

The EPRA Report

Blueprints for the Treatment and Throughcare of Prisoners with Histories of Drug Dependence

A Report from the Ex-Prisoners
Recovering From Addiction
(EPRA) Working Group

Chaired by **Lord Patel of Bradford**

Foreword

FOREWORD BY LORD PATEL

I was asked to take on the role of Chair of the EPRA Working Group and was very happy to do so, given its remit to identify evidence-based, cost-effective ways to support substance-misusing prisoners through prison and on release. I was already all too aware of the fundamental challenges facing prisoners as they leave prison and try to reintegrate into their communities – and also the considerable challenges faced by those working to help them. I have worked for many years, as a practitioner, manager and policy maker in the field of drug treatment and having chaired the Prison Drug Treatment Strategy Review Group which produced the Patel Report in 2010, was mindful of the complexities involved in tackling drug problems in prison. The EPRA mission has built on this work in seeking to identify evidence-based, cost-effective ways to support prisoners with histories of substance dependence who want to make transformative changes to their substance use and wider lives, through prison and into the community.

A fundamental part of EPRA's approach has been to thoroughly engage with people who have lived experience of going through drug treatment in prison, to elicit their views on what works best inside and what would work best for them on release. The Forward Trust and Phoenix Futures have been immensely helpful here and have allowed us to ground our recommendations in the reality of our target group's understandings and experiences. However, I also wish to thank the service users that took part in the discussion groups that have proved so influential in terms of the models we have developed.

The EPRA Working Group was set up as a completely independent body and by that, I mean that we did not seek to have any current policy-makers or prison staff on our membership. However, we have engaged with policymakers in government departments from the start and certainly do not see our report as antithetical to the current policy environment. Indeed, there is much in current and planned policy within the Ministry of Justice and Department of Health and Social Care which chimes with EPRA's recommendations.

I am very grateful to Charlie Lloyd and Geoff Page who have been the driving force behind the setting up of the EPRA Working Group and instrumental in 'feeding' EPRA with the evidence and drafting the outputs. And, of course, I am particularly thankful to all the Working Group members who willingly gave up their time and contributed their wisdom and experience to this collective endeavour.

Lastly, I think this report sounds a clarion call to all those who think that prisoners who have served their time inside deserve an opportunity to make radical, positive changes in their lives, and have a right to be properly supported in so doing. It is simply not acceptable that prisoners who genuinely want to make radical changes in their lives face a cliff-edge of support on release, leaving prison without housing, employment and often, without much hope. I know the current Government also sees this as unacceptable and I hope that we can work together and with the excellent voluntary sector organisations in the field, in providing evidence-based, effective support for prisoners who want to make transformational changes to their substance use and in their wider lives.

Professor Lord Patel of Bradford OBE

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EPRA also owes a great vote of thanks to Geoff Page who has researched and prepared papers for consideration by the Working Group and drafted the final report. Thanks are also due to Steve Parrott who provided us with the benefit of his considerable expertise in commenting on the cost benefit analysis, and Sarah Nettleton and Sharon Grace who played a role in developing and supporting the initial stages of the project. Lastly, we would like to thank Ian Wardle for his input into EPRA's work early on in its development.

EPRA members

Recommendation

- The EPRA Working Group recommends that evaluated trials are undertaken of the blueprints presented here. We believe these will demonstrate clear benefits and cost savings, by transforming post-release support for prisoners who seek to make fundamental changes in their lives.

Background

- Previous research has shown a 'cliff-edge' of support for released prisoners recovering from substance abuse.
- Prison interventions can effectively initiate recovery journeys. However, prisoners' hopes for transformation become unrealistic when they are released homeless and unsupported.
- The Ex-prisoners Recovering from Addiction (EPRA) Working Group was set up to produce evidence-based blueprints for the effective treatment and throughcare of prisoners recovering from addiction to drugs and/or alcohol.
- In the course of its work, EPRA has considered reviews of the research evidence, received reports on promising approaches around the country and had feedback from focus groups of male and female prisoners with histories of substance misuse.
- Reflecting different needs and opportunities, four blueprints have been developed separated by gender (men and women) and sentence length (short and longer sentences).

The Target Group

- The EPRA target group is people who are abstinent from alcohol, illicit substances and Opioid Substitution Therapy (OST) and who wish to remain abstinent on release.
- This target group was selected on the basis of evidence from the Evaluation of Drug Recovery Wings. The separate and particular needs of this group have not historically been considered in policy, or in the context of through-the-gates provision.
- This does not imply that the blueprints are appropriate for all substance dependent prisoners. EPRA has emphasised that no-one should be persuaded to detoxify from OST.
- However, the blueprints offer greatly enhanced support to individuals who actively choose to detoxify whilst in prison. This group are at the greatest risk of overdose following release, but currently lack access to robust, specified throughcare pathways.

The Blueprints

A number of common features underpin the EPRA blueprints:

- A 'life-changing' phase of treatment, which is essential for transformative change.
- Dedicated, segregated units within prisons providing secure environments for initiating prisoners' recovery journeys, free from novel psychoactive substances and other drugs.
- Maximised use of the Home Detention Curfew (HDC) which allows prisoners to be released early, reducing the costs of imprisonment and overcrowding. While HDC rates have increased, prisoners with no secure address are not eligible. This includes a significant proportion of the EPRA target group.

- OST detoxification taking place prior to entry into abstinence-focused prison units.
- Psychosocial support as the cornerstone of treatment, delivered by diploma-level counsellors and supported by recovery workers with relevant lived experience.
- Treatment completion is timed to coincide with HDC eligibility, creating a seamless supported transition whilst reducing both the costs of imprisonment and overcrowding.
- Prisoners move from abstinence-focused prison treatment into abstinence-focused, substance misuse specialist community accommodation.
- Ex-prisoners are motivated to engage with the full treatment pathway by benefits including early release and a gold standard package of enhanced post-release support.
- HDC requires individuals to continue engaging with residential treatment. Disengagement results in their return to prison through a fixed-term recall.
- Throughout both prison and community provision, a strong emphasis is placed on progressing to secure independent tenancies, maintaining or re-establishing family ties and providing education, training and employment opportunities.

Men's prisons

- For prisoners with only a few months left to serve intensive prison treatment is an essential starting point, providing prisoners with introductions to tools for abstinence initiation and maintenance, support networks, and an understanding of the pathway into the community. The EPRA model consequently pairs a short prison intervention with a longer, intensive, life-changing phase of residential treatment following their release.
- Longer term prisoners can access substantive abstinence-focused programmes (such as 6-18 month Therapeutic Communities), which mirror community-based residential treatment. Following this life-changing phase of treatment, ex-prisoners would enter less intensive drug-free supported housing with a focus on meeting other resettlement needs.

Women's prisons

- Reflecting their greater levels of more complex needs, programmes must take account of historic trauma, women's concerns around childcare and custody, and abusive partners.
- Women released from long-term prison programmes should ideally move on to women-only residential treatment services. However, there are few of these.
- All staff working in prison units should be trauma aware. All units should be women-only.
- Treatment should be evidence-based, theory-informed and trauma aware, although no such prison programmes have been identified.
- The lack of women-only community services argues for doing as much as possible inside prison – delivering longer, life-changing prison interventions wherever this is possible.
- However, all prison programmes have to be followed by packages of support that can enable women to sustain life changes after release. Piecing these together requires serious consideration of local conditions, and the context to which women will return.

Cost-benefit analysis

- Our analysis shows that even the most intensive community-based residential programmes cost about the same as imprisonment for men and are cheaper than imprisonment for women. Specialist drug-free supported housing is much cheaper than imprisonment.
- Models estimating the costs of the elements described in the blueprints show that:
 - the blueprints for men and women serving longer sentences would be cheaper than current provision, even without reductions in re-offending and re-imprisonment; and
 - in the short-term blueprints, investment would be needed in order to fund residential treatment in the community. However, small reductions in offending would outweigh these costs. Prisoners eligible for these interventions currently receive little support, but are attended by much higher rates of reoffending.
- Nearly 20% of prisoners serving short sentences are released homeless, with 10% released to unsettled accommodation. Even higher proportions of the EPRA target group fall within these categories. As they are unlikely to be released on HDC and re-offend at a very high rate, the investment required to deliver the short-term blueprint brings with it much greater transformative (and cost-saving) potential.
- We believe that these blueprints offer an outstanding potential for spending better to save, by conceiving of abstinence-focused interventions as a start-to-end process and not a process that begins in prisons, and ends at the prison gates.

Introduction

The spur that has driven EPRA and the production of this report is the repeated and transparent failure of efforts to link up drug treatment inside prison with adequate support on release. This was brought home in the recent Drug Recovery Wings (DRW) Evaluation¹: a substantial evaluation of ten pilot projects aimed at ‘challenging offenders to come off drugs.’ This research yielded some important insights into recovery-oriented programmes in prison and provided some promising models to draw on. Perhaps most significant has been the finding of a ‘cliff edge’ of support on release from prison, even in the context of high-profile initiatives intended to include much better aftercare provision. Figure 1 depicts prisoners’ pathways through many of the most well-resourced and highly ambitious abstinence-focused DRWs, wherein treatment staff were unable to guarantee programme graduates security and support.

Figure 1. Current Provision



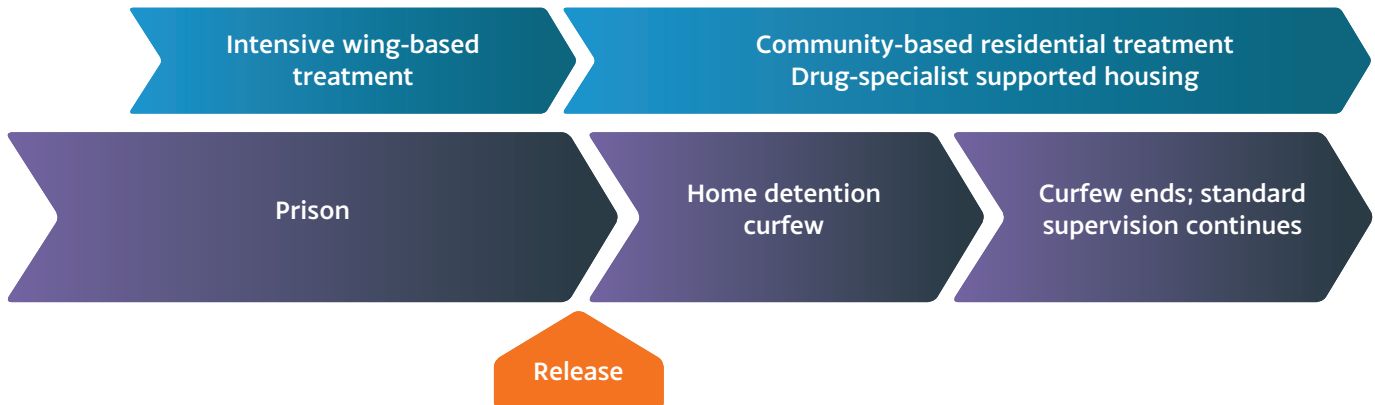
In some instances, highly motivated, drug- and alcohol-abstinent prisoners were returned to general population wings with high levels of drug availability. Across all DRWs, prisoners were routinely released homeless and unsupported. This was particularly likely for those with extensive criminal records, histories of heroin dependence, and no personal resources – the group attended by the greatest social and economic costs, most likely to reoffend, and most likely to overdose.

Ex-Prisoners Recovering from Addiction (EPRA) was therefore formed to draw on research evidence and lived experience in producing blueprints for effective through-care for prisoners with a history of substance dependence who are motivated to make transformational changes to their substance use and wider lives. Chaired by Lord Kamlesh Patel, the working group met four times over a one year period between 2016 and 2017, its work supported by a series of evidence reviews, visits to promising programmes around the country, and a strong input from people with lived experience.

At an early stage, it was clear that the differences in needs, experiences and provision for women prisoners necessitated separate blueprints. As the work has progressed, it has also become clear that the potential for through-care and treatment models for short-term and longer-term prisoners also differed greatly. There are therefore four detailed blueprints included in this report, divided by gender and sentence length. All share the same core structure, set out in Figure 2.

¹ Lloyd *et al.*, 2017a

Figure 2. Proposed model



This model rests on clear linkage between prison treatment and residential treatment providers in the community, supported by the use of Home Detention Curfew (HDC). With some restrictions, HDC is available to prisoners serving between 3 months and 4 years. It allows prisoners to be released to a safe address after serving at least one quarter of their sentence, with a maximum reduction of 135 days. HDC has historically been under-used, with just 21% of eligible prisoners benefiting from it in 2016. Despite recent increases in HDC, eligibility still requires a secure address; and many of the most socially costly prisoners with histories of drug dependence are released homeless.

To this end, we propose systematically linking intensive abstinence-focused prison treatment programmes with sentence planning and HDC decisions, using nominated residential treatment providers as prisoners' HDC address. This has five key benefits:

1. Dedicated wings within prisons provide secure environments for initiating prisoners' recovery journeys, free from novel psychoactive substances and other drugs;
2. HDC is maximised, reducing the costs of imprisonment and reducing overcrowding;
3. Prisoners move from abstinence-focused prison treatment into community accommodation that can enable them to maintain abstinence;
4. Ex-prisoners are motivated to engage with the full treatment pathway, as they benefit from early release to enhanced supportive housing; and
5. HDC requires individuals to continue engaging with residential treatment. Disengaging results in their return to prison through a fixed-term recall.

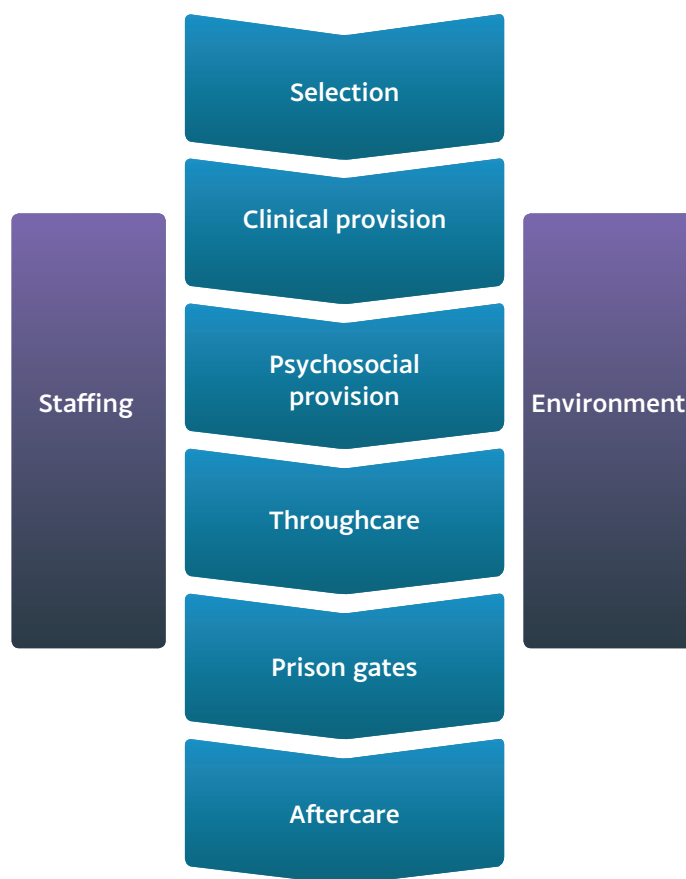
The specific blueprints we propose are simple (see Figure 3²). Based on the best available evidence, each details:

1. Prisoner selection;
2. Clinical provision (in prison);
3. Psychosocial provision (in prison);
4. Throughcare;
5. Prison gates support;
6. Aftercare (community provision).

We also provide evidence-based recommendations on the kind of prison environment, and the nature and variety of staff, that might best support prisoners to achieve and sustain transformative change. Throughout, we have adopted a realistic position. The widespread availability of novel psychoactive substances is causing serious problems for security and rehabilitation in prisons throughout the UK. Any abstinence-focused initiative consequently needs to ensure that prisoners have access to a secure, drug-free environment. Additionally, the evidence identifies that despite some positive work by the National Probation Service (NPS) and Community Rehabilitation Companies (CRCs) prison resettlement provision, particularly for short-term prisoners, is failing³. Prisoners released homeless and unemployed with empty days cannot be expected to maintain drug or alcohol abstinence⁴. We consequently believe that the only robust means of supporting ex-prisoners in sustaining abstinence is providing guaranteed new pathways into designated support – which we describe.

Clearly, any proposal for ambitious change must consider the potential costs and benefits involved. On the basis of a simple comparison of residential costs, even the most intensive community-based residential programmes cost about the same as keeping a man in prison⁵ and are much cheaper than imprisoning women⁶. Specialist drug-free supported housing is cheaper still – between one-third and one-quarter of the cost of imprisonment. In this context, maximising HDC by targeting prisoners with longer sentences makes the service costs of our proposed models equivalent to or substantially cheaper than current provision, even without projecting any reductions in reoffending. For prisoners serving shorter sentences, investment in post-release treatment would be required. However, given the likelihood of recidivism and recall to prison for this group, small reductions on reoffending would cover such costs.

Figure 3. Blueprints



² See also pp.31-36 for men's blueprints, and pp.44-47 for women's blueprints

³ e.g. NAO 2017:8; CJI 2016; CJI 2017

⁴ e.g. Lloyd *et al.*, 2017a:197

⁵ 80.8% of men are imprisoned in Category C training (£606.83 per week) or male local (£657.57 per week) prisons. Depending on the length and nature of the programme, community-based residential treatment costs approximately £600-650 per week (MoJ 2018).

⁶ 94% of women are imprisoned in women's local (£913 per week) or closed (£859.77 per week) prisons (MoJ 2018).

The current funding environment presents real challenges to this kind of joined-up provision – there are no funding pathways that follow individuals through prison and into the community. This is precisely why so many prisoners can attend highly ambitious treatment programmes, only to find themselves homeless and without support on the day of release. It is for this reason that we believe this funding disconnect must be addressed if abstinence-focused interventions are to be meaningfully delivered in prisons, and the resources invested in prison treatment are to be fully utilised. Initially, we propose pilot funding for a trial of this treatment model. We believe this will demonstrate clear benefits and cost savings, and the need for a radical transformation of models of funding for current and ex-prisoners.

The role of opioid medication

Following on from the DRW evaluation, EPRA has been focused primarily on prisoners who are motivated to make transformational changes to their substance use and wider lives. While EPRA recognises that such a definition includes people on Opioid Substitution Therapy (OST), the blueprints described here have focused on people who have become abstinent and wish to remain abstinent from alcohol, recreational drugs, and substitute medication (including OST).

It is important to emphasise that this focus certainly does not imply that the pathways outlined here are those that all drug and alcohol dependent prisoners should follow. No DRW that delivered a comprehensive treatment programme engaged more than 11% of the prisoners within its institution, and we anticipate that the abstinence-focused models set out here would be appropriate for no more than 20-70 prisoners in an adult male establishment. EPRA does not accept that there is any simple opposition between harm reduction and recovery, and endorses Public Health England's emphasis on service user choice:

It is inappropriate, in providing ethical, evidence-based treatment, for services to create a sense that those opting for OST maintenance are making a poorer choice than those opting for an abstinence-oriented or abstinence-based treatment. Equally, prescribing services should not discourage a patient who wishes to pursue detoxification, but should provide the best information on benefits and risks, and support the patient's considered decision (2017:38).

Prisoners with histories of opioid dependence do not fall into two clearly-defined 'abstinent' and 'prescribed' categories, and may make different choices at different stages within various sentences. They may also change their treatment goals during a single sentence.

However, on deliberation, it has become apparent that rather different environments, contexts, and treatment and resettlement programmes are required to meet the needs of prisoners who wish to maintain an OST prescription, and those who have detoxified: for example, the kind of small, separate prison units with tight-knit groups of prisoners and intensive interventions delivered by suitably qualified staff (such as those found in the most promising DRWs) make less sense in the context of ongoing OST, where the primary need may be for optimised clinical care on regular wing accommodation with access to prison-wide education, employment, and resettlement activities. Furthermore, for those that have become abstinent from opioids while in prison, the overdose risk at community re-entry is so great that there is a particularly strong argument for ensuring proper ongoing support on release (where prisoners choose not to re-toxify).

Governance – considerations

The transition between prison and the community has long been a highly visible and well-documented disconnect⁷, but fragmented governance structures are also a serious problem if wing-based prison treatment is to work.

Drug treatment in prisons has historically comprised two entirely separate entities. Treatment providers shape and structure the nature and content of treatment programmes designed to achieve rehabilitative ends, but they have no direct control over prison facilities, beds or discipline staff; and this can seriously undermine the delivery of programmes⁸. Unless officers are 'protected' – with guaranteed shifts on treatment wings – they can be deployed to other wings to cover staff shortages⁹. At a minimum this can seriously disrupt treatment, with prisoners unable to leave their cells for treatment (or any other purposeful activity) if officer numbers drop below specified levels¹⁰. Drawing on the DRW evaluation, explicitly due to shortages in discipline staff treatment stopped entirely in one DRW; another wing was losing 40-60% of treatment days¹¹. Nearly all DRWs fell well behind their treatment schedules, compromising the delivery of full therapeutic programmes.

Similar problems were apparent when treatment units were staffed by officers with specialist training in substance misuse¹². In such cases, cross-deployment could lead to unsympathetic officers being brought in, who were cynical about drug-dependent prisoners and drug treatment in general¹³. Open expressions of cynicism and a general reluctance to support a wing's mission could undermine the ethos of a wing, and compromise both individual and group treatment gains. Clearly, staffing problems do not only impact on therapeutic wings. Prison officers are a precious commodity, and prisons across the country are struggling with staff shortages and reduced budgets. Whilst protecting staff for therapeutic wings is a key recommendation of this paper, this also highlights the need to consider the impact of austerity on the rehabilitation of prisoners more generally.

Beds on treatment units also need protection: ideally, treatment staff should have the final say over who enters and leaves an abstinence-focused treatment wing¹⁴. Across nearly all DRWs, the allocation of empty beds to non-programme 'lodgers' made it far harder to develop a pro-recovery treatment ethos or to achieve positive treatment outcomes¹⁵. Few lodgers wanted to engage with treatment; some had been removed from other locations due to bullying, violence, or drug dealing¹⁶. Still others had no history of drug use, and were openly critical of former drug users¹⁷.

All of this points to the need for added collaboration between prison governors and treatment staff, and the consideration of proactive measures for safely managing wing populations – for example, maintaining waiting lists, or retaining some programme graduates as peers. Treatment units might be very small – perhaps only 20 or 30 beds. However, the proactive support of a senior management team can make the difference between a thriving, pro-social, therapeutic wing community¹⁸; and a wing with a fragmented community with access to little structured treatment and few chances of achieving rehabilitative ends.

⁷ E.g. Social Exclusion Unit 2002; Home Office 2004; MacDonald 2011

⁸ e.g. Lloyd *et al.*, 2017a:22; Lloyd *et al.*, 2014:42

⁹ Lloyd *et al.*, 2017a:66

¹⁰ Lloyd *et al.*, 2014:227

¹¹ Lloyd *et al.*, 2017a:89

¹² Lloyd *et al.*, 2014:23; see also footnote 5, Lloyd 2014:134

¹³ Lloyd *et al.*, 2014:139-140; see also Tait 2011 and Lloyd *et al.*, 2017b

¹⁴ NGO Chief Executive, quoted Lloyd *et al.*, 2017a:262

¹⁵ Lloyd *et al.*, 2017a:82; for problems in specific units see 62 (Brixton); 64 (High Down); 65 (Holme House); 70 (Styal)

¹⁶ Lloyd *et al.*, 2014:75; Lloyd *et al.*, 2017a:57

¹⁷ Lloyd *et al.*, 2017a:65

¹⁸ e.g., see staff comments on Manchester's highly supportive governor – Lloyd *et al.*, 2017a:68

Evidence Review: Men's Prisons

Introduction

Due to considerable variations in service structures and the highly gendered nature of prisoners' needs, this blueprint offers separate models for men and women. In each case, drawing on the available evidence, the workings of EPRA, and service user feedback, we detail essential components of selection; psychosocial provision; clinical provision; throughcare; support at the prison gates; and ongoing aftercare. We also set out key staffing requirements, and essential features of a wing-based treatment environment.

Having described these components in broad terms, we proceed to offer specific examples of how these might be operationalized.

Environment

One key consideration for intensive prison treatment services is the mode of delivery. Historically, many such programmes have been delivered as though they were educational or vocational programme: taught in central locations, with prisoners housed in a variety of houseblocks or residential wings able to attend. This has meant that there was no link between taught material and prisoners' residential environment. The widespread availability of novel psychoactive substances and record levels of violence and disorder within UK prisons makes this approach increasingly untenable for any intervention hoping to achieve radical or transformative ends.

In this context, some interventions have placed an emphasis on establishing pro-social, drug-free prison environments in which learning and community are intrinsically combined¹⁹. Therapeutic communities (TCs) are an example with a particularly robust international evidence base²⁰, creating a secure therapeutic environment by segregating wing residents (all of whom are engaged in treatment) from the main prison regime²¹. Such segregation underpinned established TCs and 12-step programmes in UK prisons²², and became the model preferred by the Coalition Government for supporting prisoners towards abstinence²³. When DRWs then implemented segregation, it was well received – with staff and prisoners asserting that it reduced drug availability²⁴, limited access to diverted medication²⁵, increased security²⁶, and above all allowed the development of a trusting therapeutic environment free from the constraints of traditional 'prisoner culture'²⁷. Segregation greatly increases the chances of providing the secure drug- and NPS-free environment that motivated prisoners need in order to initiate change.

Service user focus groups also favoured therapeutic segregation²⁸; and so we believe this should form a founding feature of treatment and throughcare for prisoners recovering from addiction. However, segregation requires considerable resourcing: as prisoners do not have access to the purposeful activity offered on other locations, a full-time programme of therapeutic or community events is required in order to ensure that treatment clients are not subjected to a regime that offers little but extended periods behind locked cell doors. Such problems were apparent in one DRW, where – within a segregated regime – wing residents were only able to access 4 hours of structured treatment per week, spending the rest of their time behind cell doors²⁹. Segregation is also not an intrinsic good – rather, it concentrates and distils

¹⁹ e.g. the Forward Trust's Substance Dependence Treatment Programme and Therapeutic Communities (both accredited programmes)

²⁰ e.g. Magor-Blatch *et al.*, 2014; Mitchell *et al.*, 2006; Holloway, Bennett and Farrington 2006

²¹ e.g. Lloyd *et al.*, 2014:33

²² e.g. Centre for Social Justice (CSJ) 2006:60

²³ HM Government 2010:21; MoJ 2010:18

²⁴ e.g. Lloyd *et al.*, 2017a:67;

²⁵ e.g., Lloyd *et al.*, 2014:297

²⁶ e.g., Lloyd *et al.*, 2014:291

²⁷ e.g. Lloyd *et al.*, 2017a:261

²⁸ See Appendix 5. Forward Trust focus group – women

²⁹ Lloyd *et al.*, 2017a:262

relationships³⁰. With skilled staff, segregation can yield outstanding therapeutic environments; but with brusque and poorly-equipped staff, it can also create a particularly toxic environment.

The evaluation of Pilot DRWs identified two promising models for delivering intensive, wing-based, therapeutic segregation. Shorter treatment programmes (6-8 weeks³¹) can be supported by increasing treatment intensity, engaging relatively small cohorts of prisoners (12-16 people) in wings of approximately 20 people³². This allows some prospective entrants and some programme graduates or peers to reside on the wing, alongside a cohort undergoing treatment together (both peers and cohorts were strongly favoured by service user focus groups). Such wings can also be more readily protected from 'lodgers'³³. Within this model, prisoners serving short sentences can be engaged, treatment is brief, and rates of 'churn' are high. Service users were highly positive about this model, seeing particular value in the use of cohort-based treatment models and the widespread use of programme graduates as 'peers'³⁴.

Contrastingly, longer abstinence-focused treatment programmes are currently delivered by the Forward Trust's Substance Dependence Treatment Programme (SDTP)³⁵ and by therapeutic communities (TCs)³⁶. Each model seeks to instil progressive change in prisoners by immersing them in a pro-social community of their peers, supported by structured group treatment programmes. Founded on the development of long-term pro-social prisoner communities, these programmes are larger (up to 70 beds in HMPs Wymott and Holme House³⁷), and longer-term (a minimum of six months). Such models can only engage prisoners serving longer sentences; but treatment is extensive, and rates of churn are reduced (approximately 7-10 prisoners per month in HMP Wymott³⁸). In a move strongly endorsed by service user feedback, these models also make considerable use of programme graduates as peers³⁹.

Staffing

The core operations of an intensive treatment unit involve two key staff groups: prison officers, and psychosocial treatment workers. As we later describe⁴⁰, access to clinical staff is also necessary; though clinical workers would not be expected to be on the wing to the same extent as full-time psychosocial or discipline staff, and so have less of a role in structuring the wing community.

A key consideration is that all staff need to be able to work with drug dependent prisoners, who are likely to present with complex needs and overlapping dependencies and will often have experience of highly disadvantaged, neglectful, or abusive childhoods⁴¹. The literature suggests that some officers may be better suited to working in caring environments⁴². This message was reinforced by the evaluation of pilot DRWs, wherein some officers were clearly able to buy in to a therapeutic ideal⁴³, whilst others struggled to embrace less authoritarian ways of working and so undermined the delivery of treatment programmes⁴⁴.

³⁰ Lloyd *et al.*, 2017a:264

³¹ For example, 'The Bridge' programme (Disbury *et al.*, 2015; Lloyd *et al.*, 2017a:130)

³² Page *et al.*, 2016:53-4

³³ Lloyd *et al.*, 2017a:82

³⁴ See Appendix 6. Forward Trust focus group - men; Appendix 8. Phoenix Futures focus group - women

³⁵ Kopak *et al.*, 2015

³⁶ Phoenix Futures 2017

³⁷ MoJ 2018

³⁸ Field notes from EPRA evidence-gathering visit to HMP Wymott. (Information drawn from prisoner information board within TC.)

³⁹ E.g. Kopak *et al.*, 2014:255; HMIP 2017:27

⁴⁰ See Clinical provision

⁴¹ See, for example, Page *et al.*, 2016:52; Boreham *et al.*, 2007:24-26; Jones *et al.*, 2007; ACMD 2013.

⁴² E.g. Tait, 2011; Lloyd *et al.*, 2017b.

⁴³ E.g. Lloyd *et al.*, 2014:195; Lloyd *et al.*, 2014:157.

⁴⁴ E.g. Grace *et al.*, 2017; Lloyd *et al.*, 2014:265.

Psychosocial treatment staff also need specific skillsets: the prison environment is an intrinsically 'painful'⁴⁵ and untherapeutic⁴⁶ place, and treatment clients may have spent decades masking painful memories with drug use. Consequently, a core team of highly trained therapeutic staff are an absolute necessity: for enabling prisoners to begin unpicking the factors that drove their dependent drug use; for ensuring that sensitive disclosures remain safe and bounded despite the prison environment; and, through these processes, ensuring that that treatment can offer prisoners a substantive 'life changing phase'⁴⁷. The only DRW wherein prisoners routinely described such an environment was staffed by a team of diploma-level counsellors⁴⁸. Whilst there may be other routes to therapeutic competence, a diploma in counselling offers a good benchmark for assessing the level of skill that is required for adequately helping prisoners to uncover and address the issues that drove their drug use and offending. As several authors have noted, this expectation runs against some trends in programme delivery, which has increasingly been tasked to prison officers and less trained third-sector staff⁴⁹.

Beyond a core group of counsellors, service user focus groups called for the inclusion of people with diverse backgrounds and qualifications within the psychosocial treatment team as 'having a balance of both qualified and unqualified persons provides a mix of experience and relatability, increasing recovery potential'⁵⁰. An imaginative approach to staffing might be difficult to achieve when staff teams are small; but more creative solutions could also be used. For example, ex-prisoners could return to prison from community-based residential services in order to deliver groups, thereby giving ex-prisoners valuable experience whilst demonstrating to current prisoners the benefits offered by the treatment pathway⁵¹. Similarly, staff from community providers could come into prison, delivering groups focused on preparation for release and the expectations of aftercare services. Each of these measures adds to the diversity of the treatment team, whilst breaking down barriers between prison and the community. Service user focus groups warmly endorsed these measures, and the benefits they offered⁵².

Recruitment

Reviews of relevant models and guidelines⁵³ identified some cornerstones of recruitment to services (e.g. initial screening, comprehensive assessment, and care planning⁵⁴), but little that could effectively guide the selection and recruitment processes of abstinence-focused treatment wings. This notwithstanding, some features of the recruitment process flow necessarily from the blueprint's focus on delivering continuous care; any proposals that make it impossible for prisoners to transfer to community providers will undermine any benefits we seek to offer. Other aspects draw on evidence from the Rapid Assessment of DRWs (which offered detailed comparative insights into the selection and recruitment processes of all ten wings⁵⁵), the deliberations of the EPRA working group, EPRA site visits, and service user feedback.

⁴⁵ Sykes 1957

⁴⁶ Lloyd 2018

⁴⁷ EPRA members were clear that this needed to be central to any programme aimed at supporting people into long-term change.

⁴⁸ Lloyd *et al.*, 2017a:130

⁴⁹ e.g. Mews, Di Bella and Purver 2017; Raistrick 2017

⁵⁰ Appendix 7. Phoenix Futures focus group – men; see also Appendix 8. Phoenix Futures focus group – women

⁵¹ The use of peers and visible recovery champions is encouraged in prison prescribing guidelines (PHE 2017:39), and also worked well in DRWs (Lloyd *et al.*, 2017a:130)

⁵² See Appendices 5-8

⁵³ e.g. DoH 2006; PHE 2017

⁵⁴ E.g. NTA 2010:10; DoH 2006:12; PHE 2017:

⁵⁵ See Page *et al.*, 2016 for an overview of the shape and impact of differing recruitment processes. For full accounts of specific wings, see Lloyd *et al.*, 2014:77 (Brinsford); 2014:98 (Bristol); 2014:117 (Brixton); 2014:141 (Chelmsford); 2014:181 (High Down); 2014:214 (Holme House); 2014:248 (Manchester); 2014:261 (New Hall); 2014:286 (Styal); 2014:291 (Swansea).

As stated above, the focus on continuity has implications for recruitment processes. Firstly, recruitment in prison is closely tied to an onward path into specific community services. To ensure that recruits are capable of providing fully informed consent, they must be informed of the nature and requirements of community treatment from the outset. Service user feedback⁵⁶ suggested that this process could be enhanced by providing clear visual representations of the treatment pathways, highlighting key treatment stages and the benefits individuals might expect to access at each stage. Benefits may be substantial: for example, the expectation of HDC, the provision of a secure HDC address, and the consequent likelihood of early release. These could be bolstered by the deployment of leaflets at reception⁵⁷ and individualised care plans (with copies kept by individual service users) setting out the kinds of support they can expect to access, and when they might expect to progress⁵⁸.

A second key consideration centres on the requirements of linked community providers. In this context, a review of residential provision in the community⁵⁹ highlighted some potential constraints. Of particular note, many residential rehabs and supported housing schemes are unable to house people with histories of arson or sexual offending⁶⁰. Such exclusions may have to inform recruitment to prison-based services: to engage someone who cannot access linked community providers obviates this blueprint's key benefit (guaranteed continuity of care).

Service user focus groups disliked this aspect of the blueprint, voicing concerns that individuals might be excluded from treatment on the basis of their offending history⁶¹. However, this is not an issue that can be easily resolved. Developing links with establishments that are used to working with high-risk offenders may remove some restrictions, but cannot remove them all⁶². Alternatively, prison services may be able to guarantee the availability of alternative community residential services for prisoners who cannot follow the core treatment pathway. However, this is likely to further complicate pathways that are already complex. In our view, establishing a robust core pathway between prison and a dedicated residential provider should consequently be services' first goal.

Thirdly, consideration must be given to the relationship between treatment, sentence planning, and prisoners' release dates. Timing is essential here: TCs and full 12-step programmes take 5-18 months⁶³; shorter 'introductory' programmes take 6-8 weeks. Additional benefits for both prisoners and the prison service can be realised by maximising HDC, positioning the end of structured treatment up to 4.5 months before individuals' automatic release date. This would suggest that the model will offer the greatest savings if, for example, someone sentenced to 18-48 months and entering a 6-month prison programme has 10.5 months left before their automatic release date. Service users were clear that HDC has the potential to enhance prisoners' motivation to engage with prison treatment (through the offer of early release), and to engage with aftercare in the community (by requiring residence at a specific therapeutic address)⁶⁴. More broadly, service users saw HDC as 'an amazing opportunity – a gift,' with the potential to reduce anxiety about the next steps in treatment following release⁶⁵.

⁵⁶ See Appendices 5-8

⁵⁷ See Appendix 6. Forward Trust focus group – men

⁵⁸ See Appendix 5

⁵⁹ PHE 2018

⁶⁰ PHE 2018

⁶¹ See Appendix 7. Phoenix Futures focus group – men

⁶² The Bridges in Hull specialises in working with ex-prisoners. Despite this, it still has key exclusions including people with 'multiple arson convictions,' 'schedule one offenders,' and 'offenders assessed as high / very high risk of harm' (PHE 2018).

⁶³ See supporting document – review of treatment within the criminal justice system

⁶⁴ See Appendix 5. Forward Trust focus group – women; Appendix 6. Forward Trust focus group – men; Appendix 7. Phoenix Futures focus group – men; Appendix 8. Phoenix Futures focus group – women

⁶⁵ See Appendix 5. Forward Trust focus group – women

Fourthly, consideration needs to be given to potential recruits' OST status⁶⁶. UK prison prescribing guidelines are clear that detoxification should not be encouraged⁶⁷. However, they are also clear that 'prescribing services should not discourage a patient who wishes to pursue detoxification,'⁶⁸ and some prisoners will inevitably choose to follow this route.

This creates a need to consider the positioning of OST detoxification within the treatment pathway. From the evaluation of pilot DRWs, it was apparent that the provision of OST in abstinence-focused units can cause division⁶⁹. Although some DRWs provided supportive environments for detoxification⁷⁰, many residents felt deeply ambivalent about the presence of prescribed opioids on the wing and struggled to cope with peers who were visibly drowsy or detoxifying⁷¹. This was particularly the case for residents with histories of opioid dependence, who sometimes described cravings being triggered by the presence of OST or the sight of medicated peers. As Raistrick notes⁷², OST medication and detoxification can also limit the capacity of individuals to engage with intensive psychosocial treatment. As such, we believe detoxification is likely to be most appropriately managed on other locations, before prisoners enter abstinence-focused treatment wings. Without exception, service user feedback was strongly supportive of this recommendation, endorsing our concerns whilst describing prior detoxification as a clear indicator of individuals' 'motivation and dedication'⁷³.

Fifthly, beyond OST there are other core aspects of clinical need that require attention. Drug dependent prisoners present with a range of complex comorbidities and layered needs⁷⁴. Many will also have challenging clinical presentations, with longstanding prescriptions for non-opioid drugs (e.g., gaba drugs, benzodiazepines, mood stabilisers) that may complicate engagement with abstinence-focused programmes⁷⁵. Whilst none of these factors rule out recruitment (particularly by long-term programmes, wherein individuals have more time to enact gradual change), staff responsible for assessments will need to retain a realistic picture of what is achievable by the point of release, and the impact of any complexities on both individual prisoners and the wing community. Additional risks should be documented and regularly reviewed – for example, if sustaining abstinence looks unrealistic for an individual by the end of prison treatment, then re-toxification should be clearly offered as part of a risk management programme.

Finally, two overarching messages about recruitment processes emerged from the evaluation of Pilot Drug Recovery Wings. Firstly, staff who are responsible for delivering prison treatment should also be responsible for recruiting individuals to their wings. Recruitment processes carried out by other staff (for example, core CARAT teams) could lead to services being inaccurately described, and / or unmotivated individuals being recruited⁷⁶. Secondly, empty beds proved a persistent issue across abstinence-focused treatment DRWs⁷⁷. Even some small, intensive DRWs persistently struggled to fill more than a third of their beds⁷⁸, particularly when residents were expected to detoxify from OST⁷⁹. We expect that this problem will be mitigated by the substantial benefits offered by offering a high quality treatment programme, early release, and HDC. Combinations of these have proven effective at filling both small and large-scale abstinence-focused units⁸⁰.

⁶⁶ e.g. Page *et al.*, 2016; Duke 2013; ACMD 2013.

⁶⁷ PHE 2017:38

⁶⁸ PHE 2017:38

⁶⁹ Page *et al.*, 2016; Lloyd *et al.*, 2017a:135-6

⁷⁰ Page *et al.*, 2016:54

⁷¹ Lloyd *et al.*, 2017a:135-6

⁷² 2017

⁷³ See Appendix 7. Phoenix Futures focus group – men; Appendix 8. Phoenix Futures focus group – women

⁷⁴ e.g. Singleton *et al.*, 1998; Fazel and Danesh 2002

⁷⁵ PHE 2018

⁷⁶ Lloyd *et al.*, 2014:214-17

⁷⁷ e.g. Lloyd *et al.*, 2017a:261

⁷⁸ Grace *et al.*, 2016; Lloyd *et al.* 2014:277 (Styal)

⁷⁹ Page *et al.*, 2016; Lloyd *et al.*, 2014:262 (New Hall).

⁸⁰ Lloyd *et al.*, 2017a:261; see also supporting document on EPRA site visits.

Clinical provision

Individuals with drug and alcohol problems often have substantial needs for clinical support. Such problems are exacerbated in prison populations, where histories of self-harm and suicidality⁸¹, serious mental illness⁸², and poor physical health⁸³ are highly prevalent, but may combine to severely hamper recovery from drug dependence⁸⁴. For any drug dependent prisoner, periods of abstinence from drugs or alcohol arising from imprisonment may uncover or exacerbate mental or physical health problems and this may also be the case for those who detoxify from OST.

In this context, whilst we anticipate that our cohort will need limited clinical support related to OST, we expect them to benefit from robust access to clinical services. In many cases, these may need to follow them through the prison gates – for example, through embedded referral pathways to Community Mental Health Teams.

A final clinical consideration centres on retoxification – the re-prescribing of OST towards the end of a sentence, to mitigate the risk of overdose. Certainly, the best available evidence identifies retoxification as an effective and potentially life-saving measure⁸⁵. EPRA members were clear that this must be offered to prisoners who have detoxified during their sentence as a cornerstone of ethical practice. However, it should also be noted that a decision to retoxify may have consequences for individuals' release. Insofar as residential treatment providers and drug-specialist supported housing require residents to be free of OST, a decision to retoxify could lead to an individual losing their nominated housing and so their access to HDC. Prisoners may consequently feel pressured to make decisions that are not in their best clinical interest. Staff must be aware of this, and able to ensure that prisoners' decisions are fully informed.

Psychosocial provision

Psychosocial support is the cornerstone of this blueprint. Psychosocial programmes can enable prisoners to begin unpicking the reasons for their drug use, provide them with alternative tools for managing difficult emotions and situations, enhance their motivation for sustained change following release, and link prisoners in to lifelong networks of support. The evaluation of pilot DRWs⁸⁶ and field visits for this blueprint⁸⁷ evidenced that prisons' psychosocial programmes can achieve these goals very effectively. Peer-reviewed evaluations of RAPT's accredited programmes have also shown them to be effective at improving prisoners' wellbeing and enhancing their motivation up to the point of release⁸⁸. The main problem is that such programmes have historically been delivered as discrete prison programmes, without clear and consistent linkage to either sentence planning (including key moments such as HDC or release) or community support sufficiently robust to realistically allow prisoners to sustain their progress.

To support segregation⁸⁹ and maximise the benefits of treatment, programmes should be full-time. The programme delivered can be selected according to the requirements of a regime: several accredited programmes are abstinence-focused, evidence-based, and theoretically informed⁹⁰. One of the key distinctions between these interventions is their duration: there is a clear split between short-term interventions lasting up to two months⁹¹ and those requiring between

⁸¹ ACMD 2013; SEU 2002

⁸² Bradley 2009; Singleton *et al.*, 1998; Fazel and Danesh 2006

⁸³ ACMD 2013; SEU 2002

⁸⁴ e.g. Best and Laudet 2010

⁸⁵ e.g. HM Govt 2017:153; Marsden *et al.*, 2017

⁸⁶ Lloyd *et al.*, 2017a:130

⁸⁷ see also supporting document on EPRA site visits.

⁸⁸ Disbury *et al.*, 2014; Kopak *et al.*, 2015

⁸⁹ See Environment

⁹⁰ See supporting Evidence Review

⁹¹ See supporting Evidence Review see also Disbury *et al.*, 2014

5 and 18 months⁹². The choice of programme has implications for wing size and churn. Shorter term programmes are better-suited to cohort-based models of treatment, with a single group undergoing treatment together. This model allows a prisoner community to develop in a shorter time, was particularly welcomed by service users⁹³, and underpins the only short-term abstinence-focused programme we are aware of⁹⁴. It may therefore be better suited to smaller wings, with the expectation of nearly 100% churn (a handful of peers aside) every couple of months. Contrastingly, longer interventions may be able to house up to 70 prisoners in a long-term, relatively stable therapeutic environment⁹⁵. In the Therapeutic Community visited as a part of EPRA's fieldwork, approximately 10% of residents arrived or left each month⁹⁶.

Additionally, the nature of prison treatment structures the forms of throughcare and aftercare that can most appropriately develop truly seamless treatment pathways. Short-term abstinence focused programmes are designed as little more than an introduction to abstinence-focused thinking, and key treatment concepts⁹⁷. In this context, EPRA members identified that it was important to build in a 'life-changing phase' of treatment, which could be effectively delivered by community-based residential programmes. Contrastingly, long-term abstinence focused programmes mirror community-based residential treatment, and may realistically deliver a 'life-changing phase' of treatment. For people leaving prison after a year of intensive psychosocial treatment, being released to further intensive treatment could result in disengagement due to understandable 'therapeutic fatigue'. Consequently, pathways into drug-free supported housing (backed up by enhanced resettlement provision) may be more appropriate for this group of treatment graduates⁹⁸.

Throughout EPRA's deliberations, there have been concerns about determining people's access to treatment pathways based on the length of their sentence alone. Service users expressed this succinctly, asserting that length of someone's sentence and treatment programme do not necessarily reflect their levels of need⁹⁹. This suggests that there may be real benefits to offering prison treatment leavers a choice of low- or high-intensity residential support according to their preferences or needs. This does, however, add to the complexity of developing a short- or long-term pathway. As such, the blueprints presented here focus on the establishment of single pathways, from short-term prison programmes to residential aftercare; and from long-term prison programmes to supported housing.

Throughcare and Aftercare

Throughcare and aftercare are defined by Fox and Khan as:

...arrangements for managing the continuity of care which started in the community or at an offender's first point of contact with the criminal justice system through custody, court sentence, and beyond into resettlement. "Aftercare" is the package of support that needs to be in place after a drug-misusing offender reaches the end of a prison-based treatment programme, completes a community sentence or leaves treatment. It is not one simple, discrete process involving only treatment but includes access to additional support which may include mental health, housing, managing finance, family problems, learning new skills and employment¹⁰⁰.

⁹² See supporting Evidence Review TCs and SDTP; see also Kopak *et al.*, 2015; MoJ 2016

⁹³ See Appendices 5-8

⁹⁴ See supporting Evidence Review; see also Disbury *et al.*, 2014.

⁹⁵ See supporting document – EPRA site visits; see also HMIP 2016

⁹⁶ See supporting document – EPRA site visits

⁹⁷ Disbury *et al.*, 2014:557; See also supporting Evidence Review

⁹⁸ Lloyd *et al.*, 2017

⁹⁹ See Appendix 7. Phoenix Futures focus group – men

¹⁰⁰ 2005:49; cited in MacDonald 2011:3

Here, we primarily focus on elements of provision that might enable graduates from abstinence-focused prison treatment to sustain their progress through the prison gates. In this, we have adopted a realistic position. Prisoners released homeless, unemployed, and unsupported cannot be expected to maintain drug or alcohol abstinence¹⁰¹. Being housed in chaotic hostels with prolific drug availability¹⁰² or in the houses of relatives who are themselves drug users¹⁰³ is little better. With few and isolated examples, the evidence identifies that prison resettlement provision, particularly for short-term prisoners, is failing¹⁰⁴. More broadly, CRCs are failing (though this should not prevent local models from drawing on positive examples of CRC or NPS support as and where it is available). We consequently believe that robust alternative support mechanisms are needed¹⁰⁵.

Pathway 1: Residential rehabilitation

Residential rehabilitation units offer one clear solution. Residential treatment immediately guarantees ex-prisoners a safe, secure bed in a drug-free environment at the point of release. Residential providers may also achieve considerably better long-term resettlement outcomes than prison services: during fieldwork, we visited one unit that specialises in working with ex-prisoners. It claims to have supported all treatment graduates for over a decade into secure housing, with 95% finding independent tenancies¹⁰⁶. This contrasts with 2% of prisoners who were found housing by through the gate services across two Joint Inspectorate reviews¹⁰⁷. As a core component of residential rehabilitation, community providers also support service users in rebuilding family relationships, developing basic living skills, and identifying local education, training and employment opportunities. Again, this contrasts with near-total failure in these areas by mainstream prison services¹⁰⁸ (though where good practice is being delivered by CRCs or the NPS, we endorse local providers drawing on the resources available).

Moving prisoners with histories of substance dependence into residential rehabilitation on release consequently reduces the need for prisons' practical resettlement support in the first instance, arguably to nil. Any concerns that prisoners could be missing out by not accessing standard services can be addressed by specifying residential treatment as ex-prisoners HDC address¹⁰⁹. Disengaging from residential treatment then results in a return to prison (a recommendation strongly supported by service user focus groups¹¹⁰). With this, they regain access to standard through the gate services.

There are some clear limitations to residential rehabilitation. UK data identifies that those accessing residential services have higher levels of need than comparable individuals in community provision, but are attended by greater levels of motivation¹¹¹. Rates of dropout can also be significant – up to two-fifths of those starting treatment from the community¹¹². Extrapolating from this data to prison leavers is impossible – our proposed cohort of ex-prisoners present with a different array of needs to those of community clients, and are likely to be motivated in different ways (for example, HDC conditions and a lack of alternative accommodation may motivate ex-prisoners to continue engaging with residential treatment. Contrastingly, the offer of better conditions and the fact that prisoners are engaged in treatment some weeks or months before arriving at a residential provider may mean their motivation dwindles in the intervening period).

¹⁰¹ e.g. Lloyd *et al.*, 2017a:197

¹⁰² Lloyd *et al.*, 2017a:198

¹⁰³ Lloyd *et al.*, 2017a:167; 199-201

¹⁰⁴ e.g. NAO 2017:8; CJJI 2014; CJJI 2016; CJJI 2017

¹⁰⁵ See supporting Evidence Review; see also e.g. CJJI 2014; Niven and Stewart 2005

¹⁰⁶ The Bridges 2017

¹⁰⁷ CJJI 2016:28; CJJI 2017:8

¹⁰⁸ e.g., '[n]one of the prisoners we met were assisted into employment or training via the Through the Gate arrangements' (CJJI 2016:30)

¹⁰⁹ This is a service already offered by some residential providers. See, for example, PHE 2018

¹¹⁰ See Appendices 5-8

¹¹¹ HM Govt 2017:149

¹¹² HM Govt 2017:149

However, a level of dropout is likely, and it important that appropriate clinical care is made available to those leaving residential treatment – including, for example, retoxification.

Pathway 2: Specialist supported housing

Residential rehabilitation may be particularly well-suited to graduates of shorter, introductory abstinence-focused prison programmes, providing a follow-on 'life changing phase' of treatment in the community. For prisoners who have completed comprehensive prison programmes, progressing to residential treatment may feel repetitive or excessively coercive, and so prove counterproductive¹¹³. Drawing on the central finding of the Evaluation of Pilot DRWs, it is nonetheless our view that it is essential that all those accessing abstinence-focused prison treatment can be guaranteed secure, drug-free accommodation at the point of release¹¹⁴. The importance of this measure was highlighted by DRW graduates' resettlement journeys – with the majority released street homeless or to insecure hostels. Consequently, to fail in the provision of therapeutic housing is likely to obviate any benefits delivered by prison services and, given the increased risk of death faced by abstinent ex-prisoners, calls into question the ethics of delivering abstinence-focused prison treatment.

To this end, we recommend establishing clear and guaranteed pathways into specialist supported housing. As part of the evidence gathering process for this blueprint, we visited a drug-free supported housing scheme established by Phoenix Futures (which is both a substance misuse treatment provider, and a Housing Association). Such units are few in number, but rapidly expanding; and can house ex-prisoners with histories of substance misuse for up to a year in a drug- and alcohol-free environment with access to 24-hour support¹¹⁵. Throughout an individual's stay, the focus is on building skills towards independent living:

Residents must learn how to maintain a tenancy and live by the rules of the house, learning to cope with the pressures of life without resorting to drugs or alcohol. Residents are encouraged to fill their week with meaningful activities including attending college, volunteering and working towards gaining employment¹¹⁶.

The costs of provision are covered by enhanced rates of housing benefit¹¹⁷. Expanding such provision offers one alternative to residential rehabilitation, which still allows ex-prisoners to sustain the progress they make during their sentence. Service user focus groups were very positive about the use of HDC to facilitate early release to supported housing, offering concrete benefits to released prisoners whilst ensuring they remain engaged with rehabilitative services¹¹⁸.

¹¹³ See Appendix 7. Phoenix Futures focus group – men

¹¹⁴ Lloyd *et al.*, 2017a:269

¹¹⁵ See supporting document – EPRA site visits

¹¹⁶ Phoenix Futures 2018

¹¹⁷ From 2020, supported housing schemes will be reliant on local government block grants (DCLG and DWP 2017)

¹¹⁸ See Appendices 5-8

Other elements of throughcare and aftercare

Our review of the evidence¹¹⁹ highlighted the particular importance of support in three areas: housing; family; and education, training, and employment (ETE). Having addressed housing pathways, we now turn to the other two areas of need. In this section, we also seek to respond to service user focus groups' calls for imaginative recovery-focused provision.

The benefits of sustaining and improving family ties have been consistently evidenced as an effective pathway to reduced drug use and offending¹²⁰. Some prisons have trialled enhanced family visits for drug dependent prisoners¹²¹, and these may extend as far as having full-day visits in open settings with access to play equipment¹²². Other possible additions include the use of dedicated family mentors, and through-the-gates family support¹²³. Finally, 'Storybook Dads' is an initiative in which prisoners are supported in recording bedtime stories for their children¹²⁴. Not only does it seem probable that these initiatives improve prisoners' chances of sustaining treatment gains following release, they also improve their quality of life and potentially their motivation during their sentence. Any such measures should consequently be welcomed as a core part of prison treatment.

Whilst service user focus groups endorsed these measures, they highlighted concerns that prisoners who had lost contact with their families, or whose families were not prosocial sources of support, should not be unduly disadvantaged¹²⁵. To this end, additional programmes of groups were suggested – focusing on, for example, 'recovery through nature'; 'recovery through art'; or 'recovery through sport'¹²⁶. We see these as very useful additions.

Education, training and employment also require some immediate consideration for prisoners who are likely to enter supported housing. Again, the outcomes delivered by CRCs and Probation appear to be very poor¹²⁷, with prisoners generally relying on informal contacts in order to secure work or education at the point of release¹²⁸. However, there are some programmes that prisons may be able to utilise, and which may offer a limited number of guaranteed jobs to drug-abstinent ex-prisoners. These include RAPT's Blue Sky programme, Timpson's, and Virgin Rail¹²⁹.

Throughcare is also likely to be more effective if prisoners can begin to form relationships with the community workers responsible for their future care whilst still in prison¹³⁰, a point heavily emphasised by service user focus groups¹³¹. This opens up the possibility for imaginative ways of working, aimed at building ties between community-based and prison treatment services. One possibility is for community providers to deliver some elements of the prison treatment programme. Service users suggested that this could include support workers from housing initiatives delivering 'preparation for release' groups; or staff from residential treatment providers delivering elements of prison treatment programmes¹³². Similar measures have been successfully implemented elsewhere¹³³, and may be of additional value if ex-prisoners are able to return from community programmes to the wing to talk about their experiences of the treatment pathway. Service users feedback was clear that hearing from peers and programme graduates is important; and this also has the potential to give ex-prisoners a chance to contribute in a way that emphasises their value.

¹¹⁹ See supporting Evidence Review

¹²⁰ See supporting Evidence Review

¹²¹ e.g. Clancy and Maguire 2017; Lloyd *et al.*, 2014:61

¹²² Clancy and Maguire 2017:49

¹²³ Clancy and Maguire 2017:38-9.

¹²⁴ Lanskey *et al.*, 2016:44

¹²⁵ See Appendix 8. Phoenix Futures focus group – women

¹²⁶ See Appendices 5-8

¹²⁷ CJI 2016:38

¹²⁸ See supporting Evidence Review; see also Lloyd *et al.*, 2017a; Niven and Stewart 2005

¹²⁹ See supporting Evidence Review

¹³⁰ e.g. supporting Evidence Review; see also Senior *et al.*, 2011

¹³¹ See Appendix 6. Forward Trust focus group – men; Appendix 7. Phoenix Futures focus group – men

¹³² See Appendix 5. Forward Trust focus group – women

¹³³ e.g. Lloyd *et al.*, 2017a:69 (Styal); 72 (Swansea)

We also envision real potential for the imaginative use of Release on Temporary Licence (ROTL), a measure that has attracted recent interest from the Justice Secretary¹³⁴. ROTL allows prisoners approaching the end of their sentence to engage with resettlement activities in the community¹³⁵. This could be used to further break down the barriers between prison and the community, with prisoners attending their future residential service and engaging with groups before the end of their sentence. This offers multiple benefits – acquainting prisoners with the expectations and benefits of community treatment; supporting the development of between prisoners and community clients and staff; and ensuring that on the day of release prisoners return to a familiar, safe environment. All of these measures are likely to improve treatment retention, and so treatment outcomes.

Prison gates

The day of release is a difficult time for ex-prisoners¹³⁶, with even the first hour being critical¹³⁷. Well-managed transitions have the potential to support released prisoners in sustaining therapeutic gains through the prison gates. Gold standard provision would involve workers or peers known to released prisoners (from the residential programme the prisoner is going to) picking them up at the prison gates, taking them to any first-day appointments, and then ensuring they are settled in their housing. Service users suggested there might also be room for some flexibility here – released prisoners may want to “feel human” on their day of release, instead of being moved directly from one institution to another¹³⁸. In this vein, building in time to take them shopping or to visit family or friends may support the delivery of a more humane first day in the community – and so support individuals’ continued willing engagement with treatment¹³⁹. An additional suggestion centred on providing ex-prisoners with ‘starter kit including information regarding the local area such as locations of food shops, benefits offices, banks, walks, recovery meetings etc’¹⁴⁰.

Throughout this evidence review, the benefits of HDC have been highlighted. It is at the point of release that they become most apparent: if specified therapeutic housing is identified as released prisoners’ HDC address, then a failure to attend constitutes a breach of licence and so would trigger a return to prison. Service users saw this as a positive way of ensuring continued engagement with treatment¹⁴¹. Even those serving short sentences can have the start of their residential treatment mandated. For example, someone sentenced to 6 months could have residential treatment specified as their HDC address for 6 weeks.

¹³⁴ <https://www.gov.uk/government/speeches/prisons-reform-speech>

¹³⁵ PRT 2018

¹³⁶ PHE 2017:160

¹³⁷ Lloyd *et al.*, 2017a; Maguire *et al.*, 2010:65

¹³⁸ Appendix 8. Phoenix Futures focus group – women

¹³⁹ See Appendix 8. Phoenix Futures focus group – women

¹⁴⁰ See Appendix 8. Phoenix Futures focus group – women

¹⁴¹ See Appendix Service User Feedback

Blueprint 1. Men serving short sentences

This blueprint seeks to optimise prison throughcare and aftercare by linking together several mutually complementary constituent parts. It is designed to engage short term prisoners and could, in principle, engage those imprisoned for as little as two months. However, this pathway is likely to be most effective if residential treatment can be identified as prisoners' HDC address for at least the start of community treatment. As HDC can only offer remission of one-quarter of an individual's sentence, this may be complicated for those serving short sentences; however, someone sentenced to 6 months can still benefit from up to 6 weeks of early release in residential treatment. A key additional benefit is the guaranteed provision of a secure HDC address. This ensures that the greatest potential gains are likely to be secured by engaging one of the most socially costly prisoner groups – those who are otherwise released homeless, and who are both unable to access HDC and more likely to reoffend without this model's housing offer.

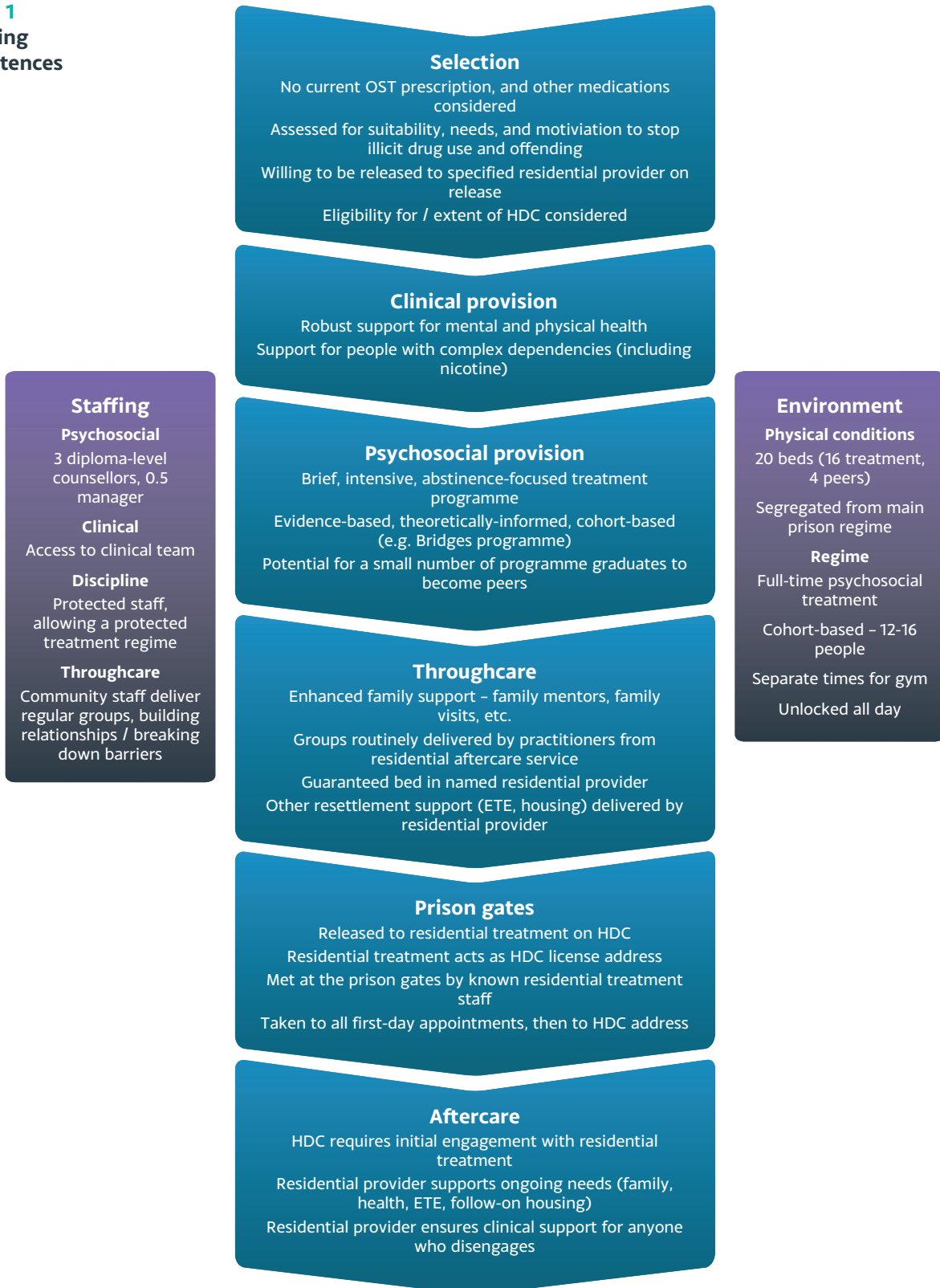
The intention of this pathway is to use a brief, intensive, cohort-based intervention in prison to develop individuals' motivation towards abstinence; progressing to full residential rehabilitation following release. This process offers five key benefits:

1. Dedicated wings within prisons provide secure environments for initiating prisoners' recovery journeys, free from novel psychoactive substances and other drugs;
2. HDC is maximised, reducing the costs of imprisonment and reducing overcrowding;
3. Prisoners move from abstinence-focused prison treatment into community accommodation that can meaningfully enable them to maintain abstinence;
4. Ex-prisoners are motivated to engage with the full treatment pathway, as they benefit from early release to enhanced supportive housing; and
5. HDC requires individuals to continue engaging with residential treatment. Disengaging results in their return to prison through a fixed-term recall.

Using residential rehabilitation for aftercare offers considerable advantages, too. Firstly, the use of residential treatment for prison aftercare is strongly supported by the best international evidence¹⁴². There is consequently a powerful justification for systematically trialling this model in the UK. Secondly, residential treatment services are adept at supporting their clients to find housing, education, training, and employment; and at rebuilding family ties. According to their internal data, RAPT's The Bridges in Hull – a residential rehab specialising in work with ex-prisoners – claim to support 95% of treatment graduates into independent tenancies. In this way, ex-prisoners engaged by residential treatment gain access to greatly improved resettlement resources when compared with those who can only access standard prison provision.

¹⁴² Pelissier *et al.* (2007); Mitchell *et al.* (2002)

Blueprint 1
Men serving
short sentences



Blueprint 2. Men serving longer sentences

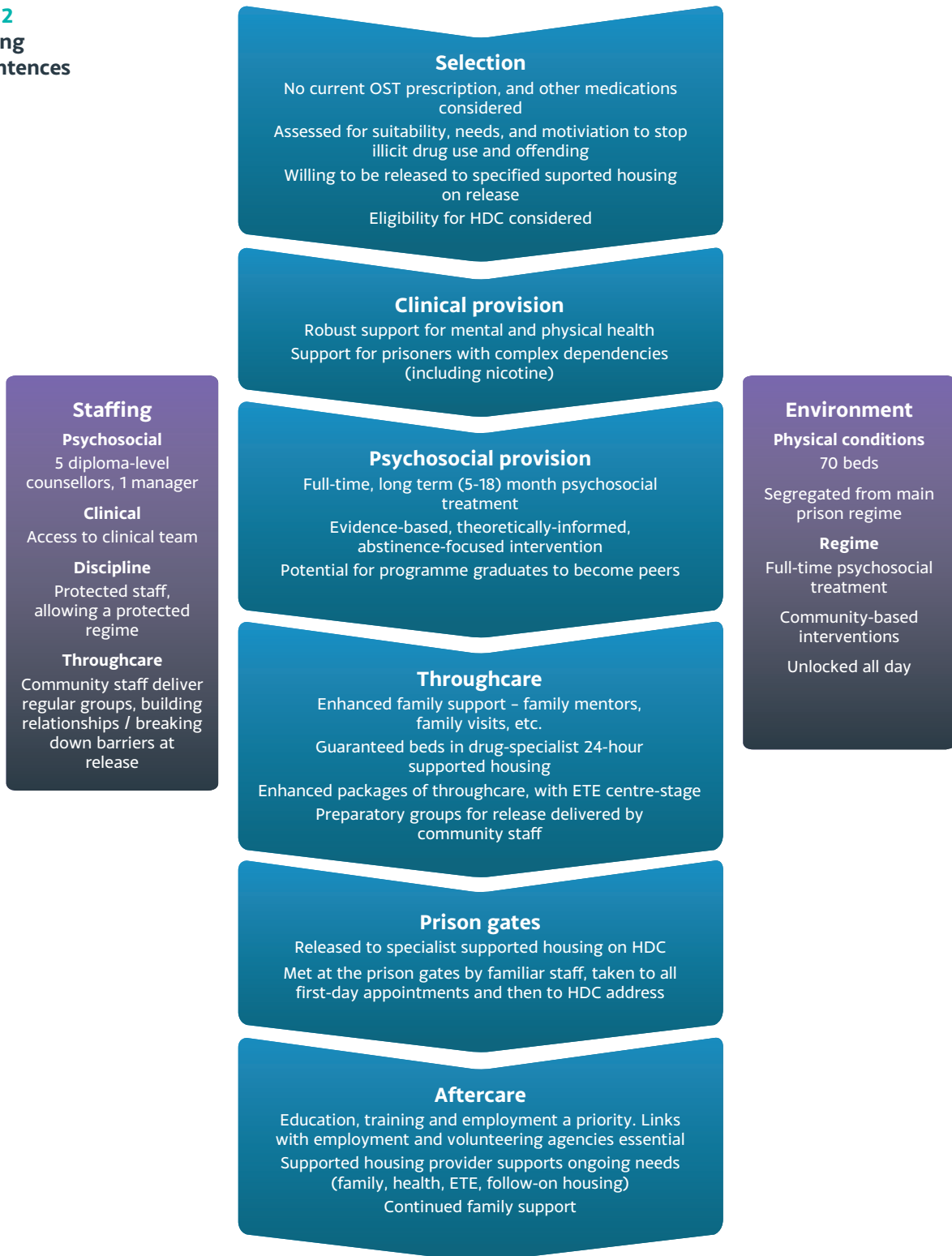
This blueprint seeks to describe an optimal pathway of care for prisoners serving longer sentences. To do so, it draws on existing extensive packages of care, linking them to enhanced throughcare and aftercare provision that should enable ex-prisoners to continue their recovery journeys in the community. This contrasts markedly with current models of provision, wherein those who complete comprehensive packages of intervention in prison risk encountering a 'cliff-edge of support' on release, potentially accompanied by a swift return to drug use and offending (Lloyd *et al.*, 2017). Whilst this blueprint is able to engage people serving as little as 6 months, it is likely to be most effective when focused on those with sentences of 12-48 months and able to access a full 4.5 months of HDC. Additional benefits are likely to be achieved engaging prisoners who would otherwise be released homeless.

The intention of this pathway is to provide the mainstay of therapeutic intervention in prison. This can offer substantive advantages. Firstly, treatment can be more extensive than similar programmes in the community. Whilst some shorter programmes are about the same length as community-based residential treatment (3-6 months), full progression through a Therapeutic Community can result in up to 18 months of immersion in a pro-social treatment environment. Secondly, costs are comparatively lower than community provision. Treatment clients are already imprisoned; there are no additional costs related to accommodation, food, etc. Cost-benefit analyses identify that a prison TC costs between £65-105 per week, compared to £550-650 for comparable treatment in the community.

This opens up outstanding potential for spending better to save. However, for any gains made in treatment to be fully realised, extensive treatment must be followed by the kind of aftercare that can meaningfully enable ex-prisoners to continue their progress. For those lacking genuinely secure and supportive housing, guaranteed beds in secure, drug-free housing is an absolute necessity here; an inability to provide this calls any aspirational abstinence-focused venture into question. Drug-specialist, abstinence-focused supported housing is a particularly promising model, offering ex-prisoners up to a year to progress with social reintegration by engaging with volunteering, education, and training opportunities in a safe and supportive environment. As an additional advantage, specialist supported housing has the potential to be funded through existing Housing Benefit pathways.

As in any time-limited programme, move-on housing must also be an essential consideration within this blueprint. Allowing ex-prisoners continued access to floating support workers may improve their chances of continued integration after they leave supported housing.

Blueprint 2
Men serving
longer sentences



Evidence review: Women's prisons

Introduction

Many of the considerations already described also apply to women. However, as attested to by a substantial body of literature, women cannot be understood as having the same needs as men; nor can they be assumed to benefit from similar access to services¹⁴³. In essence, drug dependent women prisoners have higher levels of complex needs than comparable men, with patterns of drug use that are more frequently tied to their offending behaviour, historic trauma, and to destructive relationships with men¹⁴⁴.

This means that pathways for women's treatment come with some basic pre-requisites. Firstly, policy, practice and research consistently recommend that any treatment programme in the community must be woman-only¹⁴⁵. Feedback from women service users was also clear that this approach should be extended to staff working in prison-based programmes, with no role for male staff¹⁴⁶. Secondly, any such treatment must be trauma aware¹⁴⁷. Again, women service users saw this as an essential component of these blueprints¹⁴⁸. Thirdly, any pathway must take account of women's relationships. For some women, their absolute priority may be returning to their home town to regain contact with and custody of their dependent children. For others, putting distance between themselves and abusive ex-partners or family members may be their main goal.

Developing an adequate response to all of these factors already presents a substantial task. However, this is further complicated by the scarcity of women's services. Across England and Wales there are just 12 women's prisons. Two of these are open prisons housing very few women¹⁴⁹. Concomitantly, there are only 9 women-only residential rehabilitation units (see Table 1, and Appendix A). Their locations do not map on to the women's prison estate in any way that might support comprehensive, joined-up provision. Six women's prisons are over 40 miles from the closest women-only residential rehab; Low Newton has no such services within 136 miles; the scarcity of women-only residential treatment in the Midlands and North leaves just one provider (with 11 beds) as the closest unit for 6 women's prisons; and a cluster of women-only treatment centres in Dorset contrast with the complete absence of women's prisons in South West England.

Thus, women's relationships mean they are more likely to want to live in or avoid certain areas, complicating the specification of any single prison-to-treatment provider pathway; whilst patterns of service provision make it harder still to establish links between prisons and community providers. The obvious need is for additional provision: as a recent report notes, although women represent 29% of those in treatment, just 7% of residential services are set up for their needs¹⁵⁰. However, in the absence of radical reform, any blueprint must acknowledge and seek to address these multiple additional obstacles facing drug-dependent women prisoners.

¹⁴³ See Appendix Evidence Review

¹⁴⁴ Light *et al.*, 2013:6; Corston 2007

¹⁴⁵ e.g. Corston 2007; Covington *et al.*, 2008

¹⁴⁶ See Appendix 5. Forward Trust focus group – women; Appendix 8. Phoenix Futures focus group – women

¹⁴⁷ e.g. Corston 2007; Covington *et al.*, 2008

¹⁴⁸ See Appendix 5. Forward Trust focus group – women; Appendix 8. Phoenix Futures focus group – women

¹⁴⁹ HMP Askham Grange can accommodate approximately 128 women; HMP East Sutton Park houses approximately 100.

¹⁵⁰ Agenda 2017:13

Table 1

Prison	Beds	Conditions	Closest women-only rehab	Miles
HMP Downview	311	Closed	Hope House, Clapham	11
East Sutton Park	100	Open	Kenward Naomi, Hawkhurst	16
Eastwood Park	400	Closed	Nelson Trust, Stroud	17
Styal	486	Closed	THOMAS Salford	20
Bronzefield	572	Closed	Hope House, Clapham	20
HMP Send	282	Closed	Hope House, Clapham	25
New Hall	480	Closed	THOMAS Salford	41
Drake Hall	340	Closed	THOMAS Salford	58
Foston Hall	344	Closed	THOMAS Salford	64
Askham Grange	128	Open	THOMAS Salford	67
Peterborough	360	Closed	Hebron House, Norwich	85
Low Newton	340	Closed	THOMAS Salford	136

Environment

Our preferred model for men centres on segregated wings of 20 beds for shorter cohort-based interventions, and of up to 70 beds for long-term programmes¹⁵¹. However, a brief review of women’s prisons¹⁵² identified that wings of approximately 40 beds are far more widespread. Moreover, segregation may be impossible in some prisons. Some flexibility in the structure and scale of women’s treatment units may consequently be beneficial – for example, delivering two shorter cohort-based programmes alongside one another, or providing one larger, long-term Therapeutic Community (as is currently the case in HMP Send).

The mainstay of the regime should comprise full-time psychosocial treatment. This supports both segregation and the development of protective pro-social relationships. Segregation has a potentially vital role to play in ensuring that women have access to an environment that can enable them to initiate change – free of novel psychoactive substances, other drugs, bullying and violence.

Staffing

As described earlier, discipline officers and therapeutic workers comprise the main staff presence on a therapeutic unit. Women prisoners are particularly likely to have histories of trauma and victimisation¹⁵³, compounded by detoxification from drugs and / or alcohol and exacerbated by the potentially re-traumatising prison environment. This shapes some of the core recommendations outlined here.

Firstly, the need for a highly qualified core of therapeutic staff is of the utmost importance; experienced, diploma-level counsellors are likely to provide a robust core for a psychosocial team, though service users were keen that core positions

¹⁵¹ See Environment

¹⁵² Information drawn from MoJ Prison Finder and HMIP reports.

¹⁵³ Covington *et al.*, 1998; Corston 2007

should also be open to women with lived experience of imprisonment and drug dependence¹⁵⁴. Women service users were also clear that peers should have a central role in programme delivery, as they have 'walked in the same shoes' as those undergoing treatment¹⁵⁵.

Secondly, reflecting the principles set out in the Corston Report, treatment units should be staffed entirely by women. Service users were clear that this principle should apply to both therapeutic and discipline staff, and expressed a strong preference for all staff (including discipline officers) to be trauma-aware¹⁵⁶. This is realistically deliverable, as trauma-informed workshops for prison officers are gaining traction with several hundred officers trained to date¹⁵⁷. These recommendations are firmly grounded in the evidence and were highlighted as essential by women service users¹⁵⁸.

Recruitment

We see no requirements for women's recruitment, beyond those specified for men.

Clinical provision

Levels of mental illness and trauma are exceptionally high within populations of imprisoned drug-dependent women¹⁵⁹. Moreover, signs of mental illness may become particularly apparent once women stop using drugs, or after detoxification from opioid substitution therapy¹⁶⁰. As such, robust access to mental health teams is a necessary component of any abstinence-focused treatment pathway, combined with ready access to support for other clinical needs.

Psychosocial provision

Provision should be integrated with women's sentence planning and resettlement needs, to ensure that treatment dovetails with women's release dates; and that adequate support is available following release. In principle, we see value in the models of provision described for men, with women accessing shorter introductory or longer in-depth interventions according to their sentence length and identified needs. However, there is an apparent difficulty here. Only one accredited programme for substance misuse has been specifically adapted for women: RAPT's Women's SDTP. The extent to which this is trauma-informed is unclear from the available literature. In contrast, HMP Send's Therapeutic Community has not been specifically adapted for women; but has been identified as trauma-informed¹⁶¹;

The impossibility of establishing clear aftercare pathways from many women's prisons to residential rehabilitation also creates real questions about how best to support women serving relatively short sentences. Intensive, trauma-informed and women-only drug treatment simply does not exist in many areas of the country. Even when community services do offer women-only provision, in many areas this constitutes little more than a mixed-gender service offering weekly women's groups with no underlying theory or model of women's recovery¹⁶².

In this context, there is a particularly strong mandate for doing as much as possible in prisons: whilst extensive interventions can still be followed up by reasonably secure resettlement support, it may be far harder to follow up brief prison interventions with robust community treatment.

¹⁵⁴ See Appendix women SU feedback

¹⁵⁵ See Appendix 7

¹⁵⁶ Covington *et al.*, 1998

¹⁵⁷ Grosvenor, 2018

¹⁵⁸ See Appendix 7

¹⁵⁹ e.g. Najavits 2004; Corston 2007

¹⁶⁰ e.g. Lloyd *et al.*, 2014

¹⁶¹ e.g. Grosvenor 2018

¹⁶² Agenda 2017:12

Throughcare

Shorter prison programmes may benefit from being followed up by more robust abstinence-focused aftercare; whilst more extensive prison programmes could be matched to less intensive community provision.

In terms of throughcare, women face considerably greater difficulties than men. Their increased distance from home makes it harder to establish links with local resettlement agencies¹⁶³. Even when those links are made, support related to education and employment is poor¹⁶⁴, and access to appropriate housing is limited¹⁶⁵. Moreover, family is a persistent issue affecting all areas of resettlement. Women may not wish to access education or employment, until they have regained custody of their children¹⁶⁶. Likewise, access to housing can be complicated by women's primary desire to find a home that enables them to house their children; and by a risk that, without secure independent tenancies, they may return to violent or drug using partners.

For women who are unable to access residential treatment, throughcare provision becomes far more important. It cannot be emphasised enough that standard resettlement provision is not capable of supporting women in sustaining transformative change following release, and so – without enhanced packages of support – ambitious abstinence-focused psychosocial interventions are likely to be an ineffective use of resources that puts women at considerably greater risk following release. At a bare minimum, such packages must include:

- Guaranteed secure, independent tenancies, capable of supporting women in regaining custody of their children;
- Access to meaningful opportunities for education, training, and employment; and
- Timely access to benefits, and other sources of financial information and support¹⁶⁷.

Moreover, long-term intensive treatment whilst imprisoned gives ample time to ensure such packages of support are arranged well before a woman's release date.

Throughout women's time in treatment, maintaining or rebuilding contact with family members is a priority¹⁶⁸. Similarly, developing relationships with people from their home area who might support them following release is likely to be a considerable additional boon. Potential key services here include Women's Community Services (WCS) (who specialise in working with women offenders, and are far more widely dispersed than residential treatment); the Drug Interventions Programme; and floating support workers from supported housing schemes¹⁶⁹.

Prison gates

Prison gates pick-ups are likely to carry greater significance for women than for men. Transitions for all released prisoners are a time of particular risk; but women face the additional risk of being met by drug-involved partners or drug dealers. In this context, there is a particular need to ensure that women are met by a familiar face – a WCS worker who has visited them in prison, and who is involved in their community support, for example. In practical terms, workers should have sufficient time to ensure women are taken to all first-day appointments before being settled into their secure, drug-free accommodation. In practical terms, women service users also called for more flexibility on this first day – for example, taking time to go shopping, enjoy the first day of release, and 'feel human' again¹⁷⁰.

¹⁶³ Prison Reform Trust 2016:31

¹⁶⁴ See supporting Evidence Review; see also Work and Pensions Committee 2016:15, Coates 2016

¹⁶⁵ Prison Reform Trust 2016:32

¹⁶⁶ See supporting Evidence Review

¹⁶⁷ See supporting Evidence Review

¹⁶⁸ See supporting Evidence Review

¹⁶⁹ See supporting Evidence Review; see also OSS, DIP, supported housing

¹⁷⁰ See Appendices 5-8

Aftercare

For women able to access residential treatment, aftercare will be delivered by their residential provider. For other women, the widespread absence of almost any form of supported accommodation is striking. Agenda identify four supported housing services in the UK designed for women with drug or alcohol problems¹⁷¹, and this lack of structured support leaves women ex-prisoners at considerably greater risk of encountering a cliff-edge of support when leaving prison. Certainly, appropriate therapeutic aftercare is almost non-existent: there are few residential drug services that women ex-prisoners could be confidently referred to. Pragmatic support thus becomes the main route available to support women in sustaining their recovery journey.

Secure finances, secure independent tenancies, and robust access to meaningful opportunities for education, training and employment must be available if any treatment gains are to be sustained. Ongoing access to WCS services – providing wraparound support in safe, women-only environments by trauma-aware staff – may also be beneficial.

¹⁷¹ 2017a:19; See also supporting Evidence Review

Blueprint 3. Women serving short sentences

Where this blueprint can be operationalized, it has the potential to offer women greatly improved access to treatment and resettlement resources. In so doing, it looks to improved gains from treatment whilst imprisoned; greater continuity of treatment gains following release; and improved individual and family outcomes over the longer term. Throughout, the emphasis is on responding fully and appropriately to the specific needs of drug dependent women prisoners.

Many women prisoners are serving sentences of less than 6 months. If HDC can be utilised, this is likely to enhance women's engagement with community provision. However, this also has the effect of making this blueprint better suited to women serving slightly longer sentences. From the outset, selection and recruitment processes should reflect the admission criteria of residential partners – this may mean, for example, that women with a history of arson are referred to alternative prison programmes.

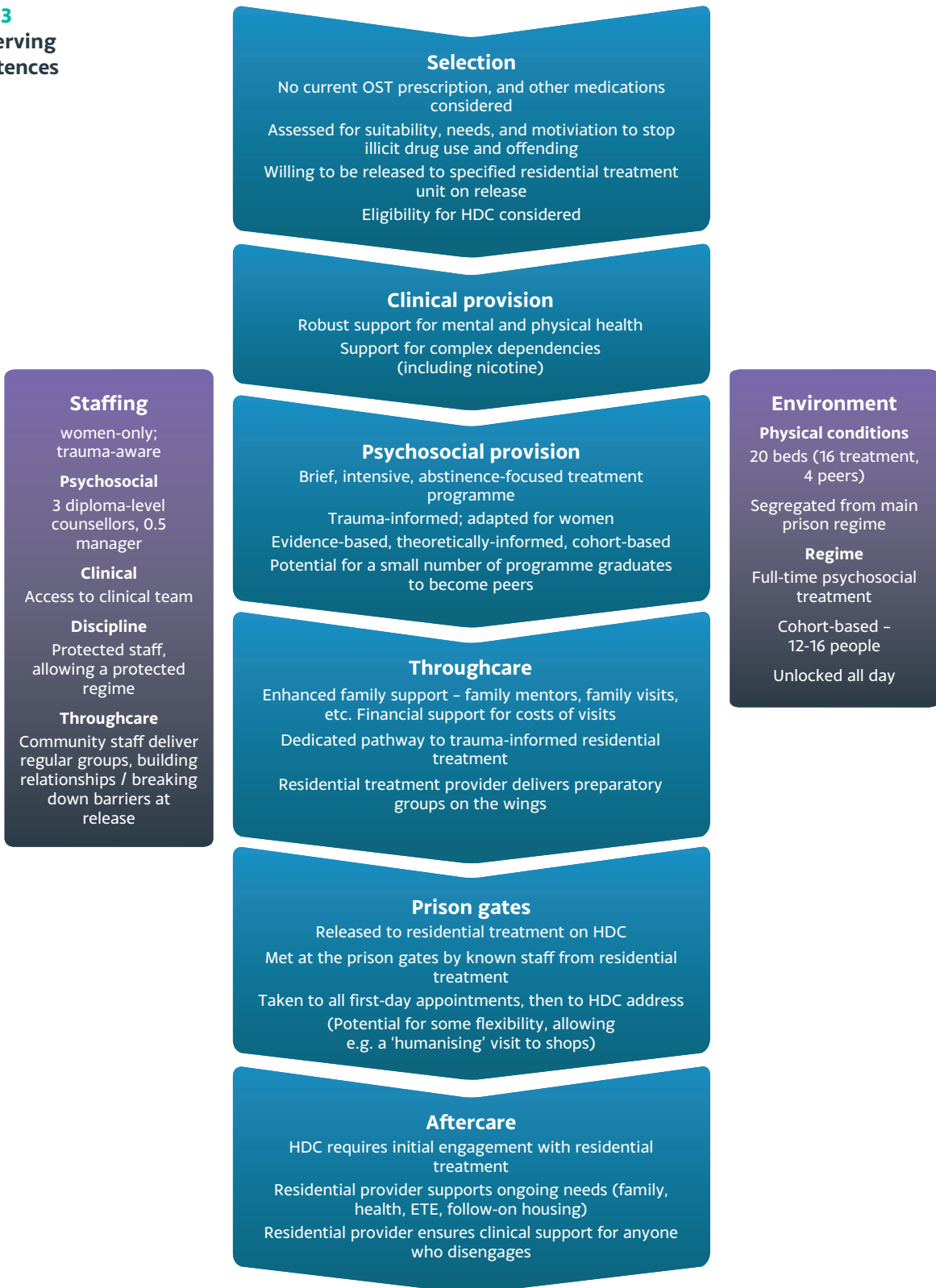
Treatment in prison is envisioned as a brief, full-time, abstinence-based intervention aimed at introducing women to key concepts in treatment, enhancing their motivation for change, and providing some tools for dealing with difficult situations in the community. Whilst RAPT's Bridge Programme appears well suited to this role, it has not been adapted for women; and this creates a noticeable gap in treatment options.

Where possible, enhanced family visits should be a mainstay of this blueprint. Practical support should be provided to overcome barriers to visits (e.g. being unable to afford public transport).

Access to aftercare is likely to be improved if women have been able to build relationships with community treatment staff. As such, it makes good sense to ensure that residential staff deliver some treatment groups in prison, ensuring that women are familiar with the expectations of residential treatment.

Ideally, release plans should integrate an element of HDC, with a woman-only residential treatment provider named as women's HDC address. This means that women benefit from early release, whilst also being encouraged to maintain their engagement with treatment: dropping out means leaving an HDC address, and so is likely to lead to re-imprisonment.

Blueprint 3
Women serving
short sentences



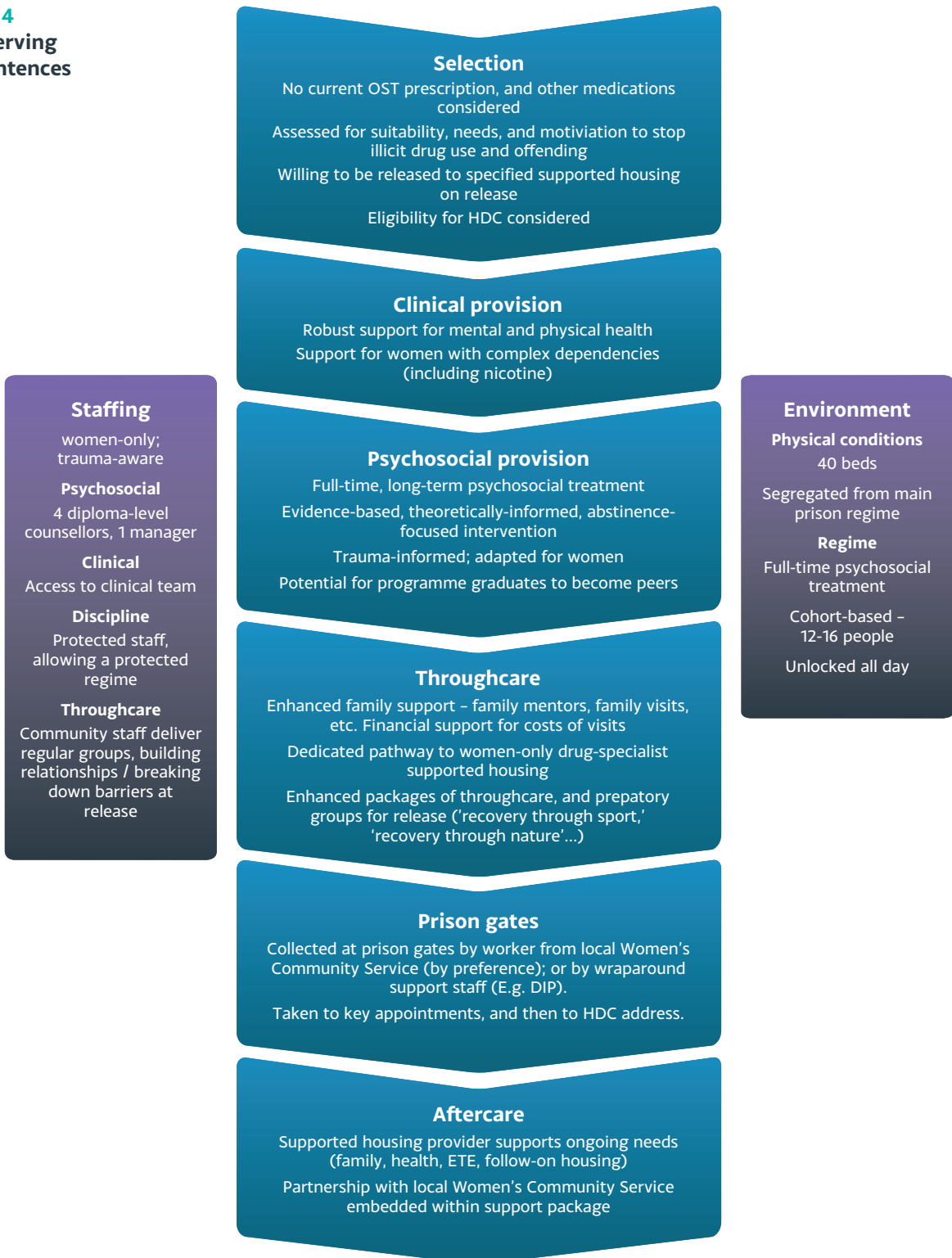
Blueprint 4. Women serving longer sentences

This blueprint seeks to maximise the opportunities available to women by linking extensive treatment in prison with robust aftercare provision. In so doing, we draw on the only accredited programme for substance misuse that has been adapted for women (no such interventions are available for women serving short sentences). This, in and of itself, points to a need for considerable innovation and change. However, even with access to this relatively strong starting point, this blueprint is still severely hampered by the lack of women-only supported housing schemes. The almost complete absence of such programmes in the UK means that it is far harder to define a clear and coherent recovery pathway for women (ex-)prisoners.

The starting point for this blueprint is RAPt's Women's Substance Dependence Treatment Programme (WSDTP). This takes 16-22 weeks, making this pathway ideally suited to women serving at least four months. Alongside the WSDTP, enhanced family support should be a mainstay of throughcare. Assembling robust packages of pragmatic support is also essential, but is likely to be one of the most challenging aspects of operationalizing this blueprint. Women are imprisoned, on average, 64 miles from home. With treatment clients coming from a wide variety of regions, and with no available structures for the provision of wraparound residential support, the only way of assembling aftercare is likely to involve the development of multiple loose, local coalitions. Women's Community Services (WCS) are likely to be key partners here. Indeed, there may be a strong case for developing residential capacities within some WCS, to enable them to provide a service that is clearly widely lacking at present. DIP workers may also provide a source of pragmatic resettlement support.

Secure housing is absolutely essential for this blueprint: women must be able to return to secure, drug-free homes that are free of violence. This ideally involves independent tenancies; whilst the costs may appear high, the potential social and economic gains may be considerable. Additional keystone resettlement partners include WCS, financial and debt advice, support with children, and – for those women who feel themselves job-ready – support with education, training and employment.

Blueprint 4
Women serving
longer sentences



Cost-benefit analysis

Introduction

This section seeks to document the known costs and potential savings arising from the models of treatment set out in this paper. To do this, we begin by setting out our headline expectations of the savings that would be required in order to render these models cost-effective, followed by a detailed explanation of our workings. Inevitably, there are limitations to this analysis. Not least, this is a proposal for an intervention: as such, it is speculative. There are no existing or directly comparable cost-benefit analyses to draw on.

However, some things can be asserted with relative confidence. The costs of imprisonment are well-documented, as are the costs of (re-)offending. With support from service providers, we have also been able to identify realistic 'best guess' costs for both prison and community treatment. This allows us to draw on real-world data to give a robust idea of the likely costs arising from delivering these blueprints, along with the scale of reductions in reoffending (and reimprisonment) that would be needed in order for them to be cost-effective.

An additional point is also worth making. Treatment in prison is considerably cheaper than comparable interventions in the community. As such, there is the potential here to spend better to save – capitalising on some of the outstanding, high quality, abstinence-focused work that is already being done in prison by bolting it onto the kind of aftercare that can enable prisoners to sustain their progress following release. As the evaluation of pilot DRWs showed, the current model of provision sees drug-, alcohol-, and OST-abstinent prisoners routinely released unsupported, unemployed, and homeless. Addressing this fundamental shortfall has the potential to deliver changes that are both personally transformative for drug-dependent prisoners, and cost-effective for society.

Overview

Table 2 sets out our expectations of the reductions in reoffending and / or reimprisonment that would need to be realised for each of our proposed models to become cost-effective.

Our proposed model for placing ex-prisoners in drug specialist supported housing following completion of a long-term abstinence-focused treatment programme prison is almost unavoidably cost-effective. The best evidence identifies that HDC without additional support leads to no increase in offending. As this model is already significantly cheaper than prison when viewed in terms of accommodation alone, the additional support that is offered would have to yield a significant increase in individuals' rates of reoffending if it were to fail to deliver significant cost savings.

The delivery of full residential rehabilitation (both primary and secondary) in the community is attended by significant additional six-month costs. However, if this connected to short duration prison interventions delivered in Category B local prisons, then modest reductions in reoffending and reimprisonment would begin to deliver financial savings over current practice. For example, preventing two burglaries and a one-year prison sentence would redeem the cost of putting at least three men through a short-term intensive prison programme followed by both primary and secondary residential treatment. This is eminently achievable– the best available UK evidence suggests that 78% of ex-prisoners who use class A drugs following release reoffend¹⁷², and many such prisoners have lifetimes of (re-)imprisonment¹⁷³, and often find themselves completely unsupported at the point of release. Given the extent to which these blueprints offer comprehensive, additional, wraparound support to a group with exceptional levels of need, we believe these models are likely to offer considerable financial savings.

¹⁷² Brunton-Smith and Hopkins 2013:19

¹⁷³ Page *et al.*, 2016

Table 2. Reductions in reoffending and imprisonment required for proposed models to be cost-neutral

	Men			Women		
	Short-duration, full residential rehabilitation	Short-duration, primary residential only	Long-duration, drug specialist supported housing	Short-duration, full residential rehabilitation	Short-duration, primary residential only	Long-duration, drug specialist supported housing
Serious wounding	0.39	0.26	-0.11	0.34	0.22	-0.23
Common assault	5.68	3.77	-1.57	4.98	3.17	-3.34
Robbery – personal	1.13	0.75	-0.31	0.99	0.63	-0.66
Burglary of a dwelling	2.53	1.68	-0.70	2.22	1.41	-1.49
Burglary not in a dwelling	2.16	1.43	-0.59	1.89	1.20	-1.27
Theft (non-vehicle)	13.03	8.64	-3.59	11.42	7.27	-7.67
Shoplifting	80.37	53.30	-22.16	70.44	44.84	-47.31
Criminal damage (commercial)	5.41	3.59	-1.49	4.74	3.02	-3.18
Male category B Trainer (months)	3.85	2.55	-1.06			
Male category C Trainer (months)	4.28	2.84	-1.18			
Male dispersal (months)	2.22	1.47	-0.61			
Male local (months)	3.95	2.62	-1.09			
Male open (months)	4.54	3.01	-1.25			
Female closed (months)				2.65	1.68	-1.78
Female local (months)				2.49	1.59	-1.67
Female open (months)				2.36	1.50	-1.59

Sources: MoJ (2018) Costs per place and costs per prisoner 2016-17. London: MoJ; Home Office (2011). Revisions made to the multipliers and unit costs of crime used in the Integrated Offender Management Value for Money Toolkit. London: Home Office

Projections and costings

We now detail the workings behind our cost-benefit calculations.

Costs: Prison

The costs of adult imprisonment in 2016-17 are set out in table 3¹⁷⁴.

Table 3. Costs of imprisonment

Function	Cost per Place per year	Cost per Prisoner per year	Cost per Place per week	Cost per Prisoner per week
Male category B Trainer	£35,341	£35,042	£679.63	£673.88
Male category C Trainer	£33,009	£31,555	£634.79	£606.83
Male dispersal	£56,678	£60,874	£1,089.96	£1,170.65
Male local	£43,281	£34,199	£832.33	£657.67
Male open	£28,051	£29,736	£539.44	£571.85
Female closed	£38,236	£44,708	£735.31	£859.77
Female local	£47,185	£47,476	£907.40	£913.00
Female open	£40,857	£50,029	£785.71	£962.10

With certain restrictions, Home Detention Curfew (HDC) can be given to prisoners serving a sentence of between 3 months and 4 years. Usually, prisoners have an automatic release date at the half way point of their sentence. However, HDC allows prisoners to be released after serving one quarter of their sentence, with a maximum reduction in time served of 135 days (4.5 months). The best available evidence suggests that HDC is cost-effective¹⁷⁵; with...

‘...offenders who received HDC... no more likely to engage in criminal behaviour when released from prison when compared to offenders with similar characteristics who were not eligible for early release on HDC. This was the case, even when controlling for the additional time that offenders on HDC are in the community, due to being released early¹⁷⁶’

This stood, despite being a comprehensive sample of all those released on HDC – all would have required a secure HDC address, but no other dedicated or additional rehabilitative measures were involved.

Although guidelines clearly state that ‘refusal of HDC for those eligible and not presumed unsuitable for release should be the exception¹⁷⁷,’ in 2016 just 21% of eligible prisoners benefited from any reduction in their sentence.

Developing a seamless pathway from prison treatment to residential support in the community has the potential to maximise the use of HDC by reducing risk both pre-release (through prison programmes) and post-release (through supervised, secure and supportive housing). Savings are likely to be maximised for those serving between 18 months and 4 years – for whom, with clearly developed pathways and robust sentence planning, reductions of 4.5 months imprisonment should be consistently deliverable.

¹⁷⁴ MoJ (2018)

¹⁷⁵ Marie, Moreton and Goncalvez (2011)

¹⁷⁶ Marie, Moreton and Goncalvez (2011)

¹⁷⁷ HMPPS Agency Board (2018) PSI 01/2018

Costs: Prison treatment

We began by modelling six months' treatment costs for four types of programme, drawing on the methodology used in the Evaluation of Pilot DRWs. Projections for each were developed, with staff salaries, informed estimates of costs and underlying assumptions fact-checked with relevant providers.

1. **Men's short-duration prison programmes:** prisoners receive an 8-week, full-time, abstinence-focused intervention. They are housed in a 20-bed unit, staffed by 3 full-time diploma-level counsellors and one 50% FTE manager. Groups are cohort-based, engaging 16 people at any one time. Approximately £187.03 per week.
2. **Men's long-duration prison programmes:** prisoners receive a six-month, abstinence-focused intervention. They are housed in a 70-bed unit, staffed by 5 full-time psychosocial drug workers and 1 full-time manager. Approximately £67.44 per week.
3. **Women's short-duration prison programme:** prisoners receive an 8-week, full-time, abstinence-focused intervention. They are housed in a 20-bed unit, staffed by 3 full-time diploma-level counsellors and one 50% FTE manager. Groups are cohort-based, engaging 16 people at any one time. Approximately £187.03 per week.
4. **Women's long-duration prison programme:** prisoners receive a six-month, abstinence-focused intervention. They are housed in a 40-bed unit¹⁷⁸, staffed by 4 full-time psychosocial drug workers and 1 full-time manager. Approximately £101.01 per week.

These (and similar) initiatives are already being delivered, though without any consistent provision of aftercare. In this context, money currently invested in prison treatment risks being lost at the point of release – we see real potential in spending better to save.

To this end, given our focus here is on projecting the *additional* costs and benefits of systematically linking these programmes to comprehensive packages of aftercare, the costs are not counted within the following analysis. However, the money spent on prison treatment can be understood as a cost saving for these blueprints – to the extent that they deliver any decreases in drug use and reoffending secured by linking enhanced prison treatment to high quality community interventions.

Costs: residential rehabilitation (community)

Residential rehabilitation is often delivered in two stages. Primary treatment involves a full-time treatment programme, often supported by intensive support and night-time curfews. Secondary treatment is focused on moving on – involving semi-independent living arrangements (perhaps in a separate house), accompanied by a full range of resettlement activities designed to integrate individuals with their local community. Each stage is approximately 12 weeks.

Few residential providers are entirely open about the costs of treatment. However, Forward Trust's *Bridges* specialises in working with ex-offenders, and offers a template for likely costs. Primary treatment is priced at £650 per week (or £7,800 for 12 weeks); secondary treatment is £550 per week (or £6,600 for 12 weeks). A full six-month treatment programme is thus priced at £14,400. Checks with alternative providers confirmed that these figures (slightly over £600) was about mid-range for the sector.

¹⁷⁸ A review of provision for women offenders identifies that 70-bed units are almost non-existent. Contrastingly, 40-bed units are widespread.

Costs: Drug specialist supported housing (community)

Drug specialist supported housing units are few and far between; just one agency in the UK acts as both a drug treatment service and a registered Housing Association. Preliminary estimates of the cost of drug-specialist supported housing were drawn up using data from a 2010 review¹⁷⁹, adjusted for inflation. We then checked whether or not our estimates were realistic with a small sample of providers (they were). This led to an estimate of £210 per person per week for drug-specialist, drug-free, 24-hour supported housing.

Costs: Housing benefit (community)

We assumed that all ex-prisoners not in receipt of specified additional support would be in receipt of standard rate single room housing benefit. This is likely to be an overestimate – prisoners who return to family homes will not need such support (though such situations were rare for prisoners leaving DRWs, and almost non-existent for those with serious dependencies or histories of opioid use). By averaging data from a 2010 DWP report, adjusted by RPI, we estimated that this would cost £105 per person per week. However, welfare payments of this type are conventionally considered ‘transfer payments’ within cost-benefit analyses – redistributions of wealth without services or goods being received in return. (Contrastingly, the costs of specialist supported housing include the cost of dedicated units, staff costs, and service overheads). In consequence, these costs are not included here.

Costs: Re-offending and re-imprisonment

In 2016-17, 47.1% of released prisoners reoffended, committing an average of 5.26 offences each¹⁸⁰. Reoffending rates were significantly worse for prisoners serving short sentences: 60.6% reoffended, with an average of 6.2 offences each¹⁸¹. (Contrastingly, 33.2% of those sentenced to between 2 and 4 years reoffended an average of 3.5 times each¹⁸²).

The RPI-adjusted unit costs of offending in 2018 are detailed in Table 4. These costs are for all offences of each named type, including those that do not result in a conviction¹⁸³. They are consequently a severe underestimate of the costs of re-offending for ex-prisoners – for whom *known* re-offending rates relate exclusively to detected offences, the vast majority of which are likely to result (at the very least) in a recall to prison, and may lead to extended detention until they are tried for a new offence.

¹⁷⁹ Department for Work and Pensions (2010) ‘Exempt and Supported Accommodation,’ London: DWP

¹⁸⁰ MoJ (2018). Proven Reoffending Tables (Annual Averages). Available at: <https://www.gov.uk/government/uploads/proven-reoffending-apr16-jun16-annual.xlsx>

¹⁸¹ MoJ (2018). Proven Reoffending Tables (Annual Averages). Available at: <https://www.gov.uk/government/uploads/proven-reoffending-apr16-jun16-annual.xlsx>

¹⁸² MoJ (2018). Proven Reoffending Tables (Annual Averages). Available at: <https://www.gov.uk/government/uploads/proven-reoffending-apr16-jun16-annual.xlsx>

¹⁸³ Estimates for shoplifting, for example, assume just 1 in 100 offences are reported (Home Office 2000:16)

Table 4. 2018 RPI-adjusted costs of offending¹⁸⁴

Offence type	Cost
Serious wounding	£29,770
Common assault	£2,023
Robbery – personal	£10,187
Burglary of a dwelling	£4,538
Burglary not in a dwelling	£5,328
Theft (non-vehicle)	£882
Shoplifting	£143
Criminal damage (commercial)	£2,125

The costs of imprisoning men in local and Category C training establishments are between £606.83 and £657.67 per week, or £31,555 and £34,199 per year¹⁸⁵. The costs of a fixed-term (28 day) licence recall are consequently at least £2,428. This does not include the costs associated with processing a recall and re-imprisoning an individual on licence.

The costs of imprisoning women in local and closed female prisons are between £859.77 and £913 per week, or £44,708 and £47,476 per year¹⁸⁶. The costs of a fixed-term recall are consequently at least £3,439.08. This does not include the costs associated with processing a recall and re-imprisoning an individual on licence.

Benefits – health care costs, and entry into the workforce

Two final benefits may arise in the form of an increase in ex-prisoners entering the workforce, and reductions in the costs of their healthcare utilisation. However, projecting any likely impact is far from straightforward. On the one hand, individuals completing residential treatment may be well-positioned to seek work. On the other hand, they will be prevented from accessing paid employment for the duration of their treatment, whilst some other ex-prisoners may return immediately to work. Additionally, UK evaluations have found drug treatment to have little benefit in terms of employment¹⁸⁷, and so potential costs / benefits are not set out here.

Secondly, the impact of treatment on healthcare costs is unpredictable. Abstinence-focused treatment may reduce costs over the longer term; but could also be associated with an increase in costs, as individuals seek help for long-term chronic conditions (potentially including dental care). Additionally, people dropping out of abstinence-focused treatment are at greater risk of overdose; and so, again, the impact on healthcare costs is likely to be far from straightforward. The best available UK evidence suggests that entering drug treatment has unpredictable effects on healthcare utilisation, and that any potential costs and benefits are likely to be small when set next to the costs of offending¹⁸⁸. For this reason, projections about likely costs / benefits related to healthcare costs are not set out here.

¹⁸⁴ Home Office (2011). Revisions made to the multipliers and unit costs of crime used in the Integrated Offender Management Value for Money Toolkit. London: Home Office

¹⁸⁵ MoJ (2018) Costs per place and costs per prisoner 2016-17. London: MoJ

¹⁸⁶ MoJ (2018) Costs per place and costs per prisoner 2016-17. London: MoJ

¹⁸⁷ e.g. Godfrey, Stewart and Gossop 2001:705; Davies *et al.*, 2009

¹⁸⁸ Godfrey, Stewart and Gossop 2001:704; Davies *et al.*, 2009:9

Cost-benefit – analytical models

We assumed that short-duration programmes engaged prisoners sentenced to an average of 6 months (who can benefit from up to 1.5 months' HDC), and that long-duration programmes engaged people sentenced to between 18 months and 4 years (who can benefit from up to 4.5 months HDC). For cost comparisons, we assumed that men were housed in male local (short-duration) or men's Category C training (long-duration) prisons; and that women were housed in female local (short-duration) or women's closed (long-duration) prisons.

We then modelled the six-month service costs for 3 types of proposed aftercare.

- 1. Residential aftercare – primary and secondary treatment:** this assumes that all prisoners leaving short-duration treatment programmes benefit from full HDC, and progress through 12 weeks of primary and 12 weeks of secondary residential rehabilitation. They then receive two weeks of standard rate single-room housing benefit.
- 2. Residential aftercare – primary treatment only:** this assumes that all prisoners leaving short-duration treatment programmes benefit from full HDC, and complete 12 weeks of primary residential rehabilitation. They then enter drug specialist supported housing for the remaining 14 weeks.
- 3. Drug specialist supported housing:** this assumes that all prisoners leaving long-duration treatment programmes benefit from full HDC, and progress to drug-free specialist supported housing until six months have elapsed.

And compared them with 'current provision':

- 1. Current provision:** this assumes that, after undergoing treatment in prison, 21% of prison leavers receive full HDC (i.e., 1.5 months for comparison with short-duration programmes; 4.5 months for comparison with long-duration programmes). On release, all ex-prisoners claim standard single-rate housing benefit until six months have elapsed.

Table 5. Comparison of the costs of current practice vs full blueprint provision.

	Men			Women		
	Short-duration, full residential rehabilitation	Short-duration, primary residential only	Long-duration, drug specialist supported housing	Short-duration, full residential rehabilitation	Short-duration, primary residential only	Long-duration, drug specialist supported housing
Current costs	£3,117.37	£3,117.37	£8,629.12	£4,327.62	£4,327.62	£12,225.93
Blueprint costs	£14,610.00	£10,740.00	£5,460.00	£14,400.00	£10,740.00	£5,460.00

As table 5 shows, progressing prisoners from long-duration prison treatment programmes into supported housing is likely to offer immediate financial savings, without projecting any reductions in reoffending. (Given the best evidence identifies that HDC *without* additional support is associated with no increase in offending, it would be remarkable if the provision of enhanced support did not improve on this). Contrastingly, without projecting any reductions in reoffending, the six-month costs of providing ex-prisoners with both primary and secondary residential treatment were between £10,072 higher for women and £11,492 higher for men than the costs of keeping them imprisoned. Finally, the costs of providing ex-prisoners with 12 weeks of primary residential rehabilitation, followed by a move into drug-specialist supported housing, were between £6,412 higher for women and £7,622 higher for men than the costs of imprisonment.

As the main savings are in the form of projected HDC, increasing HDC offers one way of reducing the costs of additional provision. This, however, invites compromises. At present, the short-term prison blueprints are predicated on the idea of engaging prisoners sentenced to an average of just 6 months imprisonment. This group re-offend at very high rates, and can conventionally access very little support; but the HDC available to them is (at most) just six weeks. Contrastingly, recruiting prisoners with longer sentences dramatically reduces the additional costs of aftercare (see table 6); but, in so doing, engages groups with lower, less prolific rates of proven reoffending.

Table 6. Additional costs of blueprint provision if full HDC is achieved.

Sentence length	Men		Women	
	Short-duration, full residential rehabilitation	Short-duration, primary residential only	Short-duration, full residential rehabilitation	Short-duration, primary residential only
6 months	£9260.33	£5,390.33	£8,050.08	4180.08
12 months	£6640.66	£2,770.66	£4,220.16	350.16
18 months	£4020.99	£150.99	£390.24	-3479.76

This raises a conundrum: the models with the best chances of providing dramatic reductions in reoffending by linking drug-dependent short-sentence prisoners to comprehensive, secure housing and drug treatment also cost the most. Contrastingly, providing the same service for people serving longer sentences is, in most cases, almost cost neutral; but is unlikely to offer the same indirect or future savings from reductions in reoffending.

An additional point cutting across both models is that prisoners who are otherwise homeless are both ineligible for HDC, and have very high proven rates of reoffending. As such, there is particularly strong potential for benefits to be realised if prisoners with no alternative housing are recruited.

A final caveat is also necessary. The figures used throughout this section are tentative, and based on cost estimates that are themselves hard to estimate. This noted, efforts have consistently been made to secure the best available data: data on the substantive costs of crime, imprisonment, and reimprisonment have been drawn from government sources; data on the costs of treatment and housing have been drawn from the best available evidence, and checked with providers in the field.

Appendix 1. Terms of Reference

Terms of Reference

Ex-Prisoners Recovering from Addiction (EPRA) Working Group

The EPRA Working Group will run from 1 November 2016 to 31 October 2017, with the central aim of producing two evidence-based blueprints for the delivery of effective treatment and through-care for prisoners recovering from addiction to drugs and/or alcohol.

Rationale

Research evidence points to a frequent mismatch between prisoners' desires to address their substance misuse and reform their lives while still inside prison and the level of support given to such individuals on release. This 'cliff-face' of support and the dangers of resuming substance use are particularly severe for those who have been drug and alcohol abstinent, or have stopped receiving opioid medication whilst imprisoned. Given the great personal and social costs associated with relapse, recidivism and reimprisonment, there is the potential to develop cost-effective treatment and through-care programmes that will smooth transitions, sustain 'recovery journeys', and aid resettlement more broadly.

Aims

1. *To take a co-production approach to identifying evidence-based, cost-effective ways to support substance-misusing prisoners through prison and on release (treatment and through-care).*
2. *Draw on research evidence and people's lived experience of imprisonment/addiction in producing two blueprints for effective through-care: one for females and one for males.*

Remit

Target group

The focus of EPRA is on prisoners with a history of substance dependence who are motivated to make transformational changes to their substance use and wider lives.

A working definition of prison treatment and through-care

For EPRA's purposes, (prison) 'treatment and through-care' is defined as the continuum of support services provided for prisoners from reception through to resettlement, including 'after-care' in the community.

Two blueprints

The EPRA's aim is to produce two evidence-based 'blueprints.' It is anticipated that these are likely to be in the form of general descriptions and recommendations, rather than explicit, detailed project descriptions. The anticipation is also that one blueprint will be produced for women and one for men, due to the often very different situations and priorities faced by males and females on release from prison.

Process

Meetings

We plan to hold five meetings at the House of Lords over the year and EPRA members have agreed to become involved on that basis. Plans are for these meetings to be held in

- November 2016
- February 2017
- May 2017
- July 2017
- Oct 2017

Support

Meeting documents, including minutes, will be prepared by the University of York team and circulated at least a week before the meeting.

Confidentiality

Discussions held within the EPRA meetings and any written materials or presentations are confidential and will not be cited, referred to or quoted outside the EPRA meetings. However, there is no secrecy surrounding the existence of EPRA.

Meetings with policy-makers

While no current policy leads from any Government department will be invited to join EPRA, meetings will be held with policy-makers in NOMS and other interested departments at appropriate points in the Working Group's deliberations. The plan here is for this to be a two-way exchange of information, given the rapidly moving prison policy environment.

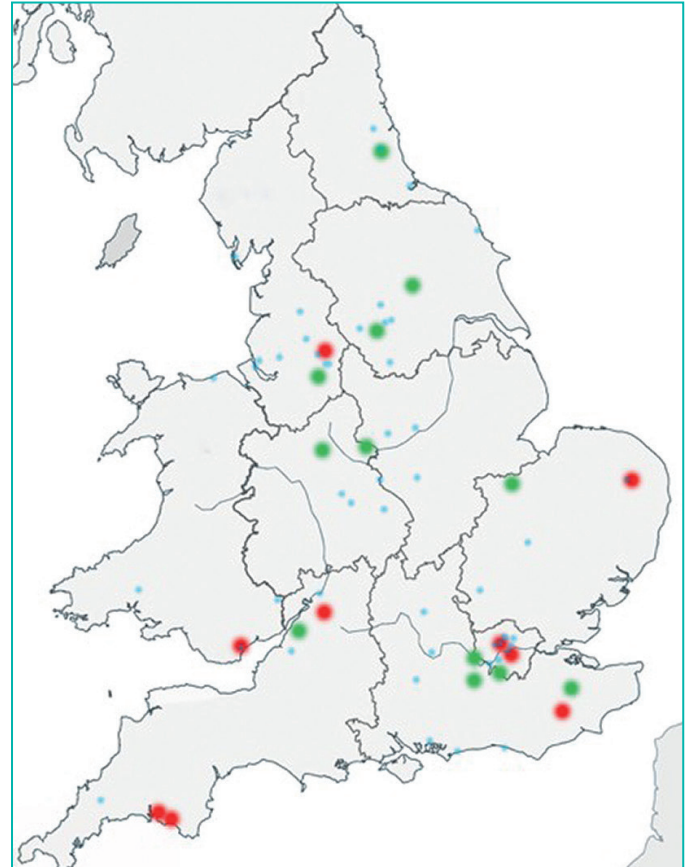
Other

The ideal vs the practical

In aiming to produce evidence-based blueprints, the emphasis is on potential effectiveness, rather than what might be achieved within current resources. Following EPRA's completion, the aim will be to seek support for demonstration projects that put the blueprints into action.

Appendix 2. Women’s prisons and women’s treatment – double distancing

Women prisoners have particularly strong reasons for being close to home. Approximately two-thirds of imprisoned women have dependent children (PRT 2015:6), and between a fifth and a third are single parents (MoJ 2012:35; PRT 2015:7). However women comprise just 5% of the UK’s prison population (MoJ 2017) and a quarter of those in drug treatment (REF), leading to a shortage of gendered provision. There are just twelve women’s prisons across England (with none in Wales), and women are imprisoned an average of 64 miles from home (Prison Reform Trust 2016:31). Concomitantly, there are just nine woman-only residential treatment centres across England and Wales (PHE 2017), and six of these are in the South of England (with one in South Wales). They consequently map very poorly onto the prison estate: of the seven women’s prisons in the Midlands or North, just one is within 40 miles of a woman-only residential treatment centre.



This creates a ‘double distancing’ effect, limiting the practical benefits of developing clear pathways tied to geography. Women are imprisoned far from home; woman-only residential treatment centres are often miles from women’s prisons. Thus, whilst HMP Eastwood Park is just 17 miles from the Nelson Trust women’s rehab, ‘20% of women in Eastwood Park are up to 150 miles from home’ (PRT 2015:8). Establishing a pathway from Eastwood Park to the Nelson Trust may consequently have little appeal for women who want to be closer to home. Similarly, HMP Low Newton is 136 miles from the closest women-only residential treatment service, again limiting the real world possibilities of developing pathways between the two. Finally, Salford’s THOMAS project is effectively the only women-only residential treatment option for all five Northern women’s prisons. If all sought to develop robust pathways into this nine-bed treatment unit, it is hard to see how it could avoid being rapidly overwhelmed. For this reason, this blueprint takes a twin-track approach. Whilst using HDC to support enhanced pathways into residential treatment make the fullest use of both prison and community resources, no intensive abstinence-focused woman-only treatment resource exists in many areas. Until such resources are developed, in such instances drug treatment should be brought forward – placing an emphasis on intensive treatment within prison, followed by genuinely enhanced packages of robust, safe, child-friendly resettlement support. As we note in the men’s blueprint, there is no point in delivering enhanced treatment in prison if the resettlement resources are not able to support women in sustaining change following the point of release.

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Appendix 4. Response to Service User focus groups

Dear Forward Trust and Phoenix Service Users,

We wanted to write to offer our heartfelt thanks for the time and commitment you so kindly gave to understanding our blueprints, commenting on them, and suggesting some changes. We were really encouraged to see some of the positive comments, which suggested that a lot of our ideas were heading in a sensible direction. These included:

- The requirement for people to detoxify from methadone or Subutex before beginning treatment;
- The use of HDC (early release) to encourage people to engage, and to reward them for making real changes in their lives;
- The use of licence conditions to ensure people stayed in residential rehab (or supported housing), with the expectation that breaching licence conditions (or leaving treatment) would result in a return to prison;
- The need to ensure that there weren't any gaps in people's care, and that people were met by familiar faces on the day of release;
- The use of treatment cohorts, with groups going through the same treatment programme together.
- The use of treatment graduates as 'peers' within the programme (and within the prison); and
- For women, ensuring that all interventions are trauma-aware.

You also made a lot of suggestions which we thought were really sensible, and wanted to add to our model. These include:

- Developing clear, visible, individual care plans for individuals, setting out the kinds of support they can access and how they might expect to progress;
- Exploring alternative means of selecting people for our current 'short sentence' or 'long sentence' pathways - we had been worried that sentence length alone might not be the best way of identifying which pathway someone accessed, and your feedback has led us to think that it would be a good idea to offer residential rehab to people leaving longer-term programmes, too. (Only as an alternative to supported housing, and only if they want it, of course.)
- Finding more ways of using peers, and programme graduates. This has got us thinking that it would be great if programme graduates were able to return to deliver groups in prison, or to act as occasional peers, following their release.
- Finding more ways of using Release on Temporary Licence (ROTL - day release from prison). Our model emphasises drug treatment over work and education (or similar activities), because we intend that residential rehab or supported housing will be able to address these needs better than prison services. However, we think it might be a really good idea to try and use ROTL to give people days attending the rehab they will go to after they're released.
- Both of the two previous points link to another suggestion, about helping people to engage with recovery communities (particularly sponsors or community resources) before they leave prison. And this ties in to another suggestion, about having a 'preparation for release' group before people finish treatment.
- A starter pack for people when they enter supported housing or residential rehab (containing details of local shops, services, the location of the JobCentre, etc) is a really good idea;
- Whilst we have emphasised families, the suggestion that we find ways of providing additional support for the recovery journeys of people without families also sounded like a really good idea. One suggestion involved 'recovery through...' groups (e.g. nature, sports, etc).
- The need to ensure that we've considered the impact of everything we suggest on children.

- The benefits of being flexible about staffing. We had suggested diploma level counsellors for everyone delivering treatment, but it's clear from feedback that people like to have a range of professionals available – including those with lived experience, or with other related personal and professional backgrounds.

There are also some things we now realise we need to describe more clearly. These include:

- That this is only meant to be one part of a prison's treatment pathway, not all of it. So we won't be able to take every prisoner into this treatment pathway (e.g., lifers, people on remand, people who want to stay on a maintenance dose of methadone or Subutex). Everyone will still have access to standard prison drug treatment services, though.
- What we mean by 'enhanced family visits'! Some examples have offered full-day visits in dedicated halls, with access to play equipment. Other possible additions include the use of dedicated family mentors, and through-the-gates family support. 'Storybook Dads' is another project that could be drawn on, with prisoners recording bedtime stories for their children.
- Prison jargon, which often isn't helpful. For example, when we wrote 'protected staff' we didn't mean staff being protected from prisoners; we meant protecting treatment staff and drug-educated prison officers from being taken off the treatment wing, to work on other wings / locations.

Finally, there are some difficult issues that we are aware of, but don't think we can really resolve. Some problems might be unavoidable in this kind of treatment programme. These include:

- The need to ensure that we only recruit the 'right' people, that everyone who accesses this pathway is fully motivated, or is entering treatment for the 'right' reasons. Lots of people have voiced concerns about this, and we know it's a big issue. But it's really hard thing to guarantee. Given this, we think the feedback from one group – that it's really hard to 'fake it,' and that people who enter treatment for the 'wrong reasons' will struggle to stay for long – is about the best we can hope to do in real-world conditions. (And there's always the possibility that someone who enters treatment for the wrong reasons may then get it.)
- The difficulty of ensuring that everyone who graduates from community treatment can get a decent, safe, secure tenancy. One group mentioned the difficulties of proving a 'local connection,' and we are aware of this. It is a really thorny issue. To an extent, we are putting our trust in residential treatment (and supported housing providers) here – we know that one residential rehab we have visited helps 95% of their treatment graduates into independent accommodation, for example.
- Choice. One focus group suggested that people who access treatment in prison should be able to choose what kind of treatment they access, so that (for example) they are not stuck with a 12-step treatment programme if that doesn't work for them. It was suggested that 'a variety of services would be on offer, including therapeutic community, Christian facilities, Alcoholics Anonymous, etc...' Unfortunately, this is unlikely to be the case – certainly for the next few years. The best we can really hope for at present is to set up a pathway linking one prison programme to one rehab. This is likely to be very small-scale, so no one will be compelled to opt into it. But it will be hard to offer much choice, until this model is better established.
- Funding. This is difficult, as one focus group pointed out. Funding for prison drug treatment is entirely separate from community treatment, and community treatment funders will often look for a 'local connection.' We think we'll need to find some money from a charity or other organisation in order to set up a pilot project, and to show that this works. (And not just that it works, but it means that money that is spent on treatment in prison isn't wasted when people are released unsupported and homeless, and return to drugs and crime!) If we can do that, we hope we will be able to ensure better, longer-term, guaranteed funding.

- Our focus on drug treatment, without access to prison-wide education, training, employment, housing support, etc. This is because we are hoping to ensure a smooth transition to community services, with residential rehab or supported housing then helping people to find work and housing over the next 3-6 months. We know that the agencies who support people through (and after) release are really struggling at the moment, and believe that dedicated support from community services (once someone is released to a safe, secure and drug free therapeutic home) will provide more useful in the longer run. If people do breach their licence conditions by dropping out of treatment and are returned to prison, then they will also gain access to standard prison resettlement services (housing, education, employment, etc).

Finally, thanks very much again for your input. You gave us a lot to think about, and we think that the model of care that we are suggesting is a lot better (and likely to be much more effective at helping people) thanks to your suggestions.

Charlie Lloyd

Reader

Department of Social Policy and Social Work

Geoff Page

Research Fellow

Department of Social Policy and Social Work

Appendix 5. Forward Trust focus group – women

05.03.18

Facilitated by Forward's Senior Research Officer & Head of Recovery. Group is comprised of 5 peer supporters at HMP Send.

One suggestion put forward in the model is offering Home Detention Curfew (HDC) to people who graduate from prison substance misuse treatment. This means they could leave prison up to 4.5 months early, but they would have to live at a specific, suitable address for that period of time (residential rehab, or supported housing).

1 What do you think would be the benefits of having to be released to residential support?

General consensus amongst the group was that this was a great idea. They agreed that it would **encourage women to participate in the programme** if there was an end goal in sight and support on release. *"It would be an amazing opportunity - a gift"*.

- Some concern that women would want to do the programme as a 'tick box' to access HDC. However, the group discussed that they didn't feel it would be possible to 'fake' engagement through the whole programme and that SUs who were engaging for the wrong reasons would deselect/be deselected. *"It's about feelings, and you can't fake that"*.
- The group felt that being able to access HDC on graduation from treatment would **reduce anxiety and concern about the next step following custodial treatment**.
 - Reduced anxiety and uncertainty can aid ability to engage effectively and complete the programme, ensuring women are present in the here and now.
 - Removes anxieties about being released from prison as NFA- sense of stability and certainty was highlighted as a massive benefit. Many women are released homeless and relapse/reoffend, lack of safe and secure accommodation was identified as a significant influence in the 'revolving door' of addiction and crime. *"You see so many women stuck in that revolving door"*.
- Discussed that being released following treatment completion (rather than remaining in custody for the rest of their sentence) would allow women to move to the next step in their recovery – **sense of progression** can increase motivation. The group felt that rehab/supporting housing would be a more appropriate and supportive environment for women at this stage in their recovery (e.g continued structure and support).

2 What do you think would be the drawbacks about having to be released to residential support?

The group felt that the benefits of offering HDC outweighed the drawbacks.

- Length of time people have been in custody for, they **may have become institutionalised**. This can be a block to integrating back into a community setting. Support prior to early release was seen as crucial- to break down women's anxieties and ensure they know where to access support.
- Need to ensure people are aware of when and where they will be released to in advance (as far in advance as possible). Last minute release can be a source of high anxiety which is a risk for relapse (*link to running a preparation for release group*).
- **Concern:** This model of HDC wouldn't apply to foreign national prisoners, or high risk offenders. Would there be an alternative pathway for these offenders who completed structured treatment but weren't eligible for HDC?

Suggestions to ensure process is effective:

- Ensure that women who have completed treatment and are eligible for HDC have a sponsor in place before release (and links to the fellowship).
- Run a 1-2 week group preparing women for HDC (include a peer in delivery). This could cover ensuring they have support in place and know how to keep themselves safe (relapse prevention work; links to sponsor and fellowship) as well as clearly outlining what is expected of them while on HDC.
- Important to assess clients' motivation and treatment readiness- ensure women aren't engaging in structured treatment when they aren't ready. Need to ensure it's just people who are genuinely committed to their recovery that are eligible for HDC - *"it won't be shown in their words, but in their actions"* (e.g. behaviour outside of the programme).

If residential support was a client's HDC address following release, the client might be recalled to prison if they dropped out of treatment.

3 What do you think would be the benefits of this?

- **Motivation to stay in treatment.** Group stated that knowing you'll be coming back to prison if you drop out of treatment can aid ongoing treatment engagement. For those that are recalled it can be a motivation for the next time they're released. *"Coming back to jail helped me stay in place - it gave me focus on what I needed to do".*
- **Knowledge of what is expected** was seen as a real benefit. The women stated that **having clear boundaries**, and knowing their responsibilities under HDC would aid them in staying on track.
- Recall to prison can be a **safety net** - knowing that you won't be homeless if something goes wrong or you relapse.

4 What do you think would be the drawbacks about this?

- **Clients many abscond** (e.g. if they've used and know they'll be drug tested & recalled if they return to rehab, they might run away - risk of being NFA and vulnerable)
- Clear boundaries and expectation need to be set to prevent people continually being given chances for HDC - as there will be a huge waiting list of people wanting the same opportunity. *"They need to work for it"*

Within the model, it is suggested that people on longer sentences go on an intensive prison treatment programme (between 4 and 18 months) before going into supported housing on release. People on short-term sentences could go on a shorter programme in prison (6-8 weeks), before going into intensive treatment in residential rehab on release.

5 What do you think are the benefits of people accessing different kinds of treatment based on their sentence length?

6 From your own experiences, can you think of any other ways of deciding which types of treatment a client should access, other than sentence length? (e.g. levels of need, motivation and treatment readiness)

The group felt that access to treatment shouldn't be based on sentence length – but on **treatment readiness & severity of substance misuse/dependency**. It's important for there to be treatment available for all clients no matter what their sentence – but you can't force people into going through treatment when they're not ready.

- If clients who aren't ready/motivated to engage in treatment are placed in structured programmes this can disrupt the group dynamics and impact negatively on other group member's recovery.
- People on shorter sentences are more likely to reoffend (e.g acquisitive crimes such as burglary to fund addiction) so it's important they are provided with short, high impact interventions.

Suggestions to ensure process is effective:

- Peer supporters need to be built throughout the model- this aids positive behavioural role modelling. Many clients relate better to peers than staff as they've "walked in the same shoes".
 - Could run short courses/workshops (high impact, short length)- in particular for those short sentence offenders at high risk of reoffending. These can be harm minimisation based, and aimed at introducing clients to the idea of abstinence based treatment. *"Even if they don't get it the first, or second time in custody, it might stick on the third"*.
 - Peer supporters should have a presence at reception (when clients first enter prison). This will allow them to speak to clients and identify those most in need, letting them know that support is available and reducing their anxieties.

7 What issues could there be with this model of continued treatment/support in the community?

- Again, the group highlighted the importance of ensuring that clients were ready to go to rehab. It depends on the persons state of mind – if too much pressure is put on someone to get clean when they're not ready it might increase their risk of relapse.
- Importance of treatment being **optional and motivational**.

In the model it is suggested that supported housing or residential rehab should be able to help people with most of their other needs, as they leave those services (finding move-on housing, finding jobs, etc.). Because of this, most of the emphasis in the model is on drug treatment services.

8 Apart from substance misuse services, what other types of support do you think are important to meet clients' needs in an effective prison based programme?

- The group agreed that **family support** was essential. At Send, the women can access Family Ties while engaging with the long term abstinence based programme (footsteps). In particular the group reported that family support helped them with their emotional and mental health.
- **Wrap around and holistic support services** were highlighted as crucial for preparing for release. This would cover: employment, housing, life and social support such as applying for a bank account and benefits.
 - A voluntary organisation called 'Making Connections' come into Send and work with the women 1:1 prior 6 months prior to release- this support is carried on in the community. The women thought this support was excellent, and reporting it reduced their worries about release and helped them prepare for the next stage in their recovery.

Appendix 6. Forward Trust focus group – men

EPRA focus group – Male Offenders

06.03.18

Facilitated by Forward's Senior Research Officer & Head of Recovery. Group is comprised of 11 service users.

One suggestion put forward in the model is offering Home Detention Curfew (HDC) to people who graduate from prison substance misuse treatment. This means they could leave prison up to 4.5 months early, but they would have to live at a specific, suitable address for that period of time (residential rehab, or supported housing).

9 What do you think would be the benefits of having to be released to residential support?

- **Ongoing support** was identified as crucial for sustained recovery following treatment completion. The group felt that the ongoing structure and support following release would be a benefit, as it's easy to fall back and relapse if nothing is set up when they are released. *"I was released with no plan in place, and I was bang at it that same day - it was all too much"*.
- HDC offers clients an **incentive to engage** in treatment while in custody - could increase motivation.
- The pathway would be laid out, **clear and easy to access** *"it's given to you on a plate"*
- Structured intensive interventions are effective, so increasing access to more people would be positive. *"More people could have access to recovery"*.

10 What do you think would be the drawbacks about having to be released to residential support?

- Clients are already required to **report to probation** on release, some of the group felt that strict regulations in supported housing/rehab could be too much additional pressure and might put people off the model.
- Clients were concerned about **available funding** for this model. It was discussed that there would be long waiting lists of people wanting to access this model, and that clients needed clear and accurate information about the model before they engaged.
 - The group felt that not enough money was put into treatment in prisons, short term course don't really work.

Suggestions to ensure process is effective:

- The group felt it was crucial that this model was delivered on a **drug recovery wing** (dedicated wing for those clients who are going through structured treatment).
- Important that clients are **motivated and willing** to engage in treatment, ensure that people are on the programme for the right reasons.
- **Clear and comprehensive information** about ongoing support following custodial treatment should be provided (e.g leaflets of all services given at reception). Clients felt it was important this was provided when they entered custody, as well as talks from key organisations such as rehabs and supporting housing providers for those who went on structured programmes.
 - The group agreed that having a clear understanding of ongoing treatment/support options could increase motivation to engage.
- Having a short course/workshop preparing clients for release - make sure this is delivered as close to release as possible (e.g week before).

Within the model, it is suggested that people on longer sentences go on an intensive prison treatment programme (between 4 and 18 months) before going into supported housing on release. People on short-term sentences could go on a shorter programme in prison (6-8 weeks), before going into intensive treatment in residential rehab on release.

11 What do you think are the benefits of people accessing different kinds of treatment based on their sentence length?

- The group felt that rehab on release would be beneficial for those who aren't able to access intensive treatment on release, but people **need to be prepared** for it.
 - E.g group to prepare people for rehab, what to expect/what is expected of them. Clearly outlining boundaries and expectations so people have a better chance at sticking with treatment.

12 From your own experiences, can you think of any other ways of deciding which types of treatment a client should access, other than sentence length?

- The group felt that for those on short sentences, they should be offered as much intensive support as possible while in custody. *"A lot of the time, you get better access to treatment in prison than you do in the community"*.
 - If they're not able to attend longer term programmes, they should do intensive work in 1:1 key working sessions

In the model it is suggested that supported housing or residential rehab should be able to help people with most of their other needs, as they leave those services (finding move-on housing, finding jobs, etc.). Because of this, most of the emphasis in the model is on drug treatment services.

13 Apart from substance misuse services, what other types of support do you think are important to meet clients' needs in an effective prison based programme?

- **Exercise:** Those participating on the programme should be guaranteed access to the gym. Exercise and physical health is really important for people in recovery – and helps with structure and routine.
 - Access to recreational activities in custody is key for building up trust, and recovery communities. The group felt that being offered exercise activities and opportunities to socialise with their peers would benefit them in treatment and allow them to gain support – e.g help with step work.
- **Family support**
- Clear information and support around what is on offer in terms of housing and employment in the community
- More support on **mental health, as well as health and wellbeing** (e.g mindfulness and alternative therapies)

Concern: Restrictions of prison regime need to be managed as much as possible to ensure clients get consistent access to treatment and support while in custody.

- The group thought building up strong relationships with the prison and prisons guards could help this. One suggestion would be dedicated prison guards on a drug free wing who are trained to work specifically on that wing (e.g knowing when people need to be let out of their cells to attend group).
- Allowing peer supporters to be cleared to be able to move freely in the prison to collect clients to take them to group and key working sessions (would need to be agreed with the prison).

Appendix 7. Phoenix Futures focus group – men

5:00 pm, 28 February 2018, Notes of EPRA Male Meeting

Present

James Graham

Leah Hogg

11 male service users from Wirral residentials

To summarise the notes:

- Supported –
 - ✓ No OST
 - ✓ HDC tag fitted for early release
 - ✓ Prison pick-up and service drop-off
 - ✓ Graduates
 - ✓ Mix of counsellor backgrounds and experience
 - ✓ Enhanced family visits – depending on one's background

- Suggestions/important points-
 - Suggested having timed variations in HDC tag
 - Importance of current psychosocial treatment i.e. groups, recovery plan, aftercare, daily structure, regular substance testing
 - Importance of having a detailed outline of what opportunities individuals can/can't do within the project
 - Suggested having a license agreement with disengagement resulting in returning to prison to finish one's sentence as normal – need to be careful as can result in opposite of the desired effect
 - Suggested having some other incentive to replace family visits for those with poor familial relationships
 - Need to make it clear that individuals are not restricted to Phoenix Futures services

- Concerns –
 - ✗ Safeguarding
 - ✗ Wasted opportunity on uncommitted prisoners
 - ✗ Funding and cutbacks
 - ✗ Local connection issues and waiting lists
 - ✗ Do not segregate based on crime/addiction background
 - ✗ Which programme do 'lifers' or those currently remanded in custody do?
 - ✗ Some contradictory/confusing terminology

Notes

Wirral Residential Service is a 32-bed, mixed-gender rehabilitation service located in Birkenhead, Merseyside. The therapeutic community approach provides detox treatment and further abstinence-based support for both men and women with substance misuse problems, through personalised one-to-ones, group work and alternative therapies. Residents stay between 3-6 months, being responsible for the day-to-day running of the house – including caring for residents' neutered dogs living in the on-site kennels – and aiding in each other's recovery, with senior residents becoming 'buddies' for new clients. During the final stage of the programme, clients are supported in their efforts to find appropriate move-on accommodation e.g. Phoenix Future's Wirral Community Housing Service.

The meeting was held in the Ballroom, beginning with James Graham distributing the brief to each resident and then reading the document aloud for those who struggled with this task, including an explanation of work that had been done. Due to all of the attending service users being male, James decided we would not discuss the women's models, and so we explored both of the proposed men's models in turn. Each bullet point was evaluated to be either positive, negative, or needing improvement, with alternative suggestions being raised when appropriate. Clients were given the chance to debrief once the discussion had concluded. Feedback sheets where service users answered the brief's questions were returned to James after the meeting had concluded, and the summary of these can be found at the end of the notes. Some issues overlap into both models but are only critically discussed once.

To offer an insight into the lives of the residents present for the meeting, here are some statistics:

- The average age of clients who attended the meeting was 40 years old
- The average length of drug use was 20 years
- The most problematic substance being heroin
- First exposure to the above substance, and consequent offending behaviour, usually around 20 years old
- All service users were unemployed at the time of treatment commencement
- All of the residents involved have served prison sentences

The group were unsure of some of the contradictory terminology used, and suggested the following be altered to avoid future confusion:

- Does 'serving 2-5 months' mean an inmate is only legible for the short-term model if his sentence is up to 5 months, or are all inmates legible towards the end of their sentence?
 - **Clarified:** this refers to anyone with a sentence up to 5 months
- Does 'serving over 6 months' mean an inmate is only legible for the long-term model if his sentence is longer than 6 months, or are all inmates legible towards the end of their sentence?
 - **Clarified:** this refers to anyone with a sentence over 6 months, or within the last 22 months of longer sentences
- What do 'enhanced' family visits entail? Does this mean increased visits, or more choice of activities to interact with families e.g. day release to go to the local park?
- What does a 'fully segregated' rehab environment mean? How would this be beneficial?

- 'Unlocked during the day' and staffing discipline of 'protected staff allowing for liberal regime/extensive unlock' is seemingly very prison-related jargon, somewhat uninviting, and doesn't really make sense i.e. are they locked up at night? Why are you making it clear that staff are protected, and that this protection somehow allows for service user liberation, in a model proposed to soon-to-be-ex-prisoners?
 - **Clarified:** the 'Environment' box is intended to describe preferred treatment conditions in prison, based on a mixture of Drug Recovery Wing evaluations and Phoenix Futures TC visits
- 70 beds seems excessive for a rehab/supported accommodation - is this a typo or is this the total from multiple supportive house?

Men serving 2-5 months

The concept of necessary detoxification during sentence/**no OST** (Opioid Substitute Therapy) prescription was welcomed by the group as this shows motivation and dedication to the cause.

The concept of **exchanging early release for a HDC** (Home Detention Curfew) tag was greatly welcomed as this gives a positive incentive and motivation to engage with services and maintain recovery i.e. "if you want it, you've got to do something for it." This also gives a chance to settle down when knowing the consequences of returning to prison if they leave without giving this opportunity a chance, and should be a reasonable requirement for early release. However, there were concerns as to whether there would be **variations in HDC** tag type allowing natural progression through rehab i.e. 7 pm curfew at the start extended to perhaps 10 pm enabling recovery meeting attendance towards end of treatment e.g. AA, CA, NA. James stated this was a good idea but also mentioned most recovery-related events tend to be held before 10 pm, and that some service users might not be ready to go to such meetings during treatment anyway.

There were concerns about whether inmates coming directly from a prison environment would be **suitable for shared rehabilitation accommodation**, in terms of displaying appropriate behaviour that benefits both individuals' recoveries and the therapeutic community in general. James explained an assessment similar to MAPA (Management of Actual or Potential Aggression) would occur prior to enrolment into this project, and that disengagement would result in returning to prison to finish one's sentence as normal.

There were concerns that this opportunity, and so the corresponding level of funding, would be **wasted on uncommitted prisoners** giving lip service and/or keyworkers pushing harder for certain individuals to succeed even if it's not deserved. Alternatively, there were concerns that people who don't want/think they need to go to rehab would **miss a potentially life-saving opportunity** as they wouldn't be displaying selection-appropriate behaviours. In spite of this, "the penny drops" as to how dependent they are on rehab about 4-weeks into treatment for most of these cases. Therefore, it is important to give everyone equal, but fair, chances to enrol.

Following on from the issue of **funding**, there were concerns as to how individuals would acquire finances in order to access this opportunity. James explained that people would need to be actively and positively engaging with a treatment provider, such as Phoenix, to even be considered for funds. Regardless, there were concerns in relation to funding **cutbacks** and some uncertainty that this project would even happen due to a perceived shift in sector focus from community aid to prison aid, meaning those currently in rehab may fall by the wayside and that their hard work might be for nothing. James then explained the concept of and opportunity for bursaries.

The group assumed that funding and treatment would end in conjunction with release dates, and so were concerned that individuals **might not be ready to leave** rehab or have their tag removed by this time, thus potentially undoing all the hard work and restarting the cycle. James validated these concerns but reassured that such factors may be affected by individual circumstances, meaning funding and treatment might be extended if required.

There were concerns regarding **Local Connection Issues** i.e. a postcode lottery affecting levels of funding and limiting possible access to services local to either one's hometown or prison. This then led to concerns about **waiting lists** – whether prisoners jump to top of list due to impending end of sentence thus disadvantaging those in the community, or if there will be specialist services dedicated solely to this cause.

There were concerns that the proposal doesn't state what **specific psychosocial treatment** prisoners will experience during their sentence or what competent skills they will leave with i.e. will this model allow ex-inmates to confidently manage the requirements and environment of a rehabilitation centre? Regardless, the group stressed the **importance of having such supportive psychosocial provisions to aid recovery**, as this information allows individuals to make well-informed decisions later in life. These provisions essentially need to include **signposting** from keyworkers during and after rehab in order to maintain recovery as sometimes "you think you're ready to face the outside world, but you're definitely not."

It was also stressed that creating a **fully supportive care plan** of individual actions from prison through to rehab, prior to plan implementation, thus allowing everyone involved to know where they stand at each step and where development is required. It was assumed this would be a fundamental part of one's psychosocial treatment, as well as group interventions. The group fully **supported the concept of groups**, stating they should remain a major part of the programme as these definitely help service users on their recovery journey.

The group **did not deem it necessary to have diploma-level counsellors** as having a balance of both qualified and unqualified persons provides a mix of experience and relatability, increasing recovery potential.

The concept of **enhanced family visits** (in this context, the group assumed this meant increased number of visits) would benefit some, but not all, individuals depending on one's background. Perhaps some other similar initiative could be formulated for these people.

The group **fully supported the concept of 'graduates'** from the project taking on roles within the prison as peers to help those currently enrolled in the scheme. This would provide a constant deterrent from graduates relapsing and give a confidence boost/inspiration for current inmates i.e. "it's possible!" It was suggested that the programme could introduce the possibility of **graduates remaining in supported housing** for longer period if agree to do this, or some other/similar incentive.

There were concerns that that **only Phoenix Futures services would be available** for this opportunity. James explained that a variety of services would be on offer including therapeutic community, Christian facilities, Alcoholics Anonymous etc... meaning individuals were at liberty to choose the most beneficial service for them. Great importance was placed on **making it clear that individuals can choose** to enrol into treatment programmes they deem most beneficial to them, and how often these would run, before fully committing to these in a release plan. James agreed with these points and stated only accredited programme options would be available e.g. CGL's Foundation for Change, and so would all provide prosocial returns depending on individual requirements.

The group **did not deem it appropriate to segregate** those in rehab whose substance misuse developed solely in the community from those with a dependency fuelled by recent prison experiences. There were concerns that ex-prisoners would be **segregated based on the crimes** they had committed or that some major offences/**factors would completely prevent access** to the project. There was unease from both parties regarding this issue i.e. those who served minor sentences worried about safeguarding and those who served major sentences worried about limited recovery potential. James stated there would most likely be no segregation of that kind and that insurance issues may possibly affect the level of service accessibility.

Men serving over 6 months

Regarding the legibility of inmates, there were concerns as to **what would happen to 'lifers', or those currently remanded in custody** with an indeterminate release date. James agreed these were valid questions, and suggested that part of one's parole may be preparing for this project opportunity.

It was suggested that having a **license agreement** as part of conditions of release/programme e.g. complying with HDC, not allowed to isolate etc... would motivate treatment continuation, and individuals must return to complete their sentence in prison if fail to meet parameters. However, there were concerns that **such measures are beneficial to a point but can result in the opposite of the desired effect** i.e. forcing recovery potentially causes backlash of relapse.

The group stressed the importance of having a **daily structure**, including weekly groups to prevent relapse and uphold maintenance, and a sponsor/keyworker to support individuals going to meetings, doing daily activities, psychosocial provisions etc... during their time at supported housing i.e. meaningful use of time. Furthermore, the need for **regular testing/breathalysing** in supported housing was stressed in order to keep service users motivated and maximise potential benefits i.e. no undesirable behaviour affecting others' recoveries.

The group fully **supported the concept of prison pick-up and direct transport to rehab/supported housing**, as this prevents the opportunity to relapse and ensures you actually turn up to the relevant service in accordance with your release plan. Furthermore, **HDC fitting on arrival** to accommodation was approved as this prevents partying thus allowing for evaluation of one's future.

The group stressed the importance of **aftercare** and having a **release plan prior to leaving** prison/supported housing, so people understand what is expected of them i.e. what they're agreeing to, and can keep stimulated during 'normal life' to decrease the risk of relapse or reincarceration. This planning needs to explore the multitude of options available e.g. training, education, voluntary work, during one's prison sentence so that people have some structure at release - inmates may require some day release to attend.

Concerns

What have we missed?

- Ensuring that the correct people are selected for this opportunity as this approach won't be for everyone and could waste monies that could be used for others' benefit.

Are there other things that you think are important?

- Daily structure within housing services; having a release plan and appropriate aftercare set up for those going straight into supported housing so there is reduced chance of relapse and a set of expectations/understanding of what people are signing up to; opportunity for and support with move-on accommodation.

We have suggested that people must be released to residential support (residential rehab or supported housing) on release, as this improves their chances of getting HDC and (we think) more treatment is likely to be better. **What about people who want to return to their families?**

- For those who wish to return to their families but not pass up this opportunity, could potentially have AA, NA, SMART Recovery etc... meetings could be undertaken in the evenings; possible weekend rehab engagement if working full-time during the week; possible weekday rehab attendance and return to family during evening and at weekends.

We have suggested people should access different kinds of treatment based on how long their sentence is. **Are there other ways we could / should do this?** Levels of need (so people with supportive families or jobs to go to might be reluctant to go to residential rehab).

- Time served doesn't predict if someone is ready for rehab or housing, this is dependent on the person being motivated and willingness to change – which is more important than sentence length – so both models may suit different people irrelevant of sentence length. It is nigh on impossible to accurately measure these factors due to complexity of multiple issues but some service users felt they were able to judge this readiness themselves in prison.

We have suggested that residential support acts as people's HDC address, following release. But this means that they might be recalled to prison if they drop out of treatment. **Is this ok?**

- **Yes** as this would give a positive incentive and motivation to engage with services and maintain recovery i.e. "if you want it, you've got to do something for it", a chance to settle knowing the consequences if they leave without giving this opportunity a chance, and should be a reasonable requirement for early release.

We have suggested that supported housing or residential rehab should be able to help people with most of their other needs, as they leave those services (finding move-on housing, finding jobs etc...). Because of this, we have put most of our emphasis on drug treatment services. **Are there other kinds of support that need to be there, earlier on?** (We have enhanced family visits; what else?)

- Need to explore the multitude of options available e.g. training, education, voluntary work, during prison sentence so that people have some structure at release – may need some day release to attend.

Appendix 8. Phoenix Futures focus group – women

10:10 am, 7 March 2018, Notes of EPRA Female Meeting

Present

Kelly Butcher

Leah Hogg

3 female service users from the Grace House women's only residential.

To summarise the notes:

- Supported -
 - ✓ No OST
 - ✓ HDC tag fitted for early release
 - ✓ Prioritising mental health provisions over clinical methods
 - ✓ Evidence-based, theoretically-informed, and cohort-based intervention
 - ✓ Graduates
 - ✓ Trauma-aware counsellors with mix of backgrounds and experience
 - ✓ Group interventions
 - ✓ Prison pick-up and service drop-off, and subsequent accompaniment to first appointments, by a familiar face
 - ✓ Segregation
 - ✓ Enhanced family visits
 - ✓ Clear abstinence-based community interventions
 - ✓ Structured diagram layout showing clear recovery journey
- Suggestions/important points -
 - Suggested having a license agreement with disengagement resulting in returning to prison to finish one's sentence as normal
 - Importance of all staff have an understanding of and ability to deal with the causes, symptoms, and consequences of trauma-related events – regardless of qualifications
 - Important to consider the adverse effects of male staff on women in prison
 - Suggested employing 'Recovery through' series for inmates with poor familial relationships to replace enhanced family visits
 - Importance of being supported by a familiar face throughout resettlement into local community, and readjustment to 'normal life'
 - Suggested providing individuals returning to families with informative leaflets to ensure recovery maintenance

- Suggested giving individuals enrolled on long-term programme the option to go to rehab instead of being channelled straight into supported housing
- Suggested employing ILLY-type system to ensure consistency and continuity of care through one's prison experience
- Suggested other kinds of support required early on could include one-to-one keyworks, financial advice, and health screenings
- Concerns -
 - ✗ The 6-8 week programme in the short-term model would not allow enough time to build a decent relationship between keyworker and inmate
 - ✗ The impact of resettlement, and related issues, on service users' children
 - ✗ Some individuals may not want to go straight to appointments on their first day out
 - ✗ Further psychological provisions required throughout aftercare
 - ✗ Individuals returning to families immediately post-release may struggle with the lack of professional guidance and support

Notes

Grace House is a 10-bed, female-only, residential rehabilitation service located in Camden, London. The therapeutic community approach provides abstinence-based support for women with substance misuse problems and complex needs, through personalised one-to-ones, group work and alternative therapies – all while residents are responsible for the day-to-day running of the house and aiding in each other's recovery. Residents stay between 12-24 weeks, gaining more independence and developing life skills as their time progresses. During the final stage of the programme, clients are supported in their efforts to find appropriate move-on accommodation e.g. The Amy Winehouse Foundation's Amy's Place.

The meeting was held in the group room, beginning with Kelly Butcher reading through and discussing both of the female models in turn – only this gender was considered due to the nature of the service and its users – including an explanation from Leah Hogg of work that had already been done. Each bullet point was evaluated to be either positive, negative, or needing improvement, with alternative suggestions being raised when appropriate. Clients were given the chance to debrief once the discussion had concluded. Feedback to some of the brief's questions are contained within the main content of this document, and some issues overlapping into both models are only critically discussed once.

To offer an insight into the lives of the residents present for the meeting, here are some statistics:

- The average age of clients who attended the meeting was 37 years old
- The average length of drug use was 23 years
- The most problematic substance being alcohol
- First exposure to the above substance usually around 13.5 years old
- The average length of time spent in Grace House was 124 days
- Residents have between one and three children in various states of social care
- However, it is important to note that none of the residents involved have served prison sentences so observations may be limited, or biased, by lack of experience

Women serving short sentences

The concept of necessary detoxification during sentence/**no OST** prescription was welcomed by the group as this:

- shows motivation and dedication to the cause through sacrificing a long-term coping mechanism for new sustainable, therapeutic methods
- has the potential to become another addiction e.g. painkiller dependency
- prevents full engagement with the programme as mind, body, and soul are “fuzzy”
- alternative medications can provide the same relief
- provides motivating opportunity to give credit to individuals that are able to reduce OST prescriptions

The concept of **exchanging early release for a HDC** (Home Detention Curfew) tag was greatly welcomed as this gives a positive incentive and motivation to engage with services and maintain recovery.

The group supported the concept of **prioritising mental health provisions** over clinical methods, as the coping skills developed during counselling sessions are more sustainable in the long term. Furthermore, individuals willing to face their emotions rather than misuse substances, or continue their OST prescription, show **true commitment to recovery**.

There were concerns that the 6-8 week programme in the short-term model would **not allow enough time** to build a trusting relationship between keyworker and inmate, or enable individuals to develop a competent skill set that can later be used in rehabilitation and ‘normal life’ settings. This **inconsistency could be detrimental** to women’s mental health and thus prevent superlative engagement with the programme.

The programme being an **evidence-based**, theoretically-informed, cohort-based intervention provided the group with comfort that current prisoners would not be ‘guinea pigs’ whose recovery may be affected by scientific experimentation. Moreover, the group agreed that **constructive feedback** once the initiative is utilised allows for constant development of the treatment programme, thus optimising recovery potential for future enlisted inmates.

The group **fully supported the concept of ‘graduates’** from the project taking on roles within the prison as peers to help those currently enrolled in the scheme. This would improve graduates’ self-esteem and confidence levels, prove someone has trust in these individuals, and provide good role-models for current prisoners.

It was suggested that having a **license agreement** as part of conditions of release/programme enrolment e.g. active engagement with programme, full attendance and concentration during groups, respecting boundaries etc... would motivate treatment continuation, with individuals being required to return to complete their sentence in prison and have their HDC tag removed if fail to meet parameters. Said parameters may be measured through the number of push-ups and pull-ups service users give and receive.

The group **fully supported the concept of employing trauma-aware counsellors**, although these staff do not all need to hold diploma-level qualifications as the combination of relatable and professional backgrounds affords recovery synergy. Furthermore once treatment has concluded, ex-service users will be well-practised in interacting with a range of personalities and perspectives, hence will be more able to competently integrate back into the community. However, it is important that **all staff have an understanding** of and ability to deal with the causes, symptoms, and consequences of trauma-related events such as domestic violence, post-traumatic stress disorder, self-harm, eating disorders, and panic attacks.

The group **fully supported the concept of groups**, stating this promotes prosocial behaviour, intellectually challenges

individuals, and starts preparing prisoners for the full daily structure of rehabilitation – a huge contrast to spending up to 23 hours per day in one’s cell, yet another motivating reason to attend group intervention sessions.

There were concerns as to the **wider impact of resettlement**, and other related factors, on service users’ children as this inconsistency could be detrimental to their development, and potentially lay the foundations for offensive behaviours in the future.

The group fully **supported the concept of prison pick-up and direct transport to rehab/supported housing**, as this provides a level of support during a difficult relocation and readjustment period. However, it is important that the pick-up is performed by someone the individual has met before who knows how to deal with personal crises e.g. panic attacks. This **familiarity** facilitates the development of a trusting, supportive, and respectful relationship between community staff and service user. Furthermore, having the **same member of staff accompany residents to essential first appointments** provides some relief to rehab staff, allowing for focus on more urgent matters, and immediately establishes continuity of care – something that is hard to arrange independently from within prison.

Albeit, there were concerns that some individuals may **not want to go straight to appointments** on their first day out of prison but might instead want to do things to make them feel more ‘human’ e.g. buying essentials. Regardless, it is important to have this **support system** in place during such a hugely vulnerable time following long-term abstinence and non-exposure to the wider world, as the chance of relapse is highly likely.

It is important to consider the **adverse effects of male staff** on women in prison – most of whom have had negative experiences with men throughout their lives – during interactions on the wing or in specific groups, which may trigger unfavourable emotional responses. Moreover, members of staff present for such incidents need to be **trained in how to support individuals** through triggered episodes during relevant group interventions or through carrying out check-ins at another time if said episode is not related to the group topic. This is so nothing is taken away from other service users attempting to progress on their journey.

The group fully **supported the concept of segregation** on the wings from prisoners not enrolled in the programme, as this provides confidentiality and a safe space to become fully immersed in one’s treatment programme and subsequent recovery.

Women serving over 6 months

Due to being unsure as to what **enhanced family visits** entail, the group made some of their own suggestions as to what this could mean – such as longer interaction times, more frequent visits, more private and intimate settings i.e. no screen. However, one’s family and/or kids may be a **greatly motivating factor** during a long-term sentence and consequent abstinence, and also allows for reconnecting/re-establishing relationships with close friends. Although for those inmates with poor familial relationships who would not benefit from this proposal, it was suggested that the **‘Recovery through’** series i.e. nature, sports, arts, could be improved to: provide an opportunity to get out of one’s cell; be a motivating factor to recover; enhance physical and mental health; and may present potential career paths post-release.

The group fully **supported the concept of having clear abstinence-based community interventions** to uphold one’s commitment to recovery and aid in ‘normal life’ goal completion, such as advice in gaining full time employment.

The group reiterated the importance of having a **familiar face** supporting those going straight into supported housing immediately following release. This is to allow the smoothest possible transition into the local neighbourhood, and to start that all-important connection with members of the community in order to build a network of long-term provisions and assistance.

There were concerns that **further psychological provisions** would be required throughout aftercare in order to maintain recovery and allow optimal reintegration back into the community following a long period of institutionalisation. These provisions could include bereavement counselling, life skills training, a dedicated social worker to explain rapid changes in modern life, and a 'starter kit' including information regarding the local area such as locations of food shops, benefits offices, banks, walks, recovery meetings etc...

There were concerns that **individuals returning to families immediately post-release may struggle** with the lack of professional guidance and support, and so may be more likely to reoffend. Although it was suggested that **informative leaflets** could be provided to these persons during discharge from prison, directing them to local long-term community weekday programmes or initiatives like Samaritans, and also to their families, advising them what to do both on a daily basis and during crises. This is to ensure the highest possible level of support, somewhat equivalent to that administered in supported housing, is accessible to ex-prisoners and their close relations.

On the other hand, it was suggested individuals enrolled on the long-term programme should be **given the option to go to rehab** and be given chance to reintegrate in their own time, rather than be channelled straight into supported housing without first experiencing a full and well-structured regime. However, advice regarding all types of move-on accommodations can be communicated but ultimately the person makes this decision for themselves.

The group appreciated the **structured layout** of the diagram that shows the **clear recovery journey** service users and their keyworkers would endure, where inmates would be treated as equals with all relevant bodies working towards the same aims in individuals' care plans. It was suggested employing an **ILLY-type system** to ensure consistency and continuity of care throughout one's prison experience.


Regarding the end-of-brief questions, the group suggested that **other kinds of support required early on** could include: full one-to-one keyworks in prison to enable adjustment to this type of session and an opportunity for confidential expression; financial advice e.g. Citizens Advice Bureau debt repayment plans; and health screenings e.g. CLASH, vaccinations.





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