Scottish Recovery Consortium

Prison Drug Treatment

A rapid review of evidence

November 2024

SRC SCOTTISH RECOVERY CONSORTIUM

Contents

Background

Over the last few years there has been a national focus on drug related deaths and the impact and harm associated with problematic substance use. The Rights, Respect and Recovery national strategy (2018) acknowledged the harm associated with problematic drug and alcohol use and it reaffirmed the Scottish Government's focus and commitment in reducing drug related deaths in Scotland. The policy also highlighted the increased number of people entering prison with problematic substance use and outlined the critical role all partners have in developing recovery-oriented systems of care in addition to medical treatment approaches for those most at risk of drug and alcohol related harm. It also provided the opportunity to create parity and equity for those people within the prison estate being able to access the same recovery activities and support as those within communities across Scotland.

Whilst it is now widely recognised and acknowledged the integral nature of lived experience, recovery, mutual aid, and peer support being aligned to treatment and support in the community, the work to embed, integrate and develop drug and alcohol recovery support in prisons is still in early development. Scottish Recovery Consortium have been working in prisons in Scotland for the past 3 years to develop recovery. The learning we have developed from our initial work can provide the basis to build and grow prison-based drug and alcohol recovery support and activities across all prisons in Scotland.

In 2024, SRC were funded by Scottish Government to expand the reach of recovery development in prisons.

Our aim is to support systemic, cultural, and operational change across the national Scottish Prison Service (SPS) estate to integrate and embed person-centered recovery from alcohol and drug substance use. This will be achieved by building understanding and implementation of a recovery focused approach which benefits prisoners, families, and all staff throughout our prisons in Scotland. This work will build coordinated and connected recovery pathways throughout SPS establishments and our communities to support the recovery pathway upon liberation for individuals who engage and participate.

Project Aims

"Through a partnership and collaborative approach, the Prison Recovery Project will create and embed an integrated and consistent approach to drug and alcohol recovery support and activities of care within the prison estate across Scotland. This approach will increase the opportunities for people to have access to drug and alcohol recovery support, mutual aid and peer support within the prison and create robust and community recovery pathways when people leave prison and return to their community".

By prioritising sustainable recovery alongside current SPS operational practice and strategic policy, we aim to not only improve Recovery Orientated Systems of Care (ROSC) and recovery options for the prison population but contribute to strategic outcomes around health, wellbeing, and choice. Developing access to recovery options and choice in prison and creating links to the community helps individuals find their own type of recovery and can potentially increase the positive destinations as people return to their own community. Creating a model of recovery options and choice will support the prison population to receive an equivalent or similar recovery model as they would find in their community setting.

To build on our initial findings over the first three years an independent external evaluation (conducted by Russell Wester) will assess the extent to which the project achieves its primary aim of promoting recovery culture in prisons. A process evaluation will provide real time feedback on emerging critical success factors and barriers to establishing a recovery culture in Scottish Prisons – and how to overcome them. The outcome evaluation will be set in the context of the current evidence base and will triangulate findings from data analysis, interviews with key stakeholders and interviews with people in prison using SRC recovery services.

To place the evaluation of the Scottish Prison Recovery Project within the context of the available research, Russell Webster conducted a Rapid Evidence Assessment (REA) of prison-based drug treatment. This EA synthesized UK and international evidence on the outcomes of substance misuse treatment (both Opioid Agonist Treatment and treatment with an abstinence/recovery focus) delivered in custodial settings.

This report outlines the findings of the REA.

Introduction

Context

Data about the prevalence of the substance use of Scottish prisons is limited as is information about the profile of people receiving treatment in Scottish correctional settings. Perkins and colleagues (2022) note that substance use data often rely on self-reporting or upon incident reports which do not present the full picture of substance use. Disappointingly, the Scottish Prisoner Survey (historically conducted every other year) has not been conducted since 2019. In the most recent iteration (Carnie and Boderick, 2019), a significant proportion (30%) of people in prison completed the survey. More than two out of five (41%) of these survey respondents reported that they engaged in problematic drug use prior to imprisonment; moreover 45% said they had been under the influence of drugs and 40% that they were drunk at the time of their offence.

Approximately two fifths (39%) said that they had used illegal drugs in prison at some point. Of these, 83% said their drug use had changed during their current period in prison. Just over four in ten respondents said their drug use decreased (44%) and in the region of one fifth reported an increase in drug use (20%) or the same use but different drugs (22%). More than one in ten stated that they only started using drugs in prison (12%).

Just over one quarter reported they had used drugs in the month prior to the survey while in prison (28%). The most commonly used drugs were cannabis (50%), benzodiazepines (46%), subutex (45%), heroin (31%) and New Psychoactive Substances – predominantly synthetic cannabis – (30%). Two percent of prisoners said they had injected drugs in the month prior to the survey.

Just under one fifth reported being prescribed methadone (18%). Of these, over half were on a maintenance dose (57%), over a quarter were on a stabilising dose (28%) and 15% on a reducing dose. One quarter (26%) of prisoners surveyed reported that they had taken another individual's prescribed medication while in prison.

The Scottish Drug and Alcohol Information System (DAISy) also provides (minimal) information about those accessing substance use treatment in prison. The latest statistical report (Public Health Scotland, 2023) can only tell us that 696 people were assessed for their drug use while in prison in the 2022/23 financial year, 104 for alcohol use and 217 for both their drug and alcohol use.

We also know (Public Health Scotland, 2024) that 64 people were released directly from prison to residential rehabilitation under the National Mission funded Prison-to- Rehab scheme.

Methodology

The aim of the Rapid Evidence Assessment was to synthesise robust UK and international evidence on prison-based treatment interventions with people using drugs. In particular the researcher looked for evidence of how these interventions effected outcomes. The two primary outcomes of interest were reducing recidivism

and reduction in drug consumption, but retention in treatment on release and reduction of risky behaviours related to drug use were also considered. Based on this aim, the scope of the REA was defined using the PICOS acronym (Campbell Collaboration 2014) set out below.

Population: Only studies involving participants who were in prison at the time of the intervention were considered. Studies were restricted to adults in prison (aged 18 years or older).

Intervention: Studies about drug treatment, including Opioid Agonist Treatment, counselling and support and recovery-oriented activities (including those which were led by people with lived experience) were all considered in scope.

Comparison involved: studies were prioritised where reoffending or drug use outcomes were compared to a control, most likely 'business as usual'. However, to draw in as wide a range of studies as possible a broad view of possible comparisons was taken.

Outcomes: The researcher sought studies where the primary outcome was a measure of recidivism such as arrests, convictions (binary, frequency, severity), or breaches of condition (e.g. recalls to custody) or a measure of drug consumption. However, anticipating that studies such as these would be relatively rare, a range of 'intermediate outcomes' were considered including, completions of license conditions, engagement in treatment and the prevalence of drug-related deaths.

Study designs: Traditionally an REA focuses on counterfactual impact evaluations and where these were found they were preferred.

Studies in scope were published in English since 2000, with preference given to those published in 2010 onwards.

The researcher searched academic databases using the following Boolean search string: (TITLE-ABS-KEY ((prison* or prisoner* OR correct*) AND ("drug treatment" or "substance *use treatment" or "recovery") AND (evaluation OR experiment* OR trial OR impact OR effect*)) AND PUBYEAR > 2000).

The websites of the following governmental agencies and organisations associated with correctional or substance use research were searched for reports and other grey literature:

- The Scottish Government
- The Scottish Prison Service
- The European Monitoring Centre for Drugs and Drug Addition
- UK Ministry of Justice
- Correctional Services Canada
- Australian Institute of Criminology
- US National Institute of Corrections
- SAMHSA - Substance Abuse and Mental Health Services Administration

The resultant studies were screened manually to restrict the REA solely to drug treatment and recovery interventions delivered in a prison setting. A total of 26 studies were read in detail and analysed for this review.

Findings

In this first section, we start by looking at the research on the overall impact of drug treatment interventions in prisons, before looking at the evidence of different treatment modalities.

Overall impact

There are a number of systematic reviews and meta-analyses of drug treatment in prison. Researchers undertaking these studies point out the challenges of conducting high quality research in a prison setting. For example, de Andrade and colleagues (2018) undertook a systematic review of 49 studies into prison-based drug treatment programmes published between 2000-2017 but rated just six of these to have a strong methodological underpinning, 20 were rated "moderate" and 23 "weak". They note that common limitations that reduced quality included small sample sizes, high attrition rates, lack of blinding, selection bias, and the use of self-report recidivism data.

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), 2023, maintains that in general interventions that are effective in tackling drug problems in the community are also found to be effective in prisons, but notes that "there tend to be fewer studies to support this". The EMCDDA recommends two important principles for drug treatment interventions in custodial settings:

1. Equivalence of care to that provided in the community and
2. Continuity of care between the community and prison on admission and after release.

Holloway and colleagues (2006) undertook a meta-analysis of 28 evaluations of drug treatment programmes delivered in a custodial setting. The meta-analysis involved calculating individual effect sizes for each study and weighted mean effect sizes for groups of studies. They found that the mean odds of offending following treatment were significantly lower among clients of the drug treatment programmes than among the comparison groups. However, the results varied by type of programme, type of evaluation methods used, and characteristics of the individuals engaging in treatment.

Outcomes varied across the different evaluations. The odds ratio (OR) was greater than 1 (suggesting that the treatment group was associated with lower offending than the control group) for 19 of the 28 studies and statistically significant ($p<0.05$) for 11 of these 19. The OR was less than 1 (suggesting that the control group was associated with lower offending than the treatment group) for 9 of the 28 studies and statistically significant for only 1 of the 9. Overall, just under half of the studies showed that the evaluated treatment was significantly more effective than the comparison in reducing criminal behaviour.

Helpfully, the researchers also calculated the mean effect size for all 28 studies using two different statistical approaches. This analysis found a substantial impact on reoffending on release. The odds of offending for the treatment groups were reduced by 29 per cent according to the Fixed Effects FE model and by 36 per cent (because according to the Random Effects RE model.

The researchers also undertook a more detailed analysis to examine which treatment modalities were most effective in reducing criminal behaviour. Participation in therapeutic communities had the most impact, followed by post-release supervision and maintenance prescribing.

De Andrade came to similar conclusions, finding that the studies she and her colleagues reviewed suggest that therapeutic communities are effective in reducing recidivism and, to a lesser extent substance use after release. They also found evidence to suggest that opioid maintenance treatment is effective in reducing the risk of drug use after release from prison for opioid users. Finally, they found that engagement in treatment after release from prison appears to enhance treatment effects for both types of interventions.

These finding were replicated by Mitchell and colleagues (2012) whose Campbell systematic review assessed seventy-four evaluations of incarceration-based drug treatment and concluded that the overall average effect of these programmes was approximately a 15 to 17% reduction in both recidivism and in relapsing into drug use. Once again, Mitchell found that therapeutic communities were the treatment modality most likely to have positive impact, with "relatively consistent but modest reductions in recidivism and drug relapse".
We shall look at the evidence base relating to these individual treatment modalities in more detail below.

Opioid Agonist Treatment

Outcomes

Opioid Agonist Treatment involves replacing illicit opioids with a prescribed replacement opioid medication, typically methadone or buprenorphine. OAT (previously often known as Opioid Substitution Treatment – OST) is a common intervention in many prison systems and is prescribed on either a maintenance or detoxification basis. The European Union Drugs Agency reported that in 2019, OAT continued from the community was available in 29 European countries and OAT initiated in prison available in 22 nations.

As we have seen from the systematic reviews of all treatment approaches delivered in prison, there are many evaluations of positive outcomes for OAT. In this section, we focus on studies solely focused on OAT. Malta and colleagues (2019) undertook a systematic review of 46 studies of opioid related treatment in custodial settings. Most (30) of these were conducted in North America but nine were in Europe (and seven in Asia/Oceania). Twenty two studies were randomized control trials (considered the gold standard of outcome evaluations), three were non-randomized clinical trials, and 21 observational studies.

They made two main conclusions; firstly that participants treated at a correctional institution with OAT had higher adherence to addiction treatment, lower rates of relapse into illicit opioid use, were less likely to be re-incarcerated, and were more likely to be working 12 months after release. The second was that participants who received opioid agonist treatment while incarcerated and were adequately linked into care post-release experienced a significant decrease in nonfatal overdose rates and mortality. Indeed, the researchers stressed that continuity of care on release significantly improved a wide range of outcomes including post-release mortality, substance use, treatment retention and reductions in offending.

The importance of continuity of care on release is confirmed by Larney and colleagues (2012) who looked at outcomes for 375 male heroin users who engaged in OAT in prisons in New South Wales, Australia. While there was no significant association between simply being in OAT at the time of release and the risk of re- incarceration; for those who maintained OAT in the community, the average risk of re-incarceration was reduced by 20% while participants remained on a prescription.

However, Moore (2019) found that methadone maintenance in prison was itself a predictor of engaging in community treatment on release. In her meta-analysis of 807 prisoners involved in three Randomised Control Studies of OAT (407 in treatment, 400 in control groups), she found that methadone provided during incarceration increased community treatment engagement.

Two Scottish studies also demonstrated other benefits of OAT on release. Bird and colleagues (2015) undertook a large-scale study which involved linking Scotland's prisoner database with death registrations to compare periods before (1996–2002) and after (2003–07) prison-based OAT was introduced. The study included 150,517 prison releases (for 131,472 individuals) between 1 January 1996 and 31 December 2007, 10,085 (7%) of whom were women. Bird found that drug-related death rates per 1000 qualifying releases in the first 12 weeks post-release fell from 3.8 to 2.2 after the introduction of the OST policy, a fall that was classified as highly statistically significant. Interestingly, the research team attributed this reduction to improved quality assurance in methadone prescribing in the outside community.

This finding was replicated in Australia by Gisev and colleagues (2015) who analysed outcomes of 16,453 individuals released on 60,161 occasions from New South Wales prisons between 1985 – 2020. They found that participation in OAT in the four weeks post-release reduced the hazard of death by 75 percent compared to opioid using prisoners who did not engage in OAT on release.

In another Scottish study, Fraser, et al. (2024) conducted a national retrospective cohort study of individuals who received at least one prescription in Scotland for OAT between 1 January 2011 and 31 December 2020 to explore whether being in OAT reduced the risk of suicide among opioid users. This large-scale study followed up a cohort of 46,453 individuals for two years after the end of their OAT episode. A total of 6,947 people tragically died during this period including 4,076 people whose deaths were drug-related and 575 whose deaths were deemed to be suicide. The impact of OAT emerged very clearly: the crude suicide mortality rate for those off OAT was more than three times higher relative to those on OAT.

The administration of OAT in prison

We can conclude that prison-based OAT can result in a number of positive outcomes, relating to engagement in community treatment and a reduction in the risk of drug- related death and suicide. We now turn to the literature which sheds light on the components of a high-quality OAT intervention in prison.

Stallwitz and Stőver (2007) undertook a review of the literature on prison-based substitution treatment and especially prison-based methadone maintenance treatment. They concluded that methadone maintenance treatment can reduce drug use and injecting behaviour in penal institutions but that to ensure retention in treatment, a sufficiently high dose of methadone (e.g., >60 mg) and the continuous provision of substitute medication throughout the entire period of imprisonment "appear crucial".

In her systematic review, Moore differentiated between different medications and individual reviews of buprenorphine and naltrexone studies showed these medications were either superior to methadone or to placebo or were as effective as methadone in reducing illicit opioid use post-release. Similarly, in a study commissioned by the Scottish Government Macneill, (2021) explored the increased use of Buvidal, a type of Prolonged Release Buprenorphine,

which was intended as a contingency measure in prisons to respond to the coronavirus pandemic.

Macneill found high levels of satisfaction about Buvidal reported by almost all patients and healthcare staff, noting a number of benefits. He reports that the desire to come off methadone was a strong motivation for most Buvidal patients, who reported that they did not like how it made them feel and that methadone was a stigmatising treatment. A further motivation tied to wanting to come off methadone was that changing to Buvidal would prevent people from having to attend a community pharmacy on a daily basis after their release from prison – a setting where they felt at risk of relapse. He also comments that Buvidal appears to alleviate cravings and reduce drug seeking behaviour, which combine to drastically reduce illicit drug use among Buvidal patients. Other benefits included the fact that Buvidal cannot be diverted to other people in prison and that its much less frequent prescribing reduces pressures on staff time. However, Macneill is careful to note that Buvidal may not be suitable for all OAT patients.

Webster et al. (2024) researched the lived experiences of OAT during and immediately following release from detention in prisons in England (188 individuals) and Scotland (19). The study found that the quality and accessibility of OAT varied considerably between custodial establishments. It was reported to be harder to access OAT in Scottish prisons and it was often hard for people in prison to get the dosage of OAT they felt they needed in both countries. It was generally harder to access buprenorphine than methadone in English prisons and only Scottish people in prison were aware of long-lasting forms of buprenorphine (such as Buvidal).

People in English prisons had very mixed experiences of the quality of help available with their opiate problem in prison, with 51% rating it “excellent” or “good” and 49% “poor” or “terrible”. People in Scottish prisons were more likely to rate the help available as poor.

Focus group discussions in the same study revealed that different individuals had developed their own decision-making processes on whether to disclose heroin dependency and seek OAT in prison. Several people were reluctant to disclose their status as heroin users to both prison staff and other people in prison, saying that it was impossible to keep information on one’s drug use confidential in prison. The main perceived negative consequences of disclosing one’s use of heroin included:

Being looked down on, considered “scum” by prison staff and other people in prison;

- Being considered weak and a target for bullying by other people in prison;
- Receiving more attention from prison security including more frequent searches of an individual and their cell; and
- Damaging the prospects of being awarded Home Detention Curfew, Release on Temporary Licence and/or parole.

Nevertheless, many people did decide to disclose their use for a range of reasons: because they were withdrawing and needed medication; because they wanted help with their drug problem and to make a change in their life or, simply, because they were already known by prison or probation staff as a heroin user.

While a large majority (88%) of those who sought OAT did receive at least some medication, almost half (45%) either had to fight hard to get their prescription or did not succeed in getting either the type or amount of medication they wanted; the most common complaint (voiced by

16% survey respondents) was that people were receiving much lower dosages than they needed with the result that they felt in considerable pain and distress. Ninety two English respondents who had been released from prison were asked whether they were offered a continuing prescription on release. Two thirds (66%) reported that they were either offered medication on release or asked for it and secured it easily. However, more than one in five (22%) either received no medication or did not get the type or as much as they wanted.

Perkins and colleagues (2022) noted particularly concerns about the growing remand population noting that prison staff "are particularly alert to the risk and vulnerability surrounding the remand population" stating they were the prison population that gave them most concern regards drug use. The report noted "general agreement that prison is not a conducive place for those on remand to address substance use issues".

In conclusion, while it appears clear from the evidence that engagement in OAT on release is an important factor in positive outcomes relating to reduced drug consumption, reduced offending behaviour and less risk of fatality, guaranteeing that continuity of care remains problematic in many jurisdictions.

Therapeutic communities

Therapeutic Communities (often shortened to TCs) are structured, psychologically informed environments – they are places where the social relationships, structure of the day and different activities together are all deliberately designed to help people's health and well-being. There is a strong emphasis on a group of drug dependent people working together to tackle their dependency.

As we have seen, those systematic reviews which examined the impact of different treatment interventions in custodial settings typically reported that therapeutic communities were the most successful (Holloway; Mitchell). In this section, we look at the evidence from studies which focused on the outcomes associated with therapeutic communities in prison.
Welsh (2007) undertook an evaluation of prison-based therapeutic community drug treatment at five Pennsylvania state prisons. Therapeutic Communities are, of course, one of the most intensive interventions and the 217 participants in Welsh's cohort received an average (mean) of 912 hours of input compared to the average of 68 hours for his 491 person strong control group. The two groups were matched for a number of variables including level of need for treatment, current and prior criminal history, and post-release employment. Welsh followed up participants for two years post-release and found that participation in these therapeutic communities significantly reduced rearrest and reincarceration rates but not drug relapse rates. Three out of ten participants (30%) were reincarcerated within the two-year period compared with 41% of the control group. Almost one quarter (24%) participants were rearrested (34% of the control group). However, more than one third (35%) of participants relapsed into drug use, only a slightly smaller proportion than the control group (38%).

Galassi, Mpofu and Athanasou (2015) undertook a systematic review of 14 studies of therapeutic communities delivered in a prison environment (thirteen programmes were based in US prisons, one in a Thailand establishment). They found that three- quarters of the studies reported therapeutic communities were effective in reducing rates of re-incarceration. About 70% of the studies that examined follow-up rates of drug misuse relapse found them effective in reducing rates of drug misuse amongst participants. Therapeutic community participation reduced re-arrests events in 55% of the studies.

The authors conclude that participation in a therapeutic community and aftercare appears effective in supporting participants to learn to adjust to life outside of prison; most likely by helping participants to learn life skills and coping strategies important to community living post-release.

Webster's study in English and Scottish prisons reported that both survey respondents and focus group interviewees particularly valued therapeutic communities (and drug recovery wings, a similarly intensive intervention, to which we now turn our attention).

Drug recovery wings

Another intensive prison drug treatment intervention is Drug Recovery Wings (DRWs). This English and Welsh initiative was piloted in eight men's and two women's prisons in 2011/12, with the intention of delivering abstinence-focused drug recovery services[1]. Prisons were given licence to develop their own DRW models to reflect local needs and the ten resulting projects varied considerably in terms of size, aims, target population, accommodation, regime, and therapeutic content and intensity. The pilots were very varied: capacity ranged from 20 to 140 beds; therapeutic content varied from structured, full-time programmes to little more than the basic support offered elsewhere in the prison; some were run by uniformed prison officers and others by third sector drug treatment professionals; and some were segregated from the rest of the prison while others shared the wider regime.

Lloyd and colleagues (2017) evaluated the pilots and identified a number of critical success factors including: physical separation from the rest of the prison; protection of DRW beds for people engaged in the therapeutic programme; a strong sense of community and good relations between staff and prisoners. They also noted that a strong sense of community seemed to develop in small or medium-sized, well- controlled wings where prisoners underwent treatment as a cohort. Also key was the careful selection of positively motivated officers who were also able to manage professional and personal boundaries well.

Interestingly, the research team concluded that "none of these features were necessary or sufficient". In particular, they found that shutting off DRW residents from the rest of the prison appeared to intensify relationships and dynamics. Lloyd found that this separation could either result in a close, supportive community where relationships were good; or considerable discord where relationships were poor.

One key finding which makes it hard to draw conclusions about the model's effectiveness was that, despite their name, DRWs did not universally focus on abstinence-focused recovery. In two, the only treatment input was harm reduction. The nature and intensity of therapeutic input varied greatly across the seven DRWs and also across time in some of the individual DRWs.

Only two DRWs had adopted conventional, well-established treatment models, both run by the third sector. Other, well-received programmes were designed in fairly ad hoc ways by prison staff.

[1] 1 There is a drug recovery wing currently operational at HMP Inverness but this initiative has not been subjected to formal evaluation.

One potentially important finding was that prisoners tended to put much more emphasis on peer relations and prisoner communities than they did on the type or nature of therapeutic provision. They also found that mutual aid groups, such as Narcotics Anonymous were very popular: providing prisoners with powerful examples of alternative ways to live their lives. This finding is replicated in Webster's (2024) study of OAT in English prisons where participants valued peer support above all other forms of drug treatment.

There was a limited outcome component to Lloyd's evaluation of the ten DRW pilots. The 109 participants followed up at six months showed considerable reductions in drug and alcohol use, and self-reported offending between the six-month period prior to custody and the six month period following release.

The evaluators' principal conclusion was the importance of post-release support:

> "Incarceration inevitably removes access to recovery capital. It can therefore be questioned whether this widely-accepted, holistic model of recovery can really be applied to a prison setting. Given this, it can be argued that the strongest emphasis should be placed on support in the community.... Akin to community services, ambitious, abstinence-focused interventions should be reserved for those who have robust recovery capital outside prison and where intensive professional support is guaranteed on release."

Other treatment modalities

There is very limited good quality outcome-based literature on other common prison-based treatment including general psycho-social support (often called drug counselling) or peer support. One exception is an outcome evaluation of the intensive. Recovery-oriented prison-based drug treatment delivered in a number of English prisons by the Rehabilitation for Addicted Prisoners Trust (subsequently re-named the Forward Trust). Kopak and colleagues (2014) examined recidivism in a group of 352 male prisoners who completed the RAPt programme, a group of 355 male prisoners who did not complete the programme, and a third comparison group of 232 male prisoners who completed another in-prison drug treatment programme. 12-month post-release recidivism data for the three groups were assessed, matching members of these three cohorts in relation to age, race/ethnicity, length of sentence, prisoners' drugs of choice, and prisoners' primary offence for imprisonment. The researchers found that RAPt completers were less likely to re-offend within one year of prison release compared to the who started but did not complete the RAPt programme and those who completed the other treatment programme.

Conclusions

Prison-based treatment has been proven effective at reducing both reoffending and relapse into drug use by a wide range of literature. However, variations in findings make it clear that effects vary considerably and that while many treatment interventions are successful, many are not. There are limitations around the quality of the literature (mainly caused by the difficulties inherent in undertaking high quality randomized controlled trials which follow up programme participants on release).

There is, however, a strong consensus across the international literature that two treatment modalities in particular are effective – therapeutic communities and Opioid Agonist Treatment. For both these modalities, the literature emphasises that continuity of care on the release is the single most important indicator of successful outcomes. The OAT literature also highlights that not all prescribing regimes are effective with maintenance prescribing at a sufficiently high dosage critical to retain people in treatment in prison and encourage participation in treatment on release. There is increasing interest in long-lasting variants of buprenorphine (particularly in Scotland) as an important choice of medication, especially for people with negative experiences of methadone.
With the exception of therapeutic communities, there is very little robust literature examining the impact of recovery-oriented drug treatment in prisons.

A final theme starting to surface in more recent studies is the increasing interest in the value of people with lived experience offering peer support which may be important for engaging and retaining people in treatment both in prison and on release.

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