



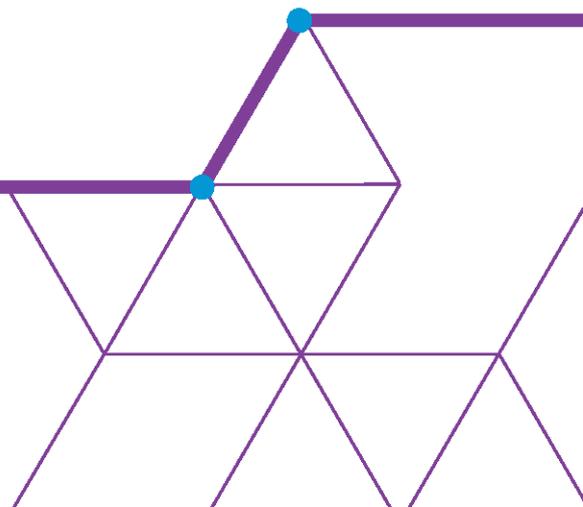
HM Prison &
Probation Service

Exploring Substance Use in Prisons: A case study approach in five closed male English prisons

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Preventing victims by changing lives



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1. Summary

Substance use is a significant issue in prisons across England and Wales and it affects the regime stability along with resident and staff health and well-being. This research used case study methodology to identify factors associated with substance use in five English prisons – all of them closed prisons for men. The aim was to explore the wider cultural features of the prisons which, according to the recovery literature, may have an impact on levels of drug use, and has not been investigated in prior research. Observations, interviews, documentation analysis and data gathering were carried out. A total of 78 staff members and 61 residents across the five prisons were interviewed. Using thematic analysis, themes to explore factors associated with substance use across the prisons were generated.

There are some limitations with case study designs; whilst qualitative methodology enables the exploration of rich, in-depth information it is difficult to generalise the findings and to explore causal relationships. The learning made may not be relevant to all staff and residents or to other prison sites – particularly to prisons at lower or higher security level or those holding women or younger people. It is also unlikely that the five selected sites will have identified all of the possible factors associated with substance use. Another limitation was that the final site selection may have been biased to sites who were more willing to be involved in research.

Nine themes emerged from the qualitative analyses, which were clustered into three domains. The first domain was entitled ‘descriptions of drug use’ comprising themes which described the extent and consequences of drug use. This included a theme around the ‘epidemic’ nature of drug use, which encapsulated the perceptions that the extent of substance use was widespread, had major impacts on the prison, staff and residents, and was akin to an epidemic in prisons. Psychoactive substances were the most problematic drug reported. Also identified was a theme around the reasons for drug use, entitled ‘escapism’, to reflect the most commonly cited reason for drug use across the five prisons, as well as a theme entitled ‘prison type and population’, which grouped together perceptions of different contextual factors which impact on drug use, including the specifics of the population held at the prison, the prison type, the regime and staffing levels. The second domain was ‘rehabilitative focus’, and contained three themes: relationships, hope and prison culture. Relationships between staff and residents, and within staffing groups were perceived as fundamental, and differed between prisons with higher levels of substance use and those with lower levels of substance use. In prisons with a more prominent drug problem and amongst those who reported using drugs, there was a real sense of hopelessness and

helplessness amongst both staff and residents. The culture of the prisons also seemed to be related to substance use, with more punitive cultures existing in the prisons with greater levels of substance use. The third domain was called 'enablers of a more effective response to drug use' and included themes around resources (e.g. staff numbers and time), treatment provision, and prison regime/activity, all of which were factors which could help better address substance use. Resourcing was perceived to be key in dealing with the issue of drug use in prisons. Particularly in prisons with higher levels of drug use, many staff said that they did not have the time to devote to meaningful activity with residents, being instead overrun with paperwork, and managing processes and the consequences of drug use. There was limited treatment provision for substance use across all five prisons, and services were often observed to be quite separate from the rest of the prison rather than an integral part. The provision and availability of purposeful activity and a full regime were deemed important to support the reduction of substance use in prisons.

Recommendations arising from this predominantly qualitative analysis included recognising the extent of drug use, the need to focus on 'recovery capital', and adopting a prison wide approach. Improving and strengthening staff and residents' relationships, a greater use of rehabilitation over a solely punitive stance, better training for staff, a focus on improving procedural justice, and improving communication between staffing groups regarding Substance Misuse Services (SMS) and healthcare services were also recommended.

2. Context

2.1 Background: The problem of drug use in prisons

It is well known that there is a strong relationship between substance use and crime (National Treatment Agency for Substance Misuse, 2012), as well as substance use and reoffending (May, Sharma & Stewart, 2008). Substance use can threaten the security and stability of the prison system, as well as the health and safety of residents and staff. Substance use can impact on violence in prison, contribute to debt and the illicit economy (Hammill & Newby, 2015), and also impact on reoffending outcomes (MoJ, 2010). The rise in violence, assault rates, self-harm and suicide in prisons in England and Wales in recent years (HMIP, 2019), often attributed to insufficient staff resource, has also been theorised to be in part due to substance use (Wheatley, Stephens & Clarke, 2015). In fact in a recent rapid evidence assessment of violence in prison, those with a history of drug offences or drug abuse were identified to be more likely to commit incidents of violent disorder within establishments (McGuire, 2018).

Psychoactive substances (PS)¹ are drugs, which are either naturally occurring or synthesized from other substances, designed to mimic the effects of other traditional illicit drugs (see Wheatley, Stephens & Clarke 2015). The rise in the use of PS amongst residents has also led to a number of health-related and behavioural problems. There is evidence that as PS use in prisons has increased, so too have levels of violence suggesting an association between them (although there has been no experimental evidence demonstrating a causal link between the two). It is known that use of PS can result in violent outbursts but the further potential effects of PS for users include sedation, relaxation, euphoria and altered perception. Two recent evidence reviews have examined the health effects of PS (Karila, Megarbane, Cottencin & Lejoyeux, 2015; Zawilska & Andrzejczak, 2015). According to these reviews, cardiac, psychiatric and neurological adverse effects are the most commonly reported health effects of PS. PS use might also lead to violence, homicidal combative behaviour, self-mutilation, coma and death. PS use can also trigger underlying mental health issues and can adversely affect the recovery journey of problematic drug users (Ralphs, Williams, Askew & Norton, 2017a). Research indicates that PS use is particularly prevalent amongst vulnerable groups, who may use PS to cope with living in prison, or during periods of homelessness (Ralphs, Gray & Norton, 2017b). The small body of research around PS has suggested that users are presenting significant challenges to the Criminal Justice

¹ Previously referred to as New Psychoactive Substances. They are referred to as Psychoactive Substances as they are not novel or new anymore.

System due both to their volatile behaviour while using but also to the lack of knowledge and experience of staff in dealing with the problem (Addison et al., 2017). It is also clear that PS use can contribute to debt, bullying, violence, self-harm and suicides in prison, and is placing demands on staff time and resilience (HMIP, 2016; User Voice, 2016).

2.2 The scale of drug use in prisons

Recent estimates from Public Health England suggest that over half of adults residing in secure settings were in contact with drug and alcohol treatment services during 2016–2017 (Public Health England, and Department of Health and Social Care, 2018). A report by the Centre for Social Justice in 2015 describes the drug problem in prisons as ‘serious’ with just under one third of residents admitting that it is easy to get drugs in prison, and almost a fifth reporting that they first took heroin inside prison. A recent report into the needs of those in custody, indicated that drug misuse needs were highly prevalent; around 45% had drug misuse identified as a need (MOJ, 2019b).

A thematic report by Her Majesty’s Inspectorate of Prisons (HMIP) in 2016 reports on the significant rise in the use of PS in the prison system in England and Wales. Whilst the extent of PS use will vary from prison to prison, recent evidence estimates that up to 50% of residents have used PS in prison (User Voice, 2016), and many residents may be regular users (User Voice, 2016). In a recent annual review of drug use in prisons, it was reported that PS were present in 51% of all positive MDT samples, overtaking cannabis, opiates and buprenorphine by a large margin (MOJ, 2019c). Drug seizure data also suggests a significant increase in the use of PS and a decrease in traditional drugs (Centre for Social Justice, 2015) in recent years. Since 2016, with the introduction of the Psychoactive Substances Act, the production, supply and/or possession with the intent to supply a psychoactive substance if it produces a psychoactive effect were criminalised. Possession of PS is also now a criminal offence in a custodial setting.

2.3 Motivations for drug use in prisons

Understanding the motivations behind substance use can go some way to help us to identify what strategies might assist in reducing uptake or demand of these substances in prisons. However, the research behind motivations for drug use in prison is limited, particularly in England and Wales. A recent study by Mjaland (2016) explored resident and staff perceptions of drug use across two prisons in Norway. The research found that prison staff emphasised addiction and troubled life trajectories when explaining drug use in prisons, whereas residents explain drug use as 1) a way of alleviating some of the pains of

imprisonment, 2) an integral part of social life in prison, 3) a route to status in the prison community, and 4) a defiant way to subvert institutional rules and expectations.

There has been some research into the various motivations behind PS use in prisons (Baker, 2015; HMPPS, unpublished; Ralphs et al., 2017a; User Voice, 2016). These include: accessibility and the low cost of PS; the fact that before 2016 PS was not detectable in drug testing (MDTs); using PS as a coping mechanism to deal with life in prison and personal issues; to cope with boredom and lack of purposeful and engaging activity (providing a sense of “escape” from prison life); having an addiction for PS which either replaced addiction for another illicit drug or developed over time; believing that everyone else is doing it, thus making it more socially acceptable; and enjoyment, for both the effects of PS and the entertainment of spiking others. Some of these replicate reasons for general substance use, but there seem to be some reasons specifically explaining the rise of PS in the prison system (e.g. cost, accessibility and detection). Previous research has also indicated that there may be a lack of appropriate drug treatment services for PS users specifically (Ralphs et al., 2017b). Some PS users see little point in engaging in treatment without an available substitute drug, in the way that methadone substitutes for heroin. Lloyd, Perry and Grace (2018) recently conducted qualitative research examining the continued use of PS on release from prison within approved premises (APs) and Community Rehabilitation Companies (CRCs). The research reported how the market for PS in prison is highly lucrative and some people are making a great deal of money from the sale of PS inside prisons which fuels its use.

2.4 Approaches to dealing with drug use in prisons

The recent HMPPS Drug Strategy (MoJ, 2019a) describes the coordinated response prisons need to adopt to deal with drugs around three objectives: 1) Restricting supply, by improving security, building intelligence, and targeting the criminal networks which aim to bring drugs into prison. Significant investment in prisons has been made to target supply; 2) Reducing demand for drugs in prison by developing more meaningful regimes, providing more constructive ways for residents to spend their time and ensuring the balance of incentives encourages residents to make the right choices; and 3) Building recovery by working closely with health and justice partners to help residents who want to overcome their substance misuse, providing those who are serious about living substance free with the environment to do so successfully. These three objectives fit nicely into the wider literature around an effective response to drug use in prisons (Centre for Social Justice, 2015).

Restricting supply depends on the adoption of robust security measures to reduce the entry of drugs into prisons. There are many drug routes into prison and these will vary by prison, dependent on various contextual factors and security measures in place (O'Hagan & Hardwick, 2017). Her Majesty's Prison and Probation Service (HMPPS) uses a number of measures to reduce supply, such as mandatory drug testing (MDT), the use of x-ray scanners, searching, drug detection dogs and enhanced gate and perimeter security. However, it is unlikely that these measures will reduce drug use if not accompanied by measures to reduce the demand for drugs. For example, although MDT may be accurate in providing trends of drug use if prisons test to the required levels, their accuracy has also been questioned by some, as well as their impact on behaviour when not combined with treatment for dependency (Du Pont, Campbell, Campbell, Shea & Du Pont, 2013; Singleton, Pendry, Taylor, Farrell & Marsden, 2005; Bonds & Hudson, 2017; Brooks & Scott, 1997).

Reducing demand and understanding the reasons for drug use is fundamental. Without attention to these two factors, it is unlikely that substance use will be reduced, as new methods of entry and evading detection may simply replace previous methods that have been displaced with enhanced security and detection procedures. Traditionally, drug policy in prisons has adopted a threat-based or control approach to encourage drug users to enter treatment, and punishment has been the usual route taken when people fail a drug test, or are found in possession or under the influence of drugs. Some researchers (e.g. McKay, 2016), argue that a different approach may better enhance the motivation of drug users, and promote better long-term outcomes. Recent HMPPS policy reflects these rehabilitative aspects; the four core pillars of prison performance, according to Her Majesty's Inspectorate for Prisons (HMIP) are safety, respect, meaningful activity and rehabilitation. All of these factors tap into an effective response to drugs based on reducing demand. Treatment provision for substance use within prisons varies across establishments, but is essential in addressing demand. Most prisons offer psychosocial interventions, as well as substitute treatment programmes, predominantly methadone maintenance (opioid substitution therapy; OST). Research indicates that the latter can reduce substance use in the prison setting (Stallwitz & Stover, 2007). Structured cognitive-behavioural treatment programmes and substitution therapy based treatment for drug use have also shown to be effective at reducing reoffending (Koehler, Humphreys, Akoensi, Sanchez de Ribera & Losel, 2014; MOJ & PHE, 2017), although the current picture is that cognitive-behavioural treatment programmes are not routinely offered.

Building recovery is the third strand. "Recovery" describes the process of supporting people out of drug dependency (Best & Wheatley, 2019; Sheedy & Whitter, 2009), and regarding

addiction recovery as not solely about gaining control of substance use, but having a broader aim of global health and active participation (UK Drug Policy Commission, 2008). Recovery includes having 'recovery capital' (Granfield & Cloud, 2001): the resources that an individual has to support their recovery pathway. The four main domains for recovery capital are described as personal capital, which includes qualities like resilience and hope; social capital, which identifies the immediate support an individual has; community capital, which identifies the support from the wider community (Best & Laudet, 2010); and justice capital (Hamilton, 2019), which involves allowing people to navigate, understand, communicate and be engaged in their systems of care and service provision available to them, which will afford better outcomes. Those who have these four forms of recovery capital are more likely to be successful on their recovery journey. But recovery does not occur in isolation. It is best characterised as a personal and individual process of growth which is supported by the wider community, family and peer support, as well as the organisations involved in peoples' care (Sheedy & Whitter, 2009).

2.5 Research aims

Whilst it is clear that substance use in prisons is a particular problem, there is a dearth of research to understand the range of factors associated with substance use. Further, previous research has not examined the wider cultural features of prisons, which according to the recovery literature, may impact on levels of drug use. The present research was conducted in order to explore the factors associated with substance use in prisons, so as to identify suggestions and practical recommendations for reducing use and in turn its impact, and to address the evidence gap by exploring the wider cultural features of prisons and how they relate to levels of drug use. Whilst there appears to be a significant problem with PS use in prisons currently, it is also clear that drug patterns are continually changing. As such, the present research focuses on substance use in general.

This study aimed to explore the contextual and situational factors associated with substance use in five closed prisons for men. The research questions which this study addresses are:

- What issues are prisons currently facing regarding substance use?
- What factors are associated with substance use?
- What can aid an effective response to substance use in prisons?

In attempting to examine these questions, the aim was to gain some insight into how to better cope with the substance use problem currently affecting adult closed prisons in

England and Wales, and generate better understanding of strategies that could be trialled to address problematic substance use in prisons.

3. Approach

3.1 Sample

Five prisons were selected to participate in this case study research. All were closed prisons for men. The prisons were selected to provide a range of geographical areas, size, population, function, MDT figures and culture/ethos to explore a breadth of potential factors associated with substance use. Six prisons were approached to take part, and one declined. The five participating prisons were located in different geographical areas in England (West Yorkshire, North Yorkshire, Nottinghamshire, East Midlands, and Suffolk).

Prison A is a Category C² training prison for adult men, located in a rural area with a capacity of 832. The prison has ten wings, and most of the cells are single occupancy. Prison A accepts people with any length of sentence, including the Indeterminate prison sentences for public protection (IPP), but not life-sentenced residents.

Prison B is a Category C resettlement prison for adult men. Since opening as a prison in 1972, it has had its accommodation capacity updated with the most recent new accommodation completed in 2008. The prison is made up of seven house blocks. The population is predominantly young men (under the age of 25), and the capacity is 1038.

Prison C opened in 1992 and was previously a large local prison holding men aged 18 years and older. At the time of this research Prison C was almost complete in transitioning into a Category C training prison with a capacity of 1210 and a newly defined additional role as a Drug Recovery Prison.

Prison D: Built in 1985, this prison is now a Category C training prison for adult men. It has had six new wings added over the years and now has a capacity of 842.

Prison E: This prison re-rolled (from a young offender institution) to a Category C prison for adult men, and re-opened in 2014. It has a capacity of 258 and serves as a national resource for Category C men on an indeterminate sentence preparing for release or

² Prisoners are categorised according to risk of escape, harm to the public if they were to escape and threat to the control and stability of the prison. Category A prisons are high security; they house prisoners who pose the most threat to the public. Category B prisons are local or training prisons, and house prisoners that are taken directly from court, and those with long-term sentences. Category C prisons are training and resettlement prisons. Category D prisons are open; they have minimal security and allow eligible prisoners to spend most of their day away from the prison on licence to work, attend education or other resettlement purposes.

progression to Category D status. The prison has a 20-bed Psychologically Informed Planned Environment (PIPE),³ and a 40 bed therapeutic community (TC).⁴

3.2 Measures

A range of data were gathered for each of the five prisons:

1. **Scrutiny documents** were examined to enable a contextual description of the key issues and strengths at each of the prisons. Specifically, Measuring the Quality of Prison Life (MQPL)⁵ and the Staff Quality of Life (SQL)⁶ reports, as well as recent HMIP⁷ reports for each prison. These documents together aimed to provide an overall picture of the current functioning of each of the prisons.
2. **Interviews** (one to one and focus groups) were conducted with staff and residents separately at each site. The semi-structured interviews used open-ended questions to explore staff and resident views on substance use and the factors perceived to be contributing to the use of drugs at each prison, and thoughts on what it was like to work or reside in the prison more generally.
3. **Observation** of activities within the prison which had the potential to shed light on the culture of the prison, the quality of staff-resident relationships, and the quality of treatment provision. The study included observation of the regime and activities available for residents to triangulate with data from interviews and scrutiny reports. Additionally, at each prison, a number of adjudications were observed to see some of

³ Psychologically informed planned environments (PIPEs) form a key part of the offender Personality Disorder (PD) strategy. They are specifically designed, contained units where staff members have additional training to develop an increased psychological understanding of their work, to create an enhanced safe and supportive environment to facilitate the development of those who live there. For more information see Turley, Payne and Webster (2013).

⁴ Therapeutic communities (TCs) are participative, group-based approaches used to help address their offending behaviour. TCs provide people with a range of therapy and they live in a collaborative setting with their peers and staff.

⁵ MQPL is a survey designed to assess prisoners' views of the quality of prison life (Liebling, Crewe & Hulley, 2011). The MQPL is made up of 21 dimensions, consisting of 128 normative statements regarding the 'moral performance' of the prison. The survey is routinely used across prisons in England and Wales.

⁶ The SQL (Crewe, Liebling & Hulley, 2011) is a survey designed to assess staff views of the quality of prison life and is routinely used across prisons in England and Wales. The SQL is made up of 117 items about the quality of working life in the prison. Most of the items make up a series of 17 dimensions, designed to measure a stable pattern of latent constructs that cannot otherwise be observed.

⁷ Her Majesty's Inspectorate for Prisons (HMIP) is an independent inspectorate which reports on the conditions for and treatment of those in prison, and young offender institutions. Prisons are inspected at least once every five years, although most are inspected every two to three years. Inspectors undertake analysis of the four 'healthy' prison areas: safety, respect, purposeful activity and rehabilitation, as well as following up recommendations from previous inspections.

the responses to men who had broken prison rules by consuming or distributing illicit substances.

4. **Performance and profile administrative data** (prison-level) were collated to describe the prison population (in terms of stability, offence type, risk and sentence length), and other prison level variables. The HMPPS Performance Hub⁸ provided information on prison level factors such as population figures, staff resident ratios, adjudication rates, Incentives and Earned Privilege (IEP)⁹ figures, assault rates and self-harm rates. The MOJ Segmentation Tool¹⁰ provided characteristics of the prison populations (in terms of risk of reoffending and assessments of criminogenic need). National drug treatment monitoring system (NDTMS)¹¹ data, owned by Public Health England, gave information on drug treatment provision and uptake at each site.

3.3 Data collection and analysis

A qualitative case study approach was used to describe the prisons and drug use (including psychoactive substances) at each establishment and to explore potential factors associated with substance misuse. A case study approach involves the 'detailed examination of single examples' (Abercrombie, Hill & Turner, 1984), and is most often used when a holistic, contextualised and in-depth investigation about a phenomena is required. The researchers visited each prison for at least two consecutive days between January and June 2018. Prison C was visited for a third day at a separate time. Table 1 shows the number of interviews and focus groups conducted at each site and the total number of individuals interviewed. Sampling for the interviews and focus groups was based on availability; the researchers spoke with as many people as was possible during visits. The type of interview used was dependent on what was easiest for the prison to facilitate. An interview topic guide

⁸ HMPPS Performance Hub has been in use since 2008 for the collection and reporting of Prison and Probation data and management information. It contains a large array of metrics, including staff-prisoner ratios of prisons, and population figures.

⁹ The Incentives and Earned Privileges scheme was the system through which prisoners could earn additional privileges by demonstrating a commitment towards their rehabilitation, engaging in purposeful activity, reducing their risk of reoffending, behaving well and helping other prisoners and staff. The higher the level the person is on, the greater the privileges received. Poor behaviour can lead to a prisoner moving to a lower level, and losing privileges as a result. In January 2020 the IEP scheme was replaced by the Incentives Policy Framework, which aims to better incentivise positive behaviour and gives governors greater flexibility to tailor incentives to local needs and challenges.

¹⁰ MOJ Segmentation Tool. This tool enables prisons and probation to look at characteristics of their populations by risk and need factors. It uses data from those who have had an Offender Assessment System (OASys) assessment.

¹¹ NDTMS. The National Drug Treatment Monitoring System is a system for monitoring the extent and use of treatment for drug and alcohol use across Prisons.

was used to structure the interviews and focus groups, though additional questions and follow-up questions were used in response to issues raised during each interview/focus group. The topic guide was tested out at the first prison visit, and amended in line with experience of its use.

The researchers requested to speak with particular groups of staff, including wing staff, drug and rehabilitation team staff (DART), education staff, workshop staff, and senior management in order to gather the views of different staff groups around the prison, and to get a feel for life working at the prison. At most prison sites this was achieved. At prison E however, fewer interviews with residents and staff were conducted as the prison regime meant that one to one interviews were easier to facilitate than focus groups. Everyone who took part in an interview or focus group gave verbal consent to take part having first been told the aims and goals of the research. The researchers also observed a number of adjudications relating to substance use (see Table 1), and had a tour around each prison, during which observations were made. The most recent MQPL and SQL reports and HMIP reports for each prison site were examined. Finally, data from the HMPPS Hub, P-Nomis and NDTMS were examined to help describe the prisons.

Table 1: Data Sources for each Prison

Prison Site	Number of one to one Interviews	Number of Focus Groups	Number of residents interviewed (total)	Number of staff interviewed (total)	Number of Adjudications (related to substance use) observed	MQPL and SQL reports	HMIP reports	Data from P-Nomis, Hub and NDTMS
A	1	7	9	35	3	yes	yes	yes
B	3	3	11	10	1	yes	yes	yes
C	3	6	25	17	1	yes	yes	yes
D	4	4	13	9	4	yes	yes	yes
E	7	1	3	7	2	yes	yes	yes
Total	18	21	61	78	11			

Following interviews and focus groups with consenting staff and residents, which were audio recorded, the data were transcribed verbatim and anonymised. A total of 416 pages (single line space, font 12) of transcript were generated from the interviews and focus groups.

These transcripts, together with the written notes of observations made during each prison visit, were then subject to thematic analysis (Braun & Clarke, 2013) which was used to generate themes. An inductive semantic approach to the analysis was taken. That is, the themes that have been identified were data-driven, and attempt to describe and summarise the data produced from the interviews and observations. Interview and researcher observation notes data were first read and re-read for familiarity. The initial coding process

generated a set of codes, which were then clustered together to form themes. The themes were then clustered together into domains. The additional information from each prison, which included MQPL, SQL, and HMIP reports, as well as data from P-Nomis, Hub and NDTMS data, enabled us to form a description of each prison, and to generate hypotheses about potential differences across the qualitative themes by prison and about effective management of, and responses to, substance use. In this way, the analysis involved a triangulation of evidence obtained from all the data collection methods applied.

Qualitative research can be critiqued for lacking quality and rigour but it is possible to set some criteria for appraising the quality of this type of study. The present research adopted the criteria proposed by Bauer & Gaskell (2003) which suggests that qualitative research should be transparent, should contain thick descriptions (using quotes from interview data for example), should use a triangulation of evidence (to enhance the validity of the findings), should adopt a clear and appropriate sampling strategy and should attempt to acquire communicative validity (the quality of the research in terms of the interpretations made in the report). The initial themes were shared with another independent researcher who read the manuscripts to ensure that the coding was appropriate. The initial findings were also shared with one of the prisons to obtain feedback on the themes and to ensure communicative validity was achieved.

3.4 Limitations and interpreting findings

There are a number of limitations with the current research which need mentioning. While qualitative methodology enables rich, in-depth information on an issue it is not always a straightforward task to generalise the findings to all prisons or to explore causal relationships. Whilst the findings were generated across five sites, and involved a great deal of data which allowed for triangulation, this learning may not be relevant to all staff and residents or to other prison sites – particularly to prisons at lower or higher security level or those holding women or younger people. It is also unlikely that the five selected sites will have identified all of the possible factors associated with substance use.

Another limitation was that the final site selection may have been biased to sites who were more willing to be involved in research. Fewer interviews with residents and staff were conducted at prison E, which compromised the ability to generalise the findings from this prison, and slightly restricted the breadth of information obtained. This limitation is taken into consideration in the analyses and discussion sections of the research.

4. Results

4.1 Prison Data

Table 2 presents the data gathered from the HMPPS Performance Hub. For all of the metrics below, the data are an average monthly rate from January 2018 to June 2018.

Table 2: Data for each Prison Site (averages based on time period Jan 2018–June 2018)

	Prison				
	A	B	C	D	E
Resident Population	793	1008	1190	813	243
Staff Resident Ratio ¹²	0.47	0.45	0.39	0.41	0.72
Staff sickness absence ¹³	10.66	6.84	15.34	4.72	9.19
Hours worked in industry (% - hours worked compared to scheduled hours) ¹⁴	76.7	68.4	85.6	79.3	88.9
Assaults on staff (monthly rate, per 1000 residents)	39.09	40.68	27.74	30.76	0
Resident on resident assaults (monthly rate, per 1000 residents)	186.63	192.49	137.03	95.98	24.66
Self-harm incidents (monthly rate, per 1000 residents)	262	180	251	160	53
Adjudications – average monthly number (per 1000 residents)	1182.85	985.12	787.39	929.88	283.95
Proportion of population on Basic IEP - N (%)	78.67 (9.9)	83.33 (8.3)	67.83 (5.7)	60.83 (7.5)	0.17 (0.1)
Proportion of population on Enhanced IEP - N (%)	184.33 (23.2)	253.00 (25.1)	369.00 (31.0)	365.00 (44.9)	224.67 (92.5)
Proportion of population on Standard IEP - N (%)	528.50 (66.6)	671.50 (66.6)	742.50 (62.4)	386.83 (47.6)	18.50 (7.6)
MDT levels (MOJ, 2017) ¹⁵	45.5%	37.1%	30.8%	10.5%	8.7%

Annex A provides a description of each of the prisons in terms of these data (along with a detailed description of the observations and document review).

¹² Number of Staff divided by number of prisoners, averaged across 6 month period.

¹³ Total working days lost in the period / Total full-time equivalent staff at the end of the month (averaged for 6 month period between January 2018 and June 2018).

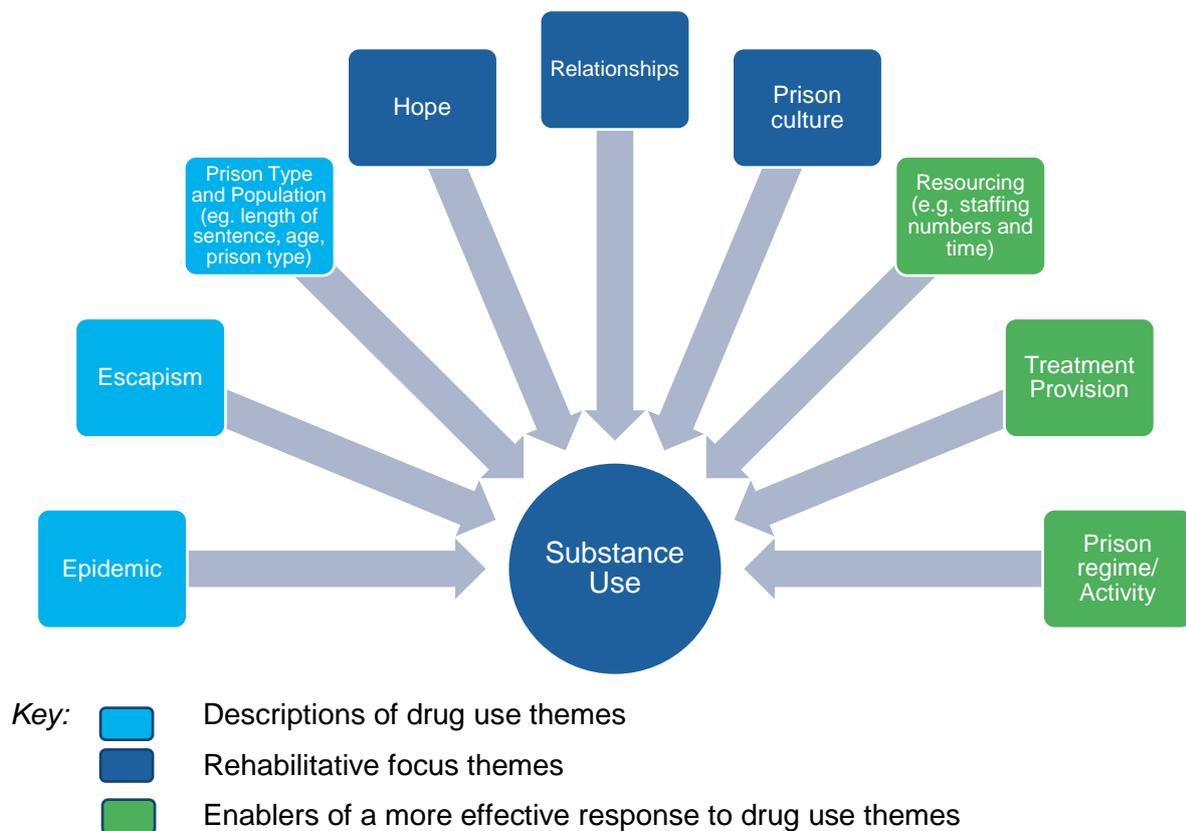
¹⁴ Hours worked in industry metric provides an indication of hours worked compared to scheduled hours. It does not provide a good metric of level of purposeful activity.

¹⁵ Derived from the Prison Priority Tool (MOJ, 2017), an internal MOJ tool used at the time to identify the most problematic prisons.

4.2 Themes

Nine key themes emerged from the qualitative analysis (see Figure 1), which clustered into three domains: descriptions of drug use, rehabilitative focus, and enablers of a more effective response to drug use. The themes are interconnected with each other, but this clustering best represents their meaning (albeit with some natural cross-over between them). The scrutiny documents and additional data were examined simultaneously, and as such also contributed to these themes.

Figure 1: Themes from the qualitative analysis



1. Descriptions of drug use

The first three themes describe the problems observed across the prisons regarding drug use, the drivers of drug use and some of the contextual factors of the prison and population which appear to be associated with drug use.

Epidemic

Based on staff and resident interviews, this study identified two main drug problems found across the five prisons. The first was the use of psychoactive substances (PS); the second was pre-admission drug problems, particularly opiate use. Both appeared to be

overwhelmingly present within the prisons (particularly the use of PS). The over-prescribing of methadone was also deemed problematic. A significant proportion of the populations in treatment at prisons A, B, C and D were being treated for opiate use, suggesting this was a significant problem. The ubiquity of drug use or perceived drug use meant that prisons seemed to be at a point of crisis, particularly in relation to PS. Both staff and residents frequently stated that drugs were widespread within the prisons, and some suggested that PS had '*ruined*' prisons, and had become an '*epidemic*' (Officer, Prison A).

'Every jail in the country is the same. Every jail in the country is ruined to spice.'

(Resident, Prison A)

To some extent, this theme emerged in all five prisons, but was particularly prominent in prisons A, B, C and D. '*Catastrophic thinking*' was evidenced by a strong sense of helplessness around the problem of drugs. Many residents spoke about feeling trapped in a cycle of drug use, which was very difficult to get out of, particularly as drugs were so readily available. A large majority of staff reported that they didn't know what to do to deal with the problem, that it was overwhelming and unpredictable, and that they spent their time '*firefighting*' and being reactive, rather than effectively targeting the root causes. Staff also said that they had tried a number of different things to combat or address the problem of drug use, but that nothing had worked. Many felt at "*breaking point*".

'You can't do your job basically. It's just crisis management.' (Mental healthcare staff, Prison A)

A number of staff suggested that the rise of PS use had come at a time when there were many problems within the Prison Service, such as staff shortages, and lack of funding, and that this, together with the changing patterns of drug use, and the emergence of PS, which originally was not detectable on MDT, had created a '*perfect storm*' – a situation ripe for the rise of illicit drug use. Staff and residents talked about the chaos that was associated with high drug use in prison.

'Spice caught them by surprise, innit, and it's just wrote them off, and they're still reeling. They're staggering. They don't know how to handle it and it's just drained them...' (Resident, Prison C)

There was discussion too of the '*catastrophic impact*' of drug use on the prison, and those residing and working there. Many spoke about the violence associated with PS use, the rise

in self-harm and mental health problems, as well as the acute physical symptoms associated with use. The bullying and debt issues arising from drug use was also frequently mentioned. Vulnerable residents were perceived to be more likely to become addicted to substances, and use drugs as a means of coping; as such, they were targeted by the suppliers. Staff frequently said that they felt unsafe at work, and residents, too, in some prisons felt unsafe as a consequence of the level of drug use. The unpredictable nature of PS means that every batch can have a different psychological and physiological impact on different individuals, as well as at different times for the same person. This makes it difficult for staff to prepare for, or deal with, the effects, as they do not quite know how things will go.

'The mental health repercussions are unbelievable. The amount of people I've talked to who are just – they're normal lads. Normally you can have a chat with them... Now he's hearing voices, you know telling him to kill himself, and this is all through using spice.' (Officer, Prison C)

One of the biggest impact of drugs in prison, reported in the interviews conducted, is the effect it had on the regime, and the quality of life for both residents and staff. Many non-drug users, and staff, reported that the time taken to deal with individuals under the influence of PS had a significant knock-on effect to everyone else. When there is a 'code blue',¹⁶ staff have to stop whatever they are doing to assist. Often activities are cancelled, people are locked up for longer, and staff do not have the time to devote to daily requests or other activities with residents. In turn, staff are then further behind on their duties/paperwork, and have to spend less time, as a consequence, with the residents. This diversion of resources is having an impact on everyone. The security measures used to manage the high use of PS also has an impact; for example, all prisons in this research were photocopying mail, as a high proportion of PS was, at the time of this research, coming in sprayed on paper. This again was perceived to have had a significant impact on staff resources.

'The residents who are conforming, we haven't got time to get to them because we're that busy dealing with code blues and people taking the drugs. Those who are doing what they need to do, they're not getting our attention.' (Officer, Prison C)

¹⁶ Code blue is a term used within prisons to indicate that an individual has difficulty breathing or is unconscious.

In prisons D and E, the culture appeared to be calmer, and consequently was described by those interviewed as less reactive. Whilst staff in these prisons still felt drugs were a major problem, the rhetoric was more about targeting the problem rather than just trying to deal with the consequences.

'Because it is so relaxed, and you're not looking over your shoulder. Never any violence really, no alarm bells going off.' (Resident, Prison E).

Escapism

The second subtheme was entitled 'escapism', and encapsulated a series of perceptions particularly related to the reasons for drug use in prison. The reasons most frequently cited related to the concept of '*killing time*'; relieving boredom, occupying time and giving people something to do: effectively drug use was described as a form of escapism, a way to escape from the monotony of daily prison life and dealing with the prison environment. The lack of purposeful activity and lack of positive things to occupy time was also frequently mentioned by residents.

'Passes time, doesn't it, and gives you something to do, chasing it and that. It occupies your mind, doesn't it?' (Resident, Prison A)

Others reported using drugs to self-medicate, sometimes when other prescribed medications were being withheld, or as an aid to sleep. Some cited drug use as a means of coping with personal or mental health problems as well as wider problems with prison life.

'People smoke it...to forget about stuff.' (Resident, Prison A)

Whilst some residents mentioned the excitement associated with risk taking behaviour, most talked about having nothing to lose from taking drugs. The lack of goals, and being lonely and bored, appeared to be key drivers of drug taking behaviour. Many residents interviewed talked about the difficulties of addiction, and the unavailability of support services to help with this. Particularly with reference to PS, there appeared to be some indication that their widespread use is to do with availability and vulnerability. Others mentioned the huge amounts of money which can be made from selling drugs in prison.

'It's a money source for some, and it's an escape for others.' (Officer, Prison B)

Many residents interviewed also suggested that the smoking ban¹⁷ has had an impact on increased use of PS, and on the changing methods of PS use; using vapes to smoke PS was now more common with the introduction of the smoking ban. Some staff also felt that the smoking ban had changed the nature and frequency of PS use. Others talked about the changing nature of drug use generally over time, and how drug patterns change, both in response to the availability of substances, the illicit economy associated with different substances, as well as the ease of getting the different substances into prison, and the ability of staff to detect use (PS was not detectable via MDT prior to 2016). The changing nature of PS entry into the Prison System was also referred to by both residents and all staff groups involved in this study, but particularly by security staff. Much of the PS was reported as now coming in on paper, as well as via throw overs and through visits.

Prison Type and Population

The extent of drug use in prisons differs and seems to be somewhat dependent on a number of different contextual factors, such as the population held at the prison, the prison type, the regime and staffing levels. At prisons where there was lower drug use (according to MDT levels and NDTMS data), the population were generally serving longer sentences. At prison E, for example, the population consisted of men on IPP or life sentences, who were keen to progress to release. The general view from staff and residents was that those on shorter sentences had little to lose from engaging in drug use, as they will be released regardless. Those on longer or life sentences, or those nearing the end of a long sentence, conversely, reported they had more to lose from drug-taking.

'Everyone's looking to progress and get back out and it's more stable and settled' (Resident, Prison E)

'It doesn't matter what happens. They're going home in like four months, five months, so it's not even like a big deal to them.' (Resident, Prison A)

The perception amongst most of those interviewed was that younger men were also more likely to be engaged in drug use, and were typically regarded as more likely to be involved in gang culture, which was also felt to be related to drug use. Whether the prison provided medication dispensing, particularly methadone, also may have an impact on drug use in the prison. At prison E, there were no facilities to dispense methadone. As such, anyone on a script could not reside there, which influenced the makeup of the population.

¹⁷ The Smoke Free Policy Framework was implemented across HMPPS prison in May 2018.

Factors relating to the prison structure, geographical location, layout and architecture were also relevant. Having larger perimeters and being in rural areas but with easy access were regarded as enabling drug entry into the prison (via throw overs particularly); open walkways were believed to enable transfer of drugs between residents; and larger prisons were felt to be more likely to be targeted by suppliers, for maximising financial gain.

There are some signs, based on the analysis of data collected for this study, that the age and sentence length of the prison population are also related to substance use. Prisons A–C all predominantly held residents serving sentences of 1–4 or 4+ years, whereas prison D held residents serving 4+ years or indeterminate sentences, and prison E predominantly held IPPs and those serving life sentences. The MDT and NDTMS figures indicated more frequent substance use in prisons A–C. It may be that a higher turnover of people brings less stability and higher drug use or that people serving shorter sentences have a different experience of prison and consequently turn more frequently to illicit drug use. The age of the population is less clear cut. Prisons A–D all had between 20 and 25% of the population in the 18–25 age bracket; only prison E had very few in this age category. The relevance of prison size is also not clear cut. Whilst prison E was the smallest of all the prisons in this study, prisons A and D were similar sizes, yet had noticeably different levels of substance use. This suggests that it may not just be the size of the prison that matters, or the age of the population; but that other factors are likely to be just as important as these wider context issues.

2. Rehabilitative Focus

In the second domain was a cluster of themes related to the importance of a rehabilitative focus in dealing with the issue of substance use.

Hope

One of the most powerful themes to emerge amongst those interviewed, was that of 'hope'. In prisons with a more prominent drug problem (prisons A, B and C), and amongst those who reported using drugs, there was a real sense of hopelessness and helplessness. Amongst staff involved in this study there was a sense of helplessness too, in not being able to deal with the widespread problem of PS use. Amongst residents interviewed, helplessness was related to being in prison, not being able to see any positives in their future or in their ability to change. In prisons A–C lack of hope was found to be prominent – about the future, progression and accessing the services or help needed.

'I can't think of one person now that has a proper focus on their future.'

(Officer, Prison A)

'Every single person in jail have just give up hope on everything, everyone because there isn't no incentive.' (Resident, Prison A)

Conversely, in prisons with lower substance use (prisons D and E), hope was reported to be more prominent. In prison D this seemed related to the availability of purposeful activity and more positive relationships. In prison E this seemed to be related to the wider culture of the prison, which was clearly rehabilitative and centred around a regime designed to support progression and positive change.

'The key difference from other prisons is that people have hope at X.' (Governor, Prison E)

The 'need to matter' was a key component of hope, for both residents, and staff who were interviewed. Particularly in prisons A, B and C, many residents repeatedly spoke about wanting to be treated as a person, wanting to be listened to, feeling like no one cares and things not getting done. All of these contributed to a general feeling that they don't matter to staff, or to anyone. With staff, feelings of not being listened to by Senior Management, or thanked for their hard work, or given "the correct training" to deal with the issue of drug use, also contributed to a feeling of not mattering. This was in clear contrast to prison D and E in particular where perceptions of visible leadership and a progressive regime lead both staff and residents to report that they felt that they mattered; prison residents were treated as individuals and encouraged to take responsibility for their behaviour and their future. Staff felt supported by Senior Management, and had time to facilitate activity that was purposeful and meaningful to the lives of those in their care. Having the time to facilitate activity was not solely to do with the higher staff resident ratio at prison E, but was also to do with the staff working at this prison holding a different attitude towards those in their care, caring about their job and the residents.

When asked what could help people, residents frequently stated that staff giving residents more time, help, and encouragement would be beneficial. Essentially, many mentioned wanting to have someone they could trust to talk to. Although some residents indicated that in order to change drug behaviour, people needed self-motivation, they also said that people needed to be given a chance to change, something many felt they weren't given. People

spoke about needing help identifying a *'hook for change'*, something to help them change their behaviour.

'You've gotta find something that is meaningful and purposeful from a resident's point of view to want them to change their behaviour.' (Officer, Prison A).

Relationships

This theme relates to the relationships observed within the prisons, both between residents, between staff and across staffing groups, and between staff and residents. Based on the interviews conducted, there were clear reported differences between the five prisons with respect to this theme. Though some positive relationships were discussed, for the most part relationships between staff and residents in prisons A, B and C were reported to be strained. Much of this was said to be because staff had minimal time to deal with residents' issues, but there was also a clear sense of *'us and them'*, with feelings of mistrust and lack of empathy paramount. Many residents felt that staff were *"out to get them"*, and some staff also felt that residents were out to trick and deceive them. Overall, residents felt they were not listened to, were not given the information they needed, and frequently cited that things that matter to them do not get done. They wanted to matter, to be treated as a person, but instead often felt *"like a number"* (Resident, Prison A), illustrating a lack of procedural justice.¹⁸ Residents felt that they had to fight to get what should be given to them.

*'There's no relationship. They don't give a f***, do they?'* (Resident, Prison A)

'90% of the staff think it's them against us. I don't think they set out in their day to day routine to come here and help a single person. I think they are here for the pay cheque, the lot of them' (Resident, Prison C)

In contrast, in prisons D and E, relationships were described in more positive terms. At prison E, relationships between staff and residents appeared to be genuinely rehabilitative. This seemed to be centred on the use of the key worker scheme, and the fact that staff had more time to engage with the residents, and were perceived as more respectful in their interactions. Most of the residents said they were also much more involved with decisions

¹⁸ Procedural justice theory argues that experiencing fair and just procedures leads people to view the law and authority figures as more legitimate, and to greater compliance with, and commitment to obey, rules and law (Lind & Tyler, 1988; Tyler, 1990). Procedural justice involves four principles: voice, neutrality, respect and trustworthiness (Tyler, 2008).

made about the prison, and had a voice in the processes involving the everyday running of the prison and their own progression.

'If you need an officer you could go there and you could pull them and say, "Listen, I need a chat," and you can chat to any officer at any time.'

(Resident, Prison E)

Generally across all five prisons, most staff said they supported each other well, and the majority of the staff said that support from colleagues was one of the main things that helped them in their day-to-day roles. However, in some prisons (predominantly prison A–C) there seemed to be an issue between some staff and the Senior Management Team (SMT) again illustrative of a lack of procedural justice. Some staff felt that the SMT did not understand the issues they faced on the frontline, and they were not respected or trusted. The visibility of the SMT was clearly an issue in some prisons. In prisons D and E, the SMT was reported to be present and visible, to both staff and residents. In prison E, Governors would walk around the prison, speaking with staff and residents, and resolving issues as they went. In contrast, in prison A, the perception of staff was that the SMT kept themselves '*hidden away*' in offices, and consequently it was felt that they did not understand the day-to-day issues staff were facing, didn't care about their staff, cared more about the residents, and didn't communicate effectively. In Prison C, a few staff suggested that the SMT were particularly focused on targets and less so about the safety of staff.

'There is a lot of visible leadership out there by the senior managers, and the door is always open for people to come and talk to us.' (Governor, Prison E)

'I would love for the Governors to have to don a uniform and spend not just a day, spend a few days on a house block and see what it's like.'

(Officer, Prison C)

Whilst generally across all five prisons, residents said that they got on with at least some other residents, others were fearful. This fear related to the perception that some residents '*ran the prison*' and that staff had lost power and control which had resulted in instability in the prison. There seemed to be a particular issue with this at prison B, where there was a feeling that boundaries of control were blurred; here some staff reported feeling that residents were the ones '*in control*'. Some staff also agreed that they had lost power and control of their prison; some felt that this was due to resourcing issues, and the consequent rise in drug use, other staff felt fearful in their roles, and felt they lacked legitimate authority

to deal with the situations they faced. Fear sometimes led to a lack of confidence in their ability to act to resolve or confront incidents. There was a dichotomy of 'appease or control'; there was no sense that there were other options or that staff understood how to say 'no' in a way that could be seen as respectful and fair. For many it appeared that saying 'no' would increase levels of anger and violence amongst the residents.

'There's a trade off with security and safety. We do a lot of placating here. We don't have a huge amount of control. We could have a lot more control but then it would lead to a spike in violent incidents....' (Officer, Prison B)

Prison Culture

The predominant culture of the prisons emerged as a distinct theme. The culture observed in the majority of the five prisons was predominantly punitive. Prisons felt chaotic, with staff saying they were constantly 'firefighting' and often felt unsafe; further there was a lack of cohesion or common purpose with subgroups of staff often working in isolation from each other. In prisons A, B, and C (and to a lesser extent prison D), a punitive rather than rehabilitative response to drug use was observed in the main. Continually punishing people for drug taking was frequently mentioned by both residents and staff involved in this study. Punishments varied but the most frequently mentioned punishment was being put on a basic regime (having privileges removed) or receiving extra days of imprisonment. The adjudications observed at each prison were on the whole not particularly rehabilitative (see Annex A for more detail). Individuals were generally dealt with swiftly and fairly, but there was little discussion of how best prison staff could support people to change. The adjudications at prisons D and E were found to be more rehabilitative, particularly at prison E where there was discussion of how the situation had arisen and the person adjudicated was encouraged to reflect on how they could get to where they wanted to be without using drugs, with some discussion of the support available. Overall, residents told us clearly that punishment was not working in terms of helping them to change their (drug taking) behaviour. Others indicated that rehabilitation more generally was not prioritised.

'They should be helping people get off the drugs, not punishing them for being on drugs. They're already getting punished in being in jail and it's hard enough. Rehabilitation – It's just a made up word.' (Resident, Prison A)

The views from staff were more mixed. Some felt that being more severe with punishments and having a harsher discipline would help to control the residents, and that prison should not be like 'normal life'. Some felt that prison these days was 'too soft' and that residents

were given too much freedom, and suggested that a stricter regime was needed to ensure good behaviour.

'For me, I'd happily restrict all their moves – all the resident's movements and stuff to stop the drugs being passed round the jail, but we're a cat C jail where the emphasis is on community and rehabilitation; keeping the men, you know, sort of about placating as opposed to nailing the jail down.' (Officer, Prison B)

This latter quote reveals some misunderstanding that rehabilitation is placating, rather than supporting and encouraging people to change their behaviour. Other staff, however, agreed with residents that punishment was not a deterrent, and felt that actually what was needed was to identify the cause of the problem and address that, not by punishment, but by providing the right support at the right time.

'They're not deterred by the punishment. I think we're very good at punishing the people for taking the drugs but we don't actually try and understand the reason why it's been taken to try and deal with that.' (Officer, Prison B)

Many residents also spoke about a perpetual vicious circle that people got into; after being caught taking drugs in prison, they would then lose all their privileges, which meant that they had nothing further to lose, they felt even more bored without anything to do, which would result in continued drug use and did not help people to change. Some felt stuck in this cyclical 'rut'.

'Once they've had the spice, they've gone on basic, they've lost their TV and gym. The only thing they've got to do at night is do drugs and go to sleep. Then because they're on basic, then they've lost their job, they're in debt. They can't pay this debt, so they're trying to get smashed up so they don't have to think about their debt...' (Resident, Prison A)

Both staff and residents interviewed spoke about a lack of incentive to change, and there being no rewards or recognition for positive behaviour or positive steps taken to address substance use. Examples were provided about what could be done to better address substance use, including giving people a chance, providing incentives, and giving people things to look forward to. The physical environment was mentioned as one of the ways in which change could impact on drug use by a number of residents. That is, they indicated that if the environment was more positive, some people might not turn to drugs so much.

Others talked about the need to get the basics right. Residents said that many times requests were ignored, information was not passed on to them and there was a real sense of perceived injustice to the way they were treated.

'Instead of just giving people days, taking their telly and doing things like that when they seem under the influence, why not talk to them? Find out why. Just give them a chance... do you know what I mean?' (Resident, Prison D)

In prison E more of a whole prison approach was observed, and the culture was predominantly rehabilitative, with different staff groups working together in response to the use of drugs. There was better communication between different staff groups, and staff felt like they all had a common goal. Residents knew 'where they stood', and reported they were given chances to succeed. This prison also felt calmer, less reactive and staff and residents alike generally reported feeling safe. There was a very positive community ethos throughout the prison. The principle of normality¹⁹ was central to the prison culture, and recommitment and deselection boards²⁰ helped people to take ownership of their behaviour and change. Use of peer mentors, focusing on sentence plans, and helping people build skills to cope with their drug use, were all important areas which were highlighted as being useful. The language used within a prison can also have an impact on the culture. In prison E, the fact that the word 'residents' were used, not 'offender' or 'prisoner', for example, may contribute to a greater sense that they matter.

3. Enablers of a more effective response to drugs

The third domain, enablers of a more effective response to drugs, comprised three themes: resourcing, treatment provision, and prison regime/activity. These were clustered together as enablers, as they appeared to be key factors to supporting a better response to substance use in prisons.

Resourcing (e.g. staff numbers and time)

Resourcing was seen, by those who participated in the study, as key to dealing with the issue of drug use in prisons. Overall, the majority of staff said that they did not have the time

¹⁹ The Principle of normality states that life, during the serving of a prison sentence, should be as similar as possible to life outside prison. The premise is that the punishment for committing an offence is the deprivation of freedom, and that the individual should have no other rights taken from them.

²⁰ Recommitment and deselection boards are meetings held between staff and prisoners after rule breaking or negative behaviour which help people recommit and take ownership of their progress plans, or deselect them from specific pathways until behaviour is modified.

to devote to meaningful activity with residents, being instead overrun with paperwork, with managing processes and managing the consequences of drug use. During many of the interviews at all five prisons there was mention of the benchmarking changes within the Prison Service over recent years, which had led to a reduction in resources and staff, which they believed had had an impact on safety, the availability of activities, as well as staff motivation and commitment.

'We used to get a lot of personal officer time and you could actually sit down and talk to a resident. You had time, you could engage with them, you knew the residents. (Now) you don't have the time to, to talk to them.' (Officer, Prison D)

Some staff felt deskilled and were not enjoying their roles as they used to. The majority also talked about the environment of the prisons having got worse, and identified that basics could not be met with the current staffing situation. Some staff said that they lacked the appropriate training, mentoring and knowledge to deal with the substance use problems within their prisons or to deal with the issues they were facing on the frontline on a daily basis.

'They don't give any kind of detailed training... There's no really specific training or any guidelines on what you should do...' (Officer, Prison B)

The stability of the workforce was regarded as particularly problematic. At two of the prisons (B and C), a number of staff members were off sick for issues related to secondary exposure to PS and stress, which then exacerbated the resource issues these prisons faced. There was also frequent mention of the large number of very experienced staff having left the service, and an influx of new young and inexperienced staff starting. In all prisons, the inexperience of new staff was mentioned, along with the difficulties that this brings. Evident across all prisons, there was tension between more experienced staff and new (often young) staff members. At prison A, new staff were being told not to listen to more experienced staff who some felt were not rehabilitative enough. In another prison, there was a suggestion that new staff were being led into negative ways by older staff. And in a third prison residents indicated that the new staff have no control over them and as a result could be more easily manipulated. The issue with new staff was not always attributed to age; it was also felt to be the lack of skills in dealing with difficult situations and having the right qualities to be an effective and approachable officer.

'They're a bit scared to tell you the truth, ain't they, some of the staff... They don't have the life skills as such. And communications skills, talking to people. They don't know how to talk to you.' (Resident, Prison B)

Treatment Provision

Many residents interviewed felt that there was little support or treatment for those engaging in substance use. Most talked about the need for more counselling services, more courses for substance use and more help to change. Many residents stressed the importance of understanding why people are taking drugs. Whilst in most prisons there was provision of opioid substitution therapy (OST), generally there was less provision of psychosocial treatment across all five prisons. Most residents knew little about the services that were available in the prison to help them. In a few of the prisons, the healthcare seemed quite removed and separate from the rest of the prison, which might help explain this lack of visibility. Having healthcare and SMS services embedded within the prison, rather than being seen as entirely separate, was deemed important by some staff to address this. Information sharing and communication between different disciplines and departments was also felt to be poor in some prisons. In particular, a large minority of discipline staff knew little about SMS and healthcare services. Some of the healthcare staff felt that discipline staff thought they were 'soft':

'They [Prison Officers] don't know what we do because they don't take the time to ask us and say, "So what do you do? Give us a little bit of information on it." Instead, we just get the, "Oh, you don't actually do anything. You just sit and cuddle them and do all this, 'There, there,' you know.'" (DARS worker, Prison C)

The majority of healthcare and SMS staff talked about being understaffed, under resourced, lacking training and having too many people on their caseloads. These staff groups also talked about the difficulties of the changing nature of the commissioning process, which had caused disruption to the delivery of effective services, and communication between different service provisions. There was also mention of the need for services to be more joined up so as to avoid the need for multiple assessments to access the different support required from multiple service providers. Some staff indicated that there was too much of a 'tick box' culture which meant that meaningful care plans and review processes didn't always happen. Very few staff mentioned using resources or frameworks being used to support their

planning or delivery of services, such as the UK clinical guidelines.²¹ Most of these staff also mentioned the lack of support from the rest of the prison, particularly with regard to methadone treatment. Residents could also see the lack of support for the DARS from the rest of the prison staff.

'Most of the DARS here, because I've chatted to most of them in being here and most of them are interested. They are interested. They care. They're trying innit, but without the rest of the jail supporting them there's not much what they can do.' (Resident, Prison C)

This lack of support was also framed by differing perceptions of recovery between groups of staff. Particularly amongst discipline and wing staff there appeared to remain stigma regarding opioid substitution therapy (OST), with some staff suggesting that sub-optimal low doses would be preferable. But other staff talked passionately about the recovery journey of an individual being a long-term process:

'Recovery agenda has changed and it's all about the patient journey. It is all about their recovery and what is recovery for them.' (Substance misuse manager, Prison B)

Particularly with regards to healthcare, there was some indication at a couple of the prisons that there was an issue with General Practitioners (GPs) overprescribing methadone, often for pain management. In some prisons, when someone is caught under the influence of drugs, their other medications (including methadone) are stopped, particularly if they were suspected of using PS. Residents spoke about the fact that this can elevate PS use even more, as people try to self-medicate after being taken off medication (often perceived as being unfair), or they are not accessing help or support for fear of being taken off their medication. There was also indication in some prisons that residents were trading their medications for financial and material gain. Others spoke about access to healthcare being particularly poor, and particularly access to medication. For some, this meant they self-medicated.

'...They're too scared to ask for help for the mamba addiction in case they get taken off their medication'. (Resident, Prison B)

²¹ The UK clinical guidelines outline the core elements that commonly underpin effective psychosocial interventions.

At prison C, there was discussion of how drug recovery wings, where everyone with a substance use issue is put together may not work as well as expected, as instead of helping people, they suspected at this prison that it perpetuated the issue of targeting by dealers. Equally, naming individuals and publicly identifying those who need support was also deemed to be ineffective.

“One of the men told us that [making people who illicitly used on top of methadone] was used as an opportunity by a lot of the dealers within the house block to target those vulnerable people and offer them some relief by various illicit items, so actually it was just perpetuating the same problem and it was amplifying it.” (Officer, Prison C)

Prison Regime/Activity

Availability of purposeful activity, and time out of the cell doing productive activity, emerged as the final main theme. Based on the interviews conducted, this seemed to be particularly good at prisons D and E, and poorer at the other three prisons. At prison D, there were lots of courses, programmes and activities available, and a focus on working on sentence plans. Similarly at prison E, much of the focus was around resident progression and development. At both of these prisons, residents spent longer out of their cells. In contrast, repeatedly in prisons A, B and C residents spoke of the lack of activities or opportunities they had access to. Residents mentioned the lack of availability of desired trades, courses, work places or qualifications to embark on. They also spoke about being locked up for long periods of the day, due in some prisons to the restricted regime. The following quotes show the stark contrast between prison C and Prison E.

‘There’s nothing for anyone to do, I go to the gym once a week, what are people who are trying to come off drugs and better themselves, what are they supposed to do, stay in their cells 23 hours a day and do nothing?’ (Resident, Prison C)

‘I mean Prison E is good at providing activities compared to other prisons. You have got evening things, you’ve got things like board game evening activities, you know, they can use the shop, there is mutual aid, there is a good array of activities.’ (SMS worker, Prison E)

Some staff also suggested that locking people up does little to help change the situation, and help people with their substance use. Both staff and residents generally agreed that

more activities are needed for residents to help them cope with the boredom, and prevent them from taking substances or even harming themselves.

'We can't just leave 'em behind a door for 22 hours a day and expect 'em to miraculously change their behaviour and their thoughts and processes.' (Officer, Prison B)

A perceived lack of procedural justice was also evident in statements made by some residents, with regards to the restriction of the regime or cancelling of activities. Without being told the reasons for the restricted regime, it is less likely that people will view the reasons as trustworthy and valid. Some felt that the staff just wanted to keep residents behind locked doors as it was easier than dealing with them.

'Staff just want you behind your door constantly. They don't want you out.'
(Resident, Prison C)

5. Implications and conclusions

Overall, the triangulated data from a range of sources helped to identify nine key themes. Psychoactive substances caused the greatest issues across the five prisons, followed by opioid use. The findings indicate that there are a range of factors associated with drug use, which include the culture of the prison, the relationships within the prison, the presence or absence of hope for both residents and staff, as well as the availability of resources, treatment provision and purposeful activity. The themes which appeared to most distinguish prisons with higher and lower substance misuse were the three themes concerned with rehabilitative focus (hope, relationships, and culture), as well as purposeful activity and resourcing.²² The most notable differences were cultural; prisons D and E where there was less drug use, were seen to have a more positive and rehabilitative culture, better resident-staff relationships, more visible leadership, greater perceptions of procedural justice, more hope, greater levels of purposeful activity and staff coping better with demands, than prisons A, B and C (where there were greater levels of drug use). Prisons D and E were also holding residents with longer prison sentences. The key drivers of PS use were similar across all prisons, and the treatment provision needed some improvement across all five prisons.

5.1 Implications for HMPPS practice

The design of this research does not enable the examination of causality between the factors observed. That is, it cannot be stated, for example, that lack of hope causes greater substance use, or conversely that greater substance use causes a lack of hope. What can be stated, however, is that associations between these two factors (and others) were observed and thus attempts to improve some of these factors may bring positive impacts on levels of substance use. This is certainly worthy of further investigation. This research is able to provide some suggestions for where changes in prisons can be considered in an attempt to reduce substance use, and better manage the issues faced by staff and residents in prisons. The key implications focus on the importance of rehabilitation, and provision of the right treatment and support services.

The Importance of Rehabilitation

The analysis found that having a rehabilitative focus appears central to dealing constructively with the issue of substance use in prisons. This includes enabling positive relationships across the prison and emphasising hope through purposeful activity and fair

²² For more information about the differences by theme across the five prisons, refer to Annex B.

processes leading to progression. This supports previous research around drug use which has emphasised the importance of supportive relationships (User Voice, 2018). A whole body of work is currently being driven forward around the development of rehabilitative culture in prisons (Mann, Fitzalan Howard & Tew, 2019), and this research would certainly support the continuation of this focus. Having a key worker (with the introduction of the keyworker scheme), trained to use the FMI skills (Tate, Blagden & Mann, 2017) could certainly help with building positive relationships, as could having staff champions who deal specifically with substance misuse issues, as well as effective use of peer mentors.

The evidence suggests that a purely punitive response to substance misuse in prison is unhelpful; more promising is the evidence for a rehabilitative response where there is wider understanding of the drivers of substance misuse, a firm but fair response to rule breaking in an environment where there is hope and opportunity and access to the right types of support from staff working together. Building a rehabilitative culture, where all aspects of the culture support rehabilitation, and where rehabilitation and activity are prioritised, as well as building hope amongst the residents and staff is almost certainly a key focus to help with substance use issues in prison. A positive, forward-facing culture will contribute to prisons feeling safe, decent, hopeful and supportive of change, progression and an offence-free future.

In line with McKay (2016) this analysis confirms the shift in drug policy in prisons from threat-based approach to one where sanctions are used in conjunction with supporting a recovery pathway, and addresses both demand and the supply. When substance use is viewed not as 'bad' behaviour but as an addiction or coping mechanism then the response is likely to be more effective. In this respect, the present research supports the values of CHIME (Leamy, Bird, Le Boutillier, Williams & Slade, 2011; connectedness, hope, identity, meaning and empowerment) which encapsulates the evidence on the essential elements of recovery. The framework postulates that recovery is more likely to be successful when people have good relationships and feel connected to others in positive ways; when people have hope and optimism that recovery is possible; when there is a positive sense of self and identity; when people are living a meaningful and purposeful life; and when people have control over their life, and are able to focus on their strengths.

Valuable lessons can also be learnt from the literature on desistance, particularly that identity change is critical for both desisting from offending and for the recovery process (Best, Irving & Albertson, 2017). Desistance can be supported by avoiding unhelpful labels that can stigmatise and fix someone in their past ('offender' or 'addict') not their future, providing opportunities for people in prison to take on new skills or different roles that can

prompt some identity change in their own eyes, and encouraging connection. How HMPPS respond to substance misuse in prison can determine whether or not the people in its care perceive that they have the skills, motivation and opportunity to try a different way of getting through and getting on.

What about Punishment?

Punishment is important for society; it is used to send clear signals about what is and is not acceptable behaviour, and punishment for misbehaviour supports notions of fairness that there are consequences for anti-social behaviour. However, the wider literature on the effects of punishment strongly indicates that punishment is not very successful at discouraging a person from repeating criminal acts, or at helping them to change their behaviour (Barnett & Fitzalan Howard, 2018, Bierie, 2012). Similarly, behavioural management schemes that solely emphasise punishment or loss of incentives, over reward, have been found to be less effective strategies in changing institutional adjustment, educational performance, work-related behaviour or other non-substance use related outcomes (Gendreau, Listwan, Kuhns & Exum, 2014), and to even potentially backfire through negatively affecting relationships between staff and residents (Liebling, 2008). The idea that punishment will change behaviour rests on the assumption that misbehaviour is a rational choice. In the case of substance use, the choice to continue to engage in drug use is not always rational; when people are addicted to substances, experiencing cravings, having withdrawal symptoms, or are under the influence of drugs, they may become less capable of making considered decisions. Men or women who continually fail mandatory drug tests, found to be in possession of substances or suspected of being under the influence of substances, are often caught in a continuing cycle of punishment and having privileges removed, which in turn make it more likely that they will use substances to cope with their situation. Without helping people to address the reasons for their drug use, and supporting them in their recovery journey, it is unlikely that a sole focus on punishment will be beneficial. Punishing people for drug use will not help to change their behaviour; instead people get stuck in cycles of drug use that can be hard to exit. Instead, encouraging people to engage in purposeful activity, supporting a harm reduction approach, and encouraging people to access psychosocial support and/or mutual aid, can all be helpful.

Treatment and Support Services

It is clear that access to purposeful activity and minimal time locked up in cells are important factors (User Voice, 2016). Consideration is also needed about how to provide more responsive and accessible treatment services for those dealing with substance use and review practice in the prescription of pain medication in prisons. Treatment services for

substance use will be most effective if understood and supported by all staff in the prison. As described previously by McKay (2016) this analysis suggests that treatment needs to focus on enhancing the motivation of drug users, increasing recovery capital (Granfield & Cloud, 2001) and promoting better long-term outcomes. Providing specific treatment for PS users may also be beneficial. Availability and visibility of treatment for substance misuse is paramount. Multi-disciplinary team structures and working appears to have significant benefits for the provision of appropriate treatment and support within prisons. The UK Clinical Guidelines are a helpful resource that are not always evident in operational practice and are likely to aid in planning a greater range of recovery and behavioural change interventions.

5.2 Conclusions and Recommendations

These findings are in line with more recent HMPPS policy around drugs in prison. Specifically, the current research findings support the three central elements of the Prisons Drug Strategy (MoJ, 2019), restricting supply, reducing demand and building recovery. If prisons are able to focus on these three factors, they may be more likely to see positive outcomes in relation to substance use. The present research has mainly focused on reducing demand and building recovery, but the importance of restricting supply is also acknowledged. For example, it would be worthwhile for future research to explore the impact of county lines²³ on the supply of drugs into prisons and as a driver of drug use, debt, bullying and violence.

It is important to acknowledge the difficulty many prisons are facing around substance misuse as well as continuing resourcing difficulties. It must also be acknowledged that there is growing understanding of the impact of culture within prisons; for a number of years there has been a keen focus on encouraging more rehabilitative cultures within HMPPS. Nonetheless some structural and cultural barriers to positive change appear to persist; a punitive focus was observed in several of the prisons visited, and signs of poor relationships between staff and residents and between staff in different teams, which are vital in providing a stable and supportive environment for residents. The issues appear to persist because they are so difficult to tackle.

There is also much to learn from how all of these five prisons are dealing with substance use. In all prisons, there were examples of good practice. In prisons D and E particularly

²³ County Lines refers to the illegal transportation of drugs from one area to another. Gangs and organised crime networks often groom and exploit children to transport and sell drugs.

there was good evidence of a strong community ethos, and in prison E the principle of normality was central. Prison E stood out from the other four prisons as it had a distinct purpose, regime and culture for a specific population. Although fewer people were interviewed at prison E, so some caution must be exerted in drawing conclusions from this research, there is likely value in considering replication some of this practice observed in prison E and prison D across other establishments.

Based on the findings from this research, the following recommendations are put forward for consideration as prison teams continue their efforts to respond to the toll of substance misuse in their jails:

1. One marker of success that emerges is strong, visible leadership that has a rehabilitative focus. It is recommended that this asset continues to attract focus and resource. Many of the pervasive and persistent problems facing prisons will best be addressed by continuing to focus on further developing the rehabilitative culture of prisons; building positive relationships and focusing on rehabilitation in environments that are safe, decent and fair. Cultural shift of this kind starts with leadership.
2. Procedural justice will be central in creating a rehabilitative environment. Staff need to feel like they are listened to, respected, and that they are treated fairly by Management. Residents need to feel as if they have a voice, and that processes are consistent and fair, that the people who have authority over them are trustworthy and treat them with respect. These principles appear just as relevant to the issues of substance misuse as all other aspects of prison life.
3. As an organisation, the approach to substance users has to be rehabilitative. Punishment alone and use of threat or control based approaches (including MDT) alone are unlikely to impact levels of substance use. Substance use will best be addressed if there is focus on understanding the reasons for substance use, helping people to access support services, and rewarding change. To make an impact this message needs to be clearly and consistently stated throughout the organisation. The tone of communications and policy documents needs to reflect this focus on enabling positive change enabled by staff who are perceived to care.
4. Effective prison drug strategies at the local level will describe a whole prison approach. That is, treatment and support services for substance use will be integrated into everyday life in the prison, running alongside security measures to reduce supply and disrupt the illicit economy. The evidence suggests a drug strategy will be most effective if it focuses on reducing demand and enabling recovery, as well as disrupting supply. A focus on recovery capital would be beneficial – that is helping people on their recovery pathway, by improving their personal, social and community

capital. This can be done by building hope, giving people more to do, and building supportive relationships.

5. Lower rates of substance misuse are likely to be seen when people in prison feel able to turn to staff for help, and not be fearful of a punitive response. The keyworker scheme currently being implemented across England and Wales will help improve relationships between staff and residents but there may be more to do to encourage consistent and constructive staff behaviour toward residents. Some staff interviewed for this study did not subscribe to a rehabilitative approach.
6. Treatment provision and SMS services were not always well understood by all. Greater communication and transparency is required between SMS and healthcare services, and other staffing groups. Discipline staff, particularly, need accessible and up to date information about the services available for residents and understand the role they can play in encouraging and supporting help-seeking.
7. There was little evidence of the UK Clinical Guidelines in action. It is recommended that prison teams review these and consider how to follow the guidance provided on effective responses to PS and other drugs. Efforts to promote and make more accessible any available psychosocial interventions will bring better outcomes but so too will a review of the interventions on offer. The evidence base for some interventions is thin and it is recommended that further efforts are made to establish their value through good quality research.
8. The analysis suggests that there is need for a greater focus on the right training for staff on substance use, treatment for substance use, and recovery. Staff also need adequate training on coping mechanisms, their part in supporting a person's desistance and building their own resilience. When staff have the right information and feel better able to deal with substance use issues (via training, partnership working, knowledge and time) prison residents are likely to feel the benefits.
9. Some staff may need further support in developing their rehabilitative skills in particular. All prison officers are now trained in the FMI skills (Tate, Blagden & Mann, 2017) but the current analysis suggests these are not always practiced. Some staff may still need to be persuaded or reminded of their potential to build or maintain hope and enable positive change with their encouragement, modelling and coaching.
10. Providing a greater variety and availability of purposeful activity may help reduce substance use. Getting people involved in their community, and giving them purposeful and meaningful things to do, can help people feel more positive about their situation, and relieve boredom. Generating a community ethos, and applying the principles of normality to prison life would be beneficial. Giving residents more responsibility and getting them involved in decisions can help.

5.3 Future research

It would be useful for future research to attempt to trial some of these recommendations in an experimental way to determine whether such changes can impact on substance use. For example, can a significant increase in availability, range and length of purposeful activity impact on levels of substance use? Or can training staff in resilience help them better cope with the issues they face relating to substance use? It is likely that changes in more than one area are required in order to make significant impact on outcomes. But carefully controlled experimental designs could usefully isolate the impact of different prison-level changes.

Testing the theory that poor working relationships between residents and staff, and staff and senior management have an impact on substance use would also be worthwhile. Additional research specifically focusing on management and their experience and input would be beneficial, and identifying how best the culture of a prison can be developed would also be useful to explore.

It would also be useful for further research to build on the findings around the fact that the PS use group are not attending treatment. What would a suitable treatment for those using PS look like? Additionally, examining the relationship between the two substance use problems (PS and opiates) would be worthy of further study, and would help operationalise an index of prison drug problems.

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Annex A

Detailed Description of Data, Observations and Document Review of each of the five Prisons

(For more detailed information please contact the authors)

Prison A

- At the time of this research prison A's population was predominantly made up of people serving 1–4 years (52%) or 4 years plus (33%), and the majority were serving sentences for acquisitive offences (30%) or violent offences (30%). Around 18% of the population were serving sentences for drug offences.
- Around one quarter of the population were aged 18–25 years old.
- Around 46% of the population scored in the 75–89 Offender Group Risk Scale 3 (OGRS3) risk category, indicating a large proportion of the population were high risk of reoffending.
- The data gathered for prison A (see Table 2) indicates that compared with the other four prisons, there were high rates of assaults, both on staff, and resident on resident. There were also a high number of self-harm incidents.
- The vast majority of the population were on the standard level of the IEP system.
- NDTMS data reporting from quarter 2 2018–2019 (July–Sept) suggests that 252 residents made up the treatment population. This is approximately 30% of the prison capacity, which represents quite a large minority of the population with substance use issues.
- Of those in drug treatment, 164 (65%) were receiving treatment for opiate use, 33 (13%) for non-opiate use, 31 (12%) for non-opiate and alcohol, and 24 (10%) for alcohol only. Forty percent of the treatment sample were on a maintenance script. A total of 23 clients in the treatment population presented with problem PS use (9%), 8 of whom did not present with any other substances.
- Mandatory drug testing (MDT) figures (from 2017) indicate that prison A had an overall positive MDT rate of 45.5% (one of the highest rates obtained at the time across all prisons).
- Together these data indicates that prison A may be a prison with quite high problems with substance use.

One adjudication related to PS use was observed. The individual admitted to using spice, but stated that help was not available and he requested more help to deal with his sentence and addiction. The adjudication was structured, very formal, quick and according to the researchers' observation, fair, but not particularly rehabilitative. There was little discussion of how the individual could change or access support, and little warmth was observed in the interaction.

The most recent HMIP inspection was conducted in 2015, and the most recent MQPL and SQL surveys were conducted in February 2018, just after the researchers' visit to the prison. Together these reports highlight issues with substance use and violence, and the application of systems being perceived as unfair. The reports also suggest that too many residents were locked up during the core day. There was some indication that relationships between staff and residents, and between staff and senior management were strained, and that there was presence of an overly punitive stance. Positive aspects of prison life included family contact, and staff had good relationships with their immediate colleagues and felt they had a good work-life balance.

Prison B

- At the time of this research prison B's population was predominantly made up of people serving 1–4 years (52%) or 4 years plus (29%), and the majority were serving sentences for acquisitive offences (24%) or violent offences (38%). Almost 20% were serving sentences for drug offences.
- Around 22% of the population were aged 18–25 years old.
- Around 46% of the population scored in the 75–89 OGRS3 risk category, indicating a large proportion of the population were high risk of reoffending.
- Compared to the other four prisons, the data in table 2 indicate that prison B had a high number of assaults (particularly resident on resident assaults), a low number of hours worked (by residents), and a high self-harm rate.
- The majority of the population were on standard IEP.
- Examination of the NDTMS data, indicates that the total treatment population in the 2nd quarter in 2018–2019 (July–Sept) was 401, 40% of the total prison capacity (1000). Again this represents a large proportion of the prison population with substance use issues.
- Of those in treatment, 277 (69%) were being treated for opiate use, 69 (17%) for non-opiate only use, 30 (7%) for non-opiate and alcohol use, and 25 (6%) for alcohol only use. For all of those in treatment, 40% were on a maintenance script. A total of 82

individuals in the treatment population presented with PS problems (20%), 25 of whom did not present with any other substances.

- MDT figures (2017) indicate that prison B had an overall positive MDT rate of 37.1% (relatively high in comparison to other closed male prisons).

Together these data suggest that prison B may have been suffering from significant substance use issues.

One adjudication related to an individual suspected for PS use was observed. The individual was put on basic²⁴ and referred to the independent adjudicator.²⁵ The process was clear and fair according to the researchers' observation, but there was little exploration of the reasons behind drug use or rehabilitative change with the individual.

The latest inspection at prison B was conducted in 2015, and the latest MQPL and SQL reports conducted in March 2018, a few days after the researchers visited. Findings from these reports suggest that prison B had some issues with perceptions of safety, with high levels of drug use and violence. Issues regarding residents spending too much time in their cells were also highlighted. The reports raised some concerns with the quality of relationships between residents and staff, and the ability of staff to control the prison. Positive relationships between staff and senior management were reasonably good, and staff generally felt they had good relationships with their colleagues.

Prison C

- At the time of this research prison C's population was predominantly made up of people serving 1–4 years (29%) or 4 years plus (32%), and the majority were serving sentences for acquisitive offences (27%) or violent offences (35%).
- Around one fifth of the population were aged 18–25 years old.
- Around 35% of the population scored in the 75–89 OGRS3 risk category, indicating a large proportion of the population were high risk of reoffending.
- The data from table 2 indicates that compared to the other four prisons, prison C had the largest population, the highest staff sickness rate, a reasonably high number of hours worked in industry (by residents), a mid-range number of assaults, and a high self-harm rate.

²⁴ The lowest level of the IEP scheme.

²⁵ Matters are referred to an Independent Adjudicator when the alleged offence is so serious that a punishment of additional days would be appropriate if the prisoner is found guilty.

- The majority of the population were on Standard IEP (the middle rating of the scheme).
- Examination of the NDTMS data indicates that the total treatment population in the 2nd quarter in 2018–2019 (July–Sept) was 948, which was approximately 78% of the total prison capacity (1210). This suggests that a very large proportion of the prison population have substance use issues, which is consistent with its current status as a Drug Recovery prison.
- Of those in treatment, 579 (61%) were being treated for opiate use, 202 (21%) for non-opiate only use, 104 (11%) for non-opiate and alcohol use, and 63 (7%) for alcohol only use. For all of those in treatment, 40% were on a maintenance script. A total of 55 individuals in the treatment population presented with PS problems (6%), 16 of whom did not present with any other substances.
- MDT figures (2017) indicate that prison C had an overall positive MDT rate of 30.8%.
- Together, these data suggests that prison C may have significant substance use issues.

One adjudication related to substance use was observed. The adjudication was not particularly rehabilitative. The Adjudicating Governor conveyed an approach of power and control, and didn't create opportunities for talking about why things went wrong for the individual subject to the process. The whole adjudication system at Prison C seemed to be a drain on limited resources, with more movement taking place around adjudications than going to workshops or education.

The most recent HMIP inspection at Prison C took place in 2017, and MQPL and SQL surveys were conducted in January 2018, a few months prior to the research visit to Prison C. Overall, the reports indicate that prison C had serious problems with drugs and safety. The use of force levels were high and many residents were not able to access basic requirements for daily living. There were strained relationships between residents and staff and perceptions of fairness were below average. Staff generally had lower than average perceptions of safety. Staff, however, were positive about their relationship with colleagues.

Prison D

- At the time of this research prison D's population was predominantly made up of people serving 4 years plus (74%) or indeterminate sentences (11%), and the majority were serving sentences for violent offences (42%) or drug offences (20%).
- Around 21% of the population were aged 18–25 years old.
- Around 40% of the population scored in the 75–89 OGRS3 risk category, and 31% were in the 25–49 OGRS3 risk category.

- Table 2 indicates that compared to the other four prisons, prison D has a lower staff sickness rate, a lower number of resident on resident assaults, a lower number of adjudications, and a more equal split between the proportion of the population on Standard and Enhanced IEP.
- Examination of the NDTMS data indicated that the total treatment population in the 2nd quarter in 2018–2019 (July–Sept) was 294, which was approximately 35% of the total prison capacity (843). This represents a large minority of the prison population.
- Of those in treatment, 122 (41%) were being treated for opiate use, 81 (28%) for non-opiate only use, 70 (24%) for non-opiate and alcohol use, and 21 (7%) for alcohol only use. A total of 75 individuals in the treatment population presented with PS problems (26%), 16 of whom did not present with any other substances.
- MDT figures (2017) suggest that the overall positive MDT rate for prison D was 10.5%, which was low in comparison to other similar closed male prisons.
- These data indicate that prison D may have slightly fewer problems with substances use than prisons A, B and C.

Four adjudications relating to substance use were observed. All were dealt with swiftly. The outcomes varied from being referred to the independent adjudicator to being adjourned, to being placed on report. The Adjudicating Governor discussed with individuals the support that is on offer at the prison, and whether they were accessing this. Overall, the adjudications felt moderately rehabilitative, though there were certainly improvements that could be made to make them even more rehabilitative, such as the inclusion of greater levels of warmth, and greater use of Socratic questions.

The latest HMIP inspection was conducted in 2015, and the latest MQPL and SQL surveys were conducted in July 2018, a few months after the fieldwork for this research took place. Overall the findings from these reports indicate that prison D was performing reasonably well, though some areas for improvement were noted. The most positive aspect of the prison was the levels of purposeful activity and time spent out of cell. There were concerns with the rising use of drugs and safety issues, and there was evidence of some poor relationships between residents and staff. Some issues around family contact were raised, and there was some indication of problems around the fair application of rules. Strengths included staff talking positively about their work, and the consensus that there were good relationships between and within staffing groups.

Prison E

- At the time of this research prison E's population was predominantly made up of people serving IPP or lifer sentences (85%). The majority were serving sentences for violent offences (65%).
- Only 2% of the population were aged 18–25 years old.
- The split across OGRS3 risk categories was more even than the other prisons.
- The data from Table 2 indicates that in comparison to the other four prisons, prison E has the highest staff to resident ratio, the highest number of hours worked in industry (by residents), the lowest assault rate, the lowest self-harm rate, few adjudications, and the vast majority of the population were on Enhanced IEP (92.5%).
- Examination of the NDTMS data indicated that the total treatment population in the 1st quarter in 2018–2019 (April–June) was 47, which was approximately 18% of the total prison capacity (258). This is a relatively small proportion of the prison population.
- Of those in treatment, 12 (26%) were being treated for opiate use, 10 (21%) for non-opiate only use, 18 (38%) for non-opiate and alcohol use, and 7 (15%) for alcohol only use. Just four men in the treatment population presented with PS problems (9%); all presented with other substance use too. All clients in treatment in this quarter received non-clinical structured interventions.
- MDT figures (2017) suggest that the overall positive MDT rate for prison E was 8.7%, which was one of the lowest figures observed at the time for a closed male prison.
- The data obtained for prison E suggest that there are fewer substance use issues at this prison than the others in the case study sample, and the population and regime is also very different in this prison, compared to the others.

Two adjudications were observed, both held on the units. Both were related to drug use. They were relaxed, informal, and particularly rehabilitative. The adjudicating Governor listened carefully to what the men told him, took their views on board, and showed interest and concern. Much of the discussion was targeted at what the individuals can do to address their drug use behaviour. The men were also encouraged to take ownership of their behaviour, and to generate their own plans for their future.

The latest HMIP inspection for prison E was conducted in 2015, and the latest MQPL and SQL surveys (MQPL+ and SQL+) were conducted by the Cambridge Team in 2018 and were more in depth than usual surveys. Overall the reports indicated that prison E was safe and providing good care for residents. There were low levels of violence, and very good relationships between residents and staff, and between staffing groups. The reports suggest

that prison E offers a broad range of activities for residents, and the living conditions were clean. The prison felt safe, secure and well ordered. Staff were positive and fulfilled in their roles. Prison E stands out as being an exceptional prison based on these reports.

Annex B

Key Differences between Prisons

The table below provides information on the key differences between the five prisons, in relation to the nine themes. There were greatest differences observed between prisons A, B and C, and prisons D and E. Prison E stood out as fundamentally different to the other prisons, both in terms of its regime but also the residents it holds. But prison E was similar in some respects to prison D, which also differed from the other three prisons in terms of the qualitative themes. It should be noted that each prison had a different culture, different balance of presence of themes, and different prevalent issues and strengths. As such, the table provides a summary of the main overall differences between prisons, in order to try to determine the key areas of focus to address substance use problems, but it does not attempt to capture the more nuanced differences between each of the five prisons.

Table 3: Summary of Themes by Prison

	A	B	C	D	E
Epidemic	Crisis point Numerous code blues Perfect storm Firefighting Staff given up	Struggling but coping Staff overlook drug use Through worst period	Lots of issues with PS and prescribed medication Staff exposure to PS a significant issue	Struggling with PS but just coping Calm environment Few code blues	Coping with levels of PS Calm environment Fewer with drug problems
Escapism	Boredom Lack of purposeful activity Self-medication	Boredom Lack of purposeful activity Self-medication	Boredom Lack of purposeful activity Self-medication	Boredom Lack of purposeful activity Self-medication	Boredom Lack of purposeful activity Self-medication
Prison and Population	Short sentence residents Young population Unstable population Vulnerable and large perimeter	Short sentence residents Young population Unstable population Larger	Short sentence residents Young population Unstable population Larger	Longer sentenced residents Young population Enclosed corridors/ walkways	IPPS and lifers over tariff Stable population Smaller
Hope	Lack of hope No incentives to change Helplessness	Lack of hope No incentives to change Helplessness	Lack of hope No incentives to change	Some lack of hope Focus on progression	Hope Progressive regime Positive imagery
Relationships	Poor staff-resident relationships SMT not visible Staff felt unsupported and suspicious of SMT Silo working	Respectful relationships Limited interactions SMS team and healthcare were isolated Silo working	Poor staff-resident relationships SMS and discipline staff relationship strained Silo working	Respectful staff-resident relationships Visible and supportive SMT Volatile relationship with healthcare Silo working	Positive staff-resident relationships Visible and supportive SMT Multidisciplinary working Keyworker scheme in place
Prison Culture	Punishment focused Lack of therapeutic environment Volatile/reactive Requests not always acted upon	Punishment focused (though some staff were rehabilitative) Staff lack control Focus on security and reducing supply Lack of safety	Punishment focused Lack of procedural justice Requests not always acted upon Poor living conditions Lack of safety	Punishment focused, though adjudications moderately rehabilitative Calm No code blues Well maintained and welcoming environment	Rehabilitative Inclusive Normality Residents EBM/progressive regime Community feel Procedurally just processes Well maintained and welcoming environment
Resourcing	Too few staff High volume of new/inexperienced staff	Too few staff High volume of new/inexperienced staff Lack of staff time for residents	Too few staff High levels of staff sickness Disrupted regime Security measures introduced	Too few staff Staff less stressed Introduced SMS workers	Good resources Stable staffing Staff have time Higher staff resident ratio

	A	B	C	D	E
Treatment Provision	30% of prison population in drug treatment Healthcare not visible Lack of support for SMS and healthcare services. DARS struggling with volume of caseload	40% of prison population in drug treatment Lack of support for those with substance use issues SMS and healthcare not visible Reliance on prescribed medication	78% of prison population in drug treatment DRP work promising and positive, but yet to be seen on the ground Difficulties with prescribed medication Treatment staff under resourced Treatment staff viewed as 'soft'	35% of prison population in drug treatment Commissioning structure – splitting SMS from healthcare has caused difficulty Use of peer mentors, and mutual aid groups Healthcare not visible and not available in evenings/overnight	18% of prison population in drug treatment No IDTS Integrated healthcare/SMS High rate of prescribed medication
Prison Regime and Activity	Lack of purposeful activity Long periods of time spent in cell	Lack of purposeful activity Long periods of time spent in cell	Minimal purposeful activity Long periods of time spent in cell	Variety of activities offered Greater amount of time out of cell OBPs on offer Focus on sentence planning	Variety of activities offered Greater amount of time out of cell Focus on progression