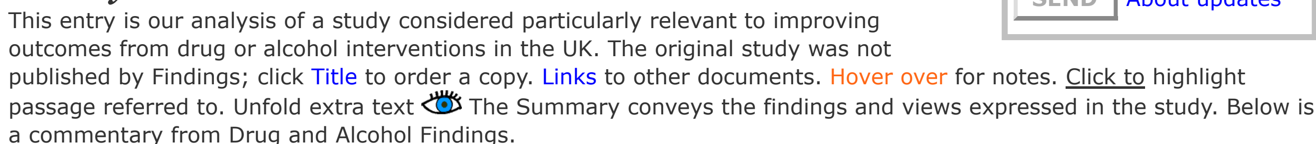

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This entry is our analysis of a study considered particularly relevant to improving outcomes from drug or alcohol interventions in the UK. The original study was not published by Findings; click Title to order a copy. Links to other documents. Hover over for notes. Click to highlight passage referred to. Unfold extra text The Summary conveys the findings and views expressed in the study. Below is a commentary from Drug and Alcohol Findings.

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▶ The evaluation of the Drug Recovery Wing pilots: Final report.

Lloyd C., Page G., McKeganey N. et al.
University of York, 2017

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The final piece of the Drug Recovery Wing evaluation jigsaw, focusing on the process and impact of implementing the model in eight men's and two women's prisons in England and Wales.

SUMMARY The first wave of Drug Recovery Wing pilots was rolled out in June 2011 for prisoners with short-term sentences in eight English men's prisons. A second wave, launched in April 2012, focused on prisoners serving a longer sentence and included two women's prisons and a young offender institution.

The Drug Recovery Wing model was based on a simple idea: a recovery-based substance use service, delivered in a prison-wing setting. This strongly appealed to prison senior management, evidenced by the rapid spread of the concept beyond the pilot prisons. Possible reasons for this were frustrations with the historically high levels of opioid substitution therapy in prison, the history of neglect with regard to treating drinking problems, and the sense that, given the importance of recovery and rehabilitation in government policy, this was an idea whose time had come.

Key points
From summary and commentary

The Drug Recovery Wing pilots tested a recovery-based substance use service model within a prison-wing setting.

Prisoners followed-up after six months living back in the community showed considerable reductions in drinking, drug use, and self-reported offending.

However, concerns about prisoners facing a 'cliff face' – a sudden drop-off in support – on leaving prison could undermine the investment of support.

In 2012, the Department of Health commissioned the University of York to undertake a detailed evaluation of the Drug Recovery Wing pilots. The evaluation was designed to understand: the processes which help and hinder the daily operation of the Drug Recovery Wing intervention; the impact of each Drug Recovery Wing on participants' drug use and recovery at the end of treatment and six months after release from prison; and whether continuing to fund Drug Recovery Wings represents good value for money.

This was broken down into five evaluation tasks:

1. A rapid assessment of all 10 pilot Drug Recovery Wings
Reported extensively in other publications (1 2 3), and as such not the focus of the featured paper, the assessment involved interviews with 97 members of staff and 102 prisoners over a six-week period.

2. An analysis of responses to the 'Measuring the Quality of Prison Life' survey from 10 pilot Drug Recovery Wings
This data was already being collected by the National Offender Management Service, which adopted the Measuring the Quality of Prison Life survey as part of its routine performance and audit measurement of prisons in England and Wales. The survey team within the National Offender Management Service agreed to introduce one new question into the survey which allowed the evaluation researchers to identify prisoners residing on the Drug Recovery Wings. This enabled the researchers to compare survey scores for Drug Recovery Wing residents and

prisoners located elsewhere in the prison to see if Drug Recovery Wings were associated with a different/better quality of life.

3. A 'process evaluation' of seven Drug Recovery Wings
Interviews were conducted with 98 prisoners and staff, plus 48 ex-prisoners and their "recovery supports" (supportive friends or relatives who were in contact with, or would know how to contact, prisoners following their release). The purpose was to determine how the model was implemented in each of the pilot areas, including exploring some of the differences and similarities across the Drug Recovery Wings and offer potential explanations.

4. An 'impact evaluation' of five Drug Recovery Wings
Structured interviews and self-completed questionnaires were completed at three points in time: on the prisoner's entry into the Drug Recovery Wing, prior to the prisoner's release, and six months after release. The purpose was to examine which Drug Recovery Wings produced the greatest reductions in drug use, improvements in quality of prison life, and recovery from drug use problems, as well as to explore which intervention components were most strongly associated with positive drug use and recovery outcomes. The ideal means of evaluating Drug Recovery Wings within prisons would have been to record the recovery progress of a sample of prisoners randomly allocated to a recovery wing, comparing their progress with a sample of prisoners who were randomly allocated to receive standard prison-based drug and alcohol treatment. For a range of reasons it was not possible to employ this 'gold standard' approach. Instead, the method was to monitor the recovery progress of a sample of prisoners from the point of their referral into a Drug Recovery Wing to the point at which they had been living back in the wider community for six months. The absence of a control or comparison group within this study design was an acknowledged weakness.

5. An economic evaluation focusing on the same five Drug Recovery Wings
Over the course of the evaluation, the researchers conducted and analysed 345 interviews, analysed data from 631 detailed impact questionnaires, and analysed data from 1,246 prisoners taking part in the Measuring the Quality of Prison Life survey. The key questions were: what are the costs of implementing and maintaining a Drug Recovery Wing within each prison; and what are the costs and savings to society associated with Drug Recovery Wing participants' liberation into the community?

Main findings

Implementation

Drug Recovery Wing pilots were implemented in a rapidly changing prison policy context, influenced by two major reviews, and responsibility for drug treatment services shifting to NHS England.

Prisons were given licence to develop their own Drug Recovery Wing models to reflect local needs, and £30,000 each to cover initial set-up costs. The resulting pilots varied in:
• capacity (ranging from 20 to 140 beds);
• therapeutic content (from structured full-time programmes, to little more than the basic support offered elsewhere in the prison);
• day-to-day running (some by uniformed prison officers and others by third sector drug treatment professionals);
• integration (from being part of the wider prison to full segregation from the rest of the prison).

Despite the policy backdrop to their development, Drug Recovery Wings did not universally focus on *abstinence-based* recovery – in fact, in two Drug Recovery Wings the only input was harm reduction. Throughout the study, abstinence-focused Drug Recovery Wings experienced difficulties attracting prisoners on opioid substitution therapy.

Aside from the chosen therapeutic or treatment approach (which could not fill the whole day), if Drug Recovery Wings wished to maintain a credible degree of segregation from the rest of the prison, they had to fill the time that prisoners would otherwise spend in employment, workshops, or education. Mutual aid groups, such as Narcotics Anonymous, were very popular. Some Drug Recovery Wings allowed additional time for participants to mix with other prisoners, while others resorted to 'lock-up'. Perhaps surprisingly, the lock-up was not necessarily unpopular with prisoners.

Manchester, Styal, and Swansea had promising Drug Recovery Wing models, which improved prisoners' quality of life. Thought to be key to their success was physical separation from the rest of the prison, protection of Drug Recovery Wing beds for people engaged in the therapeutic programme, a strong sense of community, and good relations between staff and prisoners.

A strong sense of community seemed to develop in small or medium-sized, well-controlled wings where prisoners received treatment as a cohort, and where there was careful selection of positively-motivated officers who successfully managed professional and personal boundaries. Shutting off Drug Recovery Wing residents from the rest of the prison appeared to intensify the dynamics – either resulting in a close, supportive community where relationships were good, or considerable discord where relationships were poor.

In all but one Drug Recovery Wing, drug availability appeared to be a key problem. In some wings cannabis, new psychoactive substances, and diverted medications were readily available. Where Drug Recovery Wing prisoners mixed with regular prisoners participating in opioid substitution therapy, Subutex (a medication used in the treatment of opioid dependence) tended to be easy to access.

Problems in the past and the present

A substantial minority of Drug Recovery Wing participants had histories of mental health problems, in particular depression, and some had been physically and/or emotionally abused as a child. Many had difficult childhoods, the large majority had been excluded from school, and on arrival in prison most had close friends or family members involved with offending and drug use.

The minority of prisoners who had robust family units throughout their childhood also tended to have done reasonably well at school, progressed to develop reasonably stable employment histories, and to have had fewer previous prison sentences. They often retained access to warm and supportive family units who remained willing to provide safe and secure housing and financial support on release. In contrast, many prisoners who described early lives blighted by violence, bereavement, and educational failure, often transitioned into heavy and dependent drug use at an early age, alongside spirals of repeated drug use and offending that led them to lose the trust of those who might have been able to help. For the latter group, access to informal support was scarce: they had fewer routes to finding housing or employment; and fewer skills with which to navigate the structured housing or employment markets.

For the most part, prisoners' physical and mental health declined over the course of their time on the Drug Recovery Wings, and there was little evidence of improving attitudes or hopes for the future.

In some Drug Recovery Wings with more intensive therapeutic programmes, past experiences and emotional issues were discussed. However, in most wings therapeutic content was limited, and what there was focused explicitly on substance use.

Despite resettlement being their primary concern and many prisoners' clear belief that recovery began at the point of release, prisoners were largely disappointed in the level of preparation for release. None of the interviewees reported having received a concrete offer of housing, and many feared a return to poor housing – expecting to be released into 'bed and breakfast' accommodation (B&Bs), hostels, and night shelters where they previously had negative experiences, or having to return to live in strained or harmful contexts with partners or family members.

Outcomes on release

A total of 319 prisoners were surveyed at the beginning of their Drug Recovery Wing engagement, and of these 203 were followed-up prior to their departure from the Drug Recovery Wing, and 109 again after six months living back in the community:

- 85% of the prisoners were regular smokers;
- 39% reported drinking higher strength beer almost every day over the 12 months prior to custody, and 27% reported drinking spirits with the same frequency;
- 68% had used cannabis in the six months prior to custody, 46% had used cocaine, 41% heroin, 39% crack cocaine, and 31% amphetamines;
- 37% reported having injected drugs with an average frequency of 182 times before custody;
- 20 years old was the average age at which prisoners first tried heroin or crack cocaine, compared with 14 years old for cannabis, and 13 years old for glue.

The 109 followed-up all the way through showed a significant reduction in the frequency of heroin, crack cocaine, cannabis, amphetamine, and ecstasy use, and a clear pattern of reduced spending on drugs comparing the period prior to custody and after departure from their Drug Recovery Wing. There was also a considerable reduction in daily consumption of alcohol, including normal strength beer (from 21% to 4%), strong beer (from 15% to 6%), and spirits (from 14% to 1%).

Self-reported offending dropped between the six-month period prior to custody and the six-month period following release. However, reoffending was still quite common, with 12%

reporting shoplifting, 9% theft other than from a vehicle, and 9% handling stolen goods.

There was strong support amongst participants for receiving treatment with 81% agreeing or strongly agreeing that they needed help in dealing with drug use, 82% agreeing or strongly agreeing that treatment programmes can help them, 90% agreeing or strongly agreeing that they wanted to be in treatment, and 98% agreeing or strongly agreeing that they wanted to get their life "straightened out". When asked what would most help them avoid a return to offending, 80% of prisoners cited having a job, 79% cited ceasing their drug use, and 78% cited having a place to live.

Reflecting on their time in Drug Recovery Wings, prisoners from the Manchester Drug Recovery Wing were positive about their experiences, but those from other Drug Recovery Wings were largely negative. Concerns centred on the ready availability of drugs and the lack of preparation for, and support on, release.

In-depth interviews were also carried out with 58 former prisoners six months after they had returned to the community:

- Three interviewees had stopped their drinking and drug use entirely: one drawing on intensive support from both family, and mutual aid; a second drawing on his faith community; and the third inspired by his children. All three had followed fundamentally social pathways to recovery, and each had received considerable support from parents who had offered them a safe and secure home.
- A substantial group had moderated their drug use. This was particularly the case for those who had found employment, or who had begun to (re)build relationships with partners or family members.
- A large group of former prisoners appeared to have made few changes to their pre-imprisonment levels and varieties of drinking and drug use. But most former prisoners attempted to frame their substance use as being more controlled, or recreational, though often this contrasted with their descriptions of the problems it was causing them – not least, mental health, physical health, and serious financial problems.

A substantive theme of the interviews centred around preparation for release: interviewees felt they had received little support, and said that prison life and life back in the community appeared to be worlds apart.

A handful of former prisoners looked back with some affection at the benefits of Drug Recovery Wing conditions for their physical health. Going to the gym and improving their fitness was an important part for some interviewees. Others saw prison as a means of physically recovering from the ravages of heavy and dependent drug use, even if they had every intention of returning to drug use following their release.

The housing situation of interviewees was generally poor. None felt that they had been allocated appropriate, safe or supportive housing by prison housing services, and Drug Recovery Wings did little (if anything) to improve this vital part of recovery capital for released prisoners. Those who had robust recovery capital when imprisoned generally retained it, along with access to safe and secure housing with family or friends. Those who were imprisoned with nothing generally left to find themselves in an identical situation. A large proportion of interviewees were released to be street homeless, causing one to break his restraining order so that he could find a place to sleep. Hostels were seen as not much better than street homelessness.

Those who had spent time in them identified that hostel accommodation had exacerbated mental health problems, made sustained abstinence impossible (due to the widespread availability of drugs), and led them into routine conflicts and confrontations. Hostel staff were generally seen as part of the problem, and a few interviewees were clear that a return to prison was preferable to living in a hostel.

One person sought to return to his partner, who was also his recovery support. She identified that this had never been a viable option as their relationship had been violent and controlling – his most recent sentence had been for abusing her, and their relationship had ended six years ago.

The authors' conclusions

Considerable reductions in drinking, drug use and offending were observed in the evaluation. However, this data came from the one third of prisoners living in the community who remained in contact. On that basis there is no way of knowing about the extent to which the other two third of the sample were using drugs, drinking excessively, or engaging in criminality. Nevertheless, the fact that many prisoners who were followed from treatment initiation, to

graduation, to living within the community were able to reduce their drinking and drug use, and their offending should be seen as a positive outcome.

The evaluation report makes clear that because it was not possible to follow a comparison or control sample of prisoners who received only standard prison drug and alcohol treatment, it was not possible to determine the extent to which positive outcomes can be attributed specifically to Drug Recovery Wing provision.

Where Drug Recovery Wings worked best they were able to provide (within their capacities) a protected space where prisoners could stop using drugs and alcohol, be exposed to less temptation than elsewhere in the prison, feel physically safe, engage in therapeutic programmes, and work on their motivation to make "real changes" in their lives on release. These findings emphasised the wider observation that recovery cannot be cast simply in terms of substance use cessation. While most prisoners in this evaluation gave up their substance use in prison, and many were free of prescribed drugs, their very frequent relapse on release showed the importance of other factors in their lives – most importantly, accommodation, relationships and employment.

Drug Recovery Wings had a limited impact on 'recovery capital': the "internal and external assets required to initiate and sustain long-term recovery from alcohol and other drug problems". People who entered prison with robust access to resources left in a similar position, and those who were imprisoned with nothing returned to nothing (ie, precarious housing, marginalisation from employment, and unstructured lives surrounded by the temptation of illicit earnings).

While some Drug Recovery Wings offered excellent support, delivered by highly motivated and committed staff, these efforts could not make substantial changes to people's lives without being accompanied by help on release. Many prisoners experienced a 'cliff-face' – their level of professional support dropping off to little or nothing after they left prison. This highlighted a pressing need to identify promising approaches for post-release support, which could include gradually reintroducing prisoners with substance use histories into the community, for example through 'release on temporary license', which allows prisoners to be released temporarily into the community for specific purposes, such as employment.

Any recovery programme in a prison is arguably at a disadvantage because of the setting and the situation:
• Firstly, imprisonment tends to remove what recovery capital people do have by taking them out of their social contexts, and stripping away their access to relational, personal, and practical support.
• Secondly, prison is inevitably a highly problematic arena in which to attempt to build up recovery capital. Relationships with family and friends tend to be negatively impacted by incarceration, and the opportunities to develop new, supportive, 'pro-social' networks within prison may be limited. While the provision of work programmes may provide useful skills, obtaining employment on release is hindered by the exclusion of people with criminal records from many job markets, and the difficulties of applying for work while imprisoned. Also, many prisoners lose their homes while in prison and problems of communicating with housing providers, lack of income, jobs, and the stigma of imprisonment impact on prisoners' ability to obtain accommodation on release.

With this in mind, imprisonment should be seen at best as a hiatus in the development of Drug Recovery Wing residents' recovery capital.

Looking at the implementation of Drug Recovery Wings, the model may not have been sufficiently resourced in terms of the £30,000 made available to each prison, nor sufficiently protected within the prisons in terms of staffing levels and accommodation. It was unfortunate that the development of the Drug Recovery Wing pilots happened at a time of substantial decline in prison officer numbers.

FINDINGS COMMENTARY In 2010, drug recovery wings were an important element in the Conservative-led coalition government's turn towards abstinence-based recovery and a more 'challenging' treatment regimen: "We believe that, given the substantial investment in drug services, and the strong association between drug use and reoffending, we should be more ambitious in our aims to improve efficiency and effectiveness. We will therefore focus on recovery outcomes, challenging offenders to come off drugs." Instead it seems many of the pilot wings became venues for drug use and apparently made little or no contribution to their residents's long-term recovery on release – though only a study with an adequate comparison group could definitively answer this question. More positive findings from a few of the wings

suggest that in itself the concept may not have been flawed, but that perhaps under-resourcing and strain in prisons, and misguided implementation models, undermined its potential.

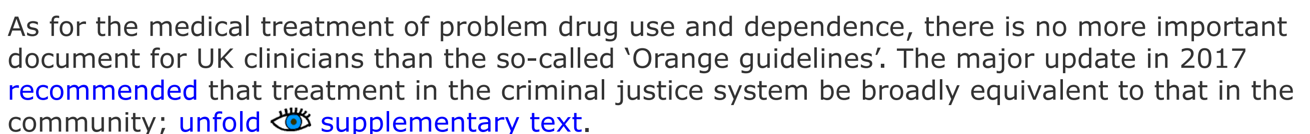
Two key take-home messages from the featured evaluation were the importance of helping prisoners prepare to re-enter and live in the community – in-prison services could be five-star but without a home, job, and supportive social network to return to, the investment could amount to nothing – and the need to tailor in-prison support and expectations to the recovery capital of the individual, recognising the resources prisoners have access to (both inside and outside prison) that are required to sustain long-term recovery.

Recovery capital was a central concept in the featured report – prison's impact on it and the pre-existing capital of individual prisoners as a key factor in their recovery after release. According to the social scientists who coined the term, 'recovery capital' includes: being able to rely on the support of acquaintances and friends; financial stability and capital; the knowledge, skills, qualifications, health, mental health, and other traits essential for optimal negotiation of daily life; and the ability to divorce oneself from subcultural norms which promote substance use and instead embrace "the prosocial norms of the dominant culture". Set against these on the negative side of the equation are physical and mental ill-health and the impact of being imprisoned. The concept is discussed in an Effectiveness Bank hot topic about treatment in the modern 'recovery era' in Britain – which coinciding with the so-called 'age of austerity', has not seen ambitious rhetoric matched by the "intensive support over long periods of time needed to become drug free".

Recovery capital featured in the 2010 UK Government drug strategy, but not explicitly in the *2017 Drug Strategy* – however, *building recovery* was one of its four key pillars. Much like the government strategy before it, the 2017 publication reflected a world view that the best way to tackle problem drug use is to encourage people to live drug-free lives. Though it affirmed a commitment to evidence-based measures, the strategy only tentatively or partially (1 2) extended this commitment to harm reduction (a term appearing only once in the strategy, and in relation to smoking). Opioid substitution therapy was acknowledged only as a legitimate life-saving tool for people transitioning from custody to the community, and as a method of addressing the spread of HIV in low- and middle-income countries. The findings of the final Drug Recovery Wing evaluation caution that ambitious abstinence- and detoxification- focused interventions should be limited to those who have robust recovery capital, informed by prison assessments and triages. For those with more depleted recovery capital, the authors identify a need for combining harm reduction approaches with much more ambitious resettlement support.

A thematic inspection by the Inspectorate of Prisons generated an overall picture of drug use and responses to it in prisons in England and Wales. Based on information collected between 2014 and 2015, it found that patterns of drug use were changing – the misuse of opiates appeared to be declining, while there had been an increase in the use of diverted medications and in synthetic cannabis – but policy and operational responses had not been sufficiently flexible and dynamic to cater to this.

As for the medical treatment of problem drug use and dependence, there is no more important document for UK clinicians than the so-called 'Orange guidelines'. The major update in 2017 recommended that treatment in the criminal justice system be broadly equivalent to that in the community; unfold supplementary text.



Thanks for their comments on this entry in draft to research author Dr. Charlie Lloyd of the University of York. Commentators bear no responsibility for the text including the interpretations and any remaining errors.

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