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Research paper

Conspicuous by their abstinence: The limited engagement of heroin users in English and Welsh Drug Recovery Wings

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ABSTRACT

Background: In recent years, an abstinence-focused, 'recovery' agenda has emerged in UK drug policy, largely in response to the perception that many opioid users had been 'parked indefinitely' on opioid substitution therapy (OST). The introduction of ten pilot 'Drug Recovery Wings' (DRWs) in 2011 represents the application of this recovery agenda to prisons. This paper describes the DRWs' operational models, the place of opiate dependent prisoners within them, and the challenges of delivering 'recovery' in prison.

Methods: In 2013, the implementation and operational models of all ten pilot DRWs were rapidly assessed. Up to three days were spent in each DRW, undertaking semi-structured interviews with a sample of 94 DRW staff and 102 DRW residents. Interviews were fully transcribed, and coded using grounded theory. Findings from the nine adult prisons are presented here.

Results: Four types of DRW were identified, distinguished by their size and selection criteria. Strikingly, no mid- or large-sized units regularly supported OST recipients through detoxification. Type A were large units whose residents were mostly on OST with long criminal records and few social or personal resources. Detoxification was rare, and medication reduction slow. Type B's mid-sized DRW was developed as a psychosocial support service for OST clients seeking detoxification. However, staff struggled to find such prisoners, and detoxification again proved rare. Type C DRWs focused on abstinence from all drugs, including OST. Though OST clients were not intentionally excluded, very few applied to these wings. Only Type D DRWs, offering intensive treatment on very small wings, regularly recruited OST recipients into abstinence-focused interventions.

Conclusion: Prison units wishing to support OST recipients in making greater progress towards abstinence may need to be small, intensive and take a stepped approach based on preparatory motivational work and extensive preparation for release. However, concerns about post-release deaths will remain.

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Introduction: A shifting landscape: UK drug policy, recovery, and prisons

The British prison system receives over 130,000 admissions per year (Patel, 2010:18), with 3935 women and 82,042 men imprisoned as of November 2015 (Ministry of Justice, 2015). Many of these prisoners have problematic relationships with alcohol or drugs. The Report of the Prison Drug Strategy Review Group (Patel, 2010) noted that 69% of new prisoners identify that they have used drugs in the previous year, with 40% of these reporting injected drug use within the preceding 28 days (2010:18–19). This scales up to present a substantial organisational challenge to both prison and health services, with 64,379 opioid substitution therapy (OST) treatment episodes in English prisons in 2012–13 (Hansard 3rd December 2012: column 667W).

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Following their election in 2010, criminal justice drug treatment offered an opportunity for the UK's Coalition Government to establish a new approach to a longstanding political concern, breaking the 'drugs-crime cycle' (e.g. Home Affairs Committee, 2012). The Coalition's first Drug Strategy consequently announced an initiative bringing 'wing-based, abstinence focused, drug recovery services' to English and Welsh prisons (HM Govt, 2010:12). A Ministry of Justice Green Paper contemporaneously highlighted a renewed 'focus on recovery outcomes, challenging offenders to come off drugs,' identifying 'pilot Drug Recovery Wings' (DRWs) as a key vehicle for achieving these ends (MoJ, 2010:29). This emphasis on abstinence and recovery, and the absence of any mention of heroin users, marked a clear ideological shift away from the policies of the preceding ten years.

In early 2011, five prisons formed the first tranche of DRW pilot sites. These wings were in one Category A and four Category B men's prisons (Category A represents the highest, and Category D the lowest men's security categorisation). They were principally expected to...

> ...offer a route out of dependency for those who are motivated to change... increase the number of short sentenced offenders participating in recovery-focused interventions and... improve continuity of care... between prisons and the community (Powis, Walton, and Randhawa, 2014:1).

In April 2012, five additional prisons began hosting pilot DRWs. These included two women's prisons, a Young Offender's Institution (YOI), and two Category B men's prisons (PIRU, 2012:2). Host prisons received no additional year-on-year resourcing, though some received £30,000 to fund local evaluations and/or set-up costs. In line with the 2010 Drug Strategy's call for services to be "locally owned and locally led" (HM Govt, 2010:19), all DRWs were expected to develop distinctive operational models tailored to local needs (MoJ, 2010:82).

Though Government documents shied away from explicitly identifying abstinence from OST as DRWs' core goal, this was a clear part of their conceptual evolution. DRWs fit within a broader recovery movement, which emerged as a reaction to the long-term dominance of treatment services by heroin users receiving OST. The term 'heroin users' is significant here, as the rise of OST can be explicitly traced back to a drive by New Labour to address the social problems – and particularly the high levels of offending – associated with heroin use (e.g. Boreham, Cronberg, Dollin, & Pudney, 2007; Godfrey, Stewart, & Gossop, 2003; HM Govt, 2002; HM Govt, 2008; Holloway & Bennett, 2004). Under a process described somewhat awkwardly by Seddon, Williams, and Ralphs as the 'riskification' of UK drug services (2012:39), New Labour ensured that drug workers were placed at every stage of the criminal justice system tasked with providing heroin using offenders with rapid access to OST, usually in the form of methadone maintenance (Duke, 2013:47; HM Govt, 2002). As the strapline for the Drug Interventions Programme, a headline New Labour initiative, surmised: 'out of crime, into treatment' (e.g. Home Office, 2008). On one level, this approach was highly successful. By 2006, New Labour had met its aspiration to double the numbers in treatment (HM Govt, 2002:11; HM Govt, 2008:4). Many of these were referred directly into OST by criminal justice agencies (e.g. Jones et al., 2007; Skodbo et al., 2007).

However, a shift in perspective then led to OST being reframed as a problematic drug dependence in and of itself:

> Drug users had been accessing treatment and stabilising their drug use through substitute prescribing... but not necessarily exiting treatment successfully, fully overcoming their addiction and reintegrating into the community (Duke, 2013:47; see also e.g. Ashton, 2008; Easton, 2006).

This call was most vigorously taken up by right-wing think tanks and politicians, and in the run-up to the 2010 general election the Conservative manifesto 'promised to deliver an abstinence-based drug strategy' (Duke, 2013:44) with 'benefit cuts for problem drug users and compulsory residential rehabilitation' (Duke, 2013) intended to encourage OST clients into total abstinence. Similar principles began to guide drug services' commissioning and delivery, with UK's National Treatment Agency calling for an end to people being 'parked indefinitely on methadone' (NTA, 2010).

More broadly, the reconceptualisation of OST as a problematic 'addiction' was part of a move away from a specific focus on heroin as the dominant concern of drug services. Dedicated funding streams for heroin users' treatment were removed, as a renewed call arose for services to focus on 'the person not the substance' (Centre for Social Justice, 2007:19) and to expand treatment for cannabis, alcohol and other drug users. Nonetheless, heroin use continues to act as a specific marker for social disadvantage and particular difficulties in achieving recovery outcomes (e.g. Advisory Council on the Misuse of Drugs (ACMD), 2013; ACMD, 2015). The rise of recovery services and the removal of protected funding arrangements for heroin users thus raises particular questions about the position of heroin users within new service models (ACMD, 2013:17). The ACMD's Recovery Committee cites US population studies indicating 'that most people who experience a period of dependence on alcohol, cocaine, or cannabis, overcome that dependence and remission is the 'norm'' (ACMD, 2013:10), making such individuals appealing targets for recovery services in an era of performance monitoring, regular recommissioning, and the prospect of Payment by Results (HM Govt, 2010:20). Simultaneously, the ACMD advises tempered expectations of recovery outcomes for heroin users, contending that the most straightforward routes to abstinence, 'forced detoxification and time-limited opioid prescribing' (2013:17), lack an evidence base and may cause harm. Instead, the report calls for 'an extensive approach... for a number of years, especially for the UK population of ageing heroin users' (2013:54). Changes to service structures consequently have the potential to place unrealistic expectations on heroin users, whilst withdrawing any protection for their levels of funding.

One of the core factors hindering heroin users' progress towards abstinence is their lack of 'recovery capital,' defined by White and Cloud as...

> ...the quantity and quality of internal and external resources that one can bring to bear to initiate and sustain recovery from addiction (2008:29).

As Cloud and Granfield surmise, a priori this has weighty implications for an individual's prospects of achieving recovery outcomes:

> An individual's capacity to terminate chronic substance misuse is very much a function of the resources that s/he has developed and maintained over the course of his/her life (Cloud & Granfield, 2008:1981).

Indeed, the 2010 Drug Strategy acknowledges this, and clearly identifies that recovery services should build 'on the recovery capital available to [service users]' (HM Govt, 2010:18).

Studies have found that heroin users have fewer recovery resources than people dependent on other drugs (Jones et al., 2007; Social Exclusion Unit, 2002), whilst heroin dependent offenders are more disadvantaged still. When compared with other arrestees, Boreham et al. identified that heroin users had one-fifth the levels of employment, and were three times as likely to be sleeping rough (2007:24–25). Half had left school before the age of 16, and a similar proportion grew up in care (Boreham et al., 2007:25–26).

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