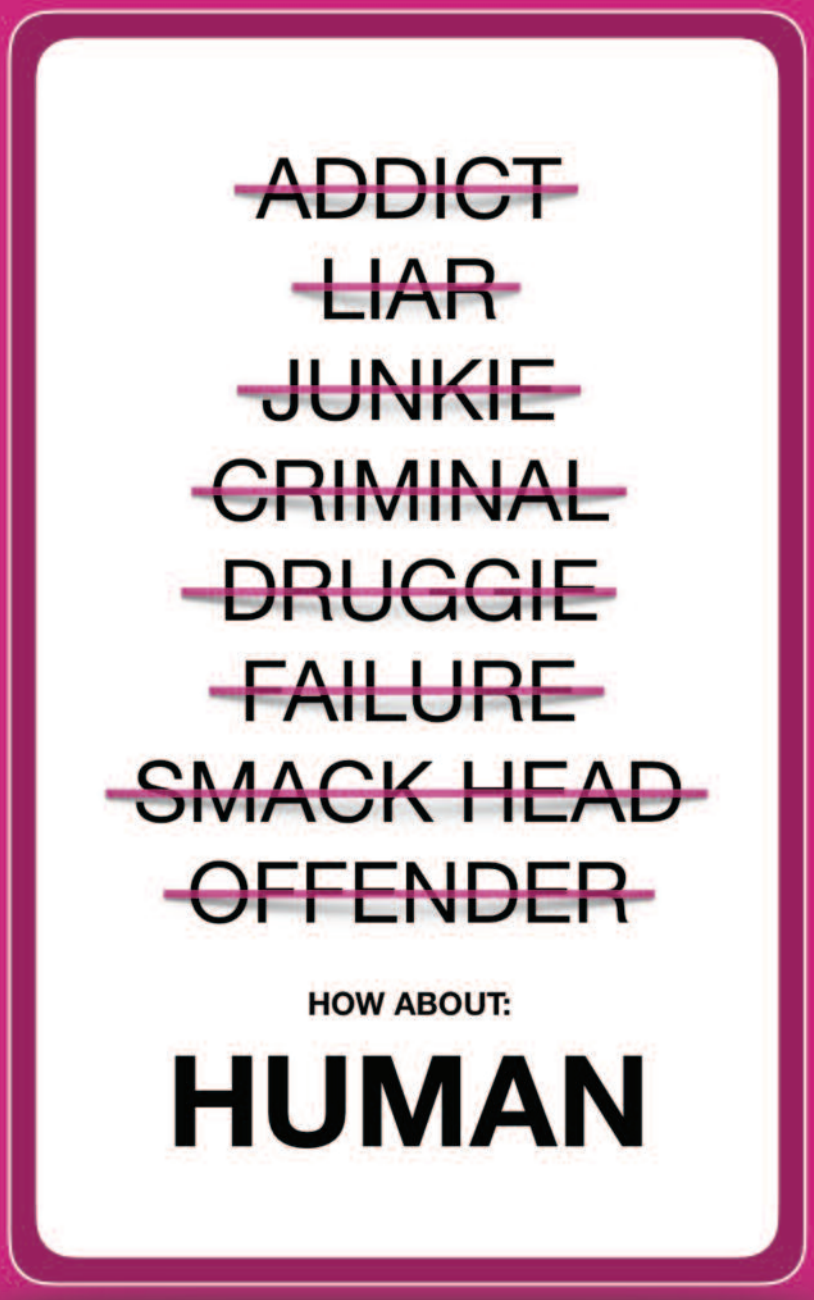
PRISON SERVICE
JOURNAL

March 2019 No 242



Special Edition

Recovery in Prison

Contents

Dave King has worked within the Recovery field for over 15 years. He is Drug Recovery Prison Programme Lead for NHS England and Head of Commissioning for Health and Justice (Cumbria and North East).

Dr David Best is Professor of Criminology at Sheffield Hallam University and Honorary Professor of Regulation and Global Governance at Australia's National University (ANU). ***Michael Wheatley*** is a senior manager and recovery advisor working in the substance misuse and mental health team in HMPPS and also works as the Drug Recovery Prison Programme Lead for HMPPS within HMP Holme House.

David Smith resides in Holme House and is a voluntary Drug and Alcohol Recovery Team worker, a servery worker and an active contributor to the DRP and associated regime activities

Dion Lee and ***Lee Ferguson*** also reside in HMP Holme House and are active contributors to the Drug Recovery Prison and associated regime activities

Michael Wheatley *is a senior manager and recovery advisor working in the substance misuse and mental health team in HMPPS and also works as the Drug Recovery Prison Programme Lead for HMPPS within HMP Holme House*

Dr Vicky Jervis is a Principal Clinical Psychologist based in the Mental Health Team at HMP Holme House.

March 2019

Printed at HMP Leyhill on 115 gsm and 200 gsm Galerie Art Satin
Set in 10 on 13 pt Frutiger Light
Circulation approx 6,500
ISSN 0300-3558

Editorial Comment

Michael Wheatley *and* ***Dave King*** *with* ***Professor David Best***

Michael Wheatley *is a senior manager and recovery advisor working in the substance misuse and mental health team in HMPPS. He also works as the Drug Recovery Prison Programme Lead for HMPPS within HMP Holme House.* ***Dave King*** *has worked within the Recovery field for over 15 years. He is Drug Recovery Prison Programme Lead for NHS England and Head of Commissioning for Health and Justice (Cumbria and North East).* ***Dr David Best*** *is Professor of Criminology at Sheffield Hallam University and Honorary Professor of Regulation and Global Governance at Australian National University.*

We are extremely grateful to Jamie Bennett and the PSJ Board for offering us the opportunity to guest edit this issue of the Prison Service Journal. Between the three of us, we have been involved with the issue of drug use in prisons and promoting recovery for many, many years. As with so many people, we all have experienced or know someone close to us who has encountered problems with using drugs, and who is now studying, working with or living in recovery. To have no exposure to this issue appears to be an exception to the rule.

When we talk about a drug, we mean any substance that when consumed causes a temporary physiological and often psychological change in the body and mind. This includes alcohol, tobacco, heroin, cocaine, cannabis, medicines and synthetic chemicals. This special edition is concentrating on overcoming drug addiction and promoting recovery from drug use in prison. However, the notion of recovery is very personal to each individual. It is a personal journey filled with learning and discoveries which help rebuild and reconnect people with their strengths and aspirations. It helps them live meaningful and satisfying lives. Recovery therefore can be applied to a range of issues such as mental health and getting better from a physical illness and is a holistic process of growth and change. It's not just about stopping drug use; it's about promoting overall wellbeing—a state characterised by good health, happiness and social satisfaction.

Drug use is an emotive subject. There is no escaping that there are different responses to those who use drugs across society whether they be supportive or punitive. Each person who uses drugs is first and foremost a person, or as the front cover reminds us, they are human. At times this vital point can be lost. Therefore, being able to devote a whole edition to recovery is both a honour and tremendous opportunity because we know that recovery happens every day. We know that when we have environments that allow recovery to grow and become visible that it is contagious moving from person to person.

So for this special issue of the PSJ, we decided to examine some of the different constituent parts that help us understand why and how people recover and how this can be used to promote recovery in prison. We have invited contributions from a wide range of people with knowledge and experience of the subject. In the first section, you can read about what we mean by recovery. The second section discusses practises within prisons that can help develop our ideas about how to respond and promote recovery. In the final section we explore the operational context in order to better understand and use it to adapt our responses. We have also provided a voice for people in recovery to contribute to this process and to tell us about their experiences. It was not possible, of course, to include articles about every relevant issue. We intend to publish studies related to recovery activity in the next edition of the PSJ as well as inspire more contributions about recovery in order to maintain a profile in forthcoming issues of this Journal.

We would like to thank all the authors who responded so positively to the invitation to contribute. We hope you find it useful and thought provoking. Drug use and recovery is multifaceted. There is no single solution. We all need to work together and get involved if we are to make a difference. Can recovery in prison happen? We believe it can.

Acknowledgments

There are many people to thank for helping us to get to where we are today. Ian Blakeman (HMPPS) and Julie Dhuny (NHS England) for their support and faith in recovery concepts; Chris Dyer (Governor) for trusting us to work within HMP Holme House; Kate Davies (NHS England) and Becky Wyse (MoJ) for leading the DRP Governance Group; Mark Gillyon-Powell (NHS E) and Kieran Lynch (PHE) for ongoing support; Alpa Parmar and Ben Hall (MoJ) for taking care of the policy implications; Maria Angulo (MoJ) for helping figure out how to evaluate the DRP programme; and the DRP Programme Team for their dedication.Cover inspiration: Brad McLeod.

Definitions of Recovery

Dr. David Best *is Professor of Criminology at Sheffield Hallam University and Honorary Professor of Regulation and Global Governance at Australian National University.* ***Michael Wheatley*** is a senior manager and recovery advisor working in the substance misuse and mental health team in HMPPS and also works as the Drug Recovery Prison Programme Lead for HMPPS within HMP Holme House.

Background

Since people have begun to consider 'addiction' as a form of disease or disorder, there has been debate about what substances and activities it should be applied to (for example, smoking, chocolate, gambling, work and exercise) and how it should be defined (by substance, the user, frequency and quantity of use, the route of administration, the severity of withdrawals or cravings). Similar issues apply to recovery, with what would appear to be a clear behaviour (stopping or moderating use), not being regarded as a satisfactory or adequate criterion for recovery. This chapter will examine some of the definitions that have been put forward, and some of the broader structural and contextual factors that are relevant. The chapter will conclude by explaining not only what recovery is but how it is likely to come about.

Consensus groups and expert opinions

The Betty Ford Institute Consensus Panel defines recovery from substance use disorders as a 'voluntarily maintained lifestyle characterised by sobriety, personal health and citizenship'.[1] The group recognised that recovery takes time and identified stages of recovery as 'early' (first year of recovery), 'sustained' recovery of between one and five years, and 'stable' recovery of more than five years. This staged process is based on work by Dennis, Foss and Scott[2] who in an eight-year outcome study, showed that the risk of relapse in the first year post-detoxification was above 50 per cent but, for individuals who achieved five years of continuous sobriety, their recovery could be described as 'self-sustaining' with little external support needed to sustain positive change.

In the UK, a similar consensus group was established by the UK Drug Policy Commission, who defined recovery as 'voluntarily sustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society'.[3] Consistent with the Betty Ford Group, there are three common elements—something about sobriety (albeit with a less stringent requirement for complete abstinence in the UK version), something about global health and wellbeing and something about citizenship or active participation in the lived community.

Both of these definitions are behavioural and static—in other words they do not capture the subjective and experiential components of recovery that, for example, Deegan[4] has identified as essential for mental health recovery. Deegan argued that the personalisation of ownership of recovery was both intrinsic to the experience and empowering. The definition also does not convey the sense of a journey or an aspiration that is characterised in Dennis and colleagues' work on stages of recovery.[5] The importance of the subjective experience has been taken to a logical conclusion by Phil Valentine[6] who has argued that 'you are in recovery if you say you are' Although this is an extreme position to adopt, it recognises that recovery can be an aspirational state as much as an achievement and that, for many, recovery feels like a journey rather than as a destination.

A third definition comes from the Substance Abuse and Mental Health Services Administration, who agreed on the following working definition of recovery: 'A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.'[7]

1. Betty Ford Institute Consensus Panel (2007) 'What is recovery? A working definition from the Betty Ford Institute', *Journal of Substance Abuse Treatment,* 33: 221-228. https://doi.org/10.1016.j.jsat2007.06.001 (p222)
2. Dennis, M., Foss, M. & Scott, C. (2008)An eight-year perspective on the relationship between the Duration of Abstinence and Other Aspects of Recovery, Evaluation Review, , 31, 585. https://doi.org/10.1177/0193841X07307771
3. United Kingdom Drug Policy Commission (2008) Reducing drug use, reducing offending: *Are programmes for problem drug-using offenders in the UK supported by the evidence?* London, England.
4. Deegan, P. (1996) 'Recovery as a journey of the heart', Psychiatric Rehabilitation Journal, 19 (3), 91–97.
5. Dennis, M., Foss, M. & Scott, C. (2008)An eight-year perspective on the relationship between the Duration of Abstinence and Other Aspects of Recovery, Evaluation Review, , 31, 585, DOI: 10.1177/0193841X07307771.
6. Valentine, P (2011). Peer based recovery support services within a recovery community organisation: The CCAR experience. In J.F. Kelly and W.L.White (Eds), *Addiction Recovery Management* (pp.259-279). New York: Humana Press.
7. SAMHSA - https://store.samsha.gov/system/files/pep12-recdef.pdf

Policy-based definitions of recovery

What systems and processes support and facilitate recovery pathways? In 2008, the Scottish Government[8] issued a new recovery based drug strategy that talked of making a 'fresh start' in tackling drug problems. The document defined recovery as 'a process through which an individual is enabled to move on from their problem drug use, towards a drug-free life as an active and contributing member of society.' The sense of subjectivity is captured in the further explanation that 'In practice, recovery will mean different things at different times to each individual person with problem drug use.'

In England, it took a further two years for recovery to be embedded in drug strategy[9] asserting that 'A fundamental difference between this strategy and those that have gone before is that instead of focusing primarily on reducing the harms caused by drug misuse, our approach will be to go much further and offer every support for people to choose recovery as an achievable way out of dependency'. The UK drug strategy (2010) recognised both the subjective and journey aspects of recovery in describing recovery as: 'An individual, person-centred journey, as opposed to an end state, and one that will mean different things to different people. We must therefore, put the individual at the heart of any recovery system and commission a range of services at the local level to provide tailored packages of care and support'.

Not only do each of these definitions recognise individualised pathways, they assert systems and services should be responsive to individual needs and that are predicated on opportunities and strengths. Although the 2017 Drug Strategy in England[10] switched back to more of a health and harm reduction focus, Chapter 3 outlines a model of recovery that claims 'We will raise our ambition for recovery by enhancing treatment quality and improving outcomes through tailored interventions for different user groups' The focus is increasingly on a partnership model that recognises the complexity of recovery and the need for addressing issues such as housing, trauma, education and employment, stigma and exclusion.

The challenge for policy-makers is how to translate those broad definitions into things that can be monitored and measured. In both Scotland and England, there remain questions about how effectively these lofty aspirations have been realised, with more basic questions around mechanisms and underpinning activities also remaining unanswered. In the next section, we move onto a consideration of a predominantly US literature that has attempted to create a framework for the implementation of a recovery model.

The challenge for policy-makers is how to translate those broad definitions into things that can be monitored and measured.

Recovery as a multi-layered and social concept

There is a growing recognition that recovery is not simply a series of behaviours or even an experiential state but also has the potential to be something much more social and societal. In their conceptualisation of recovery as a social movement, Beckwith, Bliuc and Best[11] suggested that 'recovery' is a group or movement that an individual can belong to as well as a series of experiences and changes they undergo. The article also considered whether recovery has an intrinsically social component where group membership and the resulting sense of belonging is central to the experience and expression of recovery. This idea of recovery as a social identity is described in the Social Identity Model of Recovery (SIMOR),[12] in which 12-step fellowships were used as an example of this idea of recovery as a group identity. In 12-Step programmes, the transition to stable recovery is characterised by changing from 'using' groups to 'recovery' groups as the main social supports the individual has. SIMOR makes the point that changes in social group membership involves the internalisation of the values, norms and attitudes of the new group and that this influences future identity and behaviour.

8. Scottish Government (2008) The Road to Recovery; Available at: http://www.emcdda.europa.eu/attachements.cfm/att_53209_EN_Scotland%20Strategy%202008.pdf (Accessed 26/05/2015).
9. Home Office (2010) Drug Strategy 2010 Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a *Drug Free Life.* Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/118336/drug-strategy-2010.pdf
10. UK Government (2017) 2017 Drug Strategy, Home Office: London.
11. Beckwith, M., Best, D. & Bliuc, A. (2016) What the recovery movement tells us about pre-figurative politics, *Journal of Social and Political Psychology,* 4(1), 238-251.
12. Best, D., Irving, J. & Albertson, K. (2016) Recovery and desistance: What the emerging recovery movement in the drug and alcohol area can learn from models of desistance from offending, Addiction Research and Theory. https://doi.org/10.1080/16066359.2016.1185661

So, when Longabaugh et al[13] asserted that one of the key characteristics of successful recovery was the transition from membership of groups supportive of substance use to groups supportive of recovery, they were characterising recovery in terms of both a behaviour change and a transition in identity.

This is illustrated in a randomised trial conducted by Litt and colleagues[14] which involved a group of problem drinkers who, after detoxification, were randomised to either standard aftercare or to a Network Support condition (in which participants were assertively linked to at least one person to befriend who was in long-term recovery). For individuals who had at least one completely sober person added to their social network, their likelihood of relapse to substance use was reduced by 27 per cent in the following year.

Recovery oriented systems of care

Recovery does not usually occur in isolation and so systems and services should be designed in such a way that the likelihood of sustainable change is maximised. On behalf of the Substance Abuse and Mental Health Services Administration, Sheedy and Whitter[15] outlined the concept of a Recovery-Oriented System of Care as 'networks of organizations, agencies, and community members that coordinate a wide spectrum of services to prevent, intervene in, and treat substance use problems and disorders' They draw on a paper from Gagne, White and Anthony[16] which outlined key principles for a recovery approach: in which recovery is characterised as a personalised and individualised process of growth that unfolds along a continuum and there are many pathways to recovery; that people in recovery are active agents of change in their lives and not passive recipients of services; and that people in recovery often talk about the importance of family and peer support in making the difference in their recovery. From a service perspective they suggest that recovery-oriented systems should recognise that each person is the agent of his or her own recovery and all services can be organized to support recovery, and they need to offer choice, honour each person's potential for growth, focus on a person's strengths, and attend to the overall health and wellness of a person with mental illness and/or addiction.

Sheedy and Whitter also outline guiding principles of recovery which supplements the above by adding principles indicating that recovery involves a personal recognition of the need for transformation and change, that it is holistic, culturally embedded, that it involves (re)joining and (re)building a life in the community, and that recovery emerges from hope and gratitude. They go on to suggest that recovery also involves addressing discrimination and transcending shame and stigma.

To support these goals for recovery, Sheedy and Whitter build on the definitions of recovery to argue that a recovery system can be assessed against the extent to which it:

- ❒ Is person-centred;
- ❒ Includes family and other supporters;
- ❒ Provides individualised and comprehensive support across the life course;
- ❒ Is anchored in the community;
- ❒ Continues care seamlessly between services;
- ❒ Includes consultant relationships;
- ❒ Focuses on strengths;
- ❒ Is culturally responsive and responsive to personal belief systems;
- ❒ Committed to peer recovery support;
- ❒ Include the voice of the person in recovery and their family members;
- ❒ Be integrated
- ❒ Involves system-wide education and training;
- ❒ Includes ongoing monitoring and outreach;
- ❒ Is outcomes and research based; and
- ❒ Is adequately and flexibly financed.

Recovery does not usually occur in isolation and so systems and services should be designed in such a way that the likelihood of sustainable change is maximised.

Whilst much of the evidence around recovery is drawn from the mental health recovery field, there is

13. Longabaugh, R., Wirtz, P. W., Zywiak, W. H., and O'Malley, S. S. (2010). Network support as a prognostic indicator of drinking outcomes: The COMBINE study', *Journal of Studies on Alcohol and Drugs*, 71(6), 837.
14. Litt, M.D., Kadden, R.M., Kabela-Cormier, E., & Petry, N. (2007). Changing network support for drinking: Initial findings from the Network Support Project. Journal of Consulting and Clinical Psychology, 75, 542
15. Sheedy C. K., and Whitter M., (2009) Guiding Principles and Elements of Recovery-Oriented Systems of Care: What Do We Know From the Research? HHS Publication No. (SMA) 09-4439. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.
16. Gagne, C., White, W., Anthony, W.A. (2007) Recovery: A common vision for the fields of mental health and addictions. *Psychiatric Rehabilitation Journal,* 31(1): 32-37.

significant support for some of the constituent elements outlined above and the research into recovery from addiction is increasing.

This means that we are now able to start to build recovery models that are predicated on evidence, and define recovery in a way that includes all different types of people and groups.

CHIME

In this section we describe how these elements of recovery are combined into a single model that has been amended from the mental health field. In 2011, Leamy and colleagues[17] reviewed the evidence around mental health recovery and attempted to identify 'essential elements' of effective recovery-oriented interventions, based on 97 research papers conducted in 13 countries. They identified 13 characteristics of the recovery journey:

- ❒ Recovery is an active process
- ❒ Recovery is a unique and individual process
- ❒ Recovery is a non-linear process—people have ups and downs
- ❒ Recovery is a journey
- ❒ Recovery occurs in stages or phases
- ❒ Recovery is a struggle
- ❒ Recovery involves change in many aspects of a person's life (multi-dimensional)
- ❒ Recovery is a gradual process
- ❒ Recovery is a life-changing experience
- ❒ Recovery can occur without there being a cure
- ❒ Recovery is aided by a supportive and healing environment
- ❒ Recovery can occur without professional intervention
- ❒ Recovery can often be a trial and error process while each person learns what works for them

The review concluded that there are five essential elements of the recovery process that make up the acronym CHIME. CHIME stands for Connectedness; Hope; Identity; Meaning and Empowerment, and Table 1 below outlines the key factors involved in each element of recovery:

Table 1: Essential components of CHIME

Connectedness	Peer support and support groups Relationships
Hope	Support from others Being part of the community Belief in the possibility of recovery Motivation to change
	Hope-inspiring relationships Positive thinking and valuing success Having dreams and aspirations
Identity	Dimensions of identity Rebuilding and redefining a positive sense of identity Overcoming stigma
Meaning	Giving meaning to mental illness experiences Spirituality Quality of life Meaningful life and social roles Meaningful life and social goals Rebuilding life
Empowerment	Personal responsibility Control over life Focusing upon strengths

In the conclusion to the paper, Leamy and colleagues pointed out that the vagueness of the term recovery has led to considerable uncertainty for policy makers and practitioners. They hoped that CHIME offered an 'empirically based conceptual framework which can bring some order to this potential chaos' In our view, the real contribution of CHIME is that it explains personal recovery and also suggests what helping agencies/services should focus on to help people in their recovery journey.

A social identity and recovery capital model of CHIME

In this section of the paper, we will bring together two of the models outlined above, CHIME and SIMOR (the Social Identity Model of Recovery) to consider how personal pathways to recovery it with what we know about how people change and what support they need.

A new concept, Recovery Capital[18] was introduced by Granfield and Cloud in 2001[19] to describe the assets and resources available to an individual in their recovery journey. Recovery Capital is defined as with the sum

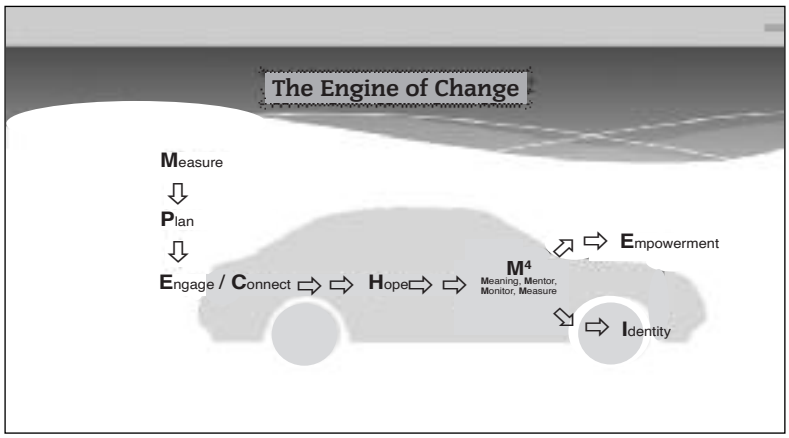
17. Leamy, M., Bird, V., Le Boutillier, C., Williams, J., and Slade, M. (2011) 'A conceptual framework for personal recovery in mental health: systematic review and narrative synthesis', British Journal of Psychiatry, 199, 445–452.
18. See Best, Hall and Collinson article in this journal for a more detailed description.
19. Cloud, W. and Granfield, R. (2008) 'Conceptualising recovery capital: Expansion of a theoretical construct', Substance Use and Misuse, 43:1971-1986.

total of one's resources that can be brought to bear on the initiation and maintenance of substance misuse cessation'[20]. This paper also introduced the concept of negative recovery capital to describe those life factors (such as significant mental health problems or prolonged involvement with the criminal justice system) that could act as barriers to recovery. Best and Laudet[21] divided recovery capital into three broad categories—personal, social and community capital. The gradual transition to a quantifiable model for recovery capital has come to fruition in Cano et al's[22] model of REC-CAP (also described in the Best, Hall and Collinson article in this issue).

The ability to measure recovery wellbeing is important for those supporting people on a recovery journey as it provides a means of assessing how an individual is doing and what resources they have to support their recovery journey. Measurement needs to include all three elements of personal skills and competences, social supports and social ties, and resources that are available and accessible in the local community. REC-CAP not only records personal progression but also assesses the accessibility and utility of recovery groups and networks in the lived community.

In a CHIME model, the importance of social factors and social support is emphasised in the Connectedness component. One way of conceptualising CHIME as a process is as a vehicle in which connections generate hope and hope is then the fuel that fires an engine that can drive changes in activity leading to changes in identity and a sense of empowerment as shown in Figure 1 below:

Figure 1: CHIME and addiction recovery



The idea here is a simple one—as outlined in the Social Identity Model of Recovery, engagement with individuals or groups who support recovery and who create a tie of belonging and identity—generates a new sense of social identity. Connections to new groups (particularly peer groups) generate a sense of hope through seeing other people succeed and social learning through observing their behaviours that generates hope and self-belief. However, this needs to inspire activity as this will be the catalyst to changes in how the person is perceived by others and how they perceive themselves.

The CHIME model explains how this works: connections to individuals or groups who are in recovery provide opportunities for social learning and social control around recovery[23]. This exposure to successful recovery creates a 'social contagion' in which recovery is transmitted from one person in recovery to another[24] The CHIME model adds the insight that what is transmitted is a sense of Hope. Thus, through watching other people succeed in recovery, the individual not only learns the techniques of successful recovery but is inspired in the belief that it is possible for them as well.

In the image of the car in Figure 1, hope is seen as the fuel that drives the engine of recovery change, (previously generally been referred to as motivation). In the CHIME model, the combination of external support (connection) and internal motivation (hope) then creates a virtuous circle of meaningful activities, a sense of empowerment and a positive change of identity (that is socially mediated as outlined in the SIMOR model).

So, consistent with the evidence from our previous work on the importance of meaningful activities in recovery[25,26] involvement in a diverse range of prosocial activities, such as volunteering, further education, team sport, fitness activities and employment, provide an impetus towards positive change. Engagement in meaningful activities has a positive effect on self-perception and identity, and generates self-esteem, self-efficacy and feelings of wellbeing. In Best et al's 2016 research, engagement in a recovery community that was based on

20. Cloud and Granfield (2008) as above (p.1972).
21. Best, D. & Laudet, A. (2010) The potential of recovery capital. RSA Projects. Royal Society for the Arts.
22. Cano, I., Best, Edwards, M. & Lehman, J. (2017) Recovery capital pathways: Mapping the components of recovery wellbeing, Drug and Alcohol Dependence, 181, 11-19.
23. Moos, R.H. (2007). Theory-based active ingredients of effective treatments for substance use disorders. Drug and Alcohol Dependence, 88, 109–121.
24. White, W (2010). Recovery is contagious. www.williamwhitepapers.com/pr/2010%20Recovery%20is%20Cantagious.pdf
25. Best, D., Gow, J., Taylor, A., Knox, A. & White, W. (2011) Recovery from heroin or alcohol dependence: A qualitative account of the recovery experience in Glasgow. Journal of Drug Issues, 11 (1), 359-378.
26. Cano, I., Best, Edwards, M. & Lehman, J. (2017) Recovery capital pathways: Mapping the components of recovery wellbeing, Drug and Alcohol Dependence, 181, 11-19.

building recovery housing in the north of England was associated with improvements not only in substance use and offending, but also in psychological health and personal recovery capital, including factors such as self-esteem and self-efficacy. The CHIME model is fundamentally social and societal in its focus. The reliance on connection and contagion as the triggers for change mean that, for all but the small minority who can achieve recovery without any external supports (what Granfield and Cloud[27] referred to as 'natural recovery') there is a need for accessible, attractive and visible recovery groups, resources and champions to promote and catalyse the recovery process. In the SIMOR paper (Best et al, 2016) we use the example of Alcoholics Anonymous to describe the process of group engagement and identification, this recovery model relies on individuals (referred to as sponsors) to support ongoing recovery processes.

There is also a further level that is relevant to Recovery Oriented Systems of Care and that is the community or societal level. It is essential that individuals who are trapped in addiction have access to visible sources of support and inspiration to create a 'therapeutic landscape' that increases the accessibility and visibility of recovery and the perception that it is a realistic objective. They not only initiate recovery but sustain it through access to resources in the community including but not restricted to peer and mutual aid groups, and by taking advantages of opportunities for a sense of belonging and engagement in the local community. Some of these things are beyond the gift of the person in recovery and will require a societal commitment to reintegrate and support people in recovery.

So what does the CHIME model of addiction recovery add to the existing literature and knowledge base? CHIME offers a framework for how people can both initiate and be sustained in their recovery journey and describes what kind of personal support and structural support is needed to support this process. At a social level, the aim is to create a group of visible recovery champions and groups to enact the contagion and to support the resulting process of change. In the prisons, this would mean an emphasis on peer champions being identified and having an active role in supporting recovery not only in the prison but with continuity of care to post-release. At a societal level, pathways to reintegration are needed to build the virtuous circle of access to housing, jobs and community engagement that will fuel the journey to recovery. This boosts the personal responsibilities and growing sense of agency that individuals must develop over the course of the personal and individual recovery journey.

How is this relevant to the prison population?

There is a significant overlap between offending and problem drug using populations: whilst drugs do not automatically lead to crime, the interplay is undeniably significant[28]. 64 per cent of the prison population have been identified as having problem drug use, and substance use is a strong predictor for recidivistic crimes[29] suggesting a strong reciprocal relationship. So, the first reason why the recovery model is relevant to prisons is that a high proportion of the prison population will need to recover. There is a second area of overlap which involves shared characteristics between the recovery journal and a journey to rehabilitation and to reintegration from a marginalised and excluded identity and status[30]. The same mechanisms of accessing community capital and building positive prosocial relationships are as highly relevant to the desistance process as are changes in self-esteem, self-efficacy and identity (both personal and social).

Conclusion

Recovery is a concept that has grown in political status and academic interest in recent years. It is still a highly contested term, in spite of 10 years of attempts to capture and encapsulate key aspects of its meaning—not only in the addictions field but also in the mental health area. Although behavioural correlates like employment, abstinence and health are generally included in definitions, it is clear that recovery is an individualised experience that will evolve over time and that it has a strong subjective component. The components of recovery can be measured and quantified using the framework of recovery capital and this provides a strengths-based approach that is more consistent with a model to build personal and social wellbeing. However, it is also clear that recovery is not a linear pathway, and that it requires personal commitment and drive, as well as also the opportunity for reintegration afforded by friends and family, and by employers, housing authorities and communities. To this extent, recovery requires a shared commitment to social justice and a belief in the capacity to rehabilitate and to participate fully in the community.

28. Van Roeyen, S., Anderson, S., Vanderplasschen, W., Colman, C. & Vander Laenen, F. (2017) Desistance in drug-using offenders: A narrative review, European Journal of Criminology, 14(5), 606-625.
29. Nurco, D. (2009) A long-term program of research on drug use and crime, Substance Use and Misuse, 33(9), 1817-1837.
30. Best, D., Irving, J. & Albertson, K. (2016) Recovery and desistance: What the emerging recovery movement in the drug and alcohol area can learn from models of desistance from offending, Addiction Research and Theory, DOI: 10.1080/16066359.2016.1185661

What Recovery Means To Me

David Smith *resides in Holme House and is a voluntary Drug and Alcohol Recovery Team worker, a servery worker and an active contributor to the DRP and associated regime activities*

I've only ever known recovery to be when '*breaking down in my car*'. That changed when I started my prison life, which I now class as overcoming a drink/drug addiction, and being in recovery, beating the addiction and trying new ways of going with day to day life instead of drowning it in drugs. All that does is block it out until the drugs wear off.

So, I'm in recovery and trying new ways, attending meetings with DART and working with peer mentors, and hoping to change my mind set and build on strengths to overcome the urge of relapsing and falling back in to old habits. Also possibly breaking the circle of friends that I have, as that could be the main trigger in taking drugs.

When in recovery, I think the main importance to recovering is having the right people and positive supports around you, so if a time does come to you relapsing, then you have the positive people around you to make sure you maintain the recovery and keep you on the right positive track in recovering, and overcome the addiction.

Keep a positive mind.
Keep busy.
Overcoming the urge.

What Recovery Means to Me

Dion Lee, *resides in Holme House and is a proud father, a Recovery Navigator and an active contributor to the DRP and associated regime activities*

Recovery is a word/term that I am not very keen on! As well as disempowering, it suggests that a person was previously 'ok' and then became ill or sick, and then after a period of 'recovery', they will be 'ok' again. Alternatively, you will be in recovery forever (in limbo), and never fully 'ok' again? As if 'ok' exists.

If I think of this term 'recovery' within the context of a person's journey, or their personal growth, terms like drug abuse, self-medicating, dependency, desistance (terms associated with identifying substance misuse) are all subjective. The root causes (disease) are always particular to the individual. Observing symptoms is a completely different thing! It may not be possible, in reality, to render an accurate diagnosis/identification of the actual disease, without the benefit of hindsight. Trial and error is par for the course 'in that sense'.

I used to think that this baseline/foundation ultimately degraded the efficiency of systems designed to support people on their journey (in their growth) to less than adequate or even a lottery. However, after years of badgering and challenging some very patient academics and professionals, I came to the conclusion that the efficiency of such systems is more dependent on the prevailing perceptions of the environment within the environment, that the systems are being deployed in.

Self-reflection is key, and any medium (other than unnecessary incarceration/isolation) that promotes and encourages honest self-reflection, without judgement, is vital not only as a harm reduction tool, but as the most effective form of treatment, for recovery and rehabilitation I think.

My life has been intertwined with all facets of drug use for over 30 years (maybe even before I was born). On reflection, I notice that most people get tired or fed up with their status quo over a period of time, and then a timely event (events) will act as a catalyst for their change/growth spurt—'the critical point'.

After such an event, in the short term, the individual may not have reached (on their journey/growth) a sustainable tempo, plateau, or level they can maintain. But, the experience that they gain will make them definitely more likely to succeed the next time they reach that 'critical point' in the future.

It is very important for service users and providers to recognise that on any individual's journey, some 'zones' (places/times) are more supportive of, or conducive to change than others, not only for individuals, but generally.

When identified, these could be definitive zones where systems and resources can be more effectively deployed.

If I try to apply an analogue, I read somewhere a while ago to try and express what I feel, then, incarceration, prison transfers or release should be viewed less as a boundary (divisive, final, restrictive), and more like a border (connective, central, enabling) a definitive zone where activity of all kinds, namely physical, mental and emotional, are more concentrated relative to before and after.

With naturally more relative 'potential' for 'events' to occur that is crossover/exchanges of ideas, ways out (critical points), the reason I prefer the term growth to recovery is because it is emotional growth and intellectual growth that cause an individual to mature over time (regardless of age!) to a stage where they can better manage life, interactions and their own natural disposition more efficiently. Every exposure to any new or alternative ideas, strategies, techniques etc. that occur in one of these 'border' zones are perfect opportunities for an individual to recognise agency in action, either from watching others go through the process of observing, adapting and modelling new activities that is crossing borders or reflecting on themselves and how they managed the border. These are events that can become critical points that precede major change/growth.

I suppose the main point is that systems of support must be structured, so as to be in place and initiate at the right time in a person's journey (at a border to potentially benefit the many). Otherwise, the window of opportunity is missed, exposure to these systems at the wrong time is more often than not consciously resisted and/or manipulated, which is a drain on resources, and more importantly, psychologically and emotionally damaging to users, providers and society.

Engineering the environment with the requisite triggers and support systems here would not take a feat of magic! However, nibbling around the edges or tinkering will not put a dent in the problem. Someone must be brave and push the boat out.

I do fully realise that institutional change is not easy. Change is a thing (ironically) resisted by all! It will be met with resistance and castigation from cynics on all sides, but I can assure you that challenges you will face implementing such change pales in comparison to the gauntlet ran by inmates (those not viewed as victims) who try to stand for what is right and promote positive change. In action, that is a 'real life tightrope walk' with no safety net.

The DRP is one of the most effective resources I have come across in the prison service, both practically and as a concept. It does not seem to be a part of the old rusty machinery. It bridges so many gaps, gets so much done, not passing the buck (fearfully or disingenuously) like most other rusty cogs in the HMPS, wherein lies the problem and the opportunity. Instead of the DRP trying desperately to cover all the deficits reactively, they could be working proactively implementing new approaches to regime, residency, as well as rehabilitation.

Service users need to see and feel more than (with respect) good intentions and sociological jargon that they don't understand. They need to see a clear, tangible path/plan to follow (orientation or induction blocks, progression blocks, mid-long term blocks, pre-release blocks etc.). We will then build our communities and moderate ourselves accordingly, reflecting the community outside. We don't need to reinvent the wheel. Help us to help ourselves to create an 'enabling environment' by structuring our entry, stay and departure from this traumatic event.

We can be pros not just cons!

What Recovery Means to Me

Lee Ferguson *resides in Holme House and is the Chair of the Democratic Council, a voluntary Drug and Alcohol Recovery Team worker and an active contributor to the DRP and associated regime activities*

My recovery is a complicated and complex issue, linked with every thought and action at the present moment in time, closely connected to what the future holds. Yet recovery is so simple, as this is the real me, a happy, productive person, who has reconnected with a love of life and people. However, a constant battle between past and present rages on inside of me, and an internal tug of war with no end in sight that could determine life or death. Within this ongoing struggle I relish each new day, and challenge, as the real human being inside of me is firmly finding a way to fill the void of addiction.

My battle of recovery is being won after embedding new core principles into my life, such as beliefs and values strong enough to speak about and hopefully influence my children. Firstly, keeping fit through regular exercise and gym is a core principle for myself. Secondly is education, for my own personal development in the short term, and in the long term. What I learn will go towards supporting my new beliefs and values around working in addiction. Instead of running away from my problems as I did in the past, I face addiction head on to strengthen my understanding of recovery.

If I give way to my desires of addiction, there will be no inner struggle, no friction, and no fight, but if I struggle to achieve my goals with desires that hinder me, I can create a fight inside worthy of winning.

Recovery is now winning this war of attraction! Breaking down addiction, to overcome myself.

Promoting Recovery in Prison

The Holme House Approach

Michael Wheatley *is a senior manager and recovery advisor working in the substance misuse and mental health team in the Safety and Rehabilitation Directorate of Her Majesty's Prison and Probation Service and also works as the Drug Recovery Prison Programme Lead for HMPPS within HMP Holme House*

Background

In May 2016, Prime Minister David Cameron and the Secretary of State for Justice, Michael Gove, proudly announced the 'biggest shake up of prisons since Victorian times'. Six reform prisons were named to test new ways of working. HMP Holme House in the North East of England was one of the six prisons. The Governor was offered extended freedoms to manage the prison in order to focus on big social reforms that would extend life changes and opportunities for all. No longer would prisons be warehouses for criminals; they were to be places where lives are changed.[1]

Later that year an idea was proposed. By pooling resources from the Department of Health (now Department of Health and Social Care) and the Ministry of Justice could a programme of work be jointly commissioned that better tackled drug use in prison and utilised the new freedoms bestowed on reform prison Governors? NHS England and Her Majesty's Prison and Probation Service (HMPPS) accepted the challenge and identified Holme House to be a pathfinder site building on the good partnerships that existed between Public Health England, NHS England, HMPPS and the prison. So, in December 2016 the Drug Recovery Prison (DRP) programme was born. Its ambition to discover new learning and ways of working that could be used to improve ways to tackle drugs in prison.

HMPPS and NHS England identified programme leads and they set about developing a plan. This plan would act as a route map and allow people to see why things could be done differently (purpose), how the programme was going to work (process) and what would be done differently to make things happen (practice). It took three months to draft the plan which involved widespread consultation with key stakeholders.

In April 2017, the programme officially began. Funding delegation letters were issued by the Ministry of Justice and Department of Health, via HMPPS and NHS England. A total budget of up to three million pounds per year was identified, divided between HMPPS and NHS England. The life of the plan was separated into three phases: Year one, developing and initiating; year two, implementing and progressing; year three, consolidating and maintaining as well as exploring options to sustain practices beyond the final year of the programme. The programme plan is revised annually to maintain focus and make adjustments in light of discoveries made during the operational period.

During the first year, the plan was aligned to the HM Government Drug Strategy 2017. This national strategy aimed to 'reduce all illicit and other harmful drug use, and increase the rate of individuals recovering from their dependence.'[2] This strategy advocated an approach focusing on four key themes: restricting supply, reducing demand, building recovery and contributing towards global action. The DRP integrated these themes into its plan.

The Purpose—Why do things differently?

The purpose of the recovery programme at Holme House is to get everyone living and working in the prison to collaborate, to create better chances for people in recovery to change and feel hopeful and optimistic about their future. Our aim is to generate opportunities for people in recovery to flourish and achieve their full potential thereby making a better life for themselves and others.

Before we explore the purpose of the DRP we should first discuss the prevalent context within which drug use in prison is set.

A widespread belief permeates our culture. Johann Hari discusses this in his book, Chasing the Scream: The first and last days of the war on drugs[3] and TED Talk[4].

1. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/565014/cm-9350-prison-safety-and-reform-_web_.pdf
2. HM Government Drug Strategy 2017. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/628148/Drug_strategy_2017.PDF
3. Hari, J (2015) Chasing the Scream: The first and last days of the war on drugs. London: Bloomsbury.
4. https://www.ted.com/talks/johann_hari_everything_you_think_you_know_about_addiction_is_wrong

He says the message, that has been promoted by Governments and the media extensively, is that drug users are criminals who need to be ashamed of what they do and controlled. Coercion is the way to stop people taking drugs; punishing and shaming drug users will make them stop. But, Hari says for many this does not work. What's more, it can make some people worse. Commentators argue this is indeed what we are seeing in prisons today.[5]

So, what if we viewed drug use in prison differently and see it instead as an adaptation, a coping response, to harsh and unstimulating environmental conditions?[6] What if prisoners have experienced adverse childhood experiences, sustain trauma and feel pain on a daily basis and cannot bear to be present with this reality? What if prisoners feel increasingly disconnected and isolated from the communities they live within?[7] What if feelings of being unsafe and insecure pervade everyday existence as a result of stigmatisation and being involved in the drug supply network?

If we understood drug use this way should we not try a different approach? To help people cope with the causes of addiction and develop different coping strategies so people no longer feel the need to seek relief and reward from drugs to ease life stresses. In doing so, reduce reoffending and improve health and wellbeing associated with ongoing drug use. Hari suggests, 'drugs are not what we think they are. Drug addiction is not what we have been told it is. The drug war is not what our politicians have sold it as for one hundred years and counting. And there is a very different story out there waiting for us when we are ready to hear it—one that should leave us thrumming with hope.'

What if prisoners have experienced adverse childhood experiences, sustain trauma and feel pain on a daily basis and cannot bear to be present with this reality?

The DRP aimed to write that different story. The DRP story begins with existing helpful practices and develops new ways of working to get the best out of people and the opportunities we can generate for each other. In doing so, we aim to help people overcome their addictions, promote recovery and achieve their full potential.

Processes and Values—How the DRP programme is innovative?

The DRP builds on the strengths of existing guidance and core services specifications.[8 9 10] These practices, over the past decade, have contributed to opportunities for people to recover and achieve their full potential. For example, using medications in recovery[11] has transformed how drug use in prison is managed. Progressive leaps in consistent and standardised practice were made between 2000 and 2015 with the introduction of the Integrated Drug Treatment System (IDTS) in prisons in England.[12 13] This system established a consistent approach to opiate substitution treatment in prison and established psychosocial interventions as a core component of the clinical management of drug misuse.[14] This effectively built a standardised framework which:

- ❒ Improved the volume and quality of clinical interventions;
- ❒ Increased the use of opiate substitution maintenance prescribing and detoxication conducted over time periods determined collaboratively;
- ❒ Promoted a consistent approach to psychosocial interventions;
- ❒ Integrated drug treatment provision between pharmaceutical and psychosocial interventions; and
- ❒ Strengthened links to community services.

The Supply Reduction Good Practice Guide published in 2009[15] is also worth highlighting. This

5. https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2015/12/Substance-misuse-web-2015.pdf
6. Alexander, B.K. (2008). The Globilization of Addiction: A study in poverty of the spirit. Oxford University Press (p195).
7. Mate, G (2008). In the Realm of Hungy Ghosts: Close encounters with addiction. Random House: Canada.
8. Department of Health (2017) Drug Misuse and Dependence: UK guidelines on clinical management. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/673978/clinical_guidelines_2017.pdf
9. Integrated Substance Misuse Treatment (Prisons in England) Service Specification. https://www.england.nhs.uk/wp-content/uploads/2018/05/service-specification-integrated-substance-misuse-treatment-service-in-prisons.pdf
10. National Offender Management Services (2014) Security Management - Service Specification. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/278927/2014-01-09_Security_Managemt_Specification_P2.2.pdf
11. https://webarchive.nationalarchives.gov.uk/20170807160631/http://www.nta.nhs.uk/uploads/medications-in-recovery-main-report3.pdf
12. Ministry of Justice (2010) Integrated Drug Treatment System: Prison Service Instruction 45/2010. www.justice.gov.uk/downloads/offenders/psi-so/psi-2010/psi_2010_45_IDTS.doc
13. http://natcent.ac.uk/our_research/research/independent-evaluation-of-the-integrated-drug-treatment-system-in-prisons/
14. http://www.dldocs.stir.ac.uk/documents/adultprisons.pdf
15. Supply Reduction Good Practice Guide (2009) https://www.whatdotheyknow.com/request/70601/response/180218/attach/4/Prison%20 Drug%20Supply%20Reduction%20 Practice%20Guide.pdf

consolidated good practice across the English prison estate and produced checklists of activities that would help stifle the availability of illicit items coming into and circulating within prisons. These practices served to reduce demand and stifle availability of drugs within prisons. They were helpful in creating opportunities for people to recover.

Building on this framework, and to bring the DRP plan to life, we introduced four strategic delivery commitments which incorporated new or revised processes designed to:

- ❒ Promote safety and security (restricting supply)
- ❒ Enhance care and wellbeing (reducing demand)
- ❒ Develop the prison environment, making it a more positive place (building recovery)
- ❒ Strengthen continuity of care post release by creating vibrant and sustainable links to communities (building recovery)

A central theme running throughout the plan is being responsive to both staff and prisoners, ensuring they understand why the programme has been introduced, how this is going to be done and what will be delivered. Clear communication and accessible information is critical to getting staff and prisoners involved and empowered.

Clear communication and accessible information is critical to getting staff and prisoners involved and empowered.

The processes within the plan are guided by five core values; things that are important, motivate and guide us.[16] These values help give meaning to our practices and are revealed via the choices we repeatedly and consistently make. Acting as our moral compass these are:

- ❒ Everything we do should contribute to safety and security for all
- ❒ Promote wellbeing through outstanding care and support
- ❒ Focus and fully utilise peoples strengths, talents Show compassion and kindness in all we do
- ❒ Build trust and belief in others through fairness and procedural justice

The practice and innovation we seek to develop should always contribute to and promote these values. Where this is the case, and resources permit, it will be supported.

Simon Sinek says 'our 'HOWs' give us a shared language to see one another's strengths, making it easier to collaborate and lean into our team mates to get things done. Bottom line is when we focus on our strengths and lean in to the strengths of others, we can make the impossible possible.'[17]

What will the DRP do?

Promoting Safety and Security

The Prison Service has a service specification for security management[18] which helps establish safety in prison. This evolved out of the Security Manual (Prison Service Order 1000) and its restricted electronic successor the National Security Framework. The principle is that 'Security is everyone's responsibility,' and rather than a discrete service, a small team should lead and guide prisons in the application of appropriate local security measures, based on a risk analysis of local physical security resources and the type of prisoners held, thereby creating a 'Local Security Strategy' for each prison.[19]

In 2008 David Blakey reviewed prison security exploring ways to disrupt the supply of illicit drug and other items into prisons. He concluded that illicit items get into prison 'over the wall', in mail and incoming goods, via Visitors (including contractors working in the prison), through corrupt staff and brought in by prisoners. He acknowledged that when disrupting one route, pressure will inevitably increase on others. The Blakey Report made recommendations to improve the effectiveness of prison security taking account of the prisons' operating environments. He suggested utilising good practice more, disrupting the use of mobile phones, increased use of searching, deployment of search dogs and better use of legislation.

The DRP builds upon the local security measures and reduces supply routes into prison by improving activities to deter, detect and disrupt illicit items entering the prison by enhancing physical, procedural and interpersonal security.

Physical security measures are being strengthened by the introduction of a new staff searching facility,

16. Williams, A. & has Payne, S. (2016). My31 Practices: Release the power of your values for authentic happiness. London: LID Publishing Ltd (p65).
17. Sinek, S, Mead, D & Docker P (2017) Find Your Why. Penguin Random House, UK.
18. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/278927/2014-01 09_Security _Managemt_Specification_P2.2.pdf
19. Blakey, David (2008). Disrupting the illicit supply of drugs into prisons. http://drugslibrary.wordpress.stir.ac.uk/files/2017/07/blakey-report-disrupting.pdf

developing an incoming goods search area including vehicles for goods storage / transportation and x-ray machine, introducing a full body x-ray facility in Reception, millimetre-wave security scanners in the visitor entry area and visits hall to detect illicit items carried on the body or in clothing, a Magnetic Resonance spectrometer to analyse seized substances or items found within the prison grounds, a mobile phone interrogation device, new mobile phone detectors, an Automatic Number Plate Recognition Camera, metal window opening restriction apparatus, toilet waste examination equipment and a new security building.

A dedicated discrete team called the Drugs Crime Reduction Unit (DCRU) was created to improve procedural security within Holme House. This team comprise of an Operational Lead, 2 Custody Managers, 12 Band 3 Prison Officers, 10 Band 2 Operational Support Grades and 1 Administrator. Procedural security controls delivered by the DCRU mitigate identified risks by working in both reactive and proactive ways to maintain safety and security. This involves developing and following policies and procedures, making necessary checks and maintaining physical security features, collecting analysing and reporting intelligence gained, screening people and goods coming into the prison, searching and applying techniques for the de-escalation of aggression and violence. Importantly, the DCRU operate according to the principles of procedural justice (see Dr Ruth Mann's paper in this issue). The DRP also implemented a Safety Integration Meeting. This is a multidisciplinary effort to better support people demonstrating persistent disruptive and challenging behaviours in order to promote change and the development of positive behaviours thereby making living in the general prison community possible.

Interpersonal relationships between prisoners, staff, partner providers, visitors and outside agencies are essential to good security. This is the foundation upon which high quality care can be delivered and wellbeing promoted. Our ambition is to have people who are both motivated and trained, willing to work in a multidisciplinary way and engaged in a collaborative system where everyone works closely together. This helps create an orderly, stable and acceptable prison environment based on legitimacy and procedural fairness, which enhances all forms of security. Opportunities for information sharing and clear communication are critical success factors.

Enhancing Care and Wellbeing

There are many pathways to recovery from drug dependence. One pathway is Medication Assisted Recovery (MAR) where medicines are prescribed and monitored by an appropriately qualified practitioner. Medicines play a significant role in helping people begin and sustain recovery, as stated previously. Medicine prescribing is an important intervention to help prevent unpleasant withdrawal symptoms, detoxify someone, reduce the frequency and intensity of cravings and help control symptoms of a condition which if left untreated could lead to a relapse. The Integrated Drug Treatment Service, particularly opiate substitution therapies, have dominated service provision for many years for good reasons. In order to further develop treatment pathways, particularly where it was felt that the focus of services had become 'stuck in a rut of harm minimisation and crime reduction rather than supporting redeeming and regenerating lives', a focus on recovery and promoting wellbeing at the heart of the care agenda emerged.[20] The DRP intended to exploit this opportunity and so move from a medicine dominated prison regime to a system orientated around promoting wellbeing for all. This does not mean, however, that medication assisted recovery is not part of the DRP approach. On the contrary, it is as are psychosocial interventions.

One pathway is Medication assisted recovery where medicines are prescribed and monitored by an appropriately qualified practitioner.

To augment medication assisted recovery, we identified six other clinical objectives. To deliver these sixth objectives healthcare provider contracts were varied by NHE England to facilitate the enhancements. (see table).

These enhancements will help improve health and care outcomes, support safer communities, reduce stigmatisation and promote social cohesion. This is done via person centered care within a seamless integrated structured clinical and psychosocial arrangement supported by effective continuity of care after release.

20. Putting Full Recovery First (2010) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/98010/recovery-roadmap.pdf

The following table describes the issues and the contract enhancements put in place.

Objective	Enhancement
Improve assessment and development of personalised care plan that can help evaluate programme outcomes and impact	Introduce Rec-Cap assessment, recovery planning and evaluation tool in partnership with the Recovery Outcomes Institute (www.recoveryoutcomes.org)
Strengthening clinical leadership and the development of a community of practice to transform service delivery	Appoint a Nurse Consultant with responsibility to address this issue by utilising the specialist skills of all available healthcare professionals
Introduce a Trauma Focused and Pain Informed approach to care and wellbeing	Appoint an Applied Psychology team to develop a new range of evidence based interventions that promote health and understanding
Better communication and improved understanding of information (more accessible)	Appoint a Speech and Language Therapist
Offer wing based community care where life inside resembles life outside as much as possible	Appoint Healthcare support workers and Pharmacy Technicians to enable and facilitate wing based community care alongside existing staff teams
Emergency medical responses are improved increasing staff confidence to deal with challenging situations requiring urgent care	Appoint a Paramedic who will respond to accidents and emergencies requiring urgent care as well as develop a Community First Responder Scheme

Strengthening Continuity of Care provision

In October 2017 a report evaluating drug recovery wings in several prisons was published and warned that drug recovery work in prison was largely futile unless suitable support was offered to people after release.[21] The researchers found that many prisoners experienced a 'cliff edge' receiving little or no professional support in the weeks preceding or following release. They concluded that without adequate support on release, people were more likely to relapse and reoffend no matter how good the support received in prison was.

This finding was replicated in several DRP focus groups with prisoners in early 2018. Men described a reluctance to engage with treatment services in the prison because benefits would not be maintained after release so 'what was the point'? They needed better support after release to sustain new behaviours and the developed of a more beneficial lifestyle.

As a result of this finding, resources were allocated to develop a team that would strengthen continuity of care provision and work alongside existing statutory and non-statutory services to better support people before and after release. This team included a team leader, five Connecting Community Co-ordinations, a Family Worker, a Building Recovery in Communities Worker and a generic support worker. This Connecting Communities team would strengthen continuity of care by supporting people as they leave the prison and return to the community by linking people to community assets and resources to support their ongoing recovery. The Connecting Communities team work very closely with the appointed Community Rehabilitation Company to ensure services are complimentary and not unnecessarily replicated.

Community Rehabilitation Companies (CRC) have a statutory responsibility to support continuity of care and promote rehabilitation after release from prison, this mandatory requirement has recently been enhanced with a revised service specification.[22] They aim to do this by deploying evidenced led resettlement services designed to improve rehabilitative outcomes and make sure people are clear about who is providing these services. Mandated resettlement pathways include accommodation, employment/training/education, finance/benefits/debt, personal/relationships/community and extra support for specific groups of people some of who may have complex needs. There is a much needed area for development with the DRP at Holme House.

The DRP working closely with the CRC covering Holme House will test out a new Recovery Management Check-Up process which demonstrated great promise in reductions in reoffending in other

21. The Evaluation of Drug Recovery Wing Pilots (2017) https://www.york.ac.uk/media/healthsciences/documents/research/mentalhealthresearch/DRWsFinalPublishedReport.pdf
22. HMPPS, 2018. Agency Instruction 05/2018 - Through the Gate Instructions and Guidance on Schedule 7.

jurisdictions. This process trains CRC Responsible Officers to follow a structured procedure and navigate people into recovery resources where required in order to maintain wellbeing and reduce the risk of reoffending.

Prison as a more positive place

A prison becomes a more positive place through a complex interaction of environmental, organisational and personal factors. A prison is both a workplace for staff and a temporary home for prisoners and therefore has to be committed to supporting health and wellbeing for everyone through its systems and structures in order to be effective. Staff and prisoner participation in prison community activities is critical to build recovery capital. Initiatives to promote health for staff should be encouraged both for staff's own wellbeing and in recognition that a healthy and motivated workforce is more able to promote health in prisoners. This whole prison approach to creating a healthy setting is likely to be complex, multifactorial and involve activities across numerous domains. We believe this can be done.

A prison becomes a more positive place through a complex interaction of environmental, organisational and personal factors.

A health promoting prison is one that is safe, secure and reforming and is underpinned by a commitment to participation, equity, partnership, respect and decency. A whole system focus means aligning and integrating a number of change programmes and initiatives happening within prison. Programmes such as Offender Management in Custody, Rehabilitative Culture, Reducing Reoffending, Organisational Development and Occupational Health all make a contribution towards building a recovery orientated culture. To ensure alignment and integration with these initiatives, the DRP appointed a Culture and Communities Integration Manager (CCIM) to work alongside staff and prisoners to ensure our recovery ambition is reflected in these complementary programmes. The CCIM seeks to reduce the risk of duplication, wasteful resource allocation and enhance staff and prisoner engagement in building a recovery culture and developing a whole prison approach.

Holme House, along with NHS England Property Services, have completed environmental upgrades to the physical surroundings. All consultation and treatment rooms, including medicine administration points, have been refurbished to NHS standards. Rooms that could be used for therapeutic areas have been catalogued, rejuvenated with paint and new furniture, to ensure sufficient space for individual or group work. As each residential community was created (we did one house block at a time) it was cleaned and painted to make it more decent (Holme House is 26 years old and starting to look dilapidated in some parts). Laundry facilities have been planned for each community following feedback from prisoner focus groups. There are plans to introduce nature scene wall art into communal areas as well as enhancements to the walkways connecting different facilities. The merits behind this approach are discussed in Dr Dominique Moran's paper in this Journal.

A range of additional meaningful and purposeful activities will be introduced to complement what is currently available. These will include arts, music, social activities, and be determined through consultation, to utilise the skills, talents and interests of the people involved and help usefully occupy time to elevate boredom—one of the precipitating factors, we are told, to someone using illicit drugs.[23] To enable and facilitate this development a dedicated budget has been allocated to fund these planned activities.

Prisoners delivering peer interventions—support delivered by prisoners for prisoners—such as mentoring, education, support and advice has been encouraged in many countries, can be of great value and do make positive contributions to improved health outcomes both for the peer deliverer and recipient.[24] Improvements noted include increased levels of confidence, self-esteem and self worth. This along with the trust bestowed upon peer support services by prison staff led to feeling more empowered with a greater sense of control over the use of their time which had a positive effect on mental health. As well as individual improvements, the organisation can benefit too especially where peer supporters were used to provide basic information or practical support to new receptions or signpost people to services. This effectively can relieve prison staff of some pressure associated with dealing with general queries and issues and enable their attention to be more effectively

23. What prisoners think about the use of spice and other legal highs in prison http://www.uservoice.org/wp-content/uploads/2016/05/User-Voice-Spice-The-Bird-Killer-Report-Low-Res.pdf
24. Woodall, J et al (2015) Expert views of peer based interventions for prisoner health. International Journal of Prison Health, Vol.11(2): 87-97, https://doi.org/10.1108/IJPH-10-2014-0039

focused on specialized duties. The DRP will particularly focus effort on developing a prisoner 'Democratic Council' and on training peers (Recovery Navigators) to support and advise others in creating opportunities to build recovery capital whilst serving their sentence. This will compliment existing peer support services such as the Listener Scheme. The Democratic Council is a collaboration between elected prisoner representatives from residential communities and prison managers that draws upon the combined experience and skills of participants to support and promote reform and opportunities for positive change. A number of peer supporters have been trained as Recovery Navigators by Professor David Best and the Recovery Outcomes Institute in the application of the Recovery Capital (Rec-Cap) tool—a strengths based assessment, planning and evaluation instrument intended to assist participants with monitoring progress in achieving self-directed recovery goals and improving the effectiveness of support services.[25] As Rec-Cap is rolled out further, more Recovery Navigators will be deployed to offer peer support. Whilst there are many positives for individuals and the prison, some risks do exist often associated with security breaches. However, the DRP advocates applying the concept of constructive risk management to all the peer interventions, hoping as has been found with previous peer interventions, that the risks in reality are minor and that the positive gains overwhelm the negative.[26]

Conclusion

Holme House has come along way since the DRP began. It still has a way to go. Patience is needed. It takes time to create supportive communities within a prison and build a recovery culture.

We have learned that new technologies supplement effective staff deployment and should not necessarily be a replacement. Some of the new technologies need adapting to improve effectiveness in the prison context. Promoting safety and security via procedurally justice principles is not expensive and just works. Good intelligence and information sharing is crucial to promoting recovery. People who use drugs should not be stigmatised; medicines like Methadone can and do assist people in recovery and save lives; and strong communities work best because of their differences. A healthy regime supports recovery. Connecting communities both inside and outside of the prison brings hope and optimism that the future can be different.

Discrimination has to be addressed and we have to remove the shame and stigma associated with using drugs in prison if we are ever to create a better place to live and work.

People use drugs in prison for many reasons and describe it as an adaptive coping strategy usually to reduce pain, stress and eliminate boredom. To remove this coping strategy by deploying robust security improvements alone without suitable replacement activities being put in place is often dangerous, cruel and counter productive. We need to get the balance right.

The Substance Abuse and Mental Health Services Administration produced some guiding principles for recovery. These are still very relevant today and advocate that recovery opportunities are best realised when:

- ❒ A holistic approach is adopted;
- ❒ Peers and allies are utilised;
- ❒ Relationships and social networks are cultivated;
- ❒ A sensitive, competent and individualised recovery culture exists;
- ❒ The cause of trauma is addressed;
- ❒ Individuals, families, peers and communities, with all their strengths, get involved; and
- ❒ Respect is promoted by everyone.

This is what the DRP aspires to do.

We are asked is the DRP working? It is too early to say for sure. But our initial findings are promising. Mandatory drug testing positive rates are down. Detection of illicit items and disruption of organised criminal activity has improved. People experiencing recovery services at Holme House report improvements in support as well as feeling more hopeful and optimistic. The stories we gather reflect this. A process evaluation is underway and through this we hope to share our discoveries, build upon what we have achieved and continue to promote recovery in prisons.

25. The Rec-Cap: What's capital got to do with recovery? https://ffrco.org/rec-cap-whats-capital-got-recovery/
26. Edgar, K., Jacobson, J. & Biggar, K (2011). Time Well Spent: A practical guide to active citizenship and volunteering in prison. Prison Reform Trust. http://www.prisonreformtrust.org.uk/Portals/0/Documents/Time%20Well%20Spent%20report%20lo.pdf

The Role of Trauma-Informed Care in Building Resilience and Recovery

Dr Vicky Jervis *is a Principal Clinical Psychologist based in the Mental Health Team at HMP Holme House.*

Introduction

Over the last decade, services have become increasingly aware of the importance of acknowledging trauma and recognising the impact of adverse childhood experiences. Post-Traumatic Stress Disorder (PTSD) and other trauma-related conditions have consistently been shown to be over-represented in mental health and the criminal justice system[1]. Moreover, trauma is costly in both human and economic terms. Economic costs include those from lost employment, presenteeism, diminished productivity and the financial implications of the increased demands on mental health services[2]. But undoubtedly the most devastating legacy lies in terms of the intra and interpersonal consequences, exhorting not only a terrible toll on the individual's health and well-being but inflicting wide-ranging consequences across generations, socially, psychologically and even genetically.[3] This article will explore definitions, prevalence and the impact of trauma before looking at an increasingly recognised response to this—trauma informed care. The role of trauma informed care in the recovery of individuals who use substances will be considered. Finally, the opportunities and obstacles of implementing this approach within a prison setting will be discussed and recommendations made.

Definition and Prevalence of Trauma

Originating from the ancient Greek word for 'wound,' the profound emotional impact of witnessing traumatic events went largely unrecognised until, perhaps unsurprisingly, the terrible events of World War One, where the term 'shell shock' entered the world's lexicon. Sadly, in the years since, further international conflicts, natural disasters and ever-increasing acts of interpersonal violence have served only to reinforce the pervasive impact of trauma on an individual's health and well-being.

Broadly speaking, trauma refers to events or circumstances that are experienced as harmful or life-threatening and that have lasting impacts on mental, physical, emotional and/or social well-being.[4] Trauma can relate to a singular or a series of events compounded over time (the latter often referred to as 'complex' traumatisation). Such exposure may occur directly or indirectly by witnessing the event, learning of the event occurring to a loved one, or repeated confrontation with aversive details of such event (for example, as in the case of emergency responders).[5]

The list of potentially precipitating events is understandably diverse, ranging from accidental injury through to natural disasters or the loss of a loved one. Less recognised early developmental traumas can also include community or social trauma such as inequality, marginalisation, racism and poverty as well as historical (generational) trauma.[6] The nature of the resulting trauma is far more complex than a simple equation of trauma equals PTSD however. Clearly individual interpretation and the accumulation of personal coping resources has a significant impact in ameliorating the impact of traumatic events.[7] Furthermore, certain traumas, for example, interpersonal victimisation, are thought to inflict greater psychological harm than accidental events such as natural disasters, possibly as a consequence of the devastating impact the realisation

1. Mauritz, M., Goossens, P., Draijer, N. & van Achterberg, T. (2013), "Prevalence of interpersonal trauma exposure and trauma-related disorders in severe mental illness". *European Journal of Psychotraumatology. (4)*
2. McCrone, P., Dhanasiri, S., Patel, A., Knapp, M., & Lawton-Smith, S. (2008). *Paying the price: the cost of mental health care in England to 2026*. London: The King's Fund.
3. Youssef, N.A., Lockwood, L., Su, S., Hao, G., & Rutter, B.P.F. (2018). The Effects of Trauma, with or without PTSD, on the Transgenerational DNA Methylation Alterations in Human Offsprings. *Brain Science*, 8 (5); 83
4. Substance Abuse and Mental Health Services Administration. (2014). *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach.* Rockville, MD.
5. American Psychiatric Association (2013). *Diagnostic and Statistical Manual of Mental Disorders* (Fifth ed.). Arlington, VA: American Psychiatric Publishing.
6. Blanch, A., Filson, B., Penney, D. and Cave, C. (2012). *Engaging Women in Trauma-informed Peer Support:* A Guidebook. National Center for Trauma-Informed Care, Rockville, MD.
7. Rice, V, Liu, B. (2016). Personal resilience and coping with implications for work. Part 1: A *review. Work,* 54: 325–333.

of deliberate harm has on an individual's beliefs and assumptions).[8 9] Unsurprisingly, sexual assault remains the strongest predictor of PTSD in both genders.[10]

Contrary to what might be popular belief, experiencing trauma is far from uncommon. A population study conducted across 24 countries with nearly 69000 adults discovered that over 70 per cent of respondents reported a traumatic event, with over 30 per cent reporting being exposed to four or more traumatic events.[11] Research has demonstrated that people in contact with the mental health system have higher rates of historical interpersonal violence than the general population, which, as discussed earlier, has a high propensity to result in post-traumatic psychological harm. A systematic review estimated that half of those in the mental health system had experienced physical abuse (ranging from 25 per cent to72 per cent) and more than one-third had experienced sexual abuse (between 24 and 49 per cent) in childhood or adulthood, significantly higher than in the general population. Unsurprisingly within the criminal justice system it is generally acknowledged that there is a much higher prevalence of serious trauma, although rates vary markedly across studies, ranging from 4 per cent to 32 per cent in male and from 16 per cent to 58 per cent in female prisoners.[12]

One theory is that experiencing complex childhood trauma creates a 'template' through which future events are processed.

Impact of trauma

There is an ever-increasing catalogue of research that implicates the role of trauma in the development of later mental health and substance abuse issues. The original Adverse Childhood Experiences (ACEs) Study formed one of the largest investigations ever conducted into associations between childhood maltreatment and later health and well-being, initiating over 50 subsequent research projects.[13] ACEs were strongly related to the development and prevalence of a wide range of health problems throughout a person's lifespan, including those associated with substance misuse, mental ill-health and behavioural problems. This impact was dose-dependent in that the more adverse life events people experience prior to the age of eighteen, the greater the impact on health and well-being over the lifespan, including; poor mental health, severe physical health problems, sexual and reproductive health issues, engaging in health-risk activities and premature death [14, 15]

But what is the mechanism underpinning this process? One theory is that experiencing complex childhood trauma creates a 'template' through which future events are processed. Within the brain neural responses become 'sensitised', ready to be reactivated by seemingly minor stresses.[16] This means that trauma survivors are 'primed' to respond to situations and relationships that embody characteristics of past traumatic events, or in which there is a perceived threat. As well as fitting with many of the therapeutic models around PTSD where the sufferer is perceived as hyper-vigilant towards threat, further studies have identified physical changes to the neurological pathways of the brain in response to extreme or prolonged stressors in childhood.[17] These changes appear to centre around the amygdala and ventromedial prefrontal cortex of the brain (areas implicated in, amongst others, the processing of fear and the ability to regulate negative emotions).

8. Janoff-Bulman, R., Timko, C., & Carli, L. L. (1985). Cognitive biases in blaming the victim. *Journal of Experimental Social Psychology,* 21(2), 161-177.
9. Freyd, J. J. (1996). *Betrayal trauma: The logic of forgetting childhood abuse.* Cambridge, MA, US: Harvard University Press.
10. Paolucci, E.O., Genius, M.L., and Violato, C. (2001). *Journal of Psychology,* 135, (1), 17-36
11. Benjet C., Bromet E., Karam E. G., Kessler R. C., McLaughlin K. A., Ruscio A. M., … Koenen K. C. (2016). The epidemiology of traumatic event exposure worldwide: Results from the World Mental Health Survey Consortium. *Psychological Medicine*, 46(2): 327–343.
12. Baranyi, G., Cassidy, M., Fazel, S., Priebe, S. & Mundt, A.P. (2018). Prevalence of Posttraumatic Stress Disorder in Prisoners. *Epidemiologic Reviews,* 40, (1): 134–145.
13. Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V., Koss, M.P., & Marks, J.S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine.* 14 (4):245-58.
14. Shevlin, M., Dorahy, M.J., & Adamson, G. (2007). Childhood traumas and hallucinations: an analysis of the National Comorbidity Survey. *Journal of Psychiatric Research.* 41:222–228.
15. Anda, R.F., Butchart, A., Felitti, V.J. and Brown, D.W. (2010). Building a framework for global surveillance of the public health: implications of adverse childhood experiences. *Preventive Medicine, Vol. 39*. (1,) :93-8.
16. Van der Kolk, B (2005) Developmental trauma disorder: towards a rational diagnosis for chronically traumatized children. *Psychiatric Annals,* 35: 401–8.
17. Koenigs, M., & Grafman, J. (2009). Post-traumatic stress disorder: The role of medial prefrontal cortex and amygdala. *Neuroscientist*, 15 (5): 540-548.

What is 'Trauma Informed Care'?

Trauma informed care (TIC) originated over in the USA and constitutes a relatively recent development in mental health treatment within the UK. TIC is, essentially, a process of organisational change, creating a revised structure, ethos and treatment framework that emphasises physical, psychological and emotional safety for both service users and providers. At its core is the recognition of the need to accurately identify trauma at the earliest opportunity, in order to prevent inadvertently triggering re-traumatisation. In essence it urges mental health services to adopt a 'do no harm' approach. Clearly key in implementing such an approach is the need for staff to be well trained regarding the impact of trauma, how a traumatised individual might perceive, adapt and respond to their traumatic experiences and develop a commitment to working with that individuals' own strengths to maximise their chances of recovery.

> ***The fundamental shift in providing support using a trauma - informed approach is to move from thinking 'What is wrong with you?' to considering 'What happened to you?'.***[18]

Trauma informed care (TIC) originated over in the USA and constitutes a relatively recent development in mental health treatment within the UK.

TIC is, by its very nature, strengths-based: reframing challenging behaviour in more compassionate terms by seeking to understand its survival function and considering it as a response to situational or relational triggers. Exploration of trauma is conducted respectfully, to avoid potential re-traumatisation (but without negating the importance of the narrative). Relational security plays a vital role in trauma informed services, unsurprisingly given the key role social connection plays in recovery, particularly with regards to addiction.[19] Building trusting, collaborative relationships therefore, both within individual and group-based situations, alongside a sense of shared purpose and community, is key in the successful implementation of TIC. Again, in order to achieve this, high quality trauma-focussed staff training and support are essential.

Six key principles of trauma-informed care have been identified within the literature and provide the scaffolding by which a service can implement their trauma-informed vision.[20] They build upon the earlier 'Resiliency and Recovery-Oriented Systems of Care (ROSC) guidance which extols the value of community-based, person-centred planning to build the resilience and strengths of the individuals and their social network. The six principles proposed by SAMHSA are:

1. Safety: Throughout the service, staff and the individuals they serve feel physically and psychologically safe.

2. Trustworthiness and Transparency: Organisational operations and decisions are conducted with transparency and the goal of building and maintaining trust between staff, service users and their families.

3. Peer Support: Peer support and mutual self- help are key vehicles for establishing safety and hope, building trust, enhancing collaboration, serving as models of recovery and healing and maximising a sense of empowerment.

4. Collaboration and Mutuality: TIC believes that healing happens in relationships, and in the meaningful sharing of power and decision-making. Key within this is the deliberate levelling of the power imbalance between staff and clients and among organisational staff (from direct care to administrators). Everyone has a role to play and a person does not have to be a therapist to be therapeutic.

5. Empowerment, Voice and Choice: The individuals' strengths and experiences are recognised and built upon; they are given the chance to experience having a voice and their choices heard. Resilience is supported and encouraged and self-advocacy and empowerment are actively encouraged.

6. Cultural, Historical, and Gender Issues: The TIC organisation actively moves past cultural stereotypes and biases, offers gender-responsive services, supports

18. Harris, M. and Fallot, R.D. (2001). *Using Trauma Theory to Design Service Systems. New Directions for Mental Health Services.* Jossey-Bass, San Francisco, CA.
19. Hari, J. (June 2015). Johann Hari: Everything you think you know about addiction is wrong. [Video File]. Retrieved from: https://www.ted.com/talks/johann_hari_everything_you_think_you_know_about_addiction_is_wrong?language=en#t-326460
20. Substance Abuse and Mental Health Services Administration. (2014). *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed* Approach. Rockville, MD.

the healing value of traditional cultural connections and recognises and addresses historical trauma.

These trauma-informed principles are by no means revolutionary and there is a significant overlap with many other well-established good practice guidelines. The principles of service-user involvement, empowerment, informed choice and control have much in common with shared decision-making[21] and collaborative care planning.[22] Similarly cultural and gender sensitivity are well-established good practice principles.[23] Peer support is emerging as an important element of UK mental healthcare,[24] with the principles of trauma-informed approaches in line with grassroots movement for peer support within recovery.[25] [26] Collectively however these six standards provide a scaffold to support services in acknowledging an individual's history of trauma, understanding their responses and identifying and supporting the paths survivors take in seeking out safety and recovery.

The Role of Trauma Informed Care in Recovery from Addiction

As discussed earlier, studies have shown that there is high comorbidity between PTSD with substance abuse disorders.[27] [28] [29] Certainly, there is a growing awareness of the inter-dependent relationship of trauma and addiction. It is recognised that many of those who use substances do so to escape emotional pain, often associated with past trauma.[30] The sad truth of many trauma survivors is that they often seek to manage their symptoms by themselves, perhaps as a consequence of the shame attached to their experiences. PTSD symptoms like agitation, depression, hypersensitivity to loud noises or sudden movements, social isolation and insomnia may appear to be ameliorated in the short term through the use of sedating or stimulating drugs (depending on the symptom). In the longer term however, these attempts to self-medicate can easily slide into a vicious cycle of avoidance and addiction. Conversely, a substance abuser's lifestyle often places them more at risk of experiencing trauma than that of a non-addicted person. Anti-social acquaintances, increased risk taking, high levels of violence, impaired driving, and other aspects commonly associated with drug and alcohol abuse may indeed predispose substance abusers to being traumatised by crime, accidents, violence and abuse.

As discussed earlier, studies have shown that there is high comorbidity between PTSD with substance abuse disorders. Certainly, there is a growing awareness of the inter-dependent relationship of trauma and addiction.

Given the symbiotic relationship of trauma and addiction it is not surprising that adopting a trauma-informed approach is highly effective in the promotion of recovery in individuals with addictive behaviours.[31] Certainly, there are inescapable parallels between the six TIC principles identified by SAMHSA and the focus on individualised care within modern addiction programmes, from the emphasis placed on safety and stabilisation during detoxification, through to the centrality of collaboration

21. Elwyn, G, Frosch, D, Thomson, R, et al. (2012) Shared decision making: a model for clinical practice. *Journal of General Internal Medicine,* 27: 1361–7.
22. Grundy, AC, Bee, P, Meade, O, et al. (2016) Bringing meaning to user involvement in mental health care planning: a qualitative exploration of service user perspectives. *Journal of Psychiatric and Mental Health Nursing*, 23: 12–21.
23. Schouler-Ocak, M, Graef-Calliess, I, Qureshi, A, et al. (2015) EPA guidance on cultural competence training. *European Psychiatry*, 30: 431–40.
24. Gillard, S, Edwards, C, Gibson, S, et al. (2013) Introducing Peer Worker roles into UK mental health service teams: a qualitative analysis of the organisational benefits and challenges. BMC *Health Services Research*, 13: 188.
25. Mead, S., & McNeil, C. (2006) Peer support: what makes it unique? *International Journal of Psychosocial Rehabilitation*, 10: 29–37.
26. Repper., J., & Carter, T. (2011) A review of the literature on peer support in mental health services. *Journal of Mental Health,* 20 (4): 392-411,
27. Mills, K.L., Teesson, M., Ross, J., & Peters, L. (2006). Trauma, PTSD, and substance use disorders: findings from the Australian National Survey of Mental Health and Well-Being. *American Journal of Psychiatry,* 163, 652–658.
28. Reynolds, M., Mezey, G., Chapman, M., Wheeler, M., Drummond, C., & Baldacchino A. (2005). Co-morbid post-traumatic stress disorder in a substance misusing clinical population. *Drug and Alcohol Dependence,* 77, 251–258.
29. Breslau, N., Davis, G.C., & Schultz, L.R. (2003). Posttraumatic stress disorder and the incidence of nicotine, alcohol, and other drug disorders in persons who have experienced trauma. *Archives of General Psychiatry,* 60, 289–294.
30. Mate, G. (2008). I*n the realm of hungry ghosts: Close encounters with addiction.* Toronto: Knopf Canada.
31. Finkelstein, N., VandeMark, N., Fallot, R., Brown, V.., Cadiz, S., & Heckman, J. (2004). *Enhancing substance abuse recovery through integrated trauma treatment*. Sarasota, FL: National Trauma Consortium.

and transparency. The presence of trauma may not always be immediately evident however, particularly following years of substance use with the aim of dulling and diluting traumatic memories. Without treating the root cause however, treatment of the addictive behaviours is unlikely to be successful and the individual is left vulnerable to further self-destructive behaviours emerging.

Trauma Informed Care in Prison—Opportunities and Obstacles

The very concept of a prison environment makes establishing and embedding a trauma informed approach towards care difficult. Prisons were originally designed to house perpetrators, not victims (although, as we now know, it is frequently the case that the two are one and the same, with many of those incarcerated in prisons having themselves been victims in the past). The operational priority within prisons however is to maintain order and discipline, not ameliorate and treat trauma, and staff are trained to assume that a prisoner is potentially violent and behave accordingly.[32] At first glance the inevitably intrusive and restrictive nature of these security measures can threaten to undermine attempts to be trauma-informed. Many of the routine security procedures in correctional environments (such as pat-downs and body searches) are themselves triggering, serving only to increase the trauma-related impulsivity and aggression. Such escalations can be difficult for prison staff to manage,[33] potentially initiating a vicious cycle of more restriction and control.

Yet, there is much evidence to suggest that by introducing trauma-informed principles prisons experience a significant reduction in institutional violence. It has long been recognised that self-destructive and suicidal behaviours and anger and aggression towards others are linked to interpersonal trauma.[34] In America, the Massachusetts Correctional Institution at Framingham developed new training initiatives and began implementing trauma-informed models in July 2006. By July 2007, use of force incidents had decreased by 65 percent, assaults on staff had decreased by 32 percent, inmate grievances had decreased by 31 percent and employee misconduct complaints were reduced by 33 percent. The impact continued, so that between 2011 and 2012, there was a subsequent decrease in inmate-on-staff and inmate-on-inmate assaults, the use of segregation, suicide attempts, and the need for mental health watches.

So, whilst the potential benefits are manifold, the systemic barriers to implementing TIC in a prison setting are undeniable. These can potentially include:

- ❒ Underfunding and a lack of resources (particularly staffing)
- ❒ Low morale and high staff turnover potentially restricting impact and reducing sustainability
- ❒ Difficulty balancing the perceived correctional nature of prison with the perception of prisoners as having their own emotional pain and treatment needs
- ❒ Implementation of a 'risk-averse' culture
- ❒ Limited opportunities for reflection on practice and feedback from staff and service users
- ❒ Frequent top-down, unpredictable change in policies and processes. When coupled with a regular plethora of new initiatives to implement, these can lead to confusion and exhaustion[35]
- ❒ A reluctance to explore the extent of trauma due to its exposure of the cruelty of human nature (thereby challenging an individual's worldview and potentially triggering a defensive response)

...given the potential obstacles, what can be done to create opportunities for TIC to flourish within our prison establishments?

In addition, research has identified a number of barriers to enquiring about childhood abuse, including holding a predominantly biomedical (as opposed to psychosocial) model of mental distress[36] and having the belief that people want to be asked about their experiences by someone of the same gender or cultural background. Positively, identifying these barriers can signpost some of the changes needed to support staff to work fully in trauma-informed ways.

32. Miller, N. A., & Najavits, L. M. (2012). Creating trauma-informed correctional care: A balance of goals and environment. *European Journal of Psychotraumatology*, 3
33. Covington, S.S. (2008). Women and addiction: a trauma-informed approach. *Journal of Psychoactive Drugs*. (5): 377-385
34. Van der Kolk et al., 1996 Van der Kolk, B., Pelcovitz, D., Roth, S., Mandel, F.S., McFarlane, A., & Herman, J.L. (1996). Dissociation, somatization and affect dysregulation: the complexity of adaptation to trauma. *American Journal of Psychiatry*. 153 (7):83-93.
35. Sweeney, A, Clement, S, Filson, B, et al. (2016) Trauma-informed mental healthcare in the UK: what is it and how can we further its development? *Mental Health Review Journal*, 21: 174–92.
36. Young, M, Read, J, Barker-Collo, S, et al. (2001) Evaluating and overcoming barriers to taking abuse histories. *Professional Psychology: Research & Practice,* 32: 407–14.

So, given the potential obstacles, what can be done to create opportunities for TIC to flourish within our prison establishments?

The Route to becoming Trauma Informed

Change at the organisational level

In order for a service to become truly trauma-informed there must first be a focus on implementing organisation-wide change, specifically though a change in culture and policy. Trying to implement trauma specific clinical practice without first making these systemic adaptations has otherwise been likened to 'throwing seeds onto dry earth'.[37] Successful organisational change requires the steady and visible support of senior leaders who can empower the workforce to be part of the evolution, ensuring buy-in at multiple levels and championing the rationale behind the transformation. It is important for the service to consider trauma when developing any new policies, procedures and practices within the prisons and attempt to limit re-traumatisation. In addition, changing culture and clinical practice will require significant resources, from rolling programmes of training to the physical modifications to the environment.

Collaborative Service Development

At the point when a service has made the commitment to move towards TIC, the inclusion of 'experts by experience' from the inception as consultants within the process is recommended. Aside from living the values of TIC with respect to choice, empowerment, collaboration and peer support; service users can provide invaluable first-hand experience and are often in a unique position to comment on suggested developments. Co-production in the form of discussion/focus groups including both staff and prisoners can be invaluable in creating shared ownership over the TIC principles and how they can be implemented in the establishment.

Staff Training

Provision of high quality, accessible training is vital, both for clinical and non-clinical staff. As well as being given a thorough grounding on the nature and impact of trauma staff should feel confident in their abilities to create a safe, non-threatening environment where relationships are themselves a therapeutic vehicle. All staff should be offered training on trauma and the trauma informed service model and how it is relevant to their work. Ideally this should be face-to-face to allow for reflection and collaborative planning, however given staffing pressures, an e-learning package may be easier to facilitate. Trauma Informed Service training materials should be incorporated into the Personal Officer Training Package and made freely available across the prison

Key within the development of frontline staff should be the promotion of the following:

- **Early identification and intervention:** Screening prisoners for trauma at induction can help them access support early on. In particular, early information made easily available around identifying triggers and effective grounding / calming techniques can help prevent rapid escalations
- **Sensitive trauma enquiry:** Judging how and when to enquire about trauma is in itself a challenge for front line staff, however trauma informed research has consistently emphasised the need to routinely enquire, particularly within mental health services, in order to uncover the presence of trauma within the population. Despite this, research has shown that between 0 and 22 per cent of service users within an adult mental heath setting report being asked about abuse experiences[38]
- **Compassionate view of coping:** It is all too easy to view some of the behaviours displayed by trauma survivors as manipulative, perplexing, dangerous or bizarre if they are not viewed through a 'trauma lens'.[39] An alternative perception can be to view their responses as their best attempt at coping, connecting and communicating.
- **Coping:** Risk taking and self-destructive behaviour may play a role in helping the individual manage their own shame, low

All staff should be offered training on trauma and the trauma informed service model and how it is relevant to their work.

37. Menschner, C. and Maul, A. (2016). *Key Ingredients for Successful Trauma-Informed Care Implementation.* Center for Health Care Strategies. Available at: http://www.chcs.org/resource/key-ingredients-for-successful- traumainformed-care-implementation/
38. Read, J, Harper, D, Tucker, I, et al. (2017) Do adult mental health services identify child abuse and neglect? A systematic review. International *Journal of Mental Health Nursing,* 27: 7–19.
39. Filson, B (2016) The haunting can end: trauma-informed approaches in healing from abuse and adversity. In *Searching for a Rose Garden:* Challenging Psychiatry, Fostering Mad Studies (eds Russo, J, Sweeney, A): 20–24. PCCS Books.

self-esteem and wider issues in regulating intense emotion that may result from their traumatic experiences

- **Connecting:** Instead of viewing behaviours as 'manipulative' or 'attention seeking' in nature, the service can reframe them as attempts to get needs met and communicate difficulties—encouraging connection rather than rejection of the individual as a result and moving towards restorative relationships and recovery.
- Communicating: As discussed childhood trauma has a major effect on neurodevelopment, making threat responses extreme and easily triggered and reducing the ability to self-soothe.[40] Distress of this kind is hard to articulate. In addition, language has failed many survivors in stopping abuse, particularly where 'No' is ignored or violation continue.

Consequently, extreme behaviours can be the only means a trauma survivor has to express or communicate the extreme distress they are in.

Staff wellbeing and support

It is well recognised within the literature that prison officers are often at a heightened risk of physical health problems, psychological distress and post-traumatic stress disorder [41] [42] [43]A multitude of factors contribute to this; including the poor working environment, lack of training, heavy workload, lack of perceived autonomy, low staffing and the emotional demands of working with a difficult population. These risks are often amplified when working in a trauma informed manner due to the potentially emotive nature of the interactions. Without safeguards in place to help both clinical and frontline staff process their emotions, anyone working with individuals who have experienced trauma may be subject to chronic emotional stress such as secondary traumatic stress, vicarious traumatisation, and burnout. This stress can then negatively affect their own physical and psychological health. Providing targeted training that creates an awareness of this emotional stress and the importance of self-care is often highly beneficial. Organisationally it is also important that there a culture of acceptance (and even encouragement) of seeking support, maintaining boundaries and undertaking considered workloads and that sufficient investment is made in staff wellbeing strategies. In addition to this regular supervision and the opportunity to access reflective supervision session can also prevent, mitigate, and even heal vicarious trauma.[44] [45] [46] [47] Research, although sparse in this area, has supported the notion that the greater the frequency and duration of nonevaluative supervision received by a worker the lower the levels of secondary traumatic stress.[48]

The former referring to the systemic awareness and sensitivity to the presence of trauma while the latter refers to the direct targeting of traumatic symptoms with treatment.

Access to Trauma Specific Interventions

A common confusion when discussing Trauma Informed Care is the distinction between this and Trauma specific interventions. The former referring to the systemic awareness and sensitivity to the presence of trauma while the latter refers to the direct targeting of traumatic symptoms with treatment. In developing a trauma responsive service

40. Van der Kolk, B (2003) The neurobiology of childhood trauma and abuse. Child and *Adolescent Psychiatric Clinics of North America,* 12: 293–317.
41. Denhof, M.D., & Spinaris, C.G. (2013a). Depression, PTSD, and Comorbidity in United States Corrections Professionals: Impact on Health and Functioning. Available at: http://desertwaters.com/wp-content/uploads/2013/06/Comorbidity_Study_6-18-13.pdf.
42. Finney, C., Stergiopoulos, E., Hensel, J., Bonato, S., & Dewa, C. S. (2013). Organizational Stressors Associated with Job Stress and Burnout in Correctional Officers: A Systematic Review. *BMC Public Health,* 13.
43. Harvey, M. (2007). Towards an ecological understanding of resilience in trauma survivors: Implications for theory, research, and practice. *Journal of Aggression, Maltreatment & Trauma,* 14, (12): 9–32.
44. Bell, H., Kulkarni, S., & Dalton, L. (2003). Organizational prevention of vicarious trauma. *Families in Society*, 84(4), 463-470.
45. Gagin, R., Cohen, M., & Peled-Avram, M. (2005). Family Support and Victim Identification in Mass Casualty Terrorist Attacks: An Integrative Approach. *International Journal of Emergency Mental Health,* 7 (2), 125-132.
46. Pulido, M. L. (2007). In their words: Secondary traumatic stress in social workers responding to the 9/11 terrorist attacks in New York City. Social Work, 52(3), 279-281.
47. Sexton, L. (1999). Vicarious traumatisation of counsellors and effects on their workplaces. *British Journal of Guidance & Counselling,* 27(3), 393-403
48. Dalton, L. E. (2001). *Secondary traumatic stress and Texas social workers.* Unpublished doctoral dissertation, The University of Texas at Arlington.

it is vital that pathways exist in order for individuals to access more intensive governed psychological interventions.

Trauma-focused cognitive behavioural therapy (CBT), such as Prolonged Exposure (PE), and Eye Movement Desensitisation and Reprocessing (EMDR) therapy, have been found to be among the most effective treatments for PTSD.[49] PE is an evidenced-based, manualised protocol based in Emotional Processing Theory, which views PTSD symptoms as a result of cognitive and behavioural avoidance of trauma-related thoughts, reminders, activities and situations. PE helps the client interrupt and reverse this process by blocking this avoidance, introducing corrective information and promoting the re-processing of the trauma memory and associated thoughts and beliefs. This is achieved through a combination of in vivo and imaginal exposure. Alternatively, EMDR focuses more specifically on the identification of unprocessed traumatic material. The client is asked to recall the worst aspect of the memory together with the associated thoughts and bodily sensations whilst simultaneously moving their eyes from side to side (or employing some other form of bilateral stimulation). The goal of this is not only to desensitise the client to the distressing memory but, more importantly, to reprocess the memory so that the associated thoughts become more functional. More recently integrated-treatment programs employing cognitive-behavioural therapy to target both trauma and substance misuse symptoms have emerged, although research into their efficacy is limited.[50]

Conclusions and recommendations

As services become increasingly aware of the far-reaching impact of past trauma on an individual's health and well-being and their vulnerability towards engaging in self-damaging behaviours, there is an urgent need for care to become more trauma-informed. Trauma Informed Care (TIC), as outlined within this article, involves a recognition of the need to accurately identify trauma at the earliest opportunity, adopting a strengths-based, compassionate and individualised approach where behaviours are understood in relation to their past experiences and there is a commitment to minimising potential re-traumatisation. Within the field of addiction ensuring traumatic experiences are addressed is crucial as part of successful recovery. Embedding TIC within a prison environment brings with it a unique set of challenges, although the potential benefits in terms of a reduction in institutional violence and self-harm and improvements in staff well-being and retention are evident.

Within this article a number of suggestions were made with regards to how to approach becoming more trauma-informed. Central to this transformation is, as with all change, ensuring senior level buy-in, engaging those with lived experience and providing ample training and support to those at the front line delivering the day-to-day relational interventions. The magnitude of the task within the prison system should not be underestimated, and a number of obstacles often lie in the way of such aspirations. This does not mean that it shouldn't be undertaken however, as the benefits for services users, staff and the prison system are significant.

49. Gerger H., Munder T., Gemperli A., Nüesch E., Trelle S., Jüni P., & Barth J. (2014). Integrating fragmented evidence by network meta-analysis: Relative effectiveness of psychological interventions for adults with post-traumatic stress disorder. *Psychological Medicine,* 44, 3151–3164.
50. McHugo, G.J., & Fallot, R.D. (2011) Multisite Randomized Trial of Behavioural Interventions for Women with Co-occurring PTSD and Substance Use Disorders. *Journal of Dual Diagnosis.* (7), 4, 280-284,

'Polite, Assertive and Sensitive': Procedurally Just Searching at HMP Holme House

Dr Ruth Mann, *Rehabilitative Culture Lead, Public Sector Prisons North*

Introduction

Prisons can easily be tense places, where staff and residents exist alongside each other, both needing the other's cooperation, but sometimes feeling uneasy about trusting or depending on each other. Prison staff make people safe through legitimate authority, and need to be able to turn their hand to numerous conflicting demands, including social work, mental health support, life coaching, control and restraint, and meeting the complex requirements of security such as searching for contraband, disrupting drug supply and preventing escape. Sometimes these goals conflict, such as when a male prisoner who has experienced childhood trauma becomes violent. His violence communicates distress, which is best met through a caring approach, but also threatens the immediate safety of others, which may be have to dealt with through use of restraint.

Prisoners, we know, want prisons to be safe, and in order to feel safe, they look to staff to communicate both that they have authority and that they care. These two messages can be difficult to communicate simultaneously.

One way that staff can effective combine authority and caring is to adopt the principles of *procedural justice* in how they deal with prisoners. Procedural justice means carrying out the duties of law or authority in a way that is perceived as fair by those you are dealing with. There are four aspects to perceived fairness:[1] (1) Voice, where everyone is able to give their side of the story; (2) Respect, where everyone is treated with courtesy; (3) Neutrality, where it is clear that all decisions are made from a neutral, unbiased starting point, and (4) Trustworthy motive, where it is clear that the authority is acting in everyone's best interests.

The importance of procedural justice is shown by a large and consistent body of research across all aspect of the criminal justice setting (police, courts, prisons) as well as in other more general aspects of life. When people perceive their treatment by the authorities to be procedurally just, they are much more likely to cooperate with laws and rules.[2] When they perceive their treatment to be procedurally unjust, people become hostile to the authority, they experience feelings of anger, and they feel alienated from the law.

In prisons, those who experience their imprisonment as less procedurally just have greater feelings of psychological distress in prison,[3] are more likely to break prisons rules including being violent,[4] and are more likely to reoffend after release.[5] Even when subject to multiple petty prison rules, people who are treated with courtesy and have the reasons for the rules and their punishments explained to them are more likely to succeed on release[6]

Procedural justice is probably the nearest thing we have to a silver bullet to make prisons safer and more rehabilitative. Even better, it has a small cost to implement. We don't, in the main, need new processes or systems; we just need to apply and administer the processes that we have in a way that is felt to be procedurally just by those on the receiving end. This applies across the whole raft of prison processes; those that have been specifically

1. Tyler, T. R. (2008). Procedural justice and the courts. *Court Review,* 44, 26-31.
2. Tyler, T. R. (2006). *Why people obey the law.* Princeton University Press.
3. Beijersbergen, K. A., Dirkzwager, A. J. E., Eichelsheim, V. I., Van Der Lann, P. H., & Nieuwbeerta, P. (2014). Procedural justice and prisoners' mental health problems: a longitudinal study. *Criminal Behavior and Mental Health,* 24, 100-112.
4. Beijersbergen, K. A., Dirkzwager, A. J. E., Eichelsheim, V. I., & Van der Lann, P. H. (2015). Procedural justice, anger, and prisoners' misconduct. *Criminal Justice and Behavior*, 42, 196-218.
5. Beijersbergen, K. A., Dirkzwager, A. J. E., & Nieuwbeerta, P. (2016). Reoffending after release: does procedural justice during imprisonment matter? *Criminal Behavior and Mental Health*, 43, 63-82.
6. Franke, D., Bierie, D., & MacKenzie, D. L. (2010). Legitimacy in corrections: A randomized experiment comparing a boot camp with prison. *Criminology & Public Policy*, 9(1), 89-117.

researched include Incentives and Earned Privileges schemes[7], Offender Management[8] and Complaints procedures.[9]

A task that prison officers must carry out is the searching of cells and prisoners for contraband such as mobile phones, illicit drugs, and cigarettes. These items are prohibited in prisons because they contribute to illegal activity, bullying, violence and distress. However, they are also highly desirable items for prisoners to possess. Mobile phones, for example, enable contact with families as well as criminal behaviour, and drugs enable people to self-medicate against the pains of imprisonment. Searching is therefore a necessary duty for staff to perform in the interests of prison safety, but it causes anxiety and stress for prisoners who face losing possessions that are important to them, or risk being caught with items that they have been instructed to hold for others, causing fear that they will be punished within the 'inmate culture' if the items are found. Searching can therefore be a flashpoint for anger, fear and violence. The nature of the interaction between an officer and the person she or he is searching can inflame these reactions or, potentially, calm them.

The nature of the interaction between an officer and the person she or he is searching can inflame these reactions or, potentially, calm them.

This article describes how the principles of procedural justice have been applied to searching at HM Holme House, a Category C training and resettlement prison specialising in drug recovery that is part of the Tees and Wear Prisons Group in the North East of England. Searching in this context refers to area searches of parts of the prison, searches of prisoners' cells, and searches of prisoners themselves, with the intent of discovering contraband articles such as mobile phones and illicit drugs. It includes physical searching and searching technology such as X Rays and Scanners. Searches can be random, targeted as a result of intelligence, or routine, such as searching all men on their arrival at the prison and again on their departure. Searching is also carried out on staff and on prison visitors, sometimes randomly and sometimes in special operations. Increased searching has been a vital component of the drug recovery programme, which seeks to reduce supply of drugs while simultaneously reducing demand for them and improving people's ability to cope without them. Since January 2018, the specialist drug searching team at Holme House has deliberately adopted a procedurally just approach. In this article I will set out the elements of their approach, drawing on interviews conducted with several members of the searching team and with their managers. The searching team were keen to emphasise that the fundamental aspect of a procedurally just approach is the way in which the authority chooses to treat the people they hold sway over:

The key message is not the resources. It's how the staff interact

Staff selection and training

Staff were invited to apply for the specialist searching role. The selection process involved an interview where the main focus was to assess interpersonal skills and attitudinal support for a procedurally just approach. Second, applicants took part in a mock search exercise. This not only assessed their searching skills but crucially their manner of interaction with the person they were searching. Could they use humour appropriately to diffuse some situations, calming skills for others, and equally be able to show care for the vulnerable? Those selected undertook specialist searching training, and also took part in training in Five Minute Intervention skills[10] and in keyworking. The new searching staff were specifically instructed that searches should not end in use of force (restraint). They were briefed to 'get people on side' while they searched them or their possessions. They were trained to understand that applying the principles of procedural justice would improve cooperation and reduce the likelihood of a hostile response from the person being searched.

7. Liebling, A. (2008). Incentives and Earned Privileges revisited: Fairness, discretion, and the quality of prison life. *Journal of Scandinavian Studies in Criminology and Crime Prevention*, 9, 25-41.
8. Bickers, I. (unpublished). Offender supervision, prisoners and procedural justice. MSt thesis, University of Cambridge.
9. Bierie, D. M. (2013). Procedural justice and prison violence: examining complaints among federal inmates (2000-2007). *Psychology, Public Policy, and Law*, 19, 15-29.
10. Tate, H., Blagden, N., & Mann, R. (2017). Prisoners' perceptions of care and rehabilitation from prison officers trained as 5 minute interventionists. Ministry of Justice Analytical Summary. Available from www.gov.uk.

The initial days: Use of cue cards to ensure a procedurally just approach

In line with published accounts of introducing procedurally just approaches to routine practice[11], the team began by using cue cards to help them remember all the components of procedural justice. The cue card used is shown below. The cue cards did not have to be used for long. Once staff were familiar with how to apply procedural justice during searching they were easily able to remember the components and adapt them to different circumstances and tasks.

Key Points	Script Reminders	Side 1
Targeted Intel	* Hello - Introduction	
Search	* Today you are being searched because intelligence suggests…….	
	* We have many code blues each month. Each code blue has an impact on your regime and could be dangerous for those directly involved.	
	* We are really keen to reduce drug use in the prison. This would be better for everyone here	
Impact	* We're also worried about tying up emergency services, reducing their ability to respond to incidents in the community.	
	* Will you help us to provide a safe secure drug free environment by giving us your co-operation today and more generally by abstaining from illicit activity?	
	* Last month's MDT figures were ##	
	* There were ## incidents of self-harm	
Drug Use / Prevention	* There were ## incidents of violence	
	* There were ## incidents at height	
	* These figures are much higher than anyone wants, staff & prisoners alike	

Key Points	Script Reminders	Side 2
Drug Use / Prevention	We are trying many things to try and reduce drug use and make the prison a safer place for all. Is there anything you think staff should be aware of doing?	
	* Can you please identify your belongings?	
	* Is there anything in this cell which does not belong to you or is an illicit item?	
Search	* Is there anything you think we need to be aware of?	
	* I will now search each of you (double cell). I will guide you through the process	
	* Once the search is complete we will bring you back and inform you of any finds / actions.	
Positive Message	I just want to finish off by thanking you (for a positive thing they have done). i.e. Your co-operation today / Keeping your cell clean & tidy / Adhering to volumetric control	
ANY FINDS TO BE PROCESSED AND ACTIONED AS NORMAL, INFORM THEM OF SUCH		

Respect: Taking care with people's possessions and speaking with courtesy

The team emphasised the care they take when searching cells, recognising that in prison a person's cell is their home, and taking the view that they should treat it with the respect that you would show to anyone else's home. This is counter to the assumption that in searching a cell it is acceptable to leave it in a mess for the occupant to clear up and return to normal. The following quotes provide further examples of the team's commitment to treating people with respect, both in their actions and in their behaviour:

When you search, put things back as you found them. Leave it so that all he has to do is make the bed, Always make sure the place is as you found it.

Once a man had his photos put up really carefully on his noticeboard. We had to take them down to look behind them. On that occasion I left them in a neat pile for him to put them back. I explained that I could see the way they were displayed was precise and important to him and I didn't want to get it wrong.

If we have to take things for examination, we're polite. Explain exactly what's gone on, what we've taken, what they should get back and when.

If you trash the cell and speak down to the man, it just causes animosity

In these ways, the team showed respect both to the men whose space they were searching, and to their colleagues: one of their mantras was, 'Never leave an angry man behind you for someone else to have to deal with.

Neutrality: Understanding the other person's perspective

The PJ component of neutrality refers to the importance of conveying to people that they do not need to fear that they will be judged unfairly because of a pre-existing bias against them or a group that they represent. In terms of cell searching, bias could exist towards prisoners as a group, for example if there was an assumption that secreting contraband is an expected expression of their criminality. Staff could potentially also hold stereotypes of drug users, mirroring those that often found in wider society. Bias could also exist towards individual prisoners because of previous behaviour, associates, ethnicity, reason for imprisonment, and so on.

One way to overcome biases of this nature is to use the strategy of perspective taking. At Holme House, the searching team emphasised that empathy was one of the deliberate features of their approach that helped them conduct their work in a procedurally just way:

11. Mazerolle, L., Antrobus, E., Bennett, S., & Tyler, T. R. (2013). Shaping citizen perceptions of police legitimacy: A randomized field trial of procedural justice. *Criminology,* 51(1), 33-63.

Put yourself in their position and think about how it feels

Using empathy enabled them to approach each person they had to search as an individual, and reminded them that his behaviour, even if he was found to be holding contraband, should be understood and not judged:

You have to think about what it is like to be addicted to drugs. If you are an addict the tablets are everything. That's why they try to hide them from us. It's not personal

'Treat him as you would want to be treated. We all have to live and work together'

Trustworthy motive: Explaining while searching

The PJ component of trustworthy motive means that people feel assured that the authority is acting in their best interests. To assure someone of trustworthy motive, you must both verbally explain your motive, and then ensure that your style of interaction throughout the engagement is congruent with your initial explanation. Transparency is an essential aspect of trustworthiness.

Prison searching has traditionally been designed to be carried out in an intimidating manner as it has been (incorrectly) thought that this makes people most likely to yield information or give up contraband. Procedurally just searches are completely different. Having a trustworthy motive means that you are searching men in order to keep the prison safe, not because you want to see people caught out or punished. This motive must be communicated transparently throughout the process. Therefore, a procedurally just search involves constantly explaining what is happening and why; and what will happen next:

We talk through the processes and the consequences if he does and doesn't hand it over. When you talk on the way, it's fine. Nine out of ten times they will hand it over. Because it is done good-naturedly—polite, assertive and sensitive

The emphasis is on good-natured relationships and good interpersonal skills. If it is indicated during a cell search that someone may have swallowed or secreted something, they are taken for a body scan. Again, the searcher will explain the process and the consequences calmly and transparently:

When it comes to the scan, we show them the images. We use previous scans to show them the difference between a clear scan and what it looks like when someone is 'plugged'. We are upfront in everything we do, and we tell them everything

Prison searching has traditionally been designed to be carried out in an intimidating manner as it has been (incorrectly) thought that this makes people most likely to yield information or give up contraband.

As a result of adopting this approach, the searchers at Holme House have never had to take anyone for a scan under restraint.

Voice: Gathering intelligence through relationships and trust

The PJ component of 'voice' means that the authority engages people in telling their side of the story and listening to their experiences and suggestions. By engaging with the voice of people in prison, the searching team came to realise that searching for contraband was not an 'us vs them' task. In fact, the majority of the men in the prison approved of their objective:

A lot of them are sick of the way it is. They live in fear or they are being bullied. They want us to know. They just need a safe way to tell us

To capitalise on this support, in one operation the search team decided to gather intelligence from a whole houseblock of the prison, where a higher level of Psychoactive Substance use had been noted. The team invited every man living on the houseblock to an individual, confidential, five minute interview. It was explained to each man in turn that he did not have to offer any information or intelligence, but that the purpose of the opportunity was for him to be able to do so if he wished too. If he did not wish to offer information, he would still be asked to stay for five minutes in the interview room making general conversation, so that others on the wing would not be able to tell who had used the time to pass on information and who hadn't. The general

conversations often involved discussions about the problems caused by drug use on the houseblock. All the men took part willingly in interviews. Some declined to pass on any information but many did; either offering specific information about drug entry and trading routes, or more general information about the price of illicit drugs and so on:

> *Some said they wouldn't speak, but they had to stay on for five minutes anyway and then some would speak, when they saw they couldn't be identified*

One important realisation was that this approach worked so well because the other components of procedural justice had already been established over a period of time. The men at Holme House knew that the searching team had a trustworthy motive and were not seeking to catch them out for punishment:

> *Everyone knows we are fair. We don't put people at risk when they give information*

Conclusion

Procedural justice research indicates that when people feel they are treated fairly, they will accept harsher outcomes more easily than people who get lighter outcomes but do not feel treated fairly.[12] Or in other words, as one of the Holme House searchers put it, '*they may not like what happens but they will like the way we do it*'.

This article has only represented the views of the staff team who conduct searches at Holme House. We have not yet heard the voice of the men who have been searched, and so we cannot assume that they perceive themselves to have been treated with procedural justice. This is an essential next step, as the men's perspectives are necessary to know whether the approach is experienced as intended, or whether any changes are needed to the approach. Furthermore, there is unfortunately no hard data or counterfactual available to confirm the searching team's belief in the effectiveness of their approach. We do not know whether the search team has uncovered more contraband using a procedurally just approach than they would have done with a more traditional searching approach, or whether the lack of need to use force is significantly different to the experience of other prisons.

However, the behavioural responses of the people being searched—especially their lack of violent resistance to searching, and their willingness to supply intelligence—suggest cooperation with the authorities, which in turn suggests that procedural justice is being experienced. To the search team, who have experienced for themselves the benefits for everyone of paying attention to procedural justice, this way of working is a no-brainer.

> *There's an easy way and a hard way to do this job. Why would you want to do it the hard way?*

12. Tyler, T. R. (2006). *Why people obey the law.* Princeton University Press.

The use of Rehabilitative Adjudications for those in Recovery

Dr Helen Wakeling *is a research psychologist working in the Evidence-Based Practice Team in HM Prison and Probation Service*

Flora Fitzalan Howard *is a forensic psychologist and researcher working in the Evidence-Based Practice Team in HM Prison and Probation Service*

Recovery, as a means of supporting people out of drug dependency, has emerged as the leading practice within addictions treatment and community engagement and transformation. This recovery movement has reaped clear benefits in jurisdictions where it has been implemented.[1] These benefits include improvement of the treatment systems, and greater provision of aftercare; increased attention on families and environments that are supportive of positive change; greater focus on a strengths-based model, centred on the values of CHIME[2] (connectedness, hope, identity, meaning and empowerment); and having an inclusive approach, where the focus for staff and clients is on improving wellbeing.

The recovery journey for those with substance use issues can be long and challenging. Within the context of prisons, where people are kept away from their family and friends, and often have to spend long hours on their own in their cell, this journey can feel even more arduous. An additional challenge within the prison context is the juxtaposition often at play between the way misconduct is typically managed and the provision of treatment and support services. Whilst on the one hand individuals in prison who abuse substances need to understand that this is not acceptable, and that there are consequences for this behaviour, if this process is conducted completely separately from the treatment and support services, then it is unlikely to successfully change substance use behaviour, or help people on their recovery journey. This article introduces the concept of rehabilitative adjudications generally, and discusses how the management of rule breaking in a prison context might be used to better support the recovery process for the men and women in our care.

Drug Use in Prisons and the Recovery Process

Drug use and addiction is a major issue for people residing in prisons across England and Wales. Recent estimates from Public Health England suggest that over half of adults residing in secure settings were in contact with drug and alcohol treatment services during 2016-17.[3] More recently in prisons there has been a significant rise in the use of psychoactive substances,[4] which has had a negative impact on the safety of prisons. Boredom and lack of purposeful activity have been cited as key reasons for the use of these substances in a prison context.[5] We also know that there is a strong relationship between drug use and crime,[6] as well as drug use and reoffending.[7] Substance use is certainly an issue with relevance to those of us working within the Criminal Justice System (CJS).

In recent times there has been a shift from regarding addiction recovery as solely gaining control over substance use, to having a broader aim of global health and active participation in communities.[8] This

1. Sheedy, C. K., & Whitter, M. (2009). Guiding principles and elements of recovery-oriented systems of care: What do we know from the research? HHS Publication No. (SMA) 09–4439. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.
2. Leamy, M., Bird, V., Le Boutillier, C., Williams, J., & Slade, M. (2011). A conceptual framework for personal recovery in mental health: Systematic review and narrative synthesis. British Journal of Psychiatry, 199, 445–452.
3. Public Health England and Department of Health and Social Care. (2018). Secure setting statistics from the National Drug Treatment Monitoring System (NDTMS). 1 April 2016 to 31 March 2017.
4. HM Inspectorate of Prisons (2016). HM Chief Inspector of Prisons for England and Wales: Annual report 2015-16.
5. Ralphs, R., Williams, L., Askew, R., & Norton, A. (2017). Adding Spice to the Porridge: The development of a synthetic cannabinoid marker in an English Prison. *International Journal Drug Policy,* 40, 57-69.
6. National Treatment Agency for Substance Misuse (2012). *Estimating the crime reduction benefits of drug treatment and recovery.* Downloaded from www.nta.nhs.uk
7. May, Sharma & Stewart (2008). Factors linked to reoffending: a one-year follow-up of prisoners who took part in the Resettlement Surveys 2001, 2003 and 2004. Ministry of Justice Research Summary.
8 UK Drug Policy Commission, U.D.P. (2008). The UK Drug Policy Commission Recovery Group: A vision of Recovery. UK Drug Policy Commission. HM Government, London. Available at https://goo.gl/a6nWXq

includes incorporation of 'recovery capital',[9] which can be defined as the resources that an individual has to support their recovery pathway. There are three domains for recovery capital;[10] personal capital (personal qualities such as resilience and hope), social capital (based on the support an individual has), and community capital (based on the support from the local community, including housing, training and employment). People who have more of these three forms of recovery capital are more likely to be successful on their recovery journey. The extent to which the prison context can develop recovery capital will vary by prison, but there are ways in which we can conduct processes in prison, that may better support the provision of recovery capital, to generate community recovery capital and therefore increase the likelihood of individual recovery.

Drug policy in prisons often adopts a threat-based approach to encourage drug users to enter treatment, and punishment is the usual route taken when people fail a drug test, or are found in possession or under the influence of drugs. In line with other researchers,[11] we argue that a different approach may offer a better way to enhance the motivation of drug users, increase recovery capital, and promote better long-term outcomes. This alternative includes focusing on rehabilitation rather than punishment, and a greater emphasis on the values of CHIME. To recap, CHIME stands for Connectedness, Hope, a positive sense of Identity, Meaning and Empowerment. The CHIME acronym was developed to encapsulate the positive or essential elements of recovery. The framework postulates that recovery is more likely to be successful when people have good relationships and feel connected to others in positive ways; when people have hope and optimism that recovery is possible; when there is a positive sense of self and identity; when people are living a meaningful and purposeful life; and when people have control over their life, and are able to focus on their strengths.

...promote compliance or reduce subsequent rule breaking. There is also little evidence around the use of adjudications specifically with those charged with using substances.

The Disciplinary Adjudication Process

Within prisons in England and Wales most misconduct is dealt with informally. Disciplinary adjudications are a formal process used in response to more serious rule breaking, including substance use.[12] After someone is charged for breaking a prison rule, court-like adjudication hearings allow for inquiry into the charge, the presentation of evidence, the right to a defence and legal advice. If found guilty, prisoners can be issued with punitive sanctions (punishments), which range in severity. Punishments can be activated immediately or suspended, typically when the adjudicator offers the prisoner a chance to change their behaviour, and if they are successful for a set period of time they may avoid the issued sanction.

Disciplinary adjudications occur often daily and at high frequencies across English and Welsh prisons. However, little attention has been paid to whether the outcomes of adjudications promote compliance or reduce subsequent rule breaking. There is also little evidence around the use of adjudications specifically with those charged with using substances. Does the typical use of adjudications support the recovery process or help people to change their behaviour? Despite the dearth of research in this area, we can look to the wider psychological and correctional evidence to consider how and when adjudications might effectively facilitate behaviour change and promote the recovery journey, and in doing so contribute to better outcomes.

Punishment

Punishment is important for society; in prisons specifically, punishment is used to send clear signals about what is and is not acceptable behaviour, and punishment for misbehaviour supports notions of fairness that there are consequences for anti-social behaviour. However, the wider literature on the effects of punishment strongly indicates that punishment is not very successful at discouraging a person from repeating

9. Granfield, R., & Cloud, W. (2001). Social context and natural recovery: the role of social capital in the resolution of drug associated problems. Substance Use Misuse, 36, 1543-1570.
10. Best, D., & Laudet, A. B. (2010). The Potential of Recovery Capital. Royal Society for the Arts, London.
11. McKay, J. R. (2016). Making the hard work of recovery more attractive for those with substance use disorders. Addiction, 112, 751-7.
12. National Offender Management Service (2013). Prison Service Instruction 47/2011: Prisoner Discipline Procedures. London: NOMS.

criminal acts, or at helping them to change their behaviour. Research shows that imprisonment (as opposed to non-custodial sanctions),[13] longer sentences,[14] harsher prison conditions[15] and punitive interventions based primarily on surveillance, control, or deterrence and discipline[16] have all largely been found ineffective at changing behaviour (or reducing reoffending). Similarly, behavioural management schemes that emphasise punishment or loss of incentives, over reward, have been found to be less effective strategies in changing institutional adjustment, educational performance, work-related behaviour or other non-substance use related outcomes,[17] and to even potentially backfire through negatively affecting relationships between staff and prisoners.[18]

There are a number of possible explanations for the fact that punishment appears ineffective at helping people to change behaviour. The idea that punishment will change behaviour rests on the assumption that misbehaviour is a rational choice, and so if we increase the cost (over the benefits) of the behaviour, then people will make different decisions. If we specifically take substance use, the choice to continue to engage in drug use is typically not rational. When people are addicted to substances, experiencing cravings, having withdrawal symptoms, or are under the influence of drugs, they become less capable of making considered decisions. Indeed, recent research supports the notion that addiction causes a 'narrowing' of the brain which also parallels a 'narrowing' of the person's environment.[19] The result of this, is that alternative sources of relief and choice become less and less accessible. Additionally, we know that the pre-frontal cortex of the brain, which is the part responsible for planning, impulse control, understanding others and weighing consequences, does not finish developing until the mid to late twenties,[20] which has implications for the behaviour of younger people, who may also be more likely to engage in substance use behaviours. The experience of traumatic brain injury is also thought to be prevalent in prison populations, which may affect thinking, behaviour and effective responses to this,[21] and additionally it has been suggested that spending time in prison may slow the development of maturity.[22] This raises important implications for how we help people to obey rules in prison, and why punishment-focussed schemes may not be effective.

Research has also identified a number of necessary conditions for punishment to successfully supress behaviour.[23] These include, amongst others, that punishment is severe, immediate and certain. Within the CJS these conditions can be very difficult to meet, which is also the case when using adjudications in response to rule breaking in prison. Substance use can go unreported or undetected (so it is not certain that punishment will follow), adjudications can often be delayed for procedural reasons (so punishment is not immediate) and punishments are issued proportionately to the misconduct (and are therefore unlikely to be most severe, although the severity of a punishment is partly subjective).

Together this evidence suggests that a scheme in prison that is premised on punishment, and delivers punishment in the way that adjudications do, is unlikely to be an effective method of helping people to desist from rule breaking and learn to behave differently. This evidence also fits with the transition to a strengths-based model in supporting individuals' change process. Adjudications are perhaps even less likely to be effective with individuals placed on report for substance use.

13. Villettaz, P., Gillieron, G., & Killias, M. (2015). The effects on re-offending of custodial vs. non-custodial sanctions: An updated systematic review of the state of knowledge. The Campbell Collaboration, 1. Retrieved from: https://www.campbellcollaboration.org/media/k2/attachments/Killias_Custodial_Update.pdf
14. Smith, P., Goggin, C., & Gendreau, P. (2002). *The effects of prison sentences and intermediate sanctions on recidivism: general effects and individual differences (User Report 2002-01).* Ottawa: Public Safety and Emergency Preparedness Canada.
15. Bierie, D. M. (2012). Is tougher better? The impact of physical prison conditions on inmate violence. *International Journal of Offender Therapy and Comparative Criminology,* 56(3), 338–355. https://doi.org/10.1177%2F0306624X11405157
16. Barnett, G., & Fitzalan Howard, F. (2018). What doesn't work to reduce reoffending? A review of reviews of ineffective interventions for adults convicted of crimes. European Psychologist, 23, 111-129. https://doi.org/10.1027/1016-9040/a000323; Mackenzie, D. L., & Farrington, D. P. (2015). Preventing future offending of delinquents and offenders: what have we learned from experiments and meta-analyses? Journal of Experimental Criminology, 11, 565-595. https://doi.org/10.1007/s11292-015-9244-9.
17. Gendreau, P., Listwan, S.J., Kuhns, J.B. & Exum, M.L. (2014). Making prisoners accountable: Are contingency management programmes the answer? *Criminal Justice and Behavior,* 41(9), 1079-1102. https://doi.org/10.1177%2F0093854814540288
18. Liebling, A. (2008). Incentives and Earned Privileges revisited: Fairness, discretion and the quality of prison life. *Journal of Scandinavian Studies in Criminology and Crime Prevention,* 9(1), 25-41. https://doi.org/10.1080/14043850802450773.
19. Lewis, M. (2018). Brain Change in Addiction as Learning, Not Disease. *New England Journal of Medicine,* 379, 1551-1560.
20. Casey, B. J. (2013). The teenage brain: an overview. *Current Directions in Psychological Science,* 22(2), 80-81. https://doi.org/10.1177%2F0963721413486971.
21. Durand, E., Chevignard, M., Ruet, A., Dereix, A., Jourdan, C., & Pradat-Diehl, P. (2017). History of traumatic brain injury in prison populations: A systematic review. *Annals of Physical and Rehabilitation Medicine,* 60(2), 95-101. https://doi.org/10.1016/j.rehab.2017.02.003
22. Dmitrieva, J., Monahan, K. C., Cauffman, E., & Steinberg, L. (2012). Arrested development: The effects of incarceration on the development of psychosocial maturity. *Development and Psychopathology,* 24(3), 1073-1090. https://doi.org/10.1017/S0954579412000545
23. Andrews, D. A., & Bonta, J. (2010). *The psychology of criminal conduct* (5th ed). London: Routledge.

Men or women who continually fail mandatory drug tests, found to be in possession of substances or suspected of being under the influence of substances, are often caught in a repeated cycle of punishment and having privileges removed, which in turn make it more likely that they will use substances to cope with their situation. Without helping people to address the reasons for their drug use, taking into consideration other factors such as psychosocial maturity and brain injury, and supporting them in their recovery journey, it is unlikely that the focus on punishment will be beneficial. So what other approaches to behaviour change are available that may help people to address their substance use, and change their behaviour?

Rehabilitation

In the last few years there has been enhanced emphasis on making prisons more rehabilitative, by focusing on the environment, by improving relationships between staff and prisoners, and by ensuring that every opportunity to focus on helping individuals to change is taken. This includes making daily interactions rehabilitative, by using pro-social modelling, reinforcement of new behaviours, skills-building interactions, and open and respectful communication between staff and prisoners.[24] 'Core correctional practices'[25] have been described as the relationship and structuring skills that, when used by prison and probation staff, are associated with reduced recidivism. These include relationships that are respectful, caring, enthusiastic, collaborative, and value personal autonomy, and the active use of pro-social or anti-criminal modelling, effective reinforcement and disapproval, cognitive restructuring, structured skill building, problem-solving, effective use of authority, advocacy/brokerage and motivational interviewing. Evidence for these practices suggests that the quality and nature of formal and informal interactions between prisoners and those in authority have the potential to impact positively on rehabilitation, even if the contact lasts for only a short time.

...formal and informal interactions between prisoners and those in authority have the potential to impact positively on rehabilitation, even if the contact lasts for only a short time.

Her Majesty's Prison and Probation Service (HMPPS) Public Sector Prisons Five Minute Intervention (FMI) project was developed from this concept. The FMI project trained custodial staff to respond differently to prisoners during everyday conversations, using these as opportunities to employ some of the skills and practices listed previously, and in doing so contribute to developing a rehabilitative culture in which all people take every opportunity to bring about, or reinforce, rehabilitative change.[26] A rehabilitative culture would also likely impact on promoting recovery; that is, the essential elements of recovery (e.g. CHIME values) would be more likely to be present within a wider rehabilitative environment. An evaluation of FMI[27] reported that prisoners describe a number of positive changes that they believed had occurred through FMI conversations, including changes to their thinking skills and self-efficacy. Such conversations are likely to be beneficial for people in recovery because the literature is clear that this group fare better with positive relationships, and the availability of meaningful activities and connections.[28] Rehabilitative contact with these individuals would also emphasise the CHIME values; ensuring people have positive connections, that they have hope, that they are able to have a positive identity and have meaning in their lives, can all be supported by effective and positive relationships. Positive social connections can also aid the development of hope and empowerment.

Alongside the combined package of day-to-day rehabilitation skills and effective treatment intervention, we also need an effective primary response to

24. Smith, P. & Schweitzer, M. (2012). The therapeutic prison. *Journal of Contemporary Criminal Justice,* 28(1), 7-22. https://doi.org/10.1177%2F1043986211432201
25. Dowden, C., & Andrews, D.A. (2004). The importance of staff practice in delivering effective correctional intervention: A meta-analytic review of core correctional practice. *International Journal of Offender Therapy and Comparative Criminology,* 48(2), 203-214. https://doi.org/10.1177%2F0306624X03257765
26. Webster, S.D. and Kenny, T. (2015). *Experiences of prison officers delivering Five Minute Interventions at HMP/YOI Portland.* London: National Offender Management Service. Retrieved from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/448854/portland-fmi.pdf
27. Tate, H., Bladgen, N., Mann, R. M. (2017). *Prisoners' perceptions of care and rehabilitation from prison officers trained as Five Minute Interventionists.* HMPPS: London. Retrieved from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads /attachment data/file/662699/prisoners-perception-of-care-from-prisoner-officers-trained-5-minute-interventionists.pdf
28. Best, D., Bird, K., & Hunton, L. (2015). Recovery as a social phenomenon: What is the role of the community in supporting and enabling recovery? In N. Ronel & D. Segev (Eds.), *Positive Criminlogy* (pp. 194-207). Abingdon: Routledge.

substance use misconduct. Whilst this evidence paints a convincing picture for a rehabilitative response to substance use in custody, there remains a societal argument that rule breaking should be met with consequences and clear messages about acceptability (via punishment) sent. The question therefore becomes, if we accept that punishment is necessary but unlikely to be effective on its own, how can we do this in a way that is most likely to bring about better outcomes, and support recovery?

Rehabilitative Adjudications

The concept of rehabilitative adjudications was borne out of the work mentioned above on FMI and core correctional practices. Research into the rehabilitative potential of adjudications[29] showed that adjudicators can, and some already do, use skills that facilitate or support rehabilitative change, despite adjudications being a traditionally investigative and punishment-focussed process. The rehabilitative skills observed that appeared to be associated with engagement, reflection and change were: Socratic questioning, active listening, using praise and reinforcement, using a respectful treatment and tone, demonstrating empathy, warmth and humour, giving choices and fostering hope, and being collaborative and transparent.

The concept of rehabilitative adjudications was borne out of the work mentioned above on FMI and core correctional practices.

The use of these skills was not found to be consistent across adjudicators, with some using rehabilitative skills more frequently than others, and some necessary skills being used infrequently by all participants. Similarly, prisoner behaviour varied, and responses to rehabilitative attempts were not always successful. Many missed opportunities for using rehabilitative skills to improve insight and support change were identified. Whilst a causal relationship between adjudicator and prisoner behaviours was not tested, associations between them were identified. The research concluded that taking a rehabilitative approach to adjudications is certainly possible and does not need to detract from the primary purpose of adjudications: investigating charges and (if proved) conveying punishment. Rather, these aims can be complementary, with rehabilitative skills being used throughout the process, whilst investigating charges, considering and giving sanctions, and in looking to the future by facilitating learning and behaviour change. How legal procedures are conducted matters as much as what the legal procedures are.

Rehabilitative adjudications also need to have the principles of procedural justice at their core. Procedural justice theory argues that experiencing fair and just procedures (how people make decisions and apply policies, rather than what the outcome is) leads people to view the law and authority figures as more legitimate, and to greater compliance with, and commitment to obey, rules and law.[30] Procedural justice involves four principles: neutrality, respect, trustworthiness and voice.[31] People need to see authority figures as neutral and principled decision-makers, who apply rules consistently and are not swayed by personal opinion or bias. People need to feel respected, believe that their rights are considered equal to those of others and that their issues will be taken seriously. People need to see authority figures as having trustworthy motives, who care and try to do what is right for everyone involved. Finally, people need to have the chance to tell their side of the story and to feel that authority figures will sincerely consider this before making a decision. A large body of research on procedural justice supports the relationship between justice perceptions and compliance with the law and orders. The research in prisons has found links between procedural injustice and misconduct, violence, non-violent rule-breaking, adjustment, compliance, prisoner health and even reoffending outcomes.[32] The implication of this research is that if

29. Fitzalan Howard, F. (2018). *Investigating disciplinary adjudications as potential rehabilitative opportunities.* London: HMPPS. Retrieved from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/661909/investigating-disciplinary-adjudications.pdf
30. Tyler, T. R. (1990). *Why people obey the law*. New Haven: Yale University Press.
31. Tyler, T. R. (2008). Procedural justice and the courts. *Court Review*, 44(1-2), 26-31. Retrieved from: https://digitalcommons.unl.edu/cgi/viewcontent.cgi?article=1254&context=ajacourtreview
32 Reisig, M. D., & Mesko, G. (2009). Procedural justice, legitimacy, and prisoner misconduct. *Psychology, Crime & Law*, 15(1), 41-59. https://doi.org/10.1080/10683160802089768; Day, J. C., Brauer, J. R., & Butler, H. D. (2015). Coercion and social support behind bars. Testing an integrated theory of misconduct and resistance in US prisons. *Criminal Justice and Behavior,* 42(2), 133-155. https://doi.org/10.1177%2F0093854814546352; Steiner, B., & Wooldredge, J. (2018). Prison officer legitimacy, their exercise of power, and inmate rule breaking. *Criminology*, 1-30. https://doi.org/10.1111/1745-9125.12191; Bierie, D. M. (2013). Procedural justice and prison violence: examining complaints among federal inmates (2000-2007). *Psychology, Public Policy, and Law,* 19(1), 15-29. http://psycnet.apa.org/doi/10.1037/a0028427; Beijersbergen, K. A., Dirkzwager, A. J. E., Eichelsheim, V. I., & Van der Lann, P. H. (2015). Procedural justice, anger, and prisoners' misconduct. *Criminal Justice and Behavior,* 42(2), 196-218. https://doi.org/10.1177%2F0093854814550710

adjudications (and any other uses of authority) are conducted in a way that is perceived to be procedurally just, then even in the face of a punitive or unfavourable outcome, this could lead to greater respect for rules and authority, acceptance of adjudication decisions, and better subsequent rule compliance.

Using Rehabilitative Adjudications to support the Recovery Process

Pulling together all of this evidence, we would suggest that there are ways in which we can conduct adjudications that hopefully give them the best chance of effectively changing prisoners' substance-related behaviour and supporting recovery. The extensive research on punishment suggests that reliance on adjudications sanctions is unlikely to successfully reduce or prevent misconduct. However, conducting the adjudication process in a way that is perceived to be procedurally just and using evidence-based rehabilitative skills (or core correctional practices) to help people to think and behave differently may help achieve the desired outcomes. For procedural justice, adjudications and adjudicators are more likely to be respected, trusted and cooperated with if, for example, prisoners have the chance to tell their story, are sincerely listened to and not interrupted, if how and why decisions are made is clear and consistent from case to case, if the intended purpose and value of adjudications are trustworthy and sincere, and if people are treated with courtesy and respect.

> … procedural justice supports the relationship between justice perceptions and compliance with the law and orders.

The way questions are phrased can affect how much people learn; Socratic questions help people to think more deeply about an issue, to help them to analyse it and learn something new. These questions can be used during adjudications, for example, to develop perspective taking, consequential thinking, challenge anti-social beliefs or prompt consideration about how else the person could behave. Using praise and reinforcement helps people to know what behaviours are valued, helps teach people what to do (rather than focussing what not to do) and motivates them to repeat those behaviours. No-one's behaviour is entirely negative, and so despite adjudications focussing primarily on rule breaking, there may be opportunities to reinforce other positive or valued behaviours (such as engagement in activities, or new insight gained during the discussion). With substance use, it is necessary to recognize and reinforce progress towards responsible, abstinent behaviour. So any break in substance use can be positive and should be reinforced and rewarded. Likewise, engagement with psychosocial support or substance use treatment should be praised, as should engagement in other supportive activities, such as mutual aid.

Research[33] has suggested that conducting adjudications in a collaborative way may help prisoners to engage and understand better, and believe that staff are treating them fairly. This can help adjudications to feel 'done with' rather than 'done to' prisoners, which may facilitate cooperation and respect. Offering choices, communicating hope and fostering autonomy, may help people to take control of their behaviour and see change as possible. Giving people hope is probably one of the critical skills needed when conducting adjudications with this group. Recovery is holistic, and involves a personal recognition of the need for change and transformation. However giving people hope for their future can help people work towards this. Helping people to reason things out for themselves and make their own choices can be far more powerful than telling people what to do, even if this is done with the best of intentions. Helping people to understand the choices available to them, and supporting them to develop pro-abstinent and supportive social networks can be really beneficial for people with substance use issues.

There is strong evidence that people attempting to recover from alcohol and drug dependency do better when integrated in positive social networks, and when they have opportunities for developing the right skills and social capital that this integration allows.[34] The adjudication context provides an opportunity to support this process. We know that people get stuck in cycles of drug use that can be hard to exit. Encouraging people to engage in purposeful activity, supporting a harm reduction approach, and encouraging people to access psychosocial support and/or mutual aid, can all be helpful. In this way, rehabilitative adjudications could be considered both an intervention in and of themselves, as well as a pathway to improved social and community capital. Adjudications can be used as a forum for helping people, finding out what the issues are and helping them

33. Fitzalan Howard, F. (2018). *Investigating disciplinary adjudications as potential rehabilitative opportunities.* London: HMPPS. Retrieved from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/661909/investigating-disciplinary-adjudications.pdf
34. Cano, I., Best, D., Edwards, M., & Lehman, J. (2017). Recovery capital pathways: Modelling the componentns of recovery wellbeing. *Drug and Alcohol Dependence,* 181, 11-19.

see other potential avenues. People need the capability, the opportunity as well as the motivation[35] to change their behaviour. The adjudication context certainly gives some scope for helping develop all of these. Being warm and using humour can help put people at ease, build rapport and diffuse difficult or emotional interactions that might otherwise lead to conflict or the person disengaging from the adjudication process. Demonstrating care and concern for the person's well-being, and being understanding and empathic about their circumstances (without necessarily condoning their behaviour or decisions) can help make interactions more human and compassionate, whilst still remaining professional. We can also learn valuable lessons from the literature on desistance, particularly that identity change is critical for both desisting from offending and for the recovery process[36]. This identity change process is social, and can begin inside the prison gates. How people are treated, labelled and stigmatised can have a significant impact on how they see themselves, and their future. Therefore ensuring that individuals are respected, are not stigmatised for their drug use, and are given the chance to change their identity and are supported in this, can all be supported within the adjudication process.

Though there is an argument that changing the outcomes for those charged with offences related to substance use may be helpful (delaying punishments, or helping people access support instead), the concept of rehabilitative adjudications is not about changing the outcome of the process. It is about supporting people, providing or guiding people to develop the skills to change, and to provide part of the recovery capital for individuals with dependency and addiction issues. This concept may work well alongside a wider array of consequences or referrals for additional support that may specifically target substance use needs.

The impact of adjudications conducted in a rehabilitative and procedurally just way is likely to be greater and more durable if they form one component of a broader focus of rehabilitation and provision of recovery capital, throughout a prison. HMPPS is promoting and actively working to develop the rehabilitative culture of prisons, including training staff in FMI. Rehabilitative and procedurally just adjudications are entirely consistent with this cultural initiative. We believe that this can also be bought into the support of people in recovery. Rehabilitative adjudications offer one way of ensuring that people's recovery journey is supported in the wider prison context. This is not about allowing people to get away with inappropriate behaviour. Rather, the concern is about enabling change through positive relationships, and guiding people to access the support they need to make this change. This approach should fit within a wider prison rehabilitative approach which emphasises positive relationships, social capital, meaningful connections, and purposeful activity. When rehabilitation and recovery are intertwined in this way, everyone benefits.

We suggest that the steps we need to take to develop this approach include:

- ❒ Developing policy that prioritises rehabilitative change as much as the technical aspects of the adjudication process itself. The focus should be on helping people to change, rather than solely punishment.
- ❒ Helping other people to recognise the potential value of rehabilitative adjudications for all those in prison, including those involved in substance use. In order to make this happen, we need staff buy in.
- ❒ Conducting a large scale impact evaluation of rehabilitative adjudications, specifically with people involved in substance use, in order to develop the evidence base.

Whilst the recovery journey is challenging, we must remember that each challenge comes with a learning experience and a chance to grow and develop. By ensuring that adjudications are rehabilitative, we can ensure that individuals are given the best possible chance to develop, grow and manage their behaviour, and that the whole prison supports them in their journey to recovery.

35. Michie, S., van Stralen, M. M., & West, R. (2011). The behaviour change wheel: A new method for characterising and designing behaviour change interventions. *Implement Science,* 6,
36. Best, D., Irving, J., & Albertson, K. (2017). Recovery and desistance: what the emerging recovery movement in the alcohol and drug area can learn from models of desistance from offending. *Addiction Research & Theory,* 25, 1-10. http://dx.doi.org/10.1080/16066359.2016.1185661

When assets collide

The power of lived experience

Damian Grainer *(MA) is a consultant, coach and psychotherapeutic counsellor.* ***Dave Higham*** *is an ex Prolific Priority Offender (PPO) having spent over 25 years in addiction and prison. Founder and CEO of The Well Communities, a leading provider in grass roots peer recovery.*

In this article we explore the importance of involving those who have overcome issues with substance misuse and crime in promoting and supporting addiction recovery both in prison and on release. We define this personal knowledge of recovering from substance misuse and desisting from crime as 'lived experience'. We support the belief that 'transformed people transform people' and in doing so, we draw upon the lived experience of those that work in peer based recovery organisations such as The Well. We suggest that utilising those with lived experience can complement and enhance the work of professional services. We will use case study evidence collected over a period of 5 years, combining personal testimonies and survey/case management based attitudinal and behavioural data to illustrate the effectiveness of work carried out by 'peers'. We will also show that those with lived experience are assets that can enhance communities and that when these assets are brought together an energy is unleashed that is both creative and healing. In our conclusion we will reiterate that those with lived experience have a significant part to play in recovery and desistance from crime, emphasising key factors that organisations recruiting those with lived experience should consider.

We refer to desistance (from crime) and recovery (from substance misuse) synonymously. There are many papers that explore the similarities between the two processes[1] and some of the common themes include:

- A change in the person's sense of self and identity are important to the process: changing values, motivations, perspectives.
- Building positive social capital[2] is crucial to sustaining changes—friendship networks, mutual aid groups, improved family and community relations. Positive Social Capital refers to the benefits and support that an individual can obtain from their social network. It is about the quantity, quality and ability to sustain these relationships.
- Experiences of trauma and adverse childhood experiences is highly prevalent amongst chronic substance misusers and within the prison population. Learning to manage stress and emotional regulation are part of the recovery process.

There is a long history of peer mentoring in the UK and as far back as 2000 the Pathways programme asked mentors with lived experience to provide resettlement and through the gate support at HMP Lewes.[3] From substance misuse, mental health and community rehabilitation services, liaison and diversion services, the importance of involving those with lived experience is not a new thing. Researchers suggest that involving those who have or are currently being supported by the criminal justice system improves service delivery and can reduce re-offending. There are many ways that people with lived experience can be involved:

- As trained professionals
- As Mentors, Coaches, Advocates and listeners
- In the research and evaluation of services
- Within mutual aid groups where people give and receive support reciprocally (e.g. Narcotics Anonymous)
- Within the commissioning, design and management of services

The notion of giving back has been a foundational principle of the recovery movement and mutual aid groups. By giving back and helping others the individual overcomes their own sense of shame, lack of confidence and self-worth. Giving back helps to give meaning and purpose to people's past as criminals and

1. http://www.revolving-doors.org.uk/file/1845/download?token=3jprn2sc
2. Social (Recovery) Capital, defined by Granfield and Cloud, as "The breadth and depth of internal and external resources that can be drawn upon to initiate and sustain Recovery from alcohol and other drug problems". Recovery capital is divided into human, physical, social and cultural.
3. From personal knowledge of working on the project at the time.

substance misusers and helps to forge a new identity, a key part of the recovery process.[4]

A common concept within peer based recovery organisations (such as The Well) is that of the 'Wounded Healer': the notion that it is in the process of overcoming and surviving illness, trauma and adversity, and accepting vulnerability, the individual gains the skills and attitudes to help support others. This is the power behind lived experience—the acceptance, appreciation, compassion and understanding that is derived from the individual's own experience of overcoming profound adversity—alongside the concept that Recovery is contagious.[5, 6] Recovery can and does spread across social networks including those within a prison environment. Those with lived experience can act as recovery carriers, spreading hope and modelling recovery behaviours. This can very much complement the work of professional services.

The Well a peer led community supporting Recovery

The Well was founded by ex-Persistent and Prolific Offender (PPO), David Higham. David had been in and out of prison since the age of 16 and was a drug user for more than 25 years. He had written himself off but a prison worker hadn't and suggested that he apply for a prison rehab. He transferred to HMP Lancaster where he was introduced to people he had known in addiction who were now free from all mood and mind altering drugs including alcohol. Since then he has remained drug and alcohol free, being released in 2007 to supporting others suffering from problems with addiction.

Identifying a big gap locally in the support for people leaving prisons who were abstinent, David decided to set up The Well. At the time there was no out of hours service and the first hub was launched in Lancaster in 2012 with David's own money, providing a safe space to meet and engage in social activities over the weekend. In the beginning, the focus was on abstinence as the particular needs of this group were not catered for by main stream services. Early recovery has a phase which George DeLeon[7] terms 'practicing abstinence': Conscious effort needs to be applied to manage the ups and downs of daily living without resorting to substance use as a coping mechanism. Therefore, social spaces that are safe and positively reinforce recovery behaviours including abstinence are vital. As the community has grown and matured, it has been increasingly able to support and welcome those who are not abstinent.

A further four sites quickly followed in Lancashire and Cumbria. These hubs now provide a place for people to come together, engage in activities including peer led educational programmes. The hubs have become a point of connection between those in recovery and the wider community thereby improving the sustainability of recovery and increasing wellbeing. Research indicates '*that recovery from addiction can be understood as a socially mediated transition typified by social network and social identity change, which drive broader improvements in quality of life*'.[8] The hubs help to provide and reinforce these networks both within the recovery and wider community. The hubs also help to challenge the stereotypes about addiction and recovery as personal connections are made, recovery stories shared and the community benefits from the altruism of those in recovery. The hubs support citizen advocacy and provide wider support to those affected by poverty through initiatives such as food banks and a social supermarket (that provides heavily discounted prices to those in need through donations from larger supermarkets). The scheme is run on a membership basis. All of this is run by those in recovery.

These hubs now provide a place for people to come together, engage in activities including peer led educational programmes.

In 2014, as part of a North West 'Through the Gate' initiative commissioned by NHS England, Public Health England and the National Offender Management Service, The Well set up supported housing. David recognised that many people being released from prison were being housed in insecure accommodation and without the benefits of a community to reinforce and reward change on the outside. He also recognised that whilst individuals may have stopped using drugs in prison they also needed a

4. Iriss Insight 13 (2012 – https://www.iriss.org.uk/sites/default/files/iriss-insight-13.pdf
5. Bathish, R, Best, D, Savic, M, Beckwith, M, Mackenzie, J, and Lubman, D, I. (2017). "Is it me or should my friends take the credit?" The role of social networks and social identity in recovery from addiction. Journal of Applied Social Psychology, 47 (1), 35-46.
6. https://en.wikipedia.org/wiki/Behavioral_contagion
7. http://www.williamwhitepapers.com/blog/2014/01/recovery-is-contagious-redux.html
8. De Leon, G. (1996). Integrative recovery: A stage paradigm. Substance Abuse, 17(1),51-63. De Leon identifies the De-Addiction stage: Detachment from active drug use; pharmacological, behavioural and social detoxification followed by the abstinence stage. Here the individual needs to learn how to be abstinent.

structure and programme to build the inner resilience necessary to maintain these changes in the community.

Those signing up to the housing also enrolled to complete an intense 3 stage behaviour change programme founded on the 12 steps of Narcotics Anonymous. Residents attend daily activities and groups and are also required to attend local mutual aid meetings. They are encouraged to become actively involved in their local community and complete the steps during their stay. This has led to a substantial growth in local mutual aid provision. A key part of the programme is dropping the masks and defences that need to be worn when living in addiction. It takes immense courage to show your vulnerability and express your true feelings. That process is much easier when your peers take the lead and model this for you.

Since its inception, the housing project has provided accommodation for 108 offenders, 76 per cent of whom have not reoffended.[9] The project has housed 12 Prolific and Persistent Offenders. Of those who have completed the full programme 100 per cent (2) have remained drug free and have not reoffended and overall, 7 (58 per cent) have remained drug and crime free for over 1 year. Of the 5 that got reconvicted, two are still in regular contact with the Well and are likely to return upon release.

Since its inception, the housing project has provided accommodation for 108 offenders, 76 per cent of whom have not reoffended

Jake

Jake had been using illicit drugs for 30 years starting when he was 16. His drug use progressed from cannabis, cocaine and ecstasy to a long term dependency on heroin. Jake turned to crime to fund his habit and ended up being arrested for 90 offences including intent to supply Class A drugs, violence and malicious wounding and theft. He ended up doing a 3 and 4 year sentence and numerous short term ones. Using drugs, committing crime and spending time in prison had become the only life he really knew. Whilst Jake wanted to change he didn't hold out much hope for himself. He made the choice countless times to stop using but on passing the gate he had ended up in the same place, time after time.

Jake started to believe change was possible when he met Brendan, a prison outreach worker from The Well. Brendan was not only someone who Jake identified with, he mirrored hope and was living proof that he too could change. Brendan understood Jake's story well—he had been in a similar place. Brendan didn't force his experience on Jake but he got alongside him and through informal chats he gradually shared his own personal experience with Jake. Brendan knew how to tell his story in a way that supports advocacy and change. This is an important skill and does not involve the retelling of detailed war stories of addiction but a way of conveying that recovery is possible and that there are many paths to recovery. He also used his coaching skills and experience of connecting to hundreds of others trapped in a cycle of addiction. Through their conversations Jake became curious about the work of The Well and decided to move into The Well's supported housing upon release.

Jake has been substance and crime free for over a year, he has his family back in his life and is positive about the future, Jake currently volunteers within The Well Communities Drug related death outreach service which reaches out to those most at risk in Barrow in Furness. Ged, the manager of the service, hopes he will be a staff member one day.

When asked how has life changed and what is the difference between now and before The Well, he stated

The difference for me is living with a 24-hour support network with positive people and the fact I can chat if I struggle. I have grown as a person and changed for the better. I have my kids back in my life, have passed several courses and now help others. I have also been back in to prison as a speaker which is massive for me. Today, I live independently and pay my own bills. I have peace of mind, long may this continue, it's not easy but neither was prison, crime and drugs.

The Well also provides prison in reach and targeted work in the community with those at most risk of dying from drug related issues. All this is founded on the power of lived experience and exposure to recovery. For David, it has been equally important to equip staff and volunteers with other tools that support behaviour change to support their lived experience. These skills include Motivational Interviewing, Brief Solution Focussed Therapy, Relapse Prevention and working in a trauma informed way.

9. Bathish, R. et al., (n 5) 35-46.

Tony

Like Jake, Tony was a prolific and long-term offender. Brendan, from The Well, supported him his parole hearing. His license conditions included living at The Well and completing their 6-month programme. He was clear that he needed to cut ties with some family members, whilst strengthening links with his daughter.

He readily acknowledges the importance of the trust, insight and tolerance that Brendan demonstrated prior to release. Crucially for Tony, he has begun to share and reflect in meetings—a vital step for someone with deep-seated trust issues. He is regularly attending mutual aid meetings (4-5 times per week), is attending the gym daily and with support from staff, has begun to re-build links with his family. He remains abstinent at The Well and is making significant progress in exploring 'the steps' and his own journey of recovery.

Originally started as an abstinence project The Well reaches out to 'the addict that still suffers' and their family. As the community has become stronger it has been able to embrace those with greater need and vulnerability. Peers with lived experience don't just have a role in initiating and supporting recovery they can also use their experience and knowledge to support harm reduction initiatives and to engage with those most removed from active support.

The Well has being carrying out targeted work with those who are at most risk of drug related death.

In partnership with Change Grow Live (CGL) and Greater Manchester Mental Health Trust (GMMH), The Well has being carrying out targeted work with those who are at most risk of drug related death. It is not only the main service provider that identifies these individuals but also the Police, Probation, Social services and other stakeholders. Many of these individuals are caught in a cycle of offending and homelessness alongside suffering from mental and physical health issues. Staff from The Well meet individuals 'where they are at'.[10] This means that they engage individuals without judgement of their lifestyle and treat each individual with compassion, patience, and respect supporting collaboration and creating a relationship of trust. The staff always follow through with what they commit to, knowing that being let down is the norm for these individuals and consistency is key to building trust. They understand that individuals are ambivalent about change and that disengagement can often be a way of coping with long histories of complex trauma. Much of the work is street based and includes advocacy, supporting engagement with health and social care services, and the provision of harm reduction information such as overdose prevention.

This work has met with much success hence the service is now being expanded into central Lancashire. Involving those with lived experience allows engagement with those beyond the reach of traditional services. They are more confident working in the environments that many of these men and women live and use in. They understand the culture, motivations and day to day barriers that are faced by those most in need. Whilst safety is paramount, organisationally it would appear that peer based organisations, such as The Well are more tolerant of risk, precisely because of the depth of understanding derived from their lived experience.

As a measure to prevent overdose, naloxone kits[11] are made available to those engaging with The Well. There is much health promotion activity in both the hubs and housing projects and members are encouraged to access health assessments and Blood Borne Virus testing. The Well is also developing transitional recovery housing to support those who receive opioid substitution treatment such as Methadone.

The Well is very much about belonging and recognising the strengths and potential inherent in everyone. It has embraced the principles of Asset Based Community Development and staff, volunteers and service users are considered members of the Well community and as such can directly influence its running and direction. It is the community that sets its own direction and how to apply its strengths.

Research suggests that it takes up to 5 years in recovery before a person has the same risk as the rest of the population of developing a drug or alcohol disorder. Many people with addiction problems, including those involved within the criminal justice system will have suffered trauma and what has been termed adverse childhood experiences (ACE's). These include physical, emotional and sexual abuse, neglect, witnessing violence and abuse, parental separation, having a parent with a mental health problem, substance misuse disorder etc. When you are helping someone else, your own experiences of trauma can be triggered. So it is vital that those with lived experience are supported in their own recovery and personal

10. Based on arrest rates.
11. See Tartarsky, A. (2007). Harm Reduction Psychotherapy. Publisher Jason Aronson.

growth. This is why 'personal recovery' should come first when involving those with lived experience. At The Well, if someone's recovery is at risk they get moved away from face to face work. The community gets around them. It is understood that you can't give away what you haven't got.

Jack and Polly

Jack and Polly who have volunteered for The Well since its inception said '*The Well is like a big family of like-minded people who all extend caring hands to each other and share experiences, strength and hope on a journey of self-discovery leading towards managing life and finding peace of mind and well-being. It also gives me the opportunity to do my bit and show gratitude for loved family members now living in recovery and who try to bring hope to others on their respective journeys.'*

Research shows that the quality of the relationship between the 'helper' and the individual has a significant impact on outcomes.[12] You don't have to have lived experience to form a therapeutic relationship but sometimes it is easier to empathise and build rapport when you have. It is, however, far more than just having the lived experience. One of the key differences at The Well is members are made to feel equal by being involved, having their strengths recognised and the focus on community rather than service delivery. Staff are encouraged to act with humility. New members soon find out that the relationships they are making with their peer supporters can and are maintained within the recovery community. The Well functions to unite. The helping relationship is a gateway to community. Community is seen as the antidote to disconnection, loneliness, depression, anxiety and ultimately relapse.

Not everyone is accepted as a volunteer member, they must have undergone that process of transformation and be secure enough in their own recovery process. Assessment comes from getting to know the individual as a member of the community over time and them evidencing that they are dependable, reliable and responsible. There is no rush and quality always triumphs over quantity. Both in the UK and USA, peer based recovery organisations such as The Well also equip peers with therapeutic tools that are going to support the process of initiating and sustaining change. Peers learn coaching skills, motivational interviewing and models such as Brief Solution Focused Therapy.

Supporting people to become financially independent and economically secure is of great importance to David. Through dialogue and mapping, transferable skills and ambitions are identified. Supported volunteer placements offer opportunities to develop new skills and get used to a work based culture. Many of the paid staff have themselves been service users at The Well and a series of new businesses have grown from the community allowing people to apply their unique skills: car valeting, maintenance contracting, catering and consultancy. To date 22 ex-prisoners have moved into paid work and a further 40 are involved in voluntary work.

...sharing lived experience goes beyond just initiating and supporting the early stages of recovery but also building a meaningful and purposeful life as an economically active citizen.

Ged

Talking about his own experience, Ged stated

The transition from client to Project Development Manager has been relatively seamless for me due to the intensely supervised phased return to work. I first started by volunteering for 6 months in early 2016 followed by a 16 hour contract for 6 months and I subsequently became a full time employee 8 months later, this allowed me to concentrate on my recovery whilst easing back in to employment. Hard work and diligence towards maintenance of recovery provided the opportunity to become Project Development Manager in 2018 and I have never looked back.

The power of sharing lived experience goes beyond just initiating and supporting the early stages of recovery but also building a meaningful and purposeful life as an economically active citizen.

12. https://www.changegrowlive.org/get-help-/advice-information/drugs-alcohol/naloxone-the-opioid-overdose-reversal-drug

Conclusion and closing comments

Being caught up in a cycle of drug use and offending is much more than having a physical dependency. It becomes a way of life, living within a culture of addiction. Like any other culture there are norms and rules, there are shared stories and beliefs and ways of being and behaving which are reinforced by those around the individual. One of those beliefs is that once you are in, you are unlikely to get out. The truth is this doesn't have to be the case. There is an emerging body of evidence which describes, that over time most people recover from substance misuse disorders (53.9 per cent).[13, 14] Recovery is not only possible, it is likely but to start with there is a need for hope. People with lived experience can be an expression of that hope. They provide a living example that change is possible and a bridge into a culture of recovery where a new identity can be forged.

A high proportion of those discharged from substance misuse services start to use again within a year and most within the first 3 months.[15] Sustaining recovery requires positive social support and integration into supportive social networks.[16] Anecdotal evidence suggests that those with lived experience are better able to support individuals in early recovery to link with and engage with these supportive networks.[17] Building new and meaningful relationships can be difficult for someone who has experienced years of trauma and mistrust and has had to develop coping skills to survive difficult and violent environments. This is why the notion of wounded healer, supplemented by training is so important. The recovery community understands these difficulties and ambivalences and still welcomes the individual. This is where profound reparation of the past can occur.

This article is based around the work of The Well but in doing so I hope that we have shown that there is a role for those with lived experience in and out of the prison estate and as part of peer led organisations or within multidisciplinary teams. From engagement, community linkage, therapeutic work right on to employment and long term resettlement there is a role for those with lived experience. However it is imperative to remember:

- ❒ Personal recovery and wellbeing must come first
- ❒ Those with lived experience complement existing services
- ❒ Being of service supports recovery but those with lived experience also need pathways to financial independence
- ❒ The person with lived experience must have undergone a process of transformation at the psychological, behavioural and social levels otherwise they may act out of their woundedness.

13. https://www.ncbi.nlm.nih.gov/books/NBK424846/
14. Drug & Alcohol Findings Mtrix Cell B4: Practitioners; Psychosocial Therapies. https://findings.org.uk/PHP/dl.php?file=Matrix/Drugs/B4.htm&s=eb&sf=sfnos
15. White W (2012) Recovery/Remission from Substance Use Disorders: An Analysis of Reported Outcomes in 415 Scientific Reports, 1868-2011.
16. Maruna S (1999) "Desistance and development: the psychosocial process of 'going straight'" The British Criminology Conferences: Selected Proceedings. Volume 2.
17. White, W. (2006). Sponsor, Recovery Coach, Addiction Counselor: The Importance of Role Clarity and Role Integrity. Philadelphia, PA: Philadelphia Department of Behavioral Health and Mental Health Services.
18. Ibid and Best ( ).
19. This comes from my own Service User Consultations carried out as part of service audits for a national provider of substance misuse services, particularly around peer mentors and recovery champions.

How the prison environment can support recovery

Dr Dominique Moran *is a Professor of Carceral Geography at the School of Geography, Earth and Environmental Sciences, University of Birmingham (d.moran@bham.ac.uk)*

Since addiction is not 'caused' by one single factor, but instead develops from the interaction of multiple influences, including biological, psychological, and social and environmental factors,[1] it follows that 'environment' should play a role in *recovery*. But what is usually meant by 'environment' is things like family, peer group, work or community—(with the associated recommendation to 'get away from' bad influences that have previously supported the development of addiction). Environment in the sense of the nature of the *spaces* inhabited by those seeking to recover from addiction, is rarely considered—and even if it was, the same advice to 'get away' would be of little benefit to prisoners who have relatively little control over the nature of their environment.

In this paper I ask whether there are certain types of environment—and by that I mean types of physical *spaces*—that might support recovery in prison. This is an important question to address, at a time when the quality of some prison environments has been criticised in inspection reports, when substance misuse is a grave challenge for the prison system, and when there a live debate about what kinds of *new* prisons should be built to deliver the government's plans for a modern prison estate. It is particularly important for the many prison management teams seeking to use their limited resources judiciously to make improvements to their own prison environments. They all need to know what 'works', and that means answering a very challenging question about what evidence there is that certain types of environmental changes will support desired outcomes. In terms of the *overall* purpose of prisons to enable rehabilitation, this remains an area of active research, but in relation to the specific issue of addiction recovery, there are some research findings that provide a steer.

In this paper, I will consider two types of evidence, both *from* prisons and relevant to them. First, work from healthcare facilities (such as hospitals and other clinical settings) which considers the types of environments which support addiction recovery outside prison. Second, research findings from (the very few) prison-based studies into the effects of environment on addiction recovery, and from the growing body of prison-based research which seeks to 'test' the transferability of findings from the healthcare sector to the custodial setting.

First, a quick note. Whilst other contributors to this special issue are grappling with the problematic notion of 'recovery', for the purposes of this paper, my understanding of this term is informed by its medical use connoting a return to health following trauma or illness.[2] This means that my focus here is on the types of environment that support recovery in this sense.

Recovery and Environment

The question about what kind of environment fosters recovery from addiction is part of a much wider query about the type of environment that supports recovery from illness and trauma in general—and this is a question which has preoccupied researchers for some time. Much of their work was stimulated by a 1984 study of the positive effects of views of nature on patients' recovery from surgery,[3] and numerous subsequent studies have demonstrated the effects of a variety of built environment features, such as acoustics, ventilation, layout, and natural lighting, on health and wellbeing, largely in healthcare facilities. In these studies, the most robust data often relates to contact with the natural environment, which is often identified as a health-enabling feature. Within this wider body of work, very few studies focus *solely* on addiction recovery as the *specific* outcome of interest—but in those that do, findings are in line with those for other health outcomes. In other words, the same types of environment that support health and wellbeing in general, also support addiction recovery. And it is worth

1. Glantz,M. D., & Pickens, R.W. (1992). Vulnerability to drug abuse. Washington, DC: American Psychological Association.
2. White, W. L. (2007). Addiction recovery: Its definition and conceptual boundaries. Journal of substance abuse treatment, 33(3), 229-241.
3. Ulrich, R.S., (1984). View through a window may influence recovery from surgery. Science 224 (4647), 420–421.

making clear at the outset that although the specific focus here is on environments that support recovery in imprisoned populations, the health wellbeing of prison *staff* (who experience high levels of stress)[4] is also an important consideration.

This makes intuitive sense when we consider that a healing environment 'works' by helping patients cope with the stress that accompanies illness, thus supporting clinical recovery. Reductions in stress and an enhanced feeling of calm are at the root of this beneficial effect, and there are multiple ways in which this effect is delivered—some of which have particular relevance for addiction recovery.

Noise—the presence of unwanted sound—is a key factor.[5] Noise is not just an annoyance; it also has the potential to affect the healing process through disruption of sleep.[6] Because of the way in which the brain processes sound, certain types of noises may also lead to confusion and stress. If tranquil environments enable calmness and reflection, where listeners are in control of their own mind-states (i.e. can choose what to think about, and whether and how to concentrate on it), then environments that feature annoying or startling sounds (such as bleeps and alarms, banging and shouting) force an alertness and attentiveness that prevent such self-selective behaviour, and lead to poor health outcomes.[7] In other words, constant harsh or 'alert' sounds put the mind into a 'fight-or-flight' mode which is itself stressful, and which prevents the listener from being able to get into a calm and reflective state of mind. So, acoustic treatments (such as sound-absorbent wall panels), which reduce the harshness of sound and enable relaxation and sleep, as well as measures to reduce the production of harsh or alert sounds in the first place, all help in fostering calmness, enabling better communication, and improving health outcomes.[8]

Natural light in the daytime, and good dark at night, both help in regulating circadian rhythms (natural patterns of sleep and wakefulness) and enabling restful sleep.[9] Limiting exposure to natural daylight (e.g. through poor indoor natural lighting, or lack of access to the outdoors) and unnecessary exposure to light at night (e.g. through 24-hour artificial security lighting, or lack of curtains) both interrupt circadian rhythms and disrupt sleep. Sleep itself is health-enabling,[10] whereas sleep deprivation is a chronic stressor contributing to cognitive problems, and increasing the likelihood of illness.[11] So, measures which enable access to natural light in the daytime, and which reduce unnecessary light exposure at night, both enhance sleep, with its associated benefits, and reduce the additional stress caused by sleep deprivation—stress which would then increase the need for another type of 'calming' intervention.

Sleep disturbance is particularly common amongst individuals in recovery, and for individuals in recovery from alcohol addiction

Although noise control and natural light/dark are important for everyone, they have particular relevance for those in addiction recovery. Sleep disturbance is particularly common amongst individuals in recovery, and for individuals in recovery from alcohol addiction, it can precipitate relapse.[12] Substance misuse also has a negative effect on circadian rhythms, which may even disappear in extreme cases. It is thought that addiction recovery support should try to establish regular time patterns of waking and sleeping, and that light therapy may prevent relapse.[13] So, any interventions which support good light and dark, and which protect sleep, are likely to be of particular benefit.

4. Steiner, B., & Wooldredge, J. (2015). Individual and environmental sources of work stress among prison officers. Criminal Justice and Behavior, 42(8), 800-818.
5. Devlin, A. S., & Arneill, A. B. (2003). Health care environments and patient outcomes: A review of the literature. Environment and behavior, 35(5), 665-694.
6. Simpson, T., Lee, E. R., & Cameron, C. (1996). Relationships among sleep dimensions and factors that impair sleep after cardiac surgery. Research in Nursing and Health, 19, 213-223.
7. Andringa, T. C., & Lanser, J. J. L. (2013). How pleasant sounds promote and annoying sounds impede health: A cognitive approach. International journal of environmental research and public health, 10(4), 1439-1461.
8. Yoder, J. C., Staisiunas, P. G., Meltzer, D. O., Knutson, K. L., & Arora, V. M. (2012). Noise and sleep among adult medical inpatients: far from a quiet night. Archives of internal medicine, 172(1), 68-70.
9. Wright Jr, K. P., McHill, A. W., Birks, B. R., Griffin, B. R., Rusterholz, T., & Chinoy, E. D. (2013). Entrainment of the human circadian clock to the natural light-dark cycle. Current Biology, 23(16), 1554-1558.
10. Alvarez, G. G., & Ayas, N. T. (2004). The impact of daily sleep duration on health: a review of the literature. Progress in cardiovascular nursing, 19(2), 56-59.
11. McEwen, B. S. (2006). Sleep deprivation as a neurobiologic and physiologic stressor: allostasis and allostatic load. Metabolism, 55, S20-S23.
12. Friedmann, P. D., Herman, D. S., Freedman, S., Lemon, S. C., Ramsey, S., & Stein, M. D. (2003). Treatment of sleep disturbance in alcohol recovery: a national survey of addiction medicine physicians. Journal of addictive diseases, 22(2), 91-103.
13. Adan, A. (2013). A chronobiological approach to addiction. Journal of Substance Use, 18(3), 171-183.

Natural daylight/dark, and a gentle auditory environment (or 'soundscape') are characteristics of natural environments, and contact with nature is perhaps the environmental factor for which there is the most persuasive body of evidence in relation to human health and wellbeing. Across a wide range of studies, research has found that access to nature reduces anxiety, increases life satisfaction, reduces aggression and ADHD symptoms, increases prosocial behaviour, lowers blood pressure, and improves post-operative recovery, pain control, immune function and general health.[14] Accordingly, these findings have underpinned the inclusion of gardens, and large windows overlooking them, into the design of hospitals and healthcare facilities,[15] and effective interventions for addiction recovery frequently involve 'wilderness' and/or gardening activities in which contact with the natural environment is considered a key element of the therapeutic programme.[16]

In addition to these factors, a study of 'sober living environments' provided for free citizens seeking to overcome addiction found that a sense of 'home' (achieved through soft furnishings, potted plants, bedside tables, carpets, and so on) produced calming and reassuring environments[17], perhaps enabling them to feel closer to a sense of 'home' than would a conventional 'institutional' setting. A study of a substance abuse treatment facility for women found that colourful, light and quiet spaces were valued by residents.[18]

In summary, whatever the precise details, or the mechanisms through which they take effect, the beneficial outcome of various therapeutic environmental elements is that they foster calmness, and reduce levels of stress and tension, which in turn support recovery from illness—or from addiction.

Across a wide range of studies, research has found that access to nature reduces anxiety, increases life satisfaction, reduces aggression and ADHD symptoms.

Recovery and Environment in Prison

Such longstanding research into health-enabling environments has enabled the 'evidence-based design' of healthcare facilities which ensures that, as far as possible, hospitals and other facilities provide surroundings which support patients' clinical recovery. However, the relative lack of comparable research in prisons (coupled with a reluctance to consider them to be 'therapeutic' rather than 'punitive' settings) means that such design input is poorly developed in this sector. Put another way, because there has been little political appetite for the results of such research, we have much less direct evidence of the beneficial effects of natural light, acoustic treatments and so on in prisons than in hospitals, hence prisons are rarely designed with these factors in mind. However, given the similarities between these two types of setting (in that both prisons and hospitals are large 'institutional' buildings, with overnight residents, operating around the clock) it is quite likely that the same environmental elements that support health and clinical recovery—including addiction recovery—in healthcare facilities would also be effective in prisons. A growing body of academic research is currently focused on understanding the transferability of such research to prisons, and in the remainder of this paper I will briefly explore what we know so far, and what such a transfer of knowledge might mean.

Building on a 1981 paper[19] which reported fewer sickness calls made by prisoners with a view of nature from their cell, studies in the UK, US and elsewhere are now trying to establish whether the same calming effects of therapeutic environmental elements found in healthcare facilities—particularly access to nature—are also to be found in prisons. Although their studies do

14. See Frumkin, H., Bratman, G.N., Breslow, S.J., Cochran, B., Kahn Jr, P.H., Lawler, J.J., Levin, P.S., Tandon, P.S., Varanasi, U., Wolf, K.L. and Wood, S.A., 2017. Nature contact and human health: A research agenda. Environmental health perspectives, 125(7) for a summary of findings.
15. Sachs, N. A. (2018). Designing for Public Health With Healthcare Design Part II: Design. Health Environments Research & Design Journal 11(3) 17-21.
16. Aslan, L. (2016). A Qualitative Evaluation of the Phoenix Futures Recovery Through Nature Program: A Therapeutic Intervention for Substance Misuse. Journal of Groups in Addiction & Recovery, 11(2), 93-108; Easy, F., & Naseri, G. (2015). A study on the effect of the components of physical environment on patient satisfaction in drug rehabilitation centers. Indian Journal of Science and Technology, 8(28) 1-8.
17. Ferrari, J. R., Jason, L. A., Sasser, K. C., Davis, M. I., & Olson, B. D. (2006). Creating a Home to Promote Recovery: The Physical Environments of Oxford House. Journal of Prevention & Intervention in the Community, 31(1-2), 27-40.
18. e.g. Grosenick, J.K. and Hatmaker, C.M. (2000), Perceptions of the importance of physical setting in substance abuse treatment, Journal of Substance Abuse Treatment 18, 29 39.
19. Moore, E. O. (1981). A prison environment's effect on health care service demands. Journal of Environmental Systems, 11, 17-34.

not *directly* test effects on addiction recovery, they *are* interested in the potential for the prison environment to produce the calming, stress-reducing effects that are known to support it.

Good dark and natural daylight, and control of noise, are important for health and wellbeing, and are known to be of particular importance in addiction recovery. They are also likely to be extremely challenging to deliver in prison. Many observers have noted that prisons in a range of contexts lack natural light, with windows often high in the walls, barred, and looking onto dark or shaded areas.[20] Researchers stress that prison 'soundscapes' are complex—they are more than just 'noisy' places, and prisoners should be considered active and interested interpreters of sound, who use and work with sound in significant ways to manage their daily lives.[21] But still, they (as well as prison staff) are subjected to harsh acoustic environments in which alarms, clanging doors, rattling keys and shouted communication reverberate off hard surfaces, making quiet conversations almost impossible, and making it difficult to quickly identify the source of particular sounds.[22] Several studies have found hearing loss amongst prisoners, and have suggested that prisons' auditory environments would be very challenging for those with hearing deficits.[23] Although no study has specifically isolated the effects of either light or sound on prisoners' wellbeing—whether in general or in relation to addiction recovery, previous research has shown that both noise and unnecessary light disturb prisoners' sleep—especially if (like those recovering from addiction) they *already* have trouble sleeping.[24]

For light/dark and noise, the lack of prison-based research means that in terms of understanding the effects of these environmental factors on addiction recovery, we can only make educated guesses. However, extrapolating from research in healthcare facilities, and given the specific needs of those recovering, it is safe to say that prison environments which provide good daylight, and good dark at night, and in which the harshness of the auditory environment is reduced, would be best for supporting recovery.

In relation to the beneficial effects of access to nature, which have been so comprehensively established in healthcare contexts, there is a more robust evidence base for transferability to the custodial context. Recent prison-based research suggests that the calming, de-stressing effects of nature contact which are observed in healthcare facilities, *are* also found in prisons. A recent comparative study[25] found that in a UK facility which lacked accessible green spaces, prisoners reflected on their potential benefits:

> *You don't necessarily need to see the outside world, but something like some nature outside, what a difference it makes, to see birds or that and squirrels flying up in the trees.*

Recent research suggests that calming, de-stressing effects of nature contact are found in prisons.

Two prisoners talked about the relative absence of grass, and the inability to touch grass:

> *I find it weird to feel it, if I touch it or anything like that. You're not used to touching it now. It'd be odd to get the feeling of lying on grass. It sounds stupid but … But even just feeling it…. just the feeling of grass on your hands. I can't remember what that feels like.*

> *… we've just got tarmac and big high fences. And even the grass, even if you just got to lie on the grass. I don't know, there's just something decent about lying in some grass.*

Another, who reflected on previous experiences in other custodial facilities, explained the impact of having access to green spaces when these had previously been unavailable:

20. E.g. Stern, V. (2001). Problems in prisons worldwide, with a particular focus on Russia. Annals of the New York Academy of Sciences, 953(1), 113-119; Mazuch, R., & Stephen, R. (2005). Creating healing environments: Humanistic architecture and therapeutic design. Journal of Public Mental Health, 4(4), 48-52.
21. Rice, T. (2016). Sounds inside: prison, prisoners and acoustical agency. Sound Studies, 2(1), 6-20.
22. https://www.dbxacoustics.com/acoustic-design-in-prisons/ accessed 15.10.2018.
23. E.g. Murray, N., Butler, T., & LePage, E. (2004). Hearing health of New South Wales prison inmates. Australian and New Zealand journal of public health, 28(6), 537-541; McRandle, C. C., & Goldstein, R. (1986). Hearing loss in two prison populations. Journal of Correctional Education, 147-155.
24. Elger, B. S. (2009). Prison life: Television, sports, work, stress and insomnia in a remand prison. International Journal of Law and Psychiatry, 32(2), 74-83.
25. Data presented are from Moran, D., & Turner, J. (2018). Turning over a new leaf: The health-enabling capacities of nature contact in prison. Social Science & Medicine. Early Online at https://www.sciencedirect.com/science/article/pii/S0277953618302752.

I was sitting at the window… And someone said to me, '*What are you doing?*' *I said* '*I'm smelling the grass, which I haven't smelt for like two years', just a simple thing like grass on the ground.*

In the comparator Nordic prison, where green spaces were available, both prisoners and staff felt the benefits, and articulated their calming effects. As one staff member put it:

…when I either am outside walking because I have to go get something or someone or following somebody to a visitor, or just having my break, stepping out for five minutes to clear my head, trees, the cleanness… It feels more calming.

Another recent study at a UK prison studied the effects of nature contact in the form of outdoor green spaces and whole-wall photographic images of the natural environment. It found that in an otherwise stressful context, such elements were self-reported to increase feelings of calm, and the ability to reflect.[26]

For prisoners recovering from addiction, there is also evidence of the benefits of nature contact. A Horticultural Therapy Program 'Gardening to be Drug-Free', at Patuxent Institution in Maryland, U.S., combined therapy groups with organic gardening activities in an attempt to 'show offenders the connection between growing plant life chemical-free and keeping their own bodies chemical-free'.[27] Another study of a prison gardening programme in San Francisco suggested that it improved psychosocial functioning, reducing risk taking and depression, and lowered post-custody substance abuse.[28] Studies such as these specifically consider the effects of gardening or horticultural programmes which involve extensive contact with nature, rather than the effects of the *presence* of nature—that is there simply *being* grassed areas, trees, planted borders and so on in prison. However, it is self-evidently the case that such programmes cannot take place without prisons having suitable green areas in which to host them, and as the words of prisoners quoted above indicate, the wider prisoner population is also likely to benefit.

For prisoners recovering from addiction, there is also evidence of the benefits of nature contact.

Summary

It is perhaps intuitively clear to anyone living or working in prison that the nature of the prison environment affects the wellbeing of those within it—whether or not they are struggling with addiction. Although this may seem an obvious point, establishing exactly *how* the environment matters, and therefore how it ought to be altered or redesigned, is a question which preoccupies many researchers, myself included. There are vital issues at play here in terms of financing, security, design and commissioning processes, and the balance between punishment and rehabilitation in relation to the overall 'purpose' of imprisonment, all of which affect decision-making processes and therefore the nature of the places we build to incarcerate.[29] That the nature of a built environment matters for those within it has long been appreciated in healthcare contexts, and as a result, in this sector evidence-based design draws on research findings which demonstrate the significance of nature contact, good light and dark, and noise control, amongst a range of environmental factors. Perhaps because seeing prisons as similarly 'therapeutic' settings is more ideologically challenging, and hampered by a lack of studies testing the validity of the findings of such research in prisons, custodial design lags some way behind.

Considering the particular needs of prisoners in recovery arguably closes the gap between these two contexts. Evidence from healthcare research suggests that although those tackling substance misuse benefit from the same environmental factors known to support health outcomes in general, the particular challenges they face mean that protection of sleep is especially beneficial, and this can be supported through maintaining circadian rhythms through access to daylight, and good dark at night, and managing noise, as well as through provision of opportunities for nature

26. Moran, D (in review) Back to nature? Attention Restoration Theory and the restorative effects of indirect and vicarious nature contact in prison.
27. Richards HJ, Kafami DM (1999) Impact of horticultural therapy on vulnerability and resistance to substance abuse among incarcerated offenders. Journal of Offender Rehabilitation 29: 183–193.
28. Rice JS, Lremy L (1998) Impact of horticultural therapy on psychosocial functioning among urban jail inmates. Journal of Offender Rehabilitation 26: 169–191.
29. Moran, D., Turner, J., & Jewkes, Y. (2016). Becoming big things: Building events and the architectural geographies of incarceration in England and Wales. Transactions of the Institute of British Geographers, 41(4), 416-428.

contact, through outdoor green spaces which can be viewed through windows and encountered in person, and nature imagery.

It is worth noting that the effects of environmental factors that support addiction recovery are by no means limited to this group—and neither are they limited to prisoners. Prison staff spend extended periods of time at work, and they would also benefit, both from the environmental factors themselves, from being able to communicate more effectively with recovering prisoners in calmer, less noisy and less tense environments. Those dealing with substance misuse may derive particular benefits, but recent prison-based research suggests that, especially in relation to nature contact, increased feelings of calm, and a lower-stress environment, are likely to benefit the wider community of prisoners and prison staff, and support improvements in wellbeing right across prison establishments. If stress is a trigger for violence, then a calmer and more tranquil prison environment would not only support inhabitants' recovery, but could also support their wider wellbeing, and their safety.

What next?

With all of this in mind, what could prison management teams actually do about the physical spaces of their prisons, to support recovery (and the wellbeing of prisoners and staff more generally)? As the research findings above suggest, changes to key aspects of the environment can make a real and meaningful difference.

In relation to noise, acoustic wall treatments to deaden reverberation are very expensive (and are ideally included at design stage). Addressing the source of noise is much cheaper—and very effective. Few prisons may be in a position to move from bunches of jangling keys to quieter electronic keytag systems, but there are other practical measures to reduce the frequency or harshness of 'alert' sounds. Earpieces worn with prison radios change the prison soundscape (as well as restricting critical information to those who really need to hear it). Doors and gates do not always need to be slammed with a metallic 'clang'. In something of a virtuous circle, removing these characteristic 'prison sounds' reduces the need to shout over them, and the resulting changes both to the 'feel' of a prison, and to the types of conversation that become possible within it, are immediately noticeable.

In relation to good light and dark, provision of adequate in-cell curtains is an effective measure, and consideration could also be given to how much artificial light is minimally necessary at night. Nature contact is very important for wellbeing, and every opportunity for 'greening' of prison environments should ideally be taken—whether this means installing 'immersive' whole-wall images of natural landscapes within accommodation units, or introducing vegetation such as grass, shrubs and trees, wherever possible. Green spaces provide visual interest and attract wildlife, and birdsong is a key element of therapeutic soundscapes. Anecdotally, although security is of prime concern, such environmental features are rarely vandalised, and the weight of evidence suggests that, for the sake of their wellbeing, no prisoner (and indeed no member of prison staff) should be deprived of the sight, sound or scent of nature—or the ability to touch it.

No one familiar with the challenges facing our prisons would claim that changing their environments is 'the answer', but there is enough evidence to suggest that the key changes proposed here, (which we know support recovery), could facilitate wider and more significant changes. Prisons need to be safer and more hopeful places for all who inhabit them. From an environmental perspective that means that they need to be calmer and quieter, enabling productive and supportive interactions between less-stressed people who can sleep well, and who can benefit from access to nature.

Leadership in Recovery
Five Themes for Cultural Change?

Dave King *has worked within the Recovery field for over 15 years. He is Drug Recovery Prison Programme Lead for NHS England and Head of Commissioning for Health and Justice (NHS England—Cumbria and North East).*

Leadership

Leadership is not telling people what to do or how to do it. Leadership is about inspiring and uniting people to a common purpose, cause or belief[1] and making everyone feel safe. Leadership is about helping people to come together to achieve more than they could accomplish on their own.[2] People at all levels can be leaders and we should encourage them to be so.

Today, in many health-related areas, leadership is seen as 'the most influential factor in shaping organisational culture'.[3] The NHS Leadership Academy recognises that strong leadership directly creates better patient outcomes and care and has accordingly set out nine dimensions of leadership behaviour. We don't have to look too far into the past to learn lessons from the observed correlation between poor leadership and a negative impact on patient outcomes.[4] More recently the NHS National Improvement and Leadership Board published 'Developing People—Improving Care'[5] which described a framework to enable improvements and better leadership in NHS Services.

In the substance misuse and mental health fields, leadership is required to transform cultures and promote positive outcomes.[6, 7] John Strang recognised how important leadership is in shaping visible recovery cultures across systems.[8] 'Operationalising Recovery-Oriented Systems' makes clear that 'strong leadership is an essential ingredient for transformation to a recovery-oriented system'.[9] So, leadership is vital in developing recovery orientated systems of care and in deploying resources to effectively address the full range of substance use problems within communities.[10]

What does this mean for recovery focused services that operate both internal and external to the NHS? In particular, what role must senior leaders play in the development of effective workforce cultures to achieve positive recovery outcomes and what does this mean for prisons?

The following five leadership essentials arose from a systematic review of research into effective leadership practices for recovery services.[11]

1. Clarity of vision, values and an agreed definition of what Recovery is

Despite there being at least two consensus groups there is no universally accepted definition of what recovery is.[12 13] This is probably because of the multiple pathways and experiences people encounter as part of a personal recovery journey. This paper adopts the definition that recovery is a personal process of change to attitudes, values, and feelings that allow the individual to develop new meaning and purpose to lead a satisfying and positive life.[14]

1. https://www.ted.com/talks/simon_sinek_how_great_leaders_inspire_action#t-132180
2. https://www.ted.com/talks/simon_sinek_why_good_leaders_make_you_feel_safe
3. West, M., Armit, K., Loewenthal, L., Eckert, R., West, T and Lee, A. (2015) Leadership and Leadership Development in Health Care: The Evidence Base. London: The Faculty of Medical Leadership with the King's Fund and The Center for Creative Leadership.
4. Francis, R. (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry Executive Summary. London: The Stationary Office.
5. NHS Improvement and Leadership Development Board (2016) Developing People – Improving Care: A national framework for action on improvement and leadership development in NHS-funded services. NHS: London.
6. Alban-Metcalfe, J., and Black, J. (2013) How leadership style affects mental health recovery. Available at: www.hsj.co.uk/how-leadership-style-affects-mental-healthrecovery/ 5058380.fullarticle
7. SAMHSA (2012) 'Operationalising Recovery-Oriented Systems'. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.
8. Strang, J. (2012) Medications in Recovery Re-orientating Drug Dependence Treatment. London: National Treatment Agency For Substance Misuse.
9. SAMSHA (2012), see n.7.
10. SAMHSA (2011) Recovery-Oriented Systems of Care (ROSC) Resource Guide.
11. King, D. (2018) What is the role of senior leadership in the development of effective workforce cultures to achieve positive recovery outcomes within mental health and substance misuse services - a systematic review. Unpublished thesis.
12. http://www.ukdpc.org.uk/publication/recovery-consensus-group/
13. https://www.naadac.org/assets/2416/betty_ford_recovery_definition.pdf
14. Anthony, W. (1993) 'Recovery from Mental Illness: the guiding vision of the mental health system in the 1990s', Psychological Rehabilitation Journal, 16(4), pp. 11-23.

Service providers must understand recovery and link their vision and values to it. At a local level, staff and service users should collaborate and agree a definition and associated vision and values: It is logical that staff and service users need to be involved in defining recovery in an organisational or service context so that it has meaning for them. People engage and relate to things better when they have helped to shape them. It is also critical that this collaboration should be extended beyond those who are in receipt of the care of services, to include those who are supporting those through recovery journeys. Co-production is really important (see theme 5).

Without a co-produced understanding of recovery, then both staff and those receiving and supporting care are likely to be working at cross purposes and the outcomes for all may be negatively impacted. Part of leadership, therefore, is to create the space, provide the context and empower staff and those with lived experience to be an active part of shaping this definition. The result is not a fluid definition that is constantly in a state of change, but an established definition, vision and associated values that people then subscribe to. Evidence suggests staff work better when they have some control over their working environment which is informed by an agreed recovery definition, vision and values statement.[15]

Because everyone's recovery journey is personal, empowerment is important. We want to support people to have control over their lives and the goals they are working toward.

2. Empowering staff to lead and develop change

Because everyone's recovery journey is personal, empowerment is important. We want to support people to have control over their lives and the goals they are working toward. Services with a clear recovery focus, strong leadership[16] and a team working ethos[17] better develops innovations in delivery in order to improve outcomes within a recovery orientated system of care. The work on Recovery Oriented Systems of Care makes this point clear—recovery is a holistic phenomenon[18] for everyone. By creating the environment and culture within which people feel empowered to lead change impacts on all people, not just those who are accessing services. The outcomes for professionals may differ from services users but the positive impact upon their lives is similar.

To enable empowerment leaders need tools and approaches to make this a reality, focused on the wellbeing and quality of life of staff. Communities of practice whereby staff meet regularly to discuss recovery and their own practices and functioning are an effective way of developing and sharing understanding.[19] There are a variety of examples including away days and World Cafés,[20] 'Vision Planning Days',[21] focus groups to promote collaborative action planning and action research style approaches.[23] Such formal and informal methods should be encouraged and built into the organisational plans to promote recovery focused outcomes and leaders should instigate this.

It is important that leaders guide staff to discover new ways of working and avoid feelings of having things 'done to' or imposed upon them. Leaders should encourage alignment to organisational objectives whilst allowing their workforce to lead activities as part of their core role, thereby sharing power and responsibility for influencing change.[24] Organisational structures need

15. Chandley, M., Cromar-Hayes, M., Mercer, D., Clancy, B., Wilkie, I. and Thorpe, G. (2014) 'The development of recovery-based nursing in a high-security hospital: nurturance and safe spaces in a dangerous world?'. Mental Health and Social Inclusion. 18 (4). pp. 203-214.
16. McLean, J. (2015) 'Recovery-focused leadership in the NHS'. Mental Health and Social Inclusion, 19(2), pp. 87-94
17. Sutton, J., Family, H., Scott, J., Gage, H. and Taylor, D. (2016) 'The influence of organisational climate on care of patients with schizophrenia: a qualitative analysis of health professionals' views'. International Journal of Clinical Pharmacy, 38, pp. 344-352.
18. SAMHSA (2012), see n.7.
19. Mancini, M. and Miner, C. (2013) 'Learning and Culture Change in a Community Mental Health Setting', Journal of Evidence-Based Social Work, 10, pp. 494-504.
20. Beckett, P., Field, J., Molloy, L., Yu, N. and Holmes, D. (2013) 'Practice What You Preach: Developing Person-Centred Culture in Inpatient Mental Health Settings through Strengths-Based, Transformational Leadership'. Issues in Mental Health Nursing. 34. pp. 595-601.
21. Best, D., Loudon, L., Powell, D., Groshkova, T., and White, W. (2013) 'Identifying and Recruiting Recovery Champions: Exploratory Action Research in Barnsley, South Yorkshire'. Journal of Groups in Addiction and Recovery. 8. pp.169-184.
22. Bhanbhro, S., Gee, M., Cook, S., Marston, L., Lean, M. and Killaspy, H. (2016) 'Recovery-based staff training intervention within mental health rehabilitation units: a two-stage analysis using realistic evaluation principles and framework approach'. BMC Psychiatry, 16, pp. 1-14.
23. Henderson, J., Curren, D., Walter, B., Toffoli, L. and O'Kane, D. (2011) 'Relocating care: negotiating nursing skillmix in a mental health unit for older adults'. Nursing Inquiry. 18(1). pp. 55-65.
24. Stuber, J., Rocha, A., Christian, A. and Johnson, D. (2014) 'Predictors of Recovery-Oriented Competencies Among Mental Health Professionals in One Community Mental Health System'. Community Mental Health Journal, 50, pp. 909-914

to be flexible enough to adapt work roles to include participation in such processes,[25] so that the workforce is given freedom to shape how they work[26] and has a sense of ownership of the recovery model.

3. Encouraging positive risk taking and a learning culture

Whilst considering such collaborative and empowered approaches to define recovery and lead change, a tension emerges that it is important to note. Traditionally within health services there is a biomedical model that is hierarchical in nature and has power and status located with the professional or clinician at the top.[27] This model emphasises the view of the clinician in terms of treatment adherence, symptom reduction and staying out of hospital, rather than the person having ownership of their recovery.[28]

A main driver behind the perpetuation of a biomedical or illness management model is the predominant risk averse culture that exists in many services. Studies have recorded staff discussing anxiety regarding risk that drove their approach to, and decisions regarding, those in their care.[29] Recovery workers have reported peer pressure to conform to their organisations' risk-averse culture that subsequently impacted upon the approach they took to encourage those in their care to take positive risks.[30] This has even extended to staff reporting that they are fearful of being sued[31 32]. The view of risk within individual packages of care differs between the professional (who tends to focus on the risk of harm or violence) and the person receiving care (who tends to focus more upon social inclusion, financial need and avoiding harm).[33]

A main driver behind the perpetuation of a biomedical or illness management model is the predominant risk averse culture that exists in many services.

Positive risk taking balances the positive benefit to be gained from taking a risk against the negative impact of avoiding risk altogether. It views risk through the lens that it provides 'opportunities for learning and enabling people to make their own decisions, to exercise choice. It builds upon individual strengths and abilities rather than focusing on deficits'.[34] An interesting question therefore arises regarding how a biomedical model and/or risk averse culture impacts upon recovery where we want to encourage people to take positive risks. I believe that developing approaches at a local level that weave positive risk taking into biomedical approaches should be a priority for those in leadership positions. We need to balance keeping people safe with supporting them to move away from services when the time is right. Empowering staff to develop, lead and sustain change will be unsuccessful if at the same time they are constrained by cultures that perpetuate risk management strategies that are at odds with the philosophy and values of recovery.

Learning cultures involve collaborative working across all stakeholders to develop appropriate responses to incidents of harm as a means of promoting learning.[35] A learning culture actively seeks to understand and share both what went right and learn from what went wrong. Leaders promote lateral relationships within which all people, irrespective of hierarchy, are encouraged to be involved.[36] The workforce will not be as effective if they are constrained by risk-averse management strategies or are operating within a blame

25. Bhanbhro, 2016, see n.22.
26. Kristiansen, L., Hellzén, O. and Asplund, K. (2010) 'Left alone – Swedish nurses' and mental health workers' experiences of being care providers in a social psychiatric dwelling context in the post-health-care-restructuring era. A focus-group interview study'. Scandinavian Journal of Caring Sciences, 24, pp. 427-435.
27. McLean, 2015, see n.16.
28. Kwok, C.F.Y. (2014) 'Beyond the Clinical Model of Recovery: Recovery of a Chinese Immigrant Woman with Bipolar Disorder'. East Asian Psychiatry, 24, pp.129-133.
29. Tickle, A., Brown, D. and Hayward, M. (2014) 'Can we risk recovery? A grounded theory of clinical psychologists' perception of risk and recovery-oriented mental health services'. Psychology and Psychotherapy: Theory, Research and Practice, 87, pp. 96-110.
30. Holley, J., Chambers, M. and Gillard, S. (2015) 'The impact of risk management practice upon the implementation of recovery-oriented care in community mental health services: a qualitative investigation'. Journal of Mental Health. 25(4), pp. 315-322.
31. Kristiansen, Hellzén and Asplund (2010), see n.26.
32. Tickle, Brown and Haywood (2012), see n.29.
33. Reddington, G. (2017) 'The case for positive risk-taking to promote recovery'. Mental Health Practice, 20(7), pp. 29–32.
34. Morgan, S. and Williamson, T. (2014) 'How can 'positive risk-taking' help build dementia friendly communities?' Joseph Rowntree Foundation.
35. Tickle, Brown and Haywood (2012), see n.29.
36. https://www.scie.org.uk/publications/learningorgs/references.asp

culture. Leaders should embrace learning opportunities and encourage staff to discuss practice in this context, without fear that they will be isolated and blamed if things go wrong.

It is likely both safer and more effective to use strategies that are based upon recovery, rather than traditional control and consequence driven strategies that emerge from a biomedical approach. However, it is worth noting that there is a gap in the research on whether promoting positive risk-taking does in fact promote recovery.[37] However, if leaders are not prepared to work within their organisations to develop positive risk-taking strategies this gap will never close.

Developing a positive risk-taking culture requires a certain amount of bravery on behalf of those in leadership positions; it also requires a long-term strategy and patience. As many working within services will appreciate, recovery is not a linear journey, nor does it occur over short periods, with a time frame of five to ten years for recovery to become embedded.[38] Organisations need to accept and be open about this, with a clear commitment from leaders to support long-term development.[39]

Developing a positive risk-taking culture requires a certain amount of bravery on behalf of those in leadership positions; it also requires a long-term strategy and patience.

4. Patience is vital—change takes time to realise

The new relationships fostered through a recovery approach require significant nurturing. It is likely that this is true of not only the relationships between professionals and care receiver, but also of relationships between leaders and other professionals, families, peer supporters and mentors. It will take time for all stakeholders to be comfortable in a new recovery paradigm. Strategic leaders need to commit to enabling meaningful change[40] whilst acknowledging that both 'change and learning are slow, multifaceted processes that occur over time and across contexts'.[41]

5. Lived Experience needs to be central to change

The value of lived experience is explored in more depth by Damian Grainer and David Higham within this edition. It is important that leaders take account of the value it brings. Basset et al (2010), Gillard, Turner and Neffgen (2015), Byrne, Happell and Reid-Searl (2015), and Best et al (2017) are amongst those who have published material on the value of lived experience on developing care and social networks. As discussed above, involving and sustaining the involvement of the workforce in developing a recovery culture is of high importance. Including those with lived experience should be seen as of equal importance to those in leadership positions.

Co-production, co-facilitation and learning between professionals and those with lived experience can generate engagement, human connection and organisational commitment. All stakeholders become equal partners and co-creators in developing aspects of care and the environment within which care is located. In this approach, relationships are more lateral than hierarchical, and change is agreed rather than imposed. This idea of co-production creates opportunities that build upon the strengths of a partnership approach and if done correctly does not need to threaten professionals' knowledge, competency or autonomy.[42]

This approach to change is best viewed as the meeting of ground up and top down approaches.[43]

Values of Recovery

Values are traits or qualities that represent deeply held beliefs, they reflect those things that individuals or organisations feel are important and act as a form of behavioural compass.[44] Often values are not communicated effectively which minimises the impact

37. Reddington (2017), see n.33.
38. Kelly, J. and White, W. (2011) Addiction Recovery Management, Humana Press: New York.
39. De Vecchi, N., Kenny, A. and Kidd, S. (2015) 'Stakeholder views on a recovery oriented psychiatric art therapy program in a rural Australian mental health service: a qualitative description'. International Journal of Mental Health Systems. 9 (11). pp. 1-11.
40. Best, D., Irving, J., Collinson, B., Andersson, C. and Edwards, M. (2017) 'Recovery Networks and Community Connections: Identifying Connection Needs and Community Linkage Opportunities in Early Recovery Populations. Alcoholism Treatment Quarterly, 35(1), pp. 2-15.
41. Mancini and Miner (2013), see n.19, p.498.
42. Henderson et al (2011), see n.23.
43. Best, D., Loudon, L., Powell, D., Groshkova, T., and White, W. (2013) 'Identifying and Recruiting Recovery Champions: Exploratory Action Research in Barnsley, South Yorkshire'. Journal of Groups in Addiction and Recovery. 8. pp.169-184.
44. Williams A. and Payne, S. (2016) My 31 Practices: Release the power of your values for authentic happiness. LID Publishing: London.

that they have and prevent people from being able to engage with them.

So what can leaders do to help people align to the values of their organisation or service? Well the good news is that this is congruent with the approaches I've already articulated! For example, activities such as asking people what is important to them and establishing core values across the whole organisation (not just within management) are important. This will mean that the values are not just existential ideas dropped down from above but have been co-produced so as to engage people from the outset. They may differ slightly across recovery services but they should have meaning and value for all participants irrespective of the service. Next, establishing an effective means of communicating the values is required, after all what is the point of having values if no-one knows what these are? A clear communication plan is important.[45]

Leaders need to visibly live these values, incorporating them in their decision making, embodying them in their day-to-day interactions, and using them to engage people at all levels of the organisation. In doing so, this will reinforce the values helping others engage with them and to sustain cultural change. Recovery to a large degree is about relationships, whether it be building or rebuilding interpersonal ones, or developing relationships with communities or activities. For instance, if the relationship between nurse and person receiving care is vital, then it stands to reason that the relationship between organisational leader and nurse is of equal importance. These relationships should not be built upon different principles or values bases. Therefore, the values of recovery that each organisation has should be at the heart of all relationships within it.

Leaders need to visibly live these values, incorporating them in their decision making, embodying them in their day-to-day interactions, and using them to engage people at all levels of the organisation.

The 'behavioural compass' aspect of organisational values is in essence a sense check of activities within services. This doesn't need to be driven by managers if the work to generate, align and communicate the values has been effective. Remember, leaders exist at every level of organisations. People should feel confident to lead change if they are engaged with and understand the behavioural compass. Mike Wheatley provides the example of HMP Holme House within this edition that has followed this approach.

Conclusion

Implications for Practice

This article is intended to further the conversation regarding recovery from being focused upon interventions or service delivery elements, to consider the role and actions of leaders in the development of effective workforce cultures. A potential model of five themes or pillars that could be a guide for future practice is suggested. These are:

- ❒ Clarity of vision, values and an agreed definition of what Recovery is
- ❒ Empowering staff to lead and develop change
- ❒ Encouraging positive risk taking and a learning culture
- ❒ Patience is vital—change takes time to realise
- ❒ Lived Experience needs to be central to change

The overarching theme is that the values of recovery (as defined by organisations) should be at the heart of all relationships not just professional—client ones. Leadership needs to be seen to be in-line with recovery values, embodying these, whilst empowering those at different levels of the organisation to be leaders themselves. This model challenges some traditional views of leadership particularly in that they will be required to 'let go' of areas of control to enable co-production and the empowerment of staff.

Implications for Policy

There are potential policy implications and impact that such a model, if robustly evidenced, can help shape. Within the recovery field, the existing biomedical model and associated hierarchy that exists in many health services could be fundamentally changed. The transfer of power and influence away

45. https://hbr.org/2011/07/the-business-of-communicating

from being held within senior organisational positions is advocated. The values aligned to recovery within services and organisations support a cultural repositioning whereby power transfers from traditional hierarchical models to the front line. It is important to note that in the UK this does not conflict with the values of the NHS; rather it is congruent with them.

Organisational responses to risk need to better embrace positive risk-taking. This is not advocating reckless approaches that put staff or those receiving care in positions where they may experience harm, rather learning from the existing practices within recovery services that seek to empower people to be responsible for, and to lead, their own care.

Implications for the Prison System

Just like in many health services, prison culture is hierarchical; it is largely a top down structure with clearly defined power structures with people looking upward for clear instruction on what they should do, how they should do it and when. People can be fearful of being blamed if they try an innovation and it goes wrong. With this in mind, I argue that the five themes outlined above are just as relevant to those working a custodial role within a prison; the same rationale applies even if the uniform is different. If we do not understand or feel engaged with what we are working to achieve, it will fail. If all leaders (irrespective of employer) perpetuate the top-down, risk averse processes we will continually struggle with the same problems. If we do not engage those with lived experience within the prison (both prisoners and staff) then there will remain elements of 'them' and 'us'. If we are impatient and do not allow people and changes time to grow they will never succeed. I subscribe to the view that 'we cannot solve problems with the same thinking we used when we created them'. Therefore, the relevance to prisons is that leadership has a vital role to play in transforming them, alongside all the wonderful people and using all the ingredients within their communities, to truly become Recovery Oriented Systems of Care, because in doing so we give people the best opportunity to transform their lives. What an exciting and rewarding challenge to have! And best of all—everyone benefits.

The Illicit Economy and Recovery What we need to understand

Dr Kate Gooch *is an Associate Professor at Leicester Law School, University of Leicester*

Dr James Treadwell *is Professor of Criminology at Staffordshire University.*

Introduction: A New Illicit Economy

In the last decade, the drug economy has transformed, from one based on 'hard drugs',[1] to one based on new psychoactive substances. In 2010, there were as few as 15 recorded seizures of new psychoactive substances (PS) in prisons across England and Wales; by 2018, this had risen to 4,667 recorded seizures: more than a three hundred-fold increase.[2] Whilst the use of heroin, cocaine, cannabis, anabolic steroids, and prescription medication continues, it does so on a much smaller scale and it is the use of PS that typifies drug misuse in most prisons. This is not the only change to alter the illicit economy; the availability of internet enabled mobile telephones within prison and the ability to make online financial transactions has diversified forms of prison currency. No longer limited to items available within the prison—such as canteen, personal property and prescription medication—or the use of postal orders to add money to 'private spends', '*cash amounts*' can now be demanded and financed through bank transfers in the community. Such trading is increasingly sophisticated, organised, and connected to wider familial and criminal networks. It is also becoming a more global affair, with the use of social media, crypto-currencies and the 'dark' or 'hidden' web creating alternative methods of generating and exchanging money. Thus, the prison wall is more porous and permeable than ever before, and the changing nature of criminal behaviour both within and beyond the prison requires a different approach to policing, intelligence gathering and analysis, and multi-agency working.

In response to these challenges, the Government has emphasised the importance of supply reduction strategies, law enforcement measures and punitive responses.[3] A new HMPPS financial investigation unit has been created to supplement the work of the Regional Organised Crime Units (ROCUs).[4] Commitments have also been made to introduce: body X-Ray scanners; mobile phone detection, blocking and interrogation technology; newly trained drug dogs; a new digital tool to categorise prisoners based on wider factors other than index offence; and, improved mandatory drug testing to detect a wider range of substances (including various PS and diverted medication). Rory Stewart, the Government Minister responsible for prisons, probation and sentencing, has also pledged an additional £10 million to resource the ten prisons experiencing the most 'acute' problems, and committed to resign should he fail to reduce levels of violence and drug misuse.[5] Set against this background, however, is a wider focus on rehabilitation[6] and recovery, with HMP Holme House becoming the first drug recovery prison in England and Wales.[7] There is, then, a need to understand how it might be possible to pursue the twin aims of supply reduction and demand reduction in a way that encourages, rather than impedes, opportunities for rehabilitation and recovery.

1. Crewe, B. (2005) Prisoner society in an era of hard drugs. Punishment and Society 7(4): 457-481.
2. Ministry of Justice (2018) Annual HM Prison and Probation Service Digest 2017-2018. London. Available Online: https://www.gov.uk/government/statistics/annual-hm-prison-and-probation-service-digest-2017-to-2018.
3. Ministry of Justice (2015) New Crackdown on Dangerous Legal Highs in Prison. Available online: https://www.gov.uk/government/news/new-crackdown-on-dangerous-legal-highs-in-prison. Accessed: 25 January 2015; Ministry of Justice (2016) Prison Safety and Reform. Cm 9350 London: HM Stationery Office; Ministry of Justice (2018) Prison Reform Speech. Available Online: https://www.gov.uk/government/speeches/prisons-reform-speech. Accessed: 28 October 2018.
4. Ministry of Justice (2018) Specialist financial crime unit to crack down on prison gangs. Available Online: https://www.gov.uk/government/news/specialist-financial-crime-unit-to-crack-down-on-prison-gangs. Accessed: 28 October 2018
5. Ministry of Justice (2018) Ministers announces '10 Prison Project' to develop new model of excellence. Available Online:https://www.gov.uk/government/news/minister-announces-10-prisons-project-to-develop-new-model-of-excellence. Accessed: 28 October 2018; BBC News (2018) Prisons Minister Rory Stewart: I'll resign if drugs and violence don't come down. Available online: https://www.bbc.co.uk/news/uk-45214414. Accessed: 28 October 2018.
6. Ministry of Justice (2018) Prison Reform Speech. Available Online: https://www.gov.uk/government/speeches/prisons-reform-speech. Accessed: 28 October 2018. For an overview of rehabilitative culture in prisons, see Mann, R., Fitzalan Howard, F. and Tew, J. (2017) What is Rehabilitative Prison Culture? Prison Service Journal 235: 3-9.
7. Ministry of Justice (2018) Blitz on Drugs in Prison Underway. Available Online: https://www.gov.uk/government/news/blitz-on-drugs-in-prison-underway. Accessed: 28 October 2018.

Drawing on ethnographic and qualitative research, this article focuses on the relationship between the illicit economy, drug consumption and supply, and the recovery of those who use drugs in prison. It seeks to provide a deeper understanding about how to minimise—rather than incentivise—reliance on the illicit and drug economy in prisons, and how to promote—rather than discourage—recovery. It is argued that to establish a recovery culture, the following foundations are necessary: humane conditions; adequate access to clothes, toiletries and bedding; willing, capable and legitimate governance; effective investigations into incidents of self-harm, violence or unexplained injury, intelligence (and intelligent) analysis and preventative action; and, constructive approaches that support recovery rather than punish in ways that encourage continued drug consumption. The desire to disrupt supply can amount to a series of 'cat and mouse' games with varying degrees of success. However, it will always be a 'losing game' if the wider factors that cause the illicit economy to flourish, and generate demand for drug supply and the profits that flow from it, remain unaddressed.

Researching Drug Consumption and Supply

Our interest in prison drug consumption and supply arose from a broader research project focusing on prison violence. During the period October 2014-October 2017, we conducted ethnographic and qualitative research in three prisons: a young offender institution, a Category B local prison and a Category C prison accommodating men convicted of sex offences. The aim of the research was to understand why prison violence was a frequent occurrence in two of the sites, but low (and almost absent) in another. It was quickly apparent that drug consumption and supply was both directly and indirectly a driver of violence, underpinned by a buoyant illicit economy and maintained by men who gained power, status and reputation by controlling the illicit and drug economy. As this research concluded, a new study began. Our interest in the illicit economy continued and we sought to better understand our emerging findings that the illicit economy and associated activity was in some cases linked to organised crime and criminal activity occurring both within the prison and in the community. This work remains ongoing, and we draw on both of these studies in this article. What follows are six key findings regarding the relationship between the illicit economy, drug use and recovery.

1. Prison Conditions and the Illicit Economy: Understanding the Survival Mind-set

Sykes describes the prison as 'depriving in the extreme,'[8] and argues that the deprivation of material goods constitutes one of the central pains of imprisonment. Such 'material deprivation' can, however, be more severe in some prisons than others. Wide disparities exist in terms of the quality of living accommodation, the state of repair or disrepair, the size of the living accommodation, access to in-cell sanitation and showers, and access to in-cell telephony, laptops or kiosks. In some prisons, there has been a notable and lamentable decline in prison conditions, created and compounded by factors such as overcrowding, old and decaying buildings, reduced numbers of staff, austerity measures, and strained contractual arrangements regarding prison maintenance, causing Her Majesty's Inspectorate of Prisons to publish a critical thematic review in November 2017 of living conditions across the prison estate.[9] Whilst there is now a growing investment in the recruitment of new prison officers[10] and, to some extent, the prison environment, it is undoubtedly true that the notable decline in prison conditions combined with impoverished prison regimes has, in some prisons, driven demand for drugs, but also provided the fertile conditions for the illicit economy to take root and more entrepreneurial-minded prisoners to occupy positions of authority and leadership.

Sykes describes the prison as 'depriving in the extreme,' and argues that the deprivation of material goods constitutes one of the central pains of imprisonment.

When confronted with difficulties accessing basic 'kit'—such as bedding, mattresses, clothing, and toiletries—prisoners often feel they have no alternative but to turn to the black market simply as a way of achieving some degree of warmth and comfort, particularly in the depths of winter. Not only does the illicit economy flourish in poor conditions, but market prices increase, more items are commodified, and

8. Sykes, G. (1958) The Society of Captives. Princeton: Princeton University Press. p.63.
9. Her Majesty's Inspectorate of Prisons (2017) Life in Prison: Living Conditions. London: Her Majesty's Inspectorate of Prisons.
10. Ministry of Justice (2018) Government hits target of 2,500 new officers 7 months ahead of schedule. Available Online: https://www.gov.uk/government/news/government-hits-target-of-2500-new-prison-officers-7-months-ahead-of-schedule. Accessed: 28 October 2018.

prisoners are far more willing to steal from, assault, and/or exploit others:

> *There's different situations that arise and everything's sensitised in here a lot more. It's more magnetised. It sounds dumb, but one of the maddest things I've seen is someone pulled a frigging knife out over socks and boxers. It sounds dumb. It does sound dumb when you say it out loud but, in jail, say you haven't got much money or your family haven't got much money outside or whatever, and that person put his washing in the washing machine, whatever, dried it, put it on the side, obviously, he'd to go bang-up. So, the next day when he come down, his boxers and socks were missing. Now, he's got no boxers and socks now. Then he found out who stole his boxers and socks.* (Nathan, Category B)

In poor prison conditions, prisoners quickly (and understandably) become preoccupied with survival and the ability to access and retain basic necessities takes on a disproportionate significance. The atmosphere becomes 'charged' and prisoners recognise that their responses to the loss of personal items is extreme, as in the example above, but feel unable to effectively change or alter them. Those with few financial resources and/or who cannot rely on financial support from family members may find themselves quickly indebted to others, and for large sums of money.

Those with few financial resources and/or who cannot rely on financial support from family members may find themselves quickly indebted to others, and for large sums of money.

It is not only poor prison conditions that drives the illicit and drug economy, but poor regimes. Faced with little to do, prisoners use drugs as an antidote to boredom, even if they have never used PS before, and have no intention of doing so on release. Thus, PS is very much seen as a '*prison drug*' and a particular response to imprisonment. A recurring theme of our interviews with prisoners is that the use of PS has created a way to '*have your day out of prison*' without the stigma associated with heroin use. Whilst drug use has always been seen as a way to manage the time problem,[11] such effects are particularly exaggerated with PS and its use for such purposes is normalised:

> *I don't think anybody would argue, it's a head changer, it takes them away. So, I'd be very simple in saying that there are people who need head changes and who need to switch off to what they're living through.* Shaun, Category C)

Whilst PS is often seen as a hazardous, dangerous and risky drug with unpredictable and potentially life-threatening symptoms, the temporal relief was seen to outweigh the potential risks. Even after experiencing cardiac arrest, unconsciousness or seizures, prisoners were undeterred from future use, simply stating that it '*melts the bars away*' and '*time flies'*. There is a clear correlation between how painful and depriving the regime is perceived to be, and how hopeless people feel, and their willingness to experiment with, or regularly use, drugs in response. Attempting recovery in an environment where there is little to do, when basic items are difficult to access, where the prison is crumbling and facilities are broken or damaged, is challenging. Supply reduction techniques and efforts to engage prisoners in recovery must be matched with an equal—if not greater—commitment to accommodate prisoners in humane conditions, provide adequate clothing, bedding and toiletries, and ensure that people are busy during the working day.

2. It's 'big business': Understanding the Profit Motives

Explanations for the popularity of PS in prison are multi-faceted, but it is undoubtedly true that the low cost and ease of distribution and consumption has maintained demand and supply post-prohibition.[12] PS are largely synthesised in a laboratory (although there is a burgeoning small-scale home production industry)

11. Cope, N. (2003) 'It's No Time or High Time': Young Offenders' Experiences of Time and Drug Use in Prison. Howard Journal of Criminal Justice 42(2): 158-172.Crewe, B. (2005) Prisoner society in an era of hard drugs. Punishment and Society 7(4): 457-481; Wheatley, M. (2016) Drugs in Prison. In. Jewkes, Y., Crewe, B., and Bennett, J. (eds) Handbook on Prison. 2nd Edn, Routledge.
12. Whilst psychoactive substances had been regarded as a "legal high", the Psychoactive Substances Act 2016 prohibited the production, supply, importation and export of psychoactive substances. The Act also made specific provisions for the possession of psychoactive substances in custody – provisions that do not apply in the community.

dissolved in solvent, then sprayed onto plant material (such as dried rhubarb leaves) or paper, which is most commonly smoked. The possibility of spraying PS on domestic and legal mail not only creates a method of supply that poses far less risk than relying on drug mules, corrupt staff or drones, but the paper itself provides a means of consumption, and can be smoked or soaked into the fluid of e-cigarettes. The sale and supply of PS is lucrative, with even a 1cm^3 piece of paper fetching £25-£50. Since several pieces of paper can be sent in one delivery, vast amounts of money can be made from relatively small amounts of drug-soaked mail. Drones and throw-overs offer a way of 'getting the kilos sent in', particularly in prisons with a large number of broken or damaged windows where the possibility of creating lines to exchange goods, or fly a drone straight into the prison cell, is that much easier. Such packages may contain mobile phones and chargers, SIM cards, tobacco, drugs (including heroin, cocaine and cannabis), prescription medication, and alcohol. Items such as mobile phones are high value, attracting upwards of £300-£1000 depending on the make and model, and generating considerable profits. The illicit economy is more than a prison economy. The ability to make financial transactions online or via mobile phone apps means that individuals will often prefer to trade in 'cash' via bank accounts held in the community. Thus, many financial transactions will occur beyond the prison wall and in ways that are not easily observable, detectable or governable.

The drug economy represents something more than a way of managing confinement, but for entrepreneurial minded individuals, it is also a way to profiting from imprisonment and generating '*big money':*

> *Well, I know a lad who does nothing but little silly sentences. He'll go and do a stupid shoplifting just so he'll come in plugged up to make his money again, so he'll come back out and take the missus to the Bahamas and stupid holidays, so it's serious money. Well, one Kinder egg full of Spice can make you anything up to £4,000 or £5,000, so if you've got three of those inside you that's 15 grand.* (Anthony, Cat C)

The stakes are high; the control of the illicit and drug economy is something that prisoners are not only prepared to fight over, but even kill for.[13] Individuals can shore up profits that will maintain them during their custodial sentence and even assist their families whilst they are imprisoned:

> *Right, I will put it this simple, [drug dealing] puts food on a lot of lads tables out there and in here, you get me? We need to keep earning, and there are ways to do that. Big money, as much money as can be earned on the out, on road [in the community]. Lads will do what they have to do on the outside, you get me, and they will do what they have to do on the inside too.* (Steven, Category B).

...something more than a way of managing confinement, but for entrepreneurial minded individuals, it is also a way to profiting from imprisonment and generating 'big money'

Such individuals essentially continue their criminal enterprises in prison: they know how to 'graft' (make money), and have learnt how to do so using a combination of threat, intimidation and strict repayment conditions. The 'business model' not only relies on the supply of items at an inflated price, but on the likelihood that some will be unable to control their drug habit and/or become addicted, and quickly accumulate large amounts of debt (into the hundreds and thousands of pounds). Thus, the 'loan sharks' profit from the inability of some individuals to control their spending and take advantage of their feelings of hopelessness and helplessness. It is, however, seen as legitimate financial trade—those who engage in the economy are seen to have accepted the '*terms and conditions*' in ways that were seen to justify the penalty of violence, degradation or intimidation for non-repayment of debt.

The illicit economy is not all about the money. Those who benefit the most from the illicit economy are not only able to live in relative comfort, but they visibly display their masculine credentials to others. Lining their cells with vast quantities of canteen and

13. See for example the murder of Jamal Mahmoud at HMP Pentonville. BBC News (2017a) Pentonville Prison murder accused had "no reason to kill" 8 November. Available online: https://www.bbc.co.uk/news/uk-england-london-41920890. Accessed: 28 October 2018.

other highly sought after commodities not only demonstrates that they can hold on to this possession and are not vulnerable to victimisation and exploitation, but also displays their power, control and status within the prison.

3. Debt: Understanding Vulnerability

Initially, explanations for the rising levels of violence across the prison estate were attributed to the use of PS. However, as our research indicated, increased violence is a product of a variety of factors. Claims that PS was directly causing violent incidents were over-stated. Whilst it is undoubtedly true that some individuals react in an aggressive and sometimes violent manner, much of the violence that was linked to PS was a consequence of indebtedness, rather than the use of PS itself. The prison illicit economy has always involved some form of borrowing and lending with extortionate levels of interest demanded by the 'loan sharks.' For example, 'ticking' and 'double bubble'—where prisoners lend their possessions to others with the expectation that they are repaid twice as much in return, doubling each week until the debt is repaid—has been a common practice for many years. However, the ease of access to drugs and other contraband items, the ease with which they can be traded and trafficked, and the normalisation of PS use as an antidote to boredom, inactivity and hopeless has meant that prisoners are quickly accruing large amounts of debt. Moreover, a history of poly-drug use in the community at an earlier life-stage and age has meant that some prisoners are simply accustomed to relying on family members to repay their, often very large, drug debts. Whilst in prison, however, financial resources can quickly 'dry up'. If they are unemployed, on basic regime, have limited financial support from family, or have sold everything they own to maintain their drug use, individuals may find themselves unable to repay debts, and as interest accumulates, find that things are spiralling out of control. Escalating and unpaid debt does not go unnoticed or unpunished. Not only does it place someone at greater risk of a 'hit being put on their head' and being physically assaulted, but they may be pressured to hold contraband items (such as mobile telephones), assault a member of staff, 'pot' an officer or act as a '*drug mule*' returning to custody with large amount of drugs:

The prison illicit economy has always involved some form of borrowing and lending with extortionate levels of interest demanded by the 'loan sharks.

> *It is not that all of these recalls are earning money, if you look at who is getting recalled, they are muppets, sad cases, debtors, they are being put up to it. They are the well, the useless and hopeless sorts, they are not the ones making any money off of it, they are paying back the debts they have been driven into. It's a business model, they come back in to pay their debts.* (Liam, Category C)

Arranging assaults on staff, the 'potting' of an officer or the trafficking of drugs into the prison with those who are recalled to prison requires a degree of organisation, including contact with those in the community. Responses to such incidents by prison staff can, however, sometimes be unsophisticated, focusing on who perpetrated the incident or who is found in possession of contraband, rather than understanding the wider networks, connections or social dynamics to which such activity relates. Failing to investigate effectively, and ask questions regarding the nature of someone's involvement, can limit opportunities to gather vital information about the various nefarious activities occurring within and beyond the prison, and the networks that support them. Such intelligence could, however, be used effectively to prevent future incidents from occurring.

Failing to understand the underlying causes, can also mean that the vulnerability of some individuals is ineffectively addressed, even if their behaviour escalates. For example, when faced with threats, intimidation or the possibility of assaults, individuals may believe that their only option is to 'run for cover':

> *You get some lads, at first, they are paying their way and then after a bit their resources dry up. And then they are in a whole heap of trouble. Then you get lads hitting the back fences [moved off the wing] because they are debted up.*' (Nathan, Category B)

In such circumstances, individuals might manipulate a move to the segregation block by assaulting staff, damaging ('flat packing') their cells, climbing onto the netting or railings, or engaging in other protest behaviour that they know will secure even

a temporary move to the segregation block. Prisoners know what gets attention from staff, and what will most likely secure a move or transfer, and will act to protect and insulate themselves even at the risk of seriously harming themselves or others. In response, staff may be tempted to focus purely and primarily on the presenting behaviour, and the initial explanations offered, but there is a greater need to consider the wider dynamics and a willingness to see even very serious incidents as symptomatic of vulnerability. Moreover, even after an incident, the threat may not disappear. Those who 'hit the back fences' and seek sanctuary and protection in another wing, segregation block or prison can find that debts follow them around the prison, or even to another prison. Prisoners communicate with each other across prisons and across the estate, and 'put hits on the heads' on those who owe debts. Moreover, their 'pad mates' might inherit the unpaid debt and be required to repay on their behalf. Such individuals can find themselves vulnerable to physical reprisals even if they have not engaged in the illicit economy themselves. Thus, preventative and proactive management of individuals is needed, rather than simply waiting for the threat to materialise and reacting to the subsequent assault or self-harm.

...trafficking of drugs into the prison with those who are recalled to prison requires a degree of organisation, including contact with those in the community.

4. Playing 'Cat and Mouse' Games: Understanding Unintended Consequences

'They're always going to find a way of getting stuff in, that's just what happens in jail.' (Steven, Category C)

Whilst it is notoriously difficult to accurately assess the strength of any particular supply routes, at any one time, there will be several active supply routes within a prison typically including: visits, mail, drones, 'throw-overs', staff, new receptions (some of whom are 'drug mules') and to a lesser extent, prisoners leaving via hospital or court escort, or on ROTL (release on temporary license). There are different levels of risk associated with each of these supply routes, and the extent to which any one route is preferred may depend on the frequency, reliability and predictability of security tactics to intercept and interrupt supply. Such supply routes are agile, and prisoners adapt to changes in the risk and ease associated with particular supply routes. For example, photocopying letters may prevent drug-soaked mail entering the prison, but prisoners quickly adapt and use books (including religious texts such as Bibles) or attempt to soak clothes in drugs[14] to circumvent the photocopying. Alternatively, if domestic visits become an increasingly more hazardous route for supply, prisoners may then turn to 'throw-overs' or drones to maintain the illicit and drug economy. It can amount to a series of 'cat and mouse' games: on one hand, prisoners seeking to circumvent staff and on the other, staff seeking to disrupt nefarious activity. However, disrupting supply has often unintended consequences that must be carefully considered.

Intercepting supply will always have wider and unintended consequences. It disrupts the social equilibrium, and there may be assaults, group disorder or self-harm as a result. For example, the interception of a throw-over in one prison led to disorder on the wing involving two rival groups in one prison. In another, the interception of a large supply of drugs and mobile phones led to the serious stabbing of a prisoner, and culminated in the self-inflicted death of another. Those who are in possession of contraband on behalf of others, are often held liable for the loss of such items if confiscated by security and physically assaulted as a result. Failure to warn others about the arrival of security search teams on the wing can also attract physical reprisals. For example, an assault of one individual by a group of other, more domineering young men functioned as 'punishment' for failing to warn them that the security search team had approached their wing—a search that resulted in the seizure of mobile phones, drugs and associated paraphernalia. Thus, successful interceptions can inadvertently instigate physical violence and increase vulnerability.

Scarcity can also elevate prices, and individuals can therefore find that they are accumulating much higher levels of debt since the demand has not necessarily reduced. The reality that some prisoners—although certainly not all—will seek to manipulate or exploit perceived weaknesses or vulnerabilities in prison security (either physical or procedural) can create a temptation to 'screw everything down' or an obsession with closing down any and all opportunities for passing, training or dealing. However, the supply reduction tactics can come at the expense of opportunities for activities that might promote recovery, hope, and meaningful family contact. For example, whilst domestic visits can be a popular supply route, creating

a very controlled, austere and punitive visits environment and experience may reduce supply partially, but it does not eliminate it, and will often come at the expense of promoting strong family relationships that may support, assist and encourage desistance, hope, rehabilitation and recovery. Thus, there is a careful balancing act, and a need to take defensible risks to promote positive outcomes and opportunities.

5. Legitimate and Illegitimate Governance: Understanding the Role of Capable Staff

There has always been some degree of policing and governance provided by prisoners within the prisoner society. Prisoners enforce informal norms and codes, and demonstrate contempt for behaviour that they find unacceptable. Some will naturally rise to the apex of the social hierarchy, and operate positions of de-facto leadership. Such behaviour will occur in the context of effective, capable and legitimate governance by staff. Prisoners expect and want staff to provide confident leadership. Prisoners want staff to supervise effectively, and keep them safe from those who might pose a threat to them. There can however exist an uneasy, and quickly unsettled, equilibrium between officers and prisoners regarding the balance of power and control. Changes in either direction—whether officers are seen as being authoritarian, petty, or heavy handed in the use of power or indeed when officers are seen to 'hold back', retreat, be passive and 'turn a blind eye'—has a discernible impact on order and control, on the atmosphere of the wing, and the extent to which the most vulnerable are exposed, unaided and desperate. In the latter case, officers can appear 'ghost-like', physically present but disengaged, either because they feel unwilling, unable, or afraid to challenge and exert authority and interact with prisoners. They can retreat to the offices, leaving large numbers of unlocked men to manage themselves. When this happens, prisoners fill the power vacuum that inevitably emerges, and occupy roles that would and should be the preserve of officers. In the worst cases, staff can become conditioned and find themselves in a position where they are only allowed as much power as prisoners will allow them to have. Too much 'illegitimate and unofficial governance' or, as Skarbek describes it, 'extra-legal governance,'[15] is evident, and it contributes to a lawless society and one where victimisation, exploitation and drug consumption and supply is visible and occurs with impunity:

> *Their [the officers'] backbone has gone a little bit, but I don't think they've got the staffing numbers to intervene sometimes.* (Nathan, Category B)

> *Like I say, they can't physically control that wing. So, it takes, like, the wiser inmates to, like, police it, the cleaners, the servery, they're, the cleaners and the servery, that I'd say the wiser lot, that they wouldn't be able to, they need more staff in here. That's coming from an inmate. We do need more staff in here'.* (Mark, Category B)

When prison staff relinquish some or all control to prisoners, either deliberately or inadvertently, the illicit economy flourishes, dealers can trade without impunity, prisoners use intimidation and violence to punish behaviour that they deem to be unacceptable, and the most vulnerable are exposed. Recovery in such a climate is challenging, largely because it is those who are most need of support who find themselves furthest from it.

> ...successful interceptions can inadvertently instigate physical violence and increase vulnerability.

To avoid the worst excesses of prisoner governance, prison staff need to be visible, be prepared to challenge inappropriate behaviour, and mindful of who is given key roles such as 'cleaner', 'orderly', listener, mentor or prisoners information desk worker. It is not atypical to find that those people chosen to perform such roles are chosen because they have a degree of 'respect' from their peers, have good relationships with staff and pose 'no problem to staff'. But for some such men, their charisma, ability to simultaneously juggle both legitimate and nefarious activities (as some did in the community), their reputations for violence and custodial/criminal experience combined with the relative freedom that comes with orderly, cleanser and mentor job creates scope for them to engage more freely in the illicit economy, and or, organise 'hits', 'trades', and punishment beatings. Stabilising men may squash violence, or push it to backstage areas, but they do little to change the culture of violence and fear—rather, the atmosphere might feel 'tense,' 'edgy' 'heavy' and 'dark. Thus, in order to promote recovery, prison officers need to operate with legitimate authority, be prepared to skilfully and intelligently apply the rules,

14. Prisoners believe that the drug-soaked clothes can be subsequently washed in their sinks and paper than soaked in the sink water. It is not clear, however, whether this is an effective way of supplying psychoactive substances.
15. Skarbek, D. (2016) Covenants without the Sword? Comparing Prison Self-Governance Globally. American Political Science Review, 110(4): 845-860.

understand when a conversation will suffice and when a 'nicking' or change to IEP status is needed, and carefully discern who is genuinely performing supportive and responsible roles, and who is exploiting the opportunity for gain.

This is not to say that prisoners should not be encouraged to undertake responsible roles. As articles in this volume attest, such roles can be vital in supporting recovery and rehabilitation, but empowering prisoners to undertake positions of responsibility and peer support, is skilful work. As Liebling notes, 'some trust must flow, and be placed 'intelligently'[16] and be a decision that is based on intelligence.

6. The Importance of Trust: Understanding how to support recovery

One of the most frequently cited injunctions within prisons is the 'no grassing' or 'snitching' rule. The maxim 'snitches get stitches' is often cited and offered as a rationalisation when prisoners decline to give the names of wrongdoers to staff and are instead inclined to settle disputes between themselves. However, when prisoners form relationships built on trust, when they find the 'good officer' who keeps their word, they will disclose vulnerability, report inappropriate or criminal behaviour by their peers, report staff corruption, or warn officers of planned assaults. Such trust is established and built in the small details. It is the willingness to simply retrieve a toilet roll or provide an extra phone call in the event of a family crisis or bereavement that sets apart the 'good' and 'trustworthy' officers from the others. Equally, trust can be lost as quickly as it can be gained. Failing to act when a prisoners passes a note, reports an incident or possible incidents, or discloses difficulties managing their drug use or self-harm, can quickly lead to the conclusion that officers cannot be trusted and are unreliable in the event of a crisis. If reports of drug use are then automatically accompanied with blanket punitive measures, individuals may feel disinclined and discouraged from seeking support from uniformed staff:

> *People need help, certain people need help with drug addiction. Don't forget, certain lads don't want to chat to officers, they don't want to speak to officers about their drug issues,they don't want to speak to the healthcare staff, they'd rather speak to an inmate about their problems because it stays confidential […] They don't want to get stitched up, basically, that's what they think, if you tell an officer something, it'll go on their file, so they feel wary, but when they tell an inmate something, they know it's staying between the inmate and themselves.* (Paul, Category C)

> *They'd say, like,* '*You've got a drug problem. We'll help you.*' *They just want to put them on basic and put them behind a door, and that.* (Matt, Category C)

Typical responses to discovering an individual in possession of drug paraphernalia or under the influence of drugs include: reducing to 'basic regime' (the lowest level of the Incentives and Earned Privileges Scheme); being placed on report and appearing before the Adjudicating Governor (a 'nicking') who might impose 'losses' of items such as canteen, 'spends', time out of cell; appearing before the Independent Adjudicator and added days being added. In some cases, these added days can amount to several extra months, not just weeks, in prison. In addition, an intelligence-led or 'suspicion' mandatory drug testing might be required, which may affect opportunities for release or parole. The net effect of these punitive measures is to decrease the time out of cell, reduce access to financial resources, and reduce access to items that might be used to repay debts (such as canteen). Thus, individuals are more impoverished—not only in terms of the quality of the regime, but also in terms of the resources available to them. This risks exacerbating the problem. Drug users have less to do—and are then more incentivised to continue their drug use—and the inability to repay their debts risks increasing the level of indebtedness and vulnerability. Thus, not only does the response discourage individuals from seeking support in the future, but it also makes recovery more difficult. There must be a fundamental change in the management of drug consumption and supply within the prison estate, and a more effective and co-ordinated multi-agency approach to support recovery.

Concluding Thoughts

Understanding the relationship between the illicit economy, drug supply and recovery begins by recognising that the drug economy provides relief for both dealers and users. For both groups, it is an adaptive response, but one where there are clear winners and losers. Whilst supply reduction techniques and strategies have a role, they are both intended and unintended consequences that might exacerbate vulnerability, increase violence, self-harm, and even death. Not only do supply reduction techniques need to be proportionate, and avoid limiting opportunities that might promote rehabilitation, desistance and hope, but they have to be coupled with a commitment to effectively address the factors that promote demand. There must be a whole prison approach to supporting recovery, and one that provides human conditions, timely and appropriate access to basic, where staff govern willingly and competently, and where there is an emphasis on preventative, intelligence led efforts.

16. Liebling, A. Arnold, H. and Straub, C. (2011) An exploration of staff-prisoner relationships at HMP Whitemoor: 12 year on. Cambridge: University of Cambridge Institute of Criminology.

PRISON SERVICE JOURNAL

Purpose and editorial arrangements

The *Prison Service Journal* is a peer reviewed journal published by HM Prison Service of England and Wales. Its purpose is to promote discussion on issues related to the work of the Prison Service, the wider criminal justice system and associated fields. It aims to present reliable information and a range of views about these issues.

The editor is responsible for the style and content of each edition, and for managing production and the Journal's budget. The editor is supported by an editorial board — a body of volunteers all of whom have worked for the Prison Service in various capacities. The editorial board considers all articles submitted and decides the outline and composition of each edition, although the editor retains an over-riding discretion in deciding which articles are published and their precise length and language.

From May 2011 each edition is available electronically from the website of the Centre for Crime and Justice Studies. This is available at http://www.crimeandjustice.org.uk/psj.html

Circulation of editions and submission of articles

Six editions of the Journal, printed at HMP Leyhill, are published each year with a circulation of approximately 6,500 per edition. The editor welcomes articles which should be up to c.4,000 words and submitted by email to **jamie.bennett@hmps.gsi.gov.uk** or as hard copy and on disk to *Prison Service Journal*, c/o Print Shop Manager, HMP Leyhill, Wotton-under-Edge, Gloucestershire, GL12 8BT. All other correspondence may also be sent to the Editor at this address or to **jamie.bennett@hmps.gsi.gov.uk**.

Footnotes are preferred to endnotes, which must be kept to a minimum. All articles are subject to peer review and may be altered in accordance with house style. No payments are made for articles.

Subscriptions

The Journal is distributed to every Prison Service establishment in England and Wales. Individual members of staff need not subscribe and can obtain free copies from their establishment. Subscriptions are invited from other individuals and bodies outside the Prison Service at the following rates, which include postage:

United Kingdom		
single copy	£7.00	
one year's subscription	£40.00	(organisations or individuals in their professional capacity)
	£35.00	(private individuals)
Overseas		
single copy	£10.00	
one year's subscription	£50.00	(organisations or individuals in their professional capacity)
	£40.00	(private individuals)

Orders for subscriptions (and back copies which are charged at the single copy rate) should be sent with a cheque made payable to 'HM Prison Service' to *Prison Service Journal*, c/o Print Shop Manager, HMP Leyhill, Wotton-under-Edge, Gloucestershire, GL12 8BT.

PRISON SERVICE JOURNAL

This edition includes: