

Rapid review

Drug treatment in UK prisons. Treatment need, and treatment effectiveness

Ex-Prisoners Recovering From Addiction (EPRA)

Supporting Paper 1

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Introduction

This paper draws on a rapid review of the literature to provide an overview of evidence relating to levels of treatment need within the criminal justice system; and the efficacy of existing interventions and treatment models.

1. Levels of need

Drug use before prison

Several large-scale UK surveys have asked prisoners retrospectively about their levels of drug and alcohol use prior to being imprisoned. These have consistently identified high levels of any last-year illicit drug use, with figures clustering between 66 and 73 per cent¹.

In each study, cannabis has been the most widely used drug, used by between 38 and 65 per cent of prisoners in the preceding year². Surveys have also identified considerable variations in cannabis use in specific subgroups, with Liriano and Ramsay identifying 81% of young prisoners had smoked cannabis in the previous year³; and Singleton and Ramsay identifying male remand prisoners as particularly prone to pre-custodial cannabis use (63%) with relatively low rates in sentenced women (42%)⁴.

These studies have identified strikingly consistent levels of pre-custody heroin use, with two identifying 31% of prisoners had used heroin in the preceding year⁵, and a third identifying levels that varied between 21% (male sentenced prisoners) and 46% (female remand populations)⁶. A notable exception was an HMIP survey of 1,218 prisoners, which found that just fifteen per cent of interviewees had used heroin in the two months before they were imprisoned⁷.

¹ Singleton *et al.*, 2001:20; Liriano and Ramsay 2003; Stewart 2009. A notable exception to this cluster is Singleton *et al.*'s finding that only 55 per cent of women prisoners had used an illicit drug in the preceding year (2001:20).

² Liriano and Ramsay 2003:14; HMIP 2015:28

³ 2003:14

⁴ Singleton *et al.*, 2001:20

⁵ Liriano and Ramsay 2003:13; Stewart 2009; Newbury-Birch *et al.*, 2016:60

⁶ Singleton *et al.* 2001:20

⁷ 2015

Finally, approaches to assessing pre-custodial levels of drinking have varied; but have consistently identified considerable levels of problematic alcohol use. Between 11-43 per cent of prisoners appear to be very problematic or dependent drinkers before entering custody⁸, with between 58 and 81 per cent of male prisoners drinking hazardously prior to being imprisoned⁹. Where studies have distinguished remand from sentenced populations, remand prisoners have tended to evidence greater levels of dependency – approximately 34%, in two recent studies¹⁰. Equally, where studies have included both men and women, women have tended to show a considerably less problematic relationship with alcohol, with between 8-14% showing signs of probable dependence¹¹.

Prisoners: changes in drug use, 1990-2016

In turning to evidence related to drug use in prison (rather than in the period before imprisonment), it is important to acknowledge that patterns have shifted over time, often in response to control measures. Firstly, the introduction of mandatory drug tests is seen as being at least partly accountable for a shift from cannabis to heroin use in the mid-1990s¹². Secondly, the relative ease of avoiding traditional control methods by importing and using Novel Psychoactive Substances (NPS) has been seen as part of the reason that these drugs have recently become widespread in prisons, even as their popularity has diminished in the community¹³.

A third important shift took place in the mid-2000s, when new Department of Health prescribing guidelines¹⁴ identified an expectation that opiate-dependent prisoners likely to spend less than six months in prison should expect opioid maintenance prescribing. In prisons with large populations of short-sentenced individuals, this was associated with an upsurge in

⁸ 13% of 13,094 respondents to standard HMIP surveys identified that they had an alcohol problem before prison (HMIP 2015); Kissell *et al* identified 27 per cent of 257 male remand prisoners as having AUDIT scores of over 20, which they took to signify alcohol dependence (2014); and between 11% (female sentenced) and 17% (male remand) prisoners in Singleton *et al*'s review of psychiatric morbidity in prison were identified as having AUDIT scores of over 24 (2001:20).

⁹ Singleton *et al.*, 2001:20; Kissell *et al.*, 2014.

¹⁰ Lader *et al.*, 2000; Parkes *et al.*, 2011.

¹¹ Parkes *et al.*, 2011; Singleton *et al.*, 2001:20

¹² e.g. Crewe 2009; Wheatley 2007

¹³ e.g. CSJ 2010; RAPt 2015

¹⁴ DH 2006

the availability of prescribed opioids¹⁵, with diverted buprenorphine sometimes becoming both a considerable security problem and prisoners' drug of choice in preference to heroin¹⁶.

Such shifts in drug use limit the applicability of historical studies, and this problem is further exacerbated by the infrequency of studies – with some of the more robust surveys having been undertaken in the 1990s. Throughout this section, these limitations should be borne in mind.

Alcohol is also an occasional problem in prisons. A 2014 MoJ survey identified that 17% of prisoners had drunk alcohol whilst in custody¹⁷. HMIP reports also identify alcohol availability as a particular problem for some prisons¹⁸.

Remandees' levels of drug use

Remand populations tend to evidence higher levels of need than sentenced prisoners¹⁹, and this problem is further complicated by the challenging context of remand. Three-fifths of remandees will be sentenced to imprisonment²⁰; yet as they are not sentenced, interventions cannot form part of their sentence plan. Additionally, remandees spend an average of just 9-10 weeks before being sentenced or acquitted²¹. Most of those who are sentenced are then allocated to other prisons, whilst those who are released can access no financial or resettlement support²². For both groups, the brevity of their stay makes it very hard to access or complete interventions, which are routinely reserved for sentenced prisoners²³. Though some providers have sought to address this gap in provision²⁴, this remains an underserved population with acute levels of need.

The national review of psychiatric morbidity in prisons identified notable levels of cannabis (19% female; 36% male) and heroin (17% female; 12% male) use in imprisoned remand

¹⁵ Hansard, 3rd December 2012: c666W

¹⁶ Chelmsford 2013; Lloyd *et al.*, 2014

¹⁷ Barrett 2014. NB: this is a Telegraph article, citing findings from an MoJ survey that we have been unable to directly source.

¹⁸ e.g. Gartree's inspectorate report documented 38 finds of illicit alcohol in the preceding six months (HMIP 2014:21).

¹⁹ Singleton *et al.*, 2001:20; Newbury-Birch *et al.*, 2016:60; Graham *et al.*, 2012

²⁰ Hansard, 11 July 2011, c76W

²¹ Prison Reform Trust 2011; Watt 2016

²² Prison Reform Trust 2011; House of Commons Work and Pensions Committee 2016

²³ Newbury-Birch *et al.*, 2016.

²⁴ E.g. RAPT's Stepping Stones is available to both remandees and sentenced prisoners; and a consortium from the Universities of Teesside and Edinburgh are developing an alcohol brief intervention specifically targeting remandees.

populations, with 5% of women remandees also identifying that they had smoked crack²⁵. Of greater concern, approximately 40% of those who had used crack or heroin in prison identified that they had never used these drugs before they were imprisoned²⁶.

Sentenced prisoners' drug use

Surveys of prisoners' drug use tend to reflect the trajectory described earlier. Early studies (sampling between 1997 and 2009) found very high levels of cannabis use (22-41%²⁷), alongside somewhat more moderated levels of heroin use (14-20%²⁸). Levels of other drug use were more moderated – though Singleton *et al.* did find that 5% of sentenced men and 8% of sentenced women used crack whilst imprisoned²⁹.

More recent evidence adds complexity to this picture. A consistent decline in Mandatory Drug Tests (MDTs) showing positive for opiates can be traced from 2007 to 2011, from over 7,000 to approximately 2,000 per year³⁰. Whilst MDTs are an imperfect measure of drug use in prisons³¹, the decline in positive tests has been matched by a decrease in heroin seizures, from 1,365 in 2002 to 330 in 2011³². Concurrently, a very substantial increase in the availability of OST prescribing – and maintenance prescribing more specifically – has provided one strong rationale for a decrease in heroin use³³. In the five years from 2007-12, maintenance prescribing nearly tripled (from 12,158 to 33,198 treatment episodes), whilst detoxification dropped by one third (from 46,291 to 31,178 treatment episodes) (see Table 1)³⁴.

²⁵ Singleton *et al.*, 2001:20.

²⁶ Boys *et al.*, 2002:1554

²⁷ Singleton *et al.*'s late-1990s survey of psychiatric morbidity in prisons identified 36% of sentenced women and 41% of sentenced men had used cannabis whilst imprisoned (2001:20); the SPCR survey found 22% of sentenced prisoners had used cannabis during their sentence (Hopkins and Brunton-Smith, 2014). A notable outlier is Bullock's (2003) report of Liriano and Ramsay's (2003) sample, which were clearly highly drug-involved: 82% had used heroin before being imprisoned. Here, 54% identified that they had used cannabis during their sentence (Bullock, 2003).

²⁸ Singleton *et al.*'s late-1990s survey of psychiatric morbidity in prisons identified 20% of sentenced women and 19% of sentenced men had used heroin whilst imprisoned (2001:20); the SPCR survey found 14% of sentenced prisoners had used heroin during their sentence (Hopkins and Brunton-Smith, 2014). A notable outlier is Bullock's (2003) report of Liriano and Ramsay's (2003) sample, which were clearly highly drug-involved: 82% had used heroin before being imprisoned. Here, 27% identified that they had used heroin during their sentence (Bullock, 2003).

²⁹ 2001:20

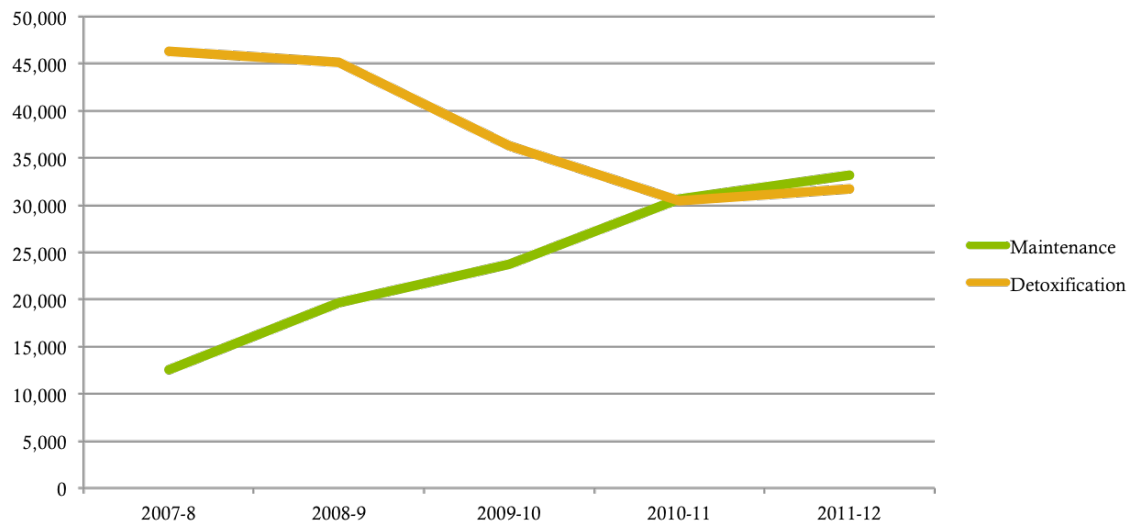
³⁰ Hansard, 3rd December 2012: c666W

³¹ Singleton *et al.*, 2005

³² Hansard, 3rd December 2012: c666W

³³ National Treatment Agency 2013; Department of Health 2006; Department of Health 2010

³⁴ Hansard 3rd December 2012: column 667W



A second rationale for declining heroin use can be found in another cluster of studies. The use of diverted OST in preference to heroin has been increasingly apparent, with the Surveying Prisoner Crime Reduction study of 1,457 UK prisoners identifying approximately 8% had used diverted opioid medication during their sentence³⁵. Additionally, emerging research highlights the increasing availability and use of NPS³⁶. A 2014 HMIP survey identified that 10% of prisoners disclosed that they had used drugs whilst imprisoned³⁷, though anecdotal evidence from prison officers and staff³⁸, deaths in prison³⁹, and small-scale qualitative evidence suggests this might be an underestimate⁴⁰. The Centre for Social Justice noted that seizures of NPS had risen from just 15 in 2010 to an estimated 737 in 2014⁴¹.

In terms of traditional drug use, Boys *et al*⁴² added considerable narrative to patterns of usage, identifying that those who identified lifetime use of a drug were very likely to continue using it whilst imprisoned. Levels of continued use varied: 64% of pre-custodial cannabis users used the drug whilst imprisoned; 61% of heroin users had also used in prison; as had 24% of crack users⁴³. The extent to which this reflects patterns of use for NPS and diverted medication may be more open to question; the specific drivers for using these drugs are intimately tied to the

³⁵ Cleary *et al.*, 2012; Hopkins and Brunton-Smith 2014

³⁶ CSJ 2015:10

³⁷ HMIP 2014; RAPt, 2015

³⁸ PHE 2014

³⁹ Prisons and Probation Ombudsman 2016

⁴⁰ e.g. Ralphs *et al.*, 2017; PHE 2014; Change, Grow, Live 2016

⁴¹ CSJ 2015:10

⁴² 2002

⁴³ Boys *et al.*, 2002:1555

prison context, and so less continuity of use between prison and the community might be expected.

2. Drug treatment in prisons

Overview

Broadly speaking, drug and alcohol interventions fall into two categories: clinical, and psychosocial. The following section reviews the operational models of and evidence for OST provision, psychosocial and clinical work (CARATs and IDTS); and specific interventions and programmes.

Clinical interventions

OST

The current context for OST prescribing in prisons has been shaped by the powerful association between opioid dependency and a greatly elevated risk of overdose in the weeks following release. Reviewing data from 48,771 UK prison releases in 1998-2000, Farrell and Marsden found that ‘relative to the general population, male prisoners were 29 times more likely to die in the week following release, while female prisoners were 69 times more likely to die during this period’⁴⁴. Overwhelmingly, excess deaths were attributable to opioid toxicity⁴⁵. Averting this elevated risk of death continues to be cited as a robust, *prima facie* rationale for prison-based maintenance OST⁴⁶, though the research evidence for its efficacy is mixed. In a data linkage study of Australian released prisoners, Degenhardt *et al* found that post-release community prescribing reduced mortality by 75%; but the impact of prison prescribing was small (though independent)⁴⁷. Bird *et al* conducted a similar data linkage review of released prisoners in Scotland, comparing periods before (1996-2002) and after (2003-2007) the introduction of prison-based OST. Their findings resembled those of the Australian study, with a significant reduction in deaths over the first twelve weeks; but not over the first 14 days⁴⁸. The authors note that this is most likely to reflect changes in community prescribing, as the protective effect of prison-prescribed OST is likely to be short-lived⁴⁹.

⁴⁴ 2008:254

⁴⁵ Farrell and Marsden 2005:41

⁴⁶ Patel 2010:21; WHO 2010:8; DoH and Addaction 2004:11

⁴⁷ 2014

⁴⁸ Bird *et al.*, 2015

⁴⁹ Bird *et al.*, 2015

OST prescribing in prisons has also been associated with other gains – most notably, small reductions in post-release drug use⁵⁰, and drug-related risk behaviours⁵¹

There have been no evaluations of the impact of prison-based OST prescribing on broader recovery outcomes.

Models of OST management: concentration vs dispersal

The DRW evaluation and HMIP summaries of prisons’ residential locations demonstrate that prisons implement different models for housing prisoners receiving OST. In some prisons, virtually all individuals receiving OST and / or undergoing clinical detoxification are housed in a single location. Perceived benefits of this model include economies of scale, as dispensing resources can be concentrated, and medication queues can be processed more efficiently⁵². Seeking to confine all opioid medication to one residential unit can also have perceived security advantages, restricting the availability of illicit medication elsewhere⁵³. Contrastingly, other prisons seek to follow a ‘dispersal’ model, housing clients receiving OST (in particular) on all locations. Staff involved in delivering this model felt that dispersal offered considerable security advantages, as it avoided the ‘deviancy amplification’ that might arise from concentrating all drug users in one location⁵⁴.

Psychosocial delivery: CARATs and IDTS

CARATs

CARATs (Counselling, Assessment, Referral, Advice and Throughcare) teams were established in prisons throughout England and Wales in 1999⁵⁵. They were intended to provide a robust baseline of psychosocial support for prisoners with drug problems passing through the prison system⁵⁶.

⁵⁰ Mitchell *et al.*, 2012

⁵¹ Hedrich *et al.*, 2011

⁵² Lloyd *et al.*, 2014

⁵³ Lloyd *et al.*, 2014

⁵⁴ Lloyd *et al.*, 2014

⁵⁵ May 2005:1

⁵⁶ May 2005:1;

As with the 300 mental health nurses described by the Director General of the Prison Service as ‘the cavalry coming over the hill’ to resolve problems with mental health care in prisons⁵⁷, CARAT teams were often understaffed, overwhelmed by prisoners’ levels of need, and sometimes struggled to deliver even basic initial assessments and adequate onward referrals⁵⁸. No impact evaluations of CARATs were commissioned or delivered. The sole Home Office research paper on CARATs was descriptive, identifying that CARAT caseloads were growing very rapidly at the start of the millennium, and that most CARAT clients had histories of heroin dependence, were arrested for acquisitive offences, and were serving short sentences⁵⁹. A small-scale qualitative evaluation identified considerable variation in practice across sites⁶⁰, and routine failures in throughcare⁶¹. Prisoner interviewees expressed particular concerns about the lack of contact with CARAT workers, and the lack of resettlement support⁶².

Combined intervention: The Integrated Drug Treatment System (IDTS)

IDTS was rolled out to English prisons in stages, beginning in 2008-9⁶³. The initiative seeks to ‘increase the volume and quality of treatment available to prisoners, with particular emphasis on early custody, and will start to address better integration between clinical and CARAT services’⁶⁴. Whilst one substantial process evaluation of IDTS has been conducted⁶⁵, it has yet to be published. There are no known publications focusing on the impact of IDTS, or on broader recovery outcomes.

Psychosocial interventions

Accredited programmes

Accredited programmes were introduced following a shift towards ‘What Works’ approaches to interventions in the early 2000s⁶⁶. Programmes are required to follow the core principles of ‘third generation’ risk management⁶⁷, targeting specific dynamic risks with interventions

⁵⁷ Brooker and Ullman 2008:13

⁵⁸ ICPR 2007:11; Fox *et al.*, 2005:7; Page 2013:245

⁵⁹ May 2005:3

⁶⁰ Harman and Paylor 2005:362

⁶¹ Harman and Paylor 2005:369

⁶² Harman and Paylor 2005:363

⁶³ HMP High Down 2009:1

⁶⁴ NTA 2011:1

⁶⁵ NatCen 2014

⁶⁶ Hollin and Palmer 2006:11-12; Cann, Falshaw and Friendship 2005:166

⁶⁷ e.g. Andrews 1989:4; Maden 2007:94

constructed according to evidence-based principles. Such programmes are ‘accredited’ by the Correctional Services Accreditation and Advisory Panel (CSAAP), and (arising from the requirement for consistency and an evidence-based methodology) – are often cognitive-behavioural in content, and heavily manualised⁶⁸. There are some notable exceptions to this model – including Therapeutic Communities (TCs), and RAPt’s long-term and twelve-step programmes (these are addressed separately – see below).

Between 2009-14, twelve accredited programmes were delivered in English and Welsh prisons⁶⁹. One of these ceased operations in 2009⁷⁰, and only limited operational data relating to the other programmes has been published. This may be largely due to responsibility for the delivery of psychosocial programmes shifting from NOMS to the Department of Health in 2011: in the year following 2011-12, the number of prisoners recorded as starting substance-related accredited programmes more than halved⁷¹; and this figure has continued to fall to levels that are unlikely to offer an accurate reflection of provision on the ground⁷².

We conducted a brief review, looking for peer-reviewed papers focused on any of the eleven operational accredited programmes. With the exception of RAPt and TCs (presented below), we identified only one study. Bowes *et al.*⁷³ conducted a randomised control trial to explore psychometric change and post-release outcomes in prisoners undergoing Control of Violence in Angry and Impulsive Drinkers (COVAID). A total of 115 prisoners were recruited, and allocated to COVAID or treatment or usual. Intermediate outcomes identified some improvements in COVAID participants’ perceived ability to control their own drinking, and qualified reductions in their associations between alcohol and violence⁷⁴. PNC matching following release identified a significant reduction in any offending over the subsequent year (20 per cent less than TAU), but no significant reduction in violent offending⁷⁵.

⁶⁸ e.g. Hannah-Moffat 2005; Cann, Falshaw and Friendship 2005:166; Porporino and Fabiano 2000; Clark, 2000

⁶⁹ Alcohol Related Violence; Building Skills for Recovery; Control of Violence for Angry and Impulsive Drinkers; FOCUS; Prison – Addressing Substance Related Offending; Prison Partnership Therapeutic Community Programme; RAPt 12 Step Alcohol Dependency Treatment Programme; RAPt 12 Step Substance Dependence Treatment Programme; Short Duration Programme; Substance Treatment and Offending Programme; and the Bridge (source: Ministry of Justice, 2016).

⁷⁰ Substance Treatment and Offending Programme (source: Ministry of Justice 2016)

⁷¹ New starters on substance-related accredited programmes in 2010-11: 9,402; 2011-12: 8,139; 2012-13: 3,748; 2013-14: 1,120; 2014-15: 921 (MoJ 2016).

⁷² MoJ data indicates that there were just 921 people commencing substance-related accredited programmes in 2014-15, with no new starters for seven of the eleven operational programmes.

⁷³ 2012; 2014

⁷⁴ Bowes *et al.*, 2012:338-339

⁷⁵ Bowes *et al.*, 2014:157

We identified no studies looking at other accredited interventions, or at broader post-release recovery outcomes.

RAPt programmes

RAPt currently offers three accredited prison-based treatment programmes: the Alcohol Dependency Programme (ADP; 6 weeks); the Substance Dependence Treatment Programme (SDTP; 16-22 weeks); and the Bridge Programme (6 weeks). An adapted version of the SDTP runs in one women's prison, Send. Each of these programmes is structured according to the principles of twelve-step programmes, with the Bridge and ADP taking clients through step one; and the SDTP supporting clients through steps one to five. All are supported by motivational enhancement and cognitive behavioural methods.

Two recent peer-reviewed publications have focused on treatment outcomes for RAPt's long-term SDTP⁷⁶ and six-week programmes⁷⁷.

Kopak *et al's* evaluation of RAPt's SDTP compared 352 treatment completers with 355 RAPt non-completers⁷⁸ and 232 prisoners engaged by another 'treatment programme of lower intensity and shorter duration'⁷⁹. The authors were able to access PNC data, allowing an analysis of known offending patterns following release. Multivariate logistic regression identified that, controlling for age, race, sentence length, offence type and drug of choice, RAPt programme completers were 49% less likely to reoffend within a year than either of the other groups⁸⁰. There were, contrastingly, no significant differences between the RAPt non-completers and completers of the alternative intervention⁸¹.

This noted, these findings should be approached with some caution. Beyond the considerable variations in intensity and duration of the RAPt and comparison programme, considerable differences existed between the three cohorts. Clients engaged by RAPt were serving sentences that were considerably longer than those on the comparison programme (43 vs 25 months)⁸². They were also more likely to identify heroin as their main drug of choice (78% vs 66%) and

⁷⁶ Kopak *et al.*, 2014

⁷⁷ Disbury *et al.*, 2015

⁷⁸ The main reasons for non-completion were voluntary disengagement (30%), repeated positive drug tests (25%), or misconduct related to a prison security issue (21%).

⁷⁹ 2014:256

⁸⁰ Kopak *et al.*, 2014:258

⁸¹ Kopak *et al.*, 2014:258

⁸² Kopak *et al.*, 2014:256

to have been imprisoned for a property crime (50% vs 38%)⁸³. Whilst steps were taken to address the substantive differences between samples, additional studies – preferably with similar programmes and / or similar cohorts – is needed before firm conclusions can be drawn.

The analysis of six-week programmes drew on RAPT's routinely collected data for 2,299 clients engaged in the ADP and Bridge between 2007-10⁸⁴. Some differences existed between clients in these two programmes. Unsurprisingly, 82% of ADP clients identified their drug of choice as alcohol; whilst Bridge clients were divided between crack cocaine (35%), heroin (25%) and 'any other drug' (25%)⁸⁵. The Bridge programme also had a lower proportion of white clients (62% vs 82%), more people imprisoned for drug and property offences (20% and 30%, vs 6% and 19%), and fewer violent offenders (32% vs 59%)⁸⁶. Both groups were combined for pre-post treatment analyses. These showed small, but statistically significant, progress in participants' 'stage of change' and social problem solving skills; and considerable gains in self-efficacy scores⁸⁷. Some other findings were notable – not least, that having heroin use as a primary drug of choice was associated with a lower chance of treatment completion, and less progress in clients' 'stage of change' and self-efficacy. No data is available on post-release outcomes (such as recidivism and drug use), due to the paper's reliance on routine data. Nonetheless, the psychometric changes documented by Disbury *et al.* create a promising starting point for improved post-release outcomes.

Therapeutic communities (TCs)

Drawing on core principles of group therapy and twelve-step theory⁸⁸, TCs originated in the US as a model of intervention designed to use communities of peers as a therapeutic tool⁸⁹. TC residents are segregated from other prisoners, and offers a regime that seeks to resocialise prisoners entirely – changes to drug use and offending are seen as a (beneficial) side effect of this more holistic regenerative programme⁹⁰. American TCs operate on hierarchical principles,

⁸³ Kopak *et al.*, 2014:256

⁸⁴ Disbury *et al.*, 2015:562

⁸⁵ Disbury *et al.*, 2015:563

⁸⁶ Disbury *et al.*, 2015:562

⁸⁷ Disbury *et al.*, 2015:568-572

⁸⁸ e.g. Flores 1997; Corey and Corey 2006; Bion, 1961

⁸⁹ e.g. De Leon, 2000; Olson and Lurigio, 2014

⁹⁰ e.g. De Leon 2000:139; Olson and Lurigio, 2014; Inciardi *et al.*, 2004; Mitchell *et al.*, 2012.

with clients progressing through stages that endow them with increasing social responsibility⁹¹. As a structured intervention, TCs are supported by one of the most robust international evidence bases: systematic reviews have repeatedly found that TC treatment is one of very few criminal justice drug treatment interventions (apart from OST) to be consistently associated with modest, but significant, reductions in post-release offending and drug use⁹².

One particularly promising model has benefited from recent evaluation. The Sheridan Correctional Centre (SCC) in Illinois houses an 848-bed hierarchical TC, supported by a mandatory post-release ‘aftercare’ programme offering a range of treatment options from outpatient counselling, through to residential rehabilitation⁹³. Olson and Rozhon compared the outcomes of 1,501 TC completers with a matched sample of 2,858 people released from other local prisons, and found that they were 48% less likely to return to prison over a seven-year period⁹⁴.

The applicability of these findings to a UK context is mixed. Contrasting with the US ‘hierarchical’ TCs, the roots of UK TCs lay in ‘democratic’ models premised upon the principles of democratisation (shared decision making by all), permissiveness, communalism, and reality confrontation⁹⁵. At the outset, they also focused almost exclusively on violent or sexual offenders⁹⁶. Democratic structures still define the operating models of some UK TCs⁹⁷ though they now accept people with histories of drug dependence so long as they are ‘drug free’⁹⁸. Contrastingly, the two TCs focused specifically on drug dependence in HMPs Garth and Wymott are structured according to hierarchical principles, with clear progression through therapeutic phases⁹⁹. The international evidence may consequently be more applicable here.

This noted, there have been no impact evaluations of the UK’s drug-focused TCs, and those few studies that have taken a broader approach to conducting qualitative research in a range of TCs have focused primarily – if not exclusively – on Grendon’s democratic and psychiatric model¹⁰⁰. Moreover, no UK TCs have, to our knowledge, embedded aftercare in their

⁹¹ De Leon, 2000:137

⁹² Mitchell *et al.*, 2012; Holloway, Bennett and Farrington 2006; McMurrin 2007

⁹³ Olson and Rozhon, 2011

⁹⁴ Olson and Rozhon, 2011

⁹⁵ Rawlings 1998:6

⁹⁶ Genders and Player 1995:7; Cooke 1989

⁹⁷ HMP Grendon, HMP Dovegate, HMP Gartree, HMP Send and HMP Warren Hill (MoJ 2017)

⁹⁸ HMIP 2013:12; MoJ 2017

⁹⁹ Phoenix Futures 2017

¹⁰⁰ Stevens, 2011

treatment model to the same extent as the SCC. Thus, whilst the international evidence base is promising, applying this to the UK requires a cautious approach.

Drug free wings (and voluntary / compact-based drug testing units)

The term ‘drug-free wing’ is an aspirational one: it is almost universally acknowledged that it is currently impossible to completely prevent access to all drugs in any area of a prison, with the possible exception of cells in a segregation block. However, it is a term that is quite widely used in the prison system. It is also a description rather than a programme: it suggests a lack of drug availability but it does not necessarily follow that there is therapeutic input. Drug-free wings are more or less segregated accommodation designed to keep abstinent prisoners away from drug using prisoners¹⁰¹.

A number of prisons report having a drug-free wing or drug-free units. For example, Wymott has a ‘substance-free unit’ on C wing, in addition to the TC, offering psychosocial interventions and the Building Skills for Recovery (BSR) programme. HMP Wayland Prison contains a Drug Free Wing, where prisoners agree to voluntary, regular drug and alcohol testing and there is increased security and AA/NA meetings. HMP Swaleside has a ‘drug- and alcohol-free unit’ on H wing in which a 12-step programme is delivered (RAPt’s Substance Dependence Treatment Programme). HMP Manchester also offers a ‘Drug Free Wing / Voluntary Testing Unit¹⁰²’, pointing to some operational overlap between Drug Free Wings and other units with related names – for example, ‘compact based drug testing units¹⁰³’, or ‘drug rehabilitation landings¹⁰⁴’

¹⁰¹ Dolan *et al.*, 2007

¹⁰² HMIP 2014

¹⁰³ HMIP 2010

¹⁰⁴ HMIP 2015

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