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Process Evaluation of Drug Recovery Wings

Final report

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Acronyms and abbreviations

CBDT	Compact Based Drug Test (this relates to voluntary drug testing)
CM	Custodial Manager
Cohort 1	Prisoners on the DRW with opioid substance misuse and dependency who are abstinent, including from OST
Cohort 2	Prisoners on the DRW with non-opioid substance misuse and dependency who are abstinent, including from alcohol
DRW	Drug Recovery Wing
DRW prisoners	Prisoners residing on the DRW (any cohort)
DSL	Drug Strategy Lead
Erlestoke	HMP Erlestoke
Featherstone	HMP Featherstone
Holme House	HMP Holme House
HMPS	His Majesty's Prison Service
HMPPS	His Majesty's Prison and Probation Service
ISFL	Incentivised Substance-Free Living unit
OFT	Oral Fluid Test
OST	Opioid Substitution Therapy
MDT	Mandatory Drug Test
MoJ	Ministry of Justice
MQPL	Measuring Quality of Prison Life survey
NHS	National Health Service in England and Wales
NPDS	National Prisons Drug Strategy
OCG	Organised Criminal Gang
RO	Residential Officer
SCRAs	Synthetic cannabinoid receptor agonists
SLT	Senior Leadership Team
SMART	Self-Management and Recovery Training
SMG	Substance Misuse Group (national team)
SMO	Substance Misuse Officer
SMS	Substance Misuse Service
TC	Therapeutic Community (the original term for the DRW at HMP Holme House)
ToC	Theory of Change
UTI	Under the Influence

Summary

Drug Recovery Wings (DRWs) are abstinence-based residential wings within prisons in England and Wales intended for those recovering from substance dependency. The Ministry of Justice (MoJ) have funded DRWs in six prisons in England and Wales. ICF were commissioned by the MoJ to carry out a process evaluation of DRWs. This report presents the findings from the process evaluation undertaken in 2024.

Research objectives and methodology

The aim of the process evaluation was to provide evidence and insight into the:

- mechanisms of how DRWs have been rolled out, implemented and delivered;
- successes, challenges, barriers, enablers and lessons learned;
- experiences of prisoners on the DRW pathway and any improved outcomes.

The methodology comprised: rapid assessment interviews with leadership staff and senior managers at six DRW prisons to map each DRW's function and approach; case study visits at DRW prisons to gather rich insight into DRW implementation; and a review of programme monitoring data provided by the MoJ. The findings presented below are subject to several limitations, including reliance on subjective perceptions to assess outcomes, incomplete programme monitoring data, the influence of prison staff on the selection of the qualitative interview sample, and constraints on interviewee availability.

Implementation of the DRWs

The study investigated the enablers and barriers to DRW implementation.

Enablers

From the national perspective, enablers included the composition of the national team, who were experienced and committed to delivery, and the generous funding allocation for prisons. In prisons, key enablers were the buy-in of Senior Leadership Teams (SLTs) to the DRW, locating the DRW on a desirable wing, having effective and experienced DRW leaders and enthusiastic and committed DRW delivery teams, and DRW staff being ringfenced. Support from the national team was helpful, including the coordination of sessions for DRWs to collaborate with one another. Access to the set-up funding enabled prisons to make enhancements to the physical environment on DRWs. The expansion of the DRW cohort requirements to include abstinent prisoners with non-opiate substance misuse and dependency had made it easier to find a sufficient number of suitable

prisoners to occupy the DRWs, as there were challenges finding OST-abstinent prisoners with opioid addiction. Good working relationships between DRW and Substance Misuse Services (SMS) staff and a DRW 'brand' were also beneficial.

Barriers

From the national perspective, the rapid pace of programme roll-out resulted in some prisons being selected for DRWs which were deemed less suitable in hindsight, and prisons had to set up their DRWs before the framework was developed. There were also challenges in gathering input into programme design, staff capacity available for the volume of work, and in navigating the existing SMS commissioning structure. Prisons experienced difficulties finding appropriate physical space for DRW activities, linked to the broader challenge of capacity pressure present across the entire prison estate. Prisons reported challenges gaining prison-wide buy-in and addressing the stigmatisation of some drug users among prison staff. Capacity issues elsewhere in the prison meant there were challenges moving prisoners off the DRW. Staff absences, departures and redeployment interrupted delivery, and widespread drug availability in prisons undermined DRW operations. There were bureaucratic issues impacting funding expenditure, and the funding did not account for restocking consumable items used on the DRWs. There were also gaps reported in the DRW framework around the regime and staff training.

Effectiveness of DRWs in facilitating prisoner recovery

The evaluation sought to understand the characteristics of DRWs that influenced the desired programme outcomes and impact – specifically, drug and drug substitute abstinence and increased mental and physical health and wellbeing (outcomes) and reduction in reoffending in prison and on release (impact).

The following features were identified as **working well** in the DRWs:

- Positive relationships between prisoners and staff, which meant prisoners were more likely to seek support from staff in situations that put their recovery at risk on the DRW than in the general prison population.
- Peer support and group work, which helped with motivation to remain abstinent and provided an opportunity to model skills and coping strategies from others.
- A culture and environment which was felt to be calmer and safer, and therefore more conducive to recovery, than wings for the general prison population.
- Involving prisoners in DRW delivery, which helped to foster a sense of ownership over DRWs among prisoners.

- A regime which kept prisoners occupied, so they could avoid the boredom which made drug use more attractive.
- Minimising mixing of DRW prisoners (those residing on the DRW) with the general prison population, thereby reducing the risk of drugs entering the DRW.

Features identified as **working less well** could be categorised into elements which were not being implemented as intended by the DRW model, implementation challenges and issues with the DRW model.

- *Not being implemented as intended:* Psychosocial interventions varied across prisons, and therefore views on their adequacy also varied. Additionally, some DRWs had lodgers (prisoners that did not fit the DRW cohort but were housed on the DRW due to prison population pressures or other reasons), which was sometimes problematic as they could exhibit behaviours which disrupted other prisoners (e.g. substance use, general non-compliance).
- *Implementation challenges:* Prisoners making it on to DRWs disingenuously (due to the nicer environment or desire to sell drugs, as opposed to having a genuine history of substance misuse and desire for recovery) could negatively impact others. Drug testing procedures were not always effective, as the voluntary testing regime on DRWs used did not detect synthetic drugs e.g. synthetic cannabinoid receptor agonists (SCRAs), making them more attractive to prisoners on DRWs wishing to use drugs. Additionally, disruption to the regime and disconnected staff teams could mean activities being cancelled at short notice, resulting in frustration and boredom among prisoners.
- *Issues with the DRW model:* There were strict criteria for prisoners to meet to access DRWs. These were designed to support the maintenance of a drug free environment, but it meant some of those who would benefit from intensive support to achieve abstinence were excluded. Likewise, there was some criticism of the DRW requirement for OST abstinence, on the basis that some prisoners on OST may wish to achieve abstinence but needed support to do so.

Progress of DRWs towards outcomes

The study looked at progress made towards the desired DRW programme outcomes.

Outcomes for prisoners

Many interviewed prisoners were engaging well with DRWs. They had positive relationships with other DRW prisoners and staff, and there were reports of improvements in their physical and mental health. DRWs were enabling prisoners to maintain abstinence

to some extent, but a key factor to adopting recovery behaviours was their personal desire for recovery – those without this ethos were more likely to use substances. It was likely prisoners were better prepared for maintaining their recovery post-DRW than had they not accessed the DRW intervention, but there were concerns about not having access to the same support in the general prison population or when leaving prison which could increase the likelihood of a relapse.

Outcomes for prisons

Substance-free, recovery-oriented cultures were reportedly created on most DRWs. This was essential to reducing prisoners' inclination to use substances, above and beyond DRW design elements (e.g. physical restrictions). Most staff and prisoners perceived lower levels of substance use and availability on DRWs. However, data suggested a more mixed picture – in half the prisons, under the influence (UTI) incidents were less common on the DRW than in the general prison population, but in the other half they were more common. There are some possible explanations – a minority may be responsible for multiple UTIs, the nature of the DRW cohort being in recovery means an inherently higher risk of relapse, and staff may monitor UTI incidents more closely on the DRW. Enhancing data collection could help to determine the extent to which this applies in future. Likewise, the extent to which DRWs supported a whole-prison approach to recovery was unclear in all but one prison (Holme House).

A flow of people from the general prison population into the DRW pipeline was in operation at most of the prisons, which was beneficial, but moving prisoners after DRW completion remained difficult. Moving back to the general prison population was not a popular option among staff or prisoners, and capacity in other substance-free wings was limited, so prisoners often stayed on the DRW until release or transfer to a Category D prison.

Unforeseen consequences

The DRWs appeared to contribute to increased job satisfaction among the Substance Misuse Officers (SMOs) working on them, and a reduced number of incidents among prisoners (violence, self-harm) compared to the general prison population. Some DRWs had provided a platform for sharing best practice in substance misuse recovery. They could also provide a setting for prisoners to upskill, supporting their future employability. However, there was also evidence to suggest DRWs could contribute to tensions among prison staff and be seen as a desirable location for drug dealers due to the history of substance misuse among the population.

1 Introduction and methodology

1.1 Introduction

Drug Recovery Wings (DRWs) are abstinence-based residential wings within prisons in England and Wales which aim to support prisoners to maintain abstinence from drugs and drug substitutes, improve their mental and physical health and wellbeing, and ultimately reduce reoffending. In 2023, the Ministry of Justice (MoJ) funded DRW implementation in eight prisons. Two of these prisons were subsequently deselected and, as of 2025, there were six DRWs in receipt of the MoJ DRW funding. ICF were commissioned by the MoJ to carry out a process evaluation of DRWs. This report presents the findings from the process evaluation and is structured as follows:

- This section (section 1) provides an overview of DRWs, the research objectives for this project and the methodology followed.
- Section 2 provides findings on the operation of the DRWs, including the process of setting up the DRWs and how DRWs are being delivered. It also explores enablers and barriers to the set up and operation of DRWs
- Section 3 presents findings on the effectiveness of DRWs in supporting prisoner recovery
- Section 4 describes the progress of DRWs towards outcomes for prisoners, and for prisons
- Section 5 presents the conclusions and considerations.

1.2 Overview of the Drug Recovery Wings

Drug Recovery Wings (DRWs) were first piloted in UK prisons in 2011 as part of a shift towards abstinence-based recovery, responding to critiques of over-reliance on opioid substitution treatment (OST) and aiming to support prisoners motivated to overcome substance dependency. These wings offered segregated, recovery-focused environments, with some prioritising complete abstinence and others integrating harm reduction approaches, and were designed to prepare prisoners for reintegration into the community through therapeutic support and continuity of care upon release. The DRWs funded by MoJ in 2023 build on these foundations and are guided by the Abstinence-Based Drug Recovery Wing Framework (HMPPS, 2023), which sets out how DRWs should operate. It establishes that the core features of a DRW should include the following elements.

- **A prisoner cohort in recovery from addiction**: The priority cohort for DRWs should be prisoners with an opiate addiction that have achieved abstinence from opioid substitution treatment (OST), illicit drugs and alcohol. If this cannot be achieved, the fallback cohort should be prisoners recovering from addiction to non-opiate substances (other illicit drugs and alcohol), and who are not on any substitute medication.

- **Drug and drug-substitute free environment:** DRWs should be located on a physically separate residential wing, separate regime, security protocols and drug testing should be in place to provide assurance that wings remain drug free and only house motivated prisoners committed to recovery.

- **Holistic, recovery-focused regime:** The regime on DRWs should include recovery focused activities including community groups, peer support, psychosocial interventions (as appropriate for the individual), recovery-oriented education, training and work, recreational activities, and incentives such as additional gym time.

- **Motivated staff:** DRW officers should be ring-fenced and permanently allocated to the DRW. These staff should be appropriately trained, experienced, and motivated to deliver recovery-oriented activities, build a community and support prisoners.

- **Multidisciplinary working:** DRWs should have sufficient physical office space to support shared office areas and multidisciplinary working between senior prison management, DRW officers, health, substance misuse, and prison offender manager teams.

- **Prisoner pathways to and from the DRW:** The indicative pathway for DRWs specifies that prisoners should spend time on an Incentivised Substance Free Living (ISFL) unit before and after their time on the DRW, before eventually transitioning back to the general population or being released. DRWs are distinct from ISFLs which are areas designated to house prisoners who commit to living in a drug-free environment, but do not necessarily have a history of substance misuse and/or dependence. Prisoners on ISFLs do not have to be abstinent from OST.

  Eight prisons were initially selected to host DRWs: Berwyn, Birmingham, Erlestoke, Featherstone, Holme House, New Hall, Stocken and Swaleside. However, two prisons

(Berwyn and Stocken) were subsequently deselected from the programme.[1] Each prison received £50,000 in set up funding to support improvements to the physical environment. Prisons receive ongoing funding for three B3 residential officers (known as Substance Misuse Officers or SMOs on DRWs[2]), one B5 Custodial Manager (CM) and one B3 Administrator.

The wider context of DRWs, including this first tranche of DRWs, are outlined in Annex 2. The full Theory of Change (ToC) for the DRW programme, which sets how the programme is expected to achieve its desired objectives in detail, can be found in Annex 3.

1.3 Research objectives

This project has three research aims, which are to provide evidence and insight into the:

- mechanisms of how DRWs have been rolled out, implemented and delivered;
- successes, challenges, barriers, enablers and lessons learned;
- experiences of prisoners on the DRW pathway and any improved outcomes.

1.4 Methodology

The methodology for this process evaluation was designed to respond to the research objectives and specifications provided by the MoJ, including budget and timeframes. It comprised interviews, case study visits and a review of programme monitoring data. The following research was undertaken and informs the findings set out in this report.

- **13 rapid assessment interviews** with leadership staff and senior managers at eight[3] DRW prisons to map each DRW's function and approach.

- **Case study visits at six DRW prisons** to gather rich insight into DRW implementation and progress towards programme objectives. Each in-person visit took place over two days and included:
  - a tour of the DRW;

[1] Accordingly, Stocken and Berwyn were not visited as part of this evaluation, although key staff participated in initial rapid assessment interviews.

[2] SMOs are distinct from externally commissioned Substance Misuse Services (SMS) staff, such as from Change Grow Live or Humankind.

[3] Berwyn, Birmingham, Erlestoke, Featherstone, Holme House, New Hall, Stocken and Swaleside. DRW funding from Berwyn and Stocken was subsequently withdrawn, therefore they were not included in the six case study visits.

  - qualitative interviews with prison staff members of varying levels (leadership, middle-management and operational staff) and roles (those involved directly in DRW delivery, as well as wider prison staff);
  - qualitative interviews with prisoners on the DRW (including those that had recently joined and those located there for three months or longer), as well as those on DRW waiting lists and/or those who had been moved off the DRW.

  Across the six prisons, 104 interviews were carried out (comprising 58 staff members and 46 prisoners). A breakdown of interviews undertaken in each prison is provided in Annex 7.

- **Eight interviews with national and regional programme team members.** This included HMPPS staff overseeing the DRW programme's design, set up and delivery, a national Substance Misuse Services (SMS) stakeholder, and a regional lead involved in the DRW at Berwyn.

- **A review of programme monitoring data provided by MoJ** to test the indicative DRW pathway. This comprised quantitative metrics collected by administrative staff in prisons such as: the number of prisoners entering or leaving DRWs; the location prior to and after DRW; average time spent on DRW; hours of treatment services and regime planned and delivered; drug testing results; and incidences of violence and self-harm.

All qualitative data was anonymised and extracted into a data management template for analysis. A thematic analysis of the data was undertaken using the data management template to identify the emerging evidence. The qualitative data was triangulated and synthesised with the MoJ monitoring data to identify the key findings. These findings are outlined in this report.

1.4.1 Strengths and Limitations

There are both strengths and limitations of the methodological approach. The **strengths** included the following.

- Qualitative interviews enabled rich, detailed data to be gathered from a range of stakeholders involved in the DRWs. Qualitative interviews were also a suitable format for exploring the differences in DRW implementation between prisons.

- In-person visits enabled researchers to see DRW operations first-hand – the physical environment of the DRW, as well as interactions between and among staff and prisoners. This enabled researchers to observe actions and behaviours (i.e. what staff/prisoners say vs. what they do), and interview questions could be tailored accordingly, helping to inform an in-depth picture of DRW implementation.
- Programme monitoring data provided an additional source of data with which to triangulate qualitative findings.
- Interviews with the national programme team and staff members provided insight into the overall design, set-up and management of the DRW programme, providing researchers with the wider context underpinning implementation at each prison.
- A member of the research team had lived experience of substance misuse and the criminal justice system. This helped to maximise the relevance of research tools (such as study information sheets and topic guides) to interviewees, as well as equipping the research team with deeper contextual understanding about substance misuse prior to undertaking fieldwork.

The primary methodological **limitation** was the poor quality and incompleteness of programme monitoring data which meant it was interpreted with caution. The specific challenges are described below.

- Data was compiled by prisons (usually DRW administrative staff members), but did not undergo subsequent data checks at prison-level prior to submission. Similarly, the data collection process was not validated by ICF, and there may have been differences in approach from prison to prison. Inconsistencies were observed, suggesting instances of data errors and misunderstandings around data categories, which affected the overall reliability of the data.
- Some DRWs were undergoing changes and development (e.g. moving to new wings, making changes to their regime) over the evaluation period. These changes may have impacted trends seen in the monitoring data but any such effect could not be easily isolated (i.e. attributed to a specific element of delivery).
- Monitoring data was bespoke to the DRW programme. Collection of monitoring data was influenced by resourcing pressures (discussed in section 3).

Other methodological limitations included the following.

- Evidence on outcomes is based on the perceptions and experiences of prisoners and staff and has not been triangulated with objective evidence on outcomes.
- Guidance was provided to prisons on a desirable sample for interviews, including types of job roles for staff and prisoners at different stages of the DRW pathway. Nevertheless, prisons had the final choice over the individuals who were interviewed and this may have introduced bias into the research (e.g. prisons may have chosen those whose views were more favourable).
- It was not always possible to interview the desired cross-section of interviewees at every prison – for example, due to staff being on leave, or not having a prisoner available for interview who was at specific stages of the DRW pathway. This meant that, sometimes, evidence from a particular perspective was limited in some prisons (e.g. it was often not possible to speak to prisoners who had left the DRW). However, on the whole, the programme of interviews was successful, with the original target of 16 interviews per prison met or exceeded in all prisons visited.
- It is also important to note that this is a process evaluation. Process evaluations take place at an earlier stage than impact evaluations and focus on implementation fidelity and context. Accordingly, this evaluation does not attempt to formally measure the impact of DRWs (e.g. using a robust counterfactual impact evaluation methodology). To do so would require an impact evaluation which would need to be commissioned separately.

2 Implementation of the DRWs

This section sets out how the DRWs were set up and delivered.

2.1 Setting up the DRWs

National stakeholders reported that the design of the DRW programme was informed by political priorities as well as previous experience of delivering DRWs; recovery research from USA which emphasised the importance of physical separation and a strong sense of community; the Dame Carol Black review (Home Office & DHSC, 2020); and consultations with stakeholders. The focus on an abstinence-based model was a government priority at the time. The DRW framework was developed to support prisons with implementation and NHS England facilitated the preparation of a specification for substance misuse services (SMS) providers, for use in local commissioning of the psychosocial interventions in the DRWs.

DRW prisons were selected for participation based on their expression of interest and an assessment of suitability by the national programme team. This assessment was largely driven by discussions with prison governors on key DRW characteristics as opposed to objective data. A key factor considered when selecting sites was the level of engagement with the national team, as it was felt that more engaged prisons would be more likely to prioritise the DRW (and therefore they would be more likely to succeed). Other considerations included the space available for a DRW and the ability for the prison to commit staff to DRW delivery. Working groups with selected sites were established, along with an oversight board. Eight prisons were initially granted DRW funding, but funding was later withdrawn from two prisons due to lack of compliance with the DRW model. At an early stage of implementation, it became apparent that there was an insufficient number of prisoners in cohort 1 - those with opioid substance misuse and dependency who were abstinent, including from OST (discussed in section 2.3). This led to the amendment of the cohort to include those with non-opioid substance misuse and dependency who were abstinent, including alcohol (cohort 2). As implementation of the DRWs progressed, the national team provided ongoing guidance to the DRWs, including site visits to better understand implementation on the ground and provide recommendations for improvements.

Prisons received £50,000 funding to set up their DRWs. Prisons reported spending this on: redecorating; furniture; repurposing existing spaces such as group rooms; gym and kitchen equipment; and equipment and supplies for other enrichment and entertainment activities. Some prisons also spent funds on other areas, such as staff training, IT and office resources, and improving prison areas outside the DRW.

Of the six case study prisons, five had set-up their DRWs from scratch, though they could sometimes build on previous experiences of wings focused on recovery for substance use. On the other hand, Holme House was able to build on the foundation of the Therapeutic Community (TC) which has been in operation for over 20 years. The DRW funding has augmented this existing TC offer by adding dedicated SMOs. Some prisons reported involving prisoners in DRW design and development through feedback gathering activities.

2.2 Delivery of the DRWs

This section summarises the features of DRW delivery. Limitations in the monitoring data (see section 1) should be noted. Full case studies on delivery in each prison can be found in Annex 1.

2.2.1 Cohort

Monitoring data shows that Cohort 1 prisoners (those with histories of opioid dependency and abstinent, including from OST) were often a minority on DRWs (averaging from as little as 3% up to 39% of the DRW population in each prison). This was corroborated during the case study visits. While the composition of the DRW populations changed over time, there was at least one month in three prisons where there were no cohort 1 prisoners. Cohort 2 prisoners (those with other drug/alcohol dependencies) were often the largest cohort - above 50% in most months in four of the prisons. There was considerable variation in the proportion of other prisoners (those not falling into Cohort 1 or 2) on the DRWs from month to month (from 0% to 100%) in all but one prison, which reported no prisoners in this category at all. This was likely driven by difficulties recruiting the preferred cohort and prison-wide capacity (discussed further in section 2.3). Each month, available capacity (free spaces) comprised less than 10% in four DRWs (two reported no capacity at all) and around 20% in the other two prisons. More detailed cohort data can be found in Annex 4.

2.2.2 Physical environment

There were no new buildings developed to house DRWs. Instead, prisons allocated an area in their existing estate as a DRW. DRWs were separated from other parts of the prison, but the extent to which full segregation was achieved varied (some were in fully segregated house blocks; others were separated by landings and gates). There were at least some shared spaces in all cases (e.g. gym facilities, visitation areas, dispensing hubs, outdoor spaces), and sometimes DRW prisoners (those residing on the DRW) had jobs outside of the DRW.

2.2.3 Regime

Regimes were at different levels of maturity across the six case study prisons. Most had developed over time, or had amendments planned (e.g. introducing/trialling more activities; efforts to improve segregation). In contrast, the longstanding drug recovery focussed regime at Holme House (the TC) was already well-established. Regimes included a structured psychosocial programme; peer support groups; structured wellbeing or recreational activities (e.g. art, exercise sessions, music, bingo etc) and unstructured activities like socialising and watching television; and staff-prisoner meetings (one-to-ones; group feedback sessions). A summary table with details on each DRW's regime is provided in Annex 5.

2.2.4 Psychosocial programme

Each of the six prisons had psychosocial interventions in place. Psychosocial recovery programmes on DRWs are delivered by SMS providers, and the NHS holds responsibility for commissioning these providers. The NHS England Clinical Reference Group advised against prescribing a specific psychosocial programme within the DRW framework. The Clinical Reference Group committed to consistent NHS service specifications, but gave commissioners and providers of psychosocial programmes flexibility to determine what could be delivered, to meet local needs. This meant the specific structure and format of the programme varied between prisons. Specifically, the programme length (ranging from 12 to 20 weeks), stages involved (inductions; aftercare/graduation), staff involved (primarily SMS staff, but with varying levels of SMO involvement), and content (all focused on addressing substance misuse and maintaining abstinence, but some encompassed harm minimisation or incorporated the SMART recovery model (SMART Recovery, n.d.)) varied to some degree.

Monitoring data suggested approximately half of DRW prisoners across the six prisons were in structured treatment, though this varied from 100%, to less than 40% across different prisons and different months. Some prisons reported months where there was no engagement. However, the data limitations (see section 1) should be considered in interpreting this data.

2.2.5 Staffing

Staffing on DRWs was largely similar. Management comprised a Drug Strategy Lead (DSL) at a senior leadership level, and a CM (usually ringfenced to the DRW) on a day-to-day basis. DRWs each had three SMOs who were ringfenced in all but one prison, where there was a larger pool of SMOs that were rotated across prison wings. DRWs had SMS staff delivering the psychosocial recovery programme (ranging from just one staff member, up to eight in one DRW). There were also administrative staff – typically one staff member in each DRW who supported with tasks such as DRW referrals, assessment processes, supporting drug testing and data entry. There were also residential officers (ROs) working on DRWs, either ringfenced or as part of a regular rotation.

2.2.6 Safety and security

A range of measures were in place with the aim of keeping the DRW a substance-free environment. DRWs had prisoner vetting processes, including additional criteria (decided upon at prison-level) beyond those required by the DRW framework (see cohort requirements in section 1.2). For example, not permitting those with a history of drug supply/dealing or Organised Criminal Gang (OCG) association to join the wing. DRW management and SMS staff met to discuss the DRW cohort and applicants, and DRW prisoners could be given a warning or deselected following UTIs or other drug-related behaviour (often with a “two-strike” policy, although more leniency was sometimes applied in practice). Prisoners may also be de-selected from the wing for other reasons (e.g. abusive behaviour). Monitoring data suggested that, on average, an equivalent of 10% of the cohort are de-selected in a given month across the six DRW prisons.

Other security measures included behavioural agreements with DRW prisoners; regular drug testing (averaging 1.4 drug tests per prisoner per month in monitoring data); efforts to avoid the risk of sharing medication (e.g. monitoring/checks by staff to ensure medication consumption and scheduled access to the medication hatch to prevent cross-over with the general prison population); prisoner and cell searches for substances; intelligence sharing between DRWs and prison security; use of drug detection dogs or Trace Detection

Equipment (handheld scanners); and removing materials that could be used to produce illicit substances (e.g. excess fruit and bread, pillows and mattresses, which may be used to brew alcohol).

2.2.7 Prisoner pathway

Monitoring data (from the five prisons that provided data on the prisoner pathway) suggests that the pathway envisaged by the DRW model (see section 1) was generally not followed in practice. Most (86%) of the DRW cohort were located in the general prison population prior to entering the DRW - only a small proportion had moved to the DRW from the ISFL (13%) or elsewhere (1%). When prisoners moved away from the DRW, it was most likely to be the general prison population (53%), for release (28%) or elsewhere (14%) - only a minority were moved to an ISFL (5%).

Prisoners could self-refer to the DRW or be referred by staff. Staff reported identifying relevant prisoners in the induction wing, either through formal screening processes or by informing new prisoners about the DRW. Staff also engaged with prisoners where substance use issues were identified and through targeted keywork. Some prisons had established relationships with other local prisons too, enabling them to refer in to the DRW.

2.3 Enablers and barriers to implementation of the DRWs for the national team

This section sets out the factors which were identified as enablers and barriers to the set-up and delivery of the DRWs from the perspective of the national team that oversaw programme delivery.

2.3.1 Enablers

The following elements facilitated DRW implementation by the national programme team.

- **Experienced and committed national team**. National staff involved in DRW implementation commended their national team colleagues for pushing the programme forward and their commitment to making the programme a success, despite the various barriers encountered. This included spending time supporting the DRW prisons with implementation, which was well received by the prisons themselves (discussed further in section 2.4).

- **Funding allocation for prisons**. There was consensus among the national team that the set-up funding (£50,000) and staff allocation (CM, two SMOs and an administrator) for each DRW prison was generous, facilitating the set-up of the programme.

2.3.2 Barriers

There were several barriers to DRW implementation which had to be navigated by the national team.

- **Rapid pace of roll-out**. The DRW programme was a government priority at its inception, which meant the programme had to be designed and set up quickly. This meant a significant amount of work for the national team over a short period. It also had several knock-on effects, including:
  - **Insufficient time to fully assess prisons for DRW suitability**. This resulted in some prisons being selected for DRWs which were deemed less suitable in hindsight - for example, due to the way they were built (size, structure and facilities available), the prisoner demographic, or because of the lack of buy-in from key prison leaders. There were similar findings in the evaluation of the first DRWs (Lloyd et al., 2017a).
  - **Initial lack of DRW framework**. The fast turnaround meant DRW prisons were chosen and had to set up their DRWs before the DRW framework had been drafted. The lack of a consistent set of criteria to refer to contributed to different approaches and some initial confusion about implementation.
- **Gathering input into programme design.** Key stakeholders were engaged on DRW programme design, including prisons, SMS providers and NHS representatives. Some interviewees (from both prison and healthcare backgrounds) felt the healthcare perspective was not adequately integrated into programme design. There were DRW features (e.g. requiring OST abstinence) which were a point of contention from a healthcare perspective. Some interviewees reported difficulties engaging with healthcare representatives (e.g. regional NHS commissioners). Nevertheless, suggestions were made for earlier collaboration or co-design of recovery programmes with key healthcare partners to better incorporate their expertise into programme design (e.g. NHS England, NHS Wales, and Collective Voice – a drug and alcohol treatment and recovery charity).

- **Resourcing pressures.** The national team encountered capacity challenges due to the high volume of work required to set up the programme over a short period. This was exacerbated by the departure of a key staff member. Additionally, initial plans to roll out DRWs in more prisons meant there was a period where the team had less time to support those DRWs that were already in the process of setting up, as they were busy engaging with other potential DRW prisons.

- **SMS commissioning structure and provider availability.** As described in section 2.2, psychosocial recovery programmes on DRWs were delivered by SMS providers who are commissioned by NHS England (or NHS Wales for Welsh prisons). The NHS England Clinical Reference Group advised against mandating a specific psychosocial offer within the DRW framework, on the basis that this should be determined according to local need. However, this limited the ability for the national team to provide guidance to DRWs on what their psychosocial intervention should look like, or how it should be delivered. In turn, this was perceived as a gap in the DRW framework by prison staff and contributed to inconsistencies across DRWs (discussed in section 2.4). One staff member felt there was a lack of national SMS providers, and providers were often strategic about which contracts they would bid for (e.g. some providers may have a 'stronghold' in a particular area), which would make it difficult to achieve consistency in SMS providers and psychosocial interventions across DRWs. Also highlighted was the lack of definition as to what recovery meant in the context of a DRW, therefore making it difficult to establish what a successful SMS programme looked like.

> *"It should be like going to hospital. [You don't] pop in and get told 'we've got a number of different people who can fix [that] for you'… Why is it addiction suffers from that? … But when it comes to services, if you can't define recovery, then you can't challenge the fact that recovery is not being delivered." – National staff member*

2.4 Enablers and barriers to implementation of the DRWs within prisons

This section sets out the factors which were identified as enablers and barriers to the set-up and delivery of the DRWs within the prisons.

2.4.1 Enablers

The following key features were identified as enabling the set up and delivery of DRWs in prisons.

- **Buy-in from Senior Leadership Teams (SLTs)**. Where prison leadership – and Number 1 / Governing Governors in particular – supported the DRW, there were fewer operational barriers. In two prisons, changes in Governing / Number 1 Governors were felt to have led to dramatic improvements in the DRW including enabling the DRW to move to a new and improved location, and ensuring DRWs were appropriately resourced (e.g. ringfencing SMOs). In another prison, the Governor's endorsement for the DRW was helping to increase awareness and support for the DRW across the leadership team, who could cascade this down within their respective departments to progress towards a prison-wide culture that supported the DRW. A senior leader in one prison stated that strong leadership helped to maintain the right cohort on the DRW. Limited SLT engagement highlighted the importance of leadership support for DRW sustainability and was a key consideration in the decision to end funding for one prison. The importance of buy-in from prison leadership was also identified in the pilot DRWs (Lloyd et al., 2017a).

> *"[Maintaining the DRW] requires a leadership team across the jail that understands and buys into it…that's what we've got now, that's directed from the number one, who's absolutely rock solid on it." – Leadership staff member*

- **The DRW being located on a desirable wing**. This gave DRWs a positive reputation among prisoners, increasing their interest in being housed there, and resulting in a longer waitlist of those wanting to join the DRW who fitted the cohort requirements (histories of dependence, and current abstinence from OST, drugs and alcohol). Having an adequate waitlist was important: when there was no waitlist or the waitlist was very small, DRWs were at greater risk of empty cells being filled by unsuitable prisoners due to prison population pressures. One prison relocated their DRW to a more desirable location (e.g. single cell occupancy with in-cell sanitation and shower facilities) and saw their waitlist increase as a result. This meant they could immediately fill any DRW spaces with the right cohort, 'protecting' the DRW from prison population challenges.

> *"[Before relocating the DRW] we'd go on the day to collect the person who's coming over [to the DRW], and he'd go … 'I've spoken to a few people, it's [bad] over there, I'm not coming'. And we'd go – ****, we've got a space, we're vulnerable, we're sitting with an empty cell, we've got inductions coming in - we're going to end up with a high-risk bully, a drug dealer, whoever it might be, just because we've got a space." – Leadership staff member*

> *"We put as many privileges as we can afford into [the wing that encompasses the DRW and ISFL] to ensure prisoners engage with the services available and that we assist them to be abstinent and reduce their reoffending and addiction*

issues...[it] works for us, we do find that privileges and things we use as levers for prisoners do work, generally." – Leadership staff member

- **Effective and experienced DRW leaders**. There were often bureaucratic and process hurdles to overcome to operationalise DRWs (e.g. gaining prison-wide buy-in, health and safety, expenditure – discussed in section 2.4.2 below). As such, DRW leaders had to be persistent in driving forward changes to strengthen the DRW's operation, which was helped by having experience of the prison system and substance misuse services.

- **Enthusiastic and committed DRW delivery teams**. Prisons highlighted the need to recruit suitable staff to deliver the DRW. While their prior experience was a consideration, a genuine interest in recovery was frequently highlighted as their most important asset. Operational staff (the CM and SMOs) were key to the support available to DRW prisoners (delivering group activities and providing one-to-one assistance) as well as the day-to-day running of the DRW. Commitment to the DRW concept was essential to creating a recovery environment that aligned with the DRW framework.

"The staff we recruited fully bought into the community ethos and they owned it." – Leadership staff member

"I am quite emotionally invested in what we do… I thought actually we can do something, we can make a difference." – DRW staff member

- **Ringfenced DRW staff**. Redeployment of ringfenced staff to other parts of the prison negatively impacted the DRW regime by interrupting planned activities. This had largely been addressed by the DRWs so that ringfenced staff were permanently based there. The positive impact this had on DRW operation was frequently mentioned. In a prison where the CM was still regularly redeployed, staff reported unsuitable prisoners were being moved on to the DRW when the CM was not there to oversee it.

"Having dedicated staff, that's been an absolute game changer." – Leadership staff member

Interestingly though, the importance of ringfencing DRW staff appeared to be less crucial in the setting of a women's prison – SMOs worked in rotation on other wings, allowing time away from the more intense emotional burden they associated with the DRW, and enabling them to address negative attitudes towards the DRW in the wider prison.

- **Change to cohort requirements**. Prisons reported difficulties finding a sufficient number of OST-abstinent prisoners with a history of opioid dependency to populate the DRWs.

Reasons included difficulties encouraging those on OST to taper off, prisoners who were already abstinent from OST and settled in other areas of the prison and therefore disinterested in the DRW offer, and the disinclination of staff on other wings to promote the DRW to potentially suitable prisoners who fit the Cohort 1 requirement (e.g. as they were sceptical about the DRW or they wanted to avoid well-behaved prisoners being moved away from their wing). The expansion of the primary cohort requirements (to include both prisoners with opioid substance misuse who were abstinent, including from OST, and prisoners with non-opiate substance misuse who were abstinent) was therefore welcomed.

- **National programme team support for DRW implementation.** Leadership staff for several DRWs mentioned the support they received from the national programme team through the Substance Misuse Group (SMG). The SMG were described as approachable and willing to help, with a genuine interest in making the DRWs a success. This helped DRW leaders to clarify elements of design and delivery.

- **The DRW funding**. The £50,000 set-up funding had enabled the prisons to make various enhancements (see 2.2), though there were some obstacles to expenditure in two prisons – these are discussed in section 2.4.2 below.

- **Collaboration between DRWs.** Sessions coordinated by the SMG for all the DRW prisons provided a forum for sharing knowledge and learning from one another. Some staff had visited other DRWs to understand how they operated, giving them ideas for improving their own DRW. In one prison, SMOs described taking on approaches to delivering the regime which were shared with them by SMOs in another DRW.

- **Good working relationships between SMS providers and DRW prison staff.** Collaboration between these teams was seen on the delivery of the psychosocial intervention offer on some of the DRWs, through the sharing of relevant data and intelligence (as prison staff and SMS providers used different data management systems), and/or in the development of joined-up approaches to managing the DRW cohort. For example, in some prisons, SMS staff were facilitating the identification of potentially suitable prisoners for the DRW and promoting it in their work with prisoners on other wings.

"It doesn't feel like there's an "us" and "them" [between prison staff and SMS providers], it doesn't feel like there's a divide…I think they all just work really well together." – Leadership staff member

Where partnership working between DRW leadership and the SMS provider was less well established, this created additional challenges for the DRW and was a factor in the decision to discontinue funding.

- **Establishing a brand for the DRW**. Some of the prisons felt creating an identity for their DRW was beneficial for raising awareness of the DRW, attracting prisoners, and giving prisoners on the wing a sense of pride. They gave their DRWs a unique brand – for example, the Phoenix Unit at Swaleside and Recovery and Change at Erlestoke. Holme House maintained their pre-existing branding as a TC. The branding was displayed throughout the wing and was thought to demonstrate an explicitly different, more supportive environment than the rest of the prison, removing some of the stigma around the wing being for drug users.

- **An established whole-prison approach to drug recovery**. Holme House had an existing wing focused on recovery, with a distinct externally commissioned substance misuse service offer, that had been funded for many years, underpinning the success of the wing. This meant the infrastructure to support recovery was well-developed, and staff working on the DRW were experienced in substance misuse. Additionally, the practice of retaining senior prisoner mentors on the wing, ensured that the recovery culture of the wing remained embedded between programme cycles.

2.4.2 Barriers

The following elements were identified as barriers to the set up and delivery of DRWs.

- **Gaining prison-wide buy-in**. Competing prison priorities and scepticism about DRWs among some prison staff not directly involved in DRW delivery had a knock-on operational impact. Issues included allocated slots for DRW prisoners to use the medication hatch or to get food being ignored, doors between the DRW and general prison population wings being left open in shared buildings, resistance among wider prison staff (at all levels of seniority) to plans to move a DRW to a more appropriate wing, and staff on other wings discouraging prisoners from relocating to DRWs.

"People might begrudge [the DRW] on the one hand, but if you really say, "would you have it any other way", I suspect the answer would be no." – Leadership staff team

Evidence of the importance of wider prison buy-in to DRWs was seen in Holme House, which already had a long-term substance recovery initiative (established 26 years ago) (see also Ayres et al., 2023). Staff considered buy-in from the wider prison, and particularly the SLT, a contributing factor to its success.

- **Stigmatisation of drug users**. There was a feeling that some wider prison staff had negative opinions of drug users, and therefore did not understand why this prisoner group should benefit from an enhanced wing (also seen in the DRW pilots) (Lloyd et al., 2017a). This contributed to the challenges of gaining prison-wide support. Some DRW delivery staff described receiving negative or critical comments about their job roles (e.g. being called *"fluffy"* or *"soft"*) due to their focus on supporting recovery, making their job feel more difficult at times. In some cases, stigma came from other prisoners too – for example, the DRW at one prison initially had a reputation as a Vulnerable Prisoners ('VP') wing,[4] housing people who were undesirable to associate with (e.g. sex offenders and *"spiceheads"* who were in debt) and where drugs were widespread. This contributed to difficulties attracting the target cohort of prisoners.

"You do get slack from the rest of the establishment for working on drug recovery. [It's] because of what we facilitate… people think about, why do we get these extra things? Why do we get the extra facilities? The extra activities? We get called 'fluffy'." – SMO

- **Limitations of the physical environment**. Identifying a suitable space for the DRWs was difficult. The structure, size and capacity of wings both within individual prison sites and across prisons varied. Creating a community feel on wings with a large amount of capacity was challenging, limited availability of group rooms impacted ease of regime delivery, and the DRW impacted the wider prison by reducing capacity for the general prison population. This meant fewer options for relocating prisoners (e.g. due to violence, debt and/or gangs). The challenge was amplified by the broader prison estate context, which was operating at 99% of its usable operational capacity (Jones and Lally, 2024). In one prison, this meant that moves between wings were complicated and sometimes required moving multiple prisoners across several days to achieve a satisfactory placement. This also introduced a

[4] A Vulnerable Prisoners wing or unit is a separated from the general prison population and houses prisoners who may be at risk from others (e.g. due to debt or the nature of their offence).

risk that the DRW may need to house prisoners that did not meet the cohort requirements, in the event that no other suitable space could be found. It was also difficult to keep prisoners within the confines of a DRW at all times as some facilities could only be accessed away from the DRW (e.g. the prison gym / sports hall; visitors' areas). Some DRWs were in buildings shared with the general prison population, increasing the difficulty of preventing prisoner mixing. There were also limitations in relation to staffing set up: several SMS and DRW staff felt it would be helpful if they could work from within the same office space on the DRW to more easily share information and tasks, but there was no location which could fit the number of desks required.

- **ISFL capacity**. ISFLs (wings housing prisoners who commit to living in a drug-free environment, part of the DRW pathway – see section 2.2) often housed long-term prisoners who wanted to live in a drug-free environment. Spaces in ISFLs were therefore not frequently available. Additionally, some prisons had a lower number of prisoner spaces on their ISFL than their DRWs. Together, this impacted prisons' ability to move prisoners that had completed the DRW programme off the DRW, as there was nowhere for them to go. In turn, this affected the flow of prisoners onto the DRW as they had to wait until a DRW space became available.

- **Bureaucratic issues impacting funding expenditure**. The £50,000 set-up funding for the DRWs had to be spent within a short timeframe (around 3-4 months) and only approved suppliers could be used. These suppliers did not necessarily sell the equipment which staff wanted for DRWs (e.g. limited selections of soft furnishings and electronics, not selling supplies like paint or art products) and their prices were felt to be overinflated. A workaround was use of a prison credit card to buy items from non-approved suppliers, but leadership staff had to spend time explaining and justifying purchases above credit card limits. At one prison, there was a perceived misunderstanding about whether funding was exclusively for the DRW or wider prison activity. This led to funds being spent on elements outside the DRW. An additional challenge for DRW leaders at this prison was overcoming health and safety concerns raised about certain purchased equipment being located on the DRW and accessible to prisoners (e.g. permission to buy cardiovascular gym machines was initially refused due to the risk assessment).

- **Staffing arrangements**. DRW staff absences (e.g. due to leave, training or sickness) and departures (e.g. promotions, leaving their role) had a knock-on impact to DRW regimes.

This included prisoners having to spend more time in their cells (*"on lock-up"*), adjustments to the regime (e.g. removing or changing the activity offer), or pausing ongoing projects intended to strengthen the DRW. Some prisons experienced staff recruitment pressures, consistent with pressures facing the wider prison system (e.g. HMIP, 2024). In one prison, the high proportion of junior staff, who were still learning how to engage with and motivate prisoners, was highlighted as a challenge by both staff and prisoners.

- **Drug availability in prisons.** The widespread presence of drugs in prisons was a threat to the DRWs' operation, as abstinent prisoners were an attractive target for drug dealers. This contributed to difficulties for prisons when it came to keeping drugs off the DRW and vetting potential DRW prisoners. Examples were shared of drug dealers working to fulfil the DRW criteria, only to *"flood"* the wing with drugs once admitted. Some staff perceived drug availability within their prison to be rising, in part due to the difficulties preventing and spotting *"drug drops"* by modified drones, which are immune to signal jamming technology.

- **Gaps in the DRW framework on regime and staff training**. The framework lacked information about the type of recovery programme required – both in terms of the structured activity and psychosocial recovery intervention (the framework was intentionally non-specific on psychosocial interventions – see section 2.2). This meant DRW regimes varied across prisons: each DRW differed in the range and frequency of activities offered, and the structure and time requirement of the psychosocial intervention. Another gap identified was the lack of information about the specific training DRW delivery staff (the CM/SMOs) should undertake. Training events organised by the SMG that took place in Summer 2024 were useful, but SMOs joining since then had not been able to benefit from it. Greater clarity on these areas would have made operationalising the DRW easier and improved consistency across the DRWs.

> *"The most logical thing that I can think of is that there should be a structured course in the same way that you get accredited interventions … Nothing that we deliver on in these courses is approved… there's no integrity to what we're delivering. We're delivering on good faith, good intentions. And we're letting prisoners kind of lead the way in what kind of things they want to discuss." – Leadership staff member*

> *"Why isn't there a national standard [for psychosocial interventions on DRWs]? That's my question. Because if you've got someone that that might want to transfer, they might have done half a course somewhere, but for whatever reason, need to stop the course to move… I think we've possibly got a way to [go to] standardising things." – Leadership staff member*

- **Ongoing resource constraints.** In some cases, consumable supplies purchased with the initial £50,000 set-up funding were running low (e.g. for creative activities such as art and creative writing, and cooking classes). However, there was no budget available to restock these items, thereby limiting what SMOs could deliver.

- **Suitability of the prison population for the DRW regime**. At two DRW prisons, prisoner stays were relatively short. For example, Birmingham was a reception prison, so many prisoner stays were temporary until they could be relocated to other prisons. New Hall was a women's prison, and average sentences were shorter. This had a knock-on impact on DRW delivery, as prisoners needed enough time on the wing to benefit from the regime and intervention offer. Conversely, at Swaleside, where some prisoners had long sentences, the point at which a prisoner was in their sentence influenced whether they were interested in the take up (with greater interest among prisoners closer to the end of their sentence).

- **Differences between men and women's prisons**. One of the DRWs was in a women's prison. As well as the shorter average sentences among women, other characteristics which were seen to differ from men's prisons were the higher levels of order and discipline with the prison regime, the trade in drugs tending to be prescription medication diverted from the medication hatch (as opposed to SCRAs in men's prisons), the types of trauma prisoners had, and the contribution of this trauma to use of substances (see also Grace et al., 2016; Corston, 2007). While not explicitly mentioned during interviews, existing research also suggests past relationships are more likely to be an influencing factor in women's substance misuse (e.g. being introduced to drugs by men they are in relationships with, having experience of sex work, and/or domestic abuse) (Corston, 2017; Light et al., 2013). These differences were seen as not sufficiently considered or addressed within the DRW framework. The psychosocial intervention offer of SMS providers was also seen as tailored towards the men's estate.

3 Factors influencing the outcomes and impact of DRWs

This chapter sets out the characteristics of DRWs that were perceived by research participants to have worked well and less well, in terms of influencing the outcomes and impact specified in the ToC (see Annex 3), namely drug and drug substitute abstinence and increased mental and physical health and wellbeing (outcomes) and reduction in reoffending in prison and on release (impact).

3.1 What worked well

The following characteristics were identified as facilitating the effectiveness of DRWs in achieving their outcomes, a number of which accord with the DRW ToC and some of which enhance or extend the mechanisms envisaged in the ToC.

- **Positive relationships between prisoners and staff (ToC – motivated staff)**. DRW staff were often described as approachable and willing to help by prisoners. The CM and SMOs had more time to provide direct support to prisoners than prison officers working with the general prison population, and prisoners recognised and valued this. SMS provider staff were similarly noted by prisoners for their assistance and understanding of substance misuse. This cultivated positive, trusting relationships between prisoners and staff on the DRW, which meant prisoners were more likely to seek support from staff in situations that put their recovery at risk. For example, by letting staff know if there were drugs on the wing or if another prisoner was using or dealings drugs, or if they were feeling like they may relapse (e.g. after receiving bad news).

> *"[If] you're committed to getting clean, this wing is the best place you're getting. You've got staff that'll help you, mentors that'll help you. The [recovery intervention lead] is one of the greatest women I've ever met… she puts the effort in, no matter how much people struggle." – DRW prisoner*

> *"Everyone, especially [SMS staff] help a lot. They give you a lot of ideas on how to be a better person, basically. [The officers] do what they can to help, they point you in the right way. " – DRW prisoner*

- **Peer support and group work (ToC – enhanced goal expectations; skills enhancement).** DRW prisoners described being able to relate to peers on the wings as they had similar experiences with substance misuse. Those earlier on in their recovery

journey described how hearing from prisoners who had been abstinent for longer made them feel more confident that they could achieve the same. Some said that hearing about the negative impact substance misuse had on the lives of their peers motivated them to continue their recovery journey, as they did not want to experience the same. For some prisoners, group work had helped them understand the underlying reasons for their drug or alcohol use (e.g. childhood trauma, pre-existing conditions, to cope with negative emotions or difficult situations). Several prisoners also described having picked up skills and coping strategies for remaining abstinent through group work. The value of peer mentors was noted too – they helped those new to the DRW to understand the regime and expectations, and could reach out to prisoners who were struggling.

> *"When I've gone and listened to people, you can actually hear them getting their point across and it can change your life. It does actually work ... When you're in addiction you don't really think it's a problem… But when you listen to people's stories, you can relate to it and think, you know what, it could be you one day if you don't sort it out." – DRW Prisoner*

- **A culture and environment conducive to recovery (ToC – absence of psychological triggers; distraction; enhanced goal values)**. Prisoners and staff noted the difference in the *"feel"* of the DRW compared to other wings for the general prison population. DRWs were described as calmer, safer, cleaner, more relaxed and with more social areas, helping to reduce prisoners' inclination to use drugs. Most the DRWs appeared to have fostered recovery-focused communities to some degree, with prisoners often describing a personal desire to remain abstinent and to support their peers on their recovery journeys too. Key to building this culture and environment was ensuring the right cohort of prisoners were on the DRW (i.e. those with a genuine desire for recovery), and action being taken remove prisoners from the DRW where they presented a risk to the community.

> *"We're all here to try and stop taking drugs, and stay clean, and a big part of it is supporting each other. From the older generations … for me to be sat there listening to their stories, they're still going through it and tell you where they were going wrong, and give you advice." – DRW prisoner*

> *"If you want to get off drugs in prison, this is the only wing you can do it on… the only wing you can get any respite. I called it the lifeboat. It was like someone had pulled me out of a raging sea into the safety of a lifeboat." – DRW prisoner*

- **Involving prisoners in DRW delivery (ToC – extension to mechanisms)**. DRWs actively involved prisoners in regime delivery to at least some extent. This included supporting or delivering group sessions, providing one-to-one support to peers, leading on

delivery of activities (e.g. fitness classes, arts and crafts), as well as a range of other tasks – such as assisting with the vetting of other prisoners who wanted to relocate to the DRW, or having cleaning or catering responsibilities. Some prisoners also commented on their ability to influence the DRW's design and operation, which they felt meant the DRW was more suited to supporting their recovery – for example, suggesting equipment, furnishings or activities for the wing, or topics they wanted to see covered during group sessions. One prison had a 'you said, we did' board on the wing, to show how they are taking prisoner feedback into account. Ultimately, this helped to foster a sense of ownership over the DRWs among prisoners, and therefore their interest in upholding the recovery culture. For prisoners in peer mentorship roles in particular, the opportunity to help others often benefitted their own wellbeing – they were pleased to support the recovery journeys of their peers, and some were even hoping they could continue in similar a role when they were released from prison.

> *When we set it up, we made it very clear that we were going to go down the Therapeutic Community route. That's what we wanted. And it really worked because we got every member of staff involved. We'd taken their ideas, we'd had forums, we had consultations. What do you guys want to see? What do you think will work? So it was kind of every single person's opinion matters. And that included prisoners." – DRW staff member*

- **A regime that keeps prisoners occupied (ToC – distraction).** Several prisoners and staff members alluded to boredom making drugs more attractive while in prison. Providing a regime with group work and activities, an environment with options for entertainment (gyms or cardiovascular ('CV') rooms,[5] TVs and games consoles, pool tables, board games etc.), and giving prisoners more time out of their cells than the general prison population, gave those on the DRW ways to occupy their time. This benefit was especially strong at Holme House, where the regime ran over a full seven days (as opposed to weekdays only). Physical activity appeared to be particularly beneficial, with several prisoners highlighting the difference it made to their wellbeing and how they felt about drugs.

> *"[Exercise]… releases a lot of endorphins and dopamine and stuff like that is vital to giving you a big pep, if you will, to be able to do what you want to do. And*

[5] Some gyms contained cardiovascular equipment only (treadmills, static bikes, rowing machines, cross-training machines) due to weights being deemed a higher risk. Accordingly, some staff referred to them as cardiovascular or 'CV' rooms.

it's positive replacement therapy in my mind. And I think you can take your time from something that's negative and do it positively." - DRW prisoner

"Devil makes work for idle hands, right?" - Leadership staff member

- **Minimising mixing of DRW prisoners with the general prison population (TOC – absence of psychological triggers/ temptation)**. This reduced the risk of drugs entering the DRW, and therefore reduced the opportunity for DRW prisoners to use them. Mixing was minimised across the prisons by having the DRW in a physical location which was segregated from the general prison population, and by limiting the amount of time DRW prisoners spent moving around the prison (though there were some wider prison constraints – see section 2.4). However, some prisoners did feel that regardless of the level of mixing, if they wanted to get drugs they could. In one prison, DRW prisoners were unhappy with the increased level of suspicion they were subject to by staff after visiting shared spaces.

3.2 What worked less well

Despite the positive features of the DRWs that supported DRWs achieving their outcomes, there were some elements of the wings that were seen as working less well. Some of these factors reflected elements of the DRW not being implemented as the model intended, others the fact that the complex prison environment posed challenges to delivery, while some appeared to relate to issues with the model itself.

DRW not implemented as intended

- **Limitations in the delivery of psychosocial interventions**. There were mixed opinions on the extent to which each DRW's psychosocial intervention was adequate. Issues raised in some prisons included the frequency of the sessions being insufficient (there was a preference for delivery across five days per week) and scepticism about the extent to which the sessions effectively engaged prisoners. These issues were less prevalent in DRWs with close working relationships between prison staff and SMS staff.

- **The presence of lodgers**. Some of the DRWs were intermittently housing 'lodgers' – prisoners who were not in the target DRW cohort and who were not participants in the DRW regime. In some cases, lodgers were a disruptive presence to the other prisoners on the DRW – they were not part of the DRW 'community', and they could exhibit behaviours which affected other prisoners such as substance use or general non-compliance. In one

prison, staff described how the DRW was a relatively calm environment, making it an attractive location (from a prison-wide management perspective) to move prisoners after they had spent time in segregation. However, their behaviour could be problematic, affecting regime delivery while DRW staff responded. One prisoner described the prison as feeling *"like a hospital"* as a result. Lodgers also occupied space which could otherwise benefit a prisoner in the target DRW cohort.

> *"[There's] one guy up [on the DRW] who's done the program before and failed. He was always under the influence. He was using an opportunity to sell his drugs on here because he knew it would be an easy target and he was also bullying. So he got thrown off … [but] on one of the days that I wasn't here, we got ordered to take him [as a lodger on the DRW] because I've got a single cell. Consequently, now I'm stuck because nobody else wants him because he's bullied and sold drugs all around the jail." – DRW staff member*

Challenges to implementation

- **Managing prisoner compliance**. To support prisoner recovery, DRWs needed to house those who (a) had genuine recovery needs (e.g. a history of substance misuse), and (b) a genuine desire to recover from substance misuse. Prisoners making it on to the DRW disingenuously (e.g. motivated by the nicer environment, or because they saw it as an opportunity to sell drugs) could negatively impact the recovery of other prisoners. However, this could be challenging for staff to manage – sanctioning processes were not always effective, and some staff and prisoners felt those repeatedly breaking the rules should be more quickly relocated. In one prison, a previously sanctioned prisoner was moved back on to the DRW as a lodger.

> *"At one point it (drug presence) was pretty bad. But it goes through, you know, stages where it gets bad and they kick a few people off. Then it goes quiet and sometimes picks back up." – DRW prisoner*

An exception to this was New Hall, where no UTIs or positive tests had occurred. This was in line with the wider context of women's prisons, where overall compliance tended to be higher than in men's prisons.

- **Limits to drug testing procedures**. CBDTs were carried out through oral fluid testing (OFTs), however OFTs could not detect synthetic drugs such as SCRAs (colloquially known as *"spice"* or *"black mamba"*), and this appeared to be well-known among prisoners. MDTs were carried out through testing of urinary samples and could detect SCRAs, but processes for using them were slow and bureaucratic. Urinary sample tests

were more costly, and staff could not administer them themselves. This meant they had to notify the healthcare team if they suspected a DRW prisoner was UTI. Sometimes, MDTs would not be carried out until sometime after a suspected UTI, so it would not be detected. These issues made SCRAs an attractive option for DRW prisoners wishing to use drugs as they were less likely to get caught. DRW staff and several prisoners suggested these testing procedures would benefit from being strengthened. Similar findings were seen in a study on ISFLs (RAND Europe, 2024) and a study on use of SCRAs in prisons (Grace et al., 2020).

"They do voluntary drug testing, but it's pointless …everyone goes and does the drug test and comes back negative, because they don't test for spice." – DRW prisoner

- **Disruption to the regime and disconnected staff teams**. This included planned sessions, activities, or time outside cells being changed with little notice, prisoners being locked up or unlocked at the wrong times, and confusion about the responsibilities of different staff (i.e. SMOs and ROs). This led to frustration and boredom among prisoners. These issues were largely caused by staffing problems (absences and redeployments), prisoner disruptions and behaviour, and lack of coordination between the different teams involved in DRW delivery (CM and SMOs, ROs and SMS staff). One prison had started DRW-wide team meetings to include all staff on the DRW, though the effectiveness of this approach was yet to be established.

Issues with the DRW model

- **Balancing prisoner risk with DRW accessibility.** As a specialist unit, DRWs had strict eligibility criteria (e.g. alignment with the cohort requirements; history of substance misuse; evidence of being committed to recovery; not being involved in drug dealing). One prison also excluded those with convictions relating to organised crime and dealing. These criteria were important: they were designed to protect the established recovery culture on the wing and enable the maintenance of a drug free environment. However, strict criteria may also act as a barrier to prisoner accessibility, excluding those most in need of intensive support to achieve abstinence, such as prisoners who would like to achieve abstinence but are struggling with substance misuse in general prison population due to the wider availability of drugs on those wings.

"We do cherry pick… unfortunately, to the detriment of the people who really need it." – Staff member

- **Requiring OST-abstinence**. There was some criticism about the initial requirement that prisoners to be entirely abstinent from OST prior to admission to the DRW which limited the pool of potential beneficiaries. There was a gap in services for those who wanted to achieve abstinence, but needed the type of additional support available on the DRW to get there. Accordingly, New Hall had made the decision to allow some prisoners on OST on their DRW providing they were committed to reducing their prescription. A non-DRW prison (Long Lartin) had recently introduced a unique concept combining elements of a DRW and an ISFL, taking in both abstinent prisoners and those on prescription working towards abstinence. UK clinical guidance (DHSC, 2017) emphasises the benefits of light-touch psychosocial intervention for people prescribed OST in forms such as motivational interviewing and contingency management. However, Raistrick (2017) notes that the focus and intensity interventions must be tailored to a service user's prescribing regime and treatment goals, with there being little value in delivering intensive psychosocial interventions to service users whose goal is maintenance, and potential challenges to engaging prisoners on higher doses of OST in ambitious, intensive interventions. Additionally, prescription changes had to be made by clinical staff. This could take a long time, which was problematic for prisoners on shorter sentences as it could leave them with insufficient time to complete the DRW programme. It also had to be led by the prisoner, as opposed to the views of SMS or DRW prison staff, which meant clinical staff had to be suitably convinced by the prisoner that pursuing abstinence was appropriate. Removing the cohort requirement for OST-abstinence would require updates the DRW framework and ensure DRWs are equipped to accommodate this group.

> *"I understand the logic, but those that are currently on opioid treatment OST have probably got some of the biggest issues, and you often find that those are the ones that have got the more deep underlying psychological issues behind using as well…I believe if they [prisoners on OST] were to integrate onto the DRW side, they would get heavier interventions that could address their needs... It's very difficult to get someone to reduce without providing that support alongside it." – DRW staff member*

> *"Being on a methadone script is not necessarily maintaining your drug use but it is maintaining your addicted mind … [you're still] chasing feeling better because you wake up feeling rubbish [and] you don't get taught it's normal to feel crap some days...[here at] the drug recovery wing you get shown and you get a better understanding that it's normal to have days to feel like crap." – Prisoner*

4 Progress of DRWs towards outcomes

The following analysis looks at progress made towards outcomes for prisoners and prisons based on the available evidence. However, the limitations of this evidence should be noted (set out in section 1).

4.1 Outcomes for prisoners

4.1.1 Engagement with DRWs

Outcomes:

- *prisoner improves their compliance with the regime (short-term)*
- *prisoner is engaged in holistic treatment to address their complex needs (short-term)*

In interviews, prisoners spoke positively about DRWs and frequently noted the benefits of their regimes compared to the general prison regime – having more time out of the cells, and more activities and entertainment. They reported willingness to comply with the regime and engage with the activities on offer, including the psychosocial recovery intervention. Quantitative data reinforced this, indicating that over half (60% or more) of DRW prisoners were in structured treatment since June 2024 (see section 2.2). Prisoners also described how their feelings (and the feelings of their peers) towards active participation in group sessions tended to improve as time went on and their initial apprehension about the DRW dissipated. As a result, they would begin contributing to discussions more and opening up about personal experiences. There was a sense that fewer prisoners self-isolated on the DRW compared to other wings.

Staff were generally positive about the level of engagement of prisoners on the DRW too. This was driven by the culture built on DRWs, which was influenced by the prisoners located there having a genuine desire for recovery and therefore willingness to comply with the regime and engage with the treatment offer. However, the maturity of the DRW culture varied among the prisons. Prisons did have processes in place to address prisoners who were not engaging with the regime or treatment (see section 2.2). Attendance at the recovery intervention sessions was mandatory, so non-attendance resulted in follow-up with the prisoner to understand why, and to offer support. If non-attendance continued and prisoners did not engage with support available, it was deemed

that they were not in the recovery mindset required to benefit from the DRW, and they would ultimately be relocated back to the general prison population. However, this process could take time and was impeded by wider prison factors, including lack of space on other wings, unwillingness of wider prison staff to support or enable the move (e.g. other wings would prefer not to house potentially disruptive prisoners), and availability of staff to enforce the move when prisoners refused to leave.

4.1.2 Physical and mental health

Outcomes:

- *prisoner's mental and physical health is improved (short-term)*
- *prisoner has gained confidence and is optimistic about their recovery journey (medium-term)*

Overall, DRWs appeared to contribute to improvements in the physical and mental health of prisoners on the DRW. Both staff and prisoners described rapid improvements in the visible health, presentation and personal hygiene of those coming on to the DRW. They also noted changes in their attitudes and behaviours over time – improved mood and ability to manage their emotions, greater awareness and application of tools to maintain their recovery (e.g. how to cope with negative situations to avoid relapse), greater willingness to seek support (e.g. from peers or DRW staff), increased optimism about their recovery and, for mentors in particular, a sense of 'purpose' and self-confidence. Staff and prisoners recognised abstinence itself as contributing to these changes, but also the DRW culture, environment and regime (discussed in section 3.1). In particular, prisoners noted the opportunities for physical activity, the ability to cook for themselves, and the calmer environment as key to supporting their physical and mental health. Other factors thought to be supporting prisoners' health included access to medications for health conditions (e.g. attention deficit hyperactivity disorder), which would not be provided if they were using substances, and improved engagement with healthcare services (which they would typically avoid if they were using substances).

> *"But even like for mental health because you do all stuff like that, you do like anxiety awareness and things like that. So then you start realising, well, wow, yeah, I was going to drink when I was stressed or I felt better when I drink because obviously from anxiety" – DRW prisoner*

4.1.3 Prisoner relationships

Outcome: prisoner develops positive relationships (short-term).

Prisoners were developing positive relationships on the DRW, both with other DRW prisoners, and DRW staff. Prisoners described how the judgement-free environment of the DRW, the openness encouraged in group sessions, direct peer support, and the honesty of their peers in sharing their experiences, all helped them to feel more comfortable to open up themselves. These honest conversations made it easier for prisoners to find a common ground, bond, and identify with one another's goals, which was not possible within the general prison population. This was similarly observed by staff, who saw prisoners' confidence to speak freely in front of others about their substance misuse increase over time – sometimes after just a few weeks on the DRW. Several prisoners acknowledged that the relationships built with DRW peers had led them to confront preconceived negative biases they may have held about other prisoners previously.

> *"It does help being on a place like this, like, you're not judged, people are supporting you because of what you've been through, but they've been through the same journey. There's people that are further on in their journey than what you are, so they know how to deal with you and what to do, it is really good…. There's staff who come check on you every week if you're looking down or your mood's not the same, they pick up on it, they're very good…. [compared to other wings] on here they notice it…and speak to you or they get your buddy to come and speak to you if you don't want to speak to them. It is good." - Prisoner*

Prisoners similarly reflected on DRW staff being more approachable and willing to help than prison staff they had interacted with when they were in the general prison population, which translated into improved relationships and perceptions of staff. These prisoner-staff relationships are discussed further in section 4.2.

4.1.4 Recovery behaviours

Outcomes:

- *Prisoner maintains abstinence from drugs and drug substitutes (short-term)*
- *Prisoner understand and has addressed factors underlying their drug use and offending (medium-term)*
- *Prisoner has developed protective factors and recovery capital (medium-term)*

DRWs were enabling prisoners to maintain abstinence from drugs and drug substitutes to at least some degree, but there were limitations. DRW prisoners who were interviewed emphasised their desire to remain abstinent and the DRW features that were supporting them to do so (discussed in section 3.1). Similarly, there was consensus among staff and prisoners that those with a genuine desire for recovery (and therefore a desire to remain

abstinent) were able to sustain this on the DRW more easily than was otherwise possible in the general prison population: drugs were less prevalent, and through the recovery intervention, prisoners could understand and address factors underlying their drug use (e.g. physical/mental health conditions, trauma, emotional challenges). Prisoners reported that the psychosocial support equipped them with tools and approaches to help remain abstinent and most felt they could easily access direct support (through staff and peers in mentorship roles), increasing prisoners' recovery capital.

"We're all in the same boat together... and if someone's using, it's like, oh come on man, what are you using for? We're all clean and we all get with it, get done with the activities, keep yourself busy to stay off the drugs." – DRW prisoner

"I've been in the job for 30 years and this is the best thing I've seen in tackling addiction in prison." – Senior staff member

However, as discussed in section 3.2, there was a challenge for prisons in ensuring DRW prisoners did have the desire for recovery, which was seen as the necessary precursor to helping them to maintain abstinence. Prisoners who did not have this ethos were reportedly more likely to use substances while on the DRW and/or negatively impact the abstinence of other prisoners. These prisoners were not always easily detected. Substance use was therefore not eliminated. This was reflected in their most recent data returns: between November 2023 and November 2024, 5% of 5,064 CBDTs were positive and there were 441 UTIs across all six DRWs. UTIs were lowest at New Hall (no UTIs over this period) and Holme House (one UTI), whereas there were between 48 and 145 UTIs in the DRWs of the other four prisons. This likely reflects the higher level of compliance in New Hall (as a women's prison) and the prior organisational expertise and established recovery programme at Holme House. It could also reflect the lack of lodgers at Holme House (none between November 2023 and November 2024, compared to between 56 and 144 at other prisons).

4.1.5 Future preparedness

Outcome: Prisoner is better prepared for return to ISFL, general prison population or release into the community (medium-term)

The DRW pathway intended for prisoners to move to an ISFL once they completed the DRW programme, but this was challenging in practice due to the limitations in ISFL capacity. As a result, prisons tried to avoid moving DRW prisoners back to the general

prison population, which meant some were continuing to stay on the DRW after completing the programme. Nevertheless, findings suggested it was likely that prisoners were better prepared for maintaining their recovery post-DRW, than had they not accessed the DRW intervention. DRW prisoners described being motivated to continue their recovery journey, often reflecting on the negative impact their substance misuse had on their families and friends and stating a desire to improve their life and wellbeing.

"I want a lot more in life than just taking drugs." (Prisoner)

They expressed confidence they could maintain abstinence using the tools and coping strategies learnt during group sessions when faced with triggering situations. A few prisoners alluded to their interest in physical activity and an intention to continue to be active outside of the DRW to help them maintain their abstinence. Staff were similarly optimistic about the DRW better preparing prisoners for the future. Some shared specific success stories of prisoners they worked with who had got back in touch with updates and letters of thanks upon their release.

However, there was also acknowledgment that prisoners would not have the same support available to them outside the DRW, increasing the likelihood of a relapse. Prisoners and staff expressed concerns about lack of access to social support, housing and work outside of prison (see Lloyd et al., 2017a, pp. 16-17). Several prisoners felt that their families' support had motivated them throughout their recovery and would help them to continue this journey upon release, but this support was not available to all DRW prisoners. Additionally, some staff raised concerns about the early release scheme (HM Government initiative to address capacity issues in prisons by releasing some types of offenders early, see UK Government, 2024), which meant some prisoners were being released before completing the DRW programme, which was seen as putting them at a higher risk of relapse.

Some prisons seem to have strengthened their links between the DRW to services that can support prisoners upon release (e.g. RECONNECT, Recovery Focussed Approved Premises, etc.), but their suitability or accessibility was yet to be determined. It will be important to track outcomes for prisoners after they are released in future research to assess the impact of the initiative on longer term outcomes.

4.2 Outcomes for prisons

4.2.1 Recovery culture

Outcomes:

- *An established social norm not to use drugs other than those prescribed (short-term)*
- *A recovery-oriented community with strong rehabilitative culture (short-term)*
- *DRW supports and enhances the whole prison approach to drug recovery (short-term)*

Sentiment about the recovery culture on DRWs was very positive - prisoners often expressed a desire to remain abstinent and both prisoners and staff highlighted the importance of keeping the DRW a drug-free space by removing those who were not aligned with this ethos (as discussed in section 3). In five of the DRWs, there did appear to be consensus among the DRW community (prisoners and staff) that substance use on DRWs was less socially acceptable than it was among the general prison population. Various examples were provided where prisoners had prevented substances from coming into the wing or responded to peers using substances by mediating with those involved and/or reporting it to staff members. DRWs were often described as being a calmer and more pleasant environment than general prison population wings, and thereby more conducive to recovery. At one prison, staff hoped to extend the DRW concept further:

> *"Whilst you've got one wing that runs drug recovery and incentivised drug free living, we'd like that to be in different places, we'd like that to be extended further. We may have more prisoners with needs to address than we can house on one particular unit." – Leadership staff member*

However, monitoring data from prisons suggested a more mixed picture. In three prisons the average number of UTI incidents per population was lower in the DRWs than in the general prison population, but in three prisons UTI prevalence was considerably higher in the DRWs. There are some possible explanations for the lack of alignment between interview feedback and the data in addition to the limitations set out in section 1. Firstly, in some cases a minority of individuals may be responsible for multiple UTI incidents – for example, one prison noted a high number of UTIs in one month due to a drug dealer having made it on to the wing. Several prisoners and staff said they would like to see those repeatedly breaking the DRW rules to be relocated more quickly, to minimise disruption to the community and ensure the substance-free culture was maintained. Additionally, the

nature of the DRW cohort being in recovery means the population is inherently at risk of relapse – one prison noted that prisoners on DRWs were particularly vulnerable to prison-wide trends in drug availability. There may also be considerations relating to data capture (i.e. UTI incidents being monitored more closely on the DRW than in the general prison population). An illustration of data on UTI incidents can be found in Annex 6.

The extent to which DRWs supported and enhanced a whole prison approach to drug recovery was similarly mixed. It was clear that prison-wide buy-in to drug recovery was present at Holme House – likely because the recovery programme there was well-established and previously evaluated positively (e.g. Ayres et al., 2023). Efforts to gain prison-wide buy-in at other DRW prisons were ongoing (see section 2.4.2). Staff often expected their prison's DRW to enhance the prison-wide approach to recovery as prison-level evidence demonstrating its effectiveness became more apparent.

4.2.2 Prisoner pathway

Outcomes:

- *Prisoner journey well planned to support progression through DRW pipeline (short-term)*
- *Whole system approach to drug recovery ensure offender flows into DRW pipeline (medium-term)*

The originally designed DRW pathway suggested prisoners should come to the DRW from ISFLs and moved back to an ISFL after completing the DRW programme. This was not happening in practice: prisoners were generally coming from the general prison population (with the exception of some at Holme House who came from an ISFL). ISFL capacity was an issue (see section 2.4.2), so prisoners were often staying on the DRW until release or transfer to a Category D prison. Sometimes prisoners were moved back to the general prison population after completing the DRW programme to create space for those on waiting lists, but this was not a popular option with staff or prisoners. Efforts had been made to establish DRW pathways at all DRW prisons, though there were differences across the prisons in the extent to which this was sufficiently developed and entrenched into the wider prison system. Most prisons did have offender flows *into* the DRW pipeline - as discussed in section 2.4.1, having DRWs on wings which were desirable to prisoners resulted in a longer waitlist of those wanting to join the DRW who fit the cohort criteria. Where challenges were experienced with waitlists being too small, it was put down to the issues gaining buy-in from the wider prison – staff on other wings reportedly discouraging

their ‘well-behaved’ prisoners from the DRW as they would prefer to keep them on the wing where they worked – and external factors, such as having only a small number of prisoners fitting the cohort requirement.

Prisons considered their vetting processes to assess prisoner suitability for the DRW to be thorough overall, despite the prison-wide challenges of navigating drug availability (see section 2.4.2). However, vetting could not account for the difficulties managing compliance (including prisoners making it on to the DRW disingenuously, despite thorough vetting) and the presence and impact of lodgers (see section 3.2). Lodgers could impede offender flows as they took up a space for a potentially suitable prisoner.

DRWs did not have systematic processes for moving prisoners once they completed the DRW programme – primarily due to those ISFL capacity difficulties – but remaining on the DRW was believed to be a lower relapse risk. Accordingly, this was thought to be preferable to moving prisoners back to the general prison population, where drugs were more widespread, and less support was available. An additional obstacle was prisoners resisting moving from the DRW, given its superior regime and facilities.

4.2.3 Substance use and availability

Outcomes:

- *Reduced availability of illicit substances (short-term)*
- *DRW contributes to reduced drug use among prisoners (medium-term)*

DRWs were likely contributing to reduced substance misuse among prisoners, though evidence was mixed. Staff and prisoners across the DRWs believed substance use on DRWs was more limited compared to the general prison population. This was thought to contribute to a safer, calmer environment on DRWs as prisoners were less *“volatile”*, there were fewer conflicts, and fewer debt-related issues. The low levels of substance use were thought to be primarily supported by the culture and environment on the DRW. While design elements were important (e.g. physical restrictions in place to limit mixing of DRW and non-DRW prisoners), several prisoners said those who wanted to obtain drugs ultimately still could if they wanted to. Instead, it was the recovery-focused DRW community where prisoners had a shared objective to remain abstinent, and the nicer environment (which prisoners did not want to lose), which were seen as essential to reducing prisoners’ inclination to use substances. Staff also mentioned that conflict resolution has also improved thanks to the recurrent group work and group meetings.

As outlined in section 4.1.4, however, monitoring data on UTIs did not always reflect the lower level of drug use in DRWs compared to the general prison population which staff and prisoners perceived: in three prisons, prevalence of UTIs as a proportion of operational capacity was higher in the DRWs. In any case, where substances were making it on to the DRWs, staff and prisoners could often link this to specific individuals. Staff would take action to address the issue, sometimes resulting in those who were dealing and/or using substances being moved away from the DRW. Some prisoners reported seeing an increase in security measures to tackle the issue (e.g. drug detection dogs) when it occurred. However, as discussed in section 3.2, CBDTs being unable to detect SCRAs was an obstacle for staff – if a prisoner was suspected of being UTI due to SCRAs and an MDT was not carried out, it was more difficult for staff to evidence the prisoner's non-compliance with the DRW as their CBDTs would still be negative.

4.2.4 Staff and prisoner relationships

Outcome: Improved relationships between prisoners and staff (medium-term)

Evidence suggested relationships between prisoners and staff were substantially improved on the DRWs across all prisons. Prisoners felt staff were approachable and willing to help. They spoke positively about the staff they interacted with on the DRW and noted that DRW staff were more supportive than staff in the general prison population, who tended to be more punitive. Staff similarly felt DRW prisoners were more compliant and more trusting of staff than they were in the general prison population. They acknowledged that there was not enough time to build personal relationships with prisoners as an officer in the general prison population, whereas this was encouraged and facilitated on the DRW. In some cases, staff described joining group sessions and sharing their own experiences of seeing substance misuse among friends and family to foster openness with the DRW community.

These relationships meant prisoners felt confident they could ask for help or support when they needed to – with their recovery journey, but also with other areas of their life (e.g. writing letters or application forms, liaising with family members, dealing with emotional challenges, etc.). Some prisoners said they were willing to inform staff when they suspected substances were present or being used on the DRW, as they knew staff would keep this information anonymous. A few prisoners recognised the efforts made to help them, motivating them to remain abstinent as they did not want to *"disappoint"* staff.

4.3 Unforeseen consequences

There were several unintended and additional consequences of the DRWs, both positive and negative. The following **positive** unintended consequences were identified.

- **Increased job satisfaction**. Staff satisfaction and retention was a national challenge for prisons (e.g. Justice Committee, 2023). However, SMOs often alluded to having a greater sense of job satisfaction than they did in their previous roles on other wings with the general prison population. SMOs valued having time to build relationships with prisoners and being able to see the impact on their lives, often alluding to *"thank you"* letters received from prisoners they had helped (some of which were displayed on notice boards in DRW staff offices).

> *"The best thing about being an SMO is having the time to have a conversation with someone. When you're Res staff, you've got a regime to follow, [there's] so many things you've got to do in a day that take priority…I didn't hate [it], but I wasn't making a difference, I knew I wasn't going to help anybody. Whereas [on the DRW], I've left crying in happiness." – DRW staff member*

- **Reduced incidents**. While the focus of DRWs was on recovery, staff also alluded to the additional benefits they had seen - fewer violent incidents, less self-harm and more positive behaviours among prisoners compared to the general prison population. This meant a nicer working environment for staff, and an improved atmosphere for prisoners.

> *"We don't have that much self-harm on here because we're occupying people's minds to keep them off drugs. It's a well-known fact in jail that people self-harm, bully, get into fights, smash up their cell out of boredom. And we rarely have any of that because we're offering them plenty to do." - DRW staff member*

- **A platform for sharing best practice**. At Erlestoke, the DRW was liaising with RECONNECT – an NHS service that sought to improve continuity of care post-custody. The service was being increasingly used to help DRW prisoners address any concerns they had about being released. Its success meant the prison was considering rolling it out for the wider prison. Likewise, the success of the DRW (and the prior recovery initiative) at Holme House had led to visits from other prisons interested in learning from the DRW.

- **A setting for prisoners to upskill**. At Holme House, prisoners were using their existing skills to perform activities as part of the regime (e.g. building animal shelters). As part of this process, they were training other prisoners. This was thought to be beneficial as it

allowed prisoners to build a portfolio of work to support their future employability upon release.

On the other hand, the following **negative** unintended consequences were identified.

- **Generating tensions among prison staff**. Difficulties gaining prison-wide buy-in and disconnect between DRW staffing teams contributed to an overall sense of dissatisfaction among officers in the wider prison about the SMO role. In some prisons, there was scepticism about building supportive relationships with prisoners, and a view that SMOs had it *"easier"* due to working on nicer wings with a compliant cohort and having preferable working hours (e.g. fewer evenings and weekends). This perception was not necessarily accurate but resulted in rumours and tensions between DRW and non-DRW staff.

- **Potential for disincentivising prisoners from progressing**. ISFL capacity meant there were limited places to move prisoners after they completed the DRW programme. There was also widespread acknowledgement that the DRW had a better regime and environment than other wings housing the general prison population. As such, a few staff speculated that prisoners may not be motivated to actually 'complete' the DRW due to concerns about being moved to a less desirable location. ISFLs themselves were also enhanced units. At the prisons where ISFLs were considered superior to the DRW (in terms of the physical environment and/or the regime), a few prisoners highlighted that being unable to move on to one made them feel *"stuck"* on the DRW.

- **A desirable location for dealing**. Staff recognised the inherent risk of the DRW being desirable to prisoners who were dealing drugs, who saw there was money to be made due to the cohort of prisoners there being in recovery. Examples were shared of drug dealers gaining access to DRWs, and consequently undermining the recovery of other prisoners.

5 Conclusions and considerations

5.1 Conclusions

The DRW programme comprised abstinence-based prison wings which aimed to support prisoners to maintain abstinent from drugs and drug substitutes and to improve their mental and physical health and wellbeing, to ultimately reduce reoffending. This process evaluation sought to provide evidence and insight into the mechanisms of DRW implementation, the successes, challenges, barriers, enablers and lessons learned, and the experiences of prisoners on the DRW pathway and any improved outcomes.

The approaches of the six DRWs to delivery were largely based on the HMPPS-issued DRW framework criteria – a wing physically separated from the general prison population, a regime comprising a psychosocial intervention alongside structured activities and peer support, a staffing structure encompassing the funded positions of a Custodial Manager and three Substance Misuse Officers, a cohort of prisoners with history of substance misuse seeking to maintain abstinence (including abstinence from OST), and security measures to minimise the risk of drugs transmission and use.

The DRWs nevertheless had operational differences, largely influenced by prison-specific structural and cultural factors. These included the stigmatisation of drug users and scepticism about DRWs among staff, the restrictions of the physical prison environment, and widespread drug availability. Staff played a key role in overcoming these barriers and successfully implementing DRWs. Positive perceptions of the DRW, especially among senior leadership, had a ripple effect on prison-wide attitudes. Having consistent, experienced and committed staff running DRWs helped with overcoming bureaucratic hurdles and establishing a stable regime. Likewise, the rapid pace of the DRW programme roll-out resulted in a considerable workload for the national team, who were essential to driving the programme forward.

Despite the differences across the DRWs, there was evidence to suggest most were making progress towards the desired DRW outcomes. Prisoners were generally positive about their DRW experiences and engaging well in the regime. Relationships between DRW staff and prisoners were stronger on the DRW than in the general prison population, and there was a shared sense that substance-free, recovery-oriented cultures were

created which were helped prisoners to maintain abstinence and contribute to improvements in physical and mental health. This success was underpinned by several DRW features: staff who were approachable and willing to help which cultivated positive prisoner-staff relationships, peer support and group work which allowed prisoners to relate and learn from one another, and a calmer and safer environment than existed on other prison wings. Keeping prisoners occupied through the regime, involving them directly in DRW delivery, and minimising mixing with the general prison population were all beneficial.

However, there were also elements of DRWs which were less conducive to the programme objectives. Some of these related to DRWs not being implemented as the framework intended – different psychosocial intervention offers and, accordingly, different views on the extent to which interventions were adequate, as well as some DRWs housing lodgers who could be disruptive. Conversely, there were some examples where implementation aligned with the framework, but this did not always work well. Specifically, there were concerns that the strict eligibility criteria – including the requirement for OST abstinence – meant that some potential beneficiaries of the intensive support offered through a DRW were being excluded. There were also implementation challenges around the DRW drug testing procedures, which did not detect synthetic drugs and therefore made them an attractive option for those wishing to use, and examples of disruption to the regime causing frustration and boredom among prisoners. The DRW pathway was not operating as originally planned.

Overall, the DRWs have made positive steps towards creating environments which support abstinence from drugs and drug substitutes, and benefit prisoner health and wellbeing. However, there remain obstacles to overcome. Efforts to address the identified barriers to implementation alongside the DRW features which hinder prisoners' ability to remain abstinent would help to strengthen progress towards these objectives.

5.2 Key considerations

The following considerations for the future were identified by the process evaluation:

- **Prioritisation of abstinence contributed to difficulties in attracting opiate users**. This was also a challenge for the first wave of DRWs. For prisoners wishing to secure detoxification, intensive prison programmes followed by smooth pathways into community

residential treatment programmes are necessary (EPRA, 2017). An opiate recovery pathway incorporating the DRWs could therefore help those on OST to achieve abstinence.

- **There were challenges to identifying psychosocial interventions for DRWs.** The varied experience that prisoners had of psychosocial interventions was present in both waves of the DRW programme. The difficulty of navigating the competing demands of centralisation and localisation are also well established (e.g. HM Govt, 2010; Duke, 2012). Prisons and SMS providers may benefit from more resources to make informed, evidence-led decisions about the psychosocial intervention offer for DRWs (e.g. a central resource of such psychosocial interventions, outlining their respective resourcing implications, training and staff needs, and any associated evidence).

- **The presence of lodgers on DRWs was a challenge.** Lodgers could be disruptive to the DRW community and regime. Supporting prisons to minimise the number of lodgers they house would yield benefits for prisoners in the target cohorts who wished to maintain abstinence. This could include working with Senior Leadership Teams to gain their support for effectively managing the DRW population, and emphasising the importance for DRWs to maintain an adequate DRW waitlist to reduce the risk of empty cells becoming available.

- **The drug testing regime could be improved.** The compact based drug test (CBDT) regime functions as an effective commitment device for prisoners on the DRWs and assists in reinforcing their choice to remain abstinent. However, it does not detect synthetic cannabinoids such as synthetic cannabinoid receptor agonists (SCRAs). A regular CBDT regime that detects SCRAs would improve the effectiveness of the drug testing regime and enable a more effective response to prisoners suspected of being under the influence (UTI).

- **There was inconsistency in the specific DRW regimes and staff training across the prisons.** Increasing the level of detail in the DRW framework (for example, providing guidance on the type and frequency of activities that should be offered) and introducing a standardised training offer for SMOs could improve the consistency and quality of DRWs, and support the delivery of structured, recovery-oriented activities beyond psychosocial recovery interventions.

- **The DRW pathway was not operating as planned.** In practice, prisoners are not moving through the indicative DRW pathway as originally envisioned, with the available space on Incentivised Substance-Free Living (ISFL) wings limited. There may be value in developing guidance for a revised standardised pathway. Alternate pathways include aligning end of DRW treatment with release to community (graduated through release on temporary license where appropriate, and comprehensive through-the-gate support), transfer to a lower category prison, such as a Category C resettlement prison or Category D prison, or return to general prison population.

- **Future evaluation of the DRWs could benefit from improvements to data collection.** This includes identifying any prisoners on OST who are enrolled on the DRW programme (and whether they are on a stable dose or actively reducing), identifying 'lodgers' on the DRWs (i.e. those who are located on the wing but not enrolled in the programme,) and incorporating results from MDTs (both prison-wide and DRW-only). Consider including Measuring Quality of Prison Life (MQPL) survey data (from DRWs and the entire prison) in data collection activities to improve understanding of the impact DRWs may have on creating recovery-focused supportive environments, compared to the rest of the prison. Data should be validated and quality assured at both the prison and national level to ensure consistent, high quality data collection processes across prisons. Clear guidance and training should be provided to DRW staff on data collection processes.

- **There was a lack of definition around what 'recovery' meant within the DRW context**. The nature of recovery has been subject to significant debate, and can be interpreted as almost any set of behaviours involving some degree of improvement to drug users' quality of life. This may hold clear value in the community, where providers are seeking to engage a wide variety of drug users in a wide variety of services offering an eclectic range of groups. However, it may be beneficial to consider what 'recovery' means within a prison setting, given that prisons strip people of the resources needed to sustain abstinence (Lloyd et al., 2019), and living conditions upon release may make abstinence unsustainable. Within this context, clear and specific terminology reflecting the clarity of other initiatives (e.g. ISFLs, CBDT wings) may help DRWs secure a clearer role and find their target audience – for example, pre-release abstinence-focused treatment wings; or OST detoxification intensive support wings.

- **DRWs can be strengthened over time**. Five of the DRWs were at an early stage of maturity, having been set up between 2023 and 2024. On the other hand, Holme House's Therapeutic Community (TC) has existed for over 20 years, delivering a consistent regime and contributing to a prison-wide recovery culture. Holme House has drawn in funding from a variety of sources – including, most recently, as a DRW. It therefore highlights pathways to embedding sustainable abstinence-focused treatment wings in prisons. Long-term investment and support to DRWs would help to embed them in host prisons' culture in the same way; turning them into enduring and protected sources of institutional pride.

- **Prison suitability is an important consideration for hosting a DRW.** Key elements which may influence suitability include the physical space available (a wing of an appropriate size with suitable facilities, which can be separated from the general prison population), the prison population (average sentence length and number of prisoners on OST and/or with substance misuse and dependency), the culture within the prison (extent to which there is genuine buy-in to the DRW concept, attitudes towards recovery from substance misuse, relationships between SMS and the prison) and staffing (availability of skills and commitment).

- **Use of existing evidence could help inform the development of future initiatives.** A first tranche of segregated, abstinence-focused, wing-based units known as Drug Recovery Wings was created in 2011-12. Prisons across England independently chose to host unofficial DRWs, running to at least 2016. However, learning from this first tranche of DRWs was not well incorporated in the development and implementation of the more recent DRWs that are the focus of this report. For example, the findings from the first evaluation suggested that few Cohort 1 prisoners would seek out or engage in abstinence-focused treatment (Lloyd et al., 2017a). Other lessons – about programme development, the challenges of lodgers, operationalising recovery, and the difficulties of moving graduates to other wings to name a few – also resonate. The extent of repeated findings suggests new initiatives could benefit from utilising existing evidence to inform their design and implementation.

Annex 1 Case studies

This annex summarises the delivery of each DRW at the time of visiting in 2024.

A1.1 Erlestoke

HMP Erlestoke is a category C men's prison. The visit to the DRW at Erlestoke took place in July 2024.

A1.1.1 Physical environment

The DRW spanned two landings which were physically separated from the general prison population. The DRW had timetabled access to a space that included a medication hatch, laundry room, and a group room. Facilities included a relaxation area, a pool table, sofas, a fish tank, TV, a group room, gym room containing cardiovascular equipment, and a kitchenette with a fridge, toaster, microwave, and air fryer. The DRW had exclusive access to a south-facing exercise yard with tarmac and planters.

Most cells were single with sanitation facilities. A few cells were adapted for prisoners with physical disabilities or care needs and could be occupied by prisoners outside the DRW cohort. The DRW branding and motivational quotes were incorporated into the wing décor.

A1.1.2 Regime

The DRW regime ran from Monday to Friday each week. Activities were led by substance misuse officers (SMOs), Care Grow Live (CGL) facilitators, peer mentors, and external facilitators for gambling support. Unstructured activities like general association or gym sessions occurred on weekends. The mandatory psychosocial intervention (the Recovery and Change (RAC) Programme) was delivered by CGL. The intervention took place over 14-weeks, covering topics such as skills resisting substance use, emotional wellbeing and self-care, followed by 14 weeks of aftercare. Also provided was one-to-one support, pop-up sessions on harm minimisation and substance awareness, SMO-led SMART Recovery, Shannon Trust, Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) sessions. Other activities, typically SMO and peer-led, included wellbeing, origami and art sessions, gym sessions and 1-hour daily outdoors exercise, and horticulture. Prisoners were also able to apply for jobs on or outside the wing.

A1.1.3 Staffing

The DRW staff team consisted of a drug strategy lead (DSL), a DRW administrative staff member, three ringfenced SMOs and a custodial manager (CM), regular residential officers (ROs) with their supervising officer, and two SMS staff (from CGL).

A1.1.4 Safety and security

Prisoners applying to the DRW were subject to a vetting process led by CGL staff, SMOs, and an admin colleague to assess their motivation and background, and to exclude active drug or gang related activities.

There were various procedures for drug prevention and detection, including regular voluntary testing using oral compact based drug tests (CBDTs) and random mandatory drug testing (MDTs). The CGL and DRW prison staff teams had weekly meetings to discuss cases, assessment and re-assessments, levels of opiate substitute treatment (OST), under the influence incidents (UTIs), and any other relevant matters. Drug-related incidents were subject to a two-strike rule, but this did not always result in de-selection.

Other security measures included regular liaison with the security department, using body scanners, metal detectors, and drug detection dogs, and monitoring prisoners on the wing and during movements. The team was also scheduled for Naloxone training to ensure prisoner safety in case of opiate overdose.

A1.1.5 Prisoner Cohort

The DRW had an operational capacity of 62. Between November 2023 and November 2024, monitoring data between indicated an average of:

- 23 prisoners in cohort 1 (former opiate users, abstinent from OST)
- 25 prisoners in cohort 2 (abstinent from any other drugs or alcohol, never been on OST but will have had previous issues with substances like cocaine, alcohol, or spice)
- 11 prisoners not meeting either of these cohort criteria.

A1.1.6 Prisoner Pathway

Prisoners could self-refer or be referred by their Prison Offender Manager (POM) to the DRW. Officers on the induction wing were expected to inform suitable prisoners of the DRW pathway. The DRW maintained a waitlist to ensure a steady flow of suitable prisoners from within the prison and from a local prison in Bristol.

Depending on their sentence, prisoners were expected to stay on the DRW for around six months. This period included 14 weeks of the RAC programme and 14 weeks of aftercare. In practice, some prisoners stayed longer due to the waitlist for ISFL, which is the next step for those who complete the RAC programme. Where appropriate, prisoners could transfer to category D prison.

The DRW established post-release support through the RECONNECT service, implementing measures such as providing rehab placements, referrals to substance use services, and a comprehensive list of resources like AA and NA meetings.

A1.2 Featherstone

HMP Featherstone is a Category C men's prison. The visit to the DRW at Featherstone took place in July 2024.

A1.2.1 Physical environment

Featherstone comprises seven house blocks. At the time of fieldwork, the DRW was being relocated from House Block 2 to House Block 7, which was previously known as the enhanced wing.

The new DRW housed 72 prisoners on six spurs. It was physically separated from the general prison population. Facilities included a group room (with more group rooms to become available once the transition is fully complete), a relaxation room fitted with bean bags and a TV, a kitchenette with cooking equipment and a table tennis table, and a gym containing cardiovascular equipment. Also available was a pool table, tennis table and a games console. The medication hatch is located on the DRW.

Most cells were single occupancy, and there were a small number of double cells. All cells had sanitation facilities.

A1.2.2 Regime

The DRW regime ran from Monday to Friday each week. The psychosocial intervention operated on a rolling basis and included one-hour structured sessions delivered each morning and afternoon by Inclusion (the SMS provider) and/or SMOs. It encompassed the Inclusion Step Forward Programme (ISFP) and SMART Recovery, the latter of which is occasionally peer-led.

Other activities included physical exercise, with prisoners having access to the main prison gym twice a week, and access to the cardiovascular (CV) room when not engaged in structured sessions during the week. Wellbeing activities, such as acupuncture, table tennis and pool tournaments, were also part of the regime. An unstructured schedule was observed over the weekend.

A1.2.3 Staffing

The DRW staff team consisted of three ringfenced SMOs and a custodial manager, one administrative staff member and wing Residential Officers. There were two full-time SMS (Inclusion) staff on the DRW, though one was absent due to illness at the time of the visit.

A1.2.4 Safety and security

The voluntary oral compact based drug tests (CBDTs) were conducted twice a month by SMOs. Mandatory drug testing (MDT) was carried out randomly or on the basis of suspicion, which staff could request if they suspected someone was using drugs based on intelligence reports.

Prisoners found with drugs on the wing or under the influence (UTI) received a warning. A second offence resulted in a review with staff to determine the appropriate course of action. Other security measures included use of search teams and drug detection dogs.

A1.2.5 Prisoner cohort

The operational capacity of the DRW was 72. Between November 2023 and November 2024, monitoring data between indicated an average of:

- 26 prisoners in cohort 1 (abstinent from OST)
- 27 prisoners in cohort 2 (abstinent from any other drugs or alcohol, never been on OST but will have had previous issues with substances like cocaine, alcohol, or spice)
- 11 prisoners not meeting either of these cohort criteria.

There have been changes over time: since August 2024 through to November 2024, the numbers in cohort 1 were much higher (between 47 and 72), while numbers in cohort 2 reduced to zero. This may be linked to the DRW's relocation.

A1.2.6 Prisoner pathway

Key workers on other wings helped to identify prisoners within the general prison population who were suitable for the DRW. These prisoners were then subject to a vetting process undertaken by SMOs and Inclusion staff. Prisoners were required to complete a 'suitability form' prior to being considered for the DRW, and Inclusion and SMOs held meetings to discuss which prisoners were ready to join the DRW.

The post-DRW pathway was not fully established at the time of visiting. However, once the DRW relocation was complete, the previous wing (House Block 2) would be split between Creating Future Opportunities (CFO) and Incentivised Substance Free Living (ISFL), and it was hoped those graduating from the DRW would be able to the ISFL there.

A1.3 Holme House

HMP Holme House is a Category C men's prison. The visit to the DRW at Holme House took place in July 2024.

A1.3.1 Physical environment

There are seven house blocks in Holme House. The DRW (otherwise known as the substance misuse therapeutic community or 'TC') was located on a wing within House Block 6, alongside the incentivised substance free living (ISFL) which was located in a separate wing in the same block. Whilst most wings in the prison are connected by internal corridors and gates, houseblock 6 is physically separate – positioned close to the perimeter wall, and connected to the rest of the prison by a covered walkway. The DRW was over two floors and decorated with various murals with portrayals of nature, people, and references to employment and education. Facilities included two group rooms, its own laundry and servery, cooking facilities, an outdoor area with animals and animal housing built by prisoners using materials donated by the community, polytunnels for gardening,

outdoor furniture, sofas, books and games. There was shared floor space on the DRW which was used for communal activities. Prisoners left the wing for gym sessions and sports.

There were a mixture of single and double occupancy cells with sanitary facilities. Prisoners initially shared double cells and could progress to single cells.

A1.3.2 Regime

The regime ran seven days per week between 8:00 and 16:00. The psychosocial intervention (the TC programme) was led by the SMS provider Humankind and was divided into two phases: a six-week induction phase and a second phase with 32 structured groups led by trained key workers. Each group session is followed by a peer support session the next day.

Other activities on the DRW included a peer-support group, carrying out community jobs or tasks (like cleaning or laundry), and community activities such as bingo, pool, carpet bowls and quizzes. Weekdays also included a community meal. On weekends, unstructured groups took place in both the morning and afternoon.

A1.3.3 Staffing

Staffing consisted of a TC manager, eight SMS staff (Humankind key workers) who were trained facilitators who work on the TC programme, and three ringfenced SMOs. SMOs were not involved in programme delivery and their role was focused on the day-to-day running of the wing and facilitating other activities. The wing required at least five staff members during the core day.

A1.3.4 Safety and security arrangements

Prisoners were tested using oral compact based drug tests (CBDTs) at least twice a month. MDTs were used to screen for drugs such as Subutex and separate dip tests were used to test for SCRAs.

The security team and the drug strategy team exchange intelligence to monitor any potential drug penetration and daily searches were carried out, including fabric checks and use of drug detection dogs. When prisoners were linked, involved or found in possession of any drugs, they were removed from the DRW, though prisoners were encouraged to ask for support then it is given.

A1.3.5 Prisoner cohort

The operational capacity of the DRW was 69. Between January 2023[6] and November 2024, monitoring data between indicated an average of:

- 2 prisoners in cohort 1 (abstinent from OST)

[6] Data from Holme House was not available prior to this date.

- 67 prisoners in cohort 2 (abstinent from any other drugs or alcohol, never been on OST but will have had previous issues with substances like cocaine, alcohol, or spice)
- No prisoners not meeting either of these cohort criteria.

A1.3.6 Prisoner pathway

Prisoners are screened by the Drug and Alcohol Recovery Team (DART) on induction to the prison to identify those motivated to address substance misuse. Prisoners on methadone must sign up and are assigned a psychosocial DART worker. If a prisoner with substance misuse declines DART and Humankind engagement, they are visited three more times to sign up. Information leaflets and a board in induction advertise the DRW.

Prisoners can refer themselves through their offender manager or probation officer during or after induction. They may come from an ISFL or the general prison population. Holme House, as a national resource, also receives referrals from prisoners in other prisons who want to address substance misuse as part of their sentence plan. DRW representatives guide prisoners through inductions.

Prisoners that complete the programme either move to the ISFL, back to general prison population or are transferred/released.

A1.4 Birmingham

HMP Birmingham is a category B men's prison. The visit to the DRW in Birmingham took place in October 2024.

A1.4.1 Physical environment

The DRW spanned the two top landings of a four-landing residential wing, while the two bottom ones, separated by a locked gate, accommodated general prison population prisoners. The entire wing shared the medication hatch and canteen. The DRW featured group rooms, a gym with cardiovascular equipment such as treadmills and a bicycle, and a room that was being repurposed.[7] Facilities included kitchen equipment, an indoor horticulture set (not in use at the time of visiting), a communal area with pool tables, a TV/Radio, chairs, and a bookshelf. Prisoners could join outdoors exercise classes in another part of the prison. Cells were mostly double occupancy, with a few singles.

A1.4.2 Regime

The regime ran from Monday to Friday each week. The mandatory psychosocial intervention (known as the Discovery programme) was delivered by Cranstoun (SMS provider) over 14-weeks. It comprised twice-weekly structured sessions covering topics such as healthy relationships, understanding emotions, cultures of addiction and recovery, relapse prevention, and building resilience. This was followed by a 14-week aftercare

[7] The room being repurposed was previously used for indoor gardening (hydroponics); prison decision was made that this was inappropriate, so there were plans to repurpose it for use as a group room and for delivering other types of activities.

programme. The Cranstoun facilitator also delivered one-to-one sessions and pop-up hubs on topics like harm minimisation and substance use. Other activities included weekly peer mentor-led aftercare sessions, SMO-led SMART Recovery, exercise classes (e.g. yoga), wellbeing (e.g. meditation, art sessions) and practical skills (e.g. cooking, Shannon Trust sessions, education and work coaching). External facilitators delivered Career Matters, DATUS Enabling Recovery (peer-led), Alcoholics Anonymous, Narcotics Anonymous and Cocaine Anonymous. An unstructured schedule was observed over the weekend.

A1.4.3 Staffing

The DRW staff included drug strategy lead (DSL), a DRW administrative staff member, three ringfenced substance misuse officers (SMOs) (one on parental leave with a cover being recruited), a Custodial Manager (CM) and one SMS (Cranstoun) staff member. Although the CM was funded through the DRW programme, they were often redeployed. Residential officers (ROs) worked on the wing as part of their regular rotation and handled operational duties.

There were plans to secure funding for an additional SMS staff member from Cranstoun to assist with program delivery and caseload.

A1.4.4 Safety and security arrangements

Prisoners were subject to regular voluntary oral compact-based drug tests (CBDT). Mandatory Drug Testing (MDT) was either suspicion-based or driven by prison-wide random testing and therefore used less frequently. Procedures to address drug trading on the DRW included intelligence gathering, supervising prescribed medication at the medication hatch, drug searches including use of scanners and drug detection dogs, and the removal of excess fruit, bread, pillows, and mattresses. A two-strike rule for substance-related incidents was in place, but some prisoners remained as lodgers due to difficulties moving them.

A1.4.5 Prisoner cohort

The operational capacity of the DRW was 47. Between November 2023 and November 2024, monitoring data between indicated an average of:

- 6 prisoners in cohort 1 (abstinent from OST)
- 31 prisoners in cohort 2 (abstinent from any other drugs or alcohol, never been on OST but will have had previous issues with substances like cocaine, alcohol, or spice)
- 8 prisoners not meeting either of these cohort criteria.

A1.4.6 Prisoner pathway

Prisoners were typically referred to the DRW on induction, through the treatment unit (a specific wing for those on OST) or from the general prison population. Potential prisoners were assessed by DRW prison staff and Cranstoun staff. Maintaining a waitlist was challenging due to the transient nature of prisoners in a reception prison and an average sentence length being 12 weeks.

Upon completion of the Discovery programme, prisoners frequently remained on the DRW due to scarce availability of spaces on the ISFL and strict admission criteria. Where appropriate, prisoners could be moved to another prison with a DRW, such as Featherstone, or to a category D establishment. Cranstoun offered support around release, such as linking with external services and setting up appointments.

A1.5 New Hall

HMP New Hall is a closed-category women's prison. The visit to New Hall took place in October 2024.

A1.5.1 Physical environment

The DRW was located on the Oak unit. The unit was divided into two sections: one side for the general prison population and the other side for the Incentivised Substance Free Living (ISFL) (bottom landing) and DRW (top landing). There was no physical separation between the DRW and the ISFL. The medication hatch and the servery are shared with the general prison population.

The space between the DRW/ISFL and the general prison population landing was used as a communal area for meetings and activities. Other DRW facilities included a kitchenette (with cooking facilities), a small laundry room, a group room, a Library Room, a gym space with mats and cardio equipment, tables and chairs, and activity resources (like art supplies). There is no dedicated outdoor space, but prisoners could access an outdoor exercise area 2-3 times per week with physical education staff.

All cells were single occupancy with sanitation facilities.

A1.5.2 Regime

The regime ran from Monday to Friday each week. The psychosocial intervention comprised the 16-week Step Forward Programme as well as SMART Recovery. These were led by a combination of Inclusion, SMOs and/or peers. External facilitators delivered Alcoholic Anonymous, Narcotics Anonymous, and Cocaine Anonymous, and some are peer-led. Other structured activities cover physical exercise (a gym officer conducts 1-2 gym sessions per week and gym sessions on the wing are peer-led) and wellbeing (art sessions, pool tournaments and library sessions). An unstructured schedule is observed over the weekend.

A1.5.3 Staffing

DRW staff consisted of the Drug Strategy Lead (DSL), Head of Residence, dedicated Custodial Manager (CM), eight SMOs, two SMS (Inclusion) staff and an administrative staff member. The SMOs were part of a regular rotation system around the prison wings. Typically, there were 2-3 SMOs working on the DRW at any given time, with each rotation lasting between 1 to 3 weeks. The CM and SMS staff were ringfenced to the DRW.

A1.5.4 Safety and security arrangements

Voluntary oral compact-based drug tests (CBDT) tests were carried out every two weeks by SMOs. The security team conducted checks and collected intelligence on applicants to ensure that the right individuals were placed on the DRW. Periodic reassessments were conducted to determine if any changes in the prisoners' circumstances made them suitable for the DRW. The security team and the drug strategy team exchange intelligence to monitor any potential drug penetration within the unit. If prisoners were found in possession of drugs or to have traded medication, their occupancy on the DRW was reviewed.

DRW prisoners have separate slots to access the medication hatch and the servery. Nurses and staff were responsible for conducting checks and observations to ensure that no medications were being stored or passed among prisoners.

A1.5.5 Prisoner cohort

The operational capacity of the DRW was 24. Between April 2024[8]and November 2024, monitoring data between indicated an average of:

- 9 prisoners in cohort 1 (abstinent from OST)
- 5 prisoners in cohort 2 (abstinent from any other drugs or alcohol, never been on OST but will have had previous issues with substances like cocaine, alcohol, or spice)
- 8 prisoners not meeting either of these cohort criteria.[9]

A1.5.6 Prisoner pathway

When the DRW opened in April 2024, 18 prisoners who met the criteria moved from the ISFL unit to the DRW. The Drug and Alcohol Recovery Team conducted interviews during induction to identify remaining suitable candidates.

The DRW programme lasts 16 weeks, but many prisoners at New Hall did not complete it due to their average sentence length of 8-12 weeks. Some prisoners left the programme for reasons like losing interest, wanting to return to work, or being released. As of October 2024, there had been no graduations, but it was expected that prisoners would move onto the ISFL after graduation.

The DRW operates a waitlist system. Prisoners express interest and complete an application form either at induction or from the general prison population. They then speak to an Inclusion team member or are referred through Inclusion during their first night to assess their support needs. Inclusion staff assess the prisoners' suitability for the wing

[8] Data for New Hall was not available prior to this date.

[9] New Hall noted presence of prisoners who were on OST and seeking to taper off during case study visits. However, it is not possible to distinguish the composition of those not meeting the cohort criteria as this was not explicitly captured in the monitoring data (for example, the average number of prisoners who were tapering off OST).

based on their motivations and stage in recovery before adding them to the waitlist. Some prisoners drop out from the waitlist as they become settled on other wings.

A1.6 Swaleside

HMP Swaleside is a Category C men's prison. The visit to Swaleside took place in September 2024.

A1.6.1 Physical environment

The DRW at Swaleside is known as the Phoenix Unit. It is located in the same wing as the ISFL, on different spurs. The DRW is decorated in a colourful style and includes a fishtank and an outdoor space. There are communal spaces with gym equipment and self-cook facilities on the wing, as well as group rooms where psychosocial support and other structures activities are delivered.

A1.6.2 Regime

The regime ran from approximately 8am to 5pm each day (with a later finish due to be implemented on Tuesdays to Thursdays, and a slightly later start time on weekends). The psychosocial intervention was known as "Foundations of Change", which was delivered by CGL. It comprised daily morning sessions and afternoon 1-to-1 follow up sessions.

Structures activities included functional key work by Band 3 staff, and downtime groups like art and yoga in the afternoons. Peer-led groups (e.g., Lifers, Cocaine Anonymous, Narcotics Anonymous, Alcoholics Anonymous) ran daily, including weekends. There was also time for unstructured socialisation and exercise.

A1.6.3 Staffing

There were three ringfenced SMOs, three band 4 supervising officers who were responsible for assigning job tasks to the Band 3s, CGL staff on the Pheonix Unit, an admin grade officer responsible for data collation, and a custodial manager who had overall responsibility for the DRW.

A1.6.4 Safety and security arrangements

Daily cell searches were carried out on the wing. A risk-based approach to security was implemented for prisoners who had been off-wing (e.g. implementing mandatory physical searches after attending gym sessions, for prisoners considered at higher risk of drug trading). Voluntary drug tests were performed on a regular basis.

To minimise DRW/non-DRW prisoner mixing, prisoners were not permitted to have a job on another wing and access to shared facilities was restricted. Prisoners with a history of drug dealing or gang activity were not permitted on the wing.

A1.6.5 Prisoner cohort

The operational capacity of the DRW was 52. Between January 2024[10] and November 2024, monitoring data between indicated an average of:

- 8 prisoners in cohort 1 (abstinent from OST)
- 34 prisoners in cohort 2 (abstinent from any other drugs or alcohol, never been on OST but will have had previous issues with substances like cocaine, alcohol, or spice)
- 4 prisoners not meeting either of these cohort criteria.

This composition has remained fairly steady over time.

A1.6.6 Prisoner pathway

Prisoners who are identified as having a substance use issue are informed about the DRW at induction, or when substance use issues become identified on other wings (e.g. following a UTI incidence). The approach to referrals aimed to be flexible (taking a “no wrong avenue” approach) and prisoners who meet the cohort criteria and express an interest are considered for inclusion in the cohort in weekly meetings.

[10] Data from Swaleside was not available prior to this date.

Annex 2 Background and context to DRWs

A2.1 Government Strategy

In 2021, the UK Government published From Harm to Hope, a 10-year drugs strategy to reduce crime, death, and the harmful effects of drug use. Within the prison system, the strategy takes a zero-tolerance approach, emphasises security measures to disrupt drug supply chains, promotes OST detoxification where clinically appropriate, and highlights the importance of comprehensive drug treatment and rehabilitation services for prisoners, including access to evidence-based programs, mental health support, education and employment opportunities.

This approach is consistent with the integration of health and criminal justice responses to drug use in the UK since the early 1990s. It is also consistent with the focus on abstinence and recovery, and rehabilitation since 2010 (Home Office, 2010; Ministry of Justice, 2010). These papers announced the piloting of DRWs focussed on OST free recovery, for the first time.

From Harm to Hope built on the foundations of the National Prisons Drug Strategy (NPDS), published in 2019, which recognises the unique challenges of drug use within prisons. NPDS focused on four key areas: supply reduction, demand reduction, harm reduction, and recovery and reintegration. The strategy emphasises the importance of providing comprehensive drug treatment and rehabilitation services to prisoners and supporting them with their recovery and reintegration into society. It recognises the issue of opioid dependency within the prison system and the significant risk it poses to the health and well-being of prisoners and its links to offending behaviour. It reiterates the importance of providing comprehensive drug treatment and rehabilitation services to prisoners with opioid dependencies, the need for harm reduction measures specific to opioid use (such as the provision of naloxone), and the importance of supporting prisoners in their recovery and reintegration into society. Of critical importance is the need for continuity of care upon release, ensuring that individuals have access to ongoing support and treatment in the community to prevent relapse and reoffending.

A2.2 Existing research into DRWs

The current tranche of DRWs builds on previous initiatives within the prison system. The first tranche of DRW pilot sites was set up in June 2011, which targeted those serving short sentences (3-12 months) and aimed to offer a route out of dependency for those motivated to change but need intensive support whilst in the initial stages of their recovery. The central mission of first tranche DRWs represented a significant shift in drug policy, based on critiques that a decade of overly-centralised provision running until 2009 had placed undue emphasis on engaging and retaining heroin users (specifically) in OST treatment (Ashton, 2008). They sought to expand treatment offers for people using non-opiates such as alcohol, cannabis and cocaine, whilst encouraging opiate users to detoxify from OST. This took place in a context that prioritised localisation, allowing individual prisons (and individual Local Authorities) to define and operationalise 'recovery' in ways that responded to local needs (HM Government, 2010). Some first tranche DRWs chose to engage existing wings of prisoners prescribed OST in slightly enhanced recovery-focused provision; others prioritised complete abstinence supported by intensive psychosocial programmes, with OST largely or entirely excluded from these wings (Page et al., 2016). These abstinence-focused DRWs housed few (if any) prisoners with histories of opiate use. Whilst both tranches of DRWs shared a mission to create segregated, 'wing-based, abstinence-focused drug recovery services' (HM Government, 2010), there were some differences in implementation. Firstly, tranche 1 DRWs were delivered in a time of austerity, and so were expected to be cost-neutral to support adoption by other prisons if the pilot wings were successful (Lloyd et al., 2017a). Reflecting this, £30,000 was provided by the Department of Health to cover set-up costs; but tranche 1 DRWs received no ongoing funding, or additional staff. Secondly, tranche 1 DRWs were envisioned as a part of a broader redesign of the prison and probation services intended to reduce reoffending. They were consequently envisioned as part of the pathway to release – and were expected to engage prisoners with six months (or less) until release, with DRW graduates returning directly to the community. Thirdly, the absence of specific directives regarding priority cohorts meant that tranche 1 DRWs employed very different models. Some provided full-time, cohort-based intensive treatment programmes to fully segregated wings of 20 people. Some prioritised local needs by converting existing stabilisation wings to DRWs, engaging cohorts of up to 120 newly-arrived opiate dependent prisoners in need of OST titration and basic harm reduction support. Such cohorts had relatively little capacity

for engaging in abstinence-focused interventions, or for considering reduction or detoxification regimes (Lloyd et al., 2017a).

An initial, internal process evaluation (Powis et al., 2014) found that the tranche 1 DRWs were generally operating well, but made a number of recommendations. These included the need for establishment support, clear selection criteria for those going onto the wings, the segregation of the wings from the main prison population and having a drug strategy in place. Additionally, sufficient interventions, including the opportunity for therapeutic work and through the gate contact with community services, were also recommended. The initial evaluation was followed by an external, mixed-method process, impact and economic evaluation (Lloyd et al., 2017a). It found that the nature and intensity of support varied and that the DRWs were not universally focused on abstinence-focused recovery, with some aimed at harm reduction. Overall, the report indicated that DRWs had improved prisoners' quality of life, based on analysis of Measuring the Quality of Prison Life survey data and interviews, and that the keys to their success were physical separation of the wing, protection of DRW beds for prisoners on the programme, strong sense of community, and good relations between staff and prisoners (see also Lloyd et al., 2017b) (supporting earlier work by Tait (2011)). However, the evaluation also found a number of challenges to implementation, including attracting prisoners on OST (see also Page et al., 2016) and drug availability on the DRWs as well as barriers to their ultimate outcomes, including the lack of continuity of care between prison and community, with the issue of a lack of housing and street homelessness being especially problematic (Lloyd, 2019).

A related, but alternative approach to the DRW model was tested through a three-year initiative that began in April 2017 when HMP Holme House became a Drug Recovery Prison. The aim was to test and develop new ways of addressing the supply and demand of drugs in prison and improving wellbeing and recovery through a 'whole prison' approach. A process evaluation of the initiative (Ayres et al., 2023) found that there were perceived improvements in safety and security, though some staff and prisoners were not aware of the whole prison approach and there was a lack of understanding and continued stigma around substitute prescribing. There were mixed views concerning impact on prisoner wellbeing (with 37% believing the initiative had a positive impact, 24% negative, 39% no change), though a psychometric measure of wellbeing indicated improvement over time. Prisoners and staff reported a reduction in drug use but increase in alcohol use and trade in prescription medication, while both staff and prisoners were positive about

through the gate support from the Connecting Communities Team, but there were still concerns about the potential for a ‘cliff edge’ in the level of support on release.

Across the range of evaluation and research on previous initiatives, common themes included the importance of separating the wings from the prisons, protecting the DRW places only for prisoners engaged in the programme, ensuring adequate drug controls such as regular testing, making sure there is sufficient therapeutic support that can help build recovery capital and measures to address the cliff-edge on release from prison, due to a lack of support in the community for continued recovery. Small intensive drug recovery units were identified as most likely to support ongoing success. These findings have influenced the design of the current DRWs and the DRW Framework, and a key role of this evaluation has been to assess the degree to which the prisons have been able to implement the DRWs as intended by the new Framework.

Annex 3 Theory of Change

The Theory of Change (ToC) sets out how a programme is expected to achieve its desired objectives by mapping out the causal pathways between the programme activities and the expected impacts. Based on evidence from a documentary analysis of the DRW Framework, MoJ DRW briefing documents and scoping interviews with MoJ, HMPPS and NHS staff, the following theories of change have been developed. These reflect the intervention as defined during the evaluation's scoping phase and have been subject to change based on updated policy and operational guidance and findings captured throughout the evaluation.

The ToC (Figure 1) captures the expected mechanisms of change, outcomes (short-term, medium-term and long-term) and impacts of DRWs.

Three causal pathways were identified:

- **Reinforcing the choice to avoid drug use:** The scientific literature on drug dependency recognises the strong influence of the environment and that 'exposure to conditioned cues can be a central issue in causing drug cravings and relapses' (Cheron and d'Exaerde, 2021). In the general prison environment, exposure to drugs, drug taking, and other related behaviours is common (Black, 2020). Creating a secure, segregated, calm and drug-free physical environment within DRWs can ensure that psychological triggers are minimised (Barnard, 2009). Alongside changes to the physical environment, commitment devices[11] can assist those recovering from substance dependency to maintain abstinence. To enter a DRW, prisoners must sign a behavioural compliance contract and voluntarily agree to regular drug testing, referred to as CBDT. In this way, prisoners have made a choice or pre-commitment to maintain abstinence, which supports them when internal or external factors, such as cravings or environmental triggers, present shorter-term challenges.

- **Enhanced capability to avoid drugs**: While evidence demonstrates that OST can be safely tapered in a residential setting, detoxification from OST is one of the least effective

[11] Commitment devices are based on an individual recognising that at some point in the future short term pressures may entice them to do something (such as take drugs) that are contrary to their longer-term goals. To help prevent this, they deliberately aim to restrict their future choices by making the undesired choice more expensive or difficult in some way to help them resist the temptation.

treatments for drug dependency, due to a high rate of relapse (Luty, 2003). Conversely, literature suggests that the maintenance of OST in prison is associated with reduced drug use, although continuation of this effect post-release from prison is contingent on adequate post-release treatment and support (Lloyd et al., 2017a). As abstinence from OST is part of the DRW eligibility criteria set out in the DRW Framework, this study considers other factors that may support continued abstinence in the target population. Previous research has identified the following factors that may support continued abstinence and recovery: psychosocial treatment of appropriate length and intensity (Luty, 2003, p.283), keyworkers' interactions with prisoners on a daily basis using 5 Minute Intervention and motivational interviewing (Luty, 2003) and the use of residential therapeutic communities (Bennett et al., 2008; Holloway et al., 2005). The intended design of DRWs closely aligns with these elements.

- **Reduced motivation for and acceptability of drug use:** Sufficient motivation to achieve abstinence is a necessary condition for prisoners to commit to recovery and engage in recovery-focused activities and treatment. Literature suggests that 'an appropriate level of motivation is a necessary foundation for the process of recovery' (Barnard et al., 2009, p.6) DRW regimes integrate celebrations of success, mutual aid groups, and regular contact with family and significant others including enhanced access to visits and telephone calls. While there is an inherent contradiction between imprisonment and the ability to build recovery capital, literature suggests that efforts should be made to reduce the erosion of recovery capital, with family support work being a critical part of this (Lloyd et al., 2019). By ensuring that all individuals on DRWs are recovering from substance dependency, prisons can also create a social norm not to engage with drugs and through role-modelling enhance goal values (the adoption and importance given to goals such as remaining drug free) and expectations (the belief that being drug free is a likely outcome) (Morgenroth et al., 2015; Page et al., 2016).

Figure 1. High-level Theory of Change diagram showing key mechanisms and causal pathways (Behavioural ToC)

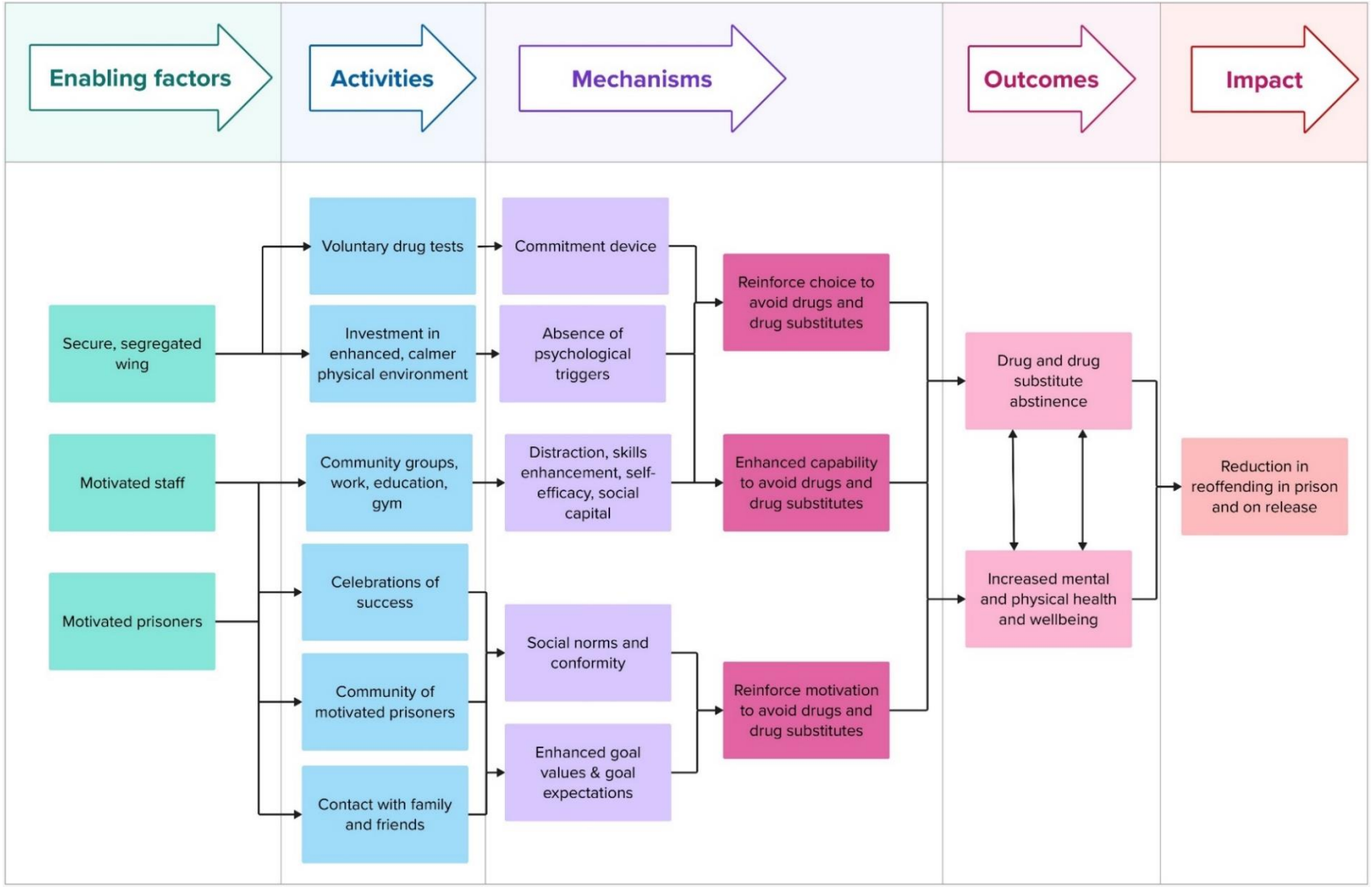
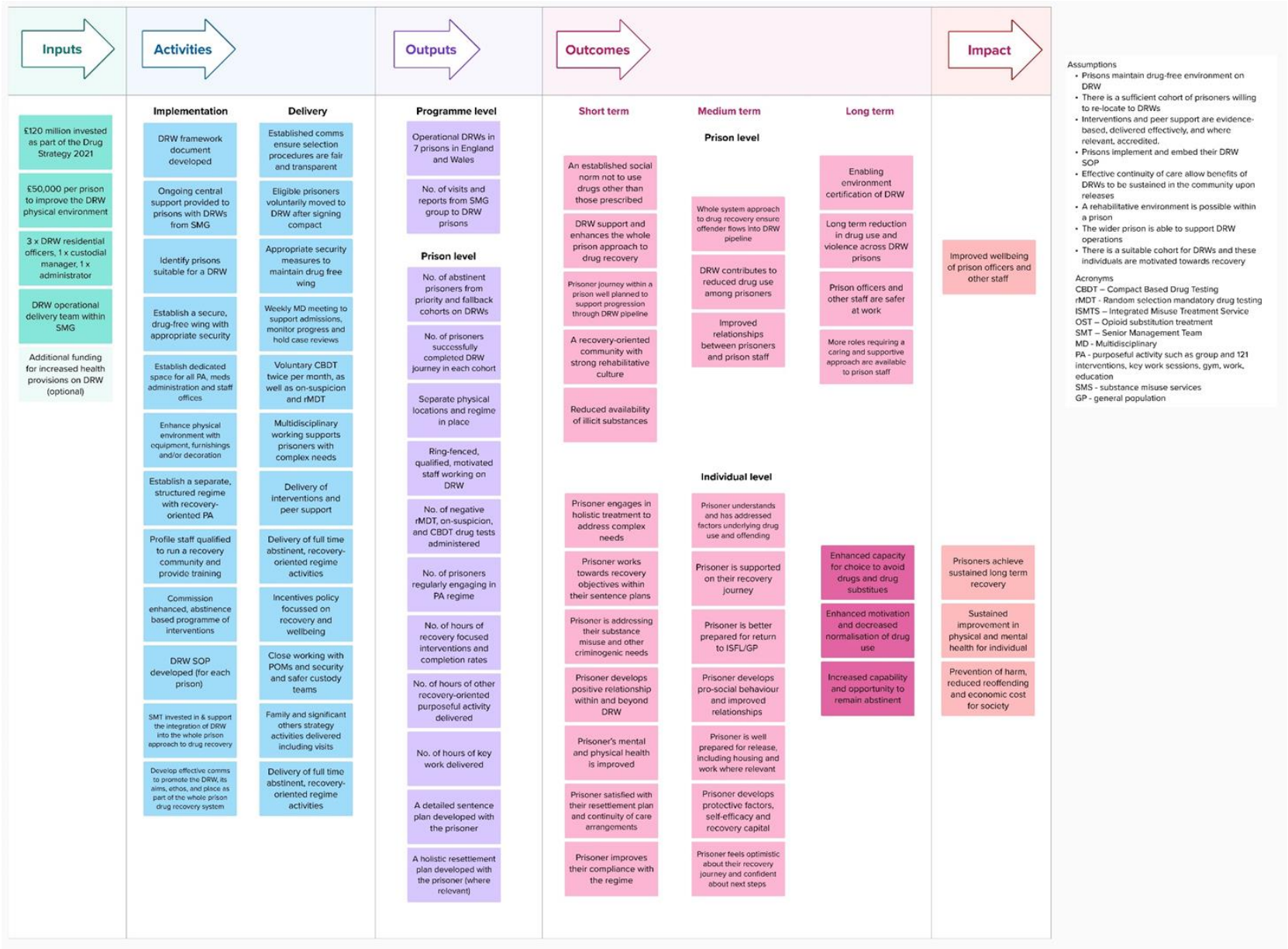


Figure 2. Detailed Theory of Change diagram



Annex 4 Cohort data

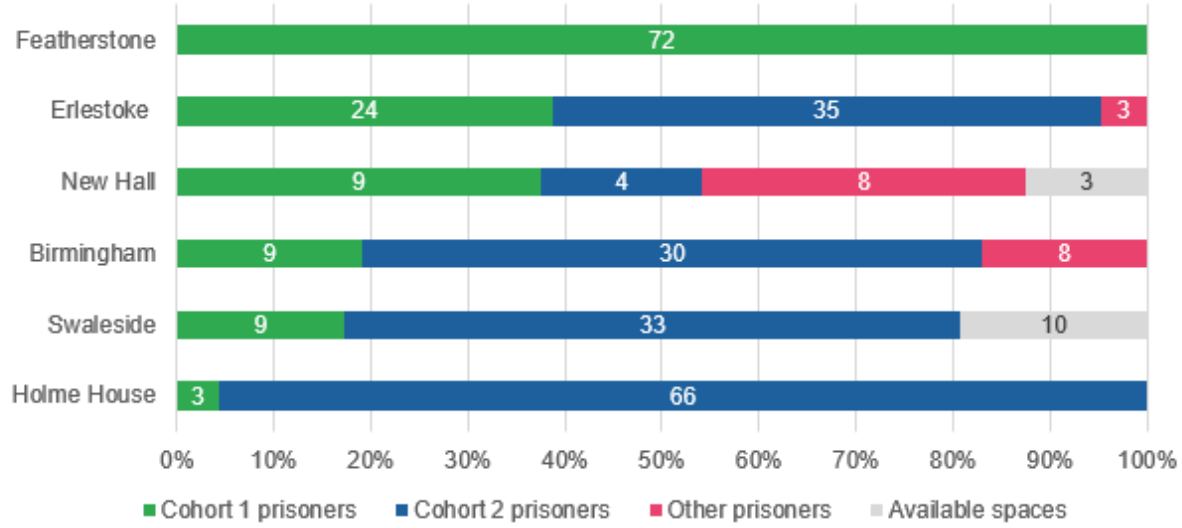
This Annex sets out the data illustrating the cohort composition of the DRWs.

Table 1. Proportion of prisoners meeting cohort 1 criteria, cohort 2 criteria, and 'other' prisoners on DRW, November 2023 – November 2024

	Birmingham			Erlestoke			Featherstone			Holme House			New Hall			Swaleside		
	Cohort 1	Cohort 2	Other	Cohort 1	Cohort 2	Other	Cohort 1	Cohort 2	Other	Cohort 1	Cohort 2	Other	Cohort 1	Cohort 2	Other	Cohort 1	Cohort 2	Other
Nov-23	0%	96%	4%	33%	22%	44%	18%	67%	15%	-	-	-	-	-	-	0%	0%	100%
Dec-23	9%	85%	6%	25%	39%	36%	8%	60%	32%	-	-	-	-	-	-	0%	0%	100%
Jan-24	6%	94%	0%	36%	31%	34%	12%	78%	10%	1%	99%	0%	-	-	-	11%	72%	17%
Feb-24	6%	94%	0%	44%	31%	26%	3%	88%	8%	0%	100%	0%	-	-	-	13%	72%	15%
Mar-24	5%	95%	0%	42%	39%	19%	12%	72%	17%	3%	97%	0%	-	-	-	17%	67%	15%
Apr-24	0%	100%	0%	45%	38%	17%	10%	60%	30%	1%	99%	0%	70%	0%	30%	17%	66%	17%
May-24	-	-	-	47%	35%	18%	11%	58%	32%	3%	97%	0%	68%	0%	32%	16%	71%	12%
Jun-24	64%	7%	30%	44%	37%	19%	58%	0%	42%	3%	97%	0%	70%	0%	30%	17%	74%	9%
Jul-24	13%	56%	31%	39%	50%	11%	13%	87%	0%	9%	91%	0%	21%	50%	29%	19%	74%	6%
Aug-24	4%	43%	52%	37%	53%	10%	76%	0%	24%	6%	94%	0%	25%	54%	21%	22%	76%	2%
Sep-24	16%	59%	25%	34%	57%	8%	81%	0%	19%	4%	96%	0%	26%	39%	35%	20%	78%	2%
Oct-24	13%	50%	37%	40%	49%	11%	100%	0%	0%	3%	97%	0%	25%	30%	45%	19%	79%	2%
Nov-24	19%	64%	17%	39%	56%	5%	100%	0%	0%	4%	96%	0%	43%	19%	38%	21%	79%	0%

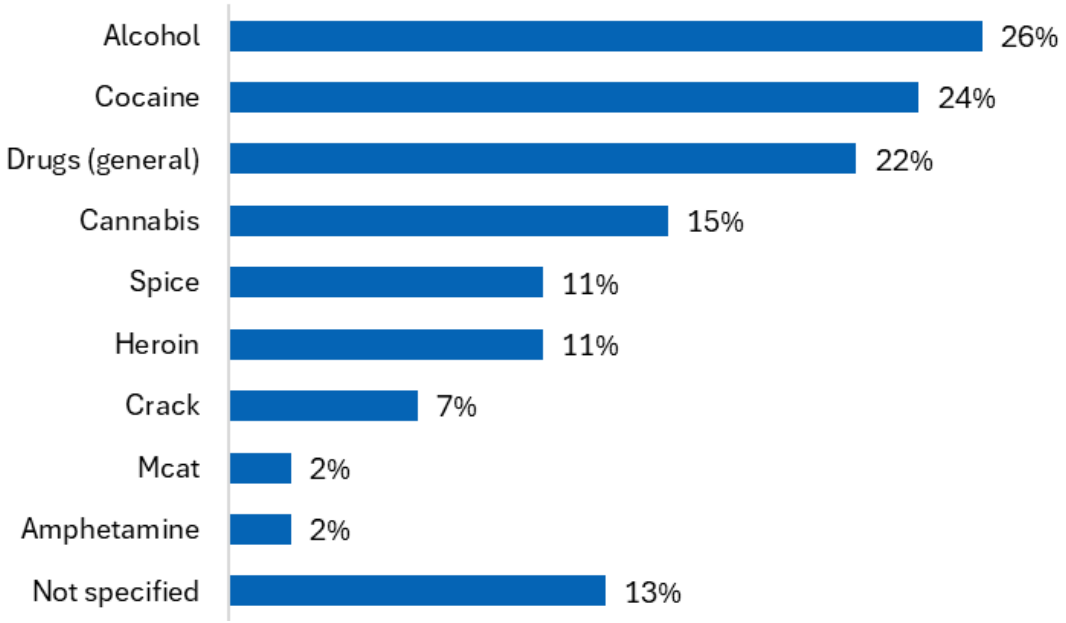
Source: MoJ data returns November 2023 – November 2024. Proportion shown is based on reported number of prisoners on DRW and does not include empty spaces. Quality issues and incompleteness (see section 1) mean this data should be interpreted with caution.

Figure 3. Composition of DRW cohort, November 2024



Source: November 2024 MoJ data return. Numbers shown in figure represent the number of prisoners in each category. Quality issues and incompleteness (see section 1) mean this data should be interpreted with caution.

Figure 4. Self-reported misuse/dependency among prisoners interviewed



Source: Prisoner interviews (n=46) – self-reported substance misuse which led to their placement on the DRW.[12] Some prisoners reported multiple drugs of dependency.

[12] Includes substance misuse and dependency reported before custody as well as during.

Annex 5 Regime summary

Table 2. Summary of the regime in place at each DRW

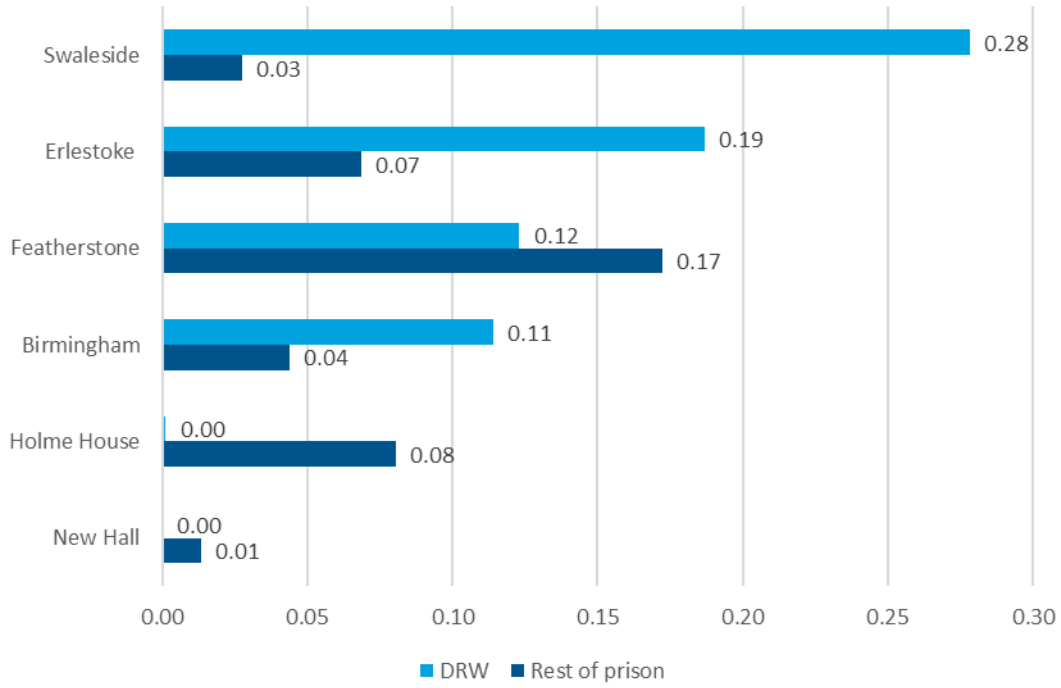
Prison	Erlestoke	Featherstone	Holme House	Birmingham	New Hall	Swaleside
Weekly routine/ core day	9:00-15:00/16:30, 5 days/week.	09:30-15:30, 5 days/week	8:00-16:00, 7 days/week.	9:00-16:00, 5 days/week.	8:00-16:30, 5 days/week.	8:00-16:45 (Mon, Fri) /17:45 (Tues-Thurs) 8:30-16:45 (weekends)
Psychosocial interventions	14-week Recovery and Change programme followed by 14-week after care. 1-to-1 sessions and pop-up hubs (e.g. on harm minimisation, substance use). Weekly peer mentor-led aftercare sessions. SMO-led Self-Management and Recovery Training (SMART).	Rolling programme of recovery-focused sessions delivered by the SMS provider and SMOs, and peer-led group sessions. DRW was in the process of developing a structured programme of delivery. This was expected to include an introductory phase of 6-8 weeks before a main structured phase lasting 10-12 weeks, concluding with a graduation period.	Two phases. Phase 1: induction, 6 weeks, 12 sessions. Phase 2: 32 structured sessions. Peer support follow up session provided the day after each group sessions.	Foundations to Change programme: 14-week Discovery programme; substance awareness and harm minimisation sessions focusing on dependencies, e.g. 'spice'; cannabis, crack, smoking, alcohol. 1-to-1 sessions also offered.	16-week Inclusion Step Forward Programme and SMART. Sessions can be led by Inclusion, SMOs or peers.	Foundations of Change rolling 12-week programme runs every morning. 1-to-1 follow ups in the afternoons. 12 step programmes including AA and NA led by peers and SMART delivered by Change Grow Live.

Prison	Erlestoke	Featherstone	Holme House	Birmingham	New Hall	Swaleside
SMS provider	Change Grow Live	Inclusion	Humankind	Cranstoun	Inclusion	Change Grow Live
Other structured activities (primarily delivered by SMOs)	Shannon Trust classes, horticulture, therapeutic colouring, and monthly prisoner forums. Peer-led sessions include origami, art, gym, wellbeing. External facilitators deliver AA, NA & GA sessions.	Games / Movie club on Fridays PM. Gym, chapel and library visits. Ad-hoc activities, such as relaxation sessions and circuits classes delivered by SMOs and peers.	SMOs facilitate structured activity in the afternoons such as chess, pool, Dungeons and Dragons, book club.	Activities included gym and exercise classes (e.g. cardio workout, yoga, strength, football), art, creative writing, library sessions and cooking (SMO and peer delivery). External facilitators delivered Career Matters, DATUS Enabling Recovery (peer-led), AA, NA & CA.	Holistic recovery activities (e.g. acupuncture), externally delivered NA, AA & CA. Gym sessions, art, pool tournaments, library sessions.	Recovery focused activities including cross-stitch, board games including chess and Dungeons and Dragons, book club, yoga, music sessions, gardening

Annex 6 Under the Influence (UTI) incidents

This section presents the data on the number of UTIs per prisoner as calculated using DRW monitoring data.

Figure 5. Number of UTIs per prisoner (average between Nov 2023 - Nov 2024)



Source: Analysis of DRW monitoring data June to November 2024 alongside 2024 prison population data. Prison population: monthly prison figures $UTIs\ per\ prisoner = \frac{Average\ UTIs\ (Nov\ 23-Nov\ 24)}{Average\ population\ (Nov\ 23-Nov\ 24)}$ *(Ministry of Justice, 2024). Quality issues and incompleteness (see section 1) mean this data should be interpreted with caution.*

Annex 7 Methodology – Additional information

The methodology for this process evaluation was designed to respond to the research objectives and specifications provided by the MoJ, including budget and timeframes.

A7.1 Scoping and Theory of Change development

A theory-based methods (TBM) approach was taken to the evaluation methodology. This comprised constructing a theory of change (ToC) for the intervention; using quantitative and qualitative data to generate evidence about the success of each stage of the theory of change; and providing an overall assessment of what the evidence indicates about impact – including the factors influencing how and why impact is achieved (e.g. Mayne, 2020; Imbens & Rubin, 2010).

At the inception of the evaluation, a scoping phase was undertaken to develop the DRW ToC (provided in Annex 3) and refine the evaluation design. The ToC was developed using the DRW framework (HMPPS, 2023) and through discussions with the MoJ project team and HMPPS staff involved in the DRW programme's design. This led to the design of a ToC showing the key mechanisms, causal pathways and overriding objectives, alongside a detailed ToC setting out delivery features and specific outcomes. The ToC was used to inform the evaluation design and research tools, including the topic guides and data analysis framework.

A7.2 Data collection

Data to inform the evaluation was collected through interviews, case study visits and a review of programme monitoring data.

A7.2.1 Rapid assessment interviews

The first stage of data collection comprised 13 rapid assessment interviews with leadership staff and senior managers at eight[13] DRW prisons to map each DRW's function and approach. This included two prisons – Berwyn and Stocken – which were in receipt of DRW funding at the time of these interviews (early 2024) but subsequently had their

[13] Berwyn, Birmingham, Erlestoke, Featherstone, Holme House, New Hall, Stocken and Swaleside. DRW funding from Berwyn and Stocken was subsequently withdrawn, therefore they were not included in the six case study visits.

funding withdrawn and therefore did not participate in the later case study visits. The purpose of these interviews was to map the functioning and approach of the DRWs at each prison. To facilitate this process, the research team reviewed prison-specific documentation shared by the MoJ research team and interviewees. This included staffing information, internal protocols, and HMIP reports relating to the DRW.

A7.2.2 Case study visits

Case study visits were subsequently carried out at six DRW prisons. The purpose of these visits was to gather rich insight into DRW implementation and progress towards programme objectives, as defined by the ToC. Topic guides used for interviews with prison staff and prisoners can be found below in section **Error! Reference source not found.**. Before case study visits commenced, a research team briefing took place on interview procedures and appropriate use of the topic guide. This included contextual information and relevant guidance on tailoring the topic guide to different groups as appropriate (for example, the types of information likely to come from senior staff members and prison officers, priority topics and prompts).

Each in-person visit took place over two days and included:

- a tour of the DRW;
- qualitative, semi-structured interviews with prison staff members of varying levels (leadership, middle-management and operational staff) and roles (those involved directly in DRW delivery, as well as wider prison staff);
- qualitative, semi-structured interviews with prisoners on the DRW (including those that had recently joined and those located there for three months or longer), as well as those on DRW waiting lists and/or those who had been moved off the DRW.

Across the six prisons, 104 interviews were carried out (comprising 58 staff members and 46 prisoners). A breakdown of interviews undertaken in each prison is provided in Table 3.

Table 3. Total number of interviews per prison and interviewee group

	Senior leadership staff	HMPS officers and managers	SMS staff	Prisoners	Total
Featherstone	3	3	3	7	**16**
Erlestoke	2	5	3	6	**16**
Holme House	3	2	3	9	**17**
Birmingham	3	9	2	6	**20**
New Hall	4	3	3	8	**18**
Swaleside	3	2	2	10	**17**
Total	**18**	**24**	**16**	**46**	**104**

A7.2.3 Interviews with DRW programme team members

Eight interviews were undertaken with national and regional members of the DRW programme team. This included HMPPS staff overseeing the DRW programme's design, set up and delivery, a national Substance Misuse Services (SMS) stakeholder, and a regional lead involved in the DRW at Berwyn. The purpose of these interviews was to gather insight into DRW implementation from a national perspective, additional context on the commissioning of psychosocial interventions in DRWs, and on the specific challenges faced by Berwyn which led to the funding withdrawal.

A7.3 Data analysis

The evaluation encompassed both quantitative and qualitative data analysis.

A7.3.1 Quantitative data analysis

A review of programme monitoring data provided by MoJ was undertaken to test the indicative DRW pathway. This comprised quantitative metrics collected by administrative staff in prisons. These metrics were determined by the MoJ and included the number of

prisoners entering or leaving DRWs; the location prior to and after DRW; average time spent on DRW; hours of treatment services and regime planned and delivered; drug testing results; and, incidences of violence and self-harm. There were various limitations to this data (discussed in section 1.4.1 in the main body of the report).

The data received was generated monthly. It was combined into a single data file for analysis. A set of contingency tables were developed in Excel summarising the frequency distribution of all the variables, with cross tabulations for relevant variables (e.g. month/year, prison) so that trends over time and in individual prisons could be reviewed.

A7.3.2 Qualitative data analysis

Where permission was granted, qualitative interviews were recorded. Interviews undertaken online were recorded using MS Teams and in-person interviews undertaken during case study visits were recorded with an encrypted Dictaphone. Interview transcripts were generated using Trint, a secure transcription software. Where research participants did not want to be recorded, interviewers took written notes. Transcripts and notes were subsequently anonymised for extraction into a data management template.

Thematic analysis was undertaken using a data management template was developed to reflect the Theory of Change and the evaluation research questions defined by MoJ. It comprised key themes and sub-themes, including:

- DRW implementation (encompassing set up and delivery on design elements, e.g. physical environment, regime, safety and security)
- Views on DRW implementation (barriers and enablers)
- Factors influencing achievement of DRW objectives (what worked well and less well in facilitating prisoner recovery)
- Progress of DRWs towards outcomes (as defined by the DRW ToC)
- Other feedback, including unintended/unforeseen outcomes
- Additionally, relevant characteristics were also recorded to facilitate the identification of typologies (e.g. job role type for staff, and substance misuse issue for prisoners)

Once extracted, the framework was reviewed for quality by a senior member of the research team. The data was then interrogated to identify emerging patterns and findings. These informed the development of categories and explanations to capture the full range of views and experiences. Following the approach described by Ritchie et al. (2013) and

Barnard (2012), this process was inductive to begin with, aiming to understand participants from their point of view. As the process progressed, existing concepts and the programme ToC were brought in to deductively help organise and contextualise the findings. This included explanatory analysis which sought to understand connections between different parts of the DRW process, including how they contributed to achieving the desired programme outcomes.

A7.3.3 Triangulation and synthesis

The evaluation team triangulated the findings from the qualitative and quantitative data analysis. Evidence was considered strongest where emerging themes were present in multiple data sources (for example, seen in multiple interviews, and/or quantitative data that corroborated themes seen in qualitative data). For areas where data was limited or inconsistent, this is identified in the report.

A7.4 Topic guides

A7.4.1 Prison staff topic guide

Introduction

- Introduce self and ICF
- Introduce the study: who it is for, what it is about *[see information sheet]*
- Provide information sheet and consent form – offer to read the information sheet to them verbally
- Once consent form is signed, recap key points:
    - Purpose of the interview
    - Length of interview
    - Voluntary nature of participation and right to withdraw
    - Confidentiality and how findings will be reported
    - Reasons for recording interview
- Any questions they have
- Check happy to continue

Background information

Aim: to understand the staff member's job role & level of interaction with the DRW.

- What is your job role?
    - Experience: Length of time in role & in the prison service more generally; Any relevant prior experience
    - Main responsibilities
    - Process of being selected to work on the DRW
- How are you involved in the DRWs?
    - Explore involvement in (a) decision-making in agreeing to host DRW [senior staff], (b) implementation (set up) and (b) current delivery of the DRW.

- Any relevant past experience & whether they received any training ahead of their involvement in DRW
- Motive for being involved (e.g. why they applied for the DRW post)

Process and implementation

Aim: to understand the staff member's experience and views of the set up and delivery of the DRW.

- How was the process of **setting up** the DRW *[if applicable]*:
  - *[If involved in decision-making] Initial reaction to DRW model (inc. any concerns) & extent to which DRW reflects any previous initiatives*.
  - *Process undertaken by the prison to set up the DRW (e.g. processes followed / guidance used, staff involved, decision-making around location and regime etc)*
  - *What went well & challenges encountered & if/how they were overcome*
- How has **delivery** of the DRW gone so far:
  - *Overview of how the DRW operates at the prison*
  - *What's working well & what's working less well*
  - *Barriers / challenges to DRW delivery (e.g. prison capacity, staff shortages, prisoner cohorts*

Cover each of the following, if not already discussed:

- What do you think of the **physical environment** of the DRW?
  - How funds were spent & why
  - Aspects that have worked well / less well / areas for improvement [use examples from the DRW tour] & why.
    E.g. physical DRW segregation from other wings, decoration, broken/dilapidated areas, routine maintenance, cleaning, recreational areas available.
- What do you think of the **regime** in place on the DRW?
  - Details about regime delivered on DRW:
    - structure (e.g. timetable / daily activities)
    - clinical / psychosocial intervention(s) in place
    - other activities & offers – exercise, wellbeing, peer support, education; key work; incentives
    - extent of mixing with non-DRW prisoners (e.g. meals, exercise, during movements etc)
    - time spent inside vs. outside cells
  - For activities & interventions, clarify: how enrolment works; their specific objectives; time commitment for prisoners; proportion of wing residents involved.
  - Differences between DRW regime and other wings (approach to discipline, activities etc) and extent to which DRW regime is segregated from other wings
  - Involvement of SMS (substance misuse service) in regime
  - What works well / less well / areas for improvement *[probe for specific links to prisoner recovery & substance misuse – why does it work (or not)? What would an 'ideal' regime look like?]*

- *In particular for clinical / psychosocial interventions, investigate*:
    - How they are delivered (enrolment; length, number & frequency of sessions; staff involved; session structure / focus)
    - How they were established & accredited (e.g. evidence based or not)
    - What works well / less well / areas for improvement *[probe for specific links to prisoner recovery & substance misuse – why does it work (or not)?]*
- What do you think of **staffing** on the DRW?
    - How staffing works on the DRW & extent to which these arrangements are adequate
    - Extent to which ringfenced staff are being utilised outside of the DRW / in other areas of the prison
    - Arrangements for staff training & views on these arrangements
    - Level of engagement (a) between DRW staff and (b) among wider staff at the prison (e.g. for resettlement)
- What is your experience of the **prisoner cohort** on the DRW?
    - Prisoner cohort on DRW (proportion in eligible/non-eligible cohorts & why) and extent to which this impacts delivery
    - Management of recruitment / graduation
    - Challenges/barriers to meeting DRW framework cohort requirements
    - Views on the priority and fallback cohort (whether cohorts are helpful / appropriate / feasible; whether changes to cohort criteria are needed)
      Probe for any specific examples of prisoners that have been on the DRW.
- What do you think about **safety and security** on the DRW? Is it a drug-free environment?
    - Protocols in place to ensure drug-free environment & their effectiveness
    - Ease / difficulty of maintaining drug-free environment & factors influencing this
    - Reflections on current supply / trade of drugs on the DRW
    - Experience of any incidents on the DRW (e.g. violence, self-harm, UTIs)
    - Culture on the DRW among prisoners (e.g. stigmatised drug use, prisoner norms)
- Could you talk me through the **prisoner pathway** for the DRW?
    - Process of identifying, transferring & supporting prisoners along pathway (inc. prisoner location prior to & after DRW, relationship with ISFL)
    - What works well / less well (inc. barriers for moving prisoners along the pathway) / areas for improvement in the prisoner pathway
- Are there **wider prison pressures** affecting DRW delivery?
    - Explore: whether prison is at operational capacity, recruitment & retention of staff, support from HMPPS SMG (substance misuse group), general prison conditions and how these affect DRW.

Early outcomes

Aim: to explore the impact that being on the DRW / the DRW pathway has had on the prison and prisoners.

- How has the introduction of the DRW impacted **prisoners**?
    - Have there been any **benefits** from the DRW for prisoners?

- Have there been any **disadvantages** of the DRW for prisoners?

Probe for:

- *Engagement with their interventions / treatment (e.g. attendance)*
- *Prisoner relationships with staff / other prisoners (inc. peer support)*
- *Changes in their mental / physical health*
- *Prisoner satisfaction & compliance with regime / resettlement plan [where applicable]*
- *Remaining abstinent (or not)*
- *Recovery from substance misuse / offending behaviour*
- *Preparedness for returning to ISFL / general prison population after DRW*
- *Preparedness for future release from prison*

- How has the introduction of the DRW impacted your **prison**?
  - Have there been any **benefits** from the DRW?
  - Have there been any **disadvantages** of the DRW?

Probe for:

- *Prison approach / culture to drug recovery & rehabilitation (inc. culture on the DRW)*
- *Availability of illicit substances (on DRW compared to within general prison population)*
- *Relationships between prisoners and staff*
- *Drug use among prisoners*
- *Extent to which DRW pathway is established / supported / facilitated*

- Do you have **any other reflections** on the impact that the DRW has had (good or bad)?

Final thoughts

- Were you aware of previous DRWs when you set up this wing? What were key lessons / concerns you took into this DRW based on any prior knowledge / experience?
  - *Probe for any reflections on the original call / criteria (what was useful / less useful)*
- What do you expect the future to hold for the DRW at your prison?
- Is there any other feedback about the DRW you'd like to share?

Thank & close

A7.4.2 Prisoners topic guide

Introduction

- Introduce self and ICF
- Introduce the study: who it is for, what it is about *[see information sheet]*
- Provide information sheet and consent form – offer to read the information sheet to them verbally
- Once consent form is signed, recap key points:
    - Purpose of the interview
    - Length of interview
    - Voluntary nature of participation and right to withdraw
    - Confidentiality and how findings will be reported
    - Reasons for recording interview
    - Disclosure
- Any questions they have
- Check happy to continue

Note to interviewer: Ensure any information shared about the prisoner's eligibility for the DRW is recorded. Aim to gather this information in your discussion about how the prisoner came to be involved with the DRW. [e.g. history of opiate addiction and prescribed OST, and/or history of any other drug use/addiction, or neither of these]

Involvement & experience of the DRW

Aim: to understand the prisoner experience of the DRW, including likes/dislikes.

- *Opening questions:*
    - We're evaluating DRWs. What does drug/alcohol recovery mean to you?
    - How do you feel about the DRW? How well do you think it's supporting prisoners towards recovery?
- What do you think of the **physical environment** of the DRW?
    - What they think of the facilities and equipment [use examples from the DRW tour]
    - How it compares with other areas of the prison (similarities / differences)
    - Any likes/dislikes, including feelings about level of separation of DRW from ISFL/general prison population
- What do you think of the **activities** that take place on the DRW?
    - Available activities and what they think of them [use examples from staff interviews]
    - What their average week on the DRW is like & how it compares to their experiences in other parts of the prison
    - If / how the activities support recovery
    - Suggestions for improvement (any activities not offered which they feel would support recovery)
- Could you talk me through **how you came to be involved with the DRW**?
    - Current prison location, and location prior to & after DRW [as applicable], including experience of ISFLs

- Time period they were located on the DRW
- How they found out about the DRW & what they thought of it, including whether they wanted to be relocated to the DRW & why
- How expectations & reality of the DRW compared (inc. the DRW's reputation on other wings)
- How they exited the DRW [If previously on DRW but not currently], including whether they successfully completed it (or not) & why
- Any expectations they have about the future [after their time on the DRW]

- What do you think of your **relationships with staff** on the DRW?
  - Are they positive / negative / neutral & why *[probe for any specific examples – e.g. staff that have helped / hindered recovery goals & why]*.
  - Any differences in DRW staff and their relationships with them, compared to staff in other areas of the prison
- How do you feel about the **other prisoners** on the DRW?
  - Are relationships positive / negative / neutral & why
  - Any differences they've noticed in prisoners on the DRW, compared to those in the rest of the prison (inc. culture on DRW, attitude towards drug use, stigma from other prisoners)
  - Any observations relating to substance misuse among DRW prisoners
- What do you think about **safety and security** on the DRW? Is it a drug-free environment?
  - Thoughts on drug testing
  - Supply / trade of drugs on the DRW compared to within the general prison population
  - Experience of any incidents on the DRW (e.g. self-harm, violence, drug use)
  - Would prisoners inform staff if drugs were being used

Early outcomes

Aim: to explore the impact that being on the DRW / the DRW pathway has had on the prisoner.

- Have you seen any **personal benefits** from being involved in the DRW?
  - Have you seen any benefits for your peers / other prisoners on the DRW?
- Have there been any **challenges or difficulties** for you, resulting from your involvement in the DRW?

For both, prompt for:

- *Feelings about their ability to achieve recovery*
- *Engagement with their interventions / treatment*
- *Relationships with staff / other prisoners*
- *Changes in mental / physical health*
- *Satisfaction & compliance with regime / resettlement plan [where applicable]*
- *Remaining abstinent (or not – and, if so, how this was dealt with)*
- *Recovery from substance misuse / offending behaviour*
- *Feelings about returning to ISFL / general prison population after DRW*

- *Feelings about future release from prison (e.g. whether DRW has improved perceived likelihood of being securely housed / settled on release)*

- Could the DRW be improved, in your opinion? How?

Final thoughts

- Is there any other feedback about the DRW you'd like to share?

Thank & close

Annex 8 Ethics

The evaluation was undertaken in compliance with the ICF Research Ethics Policy, which operationalises Government Social Research (GSR) Ethical Assurance for Social and Behavioural Research (GSR, 2011). The consideration of ethical issues is especially critical when conducting a study including prisoners as research participants. Prisoners are a vulnerable research population due to the nature of imprisonment including their reduced autonomy. This vulnerability is heightened when participants have complex needs, including around substance misuse. The following steps were taken with consideration to the ethical issues identified.

- Ensure voluntary participation of staff and prisoners based on informed consent. This comprised the creation of easy-to-read information leaflets and a corresponding consent form which set out the purpose of the research, what participation involved, how the data would be used and analysed, confidentiality and that consent could be withdrawn at any time. This information was also shared verbally at the beginning of interviews to ensure understanding and provide an opportunity to ask questions.

- In communications with prisoners, the limit of confidentiality was also explained in relation to issues that researchers were obliged to disclose (such as indications that they are considering serious self-harm or suicide or serious breaches of prison rules).

- We recognised that prisoners could feel coerced into participating by prison staff, or have concerns about repercussions for refusing to participate. We also recognised they may feel uncomfortable taking part in interviews with prison staff present. To limit the potential risk of harm to research participants, we carried out interviews in separate rooms with prison officers waiting outside. Prisoners not wishing to participate were given the opportunity to wait inside the room with the researcher for a period of time, to ensure prison staff would not know that they had chosen not to take part.

- To minimise the risk of bias in the prison's selection of interviewees, they were provided with an introductory call and written guidance on the cross-section of interviewees that were desirable to interview. This included a list of key staff roles and a range of prisoners at different stages of the DRW pathway.

- Confidentiality and data protection process were aligned with GDPR requirements, but additional steps were also taken to ensure this was upheld. Voice recorders used to record interviews were encrypted and password protected, and the written notes made by researchers were anonymised to ensure they were not attached to names of participants. Transcripts from voice recordings were anonymised prior to use for data analysis. All data collected will be permanently deleted on completion of the evaluation.
- All the evaluation researchers were fully briefed and are aware of prison guidance for visitors. A debrief with senior members of the team (the project director and project manager) took place after each prison fieldwork visit.

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