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# The potential of prisons to support drug recovery

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## Abstract

**Purpose** – Recovery is the predominant discourse within current UK drug policy, promoted as freedom from dependence. In support of such a policy driver, prison drug recovery wings have been piloted in ten prisons in England and Wales to address high drug prevalence rates in prisoner populations. The purpose of this paper is to explore the development of these specialist wings within the context of wider developments to tackle reoffending among drug-using prisoners.

**Design/methodology/approach** – The first part of the paper offers an analysis of the emergence of the recovery paradigm in the prison context through analysis of official policy documents. The second draws predominantly upon two process evaluations of the drug recovery wings, alongside literature on prison drug treatment.

**Findings** – There is limited empirical evidence to inform the debate about whether prisons can provide settings to facilitate recovery from the effects of illicit drug use. What is available suggests that effective therapeutic environments for recovering drug users could be established within prisons. Key components for these appear to be sufficient numbers of staff who are competent and confident in providing a dual role of support and discipline, and a common purpose of all prisoners committing to recovery from illicit drugs and supporting each other. Further research regarding the impact of drug recovery wings upon health, crime and wider social outcomes is needed.

**Originality/value** – This paper provides an updated perspective on the development of drug treatment in prisons, with a particular focus on the implications of the new recovery paradigm.

**Keywords** Policy, Recovery, Prisons, Drug recovery wings, Drug treatment, Reoffending

**Paper type** Viewpoint

## Background

There is extensive evidence to suggest that a significant proportion of the 85,892 prisoners in England and Wales (on 27 November 2015; Ministry of Justice, 2015a) have histories of using drugs. In addition, a considerable body of literature suggests that problem drug use is often related – albeit in a complex way – to offending behaviour (Bennett and Holloway, 2009; Hammersley, 2008). A survey of 1,453 newly sentenced adult prisoners (Light *et al.*, 2013) found that four-fifths had ever used drugs; almost two-thirds had done so in the four weeks before being imprisoned, and approximately half of these most recent drug users had taken a Class A drug (ecstasy, LSD, heroin, crack cocaine, cocaine and methadone). This recent drug user group were over twice as likely to reoffend within one year of their release (62 per cent cf. 30 per cent). These data suggest high levels of problem drug use. Coupled with evidence of drug use in prison obtained via mandatory drug testing data (in place since 1996), drug seizure statistics and HM Inspectorate of Prison inspections, they suggest the need for a concerted effort to provide access to drug treatment for prisoners, alongside tackling the broader problems relating to drug use in prison.

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This has taken place over the past 20 years. A series of strategies dating back to 1995 have sought to guide prisons in their responses to dealing with these issues. Prior to this, official reports pointed to the lack of drug treatment provision within prisons (ACMD, 1979; House of Commons Social Services Committee, 1985) and there was a reluctance to acknowledge the existence of a drug “problem” within prisons in England and Wales (Paylor *et al.*, 2010). By the late 1980s the drug “problem” could no longer be denied. A growing evidence base demonstrating the nature and extent of drug use in prison, coupled with an emerging policy network drawing attention to the risk of prisoners transmitting the HIV virus to the general population, led to “the end of the denial” (Duke, 2003, p. 67).

The first prison drug strategy – Drug Misuse in Prison: Policy and Strategy – was published in 1995 (HM Prison Service, 1995) and updated three years later (HM Prison Service, 1998) so that it aligned with the first UK national drug strategy (President of the Council, 1998). These strategic documents outlined a twin-track approach: aiming to reduce the demand for drugs within the prison whilst addressing the supply of drugs into the prison. Despite calls for harm minimisation as a pragmatic response, they focused on abstinence for fear of condoning illicit drug use. The harm reduction measures which were being rolled out in the community; for example, access to clean needles and substitute prescribing, were not offered in prisons. This represents one of the key tensions in prison drug policy, namely between treatment and punishment. We will return to this theme later in the paper when we explore the challenges of tackling drug use in prison.

In this short paper, we look critically at the development of drug recovery wings in England and Wales over the past four years. Such wings were introduced into a number of prisons in 2011 and 2012 to provide substance misusing prisoners with a drug treatment service focused on abstinence and recovery. First, we will look at the origins of drug recovery wings; outlining the emergence of the “new” recovery paradigm in the UK, and drawing out its implications for prison drug policy and practice. Second, we will discuss the implementation of the drug recovery wings, highlighting the variation across the different pilot sites whilst also drawing upon the findings of two drug recovery wing process evaluation studies. Third, we will look at the particular challenges for developing drug recovery wings, noting in particular recent changes to the drug “problem” within English and Welsh prisons and also the changing context in which drug recovery wings operate. Finally, we will outline a future research agenda for exploring this promising but unproven intervention.

### *The emergence of recovery*

As we have outlined above, the drugs “problem” has traditionally been framed as one of order, control and discipline (see Duke, 2003), rather than in terms of treatment and the prevention of harm. Consequently, the first initiatives to manage the drug “problem” included measures such as mandatory drug testing; a measure designed to discipline those who used drugs and in so doing deter others from doing so. This development has been subject to extensive research with mixed evidence regarding effectiveness (see Paylor *et al.*, 2010 for an overview). There has been less emphasis upon supporting prisoners to address their drug use. Facilitated by three significant policy changes, the 2005 drug strategy (NOMS, 2005) placed a greater emphasis upon harm reduction whilst still maintaining a commitment towards supporting prisoners to become drug-free. The first was a shift of responsibility for prison health care provision from the Prison Service to the National Health Service (Department of Health and HM Prison Service, 2002). This facilitated the development of harm minimisation measures, including opiate maintenance prescribing as an important first step on a journey towards abstinence, but also Hepatitis B immunisation and blood-borne virus testing (Marteau *et al.*, 2010). The second was increased emphasis on using the opportunities offered by all stages of the criminal justice process to channel drug users into treatment (Kothari *et al.*, 2002). Related to this, the final one was New Labour’s pursuit of the social exclusion agenda and recognition of the high rates of reoffending by prisoners, particularly those serving short sentences. Drugs and alcohol were included as one of the seven pathways in the *Reducing Reoffending National Action Plan* (Home Office, 2004). These developments led to the expansion of drug treatment within prison through the CARAT scheme (counselling, assessment, referral, advice and throughcare). Despite these efforts, it was noted in 2008 that access to drug treatment was patchy, not always of sufficient quality or appropriate, and not evidence based (Pricewaterhouse Coopers, 2008). In response to this, a Prison Drug Treatment

Strategy Review Group was convened in April 2009 to review evidence of effectiveness and make recommendations for change to promote the recovery and rehabilitation of drug users in prison and upon release (Patel, 2010). Around the same time, the Ministry of Justice published a Green Paper – “Breaking the Cycle: Effective Punishment, Sentencing and Rehabilitation of Offenders” (Ministry of Justice, 2010). This consultation document announced plans to pilot drug recovery wings. It described drug dependency as “fuel[ling] crime” (p. 8) and argued that efforts were needed to support “offenders to get off drugs for good” (p. 27).

The publication of the Patel report and the Green Paper formed part of a “new” recovery agenda with a renewed focus on abstinence. Recovery is the predominant discourse in the 2010 drug strategy – *Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug Free Life* (HM Government, 2010) – which was published by the newly formed Conservative – Liberal Democrat coalition Government shortly after its inception in May 2010. In this document, it took on a specific meaning comprising of three principles: well-being, citizenship and freedom from dependence. Recovery and abstinence are not synonymous but have been treated as such as the debate about drug treatment has become more politicised (McKeganey, 2014). This is not necessarily unique to the UK or a recent phenomenon. American commentators assert that there is a long history of institutions characterising the resolution of severe alcohol and other drug problems in moral (reformation), religious (redemption), psychological (reconstruction), criminal (rehabilitation) or medical (recovery, remission) language. They further assert that such institutions working within any of the stated paradigms tend to make strong claims regarding the origins of, and solutions for, drug dependence (White, 2005). In the UK context, the involvement of two think tanks – Centre for Policy Studies and Centre for Social Justice – have been pivotal in advancing a recovery paradigm (see Wincup, 2013), and the latter have demonstrated a particular interest in what they refer to as “drug-fuelled prisons” (Centre for Social Justice, 2015, p. 11).

In other contexts, recovery has a different meaning, placing the service user at the centre of their treatment and attempting to bridge the harm reduction/abstentionist divide (Kidd, 2010). Its origins lie in the field of mental health, and as an organising principle for treatment services in the UK and beyond, the focus has been on the process of recovery, i.e. promoting it as an active and empowering one for the service user rather than specifying what recovery is and how it might be achieved (see Thom, 2010). In contrast, a rather more prescriptive approach has been outlined for prisoners (see Patel, 2010, p. 8) which calls upon drug users “to actively engage with and assume responsibility for their own recovery, including a renewed focus on abstinence as a clear goal”. In *Putting Full Recovery First* (Home Office, 2012), the clinical guidance published five years previously was emphasised, which stated that “prisoners spending any significant period in custody will be stabilised, safely detoxified and released into the community drug free” (p. 21).

Unlike its predecessors there was less emphasis in the 2010 drug strategy on breaking the drug-crime link (Duke, 2013; Monaghan, 2012), but some attention was paid to how the criminal justice system might work most effectively with drug-using offenders. Specifically, in relation to prisoners, it introduced a series of pilots of abstinence-focused drug recovery wings. Given what we have noted already about the challenges of acknowledging the drug “problem” within prisons and responding to it in a way which does not appear to threaten order and control, we can appreciate why a concentration on abstinence might be favoured within the prison context. It appears to “square the circle” between treatment and punishment by addressing drug dependence whilst not condoning drug use. Addressing drug dependence then feeds into positive outcomes such as reduced reoffending, which has been a priority of successive governments over the past two decades.

Recovery is referred to in the 2010 drug strategy in high-level terms, i.e. in terms of freedom from dependence, well-being and citizenship, but there is also an attempt to operationalise this through emphasising that achieving and sustaining recovery requires drug users to establish recovery capital (social, physical, human and cultural, see Best and Laudet, 2010 for an overview of the concept). This has significant implications for work with drug-using prisoners who typically have low levels of recovery capital and experience problems which are likely to make it difficult for them to recover; for example, poor mental health, lack of access to suitable housing and limited work histories (Hopkins, 2012; Light *et al.*, 2013; Williams *et al.*, 2012). There is also a growing appreciation of the need to recognise that the nature and extent of recovery capital may differ for females and males (Neale *et al.*, 2014; Thom, 2010; Wincup, 2016).

The next section explores the emergence of drug recovery wings in ten prisons in England and Wales. It draws upon the only published evaluation studies of prison recovery wings (Lloyd *et al.*, 2014; Powis *et al.*, 2014) to explore whether such developments can offer an opportunity for prisoners to “recover”, and overcome some of the difficulties which have been associated with the delivery of prison-based drug treatment in the past. Both studies used semi-structured interviews to gather qualitative data from prisoners and drug recovery wing staff at the pilot sites. Powis *et al.* (2014) evaluated the first tranche of pilot sites and in total interviewed 36 members of the drug recovery wing staff, 16 members of staff from the wider establishment, 12 partnership staff members, 44 current prisoner drug recovery wing participants and six drug recovery wing participants who did not complete the regime. These interviews took place between November 2011 and June 2012, whilst the drug recovery wings were still in the early stages of implementation. Lloyd *et al.*'s (2014) rapid assessment focused on all ten of the pilot sites, interviewing 102 prisoner drug recovery wing participants overall and 97 members of staff across the sites. These interviews were conducted in 2013.

### *The emergence of drug recovery wings*

The first wave of pilot drug recovery wings were introduced into HMP Bristol (category B male), Brixton (category C/D male), High Down (category B male), Holme House (category B male) and Manchester (category A male) in June 2011 (Policy Innovation Research Unit, 2012). The second tranche were launched in the remaining five prisons in April 2012; HMP Chelmsford (category B male), New Hall (closed female), Styal (closed female), Swansea (category B male) and Brinsford (male young offenders) (Lloyd *et al.*, 2014). The specific aim of these drug recovery wings was identified to move those with substance misuse problems from dependence towards full recovery from their addiction through the provision of intensive support. The need to improve continuity of care between prisons and the community was also emphasised (Powis *et al.*, 2014).

Although the drug recovery wings have the same overarching aims, there is considerable variation in how they are run in each prison. Pilot prison sites were encouraged to develop their own drug recovery wing model based upon the needs of the local population they would be serving, and the environment of the establishment in which they were located (Lloyd *et al.*, 2014). As such, there is no universal mechanism for selecting participants onto the drug recovery wings, however, most of the sites emphasised the importance of prisoners being motivated to change and move towards abstinence as criteria for suitability to be placed on the drug recovery wings (Lloyd *et al.*, 2014). There is also considerable variation in the length of time participants spend on the drug recovery wings; for example, participants at HMP Bristol reside on the wing for approximately 28 days before being moved on (either released or moved to another wing within the establishment), whilst those at HMYOI Brinsford were able to reside on and receive the drug recovery wing services for up to two years (Lloyd *et al.*, 2014). The range of services provided at the pilot sites are also very different but generally include the following: pharmacological services, psychosocial services such as SMART recovery groups and one-one sessions with key workers, mutual aid groups such as Narcotics Anonymous and Alcoholics Anonymous, and holistic services such as life skills group sessions, education/employability sessions, extra gym sessions, acupuncture and yoga (this list is not exhaustive, please see Lloyd *et al.*, 2014 for full list of services provided at each of the drug recovery wing sites). In line with the aim to improve continuity of care between prisons and the community, the majority of the pilot drug recovery wings also provide “through the gate” services. Such services include housing and employment initiatives, access to a family support worker, pre-release meetings with community agencies and escorting participants to community appointments post-release (Lloyd *et al.*, 2014). The pilots recognised – to differing extents – that efforts are needed to allow drug users to establish different forms of recovery capital to help them achieve, and crucially sustain, full recovery. The available evidence on drug recovery wings suggests that some have at least taken steps to allow prisoners to build upon their low levels of recovery capital.

Relationships between prisoners and staff on the wing are crucial to building recovery capital. Both Powis *et al.* (2014) and Lloyd *et al.* (2014) found that prisoners, prison officers and the drug recovery wing non-custodial staff perceived the prisoner-staff relationships on the drug recovery wing to be overwhelmingly positive. A large proportion of prisoners interviewed highlighted the

high levels of support provided by the specialist prison officers on the drug recovery wing, with many suggesting that they are much more supportive than the officers from the mainstream wings within the establishment. This is captured in the following quote “other wings, it’s clearly us and them. Here there’s a family feeling” (Powis *et al.*, 2014, p. 25). These positive prisoner-staff relationships could be explained by the fact that many of the prison officers on these wings have received specialist substance misuse training, and have volunteered for or been selected for the role based upon previous experience. Past research has indicated that specially trained substance misuse officers appear to be more supportive towards and hold less negative attitudes towards drug-using prisoners than “mainstream” prison officers (McIntosh and Saville, 2006). However, although both evaluation studies found that prison officers did concur that prisoner-prison officer relationships were good, a number of the prison officers interviewed in Lloyd *et al.*’s (2014) study did note the tension between care and discipline, and the difficulty of finding the correct balance between the two.

Balancing care and discipline is a challenge for the prison system generally but is heightened on abstinence-focused drug recovery wings. Staff working on the wings have care and control functions which have typically been understood as the cause of antagonistic relationships between staff and prisoners. To understand this further it is worth dwelling on who might comprise the staff on these wings. They include prison officers but also drug workers, and it is likely that these two categories of staff have different occupational identities which could potentially result in conflict between staff, as well as between staff and prisoners. Evidence from a research study conducted in Finland and Sweden (Kolind *et al.*, 2015) found evidence of positive adaptation with drug workers integrating and reinterpreting the control, order and disciplinary sanctions of the prison environment into their treatment approach. Conversely, officers highlighted the treatment ethos in their control work. It is, of course, foolish to assume that this will automatically be replicated within other jurisdictions, but does suggest that seemingly incompatible rationalities can co-exist in practice. Since the introduction of quasi-compulsory drug treatment for offenders following the 1998 drug strategy, community-based drug workers in the UK have had to incorporate elements of control into their work with clients, as non-engagement and relapse potentially constitute a breach of their community sentence or licence conditions (see Hucklesby and Wincup, 2010).

It was not only support from staff that was deemed important in working towards recovery on the drug recovery wings, but support amongst prisoners. In both of the evaluation studies, the majority of the prisoners interviewed felt they had been supported and encouraged by their peers on the wing, with staff and prisoners reporting a more relaxed, therapeutic environment with less bullying than that found on other wings within the establishment. Both prisoners and staff often referred to the drug recovery wing as having a sense of community whereby prisoners could support each other in their efforts towards achieving recovery. This community feel may have been facilitated by the drug recovery wings at each site being either partially or fully segregated from the wider prison, thereby creating a supportive environment similar to those created by therapeutic community models. This may have been enhanced further by the numerous mutual aid sessions provided, such as the Narcotics Anonymous, Cocaine Anonymous and Recovery is Out There group sessions. Such mutual aid groups have been shown to have a positive impact on substance misuse outcomes (National Treatment Agency, 2013), particularly when accessed alongside the provision of a structured treatment programme (Fiorentine and Hillhouse, 2000). One issue related to peer support on the drug recovery wings was the placement of “lodgers”; those placed on the wing due to capacity or high-risk issues rather than to access the different substance misuse services. Research by Lloyd *et al.* (2014) and Powis *et al.* (2014) found that staff and prisoners on the drug recovery wing perceived lodgers to be problematic, impacting upon the therapeutic environment of the wing and taking up spaces which should be reserved for those prisoners wanting to recover from their dependency. This suggests that in order to keep the strong therapeutic, community feel which prisoners on the wing perceive to be an important aspect, prison managers should, wherever possible, ensure that only substance misusing offenders ready to engage with drug recovery services should be placed on the drug recovery wings.

A further challenge to the long-term effectiveness of drug recovery wings is that prisoners are accommodated for only a short period of time, hence their effectiveness hinges upon the

relationships established with other services offered in the prisons and the quality of partnership working. The literature on resettlement identifies the challenges of realising this in practice (Hucklesby and Hagley-Dickinson, 2007). The range of services provided in prisons by statutory, private, voluntary and community sector organisations offers the opportunity to embrace a holistic approach to recovery, but to work effectively requires considerable co-ordination and positive working relationships between the key players. A further consideration is that prisoners may be “resettled” to other parts of the prison rather than released straight into the community. Where they are subsequently housed is crucial, particularly given recent concerns about drug availability in prisons which we will explore in the next section of the paper. The second annual review of the 2010 drug strategy (HM Government, 2013) stated that five drug-free wings were being piloted to support “recovered” prisoners, as well as prisoners who had never had a drug problem. The third annual review (HM Government, 2015) called for their expansion. Crucially, drug recovery wings can only provide part of the solution to rehabilitating drug-using offenders and there needs to be a prison-wide commitment to recovery.

Although research by Lloyd *et al.* (2014) and Powis *et al.* (2014) found some initial positive findings regarding the pilot drug recovery wings in terms of positive prisoner-staff relationships and high levels of peer support, it is important to note that they were process evaluations and therefore unable to evaluate whether drug recovery wings have actually led to behaviour change and reductions in drug use and reoffending. Similarly, recent HM Inspectorate of Prison reports have identified potential good practice but without being able to point to evidence of effectiveness (HM Chief Inspector of Prisons, 2014a, 2014b, 2015a). Therefore, further research is required to explore whether drug recovery wings can support drug users achieve recovery whilst in prison which lead to sustained reductions in drug use and reoffending upon release. Such research has been commissioned by the Department of Health and is currently underway at a number of the pilot sites (Lloyd *et al.*, 2014). Despite being unable to draw any firm conclusions until the completion of this evaluation, approximately 35 “unofficial” drug recovery wings not part of the pilot programme have been set up in prisons across England and Wales (Centre for Social Justice, 2015).

### *Challenges for drug recovery wings*

In the short space of time since drug recovery wings have been introduced, there have been noteworthy changes to the nature of the drug “problem” in UK prisons. In consecutive annual reports, HM Inspectorate of Prisons observed that diversion of prescribed medication previously reported in high security and vulnerable prison populations was now a major concern in the majority of prisons inspected, yet largely undiscovered via random or “reasonable suspicion” drug testing (HM Inspectorate of Prisons, 2012, 2013; see also Public Health England, 2013). Aside from the health risks associated with taking medication prescribed for another person (e.g. overdose or possible interactions with other prescribed medication), diverted prescription drugs are associated with drug debts and bullying, placing individuals at risk and undermining attempts to establish prisons as safe places to live and work. By 2014-2015, the main concern of HM Inspectorate of Prisons (2015) was novel psychoactive substances (NPS), such as “Spice” and “Black Mamba”, having noted the previous year that they were an emerging problem in adult male establishments, particularly local (i.e. for remand or newly sentenced prisoners) and Category D (i.e. open) prisons (HM Inspectorate of Prisons, 2014). Again the links between these drugs and threats to safety was emphasised by their unpredictable and potentially life-threatening effects. A recent Prisons and Probation Ombudsman report further highlighted the life-threatening effects of NPS, with NPS suggested to be implicated in the deaths of 19 prisoners between April 2012 and September 2014 (Prisons and Probation Ombudsman for England and Wales, 2015). Growing demand for these substances is believed to be part of the explanation for the rising number of drug seizures over the past three years (Johnston, 2015). Again, use of these drugs is not picked up via drug testing, giving the misleading impression that drug use in prisons is continuing to fall. Addressing the potential harms caused by the unexpected increase in NPS use in the prison estate is a significant challenge for drug recovery wings.

Not only has the nature of the drug problem in prisons changed since the introduction of the pilot drug recovery wings, but also the wider prison context in which they operate. From June 2013 to

the present, the prison population has increased by approximately 1 per cent per year (Ministry of Justice, 2015b), and in 2014 it was reported by the Ministry of Justice that out of the 118 prisons in England and Wales, 80 were found to be overcrowded (Ministry of Justice, 2014). As prisons are becoming increasingly overcrowded it is questionable, given the limited capacity of prison establishments, whether prisons are able to have a separate and distinct drug recovery wing where only substance misusing prisoners engaging with the programme are located. The research of Lloyd *et al.* (2014), Powis *et al.* (2014) and a recent unannounced inspection at HMP Bristol (HM Chief Inspector of Prisons, 2015b) has highlighted that such has already been found to be challenging in the pilot sites, as it was reported at the sites that non-treatment prisoners were being placed on the wing due to a shortage of space elsewhere in the prisons. As mentioned in the previous section, this placement of non-drug recovery wing prisoners on the wings may be problematic in terms of negatively impacting upon the strong therapeutic environment apparent on such wings (Lloyd *et al.*, 2014; Powis *et al.*, 2014; HM Chief Inspector of Prisons, 2015b).

Whilst the prisoner population has risen, between 2010 and 2014, the number of public sector prison officers in post has reduced by 29 per cent, from 45,080 to 32,100 (HM Inspectorate of Prisons, 2015). This reduction in prison officer numbers is partly a result of the benchmarking process introduced into public sector prisons in 2013 (House of Commons Justice Committee, 2015), with such a process aiming to make efficiency savings and ensure the competitiveness of public sector prisons are comparable with those of commercial organisations. As staffing represents one of the major prison costs, it is of no surprise that one outcome of benchmarking has been to alter staffing complements and run the service on a reduced staff resource (House of Commons Justice Committee, 2015). The negative impact on staff-prisoner ratios resulting from this process may be detrimental to drug recovery wings, as the new prison officer staffing levels on such wings may not be sufficient to conduct therapeutic work and run the drug recovery regime efficiently and safely. Recent HM Inspectorate of Prisons reports have indicated that such may the case. In HMP Brixton it was reported that recent staff shortages had led to a reduction in the number of drug tests being completed on the drug recovery wing (HM Chief Inspector of Prisons, 2015c), whilst in HMP Bristol prison officer supervision of the medication queue on the wing was found to be insufficient, resulting in a loss of privacy and an increased risk of diversion of medication (HM Chief Inspector of Prisons, 2015b). The impact of reduced staff numbers as a result of benchmarking was also expressed by staff as a major concern by Lloyd *et al.* (2014), which reported that a number of staff felt this process undermined the work of the pilot drug recovery wings.

## Conclusion

In summary, common findings from the limited published evidence to date would suggest that a therapeutic environment can be provided within prison settings to support prisoners recover from illicit drug use. Key components for such an environment appear to be sufficient numbers of staff who are competent and confident in providing a dual role of support and discipline, and a common purpose of all prisoners committing to recovery from illicit drugs and supporting each other to do so. Many unanswered questions remain which form areas for future research activity. Crucially, further research regarding the impact of drug recovery wings upon health, crime and wider social outcomes (e.g. housing and employment) are needed. Key questions are whether commitment to the programme found on drug recovery wings leads to sustained behaviour change following prison release and reduced levels of illicit drug use, reduced reoffending behaviour and reduced social exclusion. Furthermore, it remains unclear whether therapeutic environments within the prison need to be distinct locations, or whether the therapeutic concept of recovery can be applied across the whole prison estate. This is of crucial importance since the prison population in England and Wales is rising, and therefore “stand-alone” drug recovery wings could increasingly be difficult to access given the large proportion of the prisoner population with a history of drug dependence. Finally, it is important to note that the culture of drug taking is subject to rapid change and these are likely to have an impact upon whether the prison can operate effectively as a recovery setting. For example, as we have discussed there is increasing UK evidence regarding the growing prevalence of NPS misuse in



English and Welsh prisons, and emerging evidence regarding the abuse of prescribed medication within prison settings. Therefore, whilst the key components of a therapeutic recovery programme in prison may not change, their application to specific and rapidly changing drug-using norms may well require modification.

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