might have been very useful for the development of her knowledge, it was harder to see how these visits had translated into effective links that the women might use in the future, other than contact with a housing agency in York who was hopefully going to help resettle some of the women on release.

All of the officers said that they would love to hear how the women were doing once released – and several women had indeed written to them to let them know that they were doing well. They said they would appreciate a more formal mechanism for maintaining contact and offering support on release and some mentioned post-release visits as something they would like to get involved in.

Likely impact on prisoners' futures?

Interviewees were cautiously optimistic that what they were doing on PREW would have a long term impact on the women's futures and many said that if only one person succeeded that would be good enough for them. They were fully aware too that some might take a few times to achieve recovery:

> *'They might have to come back a couple of times. We've had two girls on twice. We're not expecting miracles'*.

Most felt that PREW was at least a step in the right direction and that this approach had considerable merit in comparison to what had been tried before and that they were starting to see successes with the women who had been through the programme.

If you could change one thing?

Interviewees chose different aspects they would like to change:

- More involvement from discipline officers on the PREW panel and in the selection of prisoners
- More information about what happens to the women once they leave PREW
- Clinical supervision for discipline staff
- More support for the women, including more input from Turning Point
- A bigger unit with more input from health care and Turning Point and guest speakers from external agencies who have been through the recovery process
- A follow on unit focused on education and offering general support to ensure they are attending appointments, looking after themselves etc
- Reassurance that the women are '*going somewhere where they've got some support'*.
- More back up from senior management: *'It's got such potential, it could take over the prison if it was given the correct support* [but] *they've picked other agendas'.*

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May 2013

Appendix 10: Styal

Rapid Assessment of HMP Styal – Drug Recovery House/Fox House

Key Points

- **The Drug Recovery House is working in a similar way to a Therapeutic Community and there does appear to be considerable success in offering residents strong professional and peer support**
- **The unit is located in a separate house and is small in scale with a maximum of 19 beds available**
- **The women have a highly positive attitude to the staff who are all drug workers (not prison staff)**
- **The women have a highly structured day and are kept busy both on the programme and in work and education in the main prison**
- **The house is not yet full as there are some non-programme women living in the house which is seen as problematic by both staff and programme participants**
- **The women are very mixed in terms of their detox stage and sentence stage and length.**
- **There is no exit strategy for the women who have completed the programme and a reluctance to return them to the main prison population**
- **The programme is not currently working primarily as a pre-release initiative as originally designed which exacerbates the exit strategy problem**
- **Throughcare connections are compromised by this role not currently being within the remit of the DRW staff**
- **April 2013 sees the whole of the drug treatment services for the prison being taken over by LIFELINE including the DRW.**

Basic prison information

Styal is a closed women's facility[1] in Wilmslow, South Manchester. It was originally a children's home and is predominantly comprised of houses, on which live around 20 women, usually supervised by just one prison officer in attendance at key times during the day. 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 – the aim being that eventually this will be fully populated by 19 prisoners on the drug recovery programme. Fox is located in a quiet area of the prison, with little 'through traffic' of prisoners or staff, making isolation from the main population relatively straightforward.

In practice prisoners start their 'recovery journey' in the first night house in Styal where they are assessed by health staff and drug workers. They can start a detox whilst still living on the wing and half of the wing is designated as a stabilised/detox wing – with around 60 women receiving SMT and working towards recovery there – with a long term aim of them coming to live on Fox later on.

[1] Women's prisons are not categorised in the same way as men's. They are either open or closed and so cater for a very wide range of prisoners/offences.

The DRW pilot began in October 2012. At the time of my visit, 11 women were living on Fox and participating in the recovery programme. In addition, there was one 'graduate' from the programme still living in the house and two prisoners not on the programme 'lodging' there due to population pressures. Four more women were due to arrive the following week – so the 19 beds available in Fox are slowly filling up. The programme is run by Phoenix Futures at present. There are six staff plus a deputy manager and manager involved in delivering the programme. But at any one time, half of the staff will be working on delivering drug programmes for the main prison population, and half will be located on Fox – meaning that between two to four staff are available throughout the day on Fox.

On 2 April 2013, LIFELINE (in partnership with Delphy) took over the contract for all the drugs services in the prison (they have up to this point been running the CARAT programme only). The hope is that this will mean a greater consistency and cooperation in the drug work in the prison. Initially, all the staff will be transferred to work for LIFELINE but it is expected that there will be some re-structuring and some job losses. Because of this, there was a degree of uncertainty and tension around the future delivery of drug treatment in Styal when I visited, however, LIFELINE are committed to running the DRW as part of their new contract.

A typical day in Fox House

The women's days are generally divided into two – with the mornings being dedicated to their recovery programme work and the afternoons being more about education and/or employment – though some key worker sessions are also conducted in the afternoon. The women meet with their key worker once a fortnight (though this can increase during critical times). The women get up around 7.30 and have their breakfast and then **morning meeting** is held at 8.30 (details of which will be given later). Various activities/treatments/group work then take place from around 10am to 12 noon. The women then have their lunch on Fox and go out to work/education in the main prison in the afternoon. They come back to Fox to eat their evening meal and then are locked up in the house from 7.00pm onwards. The following table shows the week in more detail:

Table 1: A typical day in Fox House

Day of the week	Morning	Afternoon	Evening
Monday	Morning meeting + SMART recovery	Work/Education in wider prison	
Tuesday	Morning meeting + Education/Employability	Work/Education in wider prison	
Wednesday	Community meeting + Gym session	Work/Education in wider prison	Compulsory community activity
Thursday	Morning meeting + External agency visits	Work/Education in wider prison	
Friday	Morning meeting + Responsivity session	Work/Education in wider prison	
Saturday	Gym session		
Sunday			Compulsory community activity

The house has **Recovery Rules** which the women must abide by – on top of the normal prison rules from which they are not exempt in any way:

1. Full participation in Fox House regime
2. Communicate honestly
3. No illicit substance misuse
4. No dealing/trading of substances
5. Maintain each other's confidentiality

6. No glorifying substance misuse
7. Attempt to manage conflicts/issues appropriately
8. Respect each other
9. No intimate relationships with others residing in Fox House.

In addition to this, Fox House also runs a **Conflict Management System** as a way of challenging negative behaviours. Thus, if a woman believes a fellow prisoner to be acting in a negative way, she can ask them to 'refresh' as a cue that their behaviour is unacceptable and they need to think about it and change. This is an oral exchange and if the behaviour stops/changes then it stops there. However, if the behaviour continues, the woman can then submit a written recommendation about their fellow prisoner's behaviour which outlines their concerns and offers the 'accused' a chance to reflect on what impact their behaviour might have on their own recovery and on the community. These issues are then fed into the Wednesday morning's community meeting.

The morning meetings are held from 8.30 every morning Monday to Friday (bar Wednesday). This is seen as a positive start to the day, and begins with a warm up game to get everyone awake and working together. A recovery trait/skill/word is then set for that day – on the day I observed the morning meeting the word was 'appreciation' but it might also be something like perseverance, assertiveness or patience. The women are then asked to reflect on this word throughout the day and/or try and introduce the trait or skill into something they do that day. This will then be discussed in the next day's meeting. The outline for the day is also discussed and 'positive acknowledgements' are also handed out. Each woman is also encouraged to work on one aspect of their outcome star that day.

The **outcome star** is a way of assessing the progress each woman is making on the various aspects of her life that impact on her offending and drug or alcohol use. The factors that are considered are:

- Drug use
- Alcohol use
- Family and relationships
- Offending
- Money
- Accommodation
- Emotional health
- Physical health
- Meaningful use of time
- Community

Over time the woman together with her key worker will score her progress from 1 (most negative/most work to do) to 10 (this factor is under control). This is illustrated in a star shaped diagram so the woman is able to visual her progress on each factor over time and identify where she needs to focus future work. Several of the women proudly showed me their outcome star during interview.

Referrals to the house can come from any member of staff in the prison or women can self-refer themselves. There are selection criteria which centre round a detailed understanding of the woman's substance misuse needs; whether they are in the right place in their recovery; whether they have a good knowledge of the underlying causes of their substance misuse; and whether they are genuinely committed to working towards abstinence. Having received a referral, a member of the DRW staff, who has responsibility for all assessments and allocations to the unit, carries out an assessment on the prisoner. There is then a weekly allocation meeting, attended by that DRW member of staff, health care staff, SMT staff and sometimes the prisoner's house officer. They will either agree to allocate them a place there and then on the DRW or set work for the prisoner to

complete, or targets to reach (ie four weeks of no security information around drug use) and set a review date to consider them again.

Observations on physical and social environment

The house was bright and cheerful with colourful pictures on the wall and comfortable modern furniture. They were awaiting delivery of a large table for communal eating. There is a lounge area with a huge flat screen television where the women can congregate. I did not see the bedrooms, but the women were very happy with them (see below). These are on an upper level and I would imagine the women are unobserved the majority of the time they are in their rooms. They are not locked up at all during the day, except for an hour at lunch time and in the evening. Locked doors are evident however with the office, the staff toilet and the front door locked at key times and all the meeting rooms were locked. The lighting was strip lighting and the temperature varied enormously, from too hot to far too cold (in the room I did my interviews in!). The atmosphere was relaxed and informal and it didn't feel like a prison very much at all.

The interactions I observed between staff and the women were professional and respectful but quite informal and requests for help from the women were met in a highly supportive way. I didn't see much interaction in the rest of the prison, so it is difficult to know the degree to which this is exceptional or the norm. I didn't see food being served, but the women did not complain about it at all in interview. All staff and women wore their own clothes[2], apart from the one prison officer allocated to the house.

Profile of the women in the Drug Recovery House

Ten women were interviewed – of the 11 that are currently on the recovery programme. The oldest woman was 62, and the youngest 27 with an average age of 41. In terms of sentence, the longest sentence being served was 4.5 years and the shortest a 6.5 month recall on licence. The average length of sentence was 2.5 years. Two women were on remand awaiting trial/sentence.

Time in the house and where to afterwards

The majority of the women (7) had been living in Fox House for a considerable length of time: the longest seven months the shortest three. The other three women were part of a new cohort, and had been living there for between two and five weeks. The general pattern of transfer into the house was from another of the houses in Styal with six women coming from another house (having spent a short period of time on the wing at the beginning of their sentence). However, there was a degree of flexibility in this, in that four women had come straight from the wing to Fox House. This tended to be the situation if the women had arrived in prison with either a prior knowledge of Fox House and a clear desire to get on there as soon as possible and/or if they were quickly identified as being 'ready' by a drugs worker.

Where the women were going once they had finished their time on Fox was far more fraught with difficulty. Whilst most had clear plans for what they wanted once released back into the community many were more concerned about being taken off Fox to go back into the main prison population, where there was a great deal of glamorising drug talk and negative behaviours. Up to this point, there had been little rush for the women to leave as the house was not full and so those who were a long way into their recovery were able to stay. As referrals to the house increase (and four more women were arriving the following week); this is unlikely to remain the case and several of the women were very worried that they would struggle living back in the main population. One woman mentioned that there was talk of a support house as the next step – for those women like her who

[2] Women prisoners are never made to wear uniforms but are provided with work clothes.

had their ROTL status. Others said that going back into the prison and managing was part of their recovery as they would have to resist temptation once back in the community, so might as well face it in the prison first.

Drug and Alcohol history and treatment experiences

All the women had a long history of drug problems (some also with alcohol). The longest time involved with drugs was 45 years the shortest was eight, with an average problem lasting 21 years. The majority had a problem with both heroin and crack cocaine (6 women); one woman was also an amphetamine injector and one only had a problem with alcohol. Perhaps not surprisingly therefore most had done *'everything they have ever come up with'* in terms of drug treatment both inside and out of prison. In the community this mainly comprised contact with Community Drug Teams – either through a DRR or a regular methadone prescription and/or drug testing programmes. One woman described being *'dragged kicking and screaming by her parents'* to residential rehabilitation but none of others had experienced this more intensive type of treatment in the community. Most had also done the various drug and alcohol courses in prison and in fact, in Styal, had often made their initial contact with those running the DRW through these courses.

Detoxification

There was considerable variety in terms of where the women were at with their detoxification. This reflected the individual approach taken in Styal, where being totally detoxed (ie not taking any substitute drugs) was not a pre-requisite for coming onto the DRW.

Motivations, advantages and disadvantages

Again, given their long relationship with drugs misuse, it is perhaps to be expected that most women described their main motivation for coming onto Fox as being sick of the drugs and the lifestyle they had been living. Many described in painful detail the losses they had accrued over the years due to their drug use – children into care/adoption; loss of friends and family connections; and loss of mental and physical health. Several described violent, dysfunctional relationships with men – who were often drug users and drug dealers and several had relapsed back into drug use when these men had come back into their lives on release from prison. Whilst there was an acknowledgement from some that they needed to do this for their children, most also were clear that they were 'ready' this time to do it for themselves:

> *'I lost me son last January to adoption, I've got six children, 4 of them live with me mum, one died of a cot death, which sent me off the rails … it's me own fault, if I'd done more I would have got to keep him* [adopted son] *but I wasn't going to contact due to taking drugs and things like that… so it's me that's got to live with that guilt… I've had enough, I don't want to take drugs anymore, I've lost children through it, I've lost my family through it'.*

> *'I've had drug and alcohol problems since I was a 13 year old. It started from when I was raped just before I was 13 and I used it as a way of bunking school and taking substances to escape reality really…. On my last sentence which was only… last August… … I missed out on the programme and I went home to a violent relationship and it all went wrong. I'd already made me mind up that I was sick of that lifestyle and I knew that going back to that relationship was a terrible mistake, so I came back with the right attitude'.*

When asked about the key advantages of being on the programme, most women talked about the support of the other women as being the best aspect, with all of them working towards the same goals and supporting each other in this process. They described how important it was that everyone had the same 'mindset' and that the usual positive drug talk and negative aggressive behaviour endemic in prison was not present in Fox:

'Just knowing that the other girls are in the same mindset… on here it's different, the conversation's not about drugs'.

In addition, several women mentioned that there was a really community spirit in the house:

'It's a tight knit community… I know I can go to at least three people in this house and speak to them if I need to'.

The other most commonly mentioned advantage was the contact with outside agencies which gave the women lots of options to think about in terms of what help they might access in the community both in terms of drug treatment and for more general support. Having ex-users come in seemed particularly useful in providing a role model for the women and offering them real hope that long term change was possible:

'We've had quite a few ex-offenders and ex-drug addicts… it is [helpful] *because you can see how well they've done and think oh god, I want to be there'.*

It was clear that the throughcare provided was of good quality and was well integrated with the work of the CARAT team as well as staff in Fox house. Several of the women highlighted the fact that they felt they would get good 'through the gate care'.

Several women also mentioned the staff working with them, that they were available all day for quick and good quality advice and support and that the programmes offered very effective ways of challenging their old behaviours (partly through the conflict management system) and working on the underlying causes of their drug use:

'*Absolutely brilliant* [the staff] *all of them… and they always pull things out of you… and I'm learning more about myself everyday'.*

Several women described feeling very settled in the house, which meant they could focus on their issues without disruption or distraction. Others talked about how effective their key workers were at getting them to identify some of the issues they had not thought about – for example, the relationship between their use of alcohol and the way it might act as a disinhibitor leading to drug use.

There were far less disadvantages described and four of the women said they saw no disadvantages at all. The main problem, mentioned by four of the women, was that there was a mixed community in the house in that some of the women living there were not on the recovery programme. This clearly caused some issues particularly with the conflict management system, which the non-programme residents did not understand and sometimes ridiculed. It was also difficult for women trying to detox who were sharing with women not engaged in this process. However, two of the women on the programme did not like the conflict management system themselves, they felt that it was abused by some of the women and actually undermined them working together as a community:

'I'm not into this refresh thing… I don't feel like I've got the authority… I think some girls use it in a manner that they need to refresh themselves if they stood and thought about it… I just think sometimes, something like that it could turn us against each other'.

One woman also mentioned that she felt the women were not monitored effectively enough in terms of genuine engagement with the programme and were only going through the motions in order to '*look good for court*'.

Fox house itself was seen as a very good environment by the women and many described it as the best house in the prison: '*the best house I've ever lived on'* '*This is the posh house'*. They described it as being calm, stable and welcoming, with plenty of space and without a feeling of over-crowding. Most of the women were in double rooms, some in single; whereas elsewhere in the other houses there were often three or four women in a dorm (though there were single cells on the wing). There had been some issues with cleanliness, which some of the women had found difficult. Several of those who had industrial cleaning training were in the process of 'deep cleaning' the house whilst I was there and everyone was very positive about this. The only other issue was around non-programme residents (discussed elsewhere) – as one woman said *'This is a recovery house and it should stay a recovery house'*.

The women live fairly separately from the rest of the prison in that they eat, live and exercise together. They do however, go out to work and education in the wider prison and can mix with other prisoners during association. Most of the women felt this balance was about right – and those who were less confident tended to be able to keep themselves to themselves. Several pointed out that going out into the wider prison was a good test for meeting drug temptations on the outside but liked that they did not have to face this '*24/7'*, when the rest of the prison *'are running around looking for drugs'*. All the women said they felt safe in Fox House and compared this favourably to the rest of the prison. They also said they felt more settled and *'at ease'* in Fox *'like our own little safe haven really'*. One woman also compared the safe and drug free environment in Fox with the more dangerous and drug ridden bail hostel she had lived in.

It was clear that the relationships between the women and between the staff and the women were paramount in making the quality of life in Fox House much better than the rest of the prison in the eyes of the residents. Many talked about the openness and honesty and the '*give and take'* in the house that made them feel more stable and ready to work on their drug use in an in-depth way. It was also clear that getting the right help within one setting was really appreciated.

Availability of drugs in the prison more widely

Only one woman said that she was not aware of drugs being available in the prison (and she had a problem with alcohol not drugs). All the other women said that there were drugs, mainly on the wing rather than in the houses and predominantly Subutex (with occasional influxes of heroin). The key problem with drugs coming in was thought to be women coming into prison on the first night 'packed' with drugs. In contrast, several of the women said that Styal was pretty good about keeping drugs out of prison, mainly due to the fact that they did not allow contact during visits. There was trading of medications (predominantly again Subutex) and one woman said she had been offered drugs whilst waiting for her medications that morning. None of the women were aware of alcohol being available in the prison and all said that there was no problem with drugs in Fox House. Indeed, one woman had come to live on the house as a 'lodger' with a Subutex problem and the women had gone to the staff together to ask that she be removed – which she was.

A typical day on Fox House and treatments/services available

The structure of the day and the week has been described above in Table 1. There was a clear structure to each day and the women interviewed generally had a very good grasp of what that structure was and the fact that each aspect of it was compulsory. They were aware too, that this meant that if they missed any of the sessions, they might be 'refreshed' by the other women and risked being 'back-staged' in the programme. Most of the women were also constructively involved in work or education in the afternoon too, so the whole day was structured and busy. Some of the women were aware that this was part of having 'meaningful use of their time' and liked to be kept busy. One woman said that she would have preferred if the recovery programme took the whole day, but most seemed happy to be doing other things in the afternoon in the wider prison community. It was clear too, that particularly for those further on in their recovery, they sometimes

used this time to promote Fox House to the wider prison population and some worked as recovery champions, or in areas of the prison where they could be of help advising and supporting other prisoners. As well as the programmes/ sessions mentioned in Table 1, the women also mentioned undertaking 'intuitive recovery' work and many had also done more general programmes, such as life skills, health and hygiene, good tenancy, relapse prevention, crack awareness, EFT/Tapping, and bereavement counselling.

Additional treatments/services the women would like to see

Two key suggestions came up in interviews about what the women thought was missing from the programme. First was the availability of a support house to move onto once they had completed the recovery programme – which reflected the concerns some of the women had about moving back into the general prison. Second the women were keen to have some kind of reflection/relaxation/sensory room where they could spend some time alone *'to get five or ten minutes head-space'*. Whilst there was such a room available in the prison, it was felt that its use was prioritised for *'the self-harmers'* and thus not for them. Several women also suggested more alternative therapies - such as massage and some other activities – such as pamper nights. One of the women wanted to be involved in a 12-step programme and another suggested that the house be changed to self-catering – to encourage the development of basic life skills.

Attitudes to staff

The attitude to the staff delivering the programme was universally positive. The women described them as being *'really good'*; *'there for you 100%' 'really committed' 'would go out of their way to help you'*. It was clear that they trusted the staff, and though they often had the closest relationship with their key worker, felt that they could talk to whoever was on duty in the house if they had a problem and found them all to be approachable, empathetic, and understanding. This was in contrast to their opinions of the staff more generally in the prison with whom they did not have this close connection – even if they did not have any particular difficulties with them. It was clear that the availability of the Fox House staff had enabled these close relationships to develop and there was mutual respect between staff and residents. Because the women felt close to the staff, they also recognised that this meant the staff were able to *'pull more out of you'* and the women were more inclined to discuss concerns and worries with them – even as far as discussing suicidal thoughts:

> *'The staff are very good as well… they also along with the girls… get to understand, they will look and talk to you and find out different things… and they'll try and help out in the jail…. I think the facilitators by meeting with us in our one-to-ones and talking… because we have sort of got to know them we are releasing a bit more about our suicidal* [thoughts] *and a lot more's coming out… now that we're getting more comfortable with them'.*

Attitude to Fox House from the wider prison

The women felt that there were clearly some mixed attitudes amongst the wider prison population – often through misunderstandings of what went on in the house *'if you listen to the prison talk it's a bad house'*. Some said that prisoners thought that it was a *'grasses'* house because the conflict management system encouraged the women to challenge each other's behaviour. Others said that other prisoners didn't understand the motivation to go onto Fox – which they thought was probably because they weren't themselves ready for change. Some attempts had been made to publicise the house by sending out invites to visit the house during a Friday association period. This had been kyboshed by the prison officers not sending out the invitations until the Saturday morning!

Being in recovery

All of the women described themselves as being 'in recovery' and one as 'recovered'. There was a strong awareness from the majority that this would be a lifetime process: *'I'll be in recovery for the rest of my life'; 'once an addict always an addict'*. What this meant to the women varied far more and they pointed out many aspects that they felt both meant they were in recovery and that they felt had to be evident in their lives to feel that they were:

- Maintaining a drug free lifestyle/never using drugs again (3)
- Not taking any substitute medication (2)
- Looking after physical and mental health (2)
- Changing behaviours and thought processes
- Thinking constructively
- Better family relationships
- Having a home and a safety net
- Being motivated
- Feeling secure

The majority of the women also were aware that tackling their drug use would fundamentally affect their offending behaviour too – as they were inextricably linked. Thus, they felt that being in Fox House would have an impact on both behaviours long-term and were looking forward to far more positive ways of living in the future: *'I am worth more than I granted myself before'*.

Interviews with staff

There are currently eight members of staff involved in running the DRW – including a manager and a deputy manager. Prior to running the DRW, these were the staff responsible for running drug and alcohol programmes in Styal as part of the SMT. When I visited Styal in March 2013, they were all employed by Phoenix Futures as drug workers – but as discussed above from April 2013 LIFELINE would be taking over this role – and it was uncertain what this would mean for these employees. I interviewed the manager, deputy manager and three members of staff. Three of the staff had been involved in the development and implementation of the DRW. Most were experienced drug workers having worked from between 6 months and 7 and a half years with drug users (average 3.5 years) either in the community or in prison.

Staff members' responsibilities include running the daily morning meetings and the responsivity sessions on a Friday; supporting the conflict management system; acting as the 'day worker' on the unit which means being available throughout the core day to help women with any practical or emotional difficulties they might be experiencing; and acting as the key worker with a number of the women – generally this meant meeting fortnightly. The deputy manager's role spanned some of these functions and a management function – acting as a link between management and staff. The manager had a more hands-off, strategic role taking the lead on the implementation of the DRW, as well as the implementation of both the drug and alcohol treatment programmes – both of which were also at pilot stage. She was also responsible for the supervision of staff, the management and reviewing of the implementation of the DRW and of linking with the wider prison in terms of making sure everyone was aware of and on board with what they were trying to do. She covered for staff absence and so was able to do some hands-on work with the women on a regular basis.

Description of the development of the DRW

It was clear from all the interviews that the staff group had been asked, at very short notice, to develop and implement the DRW with very little guidance from senior management. This was not necessarily seen as a negative thing – in that they felt they had been given free rein to develop what they thought would work within Styal for their clientele. They had started the process in September 2012 and were given a month to set up the DRW – and did not have to run programmes during this time so that they could work full time on the project. There was awareness amongst most of the

staff that the driving force behind this development was the central Government move towards a recovery agenda. Whilst they would have appreciated more time, the staff group appeared to have worked well together to set up a unit that would have the overall aim of reducing re-offending and substance misuse in a more holistic way than had been attempted in the past – focusing not just on drug use, but on life skills and behaviours more widely to support women in their recovery. One of the interviewees discussed the need to engage the whole prison in this development and they were keen to get the various services on board: health, education and employment, alternative therapies etc so that a) they avoided too much overlap and b) they could offer the holistic help they wanted. There was awareness too that this was a pilot and that therefore there was considerable flexibility in terms of changing and evolving over time in response to how the unit was functioning.

A theme running through most of the interviews was that this was to be – at least to some degree – a type of therapeutic community (TC). The aim therefore was that the house would work with women who were some way on in their recovery journey – with a strong awareness of their own drug use and highly motivated to change. The house would provide an environment where the women could build on work already done, maintain their motivation towards recovery, and work holistically on the various aspects of their lives which might jeopardize that recovery. There was also a presumption that this was a pre-release house – though in reality this has not always been reflected in the sentence stage of women on the programme[3].

What distinguishes the DRW and strengths and weaknesses

This idea of a therapeutic community was also evident when interviewees were asked what they felt distinguished the DRW from other drug and alcohol treatment in the prison. Several interviewees emphasised that in Fox House the women had to *'live and breathe'* their drug treatment; that on the house they could use the skills they had learnt through programmes and one-to-one work on a day to day basis – acting 'As If' – to use a TC term. It was felt that this was highly beneficial in that it highlighted inconsistencies in their behaviours – and thus helped them to work on behaviours which were not helping them recover. This was contrasted with programmes, where it was far easier for the women to 'talk the talk' for two and a half hours a day, but to behave in a very different way outside of the classroom. At the same time, it made it far easier for staff to pick up on negative thinking and behaviours *'you can really see what people are like in their own environment'.* One interviewee pointed out that this made it a far more intense environment where women would for example find it far harder to hide the fact that they were not there for the right reasons:

> *'The difference between the house and that* [4-5 week intervention] *is… it's more of an intense environment… on programmes you do find occasionally that maybe people aren't there for the right reasons or maybe they don't want to … maybe they're not really too sure whether they want recovery or not whereas the house is a lot more of an intense environment, you find that people can't maybe put on a brave face or hide any of that, it's a 24 hour thing… you can't sort of come in for two and a half hours and go, you're there, you're with your peers… if you're not maybe there for the right reasons then your peers will pull you up on that and it's a lot.. very therapeutic with that as well'.*

Another said that she felt the key work they did with the women was also far more therapeutic and less directional in style than she had experienced in drug work in prison before:

> *'The key work's a lot more therapeutic than they would get in substance misuse… perhaps a different approach in the way that we do them* [one to one sessions] *because we're all facilitators in our key works… I certainly find that it's more… it's easier and it's better to be more therapeutic in that respect so perhaps not as directive'.*

[3] At the time of my visit, two women were on remand – one of whom was facing 7 years if found guilty.

It was also clear that this was a supportive environment with a community spirit – where the women should feel safe and be able to develop their skills amongst a group which understood each others' situation and were working towards the same goal. It was thought key in this process that staff were on hand all day to help with this process and support the women as well as delivering the wide variety of interventions:

> *'A huge thing with the women is the self-esteem and the confidence issues and I think the different types of interventions… that there's always staff on there… the community feel is having a significant impact on peoples' confidence and self-belief'.*

Another key point mentioned by several interviews was that the house more effectively brought *'everything together'*. That there was a lot of good work going on around the prison, but that living in a recovery house helped to bring all that into one place and into one community working towards the same goal.

When asked what the most impressive aspect of the DRW was, the idea of the development of a community was central. The support that the women were able to give to each other was seen to be essential to creating a supportive environment, where everyone could be honest and open about their problems and anxieties. This was seen as exceptional in prison, where most felt that prisoners would be reluctant to share this kind of information. In the house it was felt that the women were far more open and able to seek support from both their peers and the staff. Whilst this might be about taking a new person *'under their wing'* or simply sharing ideas because *'I've been there'*, staff felt that this was creating a new culture which was calm, supportive and open. The conflict management system was seen as important in this process, as it had moved women away from the idea of 'grassing' on their peers if they challenged them about their behaviour, including their drug use. Whilst this helped create the openness discussed above, there was an acknowledgement that this had not been easy for the women to accept as it was entirely counterintuitive to the general culture in the prison. Overtime however, it was felt that the women were starting to accept this as a supportive and positive way of dealing with conflict. All of the staff members felt that the relationships between the women in the house were very positive (albeit with the usual problems of a group of women living together!). The open ways in which conflict was dealt with was thought to have contributed to this calmer more reflective environment in which there were *'less slanging matches'*:

> *'I think one of the things that is working really well is they're actually working as a community and I feel that having the meetings together in the mornings, having activities that they have to do together, there really is a sense of community feel and I mentioned before about the conflict management system and the way that that's being delivered… it's not sort of like a negative thing, it's not there to punish people, it is a supportive measure to find out what's going on and the community understand that so they are happy to pull people up if maybe things aren't going as well for them or maybe if they're not engaging as well as they should be and it's not received by other people in a negative way and people are very open with their feelings, if things aren't going so well for them and also seeking support from each other as well as the staff. So there really is a good community feel over there'.*

The most commonly cited weakness was the lack of an exit strategy from the house. At present, because there were no pressures on numbers as the house was not yet full, it had been easy enough for women to stay on for a longer period of time than had been originally ascertained and several of the women had lived on the house from the beginning of the pilot. However, there was awareness that this would not be the case for much longer, as the beds filled up with new women on the programme but at the same time, sending the women back into the general prison population was fraught with difficulties. Ideally, it was hoped that most women would be released from the house – if it worked as designed as a pre-release service. But given this was not the case with all the women,

an alternative exit route was needed which would provide a safe environment within which the women could continue their recovery whilst still living in the prison:

> *'There's no exit strategy, for example there are people on the house who aren't due for release who have participated in it… so now they've got quite a lot from being on the house, they've genuinely developed from the house… you can absolutely see that they've built self-worth and confidence, they've built their skills and they're pulling things together and they've still got maybe twelve months or further sentence to complete so what do we do with these people?'*

Other weaknesses mentioned were that not having the house full of prisoners participating on the recovery programme was less than ideal (a problem frequently cited by the women too). There was also a feeling that the boundaries between their work and the work of other drug treatment agencies within the prison were currently blurred. For example, each woman had an SMT case worker as well as a key worker in the DRW. It was also felt that the multi-disciplinary aspects did not always work as well as they might. It was hoped that the move towards everyone working for LIFELINE would go some way to ironing out these difficulties:

> *'There is some issues because obviously the Substance Misuse Team are obviously case managing individuals and then they come onto the house and we're working with them, so I think come April when we're all one team I think it will work at lot smoother as well, I think at the moment you've got different agencies and I think sometimes the lines are blurred a little bit between the two'.*

One interviewee felt that half a day was insufficient to work on recovery and would have preferred a whole day – which would increase the amount of contact staff had with the women – particularly those for whom they were key workers. Another thought that their work needed to be more evidence-based and accredited rather than simply stemming from staff generated ideas:

> *'I think it was built bottom upwards rather than top down… it was based and generated on just ideas from staff and they're not always the best ideas, they're not always full grounded in research… they're not evidence-based so for me that's been the most difficult doing things that perhaps might not be, they appear to be okay, but might not be. I'm always concerned about that, when I'm not doing something that's accredited or something that's been evidenced, to be asked to just create something is very difficult because you just don't know'.*

There was a mix of views about whether or not the women had a better quality of life in Fox House. Some thought that the level of support and the culture and community spirit in the house meant that they did: *'Supportive, nice, a good atmosphere' 'they do things together as a group' 'the general feel of the house is much more positive'*. It was felt that the house was calmer and that the therapeutic feel of the house was *'definitely having a positive effect on their emotional well-being'*.
One staff member mentioned that the availability of staff was crucial to this, in contrast to the other houses where the women were pretty much left to their own devices, with a member of prison staff coming onto the house at key times of the day only[4]. One interviewee was keen to point out that she felt prisoners in Styal had a good quality of life (relatively speaking) generally and that prisoners had a voice in decision making within the prison. She also felt that whilst efforts had been made to make Fox a comfortable place to live, it was important that it did not become unrealistic compared to what women might face in terms of their accommodation on release.

Similarly, there was a difference of opinion about whether their relationships with the women on the drug recovery programme were qualitatively different than with other prisoners. Two staff members felt that they weren't different, in that they were professional in all their dealings with

[4] Each house has a panic button so that officers can respond to any problems at other times in the day.

prisoners, but that they might be able to help the women more effectively due to the amount of time they were able to spend with them. The manager of the programme did not have day to day contact with the women and so it was harder for her to answer this question. The other two interviewees did feel that their relationships with the women were different. Both said that they had had to take a different stance to that taken when running the programmes where there were more boundaries and more of a power relationship between facilitator and participant. These staff members felt that the time and space they had in their interactions with the women on the drug recovery programme allowed for a more therapeutic and in-depth relationship to develop which helped to develop the open and supportive culture they were trying to establish in the house:

> *'I think when you're on a programme … and we're sat up at the front and people are around here, you have a very different relationship because you only see them for two and half hours a day and you're a lot more boundaried than you are on the house and that just because you are with them all the time, so whereas on a programme you wouldn't really talk to somebody about… you wouldn't really go into depth about what they were doing or even what you were doing, where on the house they'll tell you about phone calls they've had with their families, they'll tell you more about what's going on for them, whereas I don't think you get that as much on a programme… it's a lot more of a therapeutic relationship'.*

> *'I've had to change my relationship… it's certainly felt different… it feels more positive, it feels more… there's less resistance… because you are working and being part of almost helping create some of the culture I suppose your engagement has to be different. In programmes I suppose there's a power thing there… being on the house there's more space and time… and you can say more in a chat and a coffee… just by suggesting something and doing it naturally as a conversation rather than an intervention… and I think they feel that relationship difference too in how they talk and how they related… it's very much more on an even keel, on a level'.*

Choosing the women for the programme

The process by which women are chosen for the Drug Recovery Programme is outlined above. Staff felt that the most important criterion for coming to the house was how motivated the women were to change. Most felt that if this motivation was not there, then they wouldn't cope well in such an intense environment and wouldn't respond well to the interventions. There was a degree of flexibility in terms of what work they had done, though most of the staff felt that having gone through some drug treatment was important so that the woman came into the house with a good awareness of the reasons behind their drug use. The amount of focused drug work undertaken on the recovery programme is limited – given the holistic approach that is taken - so they need to come in with a solid foundation to build upon:

> *'I definitely think people who have got a good knowledge around their substance use and it tends to be through doing programmes… where they've done some like intensive work around it so they've got an insight into why they started using and what are their risk factors … cos it gives you more to work on… if they don't really know what their areas are that they need to work on, or they've not got a solid foundation, I think somebody would struggle coming onto the house'.*

If they have this, it was generally felt that the supportive environment in the house would help them continue to make progress. There was also an acknowledgement that the women had to be 'ready' – and that other more pressing issues might mean that a delay was appropriate – for example waiting to be sentenced or dealing with other family issues. Most staff felt that as many women as possible should be given the opportunity to come on the programme and that there shouldn't be too many specific barriers to their doing so. However, there were some issues that might mean that the

programme wouldn't work for them: continuing to use substances or being too early on in their recovery; serious physical and mental health issues – particularly personality disorders that might make group work very difficult; and too short a sentence length.

Extending the programme more widely

Most staff members felt that there was scope to widen the programme more widely both in Styal itself and in other prison establishments. It was recognised that, within Styal, this would require a change of culture within the prison where every service was working towards a more recovery-based agenda – it was felt that this was developing but was in the early stages. One interviewee felt that there was no need to live in a house in order to work towards recovery and that if the whole prison was more recovery-focused the house wouldn't have to be everything to everybody as it felt a bit at the moment and that the women might arrive at the house better prepared to engage in a recovery programme. Some staff expressed the concern that widening the scope would require a lot more staff specifically trained to work in a therapeutic way.

There was a realisation that the way in which Styal was set up was particularly conducive to a DRW. The fact that it could be housed in a separate space worked well, and that it could be carried out on such a small scale meant that it could really work as a TC. In contrast, it was thought by most that housing a DRW on a large wing might cause difficulties particularly in terms of creating a community feel amongst the group which was mutually supportive and that careful selection of appropriate prisoners might be more difficult which could cause problems *'the minute you start putting the wrong people on the house it will fall apart'.* Another staff member recognised that Styal also worked in a way that generally encourages a pro-social way of living which supported such initiatives as a DRW and that this might not be so evident in other prisons. Another suggested that a logical way of extending the project in Styal would be to have two or three houses: one for detox, moving onto the next house for the programme proper; and then finally to a graduate house for continued support for those who have completed the programme.

Attitude to the DRW and its impact on the wider prison

Staff admitted that there was a considerable degree of negativity to the DRW when it first started from both staff and prisoners. Staff had seen similar attempts fail before and so were cynical as to why things should be different this time and it was thought that some didn't really understand what the unit was all about. However, over time, this was thought to be changing and there had been a lot of support from officers. It was thought that the established general respect for the Phoenix Futures team within the prison had helped a great deal. Some prisoners saw it as a 'grasses' house –an image not helped by a couple of relapsed women who had gone back into the main prison and spread negativity about what went on in Fox House. It was also thought that there was some jealousy that the women *'get things that maybe other prisoners don't'* and acknowledged that this might be particularly difficult for non-drug using women. Over time it was thought that attitudes had become more positive, particularly as the women doing well on the recovery programme acted as an advert for its achievements. Women on the programme promote the unit to other prisoners and it was thought that this was resulting in a lot of referrals and this would only get better over time *'I've no doubt over time … it'll get more and more positive'.* Another interviewee pointed out that the existence of the house can *'plant seeds'* as women reflect on their own motivation and perhaps aspire to becoming drug free knowing that there is now a place they can go to if they don't want to use drugs any more.

Level of separation from the rest of the prison

The women live separately from the rest of the prison population - working on their programme throughout the morning and eating all their meals in Fox House[5]. However, in the afternoons they mix with the rest of the population through work and education or on ROTL[6] and they are also free to mix with other prisoners during association. There has been some debate during development of the pilot about how much separation was appropriate. However, it was felt that there were so many opportunities in Styal, for example, to get qualifications, which might be just as important to their long term recovery, that it would be counter-productive to exclude them from these chances. Another interviewee thought that it was *'quite a healthy thing… that they can still integrate with the rest of the population'* and that it gave them the chance to practice their skills such as assertiveness, coping with temptations etc. However, most of the staff felt that though the women were allowed to associate, most chose not to as they were aware of the risk involved with doing so: *'Association time is drug trading time'*. The location of Fox House helped in that it was not a through way for many prisoners and therefore anyone hanging around was easily spotted and moved on.

Availability of drugs

There was an acknowledgement that drugs, and to a lesser extent alcohol in the form of hooch, was available in the wider prison, which was unsurprising given around 75% of the population come in with drug/alcohol problems. Like the women, most thought that the main problem was trading and abuse of prescription medication – particularly Subutex. They were confident that there was very little if any drug use on Fox House and that the women themselves were keen to avoid contact with drugs and drug dealers. They had had some early problems with this, and one situation where a woman 'lodging' in Fox House was a drug user, but she had been transferred very quickly (at the request of the women). They were also confident that the women would report such issues to staff if they occurred in the future.

Drug testing and the consequences of a positive test

It is the CARAT workers that test the women on the recovery programme and all had signed up for VDTs. Because it was not their role, staff were a little unsure about these tests but it appears that the women are tested fortnightly and any positive tests would be reported back to the Fox House staff. However, all the staff thought that the women in Fox House would be most likely to admit, often in advance of a test, that they had used. In these circumstances, a meeting would take place between the prisoner and both their CARAT worker and Key worker in Fox House to ascertain what had triggered the use and how to tackle this issue. There would be consequences for the prisoner in this situation, but this would not necessarily mean removal from the house though it might mean being 'back-staged'. However, if there was no admission, then the prisoner would have broken two of the Recovery House rules – using substances and dishonesty – and these would be treated far more seriously particularly if the behaviour was repeated. Key in the decision as to whether to remove the woman would be whether the drug use is indicative of them not being ready to be in the house and the impact their drug use is having on the whole community. So far two women have been removed in these circumstances – though none since Christmas.

Relationships with external agencies

Staff were aware that throughcare should be a priority, that without it long term success was far more difficult and that there was considerable scope for improvement. However, the situation in Styal was made more difficult due to the separate agencies having different responsibilities (a situation which should be rectified once everyone comes under the same organisation). The

[5] There was a large dining room table on order so that meals could be eaten communally with staff and prisoners together.

[6] Release on temporary licence – when prisoners go out into the community to work, usually as part of the preparation for release.

throughcare role was currently the responsibility of the CARAT workers and though very good connections had been made with external agencies through the Thursday morning visits, staff were conscious not to *'tread on the toes'* of the CARAT workers. Having said that, they were pleased with the links they had made through the Thursday visits and that this helped the women understand what was available to them, put faces to names and help them think about what kinds of services they might want to access on release. Like the women the staff highlighted the visits from the service users as being particularly beneficial to the women's hopes for the future. One interviewee highlighted the concern though that funding might not be available for some options – particularly residential rehabilitation. Staff received no formal feedback about how women were doing after release and most said they would appreciate more information on this. There had been an idea to do a final 'outcome star' in the community after release – but this was not part of the programme at present. Staff also said that they did get informal feedback via letters or the other prisoners.

Likely impact on prisoners' futures?

Staff were cautiously optimistic about the impact the programme might have on the women's future offending and drug use – whilst being very aware that relapse was all too likely*: 'some people have gone out and they've come back in – it's just part of substance misuse isn't it …. It might take them a few goes to get there'*. They were also clear that they felt that this was the way forward and a positive move in comparison with what had been happening in the past: *'this is definitely a step in the right direction' 'Best attempt we've had so far'*. One interviewee expressed satisfaction about being part of the recovery agenda which they saw as far more positive and ambitious than the old HR focus but acknowledged that it would take some time to *'get there'* and there was still a lot of work to do.

If you could change one thing?

All interviewees chose different aspects they would like to change:

- *'A clear, informed evidence [based programme which] would genuinely meet what it's trying to do and not other agendas …. They've got an opportunity here to step up …. You could shift a whole culture here and make a success… You could make something at Styal pretty spectacular'.*
- More alternative therapies (art therapy and laughter therapy) and pamper nights to tie in with working on the women's confidence and self esteem.
- A more realistic focus on harm reduction and relapse prevention towards the end of the sentence as preparation for release back into the community.
- More activities on the weekend.
- A more settled time, with one provider and one agenda without duplication.

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April 2013

Appendix 11: Swansea

Report on Drug Recovery Wing (DRW) at HMP Swansea

Fieldwork

Fieldwork was undertaken over two days in March and April 2013. A total of 16 interviews were completed. On both visits there were opportunities to be shown round the DRW and talk to staff.

Interviews with Prisoners

1. Nine male prisoners with a mean age of 32 years old, and a range of 25 to 53 years old. All the prisoners were White, mostly (if not all) Welsh, and local to South Wales.
2. Six interviewees had been sentenced, with a mean sentence length of 30 months and a range of 3 to 54 months. Three were on remand, though all were awaiting sentencing.
3. Index offences were dominated by possession with intent to supply (5 prisoners), with two interviewees charged with acquisitive offences, one with violence, and one with an aggravated acquisitive offence.
4. Interviewees had a mean of 24 months and a median of 12 months left until their anticipated release date. Five prisoners were within one year of release, with three of these expecting to be released within six months. Four prisoners (including two remandees) had two or more years left to serve. As HMP Swansea takes prisoners for up to two years, many of those serving (or expecting) longer sentences would most likely be transferred to other prisons during their sentence[1].
5. For three prisoners this was their first time in prison (though not necessarily their first offence), and most of the prisoners did not have long criminal records.
6. Nine interviewees identified twelve drugs of choice. Alcohol was the most prevalent substance, named by three interviewees. Two prisoners named cocaine, two named heroin, and two identified themselves as 'polydrug' users. Three drugs were mentioned once: cannabis, mephedrone, and benzodiazepines. Most of the prisoners had been using drugs since their teens.
7. Only one prisoner was receiving opiate substitute medication. One was prescribed medication related to historic alcohol abuse. Four prisoners were prescribed medication for conditions unrelated to, or indirectly arising from, their drug dependence (anti-depressants, painkillers, and medication for 'general health issues')
8. Four of the nine prisoners were on the DRW cleaning and servery team – this group can spend longer on the DRW (because of their employment position) and have some extra privileges associated with this (e.g. more time out of cells).

[1] Despite the likelihood of transfer *at some point* for these DRW residents, they would only be transferred after completing the DRW programme and being moved to another wing. They were protected from transfer whilst housed on the DRW, and this constituted one of the key incentives offered to DRW residents.

Interviews with Staff

1. Seven interviews were completed, six with a range of DRW staff and one with a representative from an external agency.
2. The seven interviewees included five prison officers (including one 'recovery officer'), one psychosocial worker, and one clinical employee. Five worked in frontline roles, whilst two held managerial responsibilities.

Description of HMP Swansea

1. HMP Swansea is a Victorian prison 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.
2. 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

1. B Wing is the DRW. It is a second phase DRW pilot which has been operational since July 2012. The DRW is a sectioned-off area of the prison, spread over two landings with a capacity of about 49 prisoners (including a safe cell). This equates to about 10-12% of the population of HMP Swansea. The entrance to the DRW is off a central area, from which staff offices and one of the general population wings can also be accessed.
2. There is also a Drug Free Wing at HMP Swansea. This is C Wing and it is located on the landing underneath the DRW. The DFW holds about 40 prisoners. The prison's small segregation Wing is accessed from C Wing.
3. The DRW is a voluntary Wing. Prisoners usually come to the DRW from the induction Wing (F Wing). When the DRW was initially set up many prisoners also received detox as part of the DRW programme. However, staff quickly realised that the DRW was operating more as a detox Wing than a recovery Wing and so changes were made. This means that prisoners now stay on the induction Wing for a little longer (as appropriate to their needs) and are therefore stable in terms of any substitute medication by the time they move to the DRW, and are ready to engage with the DRW programme. Prisoners can only move to the DRW when they are taking no more than 30ml methadone per day, and where they are continuing to reduce. There is no Subutex on the DRW. There is a meds hatch on the DRW with meds dispensed three times a day – at least one Officer is always present to monitor this part of the regime and to check that prisoners take their meds.
4. To be considered for the DRW all prisoners complete an assessment with a CARAT worker. A prisoner has to be on the CARAT list in order to transfer to the DRW – at the time fieldwork was undertaken there was a small waiting list. DRW staff then complete a further assessment with prisoners when they move to the DRW. All prisoners are assigned a personal officer and sign a compact to engage with the DRW programme – this includes engagement with psychosocial courses and weekly drug testing. There is a

'two strikes and you're out' policy with regards to possessing or taking drugs while on the DRW. A CARAT Officer will complete reviews with DRW prisoners every 4-6 weeks.

5. Prisoners cannot work (other than on the cleaning/servery team, or as the Wing barber) or engage with education while they are on the DRW - "their work is their recovery". However, prisoners are paid to be on the DRW - £2.50/week basic plus £5/week for course attendance. This is more than the unemployed rate, and cleaners get about £1/week on top of this.
6. The DRW programme is usually 8-10 weeks (the cleaning team can remain on the DRW more indefinitely) and prisoners get a certificate on completion of the recovery programme. When the DRW was first opened the programme was six weeks but it was recognised that this was not long enough. Engaging with the DRW ensures that a prisoner cannot transfer to another prison, even if their sentence is over two years.

Table 1 - Sample DRW timetables

[The Psychosocial Contractor's] Peer Mentoring Project IDTS Timetable	
9:30-11:30 every Wednesday	
1	Harm reduction
2	Overdose
3	Clinical intervention to support recovery: What do you need to know?
4	Health promotion – healthy balanced living
5	Health promotion – healthy balanced diet
6	Relaxation
7	Change is possible
8	Managing Relapse
9	Triggers and cravings
10	Alcohol awareness
11	Drugs: what you need to know
12	Heroin
13	Blood borne viruses
14	Safer injecting
15	How crack cocaine works

[The Psychosocial Contractor's] Peer Mentoring Project Certified Personal Development Timetable	
9:30-11:30 every Tuesday	
1	Anger management
2	Assertiveness skills
3	Stress management
4	Acupuncture
5	Communication skills

6	Confidence building
7	Relapse prevention
7	What to do now?

7. There are two main aspects to the DRW's drug treatment programme. Recovery modules, of which there are five, are delivered two mornings a week by DRW prison staff. An external provider runs two-hour courses twice a week (this has recently increased from once a week). Sample timetables for these two parts of the DRW programme are in Table 1. All classes are run in rooms on the DRW. The psychosocial service also offer acupuncture sessions for prisoners.
8. Further supportive elements of Swansea's DRW regime include additional DRW gym sessions, exercise, and association periods (see point 11 for details). This is more than is available to prisoners on other wings.
9. The DRW staff team is mainly prison officers (about 16, who also cover the DFW) plus Senior Officers and a Wing Governor. Staff were invited to apply to work on the DRW. In addition there is input from healthcare, CARAT workers (currently prison officers due to the loss of the CARAT contract to an external agency) and the psychosocial team – these staff are not located on the DRW but this did not appear to be a problem for staff or prisoners.
10. There is a general office on the top landing of the DRW. In this office are two large white boards which give details of all the DRW prisoners, their time on the Wing, the courses they do, the meds they are taking and so on. At the back of the bottom landing is a gate through to the DRW staff offices (and a door to other areas of the building).
11. Efforts are made to maximise the separation of DRW prisoners from the rest of the prison. The DRW shares its exercise yard only with the DFW. It also has its own servery and gym session times. There are inevitable times when separation from other prisoners is not possible (e.g. visits, prisoners moving through the DRW to get to healthcare, and the servery team who have to go through the general population A Wing to get food).
12. Broadly speaking, there is a typical day for DRW prisoners. Prisoners will get up at about 8.30am and have time for meds, breakfast and to deal with paperwork, appointments and so on. Prisoners will then spend the morning in their cells (other than days when there are courses) and this is generally the same in the afternoons. There is one hour of association time at the end of each weekday (not on Fridays but officers will generally try to give prisoners some time for showers and phone calls), and prisoners can go to the gym for up to one hour up to three times a week. There is some exercise time outside, usually in the mornings and for about 45 minutes but this is dependent on the weather and availability of staff. Overall, prisoners will spend the majority of each day in their cells. The cleaning/servery team will spend more time out of their cells because of the nature of their employment.
13. Observations of this DRW were that it seemed clean, freshly decorated, light, bright and calm. There was lots of relevant information on the walls, and also copies of some of the posters designed by prisoners (as part of a competition to describe the DRW) were on the walls.
14. Overall, the DRW at HMP Swansea has the potential to make an important contribution towards the support available to prisoners in Wales who have substance misuse

problems. The latest HMIP report on HMP Swansea (2010) recognised the things that the prison was doing well to support prisoners with drug problems, recommending that a "dedicated drug support/drug testing unit should be established where prisoners receive additional support to remain drug-free". Hence the DRW (and the DFW) can be seen as a response to this recommendation. The DRW is also important because such intensive support is not available at other Welsh prisons (requiring prisoners to transfer, potentially further away from family, to prisons in England)[2].

Summary of interview findings

The interview findings are discussed following six broad themes. These are: the DRW programme, Wing conditions, staffing and relationships on the DRW, how the DRW benefits prisoners, support services and the Drug Free Wing, and general views on the DRW.

The DRW programme

* There was positive feedback from staff and prisoners about the overall environment and atmosphere on the DRW, which appears to be conducive to recovery. Interviewees identified a number of characteristics which they felt were important in this regard – the size of the DRW, its level of separation from the rest of the prison, the staff team, and the fact that both staff and prisoners are engaged with the DRW voluntarily. The process by which prisoners are assessed for the DRW, including the experience and expertise of staff (and their knowledge of prisoners who have been at HMP Swansea previously), seems to work well, maximising the number who engage with the DRW for the right reasons. This is felt to be important
* Overall, the prisoners were positive about the psychosocial programme on the DRW, both those delivered by the DRW Officers and those delivered by the psychosocial team. Some prisoners commented on the knowledge and passion of the Officers who delivered the courses. One staff interviewee said that Officers put a lot of effort in and are keen to learn about substance misuse; for example they will sit in on the IDTS courses that the psychosocial team deliver to prisoners. Prisoners were positive about the the psychosocial team's courses, saying that they take a lot from these courses and would like there to be more of them. Every course is full and there are often waiting lists. Some prisoners appreciated doing the courses in a group with other prisoners while one prisoner commented that some of the psychosocial personnel delivering courses were themselves ex-users, adding that more such support could be part of the DRW programme. One staff interviewee said that they would like improved classroom facilities for the delivery of courses.
* An important feature of the DRW is that prisoners engage with the programme when their level of substitute medication is such that they can focus on other aspects of their recovery when they move to the DRW.

  "it's a recovery wing, it's not a stabilisation wing.....the aim of this wing is recovery"
* Several of the staff interviewees commented that the DRW has functioned better (and more in line with its core aims as a recovery Wing) when the decision was made (roughly two months after the DRW opened) to manage detox as part of induction, by increasing the time that prisoners could spend on the induction Wing before moving to the DRW.

[2] One staff interviewee told me that HMP Cardiff will soon be opening a DRW.

Furthermore, when they transfer to the DRW prisoners must be on no more than 30mls methadone per day with a firm plan to continue reducing.

* Another important decision was to not allow Subutex on the DRW. Two staff interviewees explained the rationale behind this decision.

  "....the DRW couldn't work, didn't work when we had Subutex on the Wing, the temptation was too much....no matter how diligent staff were....it just caused problems"

  "it was a disaster, an absolute disaster because it was undermining everything we were trying to do....we made a decision then not to have anyone on here on Subutex for the sake of the project, for the sake of the Wing, for the sake of what we were trying to achieve, for the sake of the individuals and the other participants, it just wasn't working, it was creating all sorts of issues and problems"

Prisoners volunteering to engage with the DRW

"...we've created an environment where they can relax a little bit without that peer pressure which is a big thing.....it's huge.....to avoid that pressure we decided from the offset really that to try and create a little bit of isolation would enable them to focus much more on their own recovery and I think we've tried to create an environment where prisoners support other prisoners on the Wing....we've tried to create almost a family environment really which I think is absolutely vital not only for the project but for the recovery of our participants"

"....people have got to be on here for themselves, for the right reasons, they're taking ownership and responsibility of looking at their recovery, of starting recovery...."

".....we want volunteers and I think that's vital for the project and for the ethos of the recovery Wing that everybody on here is a volunteer and they have to be on here for the right reasons....we want people that are genuinely interested in recovery"

"....they've chosen and volunteered and signed up to come on here and so have we so we try to have an ethos of helping each other"

"....this is an environment where we are volunteers, we all volunteer to work on here, they are volunteers so in that environment hopefully people work together you know....everybody is a volunteer"

* Despite the importance of medication reduction for prisoners as part of their engagement with the DRW, one staff interviewee felt that this approach was not always in a prisoner's best interest, suggesting that there was a need for some flexibility with this model on a case by case basis. This same interviewee added that re-scripting (including with Subutex) is sometimes necessary to support the safe release of some prisoners. A second staff interviewee was more hesitant, and did not understand the decision to re-script some prisoners who were abstinent.
* One prisoner said that he had asked for, but did not receive, an alcohol detox when he arrived at the prison, adding that he thought such support should have been available to him because of the risks of unsupported withdrawal from alcohol.

* The prisoners identified some gaps in the DRW programme and ways in which it could continue to develop. Some thought that there could be more for prisoners to do during the day, commenting on how much time they spent in their cells. One prisoner said that it made a difference when the psychosocial team started coming to the DRW twice a week as this meant more time out of cells and another opportunity to do something linked to their recovery. Some prisoners thought it was a shame that DRW prisoners could not engage with employment or education, while one prisoner wanted increased access to the library but said that staffing meant that this was not always possible.

  "I've come over here for recovery, where's the help, you know what I mean?"

* As noted above, some prisoners thought that there could be more involvement of ex-prisoners in the delivery of courses on the DRW. Related to this, one prisoner said that the DRW is missing a 'listener', something which is present on all other Wings at HMP Swansea. One prisoner has applied to do to the listener course. Another prisoner said that he had applied to do mentor training with the psychosocial team's contractor. One staff interviewee said that, in line with Government directives, there are plans to deliver targeted peer mentoring training to small groups of DRW prisoners so that there can be peer mentors on both the DRW and the DFW. Overall, it seems that both staff and prisoners are keen to be proactive in thinking about how prisoners can become more actively involved in the DRW, both during their time on the Wing and post release. One prisoner thought that something like a (drug-related) quiz could bring prisoners together, engaging them in activities that encouraged team work, and team-oriented thinking.
* One prisoner thought that the psychosocial programme needed to include more to support prisoners in understanding and dealing with their emotions and feelings (and the learned behaviours which many prisoners have in this regard related to their drug misuse and offending), and the changes that they are making through their recovery.

  "I've never seen prison as a punishment....I think it should be more about like I said all these behaviours that are learned over the years.....and you're not going to unlearn these behaviours by being stuck behind a door, I think they should be doing more to help you use these hours"

* Many of the staff interviewees highlighted the impact of staff capacity upon what prisoners could be offered, and hence the continued development of the DRW. One interviewee said that they have recently introduced an in-cell recovery work package (which will be supported by a 1:1 interview with an officer on completion of the work package to discuss the work) and said that they would like to be able to offer more group work and other interventions (including things which involve prisoners more). However, at least one staff interviewee thought that there was no need to increase what was available to prisoners as this might overwhelm them. More staff could also enable DRW officers could get more involved with supporting prisoners around release.
* Several prisoners, and at least one staff interviewee, thought that the DRW programme could be longer and more intensive. Several prisoners made comparisons with other programmes they had completed or wished to engage with, including 12-step and short-duration programmes. One staff interviewee thought that the loss of the SDP at Swansea was a backward step. Another thought the rehab Wing (that there used to be) should be reinstated as another stage of recovery. One prisoner thought that NA meetings should be available (in addition to AA meetings which are available) and that attendance at these meetings should be compulsory to the DRW.

"....[A prison 12-step programme] was the best thing I think I've ever done....[the programme at Swansea] helps, it gives you the tools but it's not intense enough, do you know what I mean"

"I think having accredited courses on top of this would be beneficial as well".

Wing conditions

* The prisoners were generally positive about the conditions and atmosphere on the DRW, describing the Wing as clean, quiet (unless Swansea FC are playing!), mellow, quite joyful, and having a good vibe. Some prisoners thought that the small and contained nature of the Wing contributed to the positive atmosphere, which can engender a feeling of community between prisoners. A safer and calmer environment was also seen to be good for first time or vulnerable prisoners. One prisoner said that the small size of the DRW means that there are shorter queues for the showers and 'phones (compared to the other bigger Wings). Several interviewees also commented that the number of issues which occur on the DRW (including assaults, bullying, self-harm and disciplinary issues) is much lower than across the rest of the prison.

  "....the other Wings run like a normal prison environment, we've tried to create our own environment really within the establishment which is unique for this establishment anyway"

  "it's definitely calmer....if someone raises their voice it's quite noticeable because it's out of the ordinary"

* Several prisoners valued the DRW because it took them away from the other prison Wings, where drugs are "rife" and which more than one prisoner described as "jungles" where prisoners are "rodents" when out of their cells, dealing drugs and so on.

* The two main negative aspects to the DRW conditions were the food and the exercise yard. Several prisoners were critical of the quantity and quality of food (some recognised that this was due to budget cuts), although some said that this is to be expected in a prison. One prisoner said that he is always hungry. Several prisoners were also critical of the exercise yard which is available for use by DRW and DFW prisoners, describing it as small and "like a cage". If it is crowded then they felt that it was barely worth going out for exercise. At least two prisoners thought that DRW residents should have set hours (separate from the rest of the prison) when they can use the larger main exercise yard. In addition, one prisoner said that most of the cells are quite small and the loos are not screened off, while another said that his area of the Wing can be cold (he is waiting for a window to be fixed).

* There was a general sense that the availability and use of drugs is much less on the DRW than across the rest of the prison, and that this contributes to the atmosphere and success of the DRW. As noted above, several factors were identified as important in reducing the availability of drugs on the DRW: the fact that prisoners make significant progress with, or complete, their detox before moving to the DRW; that Subutex is banned from the DRW medication regime; that prisoner compacts include regular drug testing, with a 'two strikes and you're out policy'; and that the Wing is voluntary and largely segregated, In addition, the DRW has its own meds hatch, with medication dispensed three times a day (one round for substitute medication and the other two rounds for other medications). Moreover, there is always at least one Officer present to check that medicines are taken correctly by prisoners and one interviewee said that

regardless of staffing issues this is never compromised (as it might be on other Wings). Finally, at least one prisoner interviewee said that there were prisoners on the DRW who would speak up if they heard about or witnessed drugs on the Wing because they wanted to keep it as drug free as possible.

Staffing and relationships on the DRW

* The prisoners were extremely positive about the DRW prison officers. Some of the words and phrases they used to describe them included - brilliant, helpful, respectful, take the time to get to know you, understanding, listen, make you feel human, can have a laugh and a joke with them. Some prisoners made comparisons with Officers on other Wings, who are seen not to care or engage positively with prisoners who are drug misusers. It was recognised that the small size of the Wing with a higher than normal staff: prisoner ratio, and where the cycle of re-offending means that prisoners are often familiar faces to Officers, contribute to good relationships between prisoners and staff. One interviewee thought that the respect which is reciprocated between prisoners and staff can support prisoners to ask for help or disclose when they have had a relapse.

Prisoner views of the DRW Prison Officers

"if they can help you in any way they will"

"the officers are helpful, probably the most helpful officers in the jail, if they can do anything to help you or if you've got any problems they'll address it, on the other wings they're not interested"

"they talk to you like human beings not like a prison which I think's a good thing"

"on this wing it's completely different, they'll give you the time of day, they'll help you in any way that they can"

"....you get respected on this wing....you get respected for taking the time to come on to this wing voluntary to have a change to your life so the staff respect you more for that so in that sense you get treated a lot different....they treat you like a normal person"

"the staff are really great....on the other wings they don't really talk to you, in here they give you the time of day and they talk to you if you've got any problems, they're really helpful, really kind, they're the best staff in the prison to be honest"

"it's like a big family"

".....get to you know you on a personal level other than other staff where you're just a name and a number to them"

"....[the other wings are] bigger wings, the officers haven't got the time and to be honest they don't really care.....they're not counselling in any way to help you with any of these drug problems"

* The Officers who work on the DRW were selected through a process designed specifically to recruit for the DRW. The staff team was seen by at least one interviewee as the most important thing about the DRW and why it is working well. The staff create the atmosphere for the DRW but, more importantly, they enjoy their work and they have ownership in the running of and development of the DRW.

* Many interviewees commented that staffing levels on the DRW presented perhaps the greatest threat to the smooth running of the Wing. Being short staffed can prevent courses from running, and reduce or eliminate association time. It can also mean that Officers from other Wings, who do not know the prisoners or understand the Wing and its regime, are moved to the DRW. At least one interviewee said that the DRW runs very well unless it does not have the correct staff team to run as it should.

  "it's our biggest problem....our biggest enemy really, without the resources we can't do all the stuff that I've just described and with staff on here from other Wings, there's a danger, it doesn't happen often but there's a danger that if that was the norm we'd slip back in to being a normal Wing....it can't work without the right staff on here"

* The other staff who contribute to the DRW are also seen to be vital to its success. This includes the input from the psychosocial team, healthcare and CARAT workers (the latter are currently Officers). However, staffing issues with both healthcare and CARAT have placed pressure on the support which is available to DRW prisoners. One interviewee thought that there should be a full-time CARAT worker assigned to the DRW, while another interviewee thought that there should be specific staff from healthcare allocated to the DRW.

Importance of the staff team for the DRW

"I liked the idea of having a new challenge...I don't want to just open and close doors, I liked the idea of working with in a wing where the ethos was completely different to a general population [wing] and if I could just get one person through their recovery I would be happy....I'm probably more passionate about it now than when I came on [to the DRW], and experience tells me that's unusual"

"I wanted to work on the Drug Recovery Wing because I have numerous years of experience as a Prison Officer, and I know the issues surrounding drugs in every prison. I'm also a member of the local community and I also know the impact that drugs are having on the community as well so I felt as it was a good opportunity to try and do something to reduce the level of offending, to reduce the level of reoffending and actually help people as well....to try and give people a better chance of not reoffending, because reoffending rates are huge, you know....60-70% I think"

"....the staff are enjoying it as well, staff feel that they've got ownership, that they are doing something positive, that they are helping prisoners address their issues so it's that sort of hands on sort of being able to change peoples lives that on the other wings staff aren't really afforded that time"

"the interaction between staff and prisoners is much more of a success than I thought it would be"

* There was also consensus that DRW prisoners get on well with, and are supportive of, each other, and that relationships are better than elsewhere in the prison. As noted above there are fewer incidences of arguing, bullying, violence and aggression. Two prisoners, one who has been on the DRW for a few weeks and another who has been on the DRW for about nine months, said that they have seen almost no trouble between

prisoners. Prisoners widely felt that there was a strong sense of family and community on the DRW.

"we all help each other, we look after each other, we're all peers in one ways, we're like a big family really....by all looking out for each other it's a good thing, we don't want drugs on the wing"

"no-one's on drugs here, everyone's getting rehabilitated, everyone just wants to talk to each other and get on, there's no fighting on here, there's no arguing"

"everyone just wants to be drug free on here I think"

"as soon as I come here [to the DRW] and I'm around like minded people...."

"everyone's nice to one another"

"....being in the right environment where people want to change, and being together collectively I think that's going to have an improvement....on this Wing everyone's singing from the same hymn sheet and they all want to change, that's going to have a positive effect"

How the DRW benefits prisoners

* For several of the prisoners the DRW presented the first real opportunity to engage with drug treatment. This may have particular significance for those prisoners who are in prison for the first time and have the opportunity to engage with the DRW. For some prisoners engagement with the DRW programme led them to understand their drug use as problematic while others stated that they were ready to change and engage with what the DRW had to offer.

  "it's time for me to change my life"

  "to be honest I didn't think I had a problem"

  "....it's your choice to come over to this Wing, nobody's made you"

  "it seems more like rehabilitation than punishment"

  "you can get all the help you need, outside it's quite hard to get the help you need, in here you get offered everything"

* There was a range of ways in which staff and prisoners thought that the DRW was helping prisoners. Some of the staff talked about prisoners taking responsibility for their addiction and gaining belief in themselves and the possibility of recovery.

  "I can see prisoners getting belief mainly, I think sometimes it's the first time they've ever had somebody believe in them....you see them grow"

  "they are starting to take responsibility for what they've done"

* For some prisoners time on the DRW was the longest time that they had been substance free since they first developed problems with drugs and/or alcohol (usually since their teens) and they talked about improvements in their physical and mental health. The prisoners also talked about how the support on the DRW was helping them to better understand their addiction and how it affected them and those around them. Some talked about learning how to manage their emotions and communicate better with others. One staff interviewee, who delivers acupuncture to prisoners, believes that it helps with sleep, withdrawal and cravings.

* There is a safer cell on the DRW, which may be used for prisoners from any wing. There have been occasions when prisoners in that cell have recognised that they have substance use problems and have asked to be moved to the main DRW.

How the DRW benefits prisoners

"....obviously when I was under the influence of drugs I thought I was invincible....I didn't care about who I was hurting....but since I've done courses and taken time out to really think about it, it's affected not just me but many other people as well"

"it's made a start, it's given me a kick start to think about things before I get out, it's given me time to think about things"

"it's helped me get in touch with my emotions and be able to talk about things with my mum and dad and realise the aspect of what I was doing and how it didn't just affect me, it affected my family, it affected my friends and things, I thought with me coming to jail it would only affect me but it doesn't, but it's a lot bigger picture if you know what I mean"

"I've just really changed in myself, before I couldn't really hold a conversation down to be honest, now I can hold a conversation down and I'm getting on better with my family members....just talk about stuff when I didn't used to, I used to hold everything in"

"it's helped me move on mentally.....since coming in here this is probably the longest I haven't smoked [in the last eleven years] and I feel so much better, my mum and dad are telling me I look a lot better in my health.....and my sleeping pattern's coming back and it's just helping me move on with my life basically.....and I would say a lot happier in general as well"

Support services and the Drug Free Wing

* The DRW at HMP Swansea has a solid partnership with a local non-statutory addiction treatment provider, who deliver psychosocial services both in the prison and in the community. This is seen to be beneficial for a number of reasons. The psychosocial service engage prisoners while they are on the DRW, and their community arm will take on all DRW prisoners as clients following release. This streamlines processes for prisoners so that they can have quick and easy access to treatment and other services. They do not, for example, have to go through the single point assessment process in order to be taken on by the prison's community partner – a process that often takes several weeks.

  "there's no gap in service..... we're capturing people at a far better time because of this link"

* Efforts are also made by the DRW and its psychosocial team to increase what is available to prisoners on release. A worker from the psychosocial contractor will be starting a new session called 'What to do next'. The aim of this course is to offer something to prisoners around release and what local information and services they will find helpful in relation to a wide range of needs. The psychosocial team also give prisoners certificates on completion of courses and will write letters (e.g. about engagement with treatment courses) to support prisoners in court. There are good links with Officers on the DRW so that the psychosocial team's community arm will get notice of a prisoner's pending release date so that they can make contact with a prisoner to set

up appointments with them on release – this is a structured and immediate process which ensures that there is no gap in care for prisoners.

* The link with the psychosocial contractor means that there is some evidence as to how the DRW can benefit prisoners. There has been an increase in the numbers of prisoners who engage with, and successfully complete treatment with, the psychosocial contractor's community services on release. The links with this agency can also support prisoners to make positive changes in other ways, for example, gaining qualifications, engaging with other services, engaging with another project which offers diversionary activities to prisoners (such as walking, cooking, art & crafts, music) which "gives them something meaningful to do with their day time". The support which prisoners receive is believed to positively influence personal development, confidence, assertiveness and communication.
* One staff interviewee thought that greater efforts could be made to support prisoners to make links with a range of other local services, for example by holding 'fayres' in the DRW/the prison where a range of external services could come and advertise what they do and what is available. Another staff interviewee said that HMP Cardiff are setting up a DRW, hoping that the two prisoners can make links and work together.
* Mental health problems were not discussed by many interviewees but one staff interviewee said that mental health needs are considered when prisoners come on to the Wing and their care plan is put together. There appear to be good links with prison mental health services. This interviewee added that they think the work of the DRW can have a positive impact through stabilising a prisoner's mental health more quickly than on other Wings.
* Several of the prisoner interviewees talked about the importance of support from family and friends while they were in prison. This suggests that there is a missed opportunity within the DRW programme to involve families (alongside prisoners) in the recovery programme, as well as supporting family members to engage with services in their own right in the community.
* The DFW at HMP Swansea is seen to be an important progression for prisoners, offering an incentive to complete the DRW programme. It also gives prisoners the opportunity to continue recovery without returning to a general population Wing. Prisoners can work when they are on the DFW.

  "....that's what you need to be looking at, the link between drug recovery to drug free"

  "[the full package of] induction, detox, drug recovery, drug free, if they choose"
* Most DRW prisoners move to the DFW, where they continue to be monitored by the DRW and subject to voluntary drug testing. However, one prisoner thought that a number of prisoners relapse quite quickly when they move to the DFW. It is important to note that there are two routes to the DFW. Whilst some referrals come directly from the DRW, others are referred from elsewhere. These prisoners may not have substance misuse problems, but want to live in a drug free environment while in prison.

General views on the DRW

* There was consensus from both prisoners and staff that the DRW is an important part of HMP Swansea.

"I think the wing is fantastic, I think it's working really really well.....I can't see how it would be practical to not have this service"

"...I think we've got the correct staff and we've got quite a good relationship with prisoners in Swansea, I think if we can work closely together then I think it can be successful, you know there's a big drug and alcohol problem in Swansea and anything they can do to address that while in custody is a good thing"

"I would like the prison service to look at this as an integral part of every prison really"

* The DRW is seen to have a positive impact on the rest of HMP Swansea. Over time staff think that there has been an increase in the number of prisoners who want to come to the Wing (helped by good feedback from prisoners who have experienced the DRW, and word of mouth among prisoners elsewhere). However, it is still the case that other prisoners 'look down' on the DRW and see it as something of a joke because there are no drugs. One interviewee talked about a competition where prisoners were invited to submit posters describing the DRW to other prisoners. There was a good response to this competition (about 20 entries) and posters were placed all over the prison (they can still be seen on the DRW and also on the induction Wing). The top three posters from this competition can be seen at the end of this report.
* When it was first developed, there was a lot of negativity from staff about the DRW (one staff interviewee said that staff sickness rates increased for a while), largely linked to the level of change which was required and the relocation of the induction Wing. While staff interviewees thought that there was still some negativity and a lack of understanding about the DRW from other Officers, they also thought that some Officers had grown more positive about the DRW and were now more likely to encourage prisoners to move to the DRW. Some were also more keen to work on the DRW

Prisoner views on the DRW

"....if one person picks something up out of it, it's a bonus....I look around and see all these young boys...if one of them picks up and actually changes it's a bonus because it saddens me, you know I'm old enough to accept my responsibilities but when I see these youngsters coming in to jail and immediately they can't wait to get out to go back to their old ways so if one of them picks up on something it's a good thing"

"it's a good experience, it one person listens it's a bonus....all in all, I'm happy it's in the prison system and I think it should be expanded to other jails, I think every jail should have a recovery wing cos there are people who don't want to carry on with addiction, find their lives unmanageable and want to address their behaviour"

"I think it works really well....it's progressed well.....people wanting to come here to sort their lives out and change"

"there should be one [a DRW] in every jail....the majority of people when they come to prison they take drugs in prison and they don't care but for a certain percentage of inmates they want to do well, they want to courses, they want to remain drug free whilst in prison, they want to keep fit and go to the gym....so I think there should be one in every jail to be honest"

"I was lucky enough to experience it and it helped me change the person I was to the person I'm becoming....I think it's given me the kick up the bum that I needed to help me want to change....if it helps people who want to change"

"I just...think it's a good idea for people who genuinely have an interest in getting clean"

* Interviewees had opinions on how the DRW could continue to develop. Some thought that the DRW could increase in size and that, if this was staff appropriately, this would not have a negative impact on the Wing. Several interviewees thought that the DRW could be segregated further from the rest of the establishment, perhaps by being housed in its own building. Interviewees also thought that the DRW programme could develop, with more courses during weekdays, in the evenings and at weekends, and by increasing engagement with community services.
* One prisoner thought that allocation departments could do more to support prisoners complete their sentences at prisons where the help they needed (or requested) was available, rather than sending them to any prison where a prisoner is more likely to be lost in the system.

  "if we can get allocation to allocate us to a jail not of our choice but a programme of our choice it will obviously help in recovery do you know what I mean rather than just chucking us in the system so to speak and leaving us to rot"
* There were concerns expressed by all the staff interviewees about the future of the DRW and in its staffing, particularly linked to the imminent changes to the prison's core day and staffing. Additionally, some staff wondered if the DRW pilot project was just a 'fad', the 'current flavour of the month', and whether it would just fizzle out over time and at the end of the pilot.

Concerns about the future of the DRW

"I get asked all the time by staff on the unit is this just going to be pie in the sky, a pilot, the pilot will come to the end and we won't go forward.....I think this is the way forward"

"....it would be a shame if they turned my role into only opening and closing doors....I hope that when they make all these changes they still allow prison staff to be involved in the rehabilitation side of prison life"

"...resources should definitely be secured, ringfenced...."

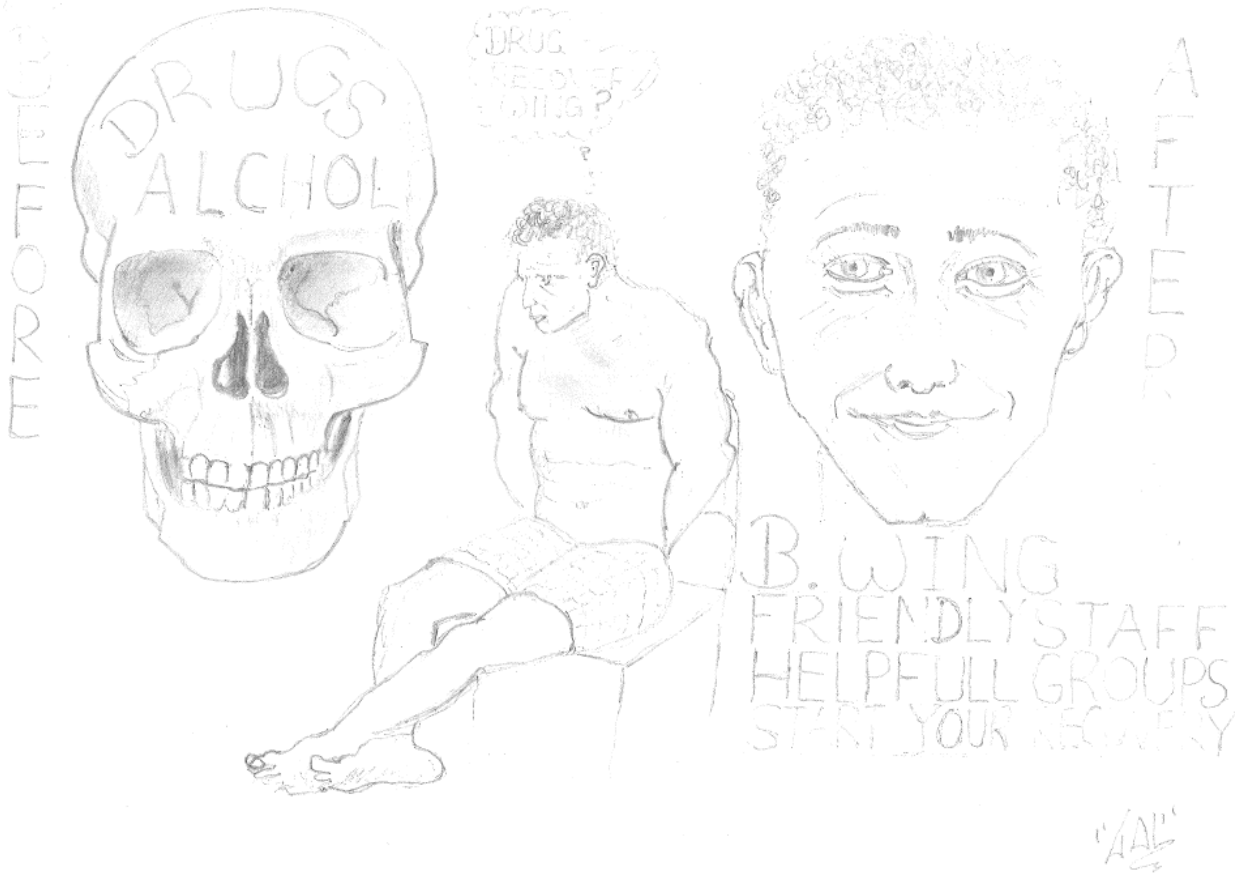
* However, despite these concerns, two staff interviewees were more optimistic that the 'benchmarking' agenda would work in the DRWs favour through recognition of what is required in terms of the core day and staffing levels. There will be a new induction Wing at HMP Swansea; this will be part of one area of the establishment also including the DRW, the DFW and the segregation unit. An additional 12 Officers will be allocated to this Unit – these staff will be allocated to the new induction Wing but it will be possible to move staff around, for example to bolster the DRW and DFW. The Officers who are currently CARAT workers will also become part of the staff team for the new Wing – under the new agenda their posts will not exist but the resource which they represent in terms of staff numbers will be included in the larger staff team, which one interviewee said was important to bolster the expertise and knowledge of the expanding staff team.

* One staff interviewee also highlighted that it needs to be recognised that the DRW at HMP Swansea is cost-effective. Staffing rates are similar to the rest of the establishment (and most of the staff training has been done), the amount of drug testing (over the DRW and DFW) does not affect costs too significantly (about £15k/year), and many of the other resources which support the DRW are at nil cost (e.g. support from the psychosocial contractor and other local agencies).

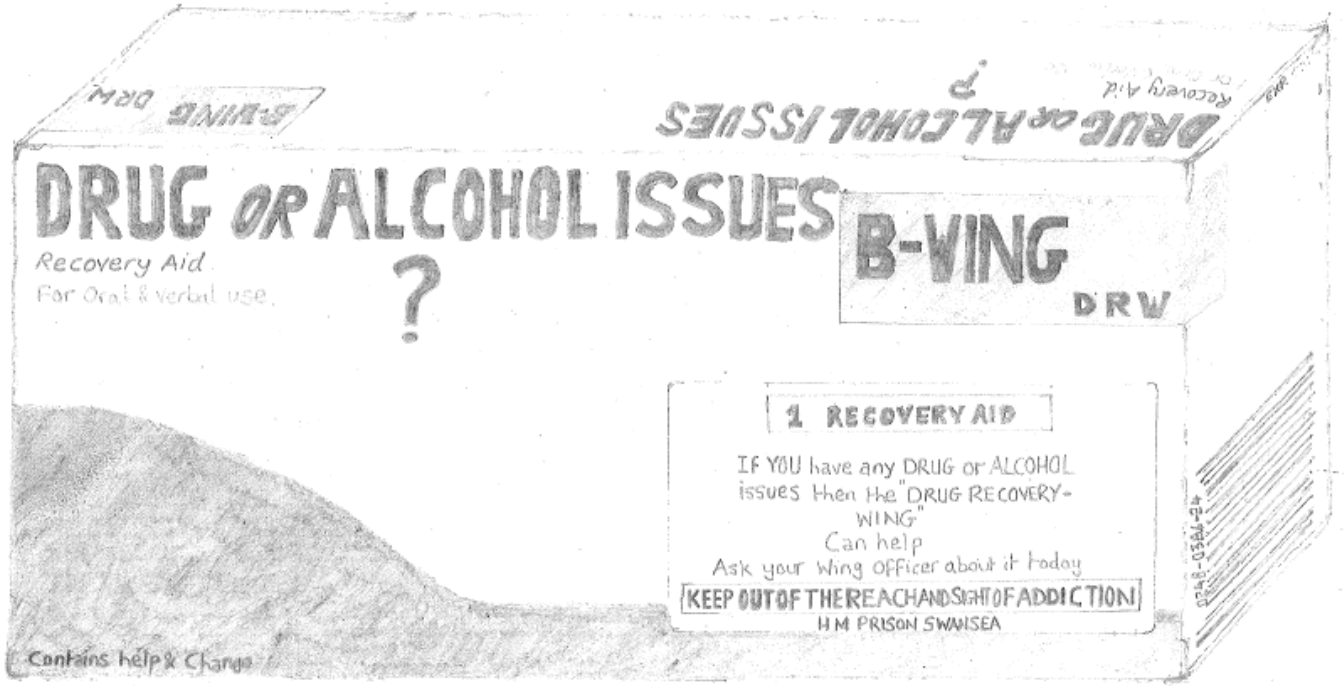
Conclusion

This is a new DRW which has been operating for less than one year. In that time the interviews with both staff and prisoners suggest that it has achieved a great deal and is making an important contribution to HMP Swansea. It should be acknowledged that there is a lack of solid quantitative evidence about the impact of the DRW on prisoners, both while they are engaged with the DRW and on release. However, a number of things appear to be contributing to interviewees' positive view of the DRW: its size and segregation from the rest of the establishment; the attitudes and experience of the staff team; the DRW's strong 'through the gates' partnership with a community drugs agency; the selection process by which prisoners move to the DRW; the relationship between prisoners and Officers; the wing's heightened prisoner:staff ratio; and the fact that much of the work around detox is undertaken on the induction Wing, thus allowing prisoners on the DRW to focus much more on other aspects of their recovery. Moreover, the DRW is continuing to develop, although there were some varying views about how the DRW programme should best evolve. The intensity of the programme and how much time prisoners spend in their cells certainly need careful consideration. There may also be a missed opportunity in terms of involving the wider family within the recovery programme. Interviewees voiced a strong belief in the DRW, but framed within a context of some uncertainty about the DRW's future given wider Prison Service changes, and their likely impact on staffing.

Appendix 1 – Prisoner posters about the DRW


BEFORE
DRUGS
ALCHOL
DRUG
HELP
ING?
AFTER
B. WING
FRIENDLY STAFF
HELPFULL GROUPS
AA

JUST THE PRESCRIPTION?



KEEP OUT OF THE REACH AND SIGHT OF ADDICTION ... DRUG RECOVERY WING (B).