Rapid review

The throughcare and aftercare of drug dependent (ex-)prisoners. Key resettlement needs and UK service-level responses

Ex-Prisoners Recovering from Addiction (EPRA)

Supporting Paper 3

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Introduction

Imprisonment causes harm. Of this, there is little doubt. Prisoners tend to come from marginalised communities. Prison then further reduces their access to the resources most able to support desistance from crime:

> Two-thirds [of prisoners] lose their job, over a fifth face increased financial problems and over two-fifths lose contact with their family. There are also real dangers of mental and physical health deteriorating further, of life and thinking skills being eroded, and of prisoners being introduced to drugs[1].

This was reflected in the evaluation of pilot Drug Recovery Wings, wherein virtually no participants were released with enhanced access to the basic, pragmatic resources they needed to initiate or sustain transformative change. This chapter consequently focuses on several key dimensions of resettlement need which the research literature has consistently identified as integral to the desistance of substance misusing offenders; and reviews the evidence on the effectiveness of interventions designed to address these needs

The rest of this paper is divided into six sections. The first five focus on the following key areas of need:

i. Drugs and Alcohol
ii. Accommodation
iii. Education, training and employment
iv. Family
v. Mental and physical health

A final section, vi, focuses on particular issues relating to women.

i. Drugs and Alcohol

In 2002, the Social Exclusion Unit noted that '[t]he majority of prisoners have a history of drug or alcohol misuse[2],' with subsequent reports identifying that Class A drug users were

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[1] SEU 2002:7
[2] 2002:61

responsible for £14bn of crime per year[3]. This association between Class A drug use and crime continued to be emphasized in several turn-of-the-millennium research papers, which identified:

- That treatment-seeking heroin users were responsible for a great deal of acquisitive crime[4];
- That arrested heroin users were responsible for a great deal of acquisitive crime[5];
- That 81% of '[heroin] misusing repeat offenders' were not in drug treatment[6]; and
- That methadone maintenance (and residential rehabilitation) greatly reduced levels of acquisitive offending, such that every £1 spent on treatment yielded between £9.50 and £18 of savings – almost entirely attributable to reductions in offending[7].

This consequently provided a strong justification for a widespread roll-out of methadone prescribing as the mainstay of community drug treatment[8].

Contemporaneously, a study of 47,771 people released from prison in 1998-2000 identified that…

> …relative to the general population, male prisoners were 29 times more likely to die in the week following release, while female prisoners were 69 times more likely to die during this period[9].

These deaths were overwhelmingly caused by opioid toxicity[10], providing a strong case for maintenance opioid prescribing in prison and on release[11], particularly for those serving short sentences[12]. This case been strengthened by subsequent studies assessing the impact of OST on post-release mortality. Drawing on data from over 150,000 eligible ex-prisoners between 1996 and 2007, Bird *et al* identified that the introduction of OST in Scottish prisons was associated with a 58% reduction in drug-related deaths (from 3.8 per thousand to 2.2 per

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[3] Gordon *et al.,* 2006
[4] Gossop, Marsden and Stewart, 2000
[5] Hollowan and Bennett 2004
[6] Holloway and Bennett 2004
[7] Godfrey *et al.,* 2003
[8] Skodbo *et al.,* 2007
[9] Farrell and Marsden 2008:254
[10] Farrell and Marsden 2005:41
[11] Patel 2010:21; WHO 2010:8; DoH and Addaction 2004:11
[12] Department of Health 2006

thousand) in the first twelve weeks[13]. More recently, an evaluation of IDTS in English prisons analysed data on 15,141 prisoners identified as opioid dependent. Here, sustained opioid prescribing on release resulted in an 85% reduction in deaths from opioid toxicity, and a 75% reduction in all-cause mortality[14].

It is hard to assess how this strong mandate for sustained OST provision reconciles with throughcare aimed at supporting transformative change. Whilst some authors have advocated for a clear place for OST within 'medication assisted recovery'[15], others have seen maintenance prescribing and recovery approaches as irreconcilable[16]. Clearly, there is a strong mandate for any recovery-based throughcare to avoid excess deaths due to opioid toxicity, which invites questions about the timing and role of OST detoxification within treatment pathways (and, specifically, whether this takes place before or after release). Along these lines, the Advisory Council on the Misuse of Drugs comments:

> The ACMD cautions against treatment which detoxifies people against their will or imposes time-limited opioid substitute treatment as both these approaches are not in line with the evidence base and are likely to result in relapse and increased risk of harm to individuals and communities[17].

Approaches seeking OST abstinence before release thus require particularly robust holistic support.

Recovery capital

Policy and research suggest that recovery capital must play a central role in considering individuals' treatment and aftercare pathways[18]. Recovery capital is conceptualised as the pragmatic, social and personal resources people need to initiate and sustain change[19], and so – by definition – shapes people's access to recovery outcomes.

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[13] 2002:1620
[14] Marsden *et al.,* 2017
[15] e.g. Strang 2010
[16] e.g. McKeganey 2012
[17] 2013:17
[18] E.g. HM Government 2010; Cloud and Granfield 2009; Best and Laudet 2010
[19] Best and Laudet 2010

The broader implications of this were highlighted by the ACMD's *What Recovery Outcomes does the Evidence Tell Us We Can Expect*[20]*?,* which pointed to the centrality of drugs of choice to understanding individuals' levels of recovery capital. For the 'UK population of ageing heroin users[21],' long criminal records, unsupportive or disrupted family relationships, and dire mental and physical health are the norm; accompanied by few formal qualifications, little or no history of employment, and little or no access to safe housing[22]. Contrastingly, people who use alcohol, cannabis and cocaine generally have far greater access to 'recovery capital,' and so 'recovery is the norm' for this group[23].

Various throughcare models may thus disproportionately benefit particular groups of drug dependent prisoners. Heroin users, in particular, may benefit from an…

> *extensive* approach – [involving] efforts to support change across the range of outcome domains for a number of years[24].

This was reflected in the evaluation of pilot DRWs, wherein services prioritising the engagement of former heroin users struggled to support them towards transformative change; whilst services prioritising transformative change struggled to engage prisoners prescribed OST[25]. In concrete terms, this poses questions for EPRA centred on operational models, and what outcomes are desired for which subgroups of prisoners. Supporting transformative change in those with robust access to robust recovery capital may be relatively achievable, but could inadvertently bypass the most marginalised and socially costly individuals. Contrastingly, supporting change in highly marginalised former heroin users may require far greater resourcing for comparatively fewer gains.

Succinctly, operational decisions about abstinence, client motivation, and behavioural change may inadvertently shape the risk and drug use profile of those who are engaged. Similar concerns have been raised in other contexts – for example, in the potential incentivisation of

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[20] 2013
[21] 2013:54
[22] e.g. Boreham *et al.,* 2006; Holloway and Bennett 2004
[23] ACMD 2013
[24] ACMD 2013:19
[25] Page *et al.,* 2016

Payment by Results interventions to 'cherry pick' clients who can be swiftly supported towards change, leaving more marginalised individuals behind[26].

Treatment models and treatment ethos

Residential treatment appears to offer the most promising model for supporting transformative change in substance misusing offenders on release from prison. A systematic review of the impact of drug treatment on offending identified therapeutic communities as the most effective interventions[27], and the UK's evidence base – whilst methodologically weak – also identifies residential treatment as an effective means of supporting reductions in both drug use and crime[28]. Residential treatment has the advantage of being able to offer community-based intensive group programmes in a highly controlled environment, and either fully addresses or widely supports other core areas of resettlement need. (For example, residential services also meet ex-prisoners immediate housing needs).

The UK's residential landscape is dominated by cognitive behavioural therapy, twelve-step, integrated / eclectic, Christian, and CBT / social learning approaches with many units offering a combination of these[29]. Comparative evaluations of CBT, twelve-step and TC modalities have tended to find little difference in their efficacy[30], though some people are likely to have preferences for specific approaches.

Alternatives to residential treatment are also available, and open up the potential for EPRA's blueprints to cater to a wider variety of individual needs. Along these lines, Illinois' Sheridan Correctional Centre offered prison leavers a range of aftercare modalities including outpatient treatment, detoxification, supported housing, and residential rehabilitation. These allowed ex-prisoners to, for example, return to family homes or access immediate full-time employment whilst still supported by treatment services. All treatment modalities were associated with reductions in reoffending[31], although there were differences in treatment completion rates of nearly 25%. Detoxification services had the highest levels of treatment completion (81.4%),

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26 Disley and Rubin 2014:8
27 Holloway, Bennett and Farrington 2006:675
28 Godfrey *et al.,* 2003
29 Public Health England 2017 [rehab finder]
30 e.g. Cutler and Fishbain 2005; Ouimette, Finney and Moos 1997
31 Olson and Rozhon 2014:105

whilst half-way houses delivered the lowest (56.5%). Residential rehabilitation (69.5%) and outpatient treatment (intensive: 63.6%; traditional 58.8%) fell between these extremes[32].

One key advantage of the Illinois approach is that it follows individuals, supporting the engagement of a wide range of prisoners with highly diverse needs. It is also well-suited to supporting large populations of prisoners. However, looking to offer a wide range of treatment modalities could also increase the complexity of EPRA's blueprints and risk losing clarity, control and deliverability. Key challenges include a need to secure broad partnerships, and a concomitant loss of control over operations and processes. Pathways would also need to be highly responsive to individuals' needs at each stage of their recovery journeys, raising questions of how this could be guaranteed.

ii. Accommodation

Originally identified as pathway 1 in the Home Office's *Reducing Re-Offending National Action Plan*[33], housing has a robustly evidenced association with reoffending. The Social Exclusion Unit's review of the evidence claimed that 'stable accommodation can make a difference of over 20 per cent in terms of reduction in reconviction,[34]' with the more recent Surveying Prisoners Crime Reduction (SPCR) study of 1,307 released prisoners identifying that people who were homeless when imprisoned were 1.86 times more likely to reoffend[35]. The relationship between housing and (re-)offending are undoubtedly complex; as Maguire and Nolan comment, 'both the homelessness and the offending may be symptoms of other problems'[36]. This contention is supported by research identifying that those with pre-existing access to informal resources such as supportive families and employment evidence far greater success at securing stable accommodation on their release[37].

Nonetheless,

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[32] Olson and Rozhon 2014:95
[33] 2004
[34] 2002:94
[35] Hopkins and Brunton-Smith 2013:23
[36] 2007:1
[37] Nevin and Stewart 2005:4

> …attention to accommodation problems is a fundamental building block for efforts to reduce re-offending: a *necessary,* if not a *sufficient* condition for the reduction of re-offending[38].

Certainly, housing has been identified as supporting gains in multiple other areas, including a three- to four-fold increase in employment[39], greatly improved mental and physical health[40], and considerably greater access to benefits and primary care[41]. Moreover, Brunton-Smith and Hopkins note that accommodation predicts re-offending independently of the most robust predictor, criminal history. Thus,

> Prisoners with extensive criminal histories but without accommodation and employment problems are less likely to re-offend on release than prisoners with similar criminal histories with accommodation and employment problems[42].

There is consequently a strong case for providing well-developed pathways into secure housing for all released prisoners, including those who apparently present the greatest risk of recidivism.

Prisoners often desire to return to the homes they lived in before they were detained, and there are some resources available that can support them in doing this. Housing Benefit can be sustained for up to a year whilst someone is detained on remand, or for NN weeks once they have been sentenced. Mortgage companies may also be willing to negotiate repayment schedules, and friends or relatives can take over tenancies or rent payments for the duration of someone's imprisonment.

However, homelessness is the norm in imprisoned populations, and levels of need are very considerable. Between 15 and 33 per cent of people are homeless when they enter prison[43], with over half of those who have a home losing it during their sentence[44]. This results in two-thirds of prisoners needing to find accommodation before they are released[45]. Whilst housing is notionally available from several sources, each is attended by specific challenges. Local

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[38] Maguire and Nolan 2007:1
[39] SEU 2002:94; Niven and Stewart 2005:2
[40] PRT 2011:23-26
[41] SEU 2002:94
[42] 2013:26
[43] Hopkins and Brunton-Smith 2014:15; SEU 2002:7
[44] SEU 2002:7
[45] Hopkins and Brunton-Smith 2014:15; Carlisle 1996:47

Authority housing is both cheap, and secure; but supplies are limited, waiting lists are often very long, and prisoners are very rarely seen as a group with a priority need. Private rented is attended by plentiful supply; but is expensive, insecure, of unpredictable quality, and often requires substantial up-front funds to cover rent and a deposit. Finally[46], 'pathways' target specific marginalised groups (including people with drug problems, and offenders). 'Linear' provision[47] is delivered according to a ladder of progress, with individuals moving from hostel accommodation to secure tenancies over a period of time:

> For example, if an offender's homelessness was linked to substance misuse, a 'staircase' model might provide detoxification in a hostel setting, followed by eventual resettlement into ordinary housing[48].

Such models have been criticised as being unsuitable for highly chaotic (and particularly drug using) individuals, as they assume linear progression through a series of assessed steps, in contrast to the general 'zig zag' pattern of desistance from crime and drug use. In the UK, individuals housed by such schemes are usually limited to between 6 and 24 months in any one location, due to organisations' funding structures and outcome measures[49]. Finally, the availability and reach of such programmes since the end of Supporting People – a funding initiative specifically focused on housing for marginalised groups – is unclear, though there is some evidence that they are currently scarce[50].

Despite being the focus of considerable attention for many years, the success of housing support services at finding accommodation for people leaving prison appears limited. In a Criminal Justice Joint Inspectorates (CJJI) thematic review of short-term prisoners, of seventy-three prisoners reliant on statutory support, just one was found housing[51]. A subsequent inspection of support for those serving 12 months or more was only marginally more promising, identifying 'little effective work by CRCs to improve access to accommodation'[52], with 'only two prisoners … found accommodation via Through the Gate arrangements[53]'. An

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[46] NB: 'Housing First' models offer an alternative to 'pathways,' but have little presence in the UK at present. Their workings are more fully explored in the accompanying 'operaitonal models' paper.
[47] Johnsen and Teixeira 2010:4
[48] Pleace and Minton 2009:43
[49] Johnsen and Teixeira 2010:16
[50] CJJI 2014:6; Wilson 2014:11; Quilgars *et al.,* 2012:16
[51] 2014:12
[52] CJJI 2017:20
[53] CJJI 2017:8

intensively resourced pilot initiative in HMP Leeds was somewhat more successful, finding temporary accommodation for half of those who were otherwise homeless[54].

In this context, ex-prisoners often find themselves reliant on family or temporary hostel accommodation. Particularly for individuals with long histories of drug dependence and repeat offending, these are likely to be difficult options. Hostels often provide unstructured and poorly supervised environments, in which drugs are widely available and interpersonal tensions are commonplace[55]. Family homes can also be difficult, both for the families that offer housing, and for the ex-prisoners that return to strained relationships defined by repeat experiences of exploitation or failure[56].

We have been able to find no literature specifically focused on UK housing interventions for ex-prisoners with histories of drug dependence. Pilot Drug Recovery Wings were, however, developed with an expectation that they would provide some form of enhanced through-the-gate provision. The process evaluation of pilot DRWs identified that not one of thirty-six otherwise-homeless interviewees within four weeks of release had been found housing, and that interviewees identified unstable and insecure housing as one of the defining features in their subsequent drug use and offending careers.

As noted earlier, one possibility here is that residential treatment might offer some potential for improving both the housing and broader recovery outcomes of EPRA's target group. The US evidence base points to promising outcomes for ex-prisoners who complete residential aftercare[57], and some residential rehabilitation units in the UK encourage referrals from prisons[58] with a stated willingness to act as a Home Detention Curfew or approved release address[59]. This also opens up the possibility of mandating residential treatment as a condition of release – a process identified as highly effective in the US literature[60] – though we have been unable to identify any UK literature focused on similar, post-release, mandated treatment programmes.

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[54] Quilgars *et al.,* 2014:49
[55] Maguire and Nolan 2007:9
[56] Maguire and Nolan 2007:3;
[57] Olson and Rozhon 2011:112
[58] e.g. THOMAS 2017; Bridges 2017.
[59] Bridges 2017
[60] Olson and Rozhon 2011:57

iii. Education, Training and Employment

Education and training

Education, training and employment are persistent needs for both prisoners and drug users. In terms of education, the SEU noted:

> Half of all prisoners are at or below Level 1 (the level expected of an 11-year-old) in reading; two-thirds in numeracy; and four-fifths in writing. These are the skills required for 96 per cent of all jobs[61].

That significant work remains to be done is evidenced in the Government's 2016 White Paper, *Prison Safety and Reform:*

> By 2020, we want to see prisoners who enter jail struggling to read, write and add up being taught the basics of maths and English to help them find work when they get out[62].

Considerable problems with education also characterise populations of problem drug users. In a sample of 1,796 people seeking treatment in the UK, the Drug Treatment Outcomes Research Study identified…

> …over one-third (38%) [of treatment seekers] had left school before the age of 16, and most reported being unemployed (77%)[63].

In this context, the authors note that addressing educational needs comprises an essential part of any rehabilitative programme[64].

From 2005 on, education within prisons was structured by the Offender Learning and Skills Service (OLASS)[65]. OLASS sought to improve education for offenders by bringing together responsibility for prison-based and community provision, and delivering a programme based on swift individual assessments of need, the provision of advice and guidance, and subsequent

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[61] 2002:44
[62] HM Government 2016:1
[63] Jones *et al.,* 2007:2
[64] Jones *et al.,* 2007:2
[65] Halsey *et al.,* 2006:1

education structured according to individual learning plans[66]. In practice, despite early signs of promising partnership work and improved processes, OLASS was found to struggle in several areas. Where provision had previously been seen to focus provision unduly on the most capable – 'Open University or Learning the Guitar'[67] – OLASS resulted in a series of less ambitious programmes[68] focused exclusively on basic skills, with few vocational qualifications or links to employers[69]. Additional difficulties arose in the development of partnerships between NOMS and the Department for Innovation, Universities and Skills, reflecting tensions over the relative prioritisation of educational outcomes and effective risk management[70].

Within this context, the 2016 Coates review of education in prison noted that, of 101,600 imprisoned learners in 2014/15, only 100 were taking Level 3 (A-level equivalent) qualifications through OLASS[71]. None were taking qualifications at Level 4 or above[72]. The Coates Review consequently argued for a system that gave responsibility for education to prison governors, with a mission to 'build social capital and improve the well-being of prisoners during their sentences,[73]' through a programme that includes basic skills; vocational training; personal and social development; proper support for prisoners with learning disabilities; arts, music and sport activities; self-employment support; self-directed study; the use of ICT; and 'through-the-gate' support for those engaged[74]. The purpose of education is also envisioned by the Coates Review as reaching beyond employability, helping older prisoners to settle into their sentence, and re-engaging those who have had negative previous experiences of education[75].

Employment

In terms of employment, the 2002 SEU report noted that:

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[66] Halsey *et al.,* 2006:1
[67] Bynner 2009:1
[68] e.g. Coates 2016:iii
[69] Bynner 2009:5
[70] Bynner 2009:5
[71] Coates 2016:iii
[72] Coates 2016:iii. An addendum is also necessary here. In the same year, through the Open University, three prisoners completed postgraduate Masters degrees; 85 secured Bachelors degrees; and slightly over 100 prisoners gained Higher Education certificates or diplomas (OU 2016:1).
[73] Coates 2016:3
[74] Coates 2016:3-4
[75] Coates 2016:iii

> Over two in three prisoners are unemployed at the time of imprisonment – around 13 times the national unemployment rate[76]

Moreover, two-thirds of those who had a job when imprisoned lost it during the course of their sentence[77]. Employment is also associated with reductions in re-offending; the SEU noted that ex-prisoners who were able to find employment were between one third and one half less likely to reoffend[78]. Similar findings have emerged from subsequent studies. Drawing on a representative sample of 4,898 released prisoners, May, Sharma and Stewart identified that prisoners who had problems with housing and / or Education, Training and Employment (ETE) were much more likely to re-offend: 46% of individuals with no problems with employment or accommodation had known re-convictions within one year, compared with 55% of people with problems in one area, and 74% of those with problems related to both ETE and housing[79]. Motivation to work was also found to be highly related to proven re-offending, with 75% of those who 'do not want to work or train' being reconvicted within one year, compared to 45% of those with paid employment to go to[80]. More recently, the Surveying Prisoners' Crime Reduction study identified that secure employment was associated with a 28% reduction in re-offending after one year, and a 36% reduction after two years[81]. Securing employment also has implications for sustained progress following prison interventions. Malloch *et al.*'s international review of prison throughcare identified that a swift transition allows prisoners to retain the learning they have taken from pre-release interventions[82].

Employment is also a perennial problem for people with histories of drug misuse. In a review of the evidence, Neale and Kemp noted that between four and fourteen per cent of heroin and crack using individuals are in education, training or employment[83], with – as of 2006 – 267,000 problem drug users claiming Incapacity Benefit, Income Support, Jobseeker's Allowance or Disability Living Allowance[84]. They continue:

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[76] 2002:53
[77] SEU 2002:53
[78] SEU 2002:52
[79] May, Sharma and Stewart 2008:6
[80] May, Sharma and Stewart 2008:6
[81] Hopkins and Brunton-Smith 2014:27
[82] 2013:20
[83] 2009:96
[84] Neale and Kemp 2009:97

> This represents 6.6 per cent of all working-age individuals receiving those benefits, yet problem drug users comprise only 1.1 per cent of the total working-age population of England

Ex-offenders are also well-represented in populations receiving welfare, with the House of Commons Work and Pensions noting that 28% of people receiving Jobseekers Allowance have a conviction[85].

Levels of need are even more prominent when drug use and offending are combined. Across three years of arrestee surveys, Boreham *et al* identified that just 10% of heroin users were in education, training or employment, compared to 49% of other arrestees[86]. Half had left school before the age of 16[87]. Similarly, the Drug Treatment Outcomes Research Study identified that drug using offenders were significantly more likely than other treatment seekers to have left school early, and to be unemployed[88].

One particular challenges for services centres on the difficulties of improving prisoners' suitability for ETE, as research has consistently identified this is strongly related to their informal access to resources. Niven and Stewart, for example, found that 79% of ex-prisoners who found work did so by drawing on their pre-existing networks, contacts or resources[89]. Past employment thus acts as a powerful predictor of future employment:

> ETE in the four weeks before custody increased the odds of having ETE arranged on release by almost seven times[90]

Employment is strongly related to other aspects of individuals lives – such as having secure housing – and large-scale attempts at supporting challenging groups into work have historically encountered limited success. One of the real difficulties here lies in identifying ways of structuring interventions that offer pathways to genuine change, instead of creaming off the most promising few individuals for recruitment into interventions. As Maruna and Burnett note of one group of prisoners engaged by an ambitious employment programme…

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85 Work and Pensions Committee 2017:6
86 2007:24-25
87 Boreham *et al* 2007:25-26
88 Jones *et al.,* 2007:6
89 2005:2
90 Niven and Stewart 2005:2

> …they were self-described by one prisoner volunteer as 'la crème de la crème' among prisoners[91]

Private initiatives – such as those delivered by Virgin and Timpson, aimed at training prisoners for work, and employing them following their release – also have strong business motives for recruiting the most work-ready and capable prisoners from a very large pool.

Beyond a narrow range of committed employers, ex-prisoners face considerable barriers to entering the workplace. A 2010 review by the Chartered Institute of Personnel and Development identified ex-prisoners as 'the most disadvantaged of all the labour market':

> Only 12 per cent of employers surveyed said that they had employed somebody with a criminal record in the past three years, and around one in five employers (19 per cent) said they did exclude or were likely to exclude them from the recruitment process[92]

Similarly, a 2016 survey commissioned by the DWP identified that 50% of employers would not consider employing an offender or ex-offender, and only 15% described having no concerns[93]. Contrastingly,

> 40% were worried about the public image of their business and 45% were concerned that ex-offenders would be unreliable[94]

This contrasts sharply with the experiences of employers who have recruited ex-offenders, who are highly positive about their experiences[95]. As noted above, some such accounts may – in part – reflect their capacity to 'cherry pick' the most motivated few[96].

Other challenges facing ex-prisoners include the need to declare unspent convictions when applying for roles. Despite changes under the Legal Aid, Sentencing and Punishing of Offenders Act 2012 that shortened the time before most convictions are spent, convictions resulting in any prison sentence need to be declared to potential employers for some time after their licence period has expired. Inappropriate or ill-informed advice may compound the

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[91] Burnett and Maruna 2006:92
[92] Cited by RSA 2016:115
[93] Work and Pensions Committee 2016:30
[94] Work and Pensions Committee 2016:30
[95] RSA 2016:116; Work and Pensions Committee 2016:14
[96] Disley and Rubin 2014:8

difficulties of disclosure, with some staff advising ex-prisoners to lie on job applications; potentially resulting in their re-imprisonment[97]. Moreover, prisoners have scant access to job markets, or to jobcentre staff. The Work and Pensions committee note that, although there are 150 jobcentre staff working in prisons, their work is dedicated entirely to supporting benefit claims (rather than supporting people into employment)[98].

One promising avenue into employment is increased use of Release on Temporary Licence (RoTL), enabling prisoners to begin work before the end of their sentence. This has been recognised as a 'gold standard' of vocational treatment by the Government[99], and a 'critical bridge between prison and the community' by Release[100]. However, following serious breaches of RoTL in 2013, PSI 13/2015 greatly restricted the use of RoTL; and it has subsequently proved harder for prisoners and their potential employers to access[101]. Other potential avenues include 'intermittent custody,' enabled by the Criminal Justice Act 2003 and trialled across 11 Probation Service areas from 2004[102]. Supporting sustained access to employment was a central feature of the programme:

> Part-time imprisonment can avoid some of the negative outcomes of even relatively short custodial sentences, such as loss of employment and accommodation, or family breakdown[103]

Orders were particularly targeted on offenders with existing employment and / or childcare responsibilities[104]. Although 90% of those subjected to the orders were compliant, low levels of uptake by sentencers led to the scheme being dropped in 2006[105]. Whilst David Cameron heralded the re-introduction of 'weekend prison' in 2016[106], no such plans were contained in the subsequent white paper[107].

Framed by this challenging context, Community Rehabilitation Companies represent the most recent attempt at providing enhanced resettlement support for low-risk prisoners following

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[97] Work and Pensions Committee 2016:26
[98] Work and Pensions Committee 2016:12
[99] Work and Pensions Committee 2016:3
[100] Cited by Work and Pensions Committee 2016:14
[101] Work and Pensions Committee 2016:14
[102] Penfold, Hunter and Hough 2006:v
[103] Penfold, Hunter and Huogh 2006:v
[104] Penfold, Hunter and Hough 2006:iv
[105] BBC 2006
[106] HM Government 2016
[107] MoJ 2016

release; yet a recent HMI Probation review identified that, of sixty-two short-sentenced men, none were found employment by CRCs[108]. Other Government initiatives have included Progress 2 Work, a Jobcentre initiative focused on problem drug users. We have been able to identify no evaluations of its work.

iv. Family

The centrality of family to prisoners' resettlement is such that the Criminal Justice Joint Inspectorates stated…

> …overwhelmingly, this inspection confirmed our view that an offender's family are the most effective resettlement agency[109].

Sustained family ties have routinely been identified as one of the three most important areas driving successful resettlement, alongside ETE and housing[110]. There are also indications that family may be the most important of these, as family members support ex-prisoners in finding housing, education, and / or work. In consequence, Losel *et al* surmise:

> High quality family relationships were a very strong and consistent predictor of successful resettlement outcomes for all family members…. This clearly suggests investing further planning and resources into increasing communication opportunities for all imprisoned fathers, for example, through more high quality visiting experiences and greater access to phone calls[111].

Beyond pragmatic support, families are also uniquely positioned to support changes in the personal identities of ex-prisoners…

> …allow[ing] an offender to see themselves as a normally functioning individual, rather than merely an institutionalised criminal[112]

Where available, their role in resettlement is consequently a powerful additional tool.

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108 HMI Probation 2016:31
109 2014:5
110 e.g. Niven and Stewart 2007; Brunton-Smith and ETC, 2017;
111 Losel *et al.,* 2012:12
112 CYCJ 2015:9

Drawing on a subset of the SPCR dataset[113], Brunton-Smith and McCarthy used structural equation modelling to identify the role of family attachment (and improved family attachment) in supporting 'successful resettlement outcomes (covering reoffending, drug use, and employment opportunities)'[114] Notably, within this group, prisoners who disclosed Class A drug use before their imprisonment were significantly less attached to their families, though for all prisoners, visits from parents (in particular) strengthened their ties[115]. Two years after they were released, both initial attachment and improved attachment to family were associated with significant reductions in Class A drug use, and significantly greater levels of current employment[116]. This replicates findings elsewhere[117], suggesting that family ties may be the most powerful of all resettlement aides.

However, 'imprisonment fragments families'[118]. Relationships may already be strained before an individual is imprisoned[119], and prison can then result in the loss of the family home, and increased relational distance as official visiting times fail to fit in with school hours[120]. Visiting times can be highly anxiety-provoking for family members, and practical obstacles also limit the frequency with which family members can visit prisoners[121]. For families who are already resource-stretched, prison visits can represent an additional, challenging burden:

> Prison visits are not resource neutral for family members, with costs including transportation, childcare, lodgings and time off work[122].

As McGillivray notes, such hardships can exacerbate other areas of hardship and stress:

> The financial impact of imprisonment is severe. It exacerbates the detrimental impact of a prison sentence on family health and relationships and compounds the poverty that already blights the lives of so many prisoners' families [123]

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[113] 2,617 male prisoners sentenced to between six months and four years in prison (Brunton-Smith and McCarthy 2017:468)
[114] 2017:464
[115] Brunton-Smith and McCarthy 2017:473
[116] Brunton-Smith and McCarthy 2017:475
[117] Niven and Stewart 2005:4; CJJI 2014:23; Losel *et al.,* 2012:16; SEU 2002
[118] McGillivray 2016:3
[119] Brunton-Smith and McCarthy 2017:464
[120] Barnardos 2014:23
[121] Barnardos 2014:21; Brunton-Smith and McCarthy 2017:465
[122] Brunton-Smith and McCarthy 2017:466
[123] McGillivray 2016:4

Such degradation can lead to weakened informal support structures, a related decrease in access to education, employment and housing, and increased reoffending.

For these reasons, supporting visits has often been seen as one potential means of improving prisoners' post-release prospects. Brunton-Smith and McCarthy review the visiting literature in depth, noting that the frequency of visits, their timing within a sentence, and the nature of the relationship between prisoner and visitor can all impact on relational and resettlement outcomes[124]. Prisons may support contact in several ways. Losel *et al.,* for example, note several prisons providing family and children's visits; with additional contact provided through telephone calls, letters, emails, and 'storybook dads'[125] (a programme that allows imprisoned parents to make CD and DVD recordings for their children[126]).

Imprisonment should also be understood as part of a broader process, which can affect family units in multiple ways at various stages. Barnardos, for example, document the trauma inflicted on children by witnessing arrest; the anxiety and uncertainty of the court process; and the mixed emotions and renewed sets of fears that may arise at the point of release[127]. Within this context, a robust programme of staged support for family members may offer the best chance of supporting families in staying together.

This noted, there is a need to manifest caution when seeking to rebuild family ties at the point of release. Family dynamics may have been historically poor, irrespective of imprisonment[128]. Children may have struggled with their parent's chaotic or self-centred behaviour before their imprisonment[129]. Partners left in the community might find themselves…

> …less stressed. Everything with the children is easier. There's peace and quiet, and we're financially better off. Everything is easier[130].

Within such contexts, prioritising improved resettlement for ex-prisoners may mean worse outcomes for children and partners.

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[124] 2017:472
[125] Losel *et al.,* 2012:54
[126] Storybook Dads, 2017
[127] Barnardos 2014 18-23
[128] e.g. Brunton-Smith and McCarthy 2017:464
[129] e.g. Losel *et al.,* 2012:16
[130] 'Mother of a five and seven year old,' cited Barnardos 2014:15

Adding weight to this argument, very high levels of abusive behaviour have been documented in drug dependent men[131], with levels of psychological and emotional abuse as high as 100% in some clinical cohorts[132]. Particularly strong associations have been documented between intimate partner victimisation and cocaine or alcohol misuse[133]. Family members may be the victims of prisoners' index offence[134], but abusive dynamics may also be hidden or hard to identify.

Such abuse may also extend to parents, putting them in a particularly difficult situation – parents may wish to continue providing support for their children as they leave prison, and this may be compounded by a sense of pressure if release is conditional upon a prisoner having access to secure housing. However, this may expose them to considerable emotional turmoil, accompanied by a substantive risk of (re-)victimisation[135]. Such strains are exacerbated by the tendency for prisoners to come from the most marginalised family units, where housing and space are likely to be at a premium[136].

There is also a possibility that families may not be conducive to positive resettlement outcomes. Family ties are weaker where prisoners were abused in childhood, or spent time in care[137]. Family members may have also played a substantive part in introducing prisoners to drug use or offending, and in such instances returning to share a home may have a very detrimental impact on an individual's post-release recovery outcomes. Such relationships may be particularly hard to negotiate when the involved parties are in a romantic relationship. If either one encounters difficulties, the other is likely to find it harder to avoid reverting to drug use and crime.

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[131] Gleason 1997:43; Thompson and Kingree 2006:163; Holtzworth-Munroe and Stuart 1994:484; Holtzworth-Munroe *et al.* 2000:1014
[132] Brown 1998:552
[133] Moore and Stuart 2004:386; Miller *et al.* 2000:1289; Chermack and Blow 2002:33
[134] CJJI 2014:5
[135] CJJI 2014:5
[136] McGillivray 2016:4
[137] Brunton-Smith and Hopkins 2017:468

v. Mental and physical health

Mental health

Mental health is a particular problem for drug misusing populations. Comorbid mental health and substance misuse problems are commonly referred to as 'dual diagnosis'[138]. As both mental disorder and substance misuse are independently associated with an individual's susceptibility to arrest, the chances of entering the criminal justice system are disproportionately greater for those who are dually diagnosed[139]. This is emphasised by studies of population prevalence. In a national survey of psychiatric morbidity within the general population, Singleton *et al.* identified just 3% of people suffer from two or more psychiatric disorders[140]. For prison populations, the same figure was between 71% (female sentenced) and 83% (female remand)[141]. For prisoners with drug or alcohol problems, additional mental health problems are greater still[142].

The link between mental disorder and drug misuse is particularly important given some studies have suggested that comorbid substance misuse is responsible for much – if nor all – of the additional offending of seriously mentally disordered groups[143]. In a long-term prospective cohort study, Räsänen *et al.* found that alcohol abusing schizophrenic men were 25 times more likely to violently offend than mentally healthy men[144]. The MacArthur Violence Risk Assessment study – one of largest studies of violence in schizophrenic populations – found that in the absence of substance misuse, schizophrenics evidenced a significantly lower risk of violence. However, drug using schizophrenics were substantially more violent than the general population[145], with rates of violent offending eight times higher than their non-drug-using peers[146]. Walsh, Buchanan and Fahy situate schizophrenic violence within all violent crime, attributing between 2% and 10% of all societal violence to schizophrenia. When substance misusing individuals are removed, this falls to between 0.8% and 6%[147]. Drug use

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[138] Royal College of Psychiatrists 2002a; Department of Health 2002
[139] Berkson 1946:49; Swartz & Lurigio 2007:597
[140] 2001:32
[141] 1998:23
[142] Singleton *et al.,* 1998:23
[143] Steadman *et al.* 1998:399; Monahan *et al.* 2001; Vita 2007:377
[144] 1998:437
[145] Steadman *et al.* 1998:399; Monahan *et al.* 2001; Vita 2007:377
[146] Swanson 1994:112
[147] 2006:494

may play an aetiological role in psychoses and violence, or all three may be indicative of broader chaotic lifestyles[148].

Moreover, dual diagnosis confounds treatment engagement, and is associated with negative treatment outcomes. These include suicide, exacerbated disorder, violent victimisation, violent perpetration, hospitalisation, treatment disengagement, medication non-compliance, and an increased risk of blood borne virus infection[149]. Dual diagnosis also strongly relates to recidivism[150]. Adding a final complication, services routinely fail to engage people with comorbid mental health and substance misuse problems, as drug services lack expertise in mental health, and mental health services refuse to work with individuals until they are no longer using substances (and their mental health has stabilized)[151].

In principle, a period of imprisonment should allow for such a period of stabilization, providing an opportunity for diagnosis and appropriate prescribing during a period of enforced abstinence from illicit drug use. In practice, though, drug use in prison (particularly given recent trends in the use of novel psychoactive substances) may make diagnosis more difficult. Moreover, prisons' mental health teams have routinely been overwhelmed by prisoners' levels of need, attended by the dual risks of: missing those with serious mental illness due to overwhelming levels of general need; and missing those with lower levels of need due to a pressing focus on the most severely ill[152]. This latter problem is exacerbated by the serious difficulties prisons face in securing beds in psychiatric hospitals[153] – a problem highlighted in a recent Prisons and Probation Ombudsman investigation into the suicide of a seriously mentally ill man in HMP Chelmsford following repeated failures to transfer him to a secure psychiatric bed[154].

Considerations of mental disorder should inform the development of any intervention focused on imprisoned drug users. Some residential treatment services specialize in supporting drug users with histories of serious mental illness[155]. Some mental health services can also offer enhanced access to secure housing for ex-prisoners with particularly high levels of need.

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[148] Soyka, 2000:345
[149] Dixon, 1999:S93; Soyka, 2000:345; RCP 2002b:3; DoH 2002:9
[150] Dixon, 1999:S93; Soyka, 2000:345; RCP 2002b:3; DoH 2002:9
[151] Hawkings and Gilburt 2004; Watson and Hawkings 2007
[152] Brooker and Ullman 2008
[153] Grounds 2003:S28
[154] 2016
[155] Public Health England 2017

Outside of these high-threshold, specialist contexts, partnerships with mental health providers should be a cornerstone of throughcare provision.

Physical health

The Social Exclusion Unit identified that 46% of adult male prisoners under the age of 49 had a longstanding illness or disability[156], and these are likely to be disproportionately concentrated in substance misusing populations. Those with histories of injecting are likely to evidence particular difficulties. These include high levels of blood borne viruses, with a 2012 study of Scottish prisoners identifying that 19% had antibodies for hepatitis C, indicating some historic exposure[157]. This is approximately 20 times the general population prevalence,[158] and in both prison and the community 85-90% of those testing positive have histories of injecting drug use[159]. No routine data is collected on the prevalence of HIV within imprisoned populations, though the most recent large scale survey identified that in a convenience sample of 3,942 prisoners, 0.4% were HIV positive[160]. This figure was trivially higher for those with a history of injecting drug use[161].

Other problems affecting people with histories of drug and alcohol use include arthritis, hypertension, heart disease, Chronic Obstructive Pulmonary Disorder[162], cirrhosis, circulatory problems (including deep vein thrombosis), insomnia and dental problems. These may not only impair routine functioning, they can also impede recovery-focused treatment. Hepatitis C, for example, can leave individuals lacking in energy, struggling to concentrate, and consequently unable to manage intensive psychosocial interventions[163]. Insomnia can affect every area of people's daily lives, including their ability to engage with interventions and sustain transformative change[164].

Moreover, health conditions can be intimately tied to individuals' social (re-)integration. Physically impaired people may find themselves excluded from aspects of provision centred

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[156] 2002:70
[157] Taylor *et al.,* 2012:32
[158] Taylor *et al.,* 2012:1
[159] Taylor *et al.,* 2012:1; 32
[160] Weild *et al.,* 2000
[161] Whilst the figure was 0.5%, this accounted for only four of 775 individuals with a declared history of non-injecting drug use. As such, inferences cannot be drawn from the difference. (Weild *et al.,* 2000)
[162] Rayner 2017
[163] Ware *et al.,* 1999:550
[164] Nettleton, Neale and Pickering 2011

on exercise and physical fitness. In a qualitative exploration of *The Everyday Lives of Recovering Heroin Users,* Neale, Nettleton and Pickering identified that visible signs of past drug use were 'a real source of embarrassment'[165], limiting social integration. Teeth were a particular issue here:

> Problems with teeth were a major concern to more than half the individuals in our study. Some of the most common complaints were missing teeth, snapped teeth, split teeth, cracked teeth, corroding teeth, discoloured teeth, stained teeth, painful teeth, abscesses, bleeding gums / periodontal disease, teeth with holes, crooked teeth, gappy teeth, loss of enamel, crowned teeth, and teeth with or needing fillings[166]

These problems stopped participants from laughing or smiling when in company, complicating routine interactions. Related problems include literal stigmata – physical scars caused by injecting or abscesses – that can leave individuals feeling compelled to wear long sleeved tops, or unable to wear shorts in summer weather[167].

In this context, providing a baseline of support for physical health conditions appears to be a prerequisite of any recovery-focused throughcare intervention. Interventions aimed at reducing the visible signs of drug use – such as enhanced dental support – may also have a disproportionate impact on ex-prisoners' recovery journeys. In other words, cosmetic interventions may have a disproportionate impact on recovery goals

vi. Women: additional considerations

The needs of women (ex-)prisoners are fundamentally different to those of men. This maintains both for the substantive areas of need previously covered, and for recommended responses.

Resettlement is complicated by several gendered factors. Firstly, women account for just 5% of the prison population of England and Wales[168]. In consequence, women's prisons are scarcer, and women are – on average – imprisoned 64 miles from home[169]. Developing robust

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[165] 2012:124
[166] 2012:123
[167] e.g. Haddow 2016
[168] Ministry of Justice 2017
[169] Prison Reform Trust 2016:31

throughcare arrangements is consequently more difficult, and women are further disadvantaged by a lack of both treatment provision and approved premises for them to return to. Women also tend to serve shorter sentences for petty crimes[170], further disrupting the chances of fully assessing their needs or establishing robust throughcare pathways[171].

Women's resettlement

A key limitation of the SEU's resettlement approach is highlighted by the marginalisation of women within policy and practice. This was made particularly clear by the Corston Review which, in 2007, noted that the Home Office's resettlement pathways were structured entirely according to the risks and needs of men[172]. In order to respond adequately to the needs of women offenders, two additional pathways were needed:

- Pathway 8: support for women who have been abused, raped or who have experienced domestic violence.
- Pathway 9: support for women who have been involved in prostitution[173].

The uptake of these pathways in mainstream provision has been limited[174], and they have routinely been omitted from subsequent government announcements, programming and interventions – particularly when interventions are focused on high-risk groups[175]. However, Community Rehabilitation Companies are expected to provide some support for these pathways[176], and they form a basic pre-requisite for any resettlement or recovery pathway developed for women.

Drug treatment

Rates of historic substance misuse in populations of women prisoners are higher than in comparable populations of men[177], with 58% of women using Class A drugs in the four weeks before imprisonment, and approximately half needing drug treatment[178]. The nature of

[170] Prison Reform Trust 2016:31
[171] Malloch *et al.,* 2013:13
[172] See also: Hannah-Moffat 2005
[173] Corston 2007:46
[174] 2013:50
[175] e.g. Williams and Ariel 2012; Govkovic *et al.,* 2011; Home Affairs Committee 2010
[176] CJJI 2017:6
[177] Fazel *et al.,* 2003; Singleton *et al.,* 2002:21
[178] Prison Reform Trust 2016:31

women's drug use and offending is also qualitatively different: two-thirds of women use drugs in order to offend, and / or offend in order to buy drugs; half agree that 'your offending was connected to your drug use (always)'; and 48% identify that they have offended in order to fund someone else's drug use[179] . Whilst gender-responsive therapeutic communities and cognitive behavioural drug treatment approaches have been identified as particularly effective ways of reducing women's reoffending[180], women's access to treatment appears to have dropped rapidly in recent years, with a 92% drop in the number of women starting accredited programmes related to drug misuse between 2009-10 and 2014-15[181].

As for men, establishing robust throughcare arrangements has been identified as critical to supporting the resettlement of drug dependent women[182]. The principles structuring community treatment also tend to coalesce along specific lines. Treatment should be gender-responsive[183], meaning…

> …creating an environment through site selection, staff selection, program development, content, and material that reflects an understanding of the realities of women's and girls' lives and is responsive to their strengths and challenges[184].

As Covington *et al.* note, the predominance of men within both prison and community drug treatment populations otherwise means that 'gender neutral' equates to 'designed for men[185]'. If the treatment programme involves intensive group therapy, there are also strong justifications for recommending women-only provision[186]. Drug-dependent, offending women routinely describe historically abusive or problematic relationships with men[187], and are likely to be heavily outnumbered in any treatment setting[188]. Treatment programmes that include both men and women thus expose women to a double-risk: of feeling (and being) unsafe; and of confusing the intimacy of therapeutic disclosure with sexual intimacy, and

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179 Light *et al.,* 2013:16
180 Stewart *et al.,* 2015:1; Grace 2017:2
181 Prison Reform Trust 2016:31. Some caution should be used in interpreting these data, as responsibility for commissioning accredited programmes shifted from the NTA to Public Health England in 2013. It is unclear whether or not this apparent drop may be partly attributable to changes in recording practices.
182 Stewart *et al.,* 2015:1; Grace 2017:4
183 Stewart *et al.,* 2015:1; Grace 2017:2-3
184 Covington and Bloom 2006
185 Covington *et al.,* 2008:390
186 Covington *et al.,* 2008:390
187 e.g. Corston 2007; Covington *et al.,* 2008; Flores 1997:551
188 e.g. De Leon 2000:176

starting relationships that bring an end to their time in treatment[189]. Such provision is relatively scare in the UK: Public Health England identifies only 8 women-only residential treatment units in Great Britain[190], and only one of these accepts children.

Whilst mutual aid organisations may assist with the social support of ex-prisoners[191], women may again find that gender shapes their experience. The Alcoholics Anonymous main text (the 'Big Book') contains a chapter entitled 'To Wives[192]' which, to contemporary eyes, sets out a dated picture of women's role in society and in recovery. Sexual predation – euphemistically known as 'thirteenth stepping' – is also a widespread problem in twelve-step fellowships[193], with safeguarding limited by the fellowships' flat hierarchy and informal approach to regulation[194]. In a narrative review of the literature on effective interventions for drug using women offenders, Grace surmises:

> …mixed-gender AA/NA meetings … present considerable risks for [drug using women offenders] in terms of constant drug talk, unwanted sexual encounters with men, and their stories being trivialised or ignored[195].

The availability of this form of post-release support thus becomes highly localised. Whilst some areas offer women-only meetings, others may offer little in the way of positive opportunities for women ex-prisoners.

Treatment approaches also need to be able to support women's additional levels of complex needs. Mental health and trauma are particularly prominent here[196], with the provision of a secure and safe environment constituting an absolute pre-requisite for making or sustaining progress related to drug-related needs[197]. The capacity to house children forms one basic requisite of services that aim to enable women to thrive, too[198]. A very small number of UK residential treatment services are able to house both women and their children[199], and such

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[189] Flores 1997:551
[190] PHE 2017
[191] Grace 2017:3
[192] Alcoholics Anonymous 2001:104
[193] Bogart and Pearce 2009
[194] Bogart and Pearce 2009
[195] 2017:3
[196] e.g. Najavits 2004; Covington *et al.,* 2008
[197] Najavits 2004
[198] e.g. Corston 2007:52; Barnardos 2014:15; Malloch *et al.,* 2013:13
[199] Trevi House 2017; Phoenix Futures 2017

service models may merit particular consideration for the delivery of joined-up throughcare and aftercare.

Housing

Though all ex-prisoners face housing difficulties, women are in a particularly difficult position. In practical terms, the additional distance from prisons makes it harder to build local resettlement links[200], and provision is sparse: very few Approved Premises[201] or supported housing[202] programmes can house women.

Dependent children also make women's housing situation more difficult. Somewhere between 17-18,000 children are separated from their mothers each year[203], and…

> …when a mother is sentenced, only five per cent of children remain in their own homes … While some children whose mother is imprisoned will be cared for by their father … many will either be looked after by wider family members … or enter the care system[204].

Thus, when women are released from prison, one of their first concerns may be re-gaining custody of their children. However, services can operate in ways that make this particularly complicated:

> If they do not have children in their care they are unlikely to be given priority status by housing authorities, but if they do not have suitable housing children are unlikely to be returned to their care[205].

This leaves imprisoned mothers in a particularly pernicious situation, and at increased risk of returning to abusive situations or drug-involved relationships in order to be housed.

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200 Prison Reform Trust 2016:31
201 McLeish 2005:5
202 Malloch *et al.,* 2013:13
203 Howard League, 2011:1; Corston 2007; Barnardos 2014:8
204 Barnardos 2014:14
205 Corston 2007:42; see also Malloch *et al.,* 2013:13; Barnardos 2014:15

Education, training and employment

For the greater portion of the twentieth century, women's prisons often left inmates 'infantilised by middle-class maternalism[206]'. Penal provision often focused on notions of 'domesticity, sexuality and pathology,' giving women relatively little support with pragmatic needs such as education or employment[207]. When support is provided, it tends to be heavily gendered. Evidence submitted to the House of Commons Work and Pensions Committee noted a consequent tendency for skills to be unrelated to women's practical resettlement needs:

> The skills that they are teaching, particularly in women's prisons, are not particularly applicable to today's world. They are not teaching them anything that you need in 21st Century Britain. They are teaching them hairdressing. We don't need hairdressers. We have too many hairdressers in this country. They are teaching them sewing. Life has moved on … Women in prison should be taught how to do Excel spreadsheets, coding, and business administration[208].

An additional issue centres on 'job-readiness'[209]. As noted, formerly drug-dependent women ex-prisoners have very high levels of complex need, often attended by little engagement with paid employment, and so approaches to ETE may benefit from being cautiously staged:

> …[f]or many women employment will not be regarded as an immediate need on release from prison since other pressing issues (such as drug use, accommodation, and regaining custody of children) will need to be resolved first[210]

Finally, women's position as routine sole carers means that access to childcare is a fundamental requirement before they can begin looking for ETE[211]. The cumulative impact of these gendered differences are reflected in ETE statistics: just 8.5% of women ex-prisoners find employment, compared with 26.2% of men[212].

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206 Heidensohn 2002:511
207 Gelsthorpe and Sharpe 2007:24
208 Work and Pensions Committee 2016:15
209 e.g. Neale and Kemp 2007
210 Malloch *et al.,* 2013:15
211 Work and Pensions Committee 2016:16
212 PRT 2016:30

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Appendix A: Recovery Capital

The Components of Recovery Capital

Social Capital

Social capital can be seen as the sum of resources, actual or virtual, that accrue to an individual or a group by virtue of possessing a durable network of more or less institutionalized relationships of mutual acquaintance recognition (Bourdieu and Wacquant, 1992). The central idea behind social capital is that membership in a social group confers resources, reciprocal obligations, and benefits on individuals who may use this "stock" to improve their lives. Social capital is important during life crises because it affects the options, resources, information, and supports available to people as they attempt to resolve their problems. The possession of social capital helps facilitate particular ends, whether it is in acquiring employment or whether it is overcoming a major life obstacle.

When substance-dependent persons have access to social capital and attempt to terminate their substance misuse, expectations and obligations of others can serve as valuable resources. Be it emotional support or access to opportunities that aid in a cessation effort, persons who have social capital are in a much better position to initiate and maintain a successful recovery effort than individuals who do not have these kinds of acquaintances and friendships.

Physical Capital

Physical capital, typically referred to as economic or financial capital, includes income, savings, property, investments, and other tangible financial assets that can be converted to money. While the terms wealth, material capital, or other terms could be used to refer to these assets, physical capital is the term that has been used by social economists such as Shultz (1961), Becker (1964), and Coleman (1990). Those who are financially stable, by definition, possess physical capital. Substance-dependent persons who possess physical capital have access to options for pursuing recovery or terminating substance misuse that persons without financial resources do not have. These persons generally have health insurance or are members of health maintenance organizations where some form of professional assistance, including

detoxification and inpatient or outpatient care, can be acquired. If they choose to pursue recovery without treatment, they can temporarily or permanently extract themselves from their environments and the related cues within them that sustain and promote their substance use. For example, they can take leaves-of-absence from their jobs or extended vacations to "get clean." They can temporarily or permanently relocate if they decide such a move is necessary to quit using.

Human Capital

Human capital embodies a wide range of individual human attributes that provide one the means to function effectively in contemporary society, to maximize individual benefits associated with membership in that society, and to attain personal goals. Examples of human capital include knowledge, skills, educational credentials, health, mental health, and other acquired or inherited traits essential for optimal negotiation of daily life. While the range of such human attributes is extensive, at least three of these elements are often seen by substance dependency treatment providers as intricately tied to one's ability to overcome substance dependence. These include heredity, mental health, and employability. Genetic inheritance can play a major role in determining one's future physical and mental makeup. Although the extent of influence genetics has on substance dependence has been vigorously debated (Peele, 1990; Reinarman, 2005; Schaler, 2004); substance dependent persons are at least as vulnerable to those influences as the general population.

In terms of mental health, the relationship between substance misuse and mental health, challenges large numbers of persons has been established (Kessler et al., 1996). Without employment or the necessary skills for reasonable prospects for a legitimate source of steady income, substance dependent persons can find themselves immersed in the drug subculture where selling drugs and related criminal activity can undermine their ability to cultivate prosocial values and patterns of behavior that bolster their chances for success through legitimate means.

Cultural Capital

Cultural capital embodies cultural norms and the ability to act in one's interest within those norms to meet basic needs and maximize opportunities. Cultural capital includes values, beliefs, dispositions, perceptions, and appreciations that emanate from membership in a particular cultural group (Bourdieu, 1986). Those who misuse substances, who accept conventional norms, and have a stake in societal conformity have a distinct advantage over those who have been socialized to reject them. Our research has shown that self-remitters have or "convert" to these values and belief systems as they overcome their addictions (Granfield and Cloud, 1999, 2001). Indeed, constructing new systems of meaning that are consistent with sobriety and/or nonproblematic substance use is commonly the most difficult component of any substance misuse recovery effort. Participating in a subculture of ongoing substance misuse and developing an associated "code of the street" that emphasizes the importance of street reputation, respect, and settling disputes through violence (Anderson, 1990; Terry, 2003) often fosters misuse and can delay recovery.

Often persons from disadvantaged backgrounds or oppressed groups develop behavior patterns that can be seen as adaptive for coping with oppressive conditions. Yet, these same behaviors can undermine their ability to function effectively in conventional society and employ the necessary strategies to overcome problems like substance misuse (Bourgois, 1995). Enduring membership in a drug-user subculture permits the development of discordant values that make it difficult to find quitting substance misuse appealing. The practice of associating substance use with "toughness" and "style" as well as seeing drug-related crime as a reasonable occupational option make reentry into conventional life particularly challenging (Bourgois, 1995; Terry, 2003). Whether or not one pursues terminating substance misuse with or without treatment, these well-developed, alternative values represent a potent form of negative recovery capital that can undermine motivation to pursue recovery and compromise one's ability to adequately engage in a cessation effort.

Cultural capital and human capital are uniquely interrelated, in that many of the attributes of human capital can be influenced by an acceptance of the prosocial norms of the dominant culture and support from one's environmental surroundings to acquire those attributes. For example, over the last decade there has been a growing concern among African American

leaders about the diminishing regard for educational achievement in middle school and high school settings by an alarming number of African American students, where “being smart” is seen as “being white” and, therefore, something to avoid (Ogbu and Fordham, 1986). Of course, this subcultural by-product of disenfranchisement can hold enormous later-life consequences for young persons who accept this ethos, be it acquiring sufficient education and skills to function in contemporary society or for deriving meaning in life through socially accepted means.

Some from various ethnic groups are very private and quite hesitant to share personal problems with those outside their immediate families and are very cautious about seeking professional assistance for such problems from those beyond their family circles (Fisher and Harrison, 2005; Mechanic, 2008; Stockdale, Tang, Belin, and Wells, 2007). Given the negative experiences of many persons of color with professional helpers, such reservations can be seen as quite understandable.Yet, this widely shared distrust of helping professionals and avoidance of professional assistance can delay help-seeking until substance misuse related problems are extremely intractable. Unfortunately, in many instances, unwanted contact with the criminal justice system is often the primary incentive to seek professional help.