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Establishing a 'Corstonian' continuous care pathway for drug using female prisoners: linking Drug Recovery Wings and Women's Community Services

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ABSTRACT

This article outlines the findings from a rapid assessment of pilot Drug Recovery Wings (DRWs) in two women's prisons and compares the DRW approach with work undertaken in Women's Community Services (WCSs) commended by the Corston Report (2007). The findings indicate that DRW1 was working more successfully in providing a 'Corstonian' approach than DRW2 and the reasons behind this are explored. The paper argues that, whilst pockets of good practice such as WCSs and 'Corstonian' DRWs are to be commended, unless there is a continuous care pathway, modelled on Corston's ideas for working with vulnerable female offenders such as recovering drug users, such work will be limited in its effectiveness. Ideas for how such a systematic approach might work will be outlined.

Key words: Prison, recovery, drug treatment, abstinence, women offenders, Corston report

INTRODUCTION

In 2007 Baroness Jean Corston produced a review of women with particular vulnerabilities in the criminal justice system (CJS). Corston called for radical changes in the way in which the CJS 'manages' such offenders. She argued for a holistic, woman-centred approach, sensitive to the complex needs of most women offenders; an emphasis on appropriate punishment in the community for low risk, non-violent women offenders; and the abolition of large prisons in favour of small geographically dispersed custodial units (Corston, 2007). The *Corston Report* also highlighted the key role drug use plays in women's offending and observed that women in prison were frequently serious Class A drug users: *"It was not uncommon to have £200 a day crack and heroin habits disclosed"* (Corston, 2007, p4).

This article outlines the findings from a rapid assessment of pilot Drug Recovery Wings in two women's prisons. It draws out the idea that the approach taken by one of the DRWs was very similar

to a 'Corstonian' approach emphasising women-centred, individual and holistic treatment - and in this way had much in common with the work undertaken in WCSs. One of the DRWs (hereafter known as DRW1) was working more successfully in providing a 'Corstonian' approach than the other (hereafter known as DRW2) and the contrasts and the reasons behind this are discussed. The paper will argue that, whilst pockets of good practice such as WCSs and DRWs are to be commended, unless there is a continuous care pathway connecting the two services and modelled on Corston's ideas for working with female offenders with vulnerabilities, such as recovering drug users, such work will always be limited in its effectiveness. Ideas for how such a systematic approach might work are outlined.

BACKGROUND

The complex needs of women prisoners

Whilst the *Corston Report* is rightly regarded as raising political awareness about the vulnerability of women prisoners (House of Commons Justice Committee, 2013), the issues it raised have been well known in academic and campaigning fields for decades. Namely that the majority of women in prison have highly complex needs, suffer from multiple disadvantages and that their offending is often directly caused by the impoverished and difficult social circumstances in which they live – exacerbated by substance misuse, mental health issues, and experiences of physical, mental and/or sexual abuse (see *inter alia* Malloch and McIvor, 2011; Hamilton and Fitzpatrick, 2006; Gelsthorpe and Morris, 2002; Moloney and Mollor, 2009; Leverentz, 2006). As Evans and Walklate (2011) point out, Corston was clear in her emphasis that the vulnerability of women offenders was not to do with their individual deficits but instead was caused by external factors in their lives over which they had no control. This is an important distinction given that it has been argued that the label of vulnerability within a criminal justice policy framework can be used to further marginalise and stigmatise already powerless groups and imply that they are not capable of rational adult behaviour (Brown, 2015).

There is also clear agreement in academic and campaigning fields that prisons are not the best places to help women offenders overcome their difficult life experiences and move on to lives free from abuse, drug and alcohol use and crime (Carlen and Tombs, 2006; Barlett, 2007; Clarke, 2004). Indeed it has been argued that time in prison exacerbates women's problems to the extent that they return to the community in a far worse position that they were before their sentence (Barry and McIvor, 2010). There is also evidence that women are often sent to prison unnecessarily despite frequently presenting a low risk to the public and most commonly committing low level non-violent offences (McIvor and Burman, 2011). Just 3.2% of women in prison are assessed as being of high or very high risk of harm to others (NOMS Women and Equalities Group, 2012). It has been argued that this over-incarceration is because of a lack of effective community sentences for women (Carlen and Tombs, 2006); or because sentencers believe that the nature of women's lives (particularly those involved with drugs or alcohol) mean that they will not be able to cope with the conditions of community sentences (ibid); or, due to sentencers sending women to custody to get the help they need, for example with drug misuse[10], because they do not believe they will get this help in the community (McIvor and Burman, 2011).

The significant damage done by separation from their children can be the most painful consequence for women prisoners to bear (Hardwick, 2012; Covington, 2002). The longer term impact of this separation must also be borne in mind – in 2010 more than 17,000 children were separated from their mothers in England and Wales due to incarceration. Only nine per cent of these children were cared for by their father (Dean, 2013) and only five per cent remained in the family home (PRT, 2011). Women prisoners are also often in a worse position than males on release. It is far less likely that their partners will have maintained a family unit whilst they have been in prison, and often they

[10] Drug misuse was defined by the Advisory Council for the Misuse of Drugs (1982) as: *'Any person who experiences social, psychological, physical or legal problems related to intoxication and/or regular excessive consumption and/or dependence as a consequence of his or her use of drugs or other chemical substances'.*

are not able to return to their family home due to the risk of (further) violence (McIvor, Trotter and Sheehan, 2009). Brown and Ross (2010) highlight the absence of social support available for women on release – often because their partners are part of the problem rather than the solution. This results in many women leaving prison homeless, unemployed and without custody of their children.

Specific issues for drug using female offenders

The link between drug use and female criminality is very strong (Covington, 2002). Globally, more women are incarcerated for drug offences than for any other crime (Moloney and Moller, 2009). Drug use amongst women offenders is exceptionally high – higher than amongst male offenders - and is often the key driver in their offending. Female prisoners are more likely than males to report Class A drug use in the month before entering prison and to report that their offending was directly linked to supporting that drug use (or someone else's drug use) (Light et al, 2013). Women are more likely than men to report needing help with their drug use on entry to prison (49% compared to 29%) (ibid) and around 70% require clinical detoxification in comparison with only 50% of male prisoners (Corston, 2007; PRT, 2013). Many women are however reluctant to seek out help for their drug use (either in prison or the community) for fear that their children will be taken into care (NTA, 2010b). Conversely, research suggests that once in treatment, women are more likely than men to engage, stay longer and get better results (ibid).

The reasons behind women's drug use are more complex than that of men (NTA, 2010b) – particularly in terms of the reasons they start using drugs which is often to cope with physical and emotional pain caused by abuse or other childhood and adult trauma (Barlett, 2007). Dreissen et al (2006) reported that of the 70% of their sample of women who reported a history of child sexual abuse, 98% also reported substance misuse – predominantly heroin - and most of the women cited that abuse as the principal cause of their drug problem and thus their offending. Borrill et al (2003, p18) report that practitioners in their study found women prisoners to be *'particularly complicated,*

hard-core, end-stage drug users' and acknowledged that some women continued to use drugs in prison in order to cope with the significant stress they experience – particularly due to separation from their children (see also Barlett, 2007).

It should be acknowledged however, that time in prison can result in an improvement in health for drug using women. Regular meals, shelter and protection from violence can improve both mental and physical health (Plugge et al, 2006). Women themselves acknowledge this (Douglas et al 2009) saying that prison allows them some respite from the stresses of their lives on the outside, gives them the time to reflect on their lives, their drug use and how this was linked to their offending and gives them the opportunity to access the help they need in a relatively safe environment – isolated from drug using environments on the outside. It must be equally acknowledged however, that this can never be sufficient reason for sending a woman to custody given the other highly negative consequences of doing so (ibid).

The Work of Women's Community Services

Baroness Corston highlighted the work of Women's Centres (now more commonly referred to as Women's Community Services (WCSs)) and the holistic approach used by them which offers a tailored and individualised approach for each woman rather than a 'one-size fits all' intervention (Hedderman et al, 2008). She recommended that a network of such WCSs be established to work with women offenders and women at risk of offending (NAO, 2013). There are now around 31 WCSs in England and Wales[11] which aim to provide a women-only space which is both physically and emotionally safe and which offer a tailor-made programme of support in a non-judgemental and empathetic environment. The majority of referrals come from the Probation Service with around

[11] The situation in Scotland differs somewhat though the 2012 report from the Commission on Women Offenders recommends the establishment of Community Justice Centres for women offenders which are likened to WCSs in England and Wales.

38% of clients involved with the criminal justice system[12] and around 11% attending as part of a community order (Women's Breakout, 2011). It is argued that in this environment women are listened to, treated as equals and encouraged to become independent through the provision of practical support and one-to-one relationships with key workers (Nicholles and Whitehead, 2012). The programmes clearly recognise progress and achievement whilst acknowledging the reality of relapse and regression (ibid). A woman might be offered mentoring, self-esteem courses, debt advice, training and employment support, counselling and referrals on to more specialist agencies (Hedderman et al, 2008). The supportive relationships the women are able to develop both with their support workers and with their peers are essential (WRC, 2007). Empathy and understanding on the part of workers is seen as crucial by clients – whom research suggests feel that in WCSs they are accepted for who they are, listened to, and treated fairly and respectfully (Malloch and McIvor, 2011; WRC, 2007).

The Work of Drug Recovery Wings

In 2010, the UK Government's Drug Strategy established an intention to bring *'wing-based, abstinence focused, drug recovery services'* to English and Welsh prisons (HM Govt 2010, p12). At the same time, the Ministry of Justice Green Paper called for 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 (Ministry of Justice, 2010, p29). Pilot DRWs were to be *'entered on a voluntary basis by offenders who have the goal to be drug free'* (PIRU 2012, p2). In April 2012, five additional prisons began hosting pilot DRWs. These included two women's prisons (PIRU 2012, p2). A subset of DRW pilots was allocated £30,000 of capital funding and resources for local evaluation, but none received any additional year-on-year resources. The nature of the pilot DRWs differed considerably as individual prisons were expected to develop operational models in response to local

[12] This figure from Women's Breakout (2011, p4) includes women with a 'live' offence or sentence; those with outstanding sentences; those serving a community order or paying a fine and those who have been recently released from custody on licence.

needs (Ministry of Justice 2010). DRWs are also situated within the recent broader recovery movement leading to a call for drug services to focus on *'the person not the substance'* (Centre for Social Justice 2007, p19), and an end to people being parked indefinitely on methadone (NTA 2010b). This move towards recovery, and therefore implicitly away from harm reduction treatment toward abstinence-based programmes, is not without its critics. One concern is that the new focus on payment-by-results – with the result being abstinence – will encourage service providers to 'cherry pick' clients and thus reject those with more complex needs amongst whom are likely to be women offenders (Duke, 2013). Furthermore, women offenders are likely to struggle to easily develop the requisite 'recovery capital'[13] required to achieve abstinence due to their higher rates of mental health issues, experiences of abuse and violence and greater social stigma (Cloud and Granfield, 2008).

THE DRW RESEARCH

Methodology

In 2012 the Department of Health commissioned the University of York to lead a team of researchers from York, Glasgow and Cambridge to undertake a process and impact evaluation of the NOMS pilot Drug Recovery Wings. The evaluation aims to provide a detailed description of the operation of individual DRWs and to assess the degree to which participation within a DRW facilitates individual prisoners' recovery and rehabilitation.

In early 2013, five researchers undertook rapid assessments of all ten NOMS pilot DRWs. Researchers aimed to conduct semi-structured interviews with ten DRW staff and ten DRW prisoners in each institution, and secured a total of 94 staff and 102 prisoner interviews. The latter represented a convenience sample, with researchers relying on supportive staff to identify and unlock prisoner interviewees. All interviews were fully transcribed. NVivo 9 was used to code and

[13] Cloud and Granfield (2008) emphasise four components of recovery capital: social capital (relationships and social networks); physical capital (income, property and other assets); human capital (education, skills, health and aspirations); and cultural capital (attitudes and beliefs that link to social conformity).

analyse all transcripts, using an emergent and grounded coding system (Seale 2004). This progressed through an axial coding stage to a fully selective coding system (ibid).

Alongside the process and impact evaluations of the DRWs, a Measuring the Quality of Prison Life (MQPL) survey was undertaken in both of the women's prisons, with an oversampling of DRW cohorts allowing comparisons between the quality of life in DRWs and the wider prison population. The MQPL includes 128 items answered on a 5 point Likert scale. These are then organised into twenty-one subscales that form five conceptual categories: harmony, professionalism, security, conditions and family contact, and wellbeing and development[14].

Ethics

Ethical permission for the study was sought and received from three different bodies[15].

Structure of the DRW programmes

Both DRWs were physically separate from the rest of the prison, with the women eating and living together on the DRW. At the time of the research there were 11 women living on DRW1 and nine on DRW2 with a final target for both to accommodate 20 women. On both DRWs there were eight members of staff working on the wing – at DRW1 these were all drug workers; whilst at DRW2 they were all discipline staff[16]. On DRW1 the women's days were divided into two – with mornings dedicated to their recovery programme and afternoons involving education and/or employment and key worker sessions. In addition, there were compulsory community activities two nights per week and two gym sessions. The holistic approach taken in DRW1 was clear from the programme. Whilst drug-focused work was evident, a variety of aspects of a woman's life were worked on to support her recovery from drug use. On DRW2, the women were totally isolated from the rest of the prison,

[14] For a full explanation of the MPQL see Liebling & Arnold (2002).
[15] The University of York Department of Health Sciences Research Committee, The National Offender Management Service National Research Committee and the NRES Committee East of England - Essex
[16] On DRW1 eight staff included a deputy manager and manager (drug workers). On DRW2, there was an additional manager (prison officer) and one drug worker who was not exclusively attached to the DRW.

they did not work, and so all their time was spent on the DRW. There was a morning meeting at 9.00am and three mornings a week the women attended group work sessions which at the time of the research were all focused on mindfulness. Most afternoons were free time other than two gym sessions.

Referral to the DRW

In both DRWs the referral process was pragmatic and flexible[17] though generally the women were already engaging or had engaged in general substance misuse services within the prison before moving onto the DRW. Women could self-refer or be referred by any member of prison staff at any time in their sentence or indeed whilst on remand. Once referred, the women were assessed by a member of DRW staff or a prison drugs worker who would judge whether the woman demonstrated a clear commitment to recovery and abstinence or needed further intervention before coming onto the DRW. A multi-disciplinary team[18] within the prison then met on a weekly basis to decide whether to offer a woman a place.

Profile of the women

Sixteen women were interviewed[19] in the two DRWs[20]. Table 1 gives a brief overview of the women in terms of age, offending and sentence length.

[17] This flexibility extended to the point that two women (one on DRW1 and one on DRW2) were alcohol misusers.
[18] Comprising drug workers, disciplinary staff, health care staff and the Offender Management Unit.
[19] Eleven members of staff involved in various ways in running the DRWs were also interviewed.
[20] 10 of the 11 women on DRW1 were interviewed and 6 of the 9 on DRW2.

Table 1: Profile of the women

Interviewee	Age	Sentence	Offence
DRW1			
Lacey[21]	44	4 yrs 6 mths	Burglary
Vicky	62	4 yrs 5 mths	Allowing premises to be used for supply of Class A drugs
Jodie	42	3 yrs 8 mths	Supply of Class A drugs
Becky	35	2 yrs	Burglary
Mary	50	16 mths	Fraud/false imprisonment
Samantha	42	14 mths	Shoplifting and dangerous driving
Nicola	34	6.5 mths	Affray and shoplifting (whilst on licence)
Natalie	27	On recall	Not disclosed[22]
Fran	39	On remand	Burglary
Faye	39	On remand	Conspiracy to supply Class A drugs
DRW2			
Faith	31	4 yrs	Burglary
Ruby	31	4 yrs	Robbery
Lucy	35	3 yrs	Burglary (licence recall)
Alice	26	3 yrs	Robbery (licence recall)
Rosie	19	2 yrs 6 mths	Robbery and GBH
Anna	47	5 mths[23]	Shoplifting

It can be seen from Table 1 that only two women were serving less than 12 months. Therefore, in comparison to the average custodial sentence for women of 11.6 months in 2011 (Ministry of Justice, 2012, p74), these women were serving relatively long sentences.

Experiences of drug use and associated problems

The women ranged in age from 19 to 62 years with an average age of 38 and shared very similar profiles in terms of their drug use and associated problems. All but two of the women had a long history of drug use ranging from 8 to 46 years with an average of 17 years use. Most had their main problem with heroin and/or crack cocaine, one had an additional problem with diazepam, another with amphetamines; and two described their key current addiction being to alcohol. Rosie had developed a dependency on Subutex whilst in prison – and said that she had not had a drug problem before entering custody. Several of the women also had a long relationship with methadone – one having been 'stabilised' on it for 15 years before detoxing. The majority of women had undertaken,

[21] All names are pseudonyms.
[22] Natalie was reluctant to divulge details about her sentence length and offence - only that she had been recalled for breach of her licence.
[23] Anna was given a 12 week suspended sentence which she breached, receiving 12 weeks in custody plus 8 weeks for the breach.

or were in the process of undertaking detoxification. One of the prisons insisted on detox on entrance to the DRW (DRW2), the other was more flexible and did not pressure women to detox before participating in the other programmes available on the DRW (DRW1)[24].

Many women described in painful detail the losses they had accrued due to their drug use – three women had had children adopted or taken into care; and many described loss of friends and family connections; and a deterioration of their mental and physical health. Over half of the women described violent, dysfunctional relationships with men – who were often drug users and drug dealers - and several had relapsed back into drug use when these men had come back into their lives on release from prison. Half the women had also suffered the loss of a significant loved one (a parent, child or partner) which had (re)started their drug use:

> *'I lost me son last January to adoption, I've got six children, 4 of them live with me mum, one died of a cot death, which sent me off the rails … I've had enough, I don't want to take drugs anymore, I've lost children through it, I've lost my family through it' (Becky, DRW1).*

> *'It started from when I was raped just before I was 13 and I used it as a way of bunking school and taking substances to escape reality really….' (Nicola, DRW1)*

Peer Support

When asked about the key advantage of being on the programme, the majority of the women talked about peer support as the best aspect, with everyone working towards the same goals and supporting each other in this process. They described how important it was that everyone had the same mind-set and that the usual positive drugs talk and negative aggressive behaviour endemic in prison was not present:

[24] Six of the 10 DRW1 women were already clean or in the process of detoxing; 3 were stabilised on methadone with a detoxification plan prepared for release or if sentenced and the remaining woman's addiction was to alcohol.

'Because we're all like-minded people, we're all wanting the same thing and it's good to see that kind of community spirit' (Vicky, DRW1)

'On here it's different, it's not drug-related, or … the conversation's not about drugs, it's totally different, it's about what we're doing in here'. (Faye, DRW1).

'There's more like support. It's more from the girls than the staff, but we all know what each other's going through. On the normal wing it isn't like that'. (Rosie, DRW2).

Emotional and Physical Safety

Another key advantage highlighted centred on feeling safe, with respondents interpreting this primarily as being protected from drugs in the prison. All the women agreed that in this respect they felt far safer on the DRW that in the main prison and that this aided their recovery. This was achieved in DRW2 by isolation from the rest of the prison population and thus from the temptation of drugs:

'…especially when people are feeling really, really low… if they was just, let them out at gate, and do what they… go where they wanted… they'd be fetching drugs back onto the Unit, and that puts other people at risk as well'. (Lucy, DRW2)

'You could easily go into that main jail to go and get your hands on something. There's probably more drugs in here than there is on the streets.' (Alice, DRW2)

Even in DRW1, where the women went out into the main prison to work in the afternoon, they still felt protected from the temptation to use drugs by limiting their exposure to drug users:

'and you're out and about and you just see them and it's hi, and like if they go to offer you something you can say no, not interested. But if it's in your face 24/7, say on the wing you

were doubled up with somebody, a user, or if you were on the house then it would start to wear you down'. (Lacey, DRW1)

Some women were aware that this safety allowed them to talk more openly and freely about any temptations they were experiencing in a very different environment to that of the main prison:

'I think I feel a lot safer being on here, because you know, if there are feelings of… I'm able to talk about it. I'm able to say, well, why am I feeling like this today, and then we will talk it through'. (Nicola, DRW1)

Others felt safe because, at least for the time being, they knew they would stay on the DRW:

'It feels more at ease in your mind that you're not going to get moved somewhere else. You're settled' (Fran, DRW1)

Non-judgemental and empathetic staff

DRW1 was run exclusively by drug workers rather than discipline staff and several women mentioned the quality[25] of these staff as crucial - the fact that they were available all day for quick and good quality advice and support and that they delivered programmes which were very effective in challenging their old behaviours and working on the underlying causes of their drug use:

'Brilliant absolutely brilliant all of them'. (Jodie, DRW1)

'Very supportive… I don't think that there's anything more that they could do ... than what they do'. (Nicola, DRW1)

[25] See Lloyd et al (forthcoming) for a discussion of the quality of staff in DRWs.

'Up to now, I think they're really good, and they are there. You know, especially in the afternoon, because it's just a morning programme. But yet in the afternoon, they're still here so if you did feel you want to talk, you've just got to knock on the door'. (Fran, DRW1)

It was clear that the relationships on DRW1 both between the women themselves *and* between the staff and the women were paramount in making the quality of life much better than in the main prison. Many women talked about the openness and honesty and the '*give and take'* that made them feel more stable and ready to work on their drug use in an in-depth way. Several women described feeling very settled on DRW1, which meant they could focus on their issues without disruption or distraction. Others talked about how effective their key workers were at helping them make progress, at acknowledging that progress and at getting them to identify some of the issues they had found it difficult to address. Small steps on the way were fully acknowledged, allowing the women to see that they were moving in the right direction and avoiding them being overwhelmed about what they were aiming to achieve.

'Well, we set small goals, so instead of… it's like all my small goals now lead to my long-term ones, but it's not so scary, because the key workers talk us through our small goal settings. And we can actually write them on paper and see our progress' (Nicola, DRW1)

'Yes, they go through each aspect of the Outcomes Star[26] *we go through step by step. I did my Outcomes Star about four weeks ago with* [name of key worker] *and the difference from about three months ago is amazing* [laughs]. *It's quite good you sort of think oh yes I've achieved that' (Vicky, DRW1)*

[26] The Outcome Star tool is able to measure progress (via a score of 1 to 10 with 10 being under control) towards a more stable, drug and crime free life examining aspects of a woman's life including drug and alcohol use, family and community relationships, physical and emotional health, money and accommodation and meaningful use of time. It is commonly used in WCSs (Owers, 2010) and in DRW1. For further details see http://www.outcomesstar.org.uk/.

'I think that the facilitators by meeting with us on our one to ones and talking and now because we have got to know them we are releasing a bit more our suicidal – so a lot more's coming out, a lot more…' (Mary, DRW1)

In contrast, relationships on DRW2, which was run predominantly by discipline staff with only a small input from drug workers, were more strained. The key issue here, even with those staff who the women found generally sympathetic towards them, was their lack of understanding of the process of detoxification when powerful emotions can emerge after years of masking them with drug use (see Borrill et al, 2003):

'When the girls are going through detox and that they [staff] *don't understand the shouting and all the girls' emotions are coming out. All our emotions are out. They're just going to burst into tears and not know what they're crying for and they're going to end up getting warnings, negative comments shouted back at them' (Alice, DRW2).*

'A lot of the girls have had a quite a few problems with different members of staff. They're not supportive, they don't do nowt for you, they don't understand detox, and to an extent I think that is true'. (Lucy, DRW2)

Others were more vitriolic about the staffs' lack of understanding:

'They've got a bad attitude… It's like they shouldn't work up here. It's like they hate drug users or something. Some of them are alright. They say that these officers were handpicked. I'm sorry but whoever picked them don't know nothing about doing a detox… they treat us like children and it's wrong'. (Rosie, DRW2)

'They don't understand detox… here it's closed off, it's us and them. Now for this unit to work… they have to have an understanding, it can't work and it's not working with staff up

here… for me they either get taken away from it and go and do some training…' (Anna, DRW2)

These findings mirror those from Coles and Sandler which suggested that withdrawal and detoxification was often poorly managed in prison and *'framed in the context of punishment, rather than care' (2008, p29)*.

One stop shop

The other most commonly mentioned advantage, again predominantly on DRW1, was the contact with outside agencies which gave the women options for accessing support in the community both in terms of drug treatment and more generally. It was clear too that getting help within one setting was really appreciated.

'Well you can access them through the facilitators, if you really think you want to go down into their agency or whichever area, then they'll set it up for you – what they call through the gate care' (Vicky, DRW1).

'So I think the massive thing is that organisations come in to help us for when we get outside. It's the throughcare that's best for me, because even though I'm going to rehab, I want all these ideas for when I get out of rehab, when I'm starting on my own in my life to rebuild myself' (Nicola, DRW1).

Having ex-users come in seemed particularly useful in providing role models for the women and offering them real hope that long term change was possible:

'We've had quite a few come through and talk and we've had ex-offenders and ex-drug addicts coming through … it is [helpful] *because you can see how well they've done and think oh god, I want to be there'. (Vicky, DRW1).*

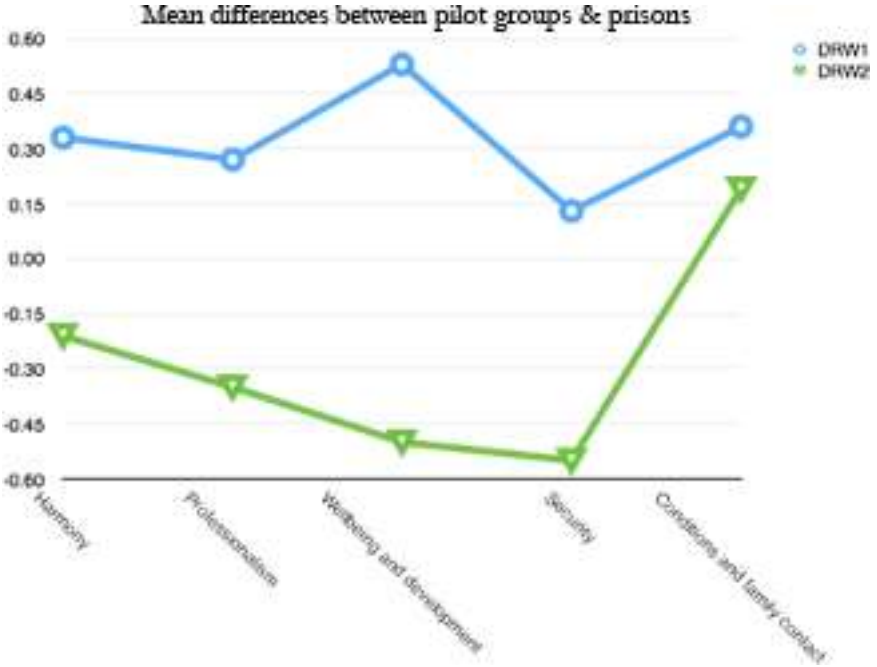
Measuring the quality of prison life analysis

The MQPL findings (Table 2) supported the contention that DRW1 provided a better quality of life than both Prison 1, and DRW2. Where direct comparisons were made between DRW and non-DRW scores, independent samples t-tests were used. The robustness of t-test when applied to small samples has been well documented, even when the distribution of scores deviates considerably from a Gaussian ideal (see, for example, Howitt and Cramer 2005:122). In such conditions, the main risk is of a type II error (see, for example, de Winter 2013). As is documented below, the differences between DRW and non-DRW conditions were such that this was not much of a consideration in our case. DRW1's quality of life scores were higher than those of other prisoners on twenty (out of twenty-one) subscales, and all five factors. These differences achieved statistical significance in four cases, with values of $p<0.06$ in a further three. Contrastingly, DRW2's quality of life scores were lower than those of non-DRW prisoners on all twenty-one subscales, and all five factors. Five attained statistical significance at the $p<0.01$ level, with women offering particularly low scores on wellbeing, safety, policing and security. The contrast between the two regimes was further demonstrated by a question asking respondents to rate their overall quality of life on a scale of 1-10. DRW1's score was slightly higher than Prison 1's score, at 6.3 compared to 5.6; whereas DRW2's score of 3.7 was significantly lower than that of Prison 2 (5.6, $p=0.021$). Strikingly, such differences stood out even when analyses were expanded to include men's prisons. DRW1 evidenced the highest mean difference across sites, and ranked in the top three for all five factors. DRW2 evidenced the lowest comparative score across sites, placing eighth out of eight on all but one factor. This analysis supports the findings from the qualitative research and reinforces the deduction that DRW1 was able to offer women prisoners a better and more supportive environment than they would have had otherwise in the wider prison population.

Table 2: Comparison of MQPL scores

	DRW1			DRW2		
	DRW	Rest of Prison	Difference	DRW	Rest of Prison	Difference
Harmony	3.38	3.05	**0.33**	2.93	3.14	**-0.21**
Professionalism	3.11	2.84	**0.27**	2.58	2.93	**-0.35**
Well-being and development	3.48*	2.95	**0.53**	2.46*	2.96	**-0.50**
Security	3.31	3.18	**0.13**	2.68*	3.23	**-0.55**
Conditions and family contact	3.68	3.32	**0.36**	3.64	3.45	**0.19**

* $p < 0.05$[27]



[27] No findings were significant or marginally significant at any level other than $p<0.05$.

Leaving the DRW

There was little consistency in where the women were moving on to once they finished their programme on the DRW. This was partly due to the flexible approach to referrals onto the DRWs which happened at various points in the women's sentences resulting in some women being released straight into the community but others having more time to serve in prison. Ideally, most hoped to stay until they were released and because neither DRW was full at the time of the research, it had been possible to continue to accommodate women who had completed the programme but still had some of their sentence to serve. However, this was unlikely to remain the case as referrals increased.

It is of significant concern that neither DRW had established a clear exit strategy[28] and that this caused considerable anxiety for prisoners who were worried about the lack of support they might face when they had completed the programme. The majority of the women were very anxious about any move back into the main prison population, even if this was to a drug-free wing:

> *'It's being around negative people, negative behaviours. You find yourself slipping back into it or thinking it's only a lapse. One time won't matter. But you're telling yourself that all the time out there when you use'. (Lacey, DRW1)*

However, a few of the women did see a move into the main population as a good way to test their resilience to temptation prior to release. Several women also voiced fears about being living in hostels on release in terms of being unsafe and due to easy access to drugs:

> *'I'm frightened of going out into hostels and all because I've been there and I know the situations'. (Mary, DRW1)*

[28] The Women's Custodial Estate Review (Robinson, 2013) recommended the establishment of an open unit at Styal prison to provide a pathway from prison to employment in their local community. This is currently in development.

'I think the biggest mistake the prison service has ever, ever made, in my opinion, is, when people get out of jail they put them in hostels. Now, the hostels are rife. In London there's dealers living in them' (Lacey, DRW1).

There was awareness amongst several of the women that they would need to continue to engage with drug services on release and that their time on the DRW was not the end of their recovery journey:

'*From the very first day I came here… I was thinking about going to rehab anyway' (Fran, DRW1)*

'I feel that I need a little bit of time away to re-establish myself, get used to life again … substance free, and re-integrate myself back into the community with the help of the rehab'. (Nicola, DRW1)

Others expressed how important a safe home, work to provide structure and a supportive partner would be to their continuing in recovery:

'*I'm from* [city] *but I live in* [town], *my partner's from* [town] *and then I'm going to get into supported housing. I'm trying to link up with some voluntary work as well to keep me occupied'. (Samantha, DRW1)*

'Whether its voluntary work or not, I need something to keep me occupied while I'm out there, and agencies to work with me. Because I'll still need that support, even though I've got [name] *my partner there, I'll still need support from different agencies and that' (Faith, DRW2).*

A similar approach?

The work carried out by WCSs was highlighted by Corston (2007) as good practice for working with women offenders and there is evidence from this research that the work carried out by DRW1 reflects much of the same good practice. Both DRW1 and WCSs are able to provide safe, non-

judgemental, supportive environments, where women's self-esteem, confidence and independence are built up through a variety of interventions – offering a combination of therapeutic and practical support within a supportive community. The approach in both is holistic and focuses on the complexity of each woman's criminogenic needs rather than solely addressing drug use or offending behaviour.

Both DRWs and WCSs are also safe places – for the DRWs this safety centred on being protected from the temptation of drugs available in the wider prison; for WCSs this is more about keeping women safe from risky and dangerous people and environments. Like WCSs, DRW1 offered an emotionally safe place too, where women felt more able to open up about their issues and concerns. It is important to note that isolation in prison is likely only to be a protective factor if other conditions are met too – in DRW2 the women were isolated but bored and insufficiently supported – which over time might impact on their resolve to stay drug free.

Whilst neither DRW was women-only (because of mixed-gender staffing), the strength that the women were able to gain through women-only peer support and through living in a like-minded community was key to their recovery, as it is in WCSs. In addition, the relationships the women developed with their key workers in DRW1 reinforced this support and again echo the importance of that relationship in WCSs.

The work done in both DRW1 and in WCSs is also able to emphasise and value women's progress towards their goals rather than being simply focused on final outcomes. This is essential, as very few women will make a simple linear journey towards a crime and drug free life so acknowledging more minor achievements on the way is crucial.

Expanding the approach?

This similarity of approach suggests that there is scope for both DRW1 and the WCSs to be used as models of good practice which could inform practice more widely within the criminal justice system for treating drug-using women offenders (and indeed, non-drug-using women offenders). There are a number of factors to consider in developing such practice. First, such an approach should examine the role WCSs might play as places to release women directly from prison and, in particular, directly from a 'Corstonian' DRW. Such a model would provide continuity of care, connecting women immediately to the community and assisting them to access the complex range of agencies who can offer them help, whilst maintaining the peer and key worker support they have had whilst in prison. Connection with the WCS could be made towards the end of the woman's sentence so that appropriate interventions could be agreed upon for her release. Whilst ideally it could be argued that many of these women do not need to have been in prison in the first place – it has to be acknowledged that the length of sentence many of the women in both DRWs were serving does suggest that they were at the more serious end of women's patterns of offending and thus, similar women are likely to continue to be given custodial sentences. Therefore realistically careful thought needs to be given as to how best to help them during their sentence. Equally, if such good practice was more widely established and consistently available it might be that, over time, WCSs could offer a legitimate alternative to custody – particularly in cases of remand or breach where they might be also able to provide alternative women-only accommodation which would protect women from inappropriate and risky mixed-gender bail hostels (Fawcett Society, 2009).

Above all, there has to be far more consistency in terms of what is on offer. This could be achieved by moving to a 'Corstonian' model of continuous care throughout a woman's sentence. First, the geographically dispersed custodial units advocated by Corston (2007) could be established. Each custodial unit could be modelled on a DRW1 type intervention which, given the holistic programmes available, could work with both drug using and non-drug using women and could be connected to a

specific WCS in the local community with a planned exit strategy straight from the custodial unit to the centre. This model would ensure that the key workers in the WCS were able to design support for the woman fully informed of progress made whilst in custody, building directly upon that progress and focussing on what she now needs to move towards an independent, drug and crime-free life. WCSs could also offer accommodation for women on release so that again they could avoid inappropriate hostel accommodation (Fawcett Society, 2009) and in time be able to take responsibility for their children. This model is already available at the 218 Centre in Scotland (Malloch et al, 2008) and there have been calls to expand such provision more widely throughout Scotland (Barry and McIvor, 2010; Commission on Women Offenders, 2012).

Whilst acknowledging that some women are already receiving the kind of good wraparound and throughcare[29] consistently linking such custodial units and WCSs could provide the type of long term support that all drug using women offenders need. It is clear that without such support, it is all too easy to slip back into a life of drug use and crime (Covington, 2002). Women clearly realise themselves that they need help, particularly from drug services, as soon as they are released (Turnbull and Hannah-Moffatt, 2009). It is equally clear that for some women, help for their substance misuse ends when they leave prison - particularly those women who are serving under 12 months (WIP, 2012) undermining all their progress made whilst in prison. However, at least for the time being, Corston's idea of custodial units has been rejected by the Government (Robinson, 2013) limiting the possibility of establishing a systematic way to establish a continuous care pathway for drug using women offenders.

[29] For example the Together Women Project now runs a drop-in centre at New Hall prison to aid the development of appropriate release plans and to connect them to their Women's Community Centres on release (http://www.togetherwomen.org/about-twp/resettlement).

Declaration of interest

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