Ministry of Justice

# Process Evaluation of the Drug Recovery Prison at HMP Holme House

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## The authors

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# Contents

# List of tables



# List of figures

# 1. Executive Summary

The Drug Recovery Prison (DRP) which began in April 2017 was a three-year initiative at HMP Holme House, jointly funded by NHS England and HM Prison and Probation Service (HMPPS) that implemented a whole prison approach to tackle drugs in prison and aid long-term recovery. It aimed to test and develop new ways of addressing the supply and demand of substances in prison, improving health and wellbeing, supporting recovery, and reducing reoffending on release into the community. As part of this initiative the Ministry of Justice/HMPPS, supported by NHS England, commissioned a process evaluation to explore the implementation of services and initiatives introduced as part of the DRP.

## 1.1 Research Approach

The field research was undertaken in two waves (wave one Nov 2018; wave two Oct 2019), finalising before the end of the DRP pilot period. The field work comprised of five strands: analysis of the DRP documents; prisoner questionnaire; interviews and focus groups with prisoners and staff; prisoner case studies; and an analysis of Management Information (quantitative) data. A mixed-methods approach allowed for triangulation of both qualitative and quantitative data to ensure the results of the research are valid and to capture the complexity surrounding the implementation of the DRP.

Although the process evaluation examined the strategic components of the DRP and their implementation (e.g. security, activities), it also referenced some beyond the remit of the DRP, which were the responsibility of HMPPS (e.g. basic needs, education and training) and/or NHSE (e.g. healthcare) but had the potential to undermine and/or act as a barrier to effectively implementing the DRP and its initiatives. Whilst issues with these wider components are noted in the report, they are not interpreted as a failure of the DRP but instead reported to inform the wider context that is necessary to facilitate successful implementation in the future. It must be acknowledged that the activities which fell outside the scope of the DRP were being proactively managed by NHS England (where health related) and HMPPS via commissioning, contract management and partnership activities (e.g. via the Improvement Board in place between 2018 and 2020).

## 1.2 Key Findings

Overall, the majority of the DRP was successfully implemented and the key findings from the research show that the DRP is perceived to have had a positive effect on prisoners and staff and appears to have met many of the expected outcomes. However, barriers to the implementation of the DRP have also been highlighted, indicating the need for further work across several areas of the DRP.

The findings are organised based on the strategic components of the DRP.

### Safety and Security

- Most prisoners were aware of at least one of the new security measures, particularly the photocopying of mail, drug dogs and body scanners, which were three of the most visible measures. However, there was a statistically significant reduction in awareness of the new measures between wave one and wave two (wave one 73%; wave two 66%), which may be because they had become a normal part of security.

- Both staff and prisoners thought most measures had some impact on security, with prisoners reporting the following measures as having the most impact: drug dogs, body scanners and photocopying of mail, which may reflect their higher levels of visibility.

- The prisoners perceived the body scanners had the biggest impact on reducing the supply of drugs, acting as a deterrent. However, by wave two, a small number of prisoners questioned the effectiveness of the scanners, suggesting they could be beaten. A small number of staff also questioned whether the reduction in illicit substances detected in the prison reflected the success of the security measures or whether the prisoners had got better at concealing the entry of substances into the prison and/or had found new supply routes.

- Staff, in particular senior management and those based within the Drugs Crime Reduction Unit (DCRU), said they needed to be dynamic in how they prevented the flow of illicit substances into the prison, with a Dedicated Security Team set up to identify and disrupt new methods of drug flow into the prison.

- Photocopying of mail was both widely known about and reported as having a negative effect on prisoners, although there was a statistically significant reduction in the proportion of prisoners with a negative perception between wave one (58%) and wave two (46%) suggesting greater acceptance of these security procedures.

- Staff and prisoners said the new security measures had successfully stabilised the prison and provided a safer and calmer environment within which to live and work. However, some prisoners also reported that the increased security had impacted negatively on them (e.g. self-harm and drug use), their visits and on their correspondence with family and friends outside. Also, in both waves, the qualitative data showed prisoners thought the new security measures made HMP Holme House feel like a higher security prison, rather than a category C prison.

## Environment, Cultural Change and Rehabilitation

- When awareness of the DRP was assessed, staff were able to describe the aims and initiatives of the DRP, but some interviewed staff did not see how their job might be associated with the DRP, even when their post was funded by the DRP budget. This was also true for the majority of prisoners who reported awareness of the DRP (wave one 87%; wave two 86%), but there seemed to be some confusion amongst the prisoners as to the aims and ethos of the DRP. Both the staff and prisoners demonstrated a lack of awareness as to the whole prison approach adopted by the DRP.

- Most staff had embraced the security elements of the DRP, but it was acknowledged by the staff interviewed that it had been more difficult to garner support for the demand reduction elements of the DRP.

- Staff spoke of the need to change the culture within the prison to allow the DRP to become fully embedded and supported but outlined that this type of cultural change takes a long time to cultivate and felt that more work was required to bring uniformed staff on board. Despite this acknowledgement, senior management were optimistic about the changes in culture already observed and the potential for further change.

- The questionnaire and qualitative data suggested an improvement in perceptions of safety on the house blocks between wave one and wave two among the staff and the prisoners. In fact, prisoners' feelings of safety were statistically significantly higher at wave two than at wave one.[1]

- Although there was a slight increase over time, at wave two just under half (45%) of questionnaire respondents felt that their basic needs were being met by the prison (wave one 37%). Although meeting a prisoner's basic needs is beyond the remit of the DRP, not meeting them is a barrier to effectively implementing the DRP and its initiatives.

- The community asset model operating on each house block was perceived to have provided greater visibility of staff, improved staff-prisoner relationships, facilitated the breaking down of barriers between staff groups, improved the sharing of information, and the promotion of demand reduction initiatives amongst staff.

- Despite some staff and prisoners describing improved relationships, there were indications from both staff and prisoners that some staff were yet to buy into the decency agenda and that stigma towards those with addictions to illicit substances amongst prisoners and staff was still observed.

- Despite the aim to reduce the stigma around substance use, there seemed to be a lack of understanding evident in both the prisoner and staff responses around the prescribing and use of methadone in HMP Holme House in that it was not always seen as a legitimate medical treatment for opiate dependence by staff and prisoners.

- Staff had concerns about the impact of any potential loss of funding on the sustainability of cultural change and hence ongoing support for aspects of the DRP.

[1] From the EssenCES, wave one mean = 12.85 and wave two mean = 13.30, where scores range from 0 to 20 with higher scores indicated a higher level of perceived safety.

## Care and Wellbeing

- The majority of prisoners were aware of mental health services at both waves (65%), although both the prisoner questionnaire and the qualitative data showed mixed levels of satisfaction with mental health and primary healthcare services. Whilst not in the remit of the DRP, a key point of contention for prisoners was the perceived long waiting lists for primary healthcare, including GPs and dentists. Work was ongoing to improve this area via an Improvement Board that was in place between 2018 and 2020. Both prisoners and staff commented on the impact of staff shortages.

- Around half of prisoners knew about the paramedic within the prison. However, they were much less aware of the trauma interventions available or the speech and language therapist, which were some of the specialist services/interventions implemented as part of the DRP. Although difficult to ascertain, it is possible, however, that the low level of awareness may have reflected the level of need among the prisoners and/or the mode of access (e.g. requirement for referral) that may have reduced the visibility of some services/interventions.

- Just over a third of prisoners (37%) at wave two reported that they perceived the DRP to have impacted positively on healthcare provision (although 24% thought it had impacted negatively and 39% perceived there to have been no change). A quarter of prisoners reported that the DRP had positively influenced health and well-being for themselves and/or other prisoners.

- Despite the move to a house block-based healthcare model, the majority of prisoners at both waves either had not noticed a change in getting to see healthcare (wave one 66%; wave two 67%) or were not sure (wave one 9%; wave two 12%), although this may have reflected the level of need among the prisoners.

- Although very few prisoners noticed a change to drug treatment since the DRP had been implemented, at wave two almost a third of prisoners reported that access to the Drug and Alcohol Recovery Team (DART) had improved since wave one. The visibility of DART staff was observed as key factor in this. At both

waves the majority of prisoners knew about the services offered by the DART and most prisoners reported positive perceptions of DART staff and treatment.

- The prisoners who completed the questionnaire at both waves reported a statistically significant improvement on the global psychological health and global physical health scales on the measure of recovery capital (REC-CAP) between wave one and wave two, suggesting that their psychological and physical health improved from wave one to wave two.

- The staff reported that the peer mentor scheme was a DRP success story and helped to create a sense of community. Some of the prisoners, however, questioned the appropriateness of some of the individuals allocated to these roles.

- At both waves the prisoner questionnaire suggested a low uptake of activities, although a number of barriers were identified in both the questionnaire and qualitative data, such as the suitability of scheduling. However, prisoners were keen for more activities to be provided and there was also a statistically significant increase in the REC-CAP Meaningful Activities recovery capital scale between waves, suggesting that the prisoners were, in fact, taking part in a greater number of the activities available to them at wave two.

- There were no differences between the two data collection waves in the prisoner questionnaire for prisoner's participation in work, training, education or programmes, although there was a statistically significant increase in the proportion of prisoners volunteering from wave one (8%) to wave two (15%).

## Continuity of Care

- Both staff and prisoners who had experience of the Connecting Communities Team's[2] work were very positive about the support they provide to prisoners before, on, and after release. A third of the prisoners reported being aware of the

[2] The Connecting Communities Team works with prisoners in the last 12 weeks of their sentence to support them on release, help with community reintegration and link in work with statutory agencies.

support offered by the Connecting Communities Team in the lead up to and on release.

- Staff mentioned concerns about a potential cliff edge in the level of support once prisoners return to the community, due to the difference in the amount of support offered inside the prison, compared to the variable levels provided by the CRCs.

- Staff were also concerned about the strength of links between the prison and community based services, and whether the referral process to the Connecting Communities Team was resulting in appropriate referrals.

### Substance Use: Medications and Illicit Drugs

- Although the findings were mixed, the prisoner questionnaire and the qualitative data from the prisoners and the staff, indicate a perceived reduction in drug use and availability in HMP Holme House.

- The perceived reduction in substances was further felt to have provided both staff and prisoners with a calmer, safer environment that was more conducive to rehabilitation and recovery. Both prisoners and staff, however, reported that reduced drug availability had led to an increase in the brewing of alcohol and the trade of prescription medications.

- The reasons given in the interviews for taking substances in prison were: to make the days bearable, to alleviate boredom, to pass the time, and to facilitate escapism and avoid reality.

## 1.3 Limitations

Several limitations need to be borne in mind when interpreting these findings.

- This was a process evaluation that focused on the implementation of the DRP pilot and as such, it did not measure impact. Any mention of ‘impact’ or ‘effect’ in this report relates to perceptions, rather than any measured impact or effect. Despite statistically significant changes being reported between waves, because there is no comparison to a counterfactual, impact cannot be attributed to the DRP.

- Other initiatives had been taking place across the prison estate during the implementation of the DRP, which may have impacted on the research findings.
- Every effort is made to ensure that the figures presented are accurate and complete. However, it is important to note that management information data have been drawn from administrative systems and may not accurately present what is happening in prisons.
- The timeframe for the research meant data collection took place before the pilot phase was complete.
- The qualitative research included a small number of prisoners and staff, and, although the sampling frames were representative of the HMP Holme House population, the over-representation/under-representation of some groups of prisoners meant that the final sample was not representative of the HMP Holme House population, which may impact on the generalisability of the findings.
- The responses to the prisoner questionnaire and qualitative research are based on perceptions of the participants and may not reflect true operational practice.
- Although the process evaluation examined the strategic components of the DRP and their implementation, it also looked at some beyond the remit of the DRP, which were the responsibility of HMPPS and NHS England (where health related).

# 2. Introduction

This report outlines the findings of a process evaluation of the Drug Recovery Prison (DRP) being piloted by Her Majesty's Prison and Probation Service (HMPPS) at HMP Holme House, a male category C training and resettlement prison in North East England.

The DRP, which began in April 2017, was a three-year initiative, jointly funded by NHS England and HM Prison and Probation Service (HMPPS), that implemented a programme of activities to support a whole prison approach to tackle drug use in prison and aid long term recovery (see Appendix A). It aimed to test new equipment, products and develop improved ways of working to restrict supply, reduce demand and build recovery in prison, in line with the Government (2017) and Prison Drug Strategy (2019). The intention was to improve health and wellbeing and reduce reoffending. As part of this initiative the Ministry of Justice/HMPPS, supported by NHS England, commissioned a process evaluation to explore the implementation of services and initiatives introduced as part of the DRP, as well as the perceptions of staff and prisoners.

The ensuing report is structured into eight main sections:

**Chapter 3: Background: Document Analysis and Literature Review**
Outlines the main components/initiatives of the DRP and the current evidence base underpinning these initiatives.

**Chapter 4: Research Methodology**
Outlines the aims of the research, the methods used to collect the data and provides details on the participatory approach adopted in this research, and the limitations.

Chapters 5 to 9 present the findings of the research.

**Chapter 5: Safety and Security**
Examines the security measures implemented as part of the DRP, before looking at prisoner awareness of these measures, as well as their perceived efficacy and impact.

**Chapter 6: Environment, Cultural Change and Rehabilitation**
Explores awareness of the DRP, as well as the changes in the environment, culture, relationships and stigma.

**Chapter 7: Care and Wellbeing**
Looks at healthcare, which includes both prisoner awareness and involvement, before going on to examine drug treatment and recovery capital, activities, work, training, education, programmes and peer involvement.

**Chapter 8: Continuity of Care**
Discusses continuity of care and the Connecting Communities service provided by the DRP.

**Chapter 9: Substance Use: Medications and Illicit Drugs**
Provides an overview of substance use data as well as perceptions of substance use and their availability within the prison.

**Chapter 10: Summary and Lessons Learnt**
Examines how the key findings from the process evaluation relate to the aims and objectives of the research, before going on to look at the lessons learnt from the DRP for any future roll out, which includes potential barriers to implementation.

It must be noted that the findings in this report are based on perceptions and knowledge of those interviewed and may not reflect true operational practice, and although the process evaluation examined the strategic components of the DRP and their implementation, it also looked at some beyond the remit of the DRP, which were the responsibility of HMPPS and NHS England (where health related). While some of the issues with these wider components are noted in the report, they are not interpreted as a failure of the DRP but instead reported to inform the wider context that is necessary to facilitate successful implementation in the future.

# 3. Background: Document Analysis and Review of the Literature

This chapter considers the evidence base for the four strands of the DRP: safety and security; environment, cultural change and rehabilitation; care and wellbeing; and continuity of care. It draws on analysis of the DRP documents (e.g. of the security manual for staff, strategies, timelines, and protocols) and existing research.

## 3.1 The Drug Recovery Prison

In March 2016, HMP Holme House was selected as one of the six pilot reform prisons, which gave prison governors more discretion and control over key aspects of prison management and service delivery (see MoJ, 2020a). As a result of a Substance Misuse Service review at HMP Holme House by senior leaders and a ministerial ambition to tackle illicit drug use in prisons coupled with an ambition to promote reform, HMP Holme House was identified as a suitable pilot site for a combined Justice and Health initiative, that then became to be known as the Drug Recovery Prison (DRP). The DRP which began in April 2017 was a three-year initiative, jointly funded by NHS England and HM Prison and Probation Service, which aspired to implement a whole prison approach to tackle drugs in prison and aid long-term recovery. In line with the Government (2017) and Prison Drug Strategy (2019) the DRP maintains a twin-track approach to tackling drugs.

Research has continually shown that prison has the potential to negatively impact on the health and wellbeing of everyone working and living there, which can include stress, sickness, absenteeism, burnout, substance use, mental ill-health and an inability to cope with their traumatic lived experiences whether experienced prior to or whilst in the prison (Ayres, 2020; Beard *et al.,* 2020; Kinman *et al.,* 2015; Møller *et al*., 2007). This is why the 'whole prison approach'[3] adopted by the DRP emphasises the importance of looking at all aspects of the prison and the whole offender journey, which is also essential for ensuring

[3] A whole prison approach is not new and was advocated by the World Health Organisation (WHO) in 1995. The Whole prison approach demonstrates 'a commitment to health and well-being through supportive policies and practices' (WHO, 2014, p. 180).

continuity of care and creating a rehabilitative culture that everyone is responsible for and can impact (Mann *et al*., 2018; Møller *et al.,* 2007). Research has, however, also identified that the whole prison approach is poorly understood, not clearly defined and not widely, or consistently, implemented across the prison estate (Select Committee, 2018; Woodall and Freeman, 2019). Therefore, the DRP aims to 'provide consistency in delivery and inform our understanding of what works best', which will contribute to developing new 'evidence-based approaches' that can eventually be rolled out across the prison estate (HMPPS, 2019, p.6). The strategic components of the DRP (safety and security; environment, cultural change and rehabilitation; care and wellbeing and continuity of care) are intended to promote change and to create:

- A safe and secure living and working environment.
- A positive prison environment with chances for change and active communities and peer-based recovery support.
- Care that is holistic and responsive which promotes health and well-being.
- Staff development through training and education.
- Prisoners who are actively involved in the support services.
- Continuity of care in prison and after release to ensure they are released into supportive home communities.

## 3.2 Safety and Security

The security strategy for the DRP adopts a whole prison approach to tackle the supply of drugs into prison espousing the principle that 'security is everyone's responsibility' (Wheatley, 2019). Premised on good practice from HMP Frankland (a high security prison), the DRP pilot involved the bolstering of security, including, for example, testing of new technology (e.g. scanners), improved physical security (e.g. window restrictors), better procedural security (e.g. security handbook) and operational changes (e.g. setting up of the new Dedicated Security Team and more searching of both goods and staff entering the prison). By increasing security, the DRP takes a traditional prison approach to reducing the supply of drugs, even though evidence suggests that as soon as one supply route is disrupted pressure is increased on the other routes, which is known as the balloon effect (Blakey, 2008). While the implementation of security measures has a positive effect, research has shown they can also have a detrimental impact on the prison, prisoners, and

staff (e.g. markets; prices increase, debts rise; new routes are found; and it negatively impacts relationships, violence, bullying and disorder in the prison) (e.g. Blakey, 2008; Edgar and O'Donnell, 1998).

The DRP acknowledges that safety and security alongside good intelligence and information sharing are integral to turning prisons into places of reform and rehabilitation (Mann et al., 2018; MoJ, 2016; Wheatley, 2019). Feelings of safety and security are integral to building healthy prisons, since research shows feeling safe is the most important determinant of distress among prisoners and staff (Kinman et al., 2014; Liebling, 2011). Feeling safe is also a basic human need that prisoners require if they are to progress and grow (Hoke and Demory, 2014; Maslow, 1948). However, evidence shows enhanced security needs to be supported by effective staff (training, capacity and deployment), which has been reflected in the practices of the DRP (see Wheatley, 2019). The recruitment of 32 new HMPPS staff, which included the creation of a dedicated DRP team was particularly important since research shows staffing issues continually undermine security and safety (Beard, 2019; HMIP, 2019), which is also influenced by and has an influence on prison culture and rehabilitation.

## 3.3 Environment, Cultural Change and Rehabilitation

A strategic component of the DRP was to change and improve the environment along with its culture to make it more conducive to therapy, treatment and rehabilitation thus creating opportunities for people in recovery to thrive. Drawing on Moran's (2016) work the DRP acknowledges that the prison estate, its buildings, architecture, and regime can all impact (positively and negatively) on the health and wellbeing of staff and prisoners as well as levels of order/disorder and safety (see also Jewkes, 2018a). Although, culture is used as an umbrella term that incorporates the different cultures commonly found in any prison (e.g. officer, organisational and inmate culture), a rehabilitative culture is defined as 'one where all the aspects of…culture support rehabilitation'. 'The aim is for everyone to feel safe…for prisons to be places of decency, where everyone treats each other with respect, and people's basic needs are understood and met' (Mann et al. 2018, p. 4).

To create a rehabilitative and enabling environment the DRP made physical changes to the prison. It refurbished the house blocks (akin to residential blocks with living areas),

treatment rooms (to NHS standards), grounds (e.g. laying flowerbeds) and walkways (e.g. the sunflower project[4]). It tried to improve living conditions (e.g. installing washing machines), alongside introducing more activities, as research shows poor living conditions combined with restricted regimes and a lack of purposeful activities contributes to continued substance use, self-harm, bullying and violence (HMCIP, 2019). Research has also shown that a failure to meet a prisoner's basic needs can undermine rehabilitative programmes and exacerbate levels of violence, disorder and rule-breaking in the prison (Hoke and Demory, 2014; Jewkes, 2018b; Maslow, 1948), which is also impacted by staff.

As part of their workforce development plan HMP Holme House tried to address staff shortages, whilst increasing capability and awareness through staff development initiatives. The DRP acknowledges the importance of training and education in changing the culture, improving relationships, enhancing security, and improving professionalism, which are all also integral to effective security and rehabilitation (Beard et al., 2020; Crawley, 2004; HMIP, 2019; Howard League, 2009; Liebling, et al., 2011). Insufficient understanding or training among staff directly affects the ability of prisons to deliver good quality care to those most at risk (HMIP, 2019; Howard League, 2009, 2017). In fact, only trained and appropriately equipped staff can lead, manage, and offer support effectively (MoJ, 2016) as well as change the culture.

Research shows organisational culture has proven hard to change and can be a facilitator and a barrier to the implementation of new initiatives and policies. An integral part of prison culture are relationships, which can determine the success or failure of any policy and can lead to 'a dearth of therapeutic integrity'[5] (Goggin and Gendreau, 2006, p. 2018) alongside a range of other issues (e.g. order/disorder, violence, escapes, corruption, drug use, self-harm, and suicide) (Crawley, 2004; Liebling et al. 2011). Organisational culture can also play a prominent role in reducing stigma and promoting safer and more integrated systems approaches (Thomas and Hardy, 2011; Till et al., 2014), which is integral for implementing a whole prison approach and initiatives like the DRP. As part of these cultural changes, the

[4] Sunflowers made out of recycled plastics adorn the walkways and were created as part of a WW1 commemoration.

[5] This means there is a gap between proposed treatment/programmes and those implemented.

DRP also proposed to alter Mandatory Drug Testing (MDT)[6] and the adjudication process to make them less punitive and more rehabilitative. The changes to MDTs were not implemented because the Senior Management did not want to alter established practices without suitable approved alternatives being available which were not developed due to limited capacity in both HQ and the prison. Rehabilitative adjudications were introduced, albeit at a delayed date, also due to limited capacity. Research has continually shown that prisons have always struggled to implement their contradictory philosophies of punishment and treatment (Genders and Player 1995), which has led to the dilution of both that can undermine rehabilitation and wellbeing.

## 3.4 Care and Wellbeing

The DRP aimed to enhance healthcare provision in line with Public Health England's review (see Leaman et al., 2017). Prison healthcare has been heavily criticised (HMIP, 2019) emphasising the need for reform. These failings have been attributed to staff shortages, restricted regimes, and insufficient training; issues the DRP has tried to address, although this has not always been possible.[7]

The DRP adopts a holistic integrated person-centred style to delivering a multi-agency community model of healthcare and substance use services with a trauma-informed approach (Jervis, 2019). Specialist posts such as a principal psychologist to develop trauma informed pathways, which address the cause of addiction, ill-health, and offending (Ayres, 2020; Carr et al., 2013; Fox et al., 2016) were implemented as part of the DRP alongside a speech and language therapist. A paramedic was also appointed to work with the healthcare team and other staff to improve their skills and confidence when responding to emergency situations. The DRP implements a community-based asset model on each house block to create active communities, which aim to test more effective ways of working, reduce stigma, build therapeutic alliances, reduce health inequalities as well as

[6] The DRP proposed to introduce periodic testing on reception, pre-exit testing for closely targeted groups of prisoners, retain on-suspicion testing, work with NHS England to look at ways of incorporating testing to provide a more holistic picture of drug treatment in prison, and expand HMPPS drug testing quality assurance programme.

[7] Although the DRP proposed to recruit more staff to specialist healthcare roles to combat staff shortages this proved challenging due to national shortages of nurses (Iacobucci, 2018) alongside other wider factors that also impacted on recruitment and retention of staff including significant community vacancies and the length of time it takes to receive security clearance. The churn of staff leaving also impacts as the levels will fluctuate irrespective of the setting.

reduce the trafficking of prohibited items, violence and substance use. They also improve continuity of care, and the health and wellbeing of staff and prisoners (Carter, 2003; Morgan and Ziglio, 2007; Foot and Hopkins, 2010). The DRP also aimed to increase the provision of peer interventions since research shows they are beneficial to prisoners, staff,[8] the prison and its culture (South et al. 2014). Thus, adopting an evidence-based approach, the DRP augments medication assisted recovery with structured clinical and psychosocial support, which evidence shows is effective for treating substance use and mental ill-health (see England et al. 2015; Perry et al. 2015). The DRP also acknowledges the importance of continuity of care.

## 3.5 Continuity of Care

To improve continuity of care the DRP established a Connecting Communities Team[9] to help prisoners' transition from custody to the community, which has been shown to be cost-effective, and reduces relapse, recidivism, and death (Butzin et al. 2006; Popovici et al. 2008). To aid continuity of care, the DRP also set up a recovery telephone support service and Breaking Free Online[10] (Elison-Davis et al. 2018). This is because evidence shows that many prisoners face a 'cliff edge' on release, which not only means they are more likely to reoffend, relapse or die, but any rehabilitative or recovery work undertaken in prison is also undermined (Lloyd et al. 2014; PHE, 2018). However, continuity of care across prisons has continually shown to be lacking with poor co-ordination, inadequate information sharing, fragmented services, poor shared working practices, high rates of attrition, and a lack of understanding accompanied by hostility and resentment between outside agencies, probation and prison staff (see PHE, 2018; Taylor et al. 2017). These failings also have a negative impact on the those accessing treatment in prison since they know the benefits will not be maintained after they are released (Wheatley, 2019).

[8] Peer interventions empower the men and staff encouraging them to work in partnership thus overcoming some of the traditional barriers which negatively impact on staff-prisoner relationships and prison culture. They also improve communication, build trust, enhance relationships and promote hope, all of which are essential for rehabilitation and a culture that promotes recovery.

[9] 'This team included a team leader, five Connecting Community Co-ordinators, a Family Worker, a Building Recovery in Communities Worker and a generic support worker' (Wheatley, 2019).

[10] A computer assisted therapy that promotes recovery via internet based interventions which provides continuity of care between prisons and the community.

The DRP, therefore aims to pilot and develop new and innovative approaches to restrict supply, reduce demand and build recovery in HMP Holme House, not just from substance use, but also mental and physical ill-health. By creating a 'Recovery Orientated System of Care',[11] the DRP aims to build recovery capital (see Best and Laudet, 2010); personal, social and community capital. Although the factors enabling a successful recovery are complex and still not fully understood, the aim of the DRP is 'to create better chances for people in recovery to change and feel hopeful and optimistic about their future' (Wheatley, 2019, p.11) as it aims to improve health and wellbeing and reduce reoffending by adopting a whole prison approach.

[11] These are 'networks of organisations, agencies, and community members that coordinate a wide spectrum of services to prevent, intervene in, and treat substance use problems and disorders' (Best and Wheatley, 2019).

# 4. Methodology

The Ministry of Justice, supported by NHS England, commissioned an independent process evaluation of the DRP pilot at HMP Holme House.

## 4.1 Aims of the Research

This process evaluation aimed to understand:

- The strategic components and key features laid out in the logic model (see Appendix A) – those initially proposed, as well as those implemented and delivered – that make HMP Holme House a DRP and provide a holistic approach to drug recovery.
- The beneficiaries of those services, from both a staff and prisoner[12] perspective, including their lived experiences and perception of outcomes, specifically whether they were aware of and understood the objectives of the DRP, their attitudes towards the DRP, the intervention activities, and their interactions with them.
- The main facilitators and obstacles to the implementation and delivery of the DRP.
- The key lessons learnt on good practice and recommendations for future implementation elsewhere in the prison estate, including how to improve the whole prison approach.

## 4.2 Research Design

The evaluation used a mixed-method approach including five primary research methodologies that were undertaken in two waves, capturing evidence on the main changes delivered as a result of the DRP over two points in time:

- Analysis of the DRP documents[13]
- A prisoner questionnaire

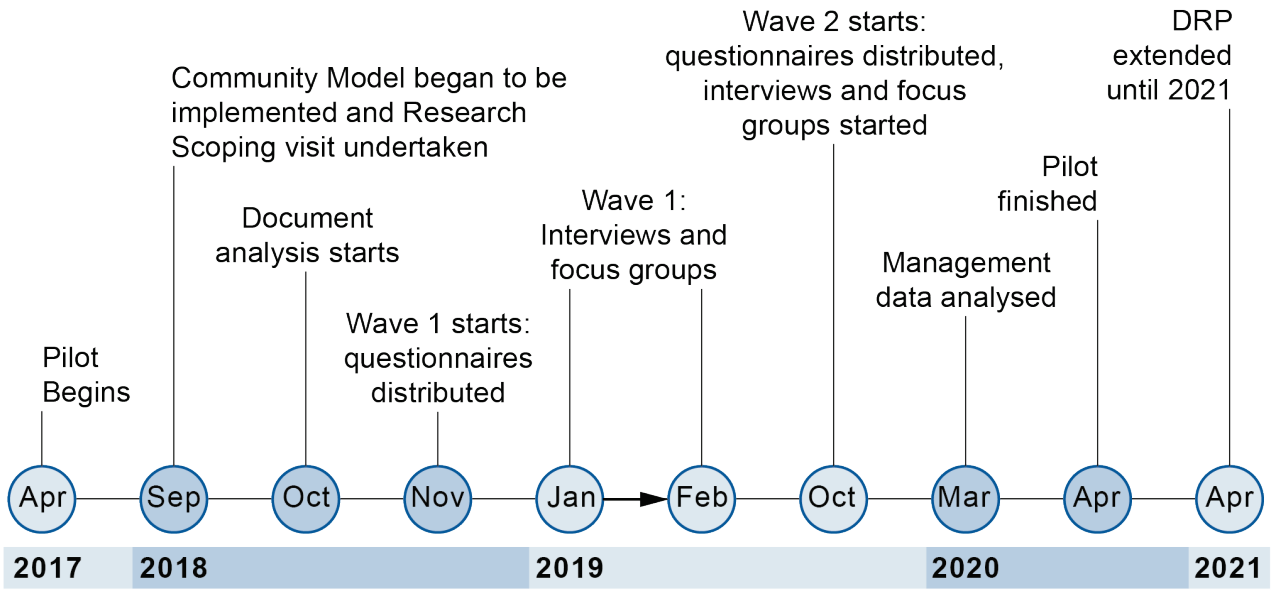
[12] Although the researchers acknowledge the word prisoner is stigmatising, prisoner has been used to differentiate between the two participant groups (staff and prisoners) and their responses.

[13] The DRP documents were analysed and the themes arising from them used to structure the literature review/background chapter as well as contributing to its contents.

- Interviews and focus groups with prisoners and staff
- Prisoner case studies
- Analysis of management information (quantitative) data

The process evaluation coincided with the implementation of the DRP as outlined in Figure 4.1.

**Figure 4.1: Research timeline**[14]




The first wave of data collection started in November 2018, which was followed by a second wave of data collection that started in October 2019 (see Table 4.1).

**Table 4.1: Research design and number of participants for each wave of data collection**

| | Number of participants | | |
|---|---|---|---|
| | **Wave one** | **Wave two** | **Participants for whom data was collected at both waves** |
| A questionnaire of prisoners' needs and awareness of the DRP | 194 | 168 | 50 |
| Focus Group with drug and non-drug users | 17 in 4 groups | 13 in 3 groups | 4 |
| In-depth interviews with prisoners | 9 | 10 | 4 |

[14] Pilot finished indicates when the original funding for the DRP was due to end. However, the pilot has been extended until 2021.

| | Number of participants | | |
|---|---|---|---|
| | Wave one | Wave two | Participants for whom data was collected at both waves |
| Case Studies | 7 | 3 | 3 |
| In-depth interviews with staff | 22 | 17 | 11 |

Implementing a mixed-method approach, the process evaluation utilised a range of qualitative and quantitative data sources to create a comprehensive story of the DRP and its implementation. However, it must be noted that when the first wave of the process evaluation was undertaken, the DRP had only been partially implemented and each element of the DRP was at a different stage of implementation. Most of the safety and security strategy had been operational for 6 months when the wave one data collection started, whereas other components (environment, cultural change and rehabilitation; care and wellbeing; and continuity of care) were at varying stages of implementation. Some planned initiatives were delayed (e.g. the community house block model, environmental changes, computers), and not all of them implemented over the three-year pilot (e.g. changes to Mandatory Drug Tests and reconfiguration of the gate) (see Appendix B for more detailed timelines). Wave two of the research was undertaken before the end of the pilot period. These factors must also be taken into consideration when reading the results outlined in this report. It is also important to note when interpreting the findings that one-half of house block 6 operates as a 65-bed hierarchical therapeutic community and house block 7 houses vulnerable prisoners. Furthermore, not all prisoners at HMP Holme House will be drug users.

The research involved a participatory research element with both prisoners and staff consulted throughout the research via the Prison Consultation Group (PCG), which fed into all stages of the research from designing the questionnaire to co-facilitating focus groups and providing feedback on the report.

The mixed-method methodology allowed for data triangulation to ensure the validity of the research due to the complexity underpinning the implementation of the DRP at HMP Holme House. Ethical approval was sought from the University of Leicester, School of Psychology Research Ethics Committee (PREC).

## 4.3 Research Approach

**Prisoner questionnaire**: at wave one, questionnaires were distributed over all seven house blocks to a stratified sample[15] of 300 prisoners. At wave two, questionnaires were distributed to the 89 prisoners from the wave one sample who were still in the prison. At wave two, a further stratified sample boosted the total sample to 281 prisoners across seven house blocks.[16] The prisoner sample was for the most part representative of the wider HMP Holme House population in terms of age, house block and ethnicity, although at wave one prisoners with a sentence length of up to 3 years were under-represented and those with a sentence length of 3 to 5 years were over-represented. At wave two there was an under-representation of 35–39 years and over-representation of 60 and over years, and for sentence length, there was an under-representation of respondents with a sentence length up to 3 years and an over-representation of sentences of 3 – 5 years and 5 – 7.5 years. Prisoners on house block 7 were over-represented while house block 5 – the smallest house block in the prison – were under-represented. The questionnaire used at wave one was reviewed and amended[17] in consultation with staff from the DRP and Ministry of Justice for wave two. In both waves the questionnaire was comprised of open[18] and closed questions, Likert scales, recognised clinical tools (REC-CAP) and validated scales (EssenCES). The Essen Climate Evaluation Schema (EssenCES) (Schalast and Tonkin, 2016) was used to assess the social and therapeutic atmosphere on the house blocks. The Recovery Capital (REC-CAP; Best and Edwards, 2017) was used to assess and quantify prisoners' recovery capital.

**Qualitative data for staff and prisoners**: prisoners were selected from those who had completed the questionnaire in the first wave who had volunteered to participate in a follow-up interview and/or focus group. The case study interviews were undertaken

[15] This aimed to ensure the sample was representative of the prison population in HMP Holme House as the sample was stratified by age, ethnicity, sentence length and house block.

[16] The response rate at wave one was 65% (*n* = 194) and at wave two was 60% (*n* = 168). Of the 89 prisoners who were still in the prison at wave two, the response rate was 56% (*n* = 50).

[17] The changes made were: 1) more specific questions about substance use, including use in prison, were added; 2) the launch event question was removed; 3) the change to MDT question was removed; 4) questions on healthcare provision/packages and treatment were added or removed; and 5) questions were added on the perceived impact of the DRP and about PID workers.

[18] The free text data from the questionnaire open-ended questions were not included in this report as it replicated much of the qualitative data obtained from the interviews and focus groups.

periodically throughout the research to enable a longitudinal view of the DRP, although the attrition rate was high (57%). The staff were purposively sampled to ensure different grades, departments and positions were represented in the interviews. Separate topic guides were developed for senior management, prison staff, and prisoner participants, with only minor changes[19] made at wave two.

**Management information data:** monthly data from HMPPS management information systems from April 2017 to March 2020 were examined, including proven adjudications, assaults, mandatory drug testing (MDT), find incidents and prisoner self-harm incidents, however only metrics that were relevant to the findings have been included in this report. Public Health England quarterly data on drug treatment from April 2016 to March 2019[20] was also analysed. As well as HMP Holme House, data were examined from a number of comparator prisons, drawn from the HMPPS Prison Performance Rating groups (MoJ, 2020b). Data from the comparator prisons was used to help contextualise changes at HMP Holme House, rather than a true counterfactual given the limited number of variables being controlled for.

**Data analysis**: At both waves, frequencies and percentages or means and standard deviations were calculated. Where it was appropriate to do so, statistical comparisons were conducted between house blocks.[21] Statistical analyses were conducted to examine if there were any differences between responses at wave one and wave two: this was done (1) for all wave one responses versus all wave two responses[22] and (2) using the data from those prisoners who completed the questionnaire at both waves.[23] Qualitative data were subjected to thematic analysis which resulted in the identification of 33 themes, which were collapsed into five overarching themes (awareness/perceptions of the DRP;

[19] The changes made were: 1) to add/remove prompts relating to activities or security measures that had been implemented/removed between the two waves; 2) to probe more about the visibility of healthcare on the house blocks; and 3) to ask the staff about their perceived ownership of the DRP.

[20] For some indices data was only available until Q4 2017/18 and Q1 2018/19 at the time of analysis.

[21] Statistical analysis for between house blocks comparisons were only conducted where sample sizes were of a sufficient size.

[22] Where responses were categorical data, chi-square analysis was conducted, and ANOVAs used for continuous data. A significance cut-off of $p$ <.05 was used, in line with statistical conventions.

[23] For categorical responses, a McNemar change test was used when the response had two categories and a marginal homogeneity test was used when there were three or more categories. Continuous data were analysed using within-subjects ANOVA. A significance cut-off of $p$ < 0.5 was used, in line with statistical conventions.

drug use; supply reduction; demand reduction; and support on release). The quotations in the following chapters were selected to best represent the emergent theme.

## 4.4 Limitations

The process evaluation aimed to report on the implementation of the DRP pilot as a whole and did not include in-depth analysis of individual elements introduced as part of the DRP or measure impact. Any impact referred to in this report pertains to the perceived effect of the DRP according to the staff and the prisoners. Therefore, findings in this report are based on perceptions and knowledge of those interviewed and may not reflect true operational practice. As there was no control group in this research it is not possible to conclude that the findings from this evaluation can be attributed solely to the DRP due to other initiatives occurring in HMP Holme House (e.g. reconfiguration of the prison so HMP Holme House no longer takes prisoners from the courts, HMP Holme House becoming smoke-free) and across the prison estate (e.g. Offender Management in Custody (OMiC) model and the key worker system).

There are limitations relating to the sample of prisoners that volunteered to participate in the qualitative data collection (e.g. self-selection bias). The prisoner questionnaire was distributed to a representative sample of prisoners, however, the over-representation/under-representation of some groups of prisoners amongst the respondents meant that the final sample was not necessarily representative of the HMP Holme House population. Additionally, the sample size may have reduced the likelihood of detecting statistically significant results when analysing some of the quantitative data. Furthermore, the wording and format of the prisoner questionnaire meant it was difficult to disentangle the DRP from wider NHSE/HMPPS initiatives, particularly in the area of healthcare, which in a prison is multifaceted and multi-disciplinary.

Physical health and mental health are broad areas of delivery encompassing both primary and secondary care, and a range of disciplines within that, which make up the full range of provision. Within the scope of this project, new trauma-focused mental health interventions were introduced that were enhancements to existing provision. Access to these interventions was through a planned pathway of care (e.g. not open access) and therefore would not necessarily be an element of provision that all the population would have

awareness of or have accessed; something that needs to be taken into account when reading this report. Therefore, to be able to understand the process of implementing the interventions, the sampling of participants and the selection of questions could have been more focused on the planned service enhancement, rather than the broader area of mental health provision. The nature of the questions could have been more specific regarding the healthcare elements of the DRP being implemented. As a result, all comments relating specifically to healthcare (physical and mental) are generic perceptions rather than an operational reality. In future evaluations, it is recommended that the specificity of questions is a key element within the planning to better capture these finer nuances.

# 5. Findings: Safety and Security

## 5.1 Introduction

The DRP focused on supply reduction through implementation of several safety and security measures, which were introduced to support the demand reduction and drug recovery initiatives. These included physical security (e.g. window restrictors, and new search areas), which included new technologies (e.g. a Millimetre Wave Scanner, a Magnetic Resonance Scanner and a Full Body X-Ray Scanner), procedural security[24] (e.g. searching of staff, a new search team) and interpersonal security[25] (e.g. training staff, creating a staff handbook). The majority of the new security measures were implemented in 2018 and had been running for four to six months when the data collection started for wave one. By wave two, the security measures had been in place for over a year, with the exception of the Millimetre Wave Scanner that was removed because it was not meeting the detection requirements of HMP Holme House. This section examines the security measures implemented and how staff and prisoners perceived these.[26]

## 5.2 Key Findings

- Most prisoners were aware of at least one of the new security measures, particularly the photocopying of mail, drug dogs and body scanners, which were three of the most visible measures. However, there was a statistically significant reduction in awareness of the new measures between wave one and wave two (wave one 73%; wave two 66%), which may be because they had become a normal part of security.

- Both staff and prisoners thought most measures had some impact on security, with prisoners reporting the following measures as having the most impact: drug

[24] Procedural security is the system and processes deployed to create safety and security (e.g. staff and room searching, patrols, intelligence gathering).

[25] Interpersonal security is how information is acquired (e.g. conversations, interviews, covert intelligence information gathering, relationships and procedural justice principles).

[26] The percentages reported in the findings relate to 194 questionnaires returned at wave one and 168 from wave two.

dogs, body scanners and photocopying of mail, which may reflect their higher levels of visibility.

- The prisoners perceived the body scanners had the biggest impact on reducing the supply of drugs, acting as a deterrent. However, by wave two, a small number of prisoners questioned the effectiveness of the scanners, suggesting they could be beaten. A small number of staff also questioned whether the reduction in illicit substances detected in the prison reflected the success of the security measures or whether the prisoners had got better at concealing the entry of substances into the prison and/or had found new supply routes.

- Staff, in particular senior management and those based within the Drugs Crime Reduction Unit (DCRU), said they needed to be dynamic in how they prevented the flow of illicit substances into the prison, with a Dedicated Security Team set up to identify and disrupt new methods of drug flow into the prison.

- Photocopying of mail was both widely known about and reported as having a negative effect on prisoners, although there was a statistically significant reduction in the proportion of prisoners with a negative perception between wave one (58%) and wave two (46%) suggesting greater acceptance of these security procedures.

- Staff and prisoners said the new security measures had successfully stabilised the prison and provided a safer and calmer environment within which to live and work. However, some prisoners also reported that the increased security had impacted negatively on them (e.g. self-harm and drug use), their visits and on their correspondence with family and friends outside. Also, in both waves, the qualitative data showed prisoners thought the new security measures made HMP Holme House feel like a higher security prison, rather than a category C prison.

## 5.3 Implementation of Security Measures

New security measures were some of the first aspects of the DRP to be implemented. As a pilot, some of the security projects planned as part of the DRP did not reach fruition (e.g.

reconfiguration of the gate[27]) or were reconsidered following unsuccessful trials (e.g. Millimetre Wave Scanner). Other security measures were wider prison service initiatives (e.g. photocopying the mail[28]). By wave two, staff saw these implementation problems as a useful function of a pilot. For example, the experience of the Millimetre Wave Scanner showed the limits of the technology and hence avoided a costly national adoption by HMPPS. This sentiment was reiterated by senior management, that there was an expectation that risks would be taken and that some of these may not be successful but that this was part of the learning process inherent in a pilot such as the DRP.

## 5.4 Awareness of Security Measures

In both waves, the prisoner questionnaire showed the majority of prisoners were aware of at least one of the extra security measures implemented as part of the DRP, although statistically significantly fewer prisoners were aware of at least one of the security measures at wave two compared to wave one (wave one 73%; wave two 66%). The questionnaire and qualitative data at both waves showed that prisoners were most aware of photocopying of the mail, followed by the scanners.

Very few prisoners, during either wave, volunteered knowledge of the increased use of window restrictors, CCTV, or security measures to search staff. However, this is unsurprising since some of these security measures are less obvious to prisoners. Nearly two thirds of prisoners at both waves were aware of the drug dogs on the wings undertaking searches, and this was mentioned by a number of prisoners during the wave two interviews, possibly reflecting their higher levels of visibility:

> ‘They’ve got the DST, the drug search team, they're on it. They’ve got the dogs. They're on it. They’ve got like metal detectors they just put on the walkway … or they have them like on the end of wings. So if you're going somewhere, you wouldn’t know. They'll just randomly hit you ... It's really good. And even though, I’d like to be off me nut, I know it's good for us to be here. Because at least I'm well and safe, not getting off me nut.’ Prisoner (wave two, interview)

[27] Due to delays in the procurement of building work and an escalation in costs.

[28] The DRP piloted photocopying of mail due to the increase in psychoactive substance use, which fed into the national guidance.

## 5.5 Perceived Impact of Security Measures on Drug Supply

The prisoners perceived the scanners had the biggest impact on reducing the supply of drugs, acting as a deterrent to both prisoners and visitors:

> 'I would say the scanner machines and the x-ray machines, yeah… the body scanner… that's for your full body … so, there's no way you can put anything up … your backside or whatever and not be seen… That's going to stop them dead basically, because they know…basically, that's put a gate up to stop them coming in.' Prisoner (wave one, interview)

However, by wave two, the prisoners also talked about a perception that they could get around the scanners, questioning the effectiveness and suggesting that they could be 'beaten', illustrating that as one supply route is disrupted, other routes become more active (Blakey, 2008):

> '… since they have got the x-ray scanner, yeah they have cut down by a big amount but there's ways around what they don't know. It's the most simplest way ever to get round it, it ridiculous that we should come up with it and think 'hang on I can see everything inside, but I can still beat that'. Prisoner (wave two, interview)

Some prisoners commented on perceived inconsistencies in the security scanning due to time restrictions imposed by the regime and getting the prisoners back on the wing after visits:

> 'There might be 50, 60 people down there, but they're got to be back on the wing for a certain time, for the roll check to be in … you'll see the staff start looking at their watches … and then they'll stop every other one, and then one every 3. To the point where 'right that's it, we've got to get them back', there might still be 20 people left to go through. Just quick pat down and away you go.' Prisoner (wave two, focus group)

HMP Holme House protocol was to use intelligence to inform searching using the security scanning equipment in both the reception and visit hall areas. Where intelligence suggested someone posed a risk to safety and security, all of these people should have

been searched. It is understandable that it may have appeared that regime time restrictions determined who was searched and who was not. By the nature of how the search was planned, it was not intended to be immediately obvious to prisoners how searching is organised. However, it must also be acknowledged that the perceived inconsistencies may also have been attributable to regime time restrictions as outlined by the prisoners.

A small minority of staff questioned whether the reduction in illicit substances detected within the prison reflected the successful deterrent and detection effect of the x-ray machines or whether the prisoners had got better at concealing the entry of substances into the prison and/or had found new supply routes.

The staff, in particular senior management and those based within the DCRU, talked about the need to be dynamic in the methods utilised to prevent the flow of illicit substances to the prison. It was recognised that the methods used by those wishing to import substances into the prison evolved over time and in response to the security measures introduced. Indeed, a Dedicated Search Team had been set up to identify and disrupt new methods of drug flow into the prison:

> ‘It's just constantly trying to be one step ahead of them and you think ‘right well they're up to this now, so we’ll have to find some way of preventing that and stopping that happening.’ Staff (wave two, interview)

Since wave one, the role of the DCRU had developed from a responsive team tasked with stabilising the prison and making it safer, to working in a more proactive manner with external agencies and in response to intelligence. Management reported that the DCRU were now regularly working with local police to disrupt organised crime groups, for example. The work of the DCRU was deemed to be very important for the functioning of the DRP and, indeed, the prison:

> ‘Closer working with the police and national teams around organised crime. It has had an impact there too through the DCRU. We have been particularly effective at that.’ Staff (wave two, interview)

> ‘Well I think the DCRU are creating a lot of differences really because they're there all of the time to intercept, to go and deal with things. Whether that’s mobiles, drugs, anything that they shouldn’t be getting up to that needs dealing with, and then we go and deal with it, so I think they’ve been really good … if they’ve got intel on anyone, the staffs here.’ Staff (wave two, interview)

## 5.6 Perceived Impact of Security Measures on Prisoner Wellbeing

Both the prisoners and staff perceived the new security measures to be having a positive impact in terms of successfully stabilising the prison and providing a safer and calmer environment within which to live and work. This has been shown by research to assist with rehabilitation and recovery (Hoke and Demory, 2014; Kinman et al. 2014; Liebling, 2011):

> ‘[The security measures] create the safe environment which then creates the environment where the men can engage and the staff can engage and it becomes a more calm place, I think they are really strong.’ Staff (wave two, interview)

However, the new security measures also had the potential to cause distress to the prisoners, with a quarter of prisoners in both waves saying the new security measures had negatively impacted on their visits:

> ‘The one thing I could say about the prison on the visits – they take longer letting your people in, and the next thing you know, you're supposed to have 2 hours for a visit, you're not having your full 2 hours. It does take time, and I think “bloody hell you should be more considerate, if peoples coming all this way”’ Prisoner (wave two, interview)

Prisoners talked about how photocopying of the mail made them feel and how some of them had stopped correspondence completely because of it. Some of the prisoners reported delays in receiving their mail and mistakes in the photocopying, which meant that prisoners received mail that was not their own. These issues were perceived to have a negative impact on the prisoner’s mental health, drug use and family ties. Questionnaire responses showed that prisoner perceptions of the photocopying of mail were statistically

significantly less negative at wave two (wave one 58%; wave two 46%) suggesting that the prisoners may have got used to it.

In both waves, the qualitative data showed the prisoners thought the new security measures made HMP Holme House feel like a higher security prison than it is, like a category A or B prison, rather than a category C prison:

> 'I've just come from a Cat. B, yeah? In a Cat. B they've got a full metal detector, get a rub down and that's it on your way. In here, you have to take our shoes off, get a rub down, do the works … inside their mouth, their hair and stuff like that. My mum doesn't want to come up no more because of it; do you know what I mean?' Prisoner (wave two, focus group)

There was also some indication from the qualitative data obtained from both staff and prisoners that the new measures also had a detrimental impact on self-harm,[29] as well as drug use:

> 'Initially it was a quick win to get security bits in but then there was a rise in self-harm because some of the other initiatives weren't in place.' Staff (wave two, interview)

This suggests that if prisoners are using substances as a coping strategy (see Ayres, 2020), then unless alternative provisions are put in place when that coping strategy is taken away, then a new, sometimes more (or equally) harmful one, will take its place. These qualitative findings may be attributable to the fact that many of the security measures were implemented before the demand reduction initiatives (see timelines in Appendix B).

[29] In the 3 months to Apr-17 there were 334 instances per 1,000 prisoners of self-harm in HMP Holme House. The number increased to 644 in the 3 months to Mar-20. However, there has been an increase in self-harm rates across the prison estate, so it is difficult to draw conclusions about the implementation of the DRP from the HMPPS management data given wider trends. See Safety in Custody Statistics for an extended time series of published statistics on self-harm in prison custody. It is important to acknowledge seasonality within the data when making comparisons across different time periods.

# 6. Findings: Environment, Cultural Change and Rehabilitation

## 6.1 Introduction

The DRP aimed to improve the environment to encourage a change in culture. The intention was to engender a more therapeutic and rehabilitative environment that promotes health, wellbeing, rehabilitation and recovery, as well as to improve disorder and safety in the prison. As part of this, the environment and its physical spaces were also changed as they too can support the recovery process (see Moran, 2019). The prisoner's rooms,[30] treatment rooms and house blocks underwent a refurbishment in 2017 and training and educational events (e.g. awareness of Psychoactive Substances), alongside DRP orientation events were organised for both the staff and prisoners. The aim of these initiatives was to raise awareness and encourage support for the DRP. This section looks at awareness of the DRP, before discussing cultural changes, changes on house blocks, relationships, stigma, and finally the future of the DRP.[31]

## 6.2 Key Findings

- When awareness of the DRP was assessed, staff were able to describe the aims and initiatives of the DRP, but some interviewed staff did not see how their job might be associated with the DRP, even when their post was funded by the DRP budget. This was also true for the majority of prisoners who reported awareness of the DRP (wave one 87%; wave two 86%), but there seemed to be some confusion amongst the prisoners as to the aims and ethos of the DRP. Both the staff and prisoners demonstrated a lack of awareness as to the whole prison approach adopted by the DRP.

[30] Room accessory upgrades were undertaken that involved improved pillows, issuing curtains to help darken rooms and promote sleep, and duvets for warmth rather than blankets.

[31] The percentages reported in the findings relate to 194 questionnaires returned at wave one and 168 from wave two.

- Most staff had embraced the security elements of the DRP, but it was acknowledged by the staff interviewed that it had been more difficult to garner support for the demand reduction elements of the DRP.

- Staff spoke of the need to change the culture within the prison to allow the DRP to become fully embedded and supported but outlined that this type of cultural change takes a long time to cultivate and felt that more work was required to bring uniformed staff on board. Despite this acknowledgement, senior management were optimistic about the changes in culture already observed and the potential for further change.

- The questionnaire and qualitative data suggested an improvement in perceptions of safety on the house blocks between wave one and wave two among the staff and the prisoners. In fact, prisoners' feelings of safety were statistically significantly higher at wave two than at wave one.[32]

- Although there was a slight increase over time, at wave two just under half (45%) of questionnaire respondents felt that their basic needs were being met by the prison (wave one 37%). Although meeting a prisoner's basic needs is beyond the remit of the DRP, not meeting them is a barrier to effectively implementing the DRP and its initiatives.

- The community asset model operating on each house block was perceived to have provided greater visibility of staff, improved staff-prisoner relationships, facilitated the breaking down of barriers between staff groups, improved the sharing of information, and the promotion of demand reduction initiatives amongst staff.

- Despite some staff and prisoners describing improved relationships, there were indications from both staff and prisoners that some staff were yet to buy into the decency agenda and that stigma towards those with addictions to illicit substances amongst prisoners and staff was still observed.

[32] From the EssenCES, wave one mean = 12.85 and wave two mean = 13.30, where scores range from 0 to 20 with higher scores indicating a higher level of perceived safety.

- Despite the aim to reduce the stigma around substance use, there seemed to be a lack of understanding evident in both the prisoner and staff responses around the prescribing and use of methadone in HMP Holme House in that it was not always seen as a legitimate medical treatment for opiate dependence by staff and prisoners.

- Staff had concerns about the impact of any potential loss of funding on the sustainability of cultural change and hence ongoing support for aspects of the DRP.

## 6.3 Awareness and Communication

The DRP's communication strategy, which included posters, display stands, staff briefings, monthly newsletters and Continuing Professional Development (CPD) events, was implemented to promote active participation in the DRP and make everyone across the prison feel involved in its execution. The majority of prisoners (wave one 87%; wave two 86%) had heard about the DRP. The most common source of information was from Drug and Alcohol Recovery Team (DART) staff (wave one 49%; wave two 55%). Only 10% of prisoners, however, indicated that they had attended a house block launch event at wave one,[33] although this varied across house blocks with the highest attendance being on house block five (27%), which was the most recent house block to have had a launch/orientation event prior to the questionnaires being distributed at wave one.

Although the majority of prisoners were aware of the DRP, at both waves, there seemed to be some confusion over the aims and ethos of the DRP and a lack of awareness as to the DRPs whole prison approach. The qualitative analysis revealed that at both waves some of the prisoners thought the DRP was located on house block six, where the therapeutic community exists, and was only for drug users. This latter misunderstanding was most likely a consequence of its name. Indeed, in the qualitative data, staff recommended a name change to better capture the wider remit of the DRP.

In relation to staff knowledge of the DRP, while they may have been able to describe the aims and initiatives of the DRP, several did not see the DRP as a whole prison initiative

[33] This question did not feature on the questionnaire at wave two.

nor did they see how their job roles might be associated with the project, even when their post had been funded from the DRP budget. More than one member of staff referred to the DRP as a 'team' rather than a programme of work, an initiative, or a project:

> 'I don't have a lot of involvement with the DRP team' Staff (wave two, interview)

Some staff were surprised, however, that there were staff working within HMP Holme House whom were not completely familiar with the ethos and approach of the DRP given the amount of information that had been shared about the initiative. Senior management outlined that they had adopted a variety of communication methods throughout the prison regarding the DRP but felt that the management of information around the DRP is a difficult and ongoing challenge.

Finding the time to adequately train and educate staff in prison that may have staff shortages is well documented, as well as its ability to undermine prisoner wellbeing, rehabilitation and the delivery of good quality care (HMIP, 2019; Liebling et al. 2011; Ministry of Justice, 2016). Senior management commented how recently appointed staff were accepting of the various DRP initiatives and its associated culture. This staff group had received recent training on recovery and strengths-based approaches and, given that they had only ever worked in HMP Holme House since the implementation of the DRP, the current culture was all they knew:

> 'Many new staff wouldn't know what the DRP are as the security arrangements were in place before they started. If you asked them about interventions taking place some will be able to tell you e.g. Community Cafés, more and more staff are aware of these things. Staff who have been here more than two years are aware of us – lots of marketing and staff briefings – these are the ones that are targeted for culture change. The newer staff just accept this as the culture, the norm.' Staff (wave two, interview)

## 6.4 Cultural Change

Staff spoke, in both waves of interviews, of the need to change the culture within the prison to allow the DRP to become fully embedded and supported. The ethos of the DRP is that it requires a 'whole prison approach' with all elements of the institution encouraging

and supporting recovery and growth. Senior staff were under no illusion that this type of cultural change takes a long time to cultivate – longer than the three years initially afforded to the DRP pilot. By wave two, HMP Holme House was just two years into operational delivery of the DRP.

At the time of the wave one interviews, staff had discussed the slow nature of cultural change, but outlined the importance of such change in promoting a setting within which demand reduction could be successful. The nature of the physical prison environment was seen to be pivotal in driving the change in culture and in supporting recovery:

> ‘The difficult bit is in … changing culture both in men, in staff, and in environment really because the environment does drive the culture whether we like it or not.’ Staff (wave one, interview)

At wave two, senior management reflected on how the frontloading of security measures, designed to reduce illicit drug supply and hence stabilise the environment, had initiated the process of cultural change. Management spoke about how the longer-term staff and prisoners (those that had been at HMP Holme House for at least two years) will have witnessed positive changes that followed the reduction in illicit drugs in the prison. It was said that staff now reported to management that they felt safer in their place of work and, consequently, were able to be more effective in delivering the care that they were there to provide. Management felt that staff were seeing and feeling the positive effect of the change in culture and were therefore more accepting of DRP related initiatives. These comments from management were substantiated in interviews with staff across different disciplines and grades, as well as prisoners:

> ‘The culture has shifted, that’s huge. The way it’s changed is that people know that the DARTs, the mental health, the DRP, whoever, that they give a damn, that’s the change. But for some people that could pull them on, because that’s a big thing, it’s a big shift.’ Prisoner (wave two, case study)

As a collective, senior management were optimistic about the changes in culture already observed and the potential for further change:

> ‘Trying to get the staff to understand why we are doing what we are doing has been … hard but we know that culture change in any establishment takes time. We’ve been working on this – keep talking to them, advertising to the staff. Put things on that staff can be involved with e.g. family days with prisoners putting on performances, joint training days, veterans with dependencies working with veteran staff … Some staff that I would never had expected to get involved have.’ Staff (wave two, interview)

However, there was a recognition amongst senior management and those working in demand reduction, that while most staff had embraced the security elements of the DRP, it was more difficult to garner support for the demand reduction elements of the DRP. This might be indicative of a more traditional prison culture[34] (Crawley, 2004), the fact supply reduction initiatives are often seen as being more ‘acceptable’ (UNODC, 2008) and the lack of understanding (stigma) demonstrated by some of the prisoner and staff responses to drugs and their users in the qualitative data (see section 6.6). It was felt that work was required to bring uniformed staff on board with the strengths-based approach to recovery was still ongoing:

> ‘The initial thing was to stabilise the environment and the men on which the DRP could be based. That gives you the breathing space. Staff were looking for reduction in substances within the prison. Achieving that brought a lot of people on board. The next stage is to change the culture and to get the staff on board with reducing demand and building recovery. This is the harder part.’ Staff (wave two, interview)

One senior manager spoke of a strategy of gradual exposure of staff to new initiatives in the prison – rushing cultural change was observed as being potentially counterproductive. This manager spoke of how a “creep in culture” had been observed in HMP Holme House as staff had observed positive changes arising from initiatives. Examples included: the Personal Achievement and Development week-long army-type training course for prisoners which was reported to be a positive experience which helped to break down barriers and build relationships between the staff and prisoners; Park Run at the prison;

[34] Officers are socialised to value the security elements of their work more than the demand reduction and rehabilitative components of their job (see Crawley, 2004).

and the inclusion of prisoner representatives on the Health Improvement Board/Residential Management Teams.

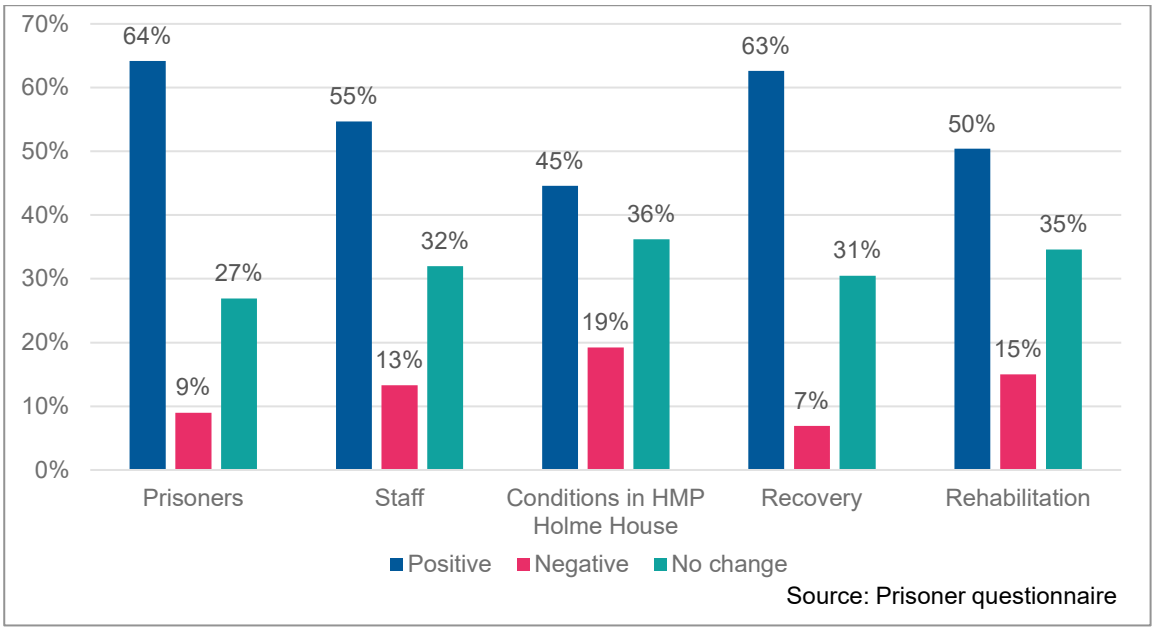
Other members of senior management offered further evidence for a shift in culture in the prison. One spoke of how '*more and more staff are coming forward with ideas for interventions with the men*' and, indeed, some staff provided examples of ideas of prisoner activities that they had put forward to management. Bottom-up initiatives are encouraged by management '*as long as* [they are] *safe and in line with the ethos of the DRP'* (wave two, interview). Another manager voiced frustration, however, at the hierarchical organisational structure in the prison, which they felt hindered staff enterprise and stifled the autonomy they required to try out new initiatives. It was recognised there was a need to do more to empower staff: '*I think we can do more and we need to do more about this*' Staff (wave two, interview).

## 6.5 Changes on House Blocks

Despite taking a whole prison approach, some aspects of the DRP were implemented at a house block level to create a sense of community and reduce stigma. The approach implemented on each house block drew on best practice of an asset-based community approach to health inequalities (Morgan and Ziglio, 2007; Foot and Hopkins, 2010).

The quantitative data on the cultural changes occurring in HMP Holme House were mixed. Overall, a third of prisoners of the overall sample completing the questionnaire (38% at wave one and 34% at wave two) reported a difference on their house block and around half reported that this change was positive (50% at wave one and 53% at wave two). The proportion of prisoners answering the questionnaire who said that this change was negative reduced from wave one (20%) to wave two (11%). While responses from the questionnaire at wave two showed that the majority of prisoners thought the DRP had impacted positively on prisoners (64%), staff (55%), recovery (63%), and rehabilitation (50%) (see Figure 6.1).

**Figure 6.1: Percentage of prisoners reporting type of impact the DRP had on prison factors at wave two**




The EssenCES scale, a standardised measure of prison climate, was used to explore cultural differences on the house blocks. The only statistically significant difference on the EssenCES scale between the two waves was the level of experienced safety: scores were statistically significantly higher at wave two than at wave one.[35] This finding was supported by the qualitative data from both staff and prisoners who reported that the prison felt safer and calmer largely due to a reduction in drugs.

Although there was a slight increase in the proportion of prisoners agreeing that their basic needs (e.g. food, hygiene, safety, warmth and shelter) were being met by the prison between wave one and wave two (37% to 45%), this increase was not statistically significant, and over half still felt that this was not the case, and their basic needs were still not being met by the prison. The importance of meeting the basic needs and treating prisoners with respect was outlined in the qualitative data, which recognised the potential impact on the culture and on relationships, a potential barrier to delivering the objectives of the DRP:

[35] Wave one mean = 12.85 and wave two mean = 13.30, where scores range from 0 to 20, with higher scores indicating a higher level of experienced safety.

> ‘[The atmosphere on the wing is] very easy going because the cleanliness leads to the decency. And I could take you to my kit cupboard and it's immaculate... Now because the staff have got it boxed off, with the help of the prisoners, we've got clean kit to give them and the decency extends. They think ‘well if he's treating me decent, I'm not going to be an arsehole’ and it's as simple as a clean towel.’ Staff (wave two, interview)

Although, the quantitative data on the cultural changes occurring in HMP Holme House were mixed, the qualitative data illustrated that the community asset model operating on each house block was largely seen as a positive development. The staff and prisoners said it provided greater visibility of staff, improved staff-prisoner relationships (see section 7.5), facilitated the breaking down of barriers between staff groups, improved the sharing of information, and the promotion of demand reduction initiatives:

> ‘There’s less of an ‘us and them’ … we sometimes still get that we’re just like care bears and all that nonsense but there doesn’t seem to be so much of that now … they're used to seeing you every day and they can kind of see that too … officers will come to me and tell me things – ‘this lad is struggling’, ‘we think this ones doing such and such’, ‘this guy’s asking for family support but doesn’t know what to do’. I can get stuck in there really quite quickly. So I definitely think attitudes are changing. That to me is massive.’ Staff (wave two, interview)

## 6.6 Relationships

An important part of the DRP cultural change was to improve relationships across the prison, which also involved recruiting more staff to ensure staff shortages did not undermine the implementation of the DRP. As part of the DRP, both HMPPS staff (28 in total) and healthcare staff (28 in total) were recruited alongside a dedicated DRP team (4 in total), which operated alongside the more general recruitment of staff to other vacancies in HMP Holme House. The questionnaire asked about prisoner’s perceptions of whether: (i) prison officers treated prisoners with more respect, (ii) prisoners treated prison officers with more respect, (iii) prisoners treat prisoners with more respect, (iv) prison officers understand about drug use, addiction and recovery better.

Across the whole sample, it was agreed by around a third of prisoners that there had been an improvement in prison officer-prisoner relationships (32%) since the DRP had been implemented, although a similar proportion disagreed (36%). An improvement in prisoner-prisoner relationships since the DRP had been implemented was reported by 38% of prisoners, with 19% disagreeing that this was the case. Around a fifth of prisoners at wave one, increasing to almost a quarter at wave two, also agreed prison officers had a better understanding of drug use, addiction, and recovery, which was illustrated in the qualitative data from staff:

> ‘It’s opened a lot of staff eyes regarding why they take drugs. Because before we didn’t know the background of why it started, but with obviously everybody sharing information… say someone’s a drug user but we've found out in his teens or when he was a child he may have been abused, so it's like a knock on effect from that. Whereas before this, we wouldn’t be sharing all this information, we wouldn’t be finding out about them so you can sort of sympathise and empathise – yes you are using drugs, but we know why you're using it, so we need to tackle that, we need to stop that trigger point.’ Staff (wave two, interview)

Some staff, however, commented on how a portion of the uniformed staff were yet to buy into the decency agenda. How widespread this was within the prison, however, is not clear from the interviews. Indeed, some uniformed staff spoke about the importance of treating the prisoners with decency and in adopting a strengths-based approach with the prisoners.

As with the interviewed staff, the interviewed prisoners also provided a mixed picture of the nature of staff-prisoner relationships. Some reported positive relationships whereas others highlighted negative incidents that served to weaken ties with staff. The recent influx of new prison staff was observed by staff to have helped in the building of staff-prisoner relationships; with an increase in the number of uniformed staff, time was now available to spend with the prisoners and mutual respect was perceived to be returning. Some of the prisoners, however, were critical of the newer members of staff for lacking in experience and hence authority, illustrating the need for better training from HMPPS for their staff.

Both prisoners and staff saw the move to house block based multi-agency working as a positive development for relationships. The prisoners, especially those involved with

DART, reported that staff-prisoner relationships were strengthened due to the greater visibility of these staff:

> ‘On this block we have got two allocated DART staff who are here constantly. They are familiar faces every day. So yeah, you have got access – you got that office there where you just knock in the door if you need anything. They’ll deal with it there for you.’ Prisoner (wave one, interview)

Staff also praised house block based working as being useful in breaking down barriers between the different disciplines within the prison and promoting the demand reduction work with uniformed staff and commented that this type of working had resulted in more information sharing on individuals that was thought to have created a more informed and empathic staff group. The DRP policy of dispersing substance users throughout the prison and across house blocks was aimed at reducing the stigma associated with drug addiction.

## 6.7 Stigmatisation

The DRP policy of dispersing substance users throughout the prison was aimed at reducing the stigma associated with drug use and addiction within the prison as well as providing a greater understanding of recovery for staff and prisoners. Prisoners and staff, however, made a number of comments, about how the stigma still prevails in the prison:

> ‘That’s, when I look at someone who’s on methadone, I think fucking hell. In that queue – I don’t like going there to pick up my thyroid tablets, never mind using that every morning, it's a zombie queue, it's degrading.’ Prisoner (wave two, interview)

Prisoners also voiced the concern that they suffered due to the behaviour of substance users in prison:

> ‘Like me personally I don’t smoke it … but because of this situation with drugs and Spice and stuff like that, our gym accessibility has right down … now we’re banged up behind the door so their solution is to keep them banged up. Even cleaners and servery workers they get banged up short, do the jobs and say right they’ll bang them straight back up.’ Prisoner (wave two, focus group)

Whether comments like these relate to real events or alternatively are perceptions, they show that the impact of drug use affects the whole prison, and suggests more work is required with both staff and prisoners to reduce the level of stigma towards those with substance use issues within the prison. In fact, despite the DRP aiming to reduce the stigma surrounding substance use, there seemed to be a lack of understanding among both prisoners and staff around the prescribing and use of methadone in HMP Holme House, in that it was not always seen as a legitimate medical treatment for opiate dependence. This is despite methadone being one of the few drug treatments with a strong evidence base (ACMD, 2015; BPS and RCP, 2008). Some prisoners spoke of their perceptions of how many prisoners were on prescribed methadone and how readily they felt it was prescribed within the prison:

> ‘They're giving it to people who shouldn’t really be on methadone. And they don’t want to have a script. They just want to get high. But … by the time they get in the community … you’ve created a new addict.’ Prisoner (wave two, interview)

Some of the staff also commented on the use of methadone within the prison too:

> ‘I mean to be honest with you, you can't turn round and say you want a truly drug free prison, when 40% of my wing is taking methadone. I've got 40% with an ongoing drug problem. 20% are kind of attracted by it because at the end of the day, if you're incarcerated and I offered you drink this juice and it’ll make your days more bearable…’ Staff (wave two, interview)

This shows there is more work to be done if levels of stigmatisation are to be reduced.

## 6.8 Future of the DRP

Overall, the quantitative and qualitative data provided an impression of a shift in culture, which, although slow, was largely supportive of the security elements of the DRP and was making ground in relation to the demand reduction initiatives. Although some change was evident, it was accepted that more needed to be done. Within the qualitative data, one senior manager spoke of the next steps for the attempt to shift the culture of the prison:

> ‘We need to celebrate successes across the relevant teams so they can see the benefits of the work completed and understand how they fit into the recovery and other strategies … so they can see how their role fits in with that and what impact they have. This will then feed into culture change as they will understand more. Consequently, this personalises it and makes it relevant to the individual.’ Staff (wave two, interview)

There was concern amongst senior management, however, that observed positive changes in culture, and any potential future ones, might not be sustainable should the DRP fail to receive sufficient ongoing funding:[36]

> ‘We know that at some point the funding will go but the culture and the attitude should be there – if the funding goes too early, it wouldn’t take long for things to unravel. Not necessarily back to how it was but to revert sufficiently to have an impact on the lives of the men, the lives of the staff and the jail as a whole. We’ve had time for the planning and the doing, now we need time for the beautifying and embedding and that carrying through to the other side … this is my biggest fear that we might not be able to do that.’ Staff (wave two, interview)

[36] At the point of publishing this report ongoing funding had been secured.

# 7. Findings: Care and Wellbeing

## 7.1 Introduction

The demand reduction initiatives implemented as part of the DRP fall under the two strands focusing on (1) care and wellbeing and (2) continuity of care. This chapter presents the findings for care and wellbeing. First it will focus on awareness of, and involvement and levels of satisfaction with healthcare, before looking at drug treatment and the REC-CAP data on quality of life and recovery capital. The activities, work, training, education, and programmes available in HMP Holme House will then be discussed, including what the prisoners think the prison could do to further support their recovery.[37]

## 7.2 Key Findings

- The majority of prisoners were aware of mental health services at both waves (65%), although both the prisoner questionnaire and the qualitative data showed mixed levels of satisfaction with mental health and primary healthcare services. Whilst not in the remit of the DRP, a key point of contention for prisoners was the perceived long waiting lists for primary healthcare, including GPs and dentists. Work was ongoing to improve this area via an Improvement Board that was in place between 2018 and 2020. Both prisoners and staff commented on the impact of staff shortages.

- Around half of prisoners knew about the paramedic within the prison. However, they were much less aware of the trauma interventions available or the speech and language therapist, which were some of the specialist services/interventions implemented as part of the DRP. Although difficult to ascertain, it is possible, however, that the low level of awareness may have reflected the level of need among the prisoners and/or the mode of access (e.g. requirement for referral) that may have reduced the visibility of some services/interventions.

[37] The percentages reported in the findings refer to 194 questionnaires returned at wave one and 168 at wave two.

- Just over a third of prisoners (37%) at wave two reported that they perceived the DRP to have impacted positively on healthcare provision (although 24% thought it had impacted negatively and 39% perceived there to have been no change). A quarter of prisoners reported that the DRP had positively influenced health and well-being for themselves and/or other prisoners.

- Despite the move to a house block-based healthcare model, the majority of prisoners at both waves either had not noticed a change in getting to see healthcare (wave one 66%; wave two 67%) or were not sure (wave one 9%; wave two 12%), although this may have reflected the level of need among the prisoners.

- Although very few prisoners noticed a change to drug treatment since the DRP had been implemented, at wave two almost a third of prisoners reported that access to the *Drug* and Alcohol *Recovery* Team (DART) had improved since wave one. The visibility of DART staff was observed as key factor in this. At both waves the majority of prisoners knew about the services offered by the DART and most prisoners reported positive perceptions of DART staff and treatment.

- The prisoners who completed the questionnaire at both waves reported a statistically significant improvement on the global psychological health and global physical health scales on the measure of recovery capital (REC-CAP) between wave one and wave two, suggesting that their psychological and physical health improved from wave one to wave two.

- The staff reported that the peer mentor scheme was a DRP success story and helped to create a sense of community. Some of the prisoners, however, questioned the appropriateness of some of the individuals allocated to these roles.

- At both waves the prisoner questionnaire suggested a low uptake of activities, although a number of barriers were identified in both the questionnaire and qualitative data, such as the suitability of scheduling. However, prisoners were keen for more activities to be provided and there was also a statistically significant increase in the REC-CAP Meaningful Activities recovery capital scale between

waves, suggesting that the prisoners were, in fact, taking part in a greater number of the activities available to them at wave two.

- There were no differences between the two data collection waves in the prisoner questionnaire for prisoner's participation in work, training, education or programmes, although there was a statistically significant increase in the proportion of prisoners volunteering from wave one (8%) to wave two (15%).

## 7.3 Awareness and Involvement with Healthcare

The DRP aimed to enhance healthcare provision, improve healthcare outcomes and support safer communities. Additional healthcare staff (28 in total) were recruited as part of the DRP to implement these changes.

Just over a third of prisoners completing the wave two questionnaire (37%) thought the DRP had impacted positively on healthcare provision,[38] and a quarter of the prisoners thought the DRP had influenced health and wellbeing for themselves and other prisoners. However, at both waves the majority of prisoners either had not noticed a change in getting to see healthcare (wave one 66%; wave two 67%) or were not sure (wave on 9%; wave two 12%) if there had been any changes, although this might reflect the prisoners not needing to access healthcare during this time and so were unaware of any changes. Just over half of the prisoners in both waves (wave one 57%; wave two 53%) knew who to speak to about their healthcare needs. The questionnaire also showed there were mixed findings with regards to the community-based house block model, with statistically significantly fewer prisoners reporting being aware of the healthcare services on their house block at wave two than at wave one (wave one 43%; wave two 36%). However, the majority of prisoners perceived that having healthcare and other services on the house block made them easier to access (with 46% perceiving it made access a little/somewhat easier and 18% perceiving it to be very much/quite a lot easier[39]).

Almost two-thirds (65%) of prisoners at both waves reported awareness of mental health services. At both waves, more than 40% of prisoners answering the questionnaire had

[38] A quarter (24%) thought it had impacted negatively and 39% thought that there had been no change.
[39] A third (35%) reported that there had been no change in access to healthcare and other services.

used mental health services at some point, with a quarter of prisoners at both waves currently engaged with them. Of these, over half were satisfied with the services at wave one, although this fell slightly by wave two (see Table 7.1). Over a third of prisoners at both waves were currently engaged with primary healthcare services (GPs and medical services), with around 40% of these being satisfied with these services at both waves (see Table 7.1).

**Table 7.1: Service engagement, satisfaction and needs at wave one and wave two[40]**

| Service | Currently Engaged with the Service | | Satisfied with the Service | | Need Help or Additional Help | |
|---|---|---|---|---|---|---|
| | Wave one | Wave two | Wave one | Wave two | Wave one | Wave two |
| **Mental healthcare** | 25% | 27% | 52% | 38% | 23% | 27% |
| **Primary healthcare** | 38% | 41% | 38% | 41% | 29% | 30% |

Source: REC-CAP data

When prisoners were asked about their opinions of the mental health services available to them at wave one, some commented that they perceived that they were not being provided with appropriate treatment and other prisoners commented that staff were 'snowed under' and consequently not able to provide the level of service that the prisoners stated they would feel they would benefit from:

> 'Yeah, mental health come and see you once a fortnight but they're snowed under… If you need them in the meantime, they just say phone the Samaritans. That's basically your other option, phone the Samaritans or call out a listener.' Prisoner (wave one, interview)

In contrast, at wave two the qualitative data showed that prisoners were more complimentary about the service they had received from the mental health team:

> 'The mental health for me personally has been really good – my needs have all been met.' Prisoner (wave two, interview)

[40] The percentages for "Were satisfied with the service" and "Need help or additional help" are of the whole sample.

Staff commented that they felt that the access to mental health support was good, saying that prisoners could request support via the self-service kiosks on the house blocks or be referred by a member of staff, and staff reported that applications were checked daily, and that support is available seven days a week, all year round. Some staff suggested that there was a misunderstanding as to the types of support that the mental health team could provide for the prisoners. They said that that they were often asked to respond to situations within the prison that they would not be asked to respond to in the community. This may explain why the prisoners thought the staff were snowed under and over stretched, not able to provide the level of service they would benefit from and thus had a low satisfaction rate. Staff also reported that the resources available to the mental health team were insufficient, especially in respect of IT equipment. It was often not possible to write up notes within the required 24 hours due to insufficient computers, which may have impacted on the provision of healthcare and the sharing of information. Although, additional computers were ordered for all of the house blocks, there was a delay in their delivery and set-up, which impacted on this element of the DRP.

Although not in the remit of the DRP, the prisoner's perceptions of physical healthcare were less complimentary (mainly GP and dentist), citing long waiting lists and delays in receiving medication. At both wave one and wave two most prisoners interviewed spoke of the long waiting times to get appointments with the GP, which was also reiterated by the staff:

> 'It's the waiting times and getting an appointment, you would be better before you see them. You might wait three weeks before you see it in your appointments, and that might be another four or five six weeks of wait and by that time they know you've fought whatever you've had away.' Prisoner (wave one, interview)

> 'I think for the size of the jail and the amount of men, there isn't enough… if there was more of it then yes, I think maybe would also help with the drug recovery programme.' Staff (wave two, interview)

Although there were also mixed responses about the quality of physical healthcare in the prison, this is not an issue unique to HMP Holme House, and reflects wider criticisms levelled at healthcare provision across the prison estate (see House of Commons, 2018).

However, some prisoners praised the support that they received once they were able to access it. Although, the provision of physical healthcare (e.g. GPs and dentists) sits outside the remit of the DRP, it is integral to the DRP achieving its aims (e.g. improving health and wellbeing) and is therefore a potential barrier to the implementation and success of the DRP, which is why efforts have been made to improve it. Some of the staff interviewed at wave two explained one of the ways in which some of these issues, specifically waiting times to see the GP, had been addressed:

> ‘They have employed a nurse practitioner who’s doing a clinic a couple of times a week. They’ve put some posters around the wings to say what ailments they can, what they can do, trying to encourage them if they’ve got anything like earache and things they can put down to see the nurse and it's a lot quicker. So that’s been helpful.’ Staff (wave two, interview)

However, senior management also spoke of how the healthcare provision within the prison had been affected by the national shortage of nurses (see Iacobucci, 2018) that had impacted on recruitment to these roles in the prison. Nurse shortages meant that reviews and official innovation/launch events of the DRP had not taken place on house blocks six and seven. Despite this, DRP elements were developing on these house blocks but not in a consistent manner due to the staffing issues. It was reported that this had been frustrating for both the DRP and nursing staff whom had been employed to undertake a particular role that had not yet been possible. It is also worth noting that long waiting lists for doctor, dentist and hospital appointments are also not uncommon in the community and so the issues reported by prisoners are not necessarily specific to HMP Holme House.

A positive finding was a statistically significant increase between wave one and wave two on two of the recovery capital scales that related to health (Global psychological health and Global physical health) among the group of prisoners who completed the questionnaire at both waves. This suggests that this group – who were in HMP Holme House for the duration of the DRP – built (personal) recovery capital in these areas.

A number of prisoners in both waves (wave one 15%; wave two 21%) had noticed a change in accessing prescribed medication over the last 6 months, with a third reporting it had become more difficult to access in both waves. This was also reflected in the

qualitative data from both staff and prisoners. One prisoner spoke of how important it was to have medication needs met implying that to him they constituted a basic need, and another commented on the potential negative effects of delays:

> 'Your bed, your food and your medication if all those 3 are sorted it's fine, you can cope with it, but mess with any one of those and it might become too difficult.' Prisoner (wave one, interview)

> 'I think delay with health care will lead on to people self-prescribing, which again is like, [NAME] might say to me 'I've got some tablets if you want some, if you've got a bad back or something' and then that leads on to possible dependency or looking for stronger items.' Prisoner (wave two, focus group)

Some of the staff also commented on how operational delays in receiving medication, such as methadone, could be problematic. It was not clear what the source of these delays were, but a small number of interviewed prisoners also commented on this issue:

> 'The nurses are often that late coming onto the wing to give people medication that you miss work anyway. So you get penalised for the staff being late.' Prisoner (wave two, focus group)

Around half of the prisoners knew about the paramedic within the prison (wave one 52% and wave two 44%). However, the prisoners were much less aware of the trauma informed care or interventions available (e.g. Dialectical Behaviour Therapy (DBT), Trauma groups, or *Eye Movement Desensitization and Reprocessing* (EMDR)) or the speech and language therapist, which were some of the specialist services implemented as part of the DRP. This was despite the Principal Clinical Psychologist[41] and the Speech and Language Therapist undertaking several events with the prisoners to talk about and explain how they could access these services, as well as being present at the house block DRP innovation/launch events. However, as the paramedic is more visible than some of the other specialist healthcare interventions and not all prisoners require these services or are able to access them without a referral (e.g. trauma informed interventions), it was perhaps

[41] The Principal Clinical Psychologist post no longer receives funding as part of the DRP as the developmental work was completed, and operational delivery was facilitated by qualified staff utilising existing funding.

unsurprising that there were low levels of awareness. It was also felt by senior management that access to trauma support might actually be better in HMP Holme House than in the community. Further, there was hope that the forthcoming re-commissioning of health contracts (completed during 2019/20), which aim to improve the integration of services, might facilitate more trauma work. One development in relation to this was the reallocation of resources to support the ongoing delivery of interventions once the developmental work of the Principal Clinical Psychologist had been completed:

> 'If all resources were available across all teams we could work together collaboratively in a different way. The new health contracts might allow this more, for example, for DBT and EMDR it doesn't need to just be the mental health nurses delivering this. The training for DBT can be opened up but we've never been in a position where from a healthcare/DART nursing team we have enough staff to release and deliver this type of work. Once the staffing is in place, these developments could be supported from a wider healthcare dept.' Staff (wave two, interview)

## 7.4 Drug Treatment

Responses to the prisoner questionnaire at both waves showed that very few prisoners noticed a change to drug treatment[42] since the DRP had been implemented (wave one 9%; wave two 10%). However, this may reflect that not all prisoners had a drug need so were not aware of changes that had taken place. However, even among substance users there was a high proportion (84%) reporting that they had not noticed any changes to drug treatment, which was statistically significantly higher than for non-substance users (69%). Despite this, at wave two almost a third of prisoners (30%) reported that access to the DART had improved since December 2018, although half were not sure if access had changed in any way, which may reflect that not all prisoners need DART support. According to the qualitative data, the improved access to DART was largely attributed to

[42] There was a statistically significant difference for noticing change to drug treatment between waves. However, this was accounted for by increased percentages of 'Not sure' responses and decrease in 'No' responses.

the visibility and accessibility of DART workers on the house blocks, which the community house block model had facilitated:

> 'On this block we have got two allocated DART staff who are here constantly. They are familiar faces every day. So yeah, you have got access – you got that office there where you just knock in the door if you need anything. They'll deal with it there for you.' Prisoner (wave one, focus group)

Almost half of prisoners reported using DART services at some point at wave one (46%) which reduced statistically significantly by wave two (35%). With regards to current engagement statistically significantly fewer prisoners reported that they were engaged in drug treatment services at wave two, compared to wave one, although satisfaction rates for those currently engaged increased slightly between waves (see Table 7.2). This decrease may be the result of fewer prisoners needing the service, perhaps as the prison population in HMP Holme House had become more stable. Similarly, the proportion of prisoners who reported having a named recovery worker was statistically significantly lower at wave two (31%[43]) than at wave one (43%[44]). Current use of alcohol treatment services was low at both waves, with high levels of satisfaction.

**Table 7.2: Drug and alcohol service engagement, satisfaction and needs[45]**

| Service | Currently Engaged with Service | | Satisfied with the Service | | Need Help or Additional Help | |
|---|---|---|---|---|---|---|
| | Wave one | Wave two | Wave one | Wave two | Wave one | Wave two |
| Drug Treatment | 41% | 32% | 66% | 70% | 13% | 9% |
| Alcohol Treatment | 11% | 11% | 77% | 79% | 4% | 6% |

Source: REC-CAP data

Treatment engagement in HMP Holme House has been historically high, Public Health England data showed that HMP Holme House was consistently above the comparator

[43] At wave two 51% did not have a named recovery worker and 18% were not sure.

[44] At wave one 37% did not have a named recovery worker and 18% were not sure.

[45] The percentages for "Were satisfied with the service" and "Need help or additional help" are of the whole sample.

prisons[46] for the proportion of prisoners starting substance use treatment within three weeks of arrival into the prison (88% to 91% from Q1 2016/17 to Q4 2017/18), compared to an average of 49% to 61% for the comparator prisons combined. All comparator prisons, but not HMP Holme House, saw a drop in proportion from Q1 2016/17 until Q3 to Q4 2016/17 before increasing again to Q4 2017/18 (which was the last quarter for which these data were available). However, as the DRP had not been fully implemented at this date, it cannot be concluded that the DRP affected treatment engagement rates, although it is notable that HMP Holme House demonstrated consistency and did not experience the dip showed by other prisons.

In relation to successful treatment completions, Public Health England data showed that HMP Holme House had around 60% successful treatment completions with no re-presentation within 6 months across Q1 2016/17 to Q1 2018/19,[47] which was in the middle of the range for all of the comparator prisons and similar to all prisons in England combined. Therefore, HMP Holme House did not appear to be doing any better or worse than comparator prisons, nor does there appear to be any effect of the DRP on this variable.

Perceptions of drug treatment and the DART staff were often positive. At wave one, responses to the prisoner questionnaire showed that two-thirds of prisoners thought they were getting the right treatment for their drug use, with 60% reporting that their treatment had been explained to them and two-thirds understood their treatment.[48] There were some very positive comments about how useful the DART workers were perceived to be:

> ‘DART’s been a good help. They come and see us on a regular basis, when I was coming downing my methadone. Kept popping in ‘you alright, how you coping?’ I’d see [NAME] who’s my DART worker at least once a week, she’d pop her head onto the wing and “how are you getting on?”’ Prisoner (wave two, interview)

[46] Comparator prisons for 2019/20 performance year were: HMP Lindholme, HMP Mount, HMP Oakwood, HMP Ranby, HMP Risley and HMP Wymott. Figures were also compared to all prisons in the North of England, all training prisons and all prisons in England.

[47] This was the last time point at which data was available for this measure.

[48] These questions were only asked at wave one.

Some spoke of a group that they attended with DART workers, DART mentors, and other prisoners, the Self-Management and Recovery Training (SMART) group. Although a small number of prisoners were concerned about participating in group work sessions, the feedback on the SMART group and DART was largely positive:

> ‘Yeah it's good … I actually wrote down how much alcohol I’d been using and drugs I’d been using – I was physically shaking with the shock of how much it was. And I kept the booklets to look back through, but the workers as well, the staff workers are brilliant. You can talk to you one on one, they just talk to you, as a friend there's no like, they don’t judge you or anything’ Prisoner (wave two, focus group)

> ‘[DART worker] brilliant. I see him in the walkway, I was going to him for about 6, 8 weeks and he still remembered my name. He sees hundreds of people a day and still remembered my name, he said “how are you doing?”’ Prisoner (wave two, focus group)

At wave two, it was mentioned that the scheduling of the SMART group had been altered for the better; it had initially been scheduled for the evening, such that it clashed with the evening association period, but it had now been moved to a morning slot. This was perceived to be an improvement and was also reported to have increased attendance. From the questionnaire, three quarters (76%) of prisoners reported that they had attended a group, with only a small number of prisoners indicating that they needed additional help beyond what they were currently accessing.

However, there were some ways in which prisoners were not satisfied with the drug and alcohol treatment services they received, which was reflected in the qualitative data. At wave one, some spoke of how they felt that DART workers were either not sufficiently available to prisoners or did not offer the type of support that they required. For example, one prisoner spoke about his desire to reduce his methadone prescription but felt that the support to help him do this was lacking and others reported that the DART staff appeared to be ‘run off their feet’ due to low staff numbers. The following quote from a wave one interviewee highlights how some prisoners expressed a desire for DART staff to be proactive in approaching those prisoners who might benefit from their help and support:

> ‘I know nothing about the recovery part of the prison because I haven’t been asked. I haven’t even been asked if I want to come off the methadone. I haven’t been encouraged to come off the methadone. I’ve had no support from DART, but in the next breath I haven’t asked to see them. But surely, as a high-risk lifer on the wing that’s not took drugs in the past who’s come here, has found a drug problem, got into violence and that, you’d think they want to come and say eh what’s going on, they don’t, they just squirrel you away, move you from wing to wing to wing.’ Prisoner (wave one, case study)

However, a view surfaced that the effectiveness of DART services was undermined by prisoners whom either did not want to address their substance use, or were not ready to engage in treatment:

> ‘To get anything out of these courses you’ve got to be 100% ready, not just go and do it because somebody’s told you, and you’ll think oh alright I’ll get the certificate and say I’ve done this and get out, crack on with the drugs and drink again’. If you want to change you’ve got to be 100% be committed.’ Prisoner (wave two, case study)

The qualitative data across both waves also showed that prisoners reported that the quality of the support available to them through DART varied depending on which house block they were located:

> ‘I’ve been put in on the case to see my drug workers, I was with [NAME], when I was in block 4. And since I’ve moved over here, no one’s come to see me. I’ve put in a request for someone to see me, no one’s come and seen me.’ Prisoner (wave one, case study)

Indeed, a member of staff commented on how this was a potential disadvantage of house block based working and the community model:

> ‘…a man transferring from house block to house block to house block to house block his support network is going to change massively. Regardless of if he has or has not changed, in his mentality, his drug addiction or whichever. He's going to

> go through so many different cultures that must be at some point confusing for someone.' Staff (wave two, interview)

This movement or 'churn' of prisoners across the prison was also identified at wave one as potentially undermining the community-based house block model since it made building a community problematic. The variability in provision of DART services on individual house blocks may have been attributable to the delays in the recruitment of staff to the clinical DART positions outlined by senior managers. Senior managers spoke of delays, but at the time of the wave two interviews, they had recruited to all positions and were awaiting the vetting of the new staff to be completed. It was hoped, therefore, that all positions would be filled within the next month. Other staff agreed with the staffing issues mentioned but praised the work of the DART staff:

> '… the response I've had from other prisoners when speaking to them, they are an absolute asset to the prison team.' Staff (wave two, interview)

At wave two, prisoners identified a greater range of demand-reduction initiatives than they had during the wave one interviews, indicating how the demand reduction work had progressed within the prison between the two waves. While the largest number of prisoners mentioned the DART service, there were also mentions for the Self-Management and Recovery Training (SMART) groups, the Community Cafés,[49] a range of activities to either support recovery/wellbeing or to occupy time, and peer-led approaches.

## 7.5 Prison Council and Peer Mentors

A key component of the DRP and its holistic integrated approach to delivering substance use and health care services was establishing a prison council that operated across the prison and empowered the prisoners and staff to work in partnership improving communication, building trust and promoting hope, alongside developing peer engagement activities. However, findings from the questionnaire suggest the prisoner's

[49] Community Cafés were intended to be a space away from the main house blocks during association time on a drop-in basis. The cafés would be a place where activities and informal conversations could take place that would help improve both health and wellbeing.

awareness of the Prison Council was low (both waves 25%). In contrast, the majority of prisoners (87%) knew about the Prisoner Information Desk (PID) workers.[50]

At both waves the majority of prisoners knew about peer mentors (wave one 70%; wave two 72%), but both the quantitative[51] and qualitative data reflected mixed findings about their effectiveness. At wave two, prisoners also spoke about the number and variety of mentor roles or peer-led approaches that existed now under the DRP banner (e.g. for veterans, five-star well-being coaches who can use acupressure and acupuncture techniques, DART mentors, democratic council and health improvement board positions).

The staff also commented that the adoption of peer-led approaches had been one of the success stories of the DRP, with many of the peer-led groups and mentors flourishing in recent months and providing agency to the prisoners:

> ‘The DART peer mentors I think are a great idea because who better to talk to than someone who used to be an addict or sort of is an addict or someone who’s coming down.’ Staff (wave two, interview)

The peer mentor schemes were also seen by prisoners as helping to support the recovery of their fellow substance users in that they help to create a sense of community and to bring people together:

> ‘The reason that I’ve noticed a difference is because there’s a lot of people that on my wing that have done the … drug course. So, they can advise people and like help people that are struggling. Do you know what I mean? Some of the things that we learnt on these courses were tools that change your life or tools for in case they’re going to relapse or whatever. Whatever tools they’ve learnt on that course, they’ve obviously used them tools on this wing to help other people that are struggling as well. And that seems to like benefit people as well.’ Prisoner (wave one, interview)

[50] This question was only asked at wave two.

[51] About a third (wave one 32%; wave two 40%) saying that they were effective, a quarter they were not effective (wave one 24%; wave two 19%) and just under half (wave one 44%; wave two 41%) not being sure.

However, although subjective, some prisoners questioned the appropriateness of some of the individuals allocated to these roles and the equality of access to mentors across the prison. The recruitment of peer mentors, however, is supposed to reflect the broad range of individuals found in the prison population, which was not always appreciated or understood by the prisoners:

> 'I have brought up about a mental health mentor for on here. I'm told there's a young lad, he's only 20, 21, he's become a listener and I was told that they're supposed to be training him up to be the mental health person. My opinion? I think he's too young, he's had no experience, and how he can go and help somebody with mental health problems, if he hasn't got no experience, no training.' Prisoner (wave two, case study)

> 'If you're on one of those wings where there are active mentors, cos on some other wings people might not be arsed to be a mentor they might just want the wage or they might just want the job for, you know, whatever, which is their way of doing their jail.' Prisoner (wave two, case study)

## 7.6 Activities, Work, Training, Education and Programmes

The DRP introduced a range of additional activities aimed at supporting recovery, which ran alongside the work, training, education and programmes (e.g. accredited rehabilitation programmes) available in HMP Holme House that were provided by HMPPS.

### Activities

There were mixed findings about the uptake of DRP activities and procurement barriers[52] meant the implementation of some activities were delayed.

Only a small percentage of prisoners (wave one 11%; wave two 14%) agreed that more activities had become available since the DRP was implemented. This was reflected in the qualitative data at wave one, where a sizeable proportion of interviewees were not able to list or name any activities that came under the DRP umbrella. By the time of the wave two

[52] The MoJ is bound by the Public Procurement Regulations and as such must be totally transparent, fair and open in all procurement activities. Any requirement with a value of over £10,000 must be competed which may mean in some circumstances time does not allow for pilot needs to be met.

interviews, however, most were able to discuss one or more of the activities funded by the DRP. Of the prisoners that did list DRP activities, the majority mentioned the Community Cafés, which were attended by some prisoners (wave one 20%; wave two 13%[53]). The staff also mentioned the Community Cafés, along with a much wider range of activities compared to the prisoners (e.g. park run, the PADs course, reading and writing support courtesy of the Shannon Trust, first responder training by the prison's paramedic, wellbeing mentors to promote healthcare to the prisoners, matchstick workshops, and veteran's events around Armistice Day).

While the prisoner questionnaire indicated a low uptake of activities, the qualitative data provided more detail about the types of activities prisoners were attending. At wave one, the prisoners reported attending and enjoying the music group and crafting sessions. Both of these were well received by the prisoners. By wave two the number and variety of activities mentioned by the prisoners had increased; prisoners now spoke of wellbeing days, the music room, spoken word/creative writing sessions, a veteran's group, a young adult's group, woodwork sessions, black history month activities, and football:

> 'There's more activities that are being run by DRP that are, that give a feeling of well-being when you're doing them. I do lots of spoken word, creative writing and stuff like that and there's been a lot of support for that.' Prisoner (wave two, interview)

Despite few prisoners engaging in these additional activities, the prisoners requested even more activities to help aid their recovery:

> 'We all want more things to do, more time out of your cell... Now, I'm not asking for a longer association period, but if they come to you and say, do you want to go on this group or do you want do that? I think more people would… People are choosing to go to church man… there's people that have signed up for church meetings just to get out of their pad.' Prisoner (wave one, case study)

[53] The fall from wave one to wave two may have been attributable to the Community Cafés stopping, which was evidenced in the qualitative data, although there seemed to be some confusion about this among the prisoners and the staff.

In particular, those on house block seven (vulnerable prisoners) commented that they felt that more activities should be available to them:

> ‘There's a lot of it, there's a lot of groups, like recently like we've got one, a couple of well-being events going on, but men on here put in to attend them well-being events, but we’re not entitled to do that because of this house block, we’re not allowed.’ Prisoner (wave two, focus group)

The low rates of participation might be attributable to the fact that the majority of prisoners also deemed the activities to be at an unsuitable time rather than the quality of the activities (e.g. they were held during association when the prisoners were out of their cells anyway). This point is relevant to the Community Cafés although they were purposefully organised to run during association due to their function. At the time of the wave two interviews on some house blocks, the prisoners and staff were not sure whether the Community Café was indeed still running.[54]

In general, staff reported these activities to be successful and that they were having a positive impact on the prison environment:

> ‘We are improving the environment to help increase people’s wellbeing which in turn improves their mood and provides a calmer atmosphere. A calmer atmosphere makes people less prone to violence and needing additional substances to get them through the day. It creates a culture of people wanting to go to work, taking responsibility for their actions as that is what happens on the outside.’ Staff (wave two, interview)

The increase in meaningful activities implemented as part of the DRP (e.g. music and art projects, Community Cafés) were supported by the statistically significant increase between wave one and wave two on the meaningful activities recovery capital scale.

[54] Initially the Community Cafés were well attended and rolled-out successfully. However, as other house blocks were implemented, staffing resources from some partners meant that the cafés were not delivered consistently. The initial purpose of the cafés changed over time and became more structured and formal and as these were delivered during association time, buy-in reduced as similar support could be accessed during the core day. The cafés became process driven and some staff raised concerns about facilitating sessions within their job role and questioned the validity of them. However, work was underway to revise the approach.

## Education, work, training and programmes

Although education, work, training and programmes were the remit of HMPPS and not part of the DRP initiative, the majority of prisoners who completed the prisoner questionnaire indicated that there was suitable work and education available in the prison, while a third said that suitable training and programmes were available. There was no statistically significant improvement in these numbers from wave one and wave two, however, and neither were there any statistically significant changes in the numbers who reported accessing education, work, training or programmes (although as these sat outside the remit of the DRP, it might not be surprising). The wave two finding that only 9% of prisoners thought the DRP had influenced work and training corroborated these findings. At both waves, half of prisoners thought the work, education, training, and programmes could be improved.

One positive finding in this area, however, was a statistically significant increase in the percentage of prisoners volunteering from wave one (8%) to wave two (15%), which has been linked to successful recovery and an increase in volunteering once released (Edgar et al. 2011).

# 8. Findings: Continuity of Care

## 8.1 Introduction

Continuity of care was identified as integral to the DRP to reduce demand for drugs and promote long-term/sustainable recovery. Evidence shows that poor continuity of care can undermine any rehabilitative or recovery work undertaken in prison (Lloyd et al. 2014), as well as result in higher rates of overdose and death upon release (PHE, 2018; PRT, 2019). Some of the initiatives implemented as part of the DRP to improve continuity of care included the mapping of local community services by the Connecting Communities Team, increased support for prisoners on release, and link in work with statutory agencies.[55] This section looks at the continuity of care under the DRP by focusing on perceptions of the Connecting Communities Team[56] and treatment engagement statistics.

## 8.2 Key Findings

- Both staff and prisoners who had experience of the Connecting Communities Team's[57] work were very positive about the support they provide to prisoners before, on, and after release. A third of the prisoners reported being aware of the support offered by the Connecting Communities Team in the lead up to and on release.

- Staff mentioned concerns about a potential cliff edge in the level of support once prisoners return to the community, due to the difference in the amount of support offered inside the prison, compared to the variable levels provided by the CRCs.

[55] The percentages reported in the findings relate to 194 questionnaires returned at wave one and 168 from wave two.

[56] Despite recruiting prisoners with a release date after 30 June 2019 (to ensure we could follow the case studies into the community to assess the continuity of care), the attrition rate was high (57%). This meant the data collected on continuity of care was somewhat lacking.

[57] The Connecting Communities Team works with prisoners in the last 12 weeks of their sentence to support them on release, help with community reintegration and link in work with statutory agencies.

- Staff were also concerned about the strength of links between the prison and community based services, and whether the referral process to the Connecting Communities Team was resulting in appropriate referrals.

## 8.3 Connecting Communities Team

In the interviews, some of the prisoners reported being very concerned about their release emphasising the need for support:

> 'I'm so afraid of getting released now that I'm quite happy to stay in and that's pretty sad really. Like I don't even know how to get on a bus, man…I've never had a phone with a camera, so I don't know anything about Facebook, only what I hear in here. I don't know how much anything is. I don't know where I'm going to get on housing. I've got no clothes.' Prisoner (wave one, case study)

A third of the prisoners who completed the questionnaire knew about the Connecting Communities Team at both waves; although very few were currently using this service, particularly at wave one.[58] There was a statistically significant increase from wave one to wave two (16% and 26% respectively), however, in the proportion of prisoners who said that they would like to access the Connecting Communities Team. It is worth noting, however, that not all prisoners were eligible to access the Connecting Communities Team, which is available only to those on a DART care pathway[59] in the last 12 weeks of their sentence. Although, the interviews reflected the findings of the questionnaire; most of the prisoners interviewed were more than twelve weeks away from their anticipated release dates and hence were not necessarily aware of the support available to them at HMP Holme House:

> 'There is something on the board. If you're coming off the wing there is something there on the board but you've not got time to spend three to four minutes looking at a notice.' Prisoner (wave one, interview)

[58] However, as the Connecting Communities service only comes into play in the last 12 weeks of a sentence, and the sample at wave one was drawn from prisoners with a potential release data after 30th June 2019, it was not expected that many prisoners would be engaged with the service at wave one.

[59] Those not on the DART caseload are picked up by OMiC and the CRCs.

A sizeable proportion of the prisoners interviewed had considered their needs on release from prison and had heard of the Connecting Communities Team and had knowledge of the support that the team can provide in the lead up to release. This knowledge, however, seemed to be limited in scope or, in some cases, inaccurate.

By the time of the wave two interviews, those who had heard of the work of the Connecting Communities Team were more knowledgeable about their remit, usually because they had direct experience of their support. These individuals were very positive about the work of the Connecting Communities Team:

> ‘She's lovely … She took us to all me appointments when I got out the last time. Brilliant. She is you know. Set me bank up, set me job centre, there was nowt to do by about 1 o’clock. She’d done it all for us. Done. We need more people like that. That’s the sort of people that you want around you.’ Prisoner (wave two, interview)

The data showed that prisoners’ knowledge of the support available to them in the weeks leading up to and on their release was mixed, but this may have been due to their eligibility. Overall, however, their experience of this support was very positive.

With regard to staff perceptions of the Connecting Communities Team, at wave one, senior management reported that the work of the Connecting Communities Team had been quickly established and was perceived positively. Other staff also commented on how the support in preparation for, and on, release had improved:

> ‘So that’s getting better and better with time. So obviously there's drugs and alcohol teams in the community, so what we do is try to have a continuation of care where, all those clinical clients on methadone they're going to need that appointment so that’s given, they're going to get appointments.’ Staff (wave two, interview)

Despite the improvements over time and the new provisions in place, staff mentioned the potential cliff edge facing prisoners once the Connecting Communities team are no longer involved in supporting them

> '[Connecting Communities Team are]… engaging men more effectively than some community services, so that when released the level of support is less than in prison. We don't want to let men into a situation within which they lack support and might relapse after a period free from drugs which could mean the consequences are more severe for them.' Staff (wave two, interview)

While it is not possible for the Connecting Communities Team to work with released prisoners indefinitely, this issue highlights the perceived disparity in the level of support available inside the prison compared to that available on release, and the concern around the impact of this reduced level of support on continued recovery in the community. It was also acknowledged that the Connecting Communities Team's work should dovetail with other through the gate initiatives, such that they complement each other more readily. By the time of the wave two interviews, it was reported that stronger links had been forged with the Community Rehabilitation Company (CRC) and processes had been devised to ensure better communication and greater delineation of roles:

> 'The Connecting Communities do the support for release as well, but they're more tailored around drug and alcohol services. So they offer the intense support for that in the community. So we link in with DART worker while they're in here, what's going on what the guys are doing. And then we still obviously speak to the Connecting Communities worker. But then we see them as well on release.' Staff (wave two, interview)

Despite these improvements, staff also identified this as an area for further development. It was felt that improved multi-disciplinary working between the Connecting Communities Team, the DRP, and other external agencies could ensure a more effective and efficient service for the prisoners on release. For example, it was stated that more contact is required between the DART and social services in relation to drug and alcohol dependency and that the prison management need assurances in relation to the support available to prisoners who leave prison on the Take Home Naloxone programme.[60] The movement or 'churn' of prisoners across the prison, which was also identified at wave one

[60] This programme allows prisoners to take Naloxone home as it counteracts the effect of opioids and is used to reverse opioid overdose thus reducing drug-related deaths.

(see Section 7.4), could also potentially undermine continuity of care, both within the prison as well as upon release.

Finally, at wave two, staff mentioned that the referral process to Connecting Communities services possibly required refinement. At the time of the interviews, prisoners could self-refer to the Connecting Communities Team, or a member of prison, probation or even the police could refer them, or they could opt-in when contacted by the team. The opt-in process used prison and DART records to generate a list of substance users due for release within the coming weeks who would then be approached by the Connecting Communities Team. There was a concern, however, that the latter referral route was capturing individuals who were not motivated to changing their illicit substance use and hence taking resources away from those who were. Despite these reservations, overall staff perceived the Connecting Community Team positively:

> 'The Connecting Communities Team and the work that they're doing at the backend of the process and supporting them into the community actually feels like it's working really well' Staff (wave one, interview)

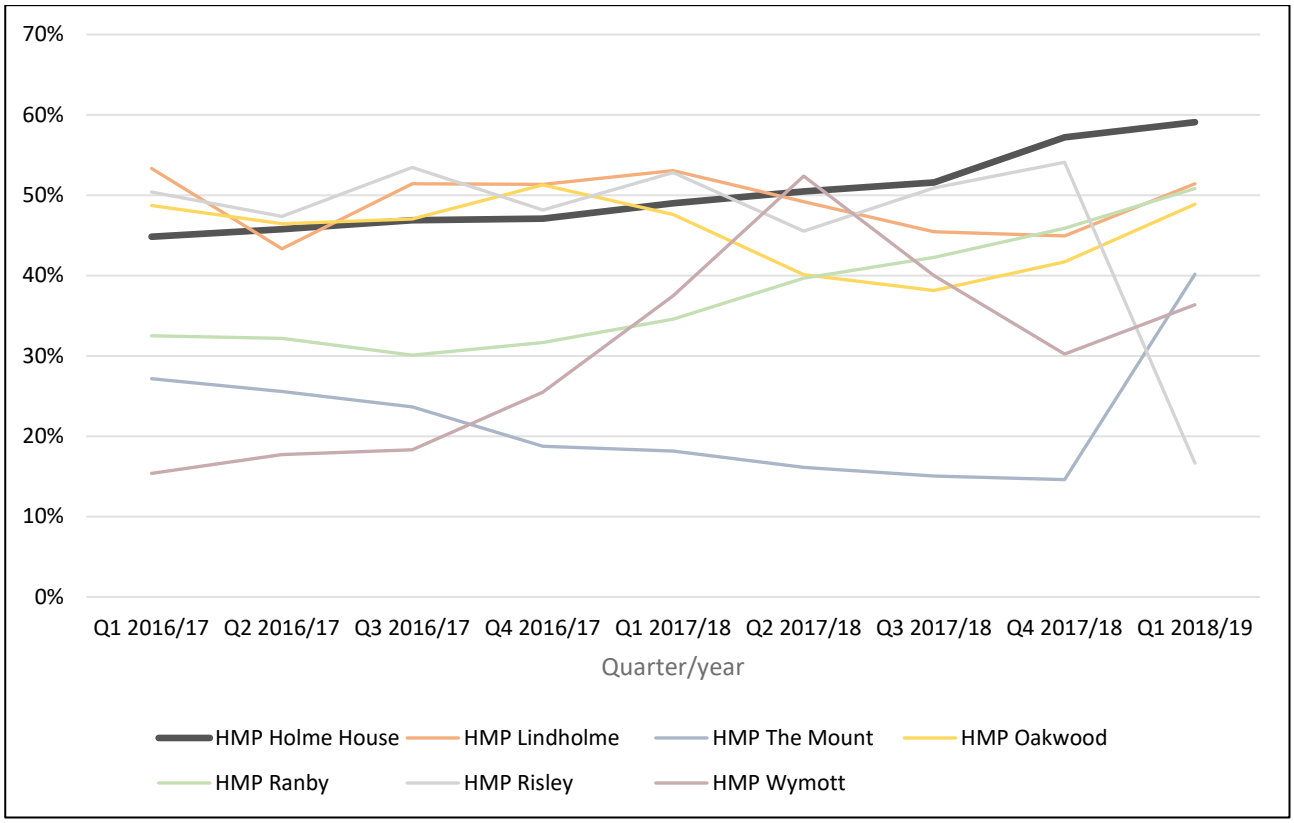
## 8.4 Substance Use Treatment Engagement and Sentence/Resettlement Plans

Although not within the remit of the DRP *per se* Sentence and Resettlement Plans are important for the provision of continuity of care. Sentence planning is the responsibility of the Offender Management Unit and is completed by the prisoner's Offender Manager, while resettlement plans are completed by the Community Offender Manager to whom prisoners are allocated to at 6 months prior to release. These plans seek to identify and address individual needs (e.g. education, health, accommodation, training, employment, finance and families). In the questionnaire it was reported that fewer than half the prisoners had a sentence plan (wave one 41%; wave two 46%), and even fewer a resettlement plan (wave one 8%; wave two 9%). The low figures relating to resettlement plans are likely to reflect that a proportion of the prisoners answering the questionnaire were more than 6 months from being released. In both instances, however, a third to half of prisoners did not understand their plans. Since the plans aim to reduce the risk of reoffending and support resettlement, it is important that the prisoners have a good

understanding to ensure engagement following release, to aid recovery, and to support desistence from crime.

The notion that Connecting Communities initiative is working really well is supported by the Public Health England data on successful engagement with community treatment following release from HMP Holme House. The data shows a gradual increase from 2016/17 to 2018/19 from 45% to 59% successfully engaging in community treatment within three weeks of release. In contrast, the figure for all prisons in England combined was 30% to 34% across the whole period.[61] Over this time, HMP Holme House moved from the middle of the comparator prisons to the top (see Figure 8.1).

**Figure 8.1: Proportion transferred to community treatment who successfully engaged within three weeks of release**




Source: Public Health England, National Drug Treatment Monitoring System

[61] Data were only available up to Q1 2018/19.

# 9. Findings: Substance Use: Medications and Illicit Drugs

## 9.1 Introduction

In line with the National Prison Drug Strategy (HMPPS, 2019), reducing the supply and use of drugs is one of the main aims of the DRP. This section will discuss prisoner drug use, followed by the impact the DRP is perceived to be having on drug use.[62]

## 9.2 Key Findings

- Although the findings were mixed, the prisoner questionnaire and the qualitative data from the prisoners and the staff, indicate a perceived reduction in drug use and availability in HMP Holme House.
- The perceived reduction in substances was further felt to have provided both staff and prisoners with a calmer, safer environment that was more conducive to rehabilitation and recovery. Both prisoners and staff, however, reported that reduced drug availability had led to an increase in the brewing of alcohol and the trade of prescription medications.
- The reasons given in the interviews for taking substances in prison were: to make the days bearable, to alleviate boredom, to pass the time, and to facilitate escapism and avoid reality.

## 9.3 Substances: Use and Supply

The prisoner questionnaire and qualitative data together indicate a possible reduction in drug use in HMP Holme House from wave one to wave two. At wave one, a quarter of prisoners (26%) reported using legal or illegal substances in the last 90 days, compared to one-fifth (19%) at wave two. Prescribed methadone was reported to be the most used

[62] The percentages reported in the findings relate to 194 questionnaires returned at wave one and 168 from wave two.

substance at both waves and a reduction was observed between the waves (14% at wave one and 7% at wave two) although this change was not statistically significant. For illicit substance use, spice was reported to be the most used at wave one (8%) which reduced to 3% by wave two, although this change was not statistically significant. By wave two, the most commonly used illicit substance was alcohol (5%). At wave two, the majority (65%) of prisoners also said that they wanted to stop using drugs, although a quarter (25%) wanted to keep their drug use the same, illustrating the need for the maintenance of medication.

Of those who completed the questionnaire, around a third of prisoners at both waves perceived that drug use had reduced as a result of the DRP (wave one 31% and wave two 33%). In relation to the quantity of drugs in prison, at both waves, over a third of prisoners reported fewer drugs in the prison (wave one 36% and wave two 39%). The questionnaire also asked the prisoners if they had seen anyone on their house block taking drugs in the previous week. A statistically significant higher proportion of prisoners reported that they had not seen anyone using drugs at wave two compared to wave one. However, for prisoners who completed the questionnaire at both time points, there were no statistically significant differences in perceptions of drug use in the prison since the DRP was implemented, the quantity of drugs in the prison, or the proportion of prisoners seeing someone on their house block taking drugs in the last week.

During wave one interviews prisoners gave mixed responses when they were asked whether they felt that the implementation of the DRP had led to a reduction in drugs in the prison. Some prisoners felt there had been no reduction in the volume of drugs in the prison while others reported an increase in the covert use of drugs, due to an increased fear of being caught in possession:

> ‘Not that I would say. A lot of them are keeping it. If they got it, they’re keeping it for when they are banged up and are not on association and can’t be caught.’ Prisoner (wave one, interview)

By the time of the wave two interviews, however, the prisoners were largely in agreement that the DRP had been successful in reducing the quantity of drugs in the prison. This view was also echoed by staff at HMP Holme House:

> 'In terms of Spice it's dramatically dropped … it's nothing like it was 2 years ago, alarms going off, people being scared to walk on walkways, prisoners fighting all the time, staff going off poorly. It was horrific, something needed to change and I definitely noticed a massive difference.' Staff (wave two, interview)

The random Mandatory Drug Test (MDT) management data[63] for traditional drugs also supported the findings of a reduction in drug use from the quantitative and qualitative primary research data: there was generally a slight reduction in the proportion of positive tests over time. This is in contrast to some comparator prisons where the rate increased across the same period. The data relating to positive random MDTs is reported for traditional drugs only, however, and excludes tests for psychoactive substances (PS), namely synthetic cannabinoids, which was a significant issue for HMP Holme House at the time. This is due to two new compounds of synthetic cannabinoids being in circulation during this time that were not able to be detected by the random MDT testing procedure (see HMPPS Annual Digest 2019/20 for more information). Given the issues around random MDT, no firm conclusions can be drawn from this data about PS use. However, both the prisoners and staff said the reduction in substances entering prison had led to an increase in the brewing of alcohol and the trade in prescription medications, illustrating what Blakey (2008) refers to as the 'balloon effect'.[64] This displacement was supported by the management data, which showed an increase in alcohol seizures[65,66] as well as the qualitative data:

> 'I know for a fact there's a lot of hooch goes on. So it's not just medication, it's self-brew if you like...' Prisoner (wave two, focus group)

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63 See Chapter 7 of HMPPS Annual Digest for an extended time series of published statistics on random mandatory drug testing.

64 The balloon effect means substance use is merely displaced onto other, sometimes, more harmful substances rather than stopping it altogether, illustrating the need to reduce demand for substances alongside supply to avoid this from happening.

65 In the 3 months to Apr-17 there were zero instances of alcohol seizures in HMP Holme House. The number increased to 33 in the 3 months to Mar-20. See Chapter 9 of HMPPS Annual Digest for an extended time series of published statistics on finds in prison.

66 Increases of incidents of finds in prisons may be as a result of more items being found, rather than attributable to an increase of the volume present in prisons.

> ‘There's been a marked increase in the development of Hooch, since the drug restrictions have been put on. As I said 16 litres the other week, in 2 cells, 10 in one 6 in the other.’ Staff (wave two, interview)

There was a consensus amongst prisoners and staff, however, that illicit substances were still available within the prison, albeit in lower numbers compared to previously; and some of the staff spoke of how it was possible to tell when a batch of illicit substances had entered the prison due to the impact it had on the social environment. At wave one, prisoners mentioned how the price of drugs had increased as a result of reduced supply and how this impacted on debt;

> ‘If anything, they’ve made it worth more…what you could get for a tenner costs you 50 quid now.’ Prisoner (wave one, case study)

However, by wave two, debt was not explicitly mentioned by prisoners as being an issue. Instead, the reduction in substances had provided both staff and prisoners with a calmer, safer environment which was more conducive to rehabilitation and recovery:

> ‘I put in to come back here [HMP Holme House]… drug abuse isn’t bad here and I'm a druggie and I cannot help myself around drugs… I've got more chance of getting like parole … if I've got a negative MDT’s and I'm not like off my nut and all that. If I was around all the drugs and that … I suffer from mental health and I get low and I just take owt that’s going because I can't help it, you know what I mean? Just being here is an opportunity for rehabilitation because as I say it's scarce, the drugs and that. That’s what I like about it.’ Prisoner (wave two, interview)

> ‘We are improving the environment to help increase people’s wellbeing which in turn improves their mood and provides a calmer atmosphere. A calmer atmosphere makes people less prone to violence and needing additional substances to get them through the day.’ Staff (wave one, interview)

This notion of utilising substances to make the days more bearable was echoed by the prisoners when they were asked why people used substances in prison. In accordance with other research in this area (Wheatley, 2007), the reasons given at both waves for

using substances in HMP Holme House were not only to make the days bearable, but to alleviate boredom, pass the time, and facilitate escapism:

> ‘I think, boredom is one. I think two, is that running away from a part of your life what they’ve left behind … A lot of it, I think is, I’ll take it just to escape from what's happening, away from their loved ones or not seeing their kids. A lot of it is escape from it.’ Prisoner (wave two, interview)

> ‘It just puts you out the game, doesn’t it?... I’d be out of the jail for a couple of hours at night time and it just gets us out of prison. I've actually come round in my cell … and then the penny drops and you're like “wow I'm in jail doing a 6 year sentence and get me back out of it”. And that’s what you were looking for.’ Prisoner (wave two, interview)

These findings illustrate the importance of cultural change and meaningful activities in prison that assuage boredom and promote rehabilitation and recovery.

Despite drugs still being available in HMP Holme House, just under half of questionnaire respondents (46%) thought prison could help their recovery. At wave one some of the prisoners spoke about their desire to reduce their methadone prescription but felt that the support to help them do this was lacking:

> ‘Yeah, [I can] tell pharmacy that I want to come off it and they’re quite happy to let you come off it but I haven’t seen my DART worker. Not at all. I saw one about four months ago, she come into work and said, I’m your new DART worker, I said I don’t even know who the old one is.’ Prisoner (wave one, interview)

The questionnaire found that a number of prisoners reported using illicit drugs, illicit prescribed medication, spice, or alcohol in any prison and/or HMP Holme House. Only a small number (9%) reported their drug use in HMP Holme House was problematic. When asked in the interviews, at both wave one and two, prisoners reported the main illicit substances that managed to get into HMP Holme House were now buprenorphine (Subutex), cannabis, and synthetic cannabinoids (spice). Very small numbers of prisoners (wave one 3% and wave two 5%) reported injecting drugs in 90 days prior to the questionnaire (which could have been in the community if they were new to HMP Holme

House[67]). Even fewer reported injecting using a needle/syringe used by someone else or been injected by someone else in the last 90 days (2% at both waves), or injecting using a spoon, water or filter used by someone else (wave one 3% and none at wave two). Although, these numbers are very low, it shows a small number of prisoners are participating in high-risk drug using behaviours in either the community or in prison. These risks are exacerbated in prison where they do not have access to clean works or sterilising equipment. Most of the prisoners at wave one (70%) reported knowing what to do if they saw someone using drugs and were concerned for their health/wellbeing and that they would tell someone to prevent an overdose or death (73%). There were slightly lower figures at wave two (65% and 63% respectively), although these differences were not statistically significant.

[67] Although there have been finds in HMP Holme House relating to steroid use.

# 10. Summary and Lessons Learnt

## 10.1 Summary

Overall, the key findings from the research show that for the most part the DRP had a positive effect on prisoners and staff and met many of the expected outcomes. However, barriers to the implementation of the DRP have also been highlighted, indicating the need for further work across some areas of the DRP. This section summarises the research, the lessons learnt and the future barriers to implementation.

The strategic components of the DRP fall into four main areas: safety and security; environment, cultural change and rehabilitation; care and wellbeing; and continuity of care. The DRP promoted a holistic whole prison approach to drug recovery specifically, and recovery (physical and mental health recovery) more broadly, that was delivered via a community house block model, alongside a trauma informed whole prison approach.

While the aim of this evaluation was not to assess impact, participants in the research gave their opinions on the perceived impact of the DRP. Overall, both staff and prisoners thought the DRP had a positive effect on prisoners, staff, the culture, feelings of safety, relationships, healthcare provision, recovery, rehabilitation, violence, and the supply and use of substances. Furthermore, the triangulated data from both staff and prisoners seem to suggest that the DRP has had some success in reducing the supply into, and demand for drugs at HMP Holme House. Despite this, there is also some evidence that reduced drug availability in the prison encouraged alternative supply routes including alcohol brewing and the trade of prescription drugs, which contributed to a displacement of use on to other substances (e.g. prescribed medications and alcohol) illustrating the need for demand reduction initiatives to work hand-in-hand with supply reduction measures.

The key findings from this research, therefore, suggest that the DRP is perceived to be making improvements at HMP Holme House, particularly in the areas of reduced substance use, increased security, cultural change, and improved continuity of care. While the majority of the DRP was successfully implemented, some components of the DRP were delayed (e.g. washing machines and environmental changes), others were removed

(e.g. Millimetre Wave Scanner), and some were never implemented (e.g. changes to the MDTs) due to procedural, procurement, financial or practical issues.

## 10.2 Perceived Lessons Learnt: Key Components of a Successful DRP

This process evaluation has identified the following components and features of a successful DRP that are recommended in any future roll out, that includes the lessons learnt:

- **A whole prison approach**: is essential for creating a rehabilitative culture which looks at the entire prisoner journey from induction through to release. This helps to ensure continuity of care and is beneficial to multi-agency ways of working and the creation of recovery-orientated systems of care which facilitate the building of recovery capital and are integral to engendering recovery and rehabilitation.

- **The prison:** needs to operate with limited staff shortages and should meet the basic needs of prisoners. Not meeting the basic needs of prisoners has the potential to undermine any rehabilitative/recovery initiatives as well as exacerbate levels of violence, disorder and rule-breaking in prison. A progressive Governor and team of supportive staff is also essential to successfully implementing the DRP and to avoid any gaps in therapeutic integrity, which can undermine treatment, rehabilitation, and any new initiatives or policies being implemented.

- **A twin-track drug policy**: that aims to reduce supply of, and demand for, substances in the prison that incorporates harm reduction and promotes recovery. Although the supply reduction initiatives acted as a deterrent and made the prison feel safer and calmer for some, getting the right balance between, and timing of, supply and demand reduction measures is important to protect against detrimental and counterproductive effects (e.g. to displace rather than stop substance use). The twin track approach to tackling drugs (e.g. health and justice approach to supply and demand reduction) has traditionally conflicted and if the DRP is to be successful, the incongruence that exists between the dichotomies of punishment and treatment need to be addressed.

- **Security:** is an important part of any prison, although it should be commensurate with the category of the prison as well as the identified threat to the prison. The prioritisation and front-loading of security reduced substance availability in the prison but also contributed to displacement and the development of new supply routes, illustrating the importance of reducing demand alongside supply. The perceived ineffectiveness of the scanners and the new supply routes showed the importance of the DCRU, dynamic security, intelligence gathering and information sharing. However, security can also have a negative impact on culture, rehabilitation, substance use, mental health, recovery, family relationships and contact with the outside world, which is why it is so important to get the balance right.

- **House block asset-based community model**: that delivers multi-disciplinary healthcare and drug treatment on each house block and aims to reduce health inequalities and build communities. This model not only aims to create a rehabilitative culture across the prison, but also promote life skills and community living among the prisoners. However, it is essential that the population remains static for the community model to be effectively established. The efficacy of the house block model also seemed to vary across house blocks, which has the potential to undermine a consistent approach to healthcare.

- **Engaging the staff and prisoners in Recovery and Future Initiatives (e.g. the DRP):** ethos and initiatives are essential to engender change, empower the prisoners and the staff, and improve buy in, which was achieved via the establishment of a Prison Council and the development of peer-led initiatives and peer mentors. Peer interventions have been shown to empower the prisoners and staff, encouraging them to work in partnership and thus overcoming some of the traditional barriers that negatively affect staff-prisoner relationships and prison culture. Staff at all grades need to be on board to ensure the successful implementation of initiatives like the DRP, which can be achieved with more education/training but also a change in culture. Celebrating success should bring about a change in culture, which will then potentially impact on relationships, substance use, violence, self-harm and safety.

- **The creation of a rehabilitative culture and improved relationships across the prison**: are essential as both can undermine the efficacy of rehabilitation and treatment, while prisons with a rehabilitative culture are believed to be safer and provide more job satisfaction for staff, inspire hope, develop fair processes, encourage change, build social capital, improve the physical environment, nurture relationships and provide supportive rehabilitative leadership. Relationships are important as they determine the experiences of everyone in the prison, affect the culture and play an important role in reducing the 'dearth of therapeutic integrity'. Both can be achieved by offering more training events for staff and prisoners as well as addressing some of the other issues identified as undermining a rehabilitative culture (e.g. environment).

- **Effective communication and the sharing of information**: across the prison (morning briefings, safety intervention meetings) and between the prisoners, staff and agencies is not only essential to ensure effective understanding, support and implementation of the DRP, but it is also essential to ensure a whole prison approach is adopted. This is also important in relation to supply reduction and security initiatives where the sharing of intelligence/information is crucial.

- **A dedicated DRP team that incorporates multi-agency working, specialist services and adequate resources:** are essential to driving change and implementing the DRP, although, this can also be a barrier to engaging other staff and engendering a whole prison approach, since staff may not feel part of the DRP. Therefore, effective multi-agency working would ensure more efficient provision across all partners, and continuity of care both in prison, and upon release.

- **Improved awareness of, access to, and understanding of healthcare, treatment and support, particularly through the gate services**: dedicated through the gate services (Connecting Communities team) are critical since research shows being released with unsuitable accommodation and support undermines any drug recovery/rehabilitation work undertaken in prison. There is also a need for better multi-agency co-operation when people are transitioning

from prison to the community, particularly for substance users, who have a higher mortality rate on release than non-substance users.

- **Even more meaningful activities, training, work, programmes and education**: that the prisoners find enjoyable and that are not held during association may help to reduce boredom and help pass the time to reduce substance use. It will also help the prisoners build recovery capital that will aid them on release.

- **HMPPS procedures and procurement:** of equipment and services is not supportive of short pilot pathfinder initiatives as they can delay implementation. Procedural barriers (e.g. relaxing the MDT and adjudications punishment, delays in procuring equipment and getting work done) led to delays in aspects of the DRP being implemented, while others were not implemented at all. It is also important to ensure equipment and resources are available to implement the DRP, otherwise they undermine the staff's ability to do their jobs, particularly in relation to healthcare provision (e.g. computers).

- **The role and reliability of MDTs needs to be reviewed:** this includes the punitive sanctions for a positive MDT if a more therapeutic/rehabilitative culture is to be created.

- **Funding and time**: this is important since there was some indication that some of the initiatives that were discontinued and the uncertainty surrounding the sustainability and longevity of the DRP had a negative effect on staff morale and support for the DRP. While it was acknowledged that other changes were going to take time to become established and bring about change (e.g. culture, staff-prisoner relationships).

Moving forward it is important to note, as highlighted by the staff, that:

> 'We need to be thinking…is the distribution of resources most effective? For example, the searching of staff versus more targeting searching of those suspected of corruption, alongside more corruption prevention resource in the prison. We also need to consider the reduced budget should the prison service

> funding not continue hence a reduced security/supply reduction function. Therefore there is a need to determine what elements should be mainstreamed and which elements are clearly DRP funded – some equipment will go if budget is reduced.' Staff (wave two, interview)
>
> 'Ensure that the foundations are fully embedded. We need to make it clear that the pilot has come to an end but it is not because the initiative has gone away, but because it is just no longer a pilot anymore and is just how things are in Holme House' Staff (wave two, interview)

Any further roll-out of the DRP would benefit from a well-planned and phased implementation to enable the different interventions to be evaluated individually (for example, by implementing a phased roll-out and picking a prison where other interventions outside of the DRP are not implemented). Ultimately, this would create a more robust evidence base underpinning each initiative.

## 10.3 Barriers to Implementation

The potential barriers to implementing the DRP relate to staff (e.g. attitudes and staff shortages), prisoners (e.g. basic needs not being met, substance use, non-engagement, attitudes and behaviour), prison procedures and cultural change, which senior management agreed would take longer than the duration of the research or the life of the DRP. IT equipment and resources for staff also undermined the ability of staff to do their jobs, and the national shortage of healthcare workers affected aspects of the DRP. Also, over half of the prisoners said their basic needs (e.g. food, hygiene, safety, warmth and shelter) were not being met by the prison and while basic needs do not fall under the remit of the DRP *per se*, failure to meet these may act as a potential barrier to the implementation of the DRP and may also undermine its efficacy. The uncertainty surrounding the longevity and sustainability of the DRP may also have been a potential barrier to engaging the prisoners and staff in its implementation and in delivering its initiatives (e.g. those focusing on demand reduction). Thus, from the research it is possible to identify fourteen barriers to the future implementation and roll-out of the DRP (those with an * are integral for a whole-prison approach):

**Table 9.1: Barriers to the future implementation of the DRP**

| | |
|---|---|
| **1)** Demand for drugs among prisoners | **2)** Poor multi-agency cooperation/working * |
| **3)** Resistance from staff (all grades) * | **4)** Time restrictions (particularly for pilots) |
| **5)** The culture (prison, prisoners and staff) * | **6)** Ineffective communication/information * |
| **7)** Not meeting the basic needs of prisoners | **8)** Timing/Scheduling of activities/initiatives |
| **9)** Stigmatisation * | **10)** Negative relationships * |
| **11)** Staff and equipment shortages * | **12)** Time restrictions |
| **13)** Competing priorities * | **14)** Lack of funding |

## 10.4 Conclusion

There is no denying the DRP is bringing about positive change and seems to be meeting many of its objectives, however the traditional incongruences that have historically existed between punishment and treatment are evident in the implementation of the DRP and its processes. Further, due to delays and the time it takes for changes and initiatives to be implemented in prison, a longer time frame for analysis may also allow some of the initiatives a better chance of effecting change, which will provide a more robust examination of whether the DRP is effective and achieving its expected outcomes.

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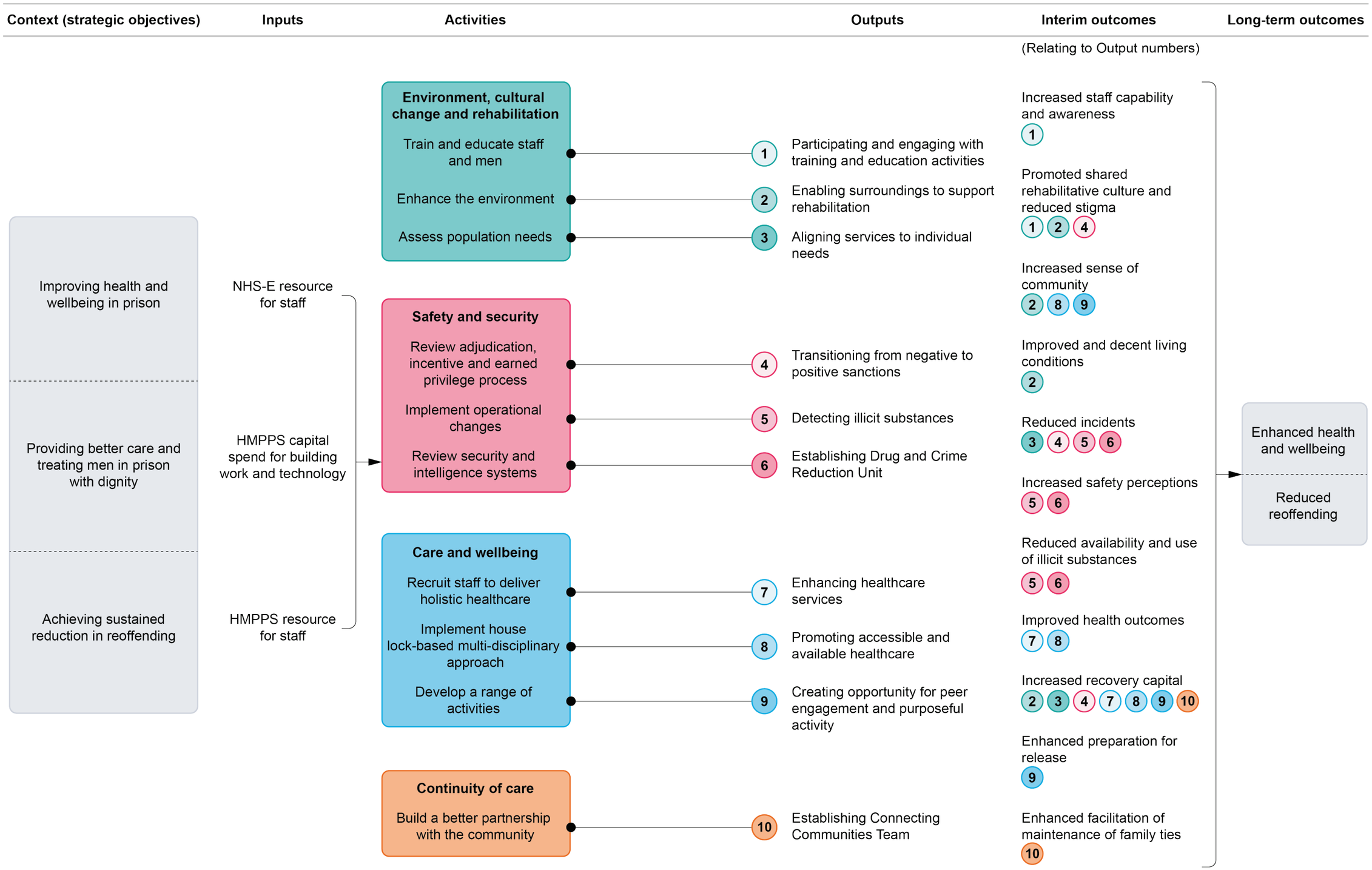
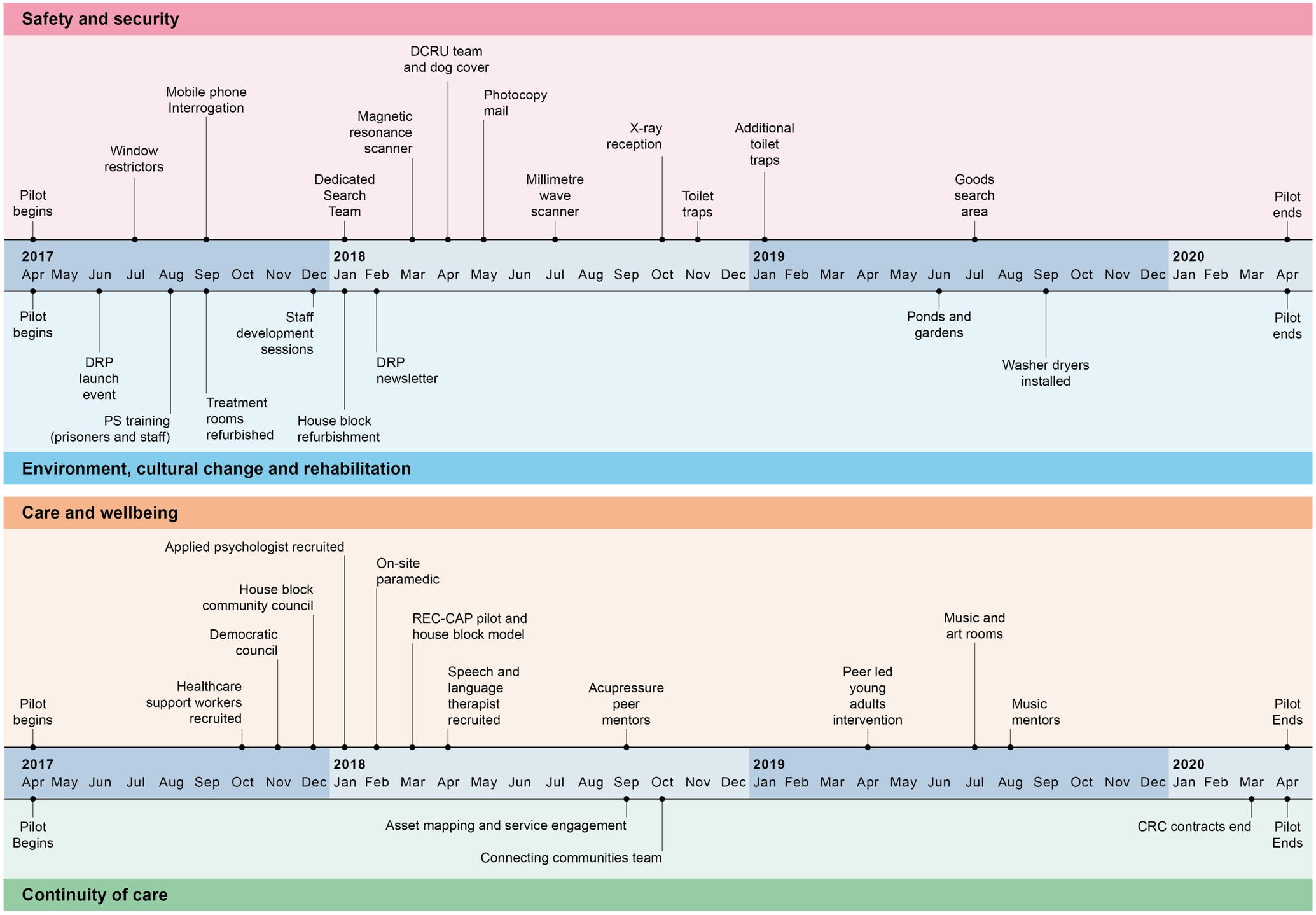
# Appendix A
# Logic Model



# Appendix B
# DRP Implementation Timelines



# Appendix C
# Additional Analysis

This section presents additional quantitative analysis conducted and is supplementary to the findings in the main report. For some metrics comparisons have been drawn between HMP Holme House and its comparator prisons (from HMPPS Prison Performance Rating groups) (MoJ, 2020b).

## Environment, Cultural Change and Rehabilitation

Table C.1 shows the EssenCES scale scores by house block at wave one. Statistical analysis showed that for Inmate Cohesion house block 6 had statistically significantly higher scores than house block 2. Furthermore, house block 5 had statistically significantly higher scores than house blocks 2, 3 and 7 for Hold and Support.

**Table C.1: EssenCES scores by house block at wave one**

| House block | Inmate cohesion Mean (SD) | Experienced safety Mean (SD) | Hold and support Mean (SD) |
|---|---|---|---|
| 1 | 8.79 (4.38) | 11.70 (4.59) | 7.36 (3.91) |
| 2 | 6.15 (4.43) | 10.74 (4.81) | 5.78 (3.39) |
| 3 | 9.73 (5.77) | 11.74 (4.70) | 7.14 (4.21) |
| 4 | 6.96 (5.18) | 12.80 (3.82) | 7.13 (4.51) |
| 5 | 10.14 (5.28) | 12.69 (3.86) | 11.64 (5.00) |
| 6 | 10.66 (5.37) | 14.52 (4.19) | 9.15 (5.10) |
| 7 | 7.44 (3.55) | 11.97 (4.16) | 6.49 (5.05) |
| Overall | 8.53 (5.00) | 12.35 (4.41) | 7.57 (4.74) |

Source: Prisoner questionnaire

At wave two, statistical analysis showed that there was a statistically significant difference between the house blocks for the Experienced Safety scale only. House block 7 had a statistically significantly lower score for Experienced Safety than house blocks 4 and 6. The means/SDs for the scales for each house block are presented in Table C.2.

**Table C.2: EssenCES scores by house block at wave two**

| House block | Inmate cohesion Mean (SD) | Experienced safety Mean (SD) | Hold and support Mean (SD) |
|---|---|---|---|
| 1 | 7.79 (4.89) | 15.23 (5.22) | 5.57 (2.50) |
| 2 | 7.35 (3.95) | 12.69 (3.40) | 7.76 (3.83) |
| 3 | 8.14 (4.09) | 14.38 (3.12) | 5.57 (4.16) |
| 4 | 8.00 (5.50) | 14.87 (3.36) | 7.08 (5.17) |
| 5 | 3.00 (4.76) | 10.00 (5.35) | 4.75 (4.86) |
| 6 | 8.37 (4.74) | 15.94 (3.47) | 7.32 (3.20) |
| 7 | 8.06 (4.50) | 11.75 (3.98) | 7.40 (4.94) |
| Overall | 7.86 (4.64) | 13.30 (4.17) | 6.98 (4.43) |

Source: Prisoner questionnaire

Comparisons between wave one and wave two were conducted for the whole sample. As can be observed in the tables above, the level of Experienced Safety was statistically significantly higher at wave two (mean = 13.30) compared to wave one (mean = 12.35) when the whole wave one/wave two samples were used. No statistically significant differences were reported for the other two scales. However, for the comparison of prisoners who completed the questionnaire at both waves, there were no statistically significant differences, which are the prisoners that were in HMP Holme House for the duration of the research.

## Prisoner-staff relationships

### Do prison officers treat prisoners with more respect?

At wave one, across the whole sample, a quarter (27%) agreed that prison officers treated prisoners with more respect, with a third disagreeing (34%) and 39% neither agreeing nor disagreeing. At wave two, across the whole sample, a slightly increased percentage (32%) agreed that prison officers treated prisoners with more respect in the last 4 months, with 36% disagreeing, 28% neither agreeing nor disagreeing, and 4% who were not sure.

### Do prisoners treat prison staff with more respect?

At wave one, a third (33%) of the sample agreed that prisoners treat prison officers with more respect in the last four months, with a 16% disagreeing and 52% neither agreeing nor disagreeing. At wave two, the percentage of the prisoners agreeing that prisoners treat

prison officers with more respect in the last 4 months increased slightly to 39%, with 22% disagreeing, 36% neither agreeing nor disagreeing, and 4% not sure.

**Do prisoners treat prisoners with more respect?**

At wave one, just over a third (38%) of the sample agreed that prisoners treat other prisoners with more respect in the last four months, with 15% disagreeing and 47% neither agreeing nor disagreeing. At wave two a similar percentage of prisoners (38%) agreed that prisoners treat other prisoners with more respect in the last four months, with 19% disagreeing, 38% neither agreeing nor disagreeing, and 6% not being sure.

**Do prison officers understand about drug use, addiction and recovery better?**

At wave one, a quarter of prisoners (24%) agreed that prison officers have a better understanding about drug use, addiction and recovery in the last four months, with 42% disagreeing and a third neither agreeing nor disagreeing. At wave two, only a fifth (19%) agreed that prison officers have a better understanding about drug use, addiction and recovery in the last four months, with 35% disagreeing, 24% neither agreeing nor disagreeing, and 22% not being sure.

## Care and Wellbeing

Table C.3 shows prisoners' awareness of healthcare services that were based on the house block at wave one and wave two.

**Table C.3: Awareness of healthcare services based on the house block at wave one and wave two**

| Wave | Strongly agree/Agree | Neither agree or disagree | Disagree/strongly disagree | Total |
|---|---|---|---|---|
| Wave one | 79 (43.4%) | 69 (37.9%) | 34 (18.7%) | 182 |
| Wave two | 57 (35.8%) | 70 (44.0%) | 32 (20.1%) | 159 |

Source: Prisoner questionnaire

**Proportion of new treatment entrants starting treatment within three weeks of arrival (from community or another custodial setting)**[68]

HMP Holme House was consistently above the comparator prisons for the proportion of prisoners starting substance misuse treatment within three weeks of arrival into the prison (88% to 91% from 2017/18 Q1 to 2018/19 Q4). Other than HMP Holme House, all prisons saw a drop in proportion until 2016/17 Q3 to Q4 before increasing again. HMP Risley had the next highest level of proportions (64% to 76%), with a group of prions that consistently had proportions around 50% (HMP Lindholme, HMP Mount, HMP Oakwood and HMP Wymott) although HMP Oakwood's initial proportion was higher (67%/68%) but decreased considerably over time, and another group whose proportions were high 60s% to mid 70s% (HMP Ranby and HMP Risley). Proportions were also higher than all prisons in England combined. As these rates were consistently high, it cannot be confidently concluded that the DRP influenced this variable, although it is notable that HMP Holme House did not experience the dip showed by other prisons.

**Proportion transferred to community treatment who successfully engaged in treatment within three weeks of release**[69]

For HMP Holme House, there was a gradual month-by-month increase over time from 45% to 59% successful engagement in community treatment. In contrast, the figure for all prisons in England combined was 30% to 34% across the whole time period. Over this time, it moved from the middle of the comparator prisons to the top with this highest proportion.

## Recovery capital

There were no statistically significant differences between wave one and wave two on the REC-CAP quality of life and satisfaction scales (see Table C.4).

**Table C.4: Quality of life and satisfaction scales**

| Scale[70] | Wave One Mean (SD) | Wave Two Mean (SD) | Significance |
|---|---|---|---|
| REC-CAP psychological health | 12.17 (5.58) | 12.77 (5.46) | ns |
| REC-CAP physical health | 12.95 (5.02) | 12.98 (5.10) | ns |

[68] Public Health England data available from 2017/18 Q1 to 2018/19 Q4 at the time of analysis.

[69] Public Health England data available from 2017/18 Q1 to 2019/20 Q1 at the time of analysis.

[70] For all scales the possible range of scores is 0 – 20, with higher scores indicating higher levels of satisfaction.

| Scale[70] | Wave One Mean (SD) | Wave Two Mean (SD) | Significance |
|---|---|---|---|
| REC-CAP overall quality of life | 11.37 (5.19) | 11.57 (5.26) | ns |
| REC-CAP quality of accommodation | 9.70 (5.29) | 9.53 (5.35) | ns |
| REC-CAP support network | 10.55 (6.32) | 11.60 (6.19) | ns |

Source: REC-CAP data

There was a statistically significant difference between wave one and wave two on only one of the recovery capital scales: Meaningful activities, with a higher score at wave two (see Table C.5), which reflects the increase in meaningful activities implemented as part of the DRP.

**Table C.5: Recovery Capital scales**

| Scale[71] | Wave One Mean (SD) | Wave Two Mean (SD) | Significance |
|---|---|---|---|
| **Personal recovery capital** | | | |
| Recovery experience | 2.81 (1.84) | 2.73 (1.85) | ns |
| Global health (psychological) | 3.21 (1.67) | 3.33 (1.71) | ns |
| Global health (physical) | 3.23 (1.76) | 3.45 (1.73) | ns |
| Risk taking | 3.24 (1.56) | 3.28 (1.57) | ns |
| Coping & life functioning | 3.31 (1.65) | 3.52 (1.59) | ns |
| TOTAL Personal recovery capital | 15.82 (7.03) | 16.39 (6.89) | ns |
| **Social recovery capital** | | | |
| Meaningful activities | 2.28 (1.72) | 2.94 (1.69) | $p$ = .001 |
| Housing & safety | 2.79 (1.89) | 2.98 (1.78) | ns |
| Citizenship/community involvement | 2.78 (1.87) | 3.06 (1.75) | ns |
| Social support | 2.93 (1.93) | 3.14 (1.83) | ns |
| Substance use & sobriety | 3.49 (1.68) | 3.59 (1.69) | ns |
| TOTAL Social recovery capital | 14.29 (7.30) | 15.71 (6.80) | ns |
| **TOTAL RECOVERY CAPITAL** | 30.08 (13.61) | 31.99 (12.99) | ns |

Source: REC-CAP

[71] For Total Personal recovery and Total Social recovery scales, the possible range of scores is 0 – 25; for the Total Recovery Capital score, the possible range of scores is 0 – 50; for the 10 recovery capital scales, the possible range of scores is 0 – 5. Higher scores indicate a higher level of recovery capital.

For those prisoners who completed the questionnaire at both waves, there was a statistically significant difference between wave one and wave two on three of the recovery capital scales: Global psychological health, Global physical health and Meaningful activities with higher scores at wave two (see Table C.6). This may reflect the prisoner's engagement with the initiatives implemented as part of the DRP and the improvements to healthcare, which have enabled the prisoners to build recovery capital in these areas over time.

**Table C.6: Recovery Capital scales for prisoners who completed the questionnaire at wave one and wave two**

| Scale[72] | Wave One | Wave Two | Significance |
|---|---|---|---|
| **Personal recovery capital** | | | |
| Recovery experience (*n* = 47) | 2.70 (1.99) | 2.74 (1.89) | ns |
| Global health (psychological) (*n* = 46) | 3.26 (1.81) | 3.72 (1.66) | *p* = .047 |
| Global health (physical) (*n* = 46) | 3.07 (1.78) | 3.59 (1.71) | *p* = .022 |
| Risk taking (*n* = 46) | 3.41 (1.60) | 3.35 (1.64) | ns |
| Coping & life functioning (*n* = 46) | 3.41 (1.59) | 3.74 (1.48) | ns |
| TOTAL Personal recovery capital (*n* = 45) | 15.82 (7.00) | 17.04 (6.93) | ns |
| **Social recovery capital** | | | |
| Meaningful activities (*n* = 46) | 2.09 (1.68) | 2.87 (1.67) | *p* = .002 |
| Housing & safety (*n* = 46) | 3.09 (1.86) | 3.00 (1.66) | ns |
| Citizenship/community involvement (*n* = 46) | 2.87 (1.72) | 3.15 (1.76) | ns |
| Social support (*n* = 46) | 3.28 (1.88) | 3.52 (1.79) | ns |
| Substance use & sobriety (*n* = 46) | 3.70 (1.65) | 3.41 (1.82) | ns |
| TOTAL Social recovery capital (*n* = 46) | 14.91 (6.70) | 15.96 (6.60) | ns |
| **TOTAL RECOVERY CAPITAL (*n* = 45)** | 31.07 (12.51) | 32.80 (12.45) | ns |

Source: REC-CAP

[72] For Total Personal recovery and Total Social recovery scales, the possible range of scores is 0 – 25; for the Total Recovery Capital score, the possible range of scores is 0 – 50; for the 10 recovery capital scales, the possible range of scores is 0 – 5. Higher scores indicate a higher level of recovery capital.

### Involvement in Recovery Groups, Support from other people and Commitment to sobriety

The Recovery Group Participation Score measures engagement in mutual support and recovery groups. There were no statistically significant differences between wave one and wave two on the REC-CAP scales of Recovery Group Participation, Support from other people, or Commitment to sobriety (see Table C.7).

**Table C.7: Recovery Group Participation, Support from other people and Commitment to sobriety scales**

| Scales[73] | Wave one | Wave two | Significance |
|---|---|---|---|
| Recovery group participation | 4.05 (4.25) | 5.35 (4.74) | ns |
| Support from other people | 17.25 (6.98) | 18.05 (7.37) | ns |
| Commitment to sobriety | 25.69 (5.60) | 26.31 (6.17) | ns |

Source: REC-CAP

Prisoners were asked about recovery groups they had attended in the last month. Three-quarters (76%) of prisoners had attended a group, with mentions of DART, recovery, SMART and mental health groups. Only a small number of prisoners indicated they needed additional help beyond what they were currently accessing.

## Activities

At wave one, only 11% of the prisoners agreed that more activities had become more available in the last 6 months (39% neither agreed nor disagreed while 50% disagreed). Only 12% of respondents agreed that the house block activities are enjoyable, with half (51%) disagreeing and 37% neither agreeing nor disagreeing. However, few prisoners (18%) reported taking part in the activities that had become available in the last four months. This may reflect the respondents' opinion that the times of activities were not suitable, as only 14% reported that they were at an appropriate time, although half (55%) the prisoners were not sure about the timing.

Very little had changed by wave two, at which only 14% of the prisoners agreed that more activities had become more available since December 2018 (44% disagreed and 42%

[73] For Recovery group participation the possible range of scores is 0 – 14; for Support from other people the possible range of scores is 4 – 28; for Commitment to sobriety the possible range of scores is 5 – 30.

neither agreed nor disagreed). Only 18% of respondents agreed that the house block activities are enjoyable, with half (49%) disagreeing and 33% neither agreeing or disagreeing. Again, few prisoners (15%) reported taking part in the activities, with 60% saying they had not and 25% were not sure. Only 18% reported that they were at an appropriate time, with 30% saying the timing was not appropriate, although half (52%) the prisoners were not sure about the timing. Overall, prisoners reported no statistically significant differences between wave one and wave two in terms of taking part in activities on house blocks, if these were enjoyable and at a suitable time.

### Work, Education and Training

At wave one, responses to the REC-CAP questions about work, training and volunteering showed that 56% of prisoners reported working full-time, 13% working part-time and 9% in education. While similar percentages were reported at wave two (64% of working full-time, 14% working part-time and 5% in education) there was a statistically significantly higher percentage of prisoners volunteering at wave two (15%) compared to wave one (8%). However, these figures are likely to be very different in the community and may be potential barriers to recovery post-release.

Prisoners reported no statistically significant differences between wave one and wave two about the availability of work, education, training and programmes; or whether they had accessed work, education, training or programmes. There were also no statistically significant differences between wave one and wave two for currently working and currently in education.

At wave one, the majority of prisoners (61%) said that there was suitable work available; over half (64%) of the respondents reported they were working full-time in the prison, with another 19% saying that they worked part-time. The vast majority of prisoners (84%) said that they had worked in the prison at some point in their sentence. There was a similar situation at wave two; over half of prisoners (55%) said that there was suitable work available, with three-quarters of prisoners (78%) reporting that they had worked in the prison at some point in their sentence.

The availability of education had a similar pattern with 65% reporting that it was available at wave one. At the time of wave one data collection, 11% of prisoners reported that they

were attending education, and 10% that they were volunteering. Overall, half (52%) of the prisoners reporting having attended education during their sentence. There were no changes by the wave two data collection, with 61% reporting that it was available. Almost half of the prisoners (47%) said they had taken part in education during their sentence.

Responses about availability of suitable training were less positive at both waves: with 34% at wave one and 36% at wave two of respondents saying that suitable training was available. At both waves, under a third of prisoners reported undertaking training during their time at HMP Holme House (wave one 29%; wave two 31%).

At wave two, only 9% of prisoners thought that the DRP had influenced work and training for prisoners, with 32% thinking it had not and 59% were not sure.

At wave one, just over a third of prisoners (38%) said that suitable programmes were available, with 40% saying that there were not and 22% were not sure. Responses at wave two were very similar: 37% of prisoners reported that suitable programmes were available, with 43% saying that there were not and 20% were not sure. Around a third of prisoners had attended a programme at both waves (wave one 34%; wave two 30%).

Half of the prisoners thought that work, education, training and programmes could be improved at both waves, which was also reflected in the qualitative data.

### Substance Use: Medications and Illicit Drugs

At wave one, a quarter of prisoners (26%) reported using legal or illegal substances in the last 90 days, compared to one fifth (19%) at wave two; however, this difference was not statistically significant. They were then asked to indicate whether they had ever had a problem with individual substances. The only statistically significant differences related to the percentage of prisoners reporting that prescribed methadone, street methadone and spice had ever been a problem. For both drugs, the percentage was lower at wave two (see Table C.8).

**Table C.8: Use of substances reported by prisoners**

| | Ever had a problem | |
|---|---|---|
| **Substance** | **Wave one** | **Wave two** |
| Alcohol | **39.3%** | **35.3%** |
| Heroin | **25.2%** | **15.8%** |
| Crack cocaine | **25.0%** | **18.5%** |
| Cocaine powder | **36.9%** | **28.0%** |
| Amphetamines | **19.0%** | **13.8%** |
| Cannabis | **38.0%** | **32.2%** |
| Methadone (prescribed) | **39.1%** | **21.0%** |
| Methadone (street) | **12.9%** | **4.3%** |
| Buprenorphine (prescribed) | **20.3%** | **13.8%** |
| Buprenorphine (street) | **20.2%** | **11.9%** |
| Benzos (prescribed) | **15.7%** | **12.8%** |
| Benzos (street) | **24.4%** | **16.9%** |
| Tobacco | **50.4%** | **42.7%** |
| Spice/other synthetic drug | **23.8%** | **12.9%** |

Note: For all of the questions, there were participants who had not provided a response. These percentages are for the full samples at both waves.

Source: REC-CAP data

A number of prisoners reported using illicit drugs, illicit prescribed medication, spice, or alcohol in any prison and/or HMP Holme House (see Table C.9).

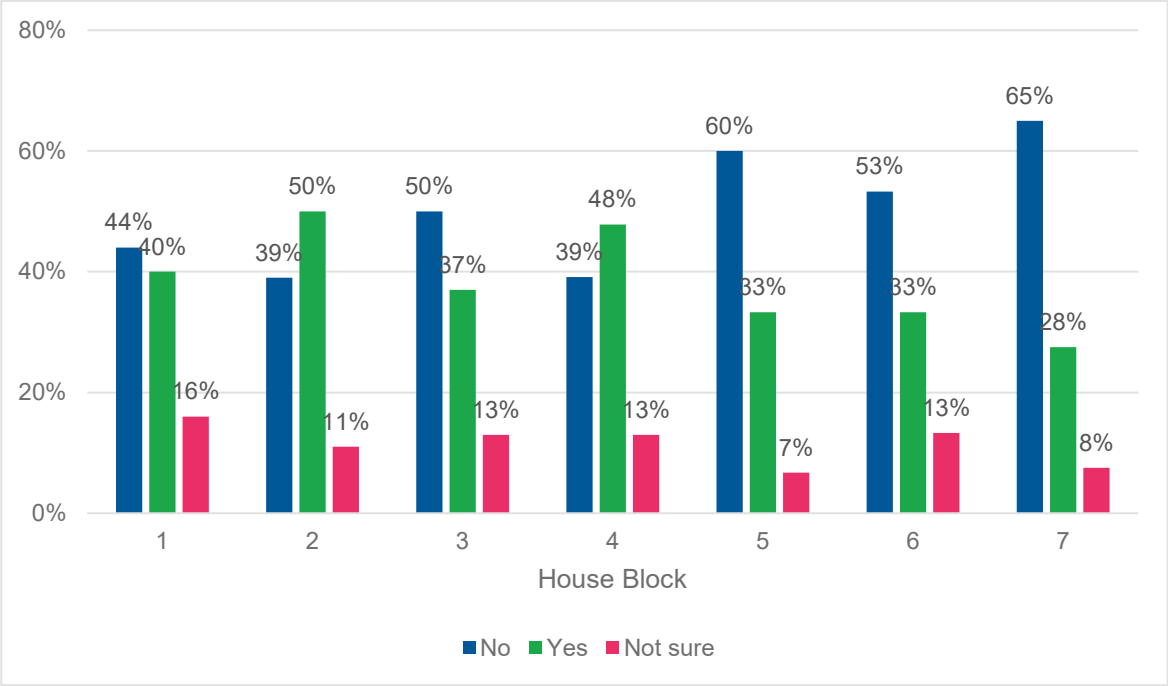
**Table C.9: Drugs used in prison: wave two**

| **Drug type** | **In any prison** | **In HMP Holme House** |
|---|---|---|
| Illicit drugs | 38 (22.6%) | 17 (10.1%) |
| Illicit prescribed medication | 32 (19.0%) | 18 (10.7%) |
| Spice | 41 (24.4%) | 21 (12.5%) |
| Alcohol | 35 (20.8%) | 14 (8.3%) |

Source: Prisoner questionnaire

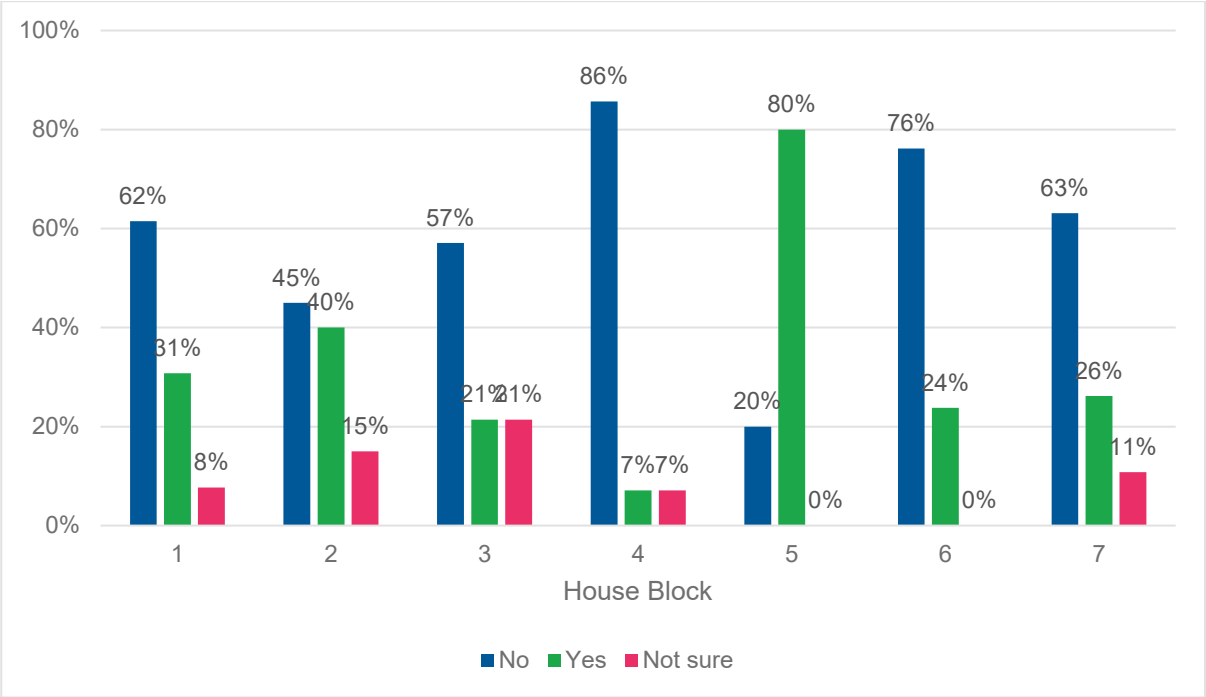
Figures C.1 and C.2 show the percentage of prisoners who reported seeing someone use drugs on their house block at wave one and wave two, broken down for individual house blocks.

**Figure C.1: Percentage of prisoners reporting seeing someone use drugs on their house block in the last week at wave one**




Source: Prisoner questionnaire

**Figure C.2: Percentage of prisoners reporting seeing someone use drugs on their house block in the last week at wave two**




Source: Prisoner questionnaire

## Random Mandatory Drug Testing (rMDT)

### Percentage of positive rMDTs (excluding NPS)

The percentage of positive rMDTs for traditional drugs showed generally a slight decrease over time. For HMP Holme House, the average rate of positive rMDTs was 9.7% for the 12 months April 2017 to March 2018; 9.5% for April 2018 to March 2019; and 5.2% for April 2019 to March 2020. This is in contrast to most comparator prisons where the rate increased across the same time period: HMP Oakwood (6.0%, 6.3%, 7.0%), HMP Mount (18.8%, 21.2%, 23.5%) HMP Ranby (7.8%, 9.3%, 13.3%) and HMP Wymott (7.9%, 9.8%, 8.4%).