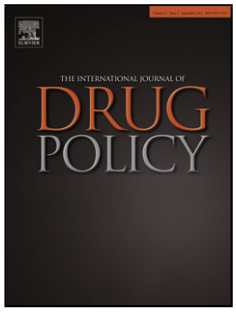
Accepted Manuscript



Title: Conspicuous by their abstinence: the limited engagement of heroin users in English and Welsh Drug Recovery Wings

Author: Geoff Page Lorna Templeton Sharon Grace Paul Roberts Neil McKeganey Chris Russell Alison Liebling Zetta Kougali Charlie Lloyd

PII: S0955-3959(15)00359-X
DOI: http://dx.doi.org/doi:10.1016/j.drugpo.2015.12.006
Reference: DRUPOL 1677

To appear in: *International Journal of Drug Policy*

Received date: 28-5-2015
Revised date: 1-12-2015
Accepted date: 9-12-2015

Please cite this article as: Page, G., Templeton, L., Grace, S., Roberts, P., McKeganey, N., Russell, C., Liebling, A., Kougali, Z., and Lloyd, C.,Conspicuous by their abstinence: the limited engagement of heroin users in English and Welsh Drug Recovery Wings, *International Journal of Drug Policy* (2015), http://dx.doi.org/10.1016/j.drugpo.2015.12.006

This is a PDF file of an unedited manuscript that has been accepted for publication. As a service to our customers we are providing this early version of the manuscript. The manuscript will undergo copyediting, typesetting, and review of the resulting proof before it is published in its final form. Please note that during the production process errors may be discovered which could affect the content, and all legal disclaimers that apply to the journal pertain.

ACCEPTED MANUSCRIPT

Conspicuous by their abstinence: the limited engagement of heroin users in English and Welsh Drug Recovery Wings

Geoff Page[a], Lorna Templeton[b], Sharon Grace[c], Paul Roberts[d], Neil McKeganey[e], Chris Russell[e], Alison Liebling[f], Zetta Kougali[g] and Charlie Lloyd[a]

[a] Mental Health and Addictions Research Group, Department of Health Sciences, University of York, YO10 5DD

[b] Independent Consultant

[c] Social Policy and Social Work, University of York, YO10 5DD

[d] Independent Researcher

[e] Centre for Drug Misuse Research, 19 Keith Street, Glasgow G11 6QQ

[f] Institute of Criminology, University of Cambridge, Sidgwick Avenue, Cambridge, CB3 9DA

[g] School of Psychology, University of East London, Stratford Campus, Water Lane, London E15 4LZ

Correspondence to: Geoff Page, ARC/208a, Area 4, ARRC Building, Department of Health Sciences, University of York, YO10 5DD.

Email address: geoff.page@york.ac.uk

Tel: 01904 321670

Accepted Manuscript

ACCEPTED MANUSCRIPT

Title: Conspicuous by their abstinence: the limited engagement of heroin users in English and Welsh Drug Recovery Wings

Key words: Prison

Recovery

Recovery capital

Drug treatment

Abstinence

Heroin users

Abstract:

Background: In recent years, an abstinence-focused, 'recovery' agenda has emerged in UK drug policy, largely in response to the perception that many opioid users had been 'parked indefinitely' on Opioid Substitution Therapy (OST). The introduction of ten pilot 'Drug Recovery Wings' (DRWs) in 2011 represents the application of this recovery agenda to prisons. This paper describes the DRWs' operational models, the place of opiate dependent prisoners within them, and the challenges of delivering 'recovery' in prison.

Methods: In 2013, the implementation and operational models of all ten pilot DRWs were rapidly assessed. Up to three days were spent in each DRW, undertaking semi-structured interviews with a sample of 94 DRW staff and 102 DRW residents. Interviews

Accepted Manuscript

ACCEPTED MANUSCRIPT

were fully transcribed, and coded using grounded theory. Findings from the nine adult prisons are presented here.

Results: Four types of DRW were identified, distinguished by their size and selection criteria. Strikingly, no mid- or large-sized units regularly supported OST recipients through detoxification. Type A were large units whose residents were mostly on OST with long criminal records and few social or personal resources. Detoxification was rare, and medication reduction slow. Type B's mid-sized DRW was developed as a psychosocial support service for OST clients seeking detoxification. However, staff struggled to find such prisoners, and detoxification again proved rare. Type C DRWs focused on abstinence from all drugs, including OST. Though OST clients were not intentionally excluded, very few applied to these wings. Only Type D DRWs, offering intensive treatment on very small wings, regularly recruited OST recipients into abstinence-focused interventions.

Conclusion: Prison units wishing to support OST recipients in making greater progress towards abstinence may need to be small, intensive and take a stepped approach based on preparatory motivational work and extensive preparation for release. However, concerns about post-release deaths will remain.

Accepted Manuscript

ACCEPTED MANUSCRIPT

Introduction: A Shifting Landscape: UK Drug Policy, Recovery, and Prisons.

The British prison system receives over 130,000 admissions per year (Patel 2010:18), with 3,935 women and 82,042 men imprisoned as of November 2015 (Ministry of Justice 2015). Many of these prisoners have problematic relationships with alcohol or drugs. The Report of the Prison Drug Strategy Review Group (Patel 2010) noted that 69% of new prisoners identify that they have used drugs in the previous year, with 40% of these reporting injected drug use within the preceding 28 days (2010:18-19). This scales up to present a substantial organisational challenge to both prison and health services, with 64,379 Opioid Substitution Therapy (OST) treatment episodes in English prisons in 2012-13 (Hansard 3rd December 2012: column 667W).

Following their election in 2010, criminal justice drug treatment offered an opportunity for the UK's Coalition Government to establish a new approach to a longstanding political concern, breaking the 'drugs-crime cycle' (e.g. Home Affairs Committee 2012). The Coalition's first Drug Strategy consequently announced an initiative bringing 'wing-based, abstinence focused, drug recovery services' to English and Welsh prisons (HM Govt 2010:12). A Ministry of Justice Green Paper contemporaneously highlighted a renewed 'focus on recovery outcomes, challenging offenders to come off drugs,' identifying 'pilot Drug Recovery Wings' (DRWs) as a key vehicle for achieving these ends (MoJ 2010:29). This emphasis on abstinence and recovery, and the absence of any mention of heroin users, marked a clear ideological shift away from the policies of the preceding ten years.

ACCEPTED MANUSCRIPT

In early 2011, five prisons formed the first tranche of DRW pilot sites. These wings were in one Category A and four Category B men's prisons (Category A represents the highest, and Category D the lowest men's security categorisation). They were principally expected to…

> …offer a route out of dependency for those who are motivated to change… increase the number of short sentenced offenders participating in recovery-focused interventions and… improve continuity of care… between prisons and the community (Powis, Walton and Randhawa 2014:1).

In April 2012, five additional prisons began hosting pilot DRWs. These included two women's prisons, a Young Offender's Institution (YOI), and two Category B men's prisons (PIRU 2012:2). Host prisons received no additional year-on-year resourcing, though some received £30,000 to fund local evaluations and / or set-up costs. In line with the 2010 Drug Strategy's call for services to be "locally owned and locally led" (HM Govt 2010:19), all DRWs were expected to develop distinctive operational models tailored to local needs (MoJ 2010:82).

Though Government documents shied away from explicitly identifying abstinence from OST as DRWs' core goal, this was a clear part of their conceptual evolution. DRWs fit within a broader recovery movement, which emerged as a reaction to the long-term dominance of treatment services by heroin users receiving OST. The term 'heroin users' is significant here, as the rise of OST can be explicitly traced back to a drive by New Labour to address the social problems – and particularly the high levels of offending – associated with heroin use (e.g. Godfrey *et al* 2003; Boreham *et al.,* 2007; HM Govt 2002; Holloway and Bennett 2004; HM Govt 2008). Under a process described

ACCEPTED MANUSCRIPT

somewhat awkwardly by Seddon, Williams and Ralphs as the 'riskification' of UK drug services (2012:39), New Labour ensured that drug workers were placed at every stage of the criminal justice system tasked with providing heroin using offenders with rapid access to OST, usually in the form of methadone maintenance (Duke 2013:47; HM Govt 2002). As the strapline for the Drug Interventions Programme, a headline New Labour initiative, surmised: 'out of crime, into treatment' (e.g. Home Office 2008). On one level, this approach was highly successful. By 2006, New Labour had met its aspiration to double the numbers in treatment (HM Govt 2002:11; HM Govt 2008:4). Many of these were referred directly into OST by criminal justice agencies (e.g. Jones *et al* 2007; Skodbo *et al* 2007).

However, a shift in perspective then led to OST being reframed as a problematic drug dependence in and of itself:

> Drug users had been accessing treatment and stabilising their drug use through substitute prescribing… but not necessarily exiting treatment successfully, fully overcoming their addiction and reintegrating into the community (Duke 2013:47; see also e.g. Easton 2006; Ashton 2008).

This call was most vigorously taken up by right-wing think tanks and politicians, and in the run-up to the 2010 general election the Conservative manifesto 'promised to deliver an abstinence-based drug strategy' (Duke 2013:44) with 'benefit cuts for problem drug users and compulsory residential rehabilitation' (ibid.) intended to encourage OST clients into total abstinence. Similar principles began to guide drug services' commissioning and delivery, with UK's National Treatment Agency calling for an end to people being 'parked indefinitely on methadone' (NTA 2010).

Accepted Manuscript

ACCEPTED MANUSCRIPT

More broadly, the reconceptualisation of OST as a problematic 'addiction' was part of a move away from a specific focus on heroin as the dominant concern of drug services. Dedicated funding streams for heroin users' treatment were removed, as a renewed call arose for services to focus on 'the person not the substance' (Centre for Social Justice 2007:19) and to expand treatment for cannabis, alcohol and other drug users. Nonetheless, heroin use continues to act as a specific marker for social disadvantage and particular difficulties in achieving recovery outcomes (e.g. Advisory Council on the Misuse of Drugs (ACMD) 2013; ACMD 2015). The rise of recovery services and the removal of protected funding arrangements for heroin users thus raises particular questions about the position of heroin users within new service models (ACMD 2013:17). The ACMD's Recovery Committee cites US population studies indicating 'that most people who experience a period of dependence on alcohol, cocaine, or cannabis, overcome that dependence and remission is the 'norm'' (ACMD 2013:10), making such individuals appealing targets for recovery services in an era of performance monitoring, regular recommisioning, and the prospect of Payment by Results (HM Govt 2010:20). Simultaneously, the ACMD advises tempered expectations of recovery outcomes for heroin users, contending that the most straightforward routes to abstinence, 'forced detoxification and time-limited opioid prescribing' (2013:17), lack an evidence base and may cause harm. Instead, the report calls for 'an extensive approach… for a number of years, especially for the UK population of ageing heroin users' (2013:54). Changes to service structures consequently have the potential to place unrealistic expectations on heroin users, whilst withdrawing any protection for their levels of funding.

One of the core factors hindering heroin users' progress towards abstinence is their lack of 'recovery capital,' defined by White and Cloud as…

ACCEPTED MANUSCRIPT

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

As Cloud and Granfield surmise, *a priori* this has weighty implications for an individual's prospects of achieving recovery outcomes:

> An individual's capacity to terminate chronic substance misuse is very much a function of the resources that s/he has developed and maintained over the course of his / her life (Cloud and Granfield 2008:1981).

Indeed, the 2010 Drug Strategy acknowledges this, and clearly identifies that recovery services should build 'on the recovery capital available to [service users]' (HM Govt 2010:18).

Studies have found that heroin users have fewer recovery resources than people dependent on other drugs (Jones *et al* 2007; Social Exclusion Unit 2002), whilst heroin dependent offenders are more disadvantaged still. When compared with other arrestees, Boreham *et al* identified that heroin users had one-fifth the levels of employment, and were three times as likely to be sleeping rough (2007:24-25). Half had left school before the age of 16, and a similar proportion grew up in care (Boreham *et al* 2007:25-26). Heroin dependence is also strongly associated with prolific, acquisitive offending, with criminal records further limiting people's access to social integration (Godfrey *et al* 2003; Holloway and Bennett 2004). In this context, heroin users' journeys towards abstinence are likely to be prolonged, comprising a series of incremental steps. As Duke (2013) notes, this potentially creates tension between recovery services and the heroin users they engage. Whilst approaching recovery as a person-centred ideal might support clients in choosing long-term or indefinite 'medication assisted recovery' (Strang 2012:5; ACMD

Accepted Manuscript

ACCEPTED MANUSCRIPT

2015), abstinence may be heavily promoted as a service- or population- level goal (Duke 2013:45).

The relationship between recovery, heroin use and abstinence is still more problematic in a prison setting. Reviewing data from 48,771 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' (2008:254). Overwhelmingly, excess deaths were attributable to opioid toxicity (Farrell and Marsden 2005:41). Averting this elevated risk of death continues to be cited as a robust, *prima facie* rationale for prison-based maintenance OST (e.g. Patel 2010:21; WHO 2010:8; DoH and Addaction 2004:11). Practical concerns also constrain the delivery of ambitious programmes. Prisons have absorbed a 41 per cent reduction in officer numbers between 2010-14, accompanied by a rise in assaults, self-harm, deaths in custody, concerted indiscipline, and prisoner complaints (House of Commons Justice Committee 2014:28-32). This difficult context may obstruct the creation of a therapeutic environment.

Indeed, prison prescribing continues to prioritise harm reduction. The UK Department of Health's *Updated Guidance for Prison-Based Opioid Maintenance Prescribing* (2006) presents maintenance regimes as the default response to heroin-dependent people detained on remand (pre-trial detention), or serving short-term sentences. Only prisoners serving longer than six months in prison are expected to engage with a reduction regime. In the five years after these guidelines were introduced, 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) (Hansard 3rd December 2012: column 667W). In 2013, the NOMS Director of Health directly identified DoH guidance as the

ACCEPTED MANUSCRIPT

main reason that prisons had not 'adjusted drugs treatment strategies… away from maintenance towards abstinence-based programmes' (Home Affairs Committee 2012:202).

Thus, while the 'recovery revolution' (White 2007) may have established firm roots in community services, prisons' OST provision appears to have moved in the opposite direction. As DRWs represent an attempt to extend the recovery agenda to prisons, and the recovery agenda has clear implications for heroin users and OST prescribing practices, this paper explores how this shaped work with opiate dependent prisoners in the nine adult pilot DRW prisons.

Methodology

In 2012 the Department of Health commissioned the University of York to lead a team of researchers from York, Glasgow and Cambridge to undertake a process and impact evaluation of pilot Drug Recovery Wings. The evaluation aims to provide a detailed description of the operation of individual DRWs and to assess the degree to which participation within a DRW facilitates individual prisoners' recovery and rehabilitation.

To inform site selection for the full process and impact studies, in early 2013 five researchers undertook rapid assessments of the one Welsh and nine English NOMS pilot DRWs. Rapid assessment methodologies are common in the development of health-focused interventions, with Stimson *et al* identifying '83 rapid assessment studies on substance misuse, involving 322 different sites in 70 countries' between 1993 and 2001 (2006:288). Rapid assessments are not standalone projects, but are likely to be positioned at the beginning of larger practice-focused or pure research projects (Stimson *et al* 1998:22). They can be broadly understood as scoping exercises, intended to develop a

Accepted Manuscript

ACCEPTED MANUSCRIPT

rich understanding of local contexts before full interventions or large-scale research projects commence. Rapid assessments offer a highly effective means of carrying out such a scoping exercise, and are defined by several features (Stimson *et al* 1998:26). Key amongst these are swiftness, the use of multiple data sources, securing respondents in multiple roles, and the use of extant data, all situated within an inductive research framework (Stimson *et al* 1998:22-3). These principles structured the fieldwork, data and analyses presented in this paper.

Researchers aimed to conduct semi-structured interviews with ten DRW staff and ten DRW prisoners in each institution, securing a total of 94 staff and 102 prisoner interviews. As is often necessitated by prison research (e.g. Heidari *et al.,* 2007; Green *et al.,* 2005; Loeb and Steffensmeier 2006), this latter represented a convenience sample. Fieldwork was conducted at short notice, during prisoners' working days, and in wings managing turnovers of up to ten new arrivals each day. In this context, full lists of wing residents were unavailable, and the availability of given prisoners could not be guaranteed. Researchers thus relied on staff to identify and unlock prisoner interviewees, though when specific interviewees were requested (following encounters on prison landings, for example) they were invariably secured. As this paper focuses on heroin dependence – which is very rare in young offender populations – only data from adult prisons are reported here.

All interviews were fully transcribed. NVivo 9 was used to code and analyse all transcripts, using an emergent and grounded coding system (Seale 2004:243-4**)**. This progressed through an axial coding stage to a fully selective coding system (Seale 2004:244**).** Researchers also had access to National Drug Treatment Monitoring System (NDTMS) data for prisons in 2012-13. NDTMS is a Public Health England recording

ACCEPTED MANUSCRIPT

system, which collates data for all people accessing drug treatment in England. NDTMS data was used to identify the proportion of self-identified heroin users accessing two prisons' treatment services.

Findings

Overview

The DRW pilots adopted contrasting approaches to nearly every aspect of recovery, making generalisation difficult. Levels of psychosocial treatment varied between twenty minutes per month and twenty-nine hours per week, with the most intensive schedules akin to community-based residential rehabilitation. The formal role and qualifications of therapeutic staff varied too. Prison officers, registered nurses, and staff employed by private contractors were responsible for delivering treatment on various DRWs. Some private contractors recruited inexperienced practitioners with few formal qualifications, whilst others sought experienced staff with postgraduate counselling qualifications. SMART recovery (a structured programme of motivational enhancement and cognitive behavioural therapy) and twelve-step fellowship meetings constituted the most widespread form of support, available in four prisons apiece. Beyond this, two DRWs offered manualised (and nationally accredited) structured group programmes, and two facilitated intensive twelve-step courses. Staff elsewhere developed local recovery programmes.

Pilot DRWs also adopted differing recruitment strategies, which shaped the four 'types' of DRW presented in this paper. Type A DRWs (hereafter referred to as 'Comprehensive Clinical Services') were large, clinical units. All prisoners receiving OST were housed in these units, alongside anyone undergoing clinical detoxification for non-opiate drug or

Accepted Manuscript

ACCEPTED MANUSCRIPT

alcohol dependence. Only one prison had a Type B ('Selective Clinical') DRW. Here, staff sought to build a recovery-focused community of fifty motivated OST recipients, recruited from a prison-wide caseload of 270. Type C ('The Person, Not the Substance') DRWs were mid-sized, and recruited anyone who aspired towards long-term abstinence. OST was not a recruitment priority (though those on high doses had to reduce before entering the wing), and prisoners with any historic drug or alcohol dependence could apply. Finally, Type D ('The Power of Few') DRWs were very small. Staff purposively recruited 'mixed cohorts' of abstinent and medicated prisoners, but anyone receiving OST was expected to detoxify before graduation and release.

[Table 1]

Type A: Comprehensive Clinical Services

Type A consisted of two large DRWs, which commenced and sustained prescribing for all heroin dependent people entering their prisons. Indeed, OST was only available on other wings in exceptional circumstances, meaning that prisoners wishing to be housed on other locations faced 'rapid detoxification supported by BritLofex' (Staff, Prison 1). Staff estimated that 'one to two per cent' of heroin dependent arrivals chose this option, and reported that very few residents attained abstinence from OST.

Several factors made abstinence an ambitious goal for Type A DRWs. Firstly, treatment was sparse. Residents could access one psychosocial one-to-one each month. Neither DRW delivered any group programmes (or interventions focused on building recovery capital), and several prisoners identified medication as the only meaningful support:

I: What have the most helpful things been?

Accepted Manuscript

ACCEPTED MANUSCRIPT

R: The methadone, really.

I: Anything else… you've found helpful?

R: Not really (Prisoner, Prison 1).

Indeed, medication was the sole eligibility criterion for Prison 1's DRW. Those who attained abstinence were transferred to other wings, and DRW staff routinely advocated for sustained prescribing over detoxification:

> The nurse and I both said it simultaneously, "we don't think [abstinence] is a good idea…" (Staff, Prison 1).

Staff estimated that 70% of Type A DRW residents were on pre-trial detention, or serving sentences of less than six months. Few such prisoners appeared keen to reduce their OST prescriptions:

> People don't [withdraw] voluntarily. None of these people have been detoxing on their own request (Staff, Prison 2).

Certainly, some prisoners were fraught at the prospect of reduction. One stated

> Without [Subutex] I'd hurt myself and cut my wrists, because I can't cope without it (Prisoner, Prison 2).

A second asserted his right to indefinite opioid maintenance, on the grounds of being 'free from torture and humane, article eight, paragraph eight'. Whilst Article Eight of the Human Rights Act has no eighth paragraph and describes the right to a private and family life, this prisoner was clearly aware of a legal background to OST prescribing in prisons and keen to assert his right to it.

Accepted Manuscript

ACCEPTED MANUSCRIPT

Whilst staff interviewees described practices that were structured by an awareness of the risk of post-release overdose, it seemed striking that none of our prisoner interviewees identified a fear of overdose as a reason for delaying medication abstinence. Prisoners' reluctance to detoxify may have consequently been rooted in their strikingly low levels of recovery capital. Of nineteen interviewees, just one was serving his first sentence. Nearly all had experienced extensive homelessness, and most entered Type A DRWs whilst vulnerable and withdrawing. Within an OST-based wing, the black market for diverted medication then offered this cohort both opportunities and risks. Some might become customers, getting into unmanageable debt; whilst others approached medication and drug dealing as a valuable resource. Staff certainly believed many DRW residents actively sought imprisonment whilst 'packed up [with drugs] to sell' (Staff, Prison 1), and one prisoner reflected:

> They're running around, swapping their scripts. The majority of them, all they're interested in is getting out of their nut (Prison 1).

The increased availability of drugs thus made abstinence more challenging for vulnerable residents, whilst the black market value of medication may have discouraged some others from detoxification. Succinctly, bigger prescriptions offered more illicit opportunities.

Type B: Selective Clinical

Prison 3 situated its fifty-bed, Type B DRW in a seventy-bed wing, with the remaining beds occupied by non-programme prisoners. The DRW was devised as a psychosocial service for only highly motivated OST recipients, and housed less than one-fifth of the prison's full OST caseload. It was originally hoped that 'creaming off' (Lipsky 2010:107) highly motivated medicated prisoners would foster an abstinence-minded community in

Accepted Manuscript

ACCEPTED MANUSCRIPT

which prisoners regularly detoxified before transferring to the prison's abstinence-focused therapeutic community. In practice, this had not happened.

Abstinence had proven elusive for several reasons. Firstly, structured intervention was limited. Standard treatment consisted of five 'induction' groups covering basic harm reduction advice, followed by one psychosocial appointment per month. Secondly, the separation of psychosocial, clinical and prison officers complicated abstinence. Recruitment was carried out by psychosocial workers, who struggled to find abstinence-minded OST recipients:

> We can't get prisoners on [the DRW]… "Oh, you're going to get us on there and you're going to forcibly detox us" (Staff, Prison 3).

They consequently stopped advertising any association between the DRW and OST reduction:

> We don't want to… tell people that by coming on here you're being forced to reduce (Staff, Prison 3).

Psychosocial support on the wing was then delivered by prison officers, who felt unqualified to participate in clinical discussions:

> I can't [say to] one of my lads "listen, you're on 20mls you've got to come down to 17, 18"… We can't get involved because it's the nurse, the healthcare team and him (Staff, Prison 3).

With neither prescribers nor prisoners pushing for abstinence, officers described several wing residents staying on stable prescriptions for over a year.

Accepted Manuscript

ACCEPTED MANUSCRIPT

Finally, it seemed likely that the scarcity of abstinence was related to prisoners' lack of recovery capital. Interviewees had served a mean of ten previous prison sentences, and only one had a history of employment. Clinical staff described prisoners arriving malnourished, with dire mental health, dental problems, and 'a lot of wounds that have just been left' (Staff, Prison 3). Opportunities to build recovery capital were also sparse, consisting of access to the gym and occasional cookery classes. In this context, senior staff had come to see abstinence as highly ambitious:

> I don't think [recovery] means abstinence because I'm not sure how realistic [that is] (Staff, Prison 3).

Prisoners concurred. Only one interviewee aspired towards abstinence before release, with others preferring stability and a transfer to community services:

> Lately I've been dropping two mil [of methadone per month]. Now I think I'm gonna chill [and] go onto Subutex when I'm out (Prisoner, Prison 3).

Prison data on 112 DRW completions in 2012-13 identified only three transfers to Prison 3's abstinence-based treatment unit.

Type C: 'The Person, Not the Substance'

Type C DRWs operated in three prisons, and were distinguished by their primary focus on abstinence. Each housed between 40 and 60 prisoners and, though none intentionally excluded former heroin users, they proved scarce:

> We've got cannabis, alcohol, crack cocaine. We've got ecstasy users. And interestingly, this morning we only had one heroin user (Staff, Prison 6).

Accepted Manuscript

ACCEPTED MANUSCRIPT

Staff in Prisons 4 and 6 confirmed that, respectively, 11% and 2% of DRW residents had histories of opiate dependence. Contrastingly, NDTMS data for 2012-13 shows that 35% of all prisoners accessing treatment in Prison 4, and 55% of those in Prison 6 named heroin as their drug of choice. Prison 5 was in Wales, meaning that NDTMS data were unavailable. Lead staff also felt unable to ask for information on opioid prescribing from clinical colleagues. The only officer who estimated the proportion of prisoners on the DRW who were prescribed methadone put the proportion at 5-10%, based on the number of prisoners queuing up for methadone in the DRW's daily, dedicated methadone round. This suggested that opiate users were likely to be less prevalent in the DRW than in prison-wide treatment services.

Type C DRWs formally disavowed themselves of any interest in drug of choice, seeing 'addiction' as a generic construct and abstinence as the most meaningful response. Within this framework, generic motivation towards change became the main selection criterion:

> It's irrelevant, their drug of choice. It could just be cannabis. It could just be alcohol. It could be crack-cocaine-heroin-everything… Do they want to change? (Staff, Prison 6).

A second criterion imposed a cap on applicants' levels of medication. No Type C DRW accepted anyone who was prescribed more than 40 millilitres of methadone, or two milligrams of Subutex. This excluded some OST recipients from the DRW, though not enough to fully explain the scarcity of former heroin users. A governor in Prison 6 stated that 'we've got circa 120 men that are taking 2 mils or less of methadone' prison-wide. Just one was in the DRW.

Accepted Manuscript

ACCEPTED MANUSCRIPT

A distinctive Type C DRW cohort emerged, defined by cannabis, cocaine and alcohol dependency, and high levels of recovery capital. Very few had served more than two prison sentences, with thirteen (of twenty-five, for whom data was secured) imprisoned for the first time. In DRW 5 and 6, nearly all interviewees had robust employment histories and secure future housing – often with partners and children awaiting their release. Even DRW 6's sole opiate dependent resident was notable for his social conformity:

> I did depend on codeine a little bit when alcohol was taken away from me. But as a habit… it probably only ever really appealed to me because you could buy it over the counter. It wasn't exactly illegal so I didn't see them as being as despicable as the rest of them to be addicted (Prisoner, Prison 6).

As he reflected, his access to recovery capital was longstanding: 'I grew up in [a] middle and higher class background.'

Staff attributed the scarcity of OST recipients on DRWs to their particular lack of motivation:

> Clients on methadone and Subutex aren't… motivated. [They] just want to come in, get their two mils a day, sit in their cells, not go to work, not get in employment, nothing (Staff, Prison 6).

However, it also seemed likely that social factors shaped the constitution of these wings. Long-term medication unites opiate users, distinguishing them from all other prisoners: those with any other drug of dependence are fully detoxified within two weeks of entering prison. This supports two forms of exclusion. Firstly, for so long as OST

Accepted Manuscript

ACCEPTED MANUSCRIPT

recipients are defined by their access to medication, abstinence-focused wings risk sending an implicit message that they are for everyone *except* heroin users. This message could be strengthened by housing all heroin users on dedicated 'stabilisation wings.' (This was the case in Prison 6, whose DRW housed the lowest proportion of heroin users across sites.) Secondly, heroin users lie towards the bottom of any hierarchy of drug users (e.g. Lloyd 2013). This was certainly the case in many rapid assessment DRWs:

> "Ah you're a smackhead a dirty scumbag. Fucking rob your nan" and all that. You do get that [from other prisoners] (Prisoner, Prison 1).

For OST recipients, DRWs that were dominated by alcohol, cannabis and cocaine users could consequently be intimidating environments. This may have further deterred applications.

Type D: 'the Power of Few'

Type D DRWs consisted of three very small units (including both of those in women's prisons), each housing between eight and twenty prisoners. None held more than 2.4 per cent of their parent prison's population.

Working with very small cohorts, staff in Type D DRWs felt that they were particularly successful at supporting former heroin users through OST detoxification. At least half of each site's residents had histories of heroin use, and were recruited whilst still prescribed OST. However, very rapid reduction regimes and complete detoxification were the norm. Full detoxification was expected of all residents in Prisons 7 and 8, with suggested completion rates as high as 'ninety per cent' (Staff, Prison 7). No such formal

Accepted Manuscript

ACCEPTED MANUSCRIPT

requirement existed in Prison 9, but its DRW residents still described some of the fastest reductions from the highest doses encountered across sites.

OST recipients' willingness to detoxify appeared to be supported by several factors. From the outset, staff recognised the scale of the challenge presented by detoxification, and purposefully housed 'stabilising populations' of fully abstinent prisoners (many of whom had histories of alcohol dependence) alongside those with OST prescriptions. Professional support was both intensive (a minimum of nineteen hours per week, mostly comprising group treatment), and geared towards the development of strong peer groups: all Type D DRW prisoners undertook treatment together.

Sharing both group therapy and accommodation seemed to support the emergence of safe therapeutic spaces. Emotional vulnerability, a sign of weakness on other wings, became a source of shared strength and personal development:

> [Victim awareness] was stressful, it was upsetting, I did cry. [But] we've got nine other guys who… were looking at it cold stone sober. We were there to support each other, If it was just one on one, I think I would have gone away and got really depressed… but doing it within the group… really helped (Prisoner, Prison 8).

Within these environs, OST recipients detoxified apace. Staff in Prison 7 described several going 'cold turkey' from 20 millilitres of methadone, willingly committing to a level of physical and emotional hardship that was unheard of in some other DRWs. In Prison 9, medicated interviewees described sustained reduction regimes of ten millilitres of methadone per week from initial doses as high as 180mls. Nearly all interviewees who were medicated on arrival had either achieved abstinence, or were well on the way to attaining it.

ACCEPTED MANUSCRIPT

Prisoners presented their peers as the most essential element of their recovery communities. Detoxification was supported in ways that seemed unimaginable on other wings:

> Upstairs… people come in, "oh, why don't you go and get this… they'll sort you out [with drugs]." Down here, they were coming in and talking to me [when] I was lying on the bed. "You know, you'll be alright" (Prisoner, Prison 7).

Contrary to the 'no grassing' ethos that dominates many prisoners' lives (see, for example, Crewe 2009:241-253; Sykes and Messinger 1960:6), when a dealer was 'lodged' in one DRW the residents took swift action:

> We all went [to the staff] and said, "look, we're not having it" (Prisoner, Prison 9).

Residents in Type D units thus took responsibility for promoting pro-recovery behaviours within their peer group, whilst 'policing out' negative influences.

Discussion

Pilot DRWs were established with the intention of bringing recovery into prisons, by establishing 'wing-based, abstinence-focused recovery services' (HM Govt 2010:12) to recruit 'offenders who have the goal to be drug free' (PIRU 2012:2). In this rapid assessment, it seemed striking that only staff in very small, hyper-selective, Type D DRWs claimed to routinely support former heroin users through a full detoxification process. This resonates with the findings of the ACMD (2013), and raises several queries about the place of imprisoned heroin users within recovery services.

Accepted Manuscript

ACCEPTED MANUSCRIPT

Firstly, do imprisoned heroin users want abstinence? In the much-referenced Drug Outcomes Research in Scotland (DORIS) study, McKeganey *et al* identified that across prison and community samples, '56% of drug users cited that becoming drug free was their sole goal from treatment' (2008:16). Whilst this may be the long-term goal of many heroin users it is notable that the question does not unpick what respondents understood by 'becoming drug free', or if this included detoxification from OST (Neale, Nettleton and Pickering 2011): the aspect of treatment that spurred the emergence of a recovery movement, and that proved most elusive for former heroin users in pilot DRWs. Indeed, prioritising motivation towards abstinence and requiring sustained progress towards that goal appeared to filter out former heroin users from DRW treatment populations. This was most starkly highlighted in Prisons 3 and 6, which each had both abstinence-focused and OST treatment wings (though they differed in which of these was called a 'DRW'). The abstinence-focused wings overwhelmingly housed formerly cocaine, alcohol and cannabis dependent prisoners (and one former codeine user); the OST wings exclusively housed former heroin users. To the frustration of staff, the two populations did not seem to mix.

This may reflect a divide between person-centred and service-level recovery goals in particular service user groups (Duke 2013:45). When creating services that explicitly pushed for medication abstinence, DRWs only attracted those who found these goals personally appealing. Building on the ACMD's (2013) expectation that former heroin users will benefit from long-term extensive treatment journeys, units wishing to support OST recipients in making greater progress towards abstinence may benefit from developing stepped treatment journeys premised on considerably more preparatory

Accepted Manuscript

ACCEPTED MANUSCRIPT

motivational work (e.g. Prochaska, Norcross and DiClemente 1997), and extensive preparation for release.

Secondly, why might imprisoned heroin users be particularly reluctant to detoxify? Systemic, structural and social factors all seem relevant here. Systemically, only OST recipients have to 'choose' abstinence in prison. Heroin users held on remand or serving short-term sentences can expect maintenance prescribing (DoH 2006), and are the only group whose dependence and tolerance is actively sustained in order to avert a risk of post-release overdose (Farrell and Marsden 2005; Farrell and Marsden 2008; DH 2006). All other prisoners are fully detoxified within two weeks of entering prison, and are consequently eligible for abstinence-focused DRWs by default.

Structurally, heroin users are disadvantaged by their lower levels of recovery capital (ACMD 2013; Cloud and Granfield 2008; Laudet and White 2008). This was reflected within this study; when compared with Type C DRW cohorts, interviewees in Type A and B units had few resources with which to attain abstinence and few reasons for desiring it. After interviewing middle-class former drug users, Cloud and Granfield were surprised when a poor, unwell, inner-city interviewee asked:

> "Get clean for what – to feel miserable all the time?" (2008:1979).

This bleak statement adequately reflects the challenge sobriety presented for many more marginalised interviewees, who realistically expected to face poverty, broken families, homelessness or dire housing, skills shortages, unemployability, and poor mental health following their release. This resonates with Cloud and Granfield's conclusion:

Accepted Manuscript

ACCEPTED MANUSCRIPT

> Whilst persons from various backgrounds can be "susceptible" to chronic substance misuse, the capacity for successfully terminating these problems after they occur is not equally distributed across all sections of society (2008:1981).

From a staff perspective, encouraging heroin dependent prisoners to make headway against such disadvantage may appear questionable due to the greatly elevated risk of death abstinence presents (Farrell and Marsden 2005; Farrell and Marsden 2008).

Finally, in social terms, heroin users are at the bottom of drug users' and prisoners' hierarchies (Crewe 2009; Lloyd 2013). OST groups former heroin users together, sometimes segregated from other prisoners in dedicated, medicated wings. Applying to an abstinence-focused treatment unit may be a bold step for this group, requiring a move to a wing where they do not 'belong'. This may go some way towards explaining the situation in Prison 6, wherein staff believed 'over 120 men' were staying on low-dose OST to avoid being transferred to other wings.

This systemic, structural and social context seems highly significant in understanding the lived meaning of motivation towards abstinence. In regarding drug of choice as 'irrelevant' to recruitment and selection, Type C DRWs ignored the fundamental inequalities that undergird motivation towards abstinence – and that, by proxy, define heroin users and their 'place' within prisons (Hannah-Moffat 2001; ACMD 2013). Formal equality of opportunity consequently led to real-world inequality of access.

This leads to a final question: what kind of services might safely support imprisoned heroin users into abstinence? This is a challenging question to answer, and it is not without reason that the 2010 Drug Strategy (HM Govt) emphasised a need for services to

Accepted Manuscript

ACCEPTED MANUSCRIPT

work with clients' *existing* recovery capital. As Best and Laudet reflect, recovery capital is very hard for services to develop / enhance:

> It is not direct treatment effects that will trigger the growth of recovery capital; rather, it is likely to be a range of life events and personal and interpersonal transitions: attachment to a conventional person (spouse); stable employment; transformation of personal identity; ageing; inter-personal skills; and life and coping skills. However, this does not mean that treatment providers or commissioners have nothing to offer – they are often best placed to act as guides to recovery communities, and they are essential in activating the basic health supports that are needed (2010:5-6).

Strikingly, services focused on building recovery capital were generally absent from DRWs. Indeed, in many ways prison militates directly against the nurturing and development of recovery capital (Cloud and Granfield 2008). With jobs that pay top-end wages of less than £15 per week, short-term prisoners can hardly hope to develop the 'economic or financial capital' that comprises physical capital, or social capital in the guise of 'membership in a social group [that] confers resources, reciprocal obligations, and benefits on individuals who may use this "stock" to improve their lives' (Cloud and Granfield 2008:1973). Indeed, the most prison-based services might realistically hope to achieve with multiply marginalised short-term prisoners is basic restitution of their capacity to negotiate daily life through knowledge, skills and education (human capital), and a realigning of DRW residents' worldview to accord with conventional pro-social norms (cultural capital) (Cloud and Granfield 2008:1974).

ACCEPTED MANUSCRIPT

To achieve this, meaningful interventions must be able to make headway against decades of structural disadvantage and systemic marginalisation. Type D DRWs appeared to thrive, increasing the impact of limited resources by engaging very small numbers of prisoners. Small wings may also offer advantages that cannot be upscaled, and that make them particularly well suited to supporting populations with high levels of complex need. Large wings present significant security problems (Woolf 1991). They also offer residents less secure and stable prisoner communities, and foster poorer interactions with staff (Johnsen and Granheim 2011; James 2003; Henley 2003). Contrastingly, small wings have a robust history of supporting cohesive, accountable and therapeutic communities, even in highly challenging populations (Johnsen 2011; Henley 2003; James 2003:97; Stevens 2013:172; Cooke 1989). Having the capacity to be highly selective, and to house 'role model' abstinent prisoners alongside those who are receiving OST, supports small wings in creating a sense of shared 'recovery purpose' (Pawson 2006:146). As Deegan reflects, this is important because…

> …it becomes very difficult to continue to convince oneself that there is no hope when one is surrounded by people who are making strides in their recovery! (1988:58).

Insofar as the scale of large, unselective wings made it hard to build momentum for change, Type D DRWs consequently seem well-designed for supporting marginalised, recovery-curious imprisoned heroin users (ACMD 2013).

Framed by this context, McKeganey *et al* reflect that larger prison-based interventions will require substantial resourcing if they are to effectively support highly marginalised groups:

ACCEPTED MANUSCRIPT

> This must mean expanding the availability of treatments which contain the flexibility and range of skills required to address the diversity and complexity of prisoners' needs… However, all of these have very significant resource implications. All… perform best the more that is invested in them (2008:2).

In the case of pilot DRWs, it seems likely that limited ongoing funding determined their capacity to deliver highly ambitious outcomes in an inordinately challenging group: no pilot DRW offered intensive treatment to large groups of heroin users, and large wings turned OST and abstinence into very uneasy bedfellows. To a considerable extent, this unintentional divide mitigated any potential concerns about the greatly elevated risk of overdose imprisoned heroin users might face should they attain medication abstinence (Farrell and Marsden 2005; Farrell and Marsden 2008). Nonetheless, it raises questions for prison-based recovery services who, in the likely absence of additional resourcing, may benefit from explicitly choosing which to prioritise: unit size; ambitious recovery goals; or small gains within the most disadvantaged and socially costly of client groups.

Declaration of interest

This is an independent report commissioned and funded by the Policy Research Programme in the Department of Health. The views expressed are not necessarily those of the Department.

Accepted Manuscript

ACCEPTED MANUSCRIPT

References

Advisory Council on the Misuse of Drugs (2013). *What Recovery Outcomes does the Evidence Tell Us We Can Expect? Second Report of the Recovery Committee*. London: ACMD

Advisory Council on the Misuse of Drugs (2015). *How can Opioid Substitute Therapy (and Drug Treatment Recovery Systems) be Optimised to Maximise Recovery Outcomes for Service Users.* London: ACMD

Ashton, M. (2008). The new abstentionists. *Druglink Special Insert,* Dec / Jan 2008, 1-16

Best, D., and Laudet, A.B. (2010). *The Potential of Recovery Capital.* London: RSA

Boreham, R., Cronberg, A., Dollin, L., & Pudney, S. (2007). *The Arrestee Survey 2003-2006. Home Office Statistical Bulletin.* London: Home Office RDS Directorate

Centre for Social Justice (2007). *Breakthrough Britain: Addictions.* London: Centre for Social Justice

Cloud, W., and Granfield, R. (2008). Conceptualising recovery capital: expansion of a theoretical construct. *Substance Use and Misuse,* 43, 1971-1986

Cooke, D.J. (1989). Containing violent prisoners. An analysis of the Barlinnie Special Unit. *British Journal of Criminology,* 29(2), 129-143

Crewe, B. (2009). *The Prisoner Society. Power, Adaptation and Social Life in an English Prison.* Oxford: OUP

Accepted Manuscript

ACCEPTED MANUSCRIPT

Deegan, P.E. (1988). Recovery: the lived experience of rehabilitation. *Psychosocial Rehabilitation Journal*, 11, 11-19

Department of Health (2006). *Updated guidance for prison based opioid maintenance prescribing*. London: Department of Health

Department of Health & Addaction (2004). *National Aftercare Research Project Report. Year 1*. London: Addaction

Duke, K. (2013). From Crime to Recovery: The Reframing of British Drugs Policy?, *Journal of Drug Issues*, 43, 39-55

Easton, M. (2006). *Drug Services Make Slow Progress*. Retrieved 10th June 2014 from http://news.bbc.co.uk/1/hi/uk/7068572.stm

Farrell, M., and Marsden, J. (2005). *Drug-Related Mortality Among Newly-Released Offenders 1998 to 2000. Home Office Online Report 40/05*. London: Home Office.

Farrell, M., and Marsden, J. (2008). Acute risk of drug-related death among newly released prisoners in England and Wales. *Addiction*, 103, 251-255

Godfrey, C., Stewart, D., & Gossop, M. (2003). Economic analysis of costs and consequences of the treatment of drug misuse: 2-year outcome data from the National Treatment Outcome Research Study (NTORS). *Addiction,* 99, 697-707

Green, B.L., Miranda, J., Daroowalla, A. and Siddique, J. (2005). Trauma exposure, mental health functioning, and program needs of women in jail. *Crime and Delinquency,* 51, 133-151

Accepted Manuscript

ACCEPTED MANUSCRIPT

Hannah-Moffat, K. (2001). P*unishment in Disguise: Penal Governance and Canadian Women's Imprisonment*. Toronto: University of Toronto Press

Heidari, E., Dickinson, C., Wilson, R., and Fiske, J. (2007). Oral health of remand prisoners in HMP Brixton, London. *British Dental Journal*, 202, online article number E5

Henley, S. (2003). *The 21st Century Model Prison. Proceedings of the 4th International Space Syntax Symposium London 2003*

HM Government (2002). *Updated Drug Strategy 2002*. London: HMSO

HM Government (2008). *Drugs. Protecting Families and Communities. The 2008 Drug Strategy.* London: HMSO

HM Government (2010). *Drug Strategy 2010: Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug Free Life*. London: HM Govt

Holloway, K. & Bennett, T. (2004). *The Results of the First Two Years of the NEWADAM Programme. Home Office Online Report 19/04*. London: Home Office

Home Affairs Committee (2012). *Ninth Report of Session 2012-13. Drugs: Breaking the Cycle.* London: The Stationery Office Ltd.

House of Commons Justice Committee (2014) *Prisons: Planning and Policies. Ninth Report of Session 2014-15.* London: HMSO

Home Office (2008). *The Drug Interventions Programme. Out of Crime, Into Treatment*. London: Home Office

Accepted Manuscript

ACCEPTED MANUSCRIPT

House of Commons Justice Committee (2014). *Prisons: Planning and Policies. Ninth Report of Session 2014-15.* London: HMSO

James, E. (2003). *A Life Inside. A Prisoner's Notebook.* London: Atlantic Books

Johnsen, B., and Granheim, P.B. (2011). Prison size and quality of life in Norwegian closed prisons in late modernity. In T. Ugelvik and Dullum J. (eds.) *Nordic Prison Practice and Policy – Exceptional or Not?* London: Routledge

Jones, A., Weston, S., Moody, A., Millar, T., Dollin, L., Anderson, T., and Donmall, M. (2007). *The Drug Treatment Outcomes Research Study (DTORS): Baseline Report*. London, Home Office

Laudet, A.B., and White, W.L. (2008). Recovery capital as prospective predictor of sustained recovery, life satisfaction and stress among former poly-substance users. *Substance Use and Misuse,* 43, 27-54

Lipsky, M. (2010). *Street-Level Bureaucracy. Dilemmas of the Individual in Public Services.* New York: Russell Sage Foundation

Lloyd, C. (2013). The stigmatisation of problem drug users: a narrative literature review. *Drugs: Education, Prevention and Policy*, 20, 85–95.

Loeb, S.J., and Steffensmeier, D. (2006). Older male prisoners: health status, self-efficacy beliefs, and health-promoting behaviours. *Journal of Correctional Healthcare*, 12, 269-278

Accepted Manuscript

ACCEPTED MANUSCRIPT

McKeganey, N., Bloor, M., McIntosh, J., and Neale, J. (2008). *Key Findings from the Drug Outcome Research in Scotland (DORIS) Study*. Glasgow: University of Glasgow Centre for Drug Misuse Research

Ministry of Justice (2010). *Breaking the Cycle: Effective Punishment, Rehabilitation and Sentencing of Offenders*. London: MoJ

Ministry of Justice (2015). *Population bulletin: weekly 20 November 2015*. Retrieved 26th November 2015 from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/478575/prison-population-figures-20-nov-2015.xls

National Treatment Agency (2010). *Business plan 2010-11*. London: NTA

Neale, J., Nettleton, S., and Pickering, L. (2011). What is the role of harm reduction when drug users say they want abstinence? *International Journal of Drug Policy,* 22, 189-193

Patel (2010). *The Patel Report. Prison Drug Treatment Strategy Review Group.* London: HMSO

Pawson, R. (2006). *Evidence Based Policy: A Realist Perspective*. London: Sage.

PIRU (2012). *Advisory Note to the Department of Health on the Evaluation of the Drug Recovery Wing Pilots Programme*. London: London School of Hygiene and Tropical Medicine

Powis, B., Walton, C., & Randhawa, K.(2014). *Drug Recovery Wings Set Up, Delivery and Lessons Learned: Process Study of First Tranche DRW Pilot Sites*. London: Ministry of Justice

Accepted Manuscript

ACCEPTED MANUSCRIPT

Prochaska, J.O., DiClemente, C.C., & Norcross, J.C. (1992). In search of how people change. Applications to addictive behaviours. *American Psychologist,* 47(9), 1102–14

Seale, C. (2004). Validity, reliability, and quality. In C Seale (ed) *Researching Society and Culture* (pp.71-83). SAGE: London

Seddon, T., Williams, L. and Ralphs, R. (2012). *Tough Choices. Risk, Security and the Criminalization of Drug Policy.* Oxford: OUP

Skodbo, S., Brown, G., Deacon, S., Cooper, A., Hill, A., Millar, T., Smith, J. and Whitham, K. (2007). *The Drug Interventions Programme (DIP): Addressing Drug Use And Offending Through 'Tough Choices'*. London: Home Office

Social Exclusion Unit (2002). *Reducing Re-Offending by Ex-Prisoners*. London: Social Exclusion Unit

Stevens, A. (2013). *Offender Rehabilitation and Therapeutic Communities. Enabling Change the TC Way*. Abingdon: Routledge

Stimson, G.V., Fitch, C., and Rhodes, T. (1998). *The Rapid Assessment and Response Guide on Psychoactive Substance Use and Prevention.* Geneva: World Health Organisation

Stimson, G.V., Fitch, C., Jarlais, D.D., Poznyak, V., Perlis, T., and Rhodes, T. (2006). Rapid assessment and response studies of injection drug use: knowledge gain, capacity building and intervention development in a multisite study. *American Journal of Public Health*, 96, 2, 289-295

Accepted Manuscript

ACCEPTED MANUSCRIPT

Strang, J. (2012). *Medications in Recovery. Re-Orientating Drug Dependence Treatment.* NTA: London

Sykes, G.M. and Messinger, S. (1960) 'The inmate code and its social functions.' In R.A. Cloward (ed.), *Theoretical Studies in the Social Organisation of the Prison.* New York: Social Science Research Council

White, W.L. (2007). A recovery revolution in Philadelphia. *Counselor,* 8, 34-38

White, W.L. and Cloud, W. (2008). Recovery capital: a primer for professionals. *Counselor*, 9, 22-27

Woolf (1991) Prison Disturbances, April 1990. Report of an Inquiry. London: HMSO

World Health Organisation (2010). *Prevention of Acute Drug-Related Mortality in Prison Populations during the Immediate Post-Release Period.* Denmark: WHO Regional Office for Europe

Accepted Manuscript

ACCEPTED MANUSCRIPT

Declaration of interest

This is an independent report commissioned and funded by the Policy Research Programme in the Department of Health (PRP reference number 011/0056). The views expressed are not necessarily those of the Department.

Accepted Manuscript

ACCEPTED MANUSCRIPT

Table 1. Drug Recovery Wings: basic characteristics, and DRW 'types'.

DRW	Kind of Prison	Beds (DRW clients)	% of prison population	DRW 'type'
DRW 1	Category B men's	132 (88)	23%	Type A ('Comprehensive clinical')
DRW 2	Category B men's	140 (92)	23%	
DRW 3	Category B men's	60 (50)	5%	Type B ('Selective clinical')
DRW 4	Category C men's	60 (40)	5%	Type C ('The user, not the drug')
DRW 5	Category B men's	49 (49)	11%	
DRW 6	Category B men's	90 (60)	6%	
DRW 7	Category A men's	22 (18)	1%	Type D ('The power of few')
DRW 8	Women's	20 (7)	2%	
DRW 9	Women's	22 (11)	2%	

Accepted Manuscript