



Research Paper

Capital depreciation: The lack of recovery capital and post-release support for prisoners leaving the Drug Recovery Wings in England and Wales

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ABSTRACT

Background: This article draws on the evaluation of the pilot Drug Recovery Wings (DRWs), which were introduced ten prisons in England and Wales, with the intention of delivering abstinence-focused drug recovery services. The DRW pilots can be seen as representing the extension of the recovery paradigm – so prevalent elsewhere in UK drug policy – to the prison system. This study aimed to provide a detailed account of DRW prisoners' expectations and experiences in the transition from prison to the community and explore the potential for 'doing recovery' in prison and on release.

Methods: In-depth, qualitative interviews were conducted in prison with 61 prisoners across six of the DRWs. Follow-up interviews six months after release were conducted with 21 prisoners and 26 'recovery supports' (people identified as being close to the prisoners). Data from one, other or both sources was available for 36 prisoners. All interviews were fully transcribed and coded.

Results: The majority of the 61 had long histories of alcohol and/or opiate dependence, childhood adversity, undiagnosed mental health problems and few educational qualifications. Nonetheless, many had long histories of employment – mostly in manual trades. The majority described themselves as being 'in recovery' at the time of the first interview in prison. While one of the main aims of the DRWs was to support prisoners' recovery journeys into the community, this aspect of their work did not materialize. Professional support at release was largely absent or, where present, ineffectual. Many were released street-homeless or to disordered and threatening hostels and night-shelters. Only three of the 36 were fully abstinent from drink and drugs at time of re-interview, although some had moderated their use. A substantial number had returned to pre-imprisonment levels of use, often with deeply damaging impacts on those around them.

Discussion and conclusions: This research suggests a fundamental contradiction between recovery and imprisonment. In large part, imprisonment serves to erode recovery capital while, at the same time, making psychoactive substances readily available. Looking to the future, every effort should be made to divert substance users from imprisonment in the first place. Where that fails, the primary aim should be to reduce the erosion of recovery capital during imprisonment: through family support work, providing proper housing, training and education opportunities and ensuring a graduated reintroduction of prisoners into the community.

Introduction

This article draws on the evaluation of the pilot Drug Recovery Wings (DRWs), which were introduced in eight men's and two women's prisons in England and Wales, with the intention of delivering abstinence-focused drug recovery services. Rather than focusing on the evaluation of these projects, which has been covered in detail elsewhere (Lloyd, Page, Russell, McKeganey, & Liebling, 2017), this article draws on detailed qualitative interviews undertaken over 2014 to 2016 with prisoners before and after their release from six of the DRWs, to draw

out what we see as some of the most important implications from this research. We focus here on the nature and extent of prisoners' recovery capital while in prison and their situation on release. The bleak picture presented by the sample's circumstances six months after they left prison raises fundamental questions about the level of community support needed by prisoners on release. It also raises important questions about the meaning of 'recovery' within a custodial setting: a setting which is almost tailor-made to deplete the wider, structural assets and sources of support thought to be so important to recovery from addiction.

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Background

Policy origins

The decision to pilot recovery wings in England and Wales can be linked to the much greater prominence of recovery within UK drug policy and practice over the past decade. Indeed, recovery has become the watchword in UK drug and alcohol treatment over this period, adopted in the title of national drug strategies and local projects alike, and representing a shift away from long-term methadone maintenance in particular, in favour of abstinence-oriented approaches and social reintegration (Duke, 2013; Stevens, 2017; Wardle, 2012). While the focus on recovery has been particularly strong in the USA and UK, it has also been reflected increasingly in international strategies and policies, such as the 2017-20 European Union Action Plan on Drugs (EU, 2017) and the United Nations Commission on Narcotic Drugs' resolution 57/4 (UNODC, 2014); and the strategies of individual countries such as Australia (Australian Department of Health, 2017). Nonetheless, recovery has been a strongly contested concept in the UK and elsewhere (Lancaster, Duke, & Ritter, 2015; Neale, Panebianco, & Finch, 2015). With its perceived roots in American notions of sobriety (Dale-Perera, 2017; Stevens, 2017), many have seen the UK recovery movement as carrying a threat to harm reduction interventions, with the potential to prematurely encourage people into detoxification and abstinence programmes (e.g. Neale, Nettleton, & Pickering, 2014), with potentially fatal consequences. The triumph of the concept in the UK drug policy context may have much to do with its mercurial nature: meaning different things to different people at different times. As Stevens (2017) describes, the successful 'absorption' of recovery into British drug policy has been achieved at least in some degree by its redefinition to include, for example, those achieving increased control over their drugs use, rather than simply those who are abstinent. So, for example, 'freedom from dependence' may have been 'the ultimate goal' on the 'person-centred journey' in the 2010 UK Drug Policy (HM Government, 2010, p.18) but that left a lot of potentially more realistic, intermediate stopping off points to which people in the sector could sign up on the way.¹

Drug users and drug treatment in prison

Previous research has shown problematic substance users to be greatly overrepresented among prisoners (EMCDDA, 2012; Fazel, Bains, & Doll, 2006; Carpentier, Royuela, Montanari, & Davis, 2018; Singleton, Meltzer, Gatward, Coid, & Deasy, 1998; Lirano & Ramsay, 2003; Stewart, 2009). While use of most drugs declines in prison following reception (Bellis et al., 1997; Bullock, 2003; Shewan, Gemmell, & Davies, 1994), the opposite appears to be the case for New Psychoactive Substances (NPS). NPS use is often initiated or increases inside prison (HM Inspectorate of Prisons, 2015) and is becoming widespread in prisons across Europe (EMCDDA, 2018b). In addition to being overrepresented in prison, people with a history of problematic substance use are also particularly likely to have experienced a wide range of other problems, such as leaving school early, unemployment, mental disorder, poor physical health, homelessness and relationship difficulties (Singleton et al., 1998; EMCDDA, 2012; Galea & Vlahov, 2002; Light, Grant, & Hopkins, 2013). Such considerations, along with the high rates of reoffending (Brunton-Smith & Hopkins, 2013) and overdose deaths (e.g. Farrell & Marsden, 2008) in this population, have led to an increasing emphasis on drug treatment in prison in many countries around the world.

A wide range of drug treatment approaches have been introduced in prisons (EMCDDA, 2012, 2018a). Quantitative evaluations of drug

treatment in prison have mainly focused on two types of intervention: Opioid Substitution Therapy and Therapeutic Communities (see Lloyd, Page, Russell et al., 2017 for a review). Both approaches have shown positive results but findings emphasize the importance of post-release treatment and support for sustained impact. A substantial body of qualitative research has focused on the dramatic increase in the provision of treatment in prison and what this means for the roles played by prison officers and treatment staff (Giertsen, Nylander, Frank, Torsten, & Tourunen, 2017; Kolind, Frank, & Dahl, 2010; Kolind, Frank, Lindberg, & Tourunen, 2014); but also the rather different functions of prison drug treatment for inmates, in terms of mitigating the pains of imprisonment more generally (Frank, Dahl, Holm, & Kolind, 2015).

Substance use, recovery capital and imprisonment

The very idea of prison 'recovery' wings raises questions about the place and meaning of recovery in a prison through-care setting. A key concept in the drug recovery field is the notion of 'recovery capital'. Granfield and Cloud (1999) state that:

[A] person's structural location in society and the relationships, networks, and other assets that adhere to one's social position greatly affect one's chances for recovery. In some ways, the intensity of intoxicant use may be less important in overcoming dependency than the contextual factors that surround addiction in a person's life (p.178).

This holistic perspective is associated with their concept of 'recovery capital': the sum total of one's resources that can be brought to bear in an effort to overcome alcohol and drug dependency' (Granfield & Cloud, 1999, p.179). This notion of recovery capital lies at the heart of recovery-focused policies and interventions in the UK, with a particularly strong emphasis on the concept in the previous drug strategy (HM Government, 2010)² and is a highly influential idea underpinning recovery-oriented interventions in a number of countries around the world.

These authors have elsewhere outlined four different components of recovery capital: social, physical, human and cultural (Cloud & Granfield, 2008, see also Best & Laudet, 2010). To briefly summarise: social capital consists of the resources available to an individual through belonging to social networks, including access to emotional and practical support at times of crisis. Physical capital is defined as a person's financial assets. Human capital comprises a range of attributes such as knowledge, skills, qualifications, genetic inheritance and health and cultural capital is defined as the 'values, beliefs, dispositions, perceptions and appreciations that emanate from a particular cultural group' (p.1974).

Recovery capital has increasingly been the subject of research, including a substantial body of work focused on its measurement and quantification (e.g. Best, McKitterick, Beswick, & Savic, 2015; Groshkova, Best, & White, 2013; Mawson, Best, & Lubman, 2016). Qualitative research has also been undertaken (Neale & Stevenson, 2015; Neale et al., 2014; Timpson, Eckley, Sumnall, Pendlebury, & Hay, 2016). Drawing on their repeated, in-depth interviews with recovering heroin users, Neale et al. (2014) applied Cloud and Granfield's model to explore variations in different types of recovery capital among female and male users. These authors also offer an interesting critique of the recovery capital concept, pointing out that in the context of their sample, the idea of physical capital in terms of financial resources had limited resonance, given the high levels of poverty and debt in their sample. Neale et al. also emphasized additional types of recovery

¹ The most recent strategy has likewise focused mainly on recovery from dependence (HM Government, 2017).

² While the phrase 'recovery capital' is not used in the most recent UK Drug Strategy (HM Government, 2017), there is a strong emphasis on recovery and, in particular, building recovery through a focus on housing, employment, family relationships and health, as well as drug treatment (p.28–38).

capital that did not appear to fit into the Granfield and Cloud model, such as physical appearance (including dental appearance) and life skills such as budgeting and cooking. They also emphasized the importance of mental and physical health, which rather than being a subcategory of human capital, should be a separate, fifth component – ‘health capital’. However, ‘most fundamentally’ (p.10), they take issue with the idea of cultural capital, asserting that the acceptance of cultural norms that make up part of the notion of cultural capital can be constraining and potentially damaging. Especially where cultural norms promote gendered roles or expectations concerning appearance or caring for others, Neale et al. argue that recovering women may be adversely affected.

In considering these points, it is instructive to note that Granfield and Cloud’s originating study (Granfield & Cloud, 1999) focused on ‘natural’ recovery – i.e. recovery without treatment or mutual aid. Of their sample of 46 ‘self-healers’, 12 were professionals and 23 were otherwise employed; and 33 of the 46 had some college education (six at postgraduate level). Their sample was therefore radically different from the type of recovering heroin users studied by Neale et al. who mostly left school at age 16 or younger and were described as ‘materially very poor’ (Neale et al., 2014, p.7). Moreover, over half of Granfield and Cloud’s sample had previously experienced drinking problems and others had problems with powder cocaine, rather than heroin. It seems very likely that the ‘goodness of fit’ for Granfield and Cloud’s model may therefore vary according to the nature and background of the sample studied.

Such considerations imply that the levels of different categories of recovery capital will vary greatly across different groups of substance users (Advisory Council on the Misuse of Drugs, 2013; Neale & Stevenson, 2015; Connolly & Granfield, 2017; Page et al., 2016). In their detailed qualitative study of the relationships of homeless substance users living in hostels, Neale and Stevenson (2015) observed that ‘social networks, and the sources of social and recovery capital, were relatively limited’ (p.481), with some describing very few close relationships with people other than professionals working in the hostel or elsewhere. Long-term injecting opiate users are also a group with notoriously low levels of recovery capital (Advisory Council on the Misuse of Drugs, 2013; Page et al., 2016). Likewise, prisoners with long histories of drug and/or alcohol dependence are a group that has particularly low levels of recovery capital. While imprisonment does not appear as a theme within Granfield and Cloud’s (1999) study, the authors observe towards the end of their book that ‘...prison life typically destroys much of the opportunity to utilize or develop the necessary recovery capital to terminate an addiction’ (ibid., p.209). It could also be argued that prisons effectively deplete what recovery capital prisoners may have had prior to incarceration, in terms of close relationships, employment, housing and mental and physical health. The most appropriate aim for drug treatment in prison may therefore be to alleviate these negative impacts (Kolind et al., 2010).

Finally, an additional feature of Granfield and Cloud’s recovery model worthy of comment in the current context is the notion of ‘turning points’ (Granfield & Cloud, 1999, p.73-78): events or experiences that dramatically disrupt peoples’ lives and provide the potential for the adoption of new identities and/or lifestyles. Such critical moments³ have been described in the addiction field as ‘epiphanies’ or ‘transformative experiences,’ and can be largely positive - such as the birth of a child or falling in love – or broadly negative, such as sudden, serious health problems, bereavement etc. (McIntosh & McKeganey, 2000). Recovery can therefore be realised as a gradual process, through

³ The idea of turning points and critical moments has a long history and wide application within the social sciences. For example, Thomson et al. (2002), provide a detailed account of the critical moments in young people’s transitions to adulthood. See also Giddens idea of ‘fateful moments’ in the project of the self (Giddens, 1991).

the slow accretion of recovery capital over many years and multiple treatment episodes, or it can occur as a ‘climactic transformation’, focused on a key turning point (White & Cloud, 2008).

The DRW evaluation

Ten Drug Recovery Wing (DRW) pilots were introduced in England and Wales: seven in adult male prisons; two in women’s prisons; and one in a Young Offender Institution. The DRW evaluation, funded by the English Department of Health, was a substantial, three-year study of the operation and impact of these pilots, over the course of which 345 qualitative interviews were conducted with prisoners and staff, 631 detailed impact questionnaires were administered to prisoners, and survey data on quality of life were analysed from 1246 prisoners.

This article draws on data collected as part of a detailed process evaluation of six of the ten DRW pilots. These six were all adult male prisons apart from one (male) Young Offender Institution.⁴ Interviews were conducted with prisoners in each prison and then follow-up interviews sought six months post-release. In addition, interviews were sought with *recovery supports*: people identified by the prisoner at the time of their prison interview who would be able to talk about the prisoner’s progress on release.

Aim of this article

This article aims to provide a detailed analysis of the recovery capital that prisoners had at their interview in prison, the support they received prior to release and the situations they found themselves in on leaving the prisons. Prisoners were also asked to reflect on what recovery meant to them and analysis of these data are also presented. As outlined earlier, the following account therefore focuses on broader aspects of recovery capital, rather than the minutiae of treatment programmes and regimes occurring in the six DRWs, which have been described elsewhere (Lloyd, Page, Russell, McKeganey, & Liebling, 2014; Lloyd, Page, Russell et al., 2017), picking up the story as the prisoners near their release date and following them into the community. In so doing, it seeks to make wider points about the post-release support needed by prisoners recovering from dependent substance use and the fundamental problems that seem to hamper any attempt to ‘do recovery’ in prison.

Methods

In each of the six prisons, we aimed to undertake in-depth, semi-structured, qualitative interviews with a sample of 10 prisoners who were within four weeks of release and then follow up as many as possible in the community at six months post-release. Potential interviewees were identified using prison records, and given Participant Information Sheets (PIS) in advance of the study. Those who were willing to be interviewed (virtually all prisoners approached) were then seen in a private interview room on the wing. After the interview, prisoners were asked to identify the recovery supports who would know of their whereabouts following their release, and who prisoners were happy for us to contact for interview. Our aim here was both to seek some triangulation of accounts of prisoners’ progress on release and to improve our chances of locating ex-prisoners themselves, given the notorious difficulty of accessing prisoners post-release.

Our analytical approach drew on adaptive theory (Layder, 1998) which, whilst recognising the principled advantages of grounded approaches (Glaser & Strauss, 1967), seeks to avoid the hazards of an entirely emergent approach. Interview topic guides were developed to

⁴ While detailed process data were collected on one of the women’s DRWs, the throughput of prisoners was very low and it was not possible to interview a sample shortly prior to release and follow them up in the community.

reflect prominent themes identified in relevant previous research and policy documents (for example, [Genders & Player, 1995](#); [HM Government, 2010](#); [Ministry of Justice, 2010](#); [Patel, 2010](#)). This thematic backbone provided the outline of a hierarchical coding tree; however, questions were often answered with considerable nuance, and in great detail and some unexpected topics arose, such as the significance of having ‘lodgers’ on the DRWs who were not engaged in the programme ([Lloyd, Page, Russell et al., 2017](#)). Supporting this flexibility, adaptive theory allows for the development of emergent codes around a coding process ‘crank-started’ by deductive means. Framed by this structure, all interview transcripts were entered into NVivo 9, wherein they were coded using an adaptive and emergent coding process ([Seale, 2004:243–4](#)). To support the use of the NVivo database across the full research team and in as-yet-unexpected contexts, codes were both wide-ranging and liberally applied. Specific case studies and site-specific instances were also coded. This yielded a final coding tree with four hierarchical levels, with seven lead nodes: case studies; DRWs’ conditions, processes, treatment, development, etc; medication; prisoners’ life histories, opinions, and experiences; recovery; relationships; staff opinions and experiences; and substantive turning points in prisoner narratives. Over 150 nodes filled the next three hierarchical levels, and these could be further analysed so that members of the research team could filter results by prison, by prison type, by interviewee type (staff / prisoner), by staff role (e.g. discipline, psychosocial, clinical) and/or by prisoner’s gender.

A note should be added here on the nature of this sample. All the prisoners had been selected to enter the six DRWs and while the selection criteria that existed varied considerably between units ([Lloyd, Page, Russell et al., 2017](#)), it can be assumed that, overall, this represents a group of prisoners who were particularly motivated to make changes to their substance use and wider lives. This was borne out in interviews with staff and prisoners in the six prisons ([Lloyd, Page, Liebing et al., 2017](#); [Page et al., 2016](#)). In thinking about the wider implications of our findings, it is therefore important to consider the particular nature of this sample. It is one that had received varying levels of input - from full-time, intensive drug treatment programmes to little therapeutic input or support beyond the conventional regime operating within that prison. It is also one that should have been receiving extra help through the prison gate, given that this was a key aim of the initiative ([Powis, Walton, & Randhawa, 2014](#)). Thus, the findings that follow can be seen in some sense as a ‘best case’ scenario: or, at least, they relate to a sample that certainly cannot be seen as having higher level of problems and disaffection than the larger population of prisoners with histories of substance dependence.

Findings

Interviews were undertaken with 61 prisoners in the DRWs and follow-up interviews were successfully undertaken with 21 prisoners and 26 recovery supports. In 11 cases, both prisoner and recovery supports were interviewed, yielding some follow-up data from at least one source on 36 prisoners. With regard to those that were lost to follow-up, in two cases they remained in prison for longer than expected and were not therefore released by the time of follow-up; in seven cases, the potential participant had been re-imprisoned; in two cases there was clear reluctance to be re-interviewed, and in the others the information was either too vague to allow proper contact or phone numbers had been changed or disconnected and letters remained unanswered.⁵

⁵ Such attrition of a qualitative sample can result in important narratives being lost to analysis. However, this study was unusual in managing to access and interview some particularly vulnerable users in hostel accommodation: the type of ex-prisoner that we would expect to be over-represented among those normally lost to follow-up. While it is impossible to be completely confident, we

Interviews in prison: recovery capital

This section looks at various elements of recovery capital reported by prisoners at the time of their interview in prison. It should be emphasised that the problems described here are largely deep-rooted and long standing (see also [McKeganey et al., 2016](#)). It is not suggested that they are wholly attributable to their current state of imprisonment.

Age, sentence and substance use histories

The six DRWs had very different assessment and selection approaches, from almost open access through to strict expectations concerning motivation and abstinence (see [Lloyd et al., 2014, 2017a](#) for further details). The mean age varied across the DRWs from 19 to 38 years (reflecting the inclusion of a Young Offender Institution among the six), and the average sentence length varied between 18 and 26 months. Most had been imprisoned for violent or acquisitive crimes.

The large majority of the sample had long histories of alcohol and/or opiate dependence and most described using drugs and/or getting drunk between the ages of 13 and 15 years, followed by a slide into increasing problematic use.

...at 12...I was smoking weed and at the age of 14 I was introduced to crack and I started smoking crack, then smoking heroin. And I started selling it and ended up in and out of prison...

For men who had not used heroin or crack cocaine, substance use tended to centre on various combinations of alcohol, cannabis and powder cocaine. Thirty-four of the 61 interviewees reported being opiate dependent on prison entry, of whom 16 had detoxified by the time of interview.

With regard to drug use in prison, drug availability was seen as a considerable challenge by the sample. In all but one of the DRWs, Novel Psychoactive Substances (‘spice’), cannabis and diverted medications (including opioid) were readily available.

Family background

Prisoners interviewed described a wide range of childhood experiences. The most prominent of these was parental separation (experienced by a majority of interviewees), bereavement and experience of being in care.

I came from a broken home really, I’m the eldest of four and we moved around a lot when I was a kid and my mum was an alcoholic and we had guys flitting in and out of our lives and I ended up in care like at a pretty early age.

Family bereavement was fairly common, with eight having lost a parent and others having lost a sibling. Many had experienced local authority care. A clear link was made by a number of interviewees between these events and the development of drug use and crime.

I lost my dad when I was five, and my mum got terminally ill when I was fourteen... And that’s when I really started to spiral out of control. I was never a violent criminal up until then, and basically they put an unruly certificate on me meaning that I couldn’t be controlled at home and put me in care. So then from care I just started getting worse, kept running away to be at home then my parents would give me back because they said it was the right thing to do, so I wouldn’t go home, I’d go to other people and get in the wrong crowd.

(footnote continued)

believe that our followed-up subsample represents a good cross-section of the wide variety of experiences and situations faced by prisoners released from DRWs.

Experiences of care were almost universally negative. As one interviewee reflected ‘there wasn’t any care in care’.

A small number had been seriously physically or emotionally abused.

My dad used to like batter the fuck out of me... I mean he used to proper fucking lay into me and that... After that I got to about the age of 13 it didn’t really bother me. I was like, I would... come home, know what’s waiting for me, walk in the door, get battered... Come back the next day, same old shit... I went to a pretty rough school and...I was fighting loads in there... And fucking got kicked out of school. Went to loads of different centres. Got kicked out of all of them. Went to college. Got kicked out of there and then just thought fuck education, you know what I mean. Not for me. And then I got to the age of 15.

However, it should be stressed that there were also more positive accounts of family background. Some described fairly innocuous childhoods, and a small number offered glowing reviews of their early years – although this was often associated with considerable guilt.

I’ve had family support. Everything. My family’s been there for me. I don’t know why I keep mucking up.

Significantly, in the context of recovery capital, several of the interviewees describing positive childhoods remained in contact with their parents, who were able to offer continuing practical assistance on release.

Education

Only very few of the interviewees had obtained good qualifications. Most had left school early, with no or very limited qualifications.

In year nine [13 to 14 years old] I got kicked out of school because I just couldn’t behave, I was too wild, and then I went to four different schools and I just kept getting kicked out, kicked out, kicked out.... And it just went down from there.

Some had been involved in fights with other pupils or, on occasion, teachers. More often, their behaviour had been disruptive, making other pupils laugh or ‘telling teachers to fuck off...’

In reflecting on why their schooling had been so problematic, some interviewees referred to coming from travelling families and fighting as a result of other children bullying them or calling them names:

Well, when I was younger through like my comprehensive [school], we used to get into a lot of trouble because they would call me gypsy, you know what other kids are like, and I used to...I basically tended to get into fights then.

Others had problems with their hearing or dyslexia that had not been properly diagnosed or responded to and one explicitly linked his fighting in school with the violence he had experienced in the home:

I was fighting loads in there. I always used to think, I’d be looking at someone and think you know you could not hurt me as much as my dad’s hurt me, you know what I mean? So I thought fuck it and that, scrapping and that, I’d have like two, three fights a week in school and that. And fucking got kicked out of school.

Nonetheless, many others put their behaviour down to simply not being interested or ‘bunking off school’ to smoke cannabis.

The young age at which many prisoners had stopped attending school suggested comprehensive, systemic failings. A group of interviewees from one DRW described being expelled from primary school, and engaging with no structured education after this point. Several stated that they were unable to read or write.

Given its dynamic nature, education offers an important area in which recovery capital can actually be enhanced over the course of a prison sentence. However, only one of the sample reported obtaining

useful qualifications in prison. There was the feeling of considerable untapped potential here:

Yeah. Well you know when I look back...it’s funny like....when I was young, when I left school, I had no interest in school. I couldn’t wait to leave. It was the best thing that could have happened to me...As I’ve got older, I’ve sort of like become more interested in politics and how the world works.

Employment

Although few had formal qualifications, substantial employment histories were commonplace. Around half of our interviewees described longstanding engagements with work, mostly in manual trades.

I was a French polisher... I done a four year apprenticeship. Stripping furniture and then going on site doing staircases, and the tops of bars, counter fittings.

Work was clearly an important part of many of these men’s views of their own masculinity.

I always earned my own money: it might have been through robbing, but I worked as well.... Because that was the sort of family I come from... As long as you’re earning your money and you make an effort and put food on the table for my kids and my partner I would be respected. It’s like “he’s a heroin addict but he does look after his kids and his family”...

Prominent trades included roofing, gardening, market stalls, scaffolding, fitting, roofing and general labouring, although many had only worked on short-term contracts or had repeatedly lost their jobs – usually on account of their substance use.

I started having a smoke of the heroin...and the more I smoked the more I became dependent on it. Ended up an addict on heroin... started missing work, jibbing out to score, getting back late, not turning up [...] So I ended up losing my job...

Very few interviewees had no experience of employment and the skills and experience the rest had built up over their lives seemed to constitute a considerable potential for the future, with many referring to job offers and contacts they would approach on release.

Mental health

Experiences of depression, anxiety and schizophrenia were common. Sometimes interviewees described such symptoms as being drug-related – with frequent reference to cannabis use causing anxiety and paranoia.

Well I would say cannabis [is a problem] because obviously it’s made me paranoid with me missus and that...

A number referred to psychotic symptoms:

I’ve had enough. I can’t let alone. Literally I’m losing my head in there. The other day I was hearing voices and that in my head...like I was shouting abuse, and it was calling and calling, and it was doing my head in man.

Prescription of psychotropic medication was common both prior to imprisonment and in prison:

I absolutely love the tablets. They help me to sleep. They stop the voices. I don’t see things no more.

A number referred to self-harming and previous suicide attempts, and others to overdoses which were neither entirely suicidal nor entirely accidental.

The meaning of recovery

The majority of interviewees thought that they were ‘in recovery’ at the time of interview, with a small sample stating that they had ‘recovered.’ However, others were clearly ambivalent about their recovery status or felt recovery was a word that did not apply to their situation.

Because I’m on medication... I hate that word, ‘recovery.’ It’s a word I don’t like to use.

Among those for whom the word had more currency, two main meanings were given. For a substantial proportion, ‘recovery’ was exclusively about changes to their drug use. In some instances, this meant complete abstinence:

Recovery is just... getting off drugs.

Another substantial subgroup understood recovery as being about specific changes to their patterns of drug use: stopping the use of drugs that had caused them problems or detoxifying from Opioid Substitution Therapy (OST) but sustaining use of other drugs, such as cannabis and alcohol. Many saw managing to use these drugs recreationally as representing a return to ‘normality.’

It’s like if someone gets married, like my nephew or my niece gets christened - I don’t want to be the oddball of the family, stood there, when everybody’s having a toast, with an orange. I want to feel... everybody wants to feel part of the group or part of their family....I just want to be normal.

Other conceptions of recovery were more in keeping with [Granfield and Cloud’s \(1999\)](#) perspective, involving broader moves towards social integration – (re)gaining employment, rekindling or repairing relationships, and achieving some sort of stability in their lives.

Just stable in life. I mean, I’m not going to sit there and say I want my own business and that... But in the next five years I just want to be stable. I want a decent pay cheque every week, I want to be able to look after my daughter and just watch her grow.

Short- and long-term goals

For many of these interviewees, there was a strong sense that they were ready to make fundamental changes to their lives: to give up their often long histories of substance abuse and seek more conventional lives and goals.

For the first time in my life I feel confident. I feel confident that I can go out of here and not even think about drinking or taking drugs.

However, predicted changes in substance use were often nuanced, including references to controlled drinking or using cannabis but not other drugs:

Yeah, I’d be alright with a joint but I can say no to the crack.

Relationships, increasing age and growing tired of a life of substance use and crime were often key in terms of explaining their motivations for such change as the quotations from three different interviewees demonstrate:

Because I am fed up. I am sick and tired of being sick and tired. I want to be back to me. I want to now try and challenge myself a bit more... I want to be a good dad to my daughter.

I’m not getting any younger, as I say, and opportunities are not going [to] keep presenting themselves to me to be able to change. My daughter’s 15 at the end of this month and I’ve missed a large chunk of her life...

...I’m getting to the age now when there’s not many chances I’ve got left, I think it’s my last one...

Age was therefore clearly a factor, with a strong sense that time was

running out for them.

In some of these accounts, there was a degree of ambiguity or lack of confidence in making radical changes to their substance use on release:

And I’m capable of doing it but [pause]...I don’t know, I think it’s when I decide to do it.

In terms of longer-term goals, there was a pronounced dissonance between their current position in often unpleasant, crowded, disordered prisons and an idealised future of wife, car and steady job. Prisoners were asked where they would *like* to be in five years’ time and the large majority responded in terms of such conventional goals.

...just staying drug-free, family, working, going to the pub on a Sunday, watching the football, a couple of pints, a game of snooker.

Preparation for release and expected support on release

DRWs were expected to put a strong focus on continuity of care and support through the prison gate ([Ministry of Justice, 2010: 29](#); [Powis et al., 2014: 1](#)) and prisoners identified resettlement as a key areas of concern.

The problem for me has never been in here, it’s always when I’m faced with reality when I leave them gates. I can be the model citizen and prisoner in here.

Many had previous experiences of homelessness or inappropriate accommodation, relapse and reoffending and emphasised that they would need more aftercare support to maintain any progress made on the DRWs. However, none reported having received a concrete offer of housing from housing services and most expected to be released to Bed and Breakfasts (B&Bs), hostels and night shelters.

Situation at follow-up

Of the 36 prisoners where follow-up interview data were available, only three were fully abstinent from drink and drugs. They had achieved this through diverse means: one through his Islamic faith, another through a desire to renew relationships with his children (without any professional support), and a third through family support and Narcotics Anonymous. A substantial additional group had moderated their substance use. Employment was often a key aspect of recovery capital that helped people reduce substance use.

The thought of going in Monday morning with a hangover, and shifting bananas at three o’clock in the morning. Wow!

However, another large group had returned to pre-imprisonment levels of substance use. Recovery supports often presented particularly bleak pictures of their partner or relative’s swift relapse and return to prison, sometimes despite apparent gains in their recovery capital.

He was fine [for the first two weeks]. And he’s got a job and everything... But he started drinking...Coming in here being a bit mouthy towards me...Then um a few months ago he started taking drugs? Alongside his drinking.

For some, the shock of release meant that they had little prospect of sustaining or building recovery capital, as they returned to immediate use:

I relapsed as soon as I come out practically, so. I don’t think I was fit enough to come out at that time... Crack was the relapse.

Interviewees were asked to reflect again on what recovery meant to them and whether they would describe themselves as ‘in recovery’. A number laughed and responded that they certainly were not in recovery, having already described their relapse. Others, despite improvements, talked about always being in recovery. Again, in terms of defining recovery, the main focus was on the level of substance use but

the men were also well aware of the wider problems in their lives and how these had affected their chances of making real changes to their substance use.

Only six of the interviewees reported receiving any level of professional support on release. Two of the six ‘escaped’ from their case-workers as soon as possible and got drunk; the other four were offered very limited support. Most commonly, the sample reported no professional support at all.

... just released. Let out the gates on me own... When I first got out...there was literally nothing. Nothing.

The most fundamental source of recovery capital needed by these ex-prisoners was housing. However, not one of them reported that they had accessed adequate housing through prison housing services. As they had feared when interviewed in prison, many were released either street homeless or to hostels or B&Bs.

Nothing. Nothing. I came out with fifty quid in my pocket, street homeless. No hostel, no night shelter, nothing. I was down housing every day looking for a place, but nothing come up. No hostels, no B & B... Turning up on mates’ doorsteps, asking if I could sofa surf for a couple of days. Spent a few nights in doorways. Fucking freezing. What can you do?

Some prisoners were offered support that was not immediately available on release. Being forced to sleep on the streets or stay with friends in the interim readily led to temptations, relapse and a return to substance dependence and offending.

The most common housing experience over the previous six months was hostels or B&B places funded by Local Authorities. None found this a positive experience and nearly all thought that living in this accommodation made a return to prison more likely: an outcome that for some might be preferable in any case:

There was a lot of... there were a lot of drugs. It was a horrible place. It was worse than jail.

These places were disordered, threatening and seemed to undermine any hopes these interviewees might have had of making changes to their lives. After the comparatively structured and orderly prison regimes they had experienced inside, the shock could be considerable:

There’s no discipline. There’s no one to do the discipline any more. Or like to keep the order, to keep any order.

Those that found ways out of these places, tended to do so through their own initiative. One took up dealing which provided him with the money to move elsewhere, one moved to a different city, one left in favour of sofa surfing and occasional street homelessness and another moved back in with his father. Lastly, after a suicide attempt, one interviewee was swiftly fast-tracked to his own flat, through the intervention of the mental health crisis team.

Interviewees did not return to live with partners. This was often because, prior to imprisonment, these relationships had ended or been seriously strained by substance dependence, theft and/or violence. However, nearly half the sample had returned to live with their parents at some point over the previous six months and for some - especially those who were younger, with shorter criminal histories and no opioid addiction - while not ideal, this worked quite well:

Living with me mam was alright. But it wasn’t practical given she’s only got a one bedroomed...Like a bungalow kind of thing....So I was on a couch you know what I mean. So. It wasn’t ideal...

For others - in particular those who had relapsed quite quickly, things had quickly spiraled out of control and they had left the parental home.

Only two had managed to maintain their tenancies over their sentence and were therefore able to return to their old address, one of whom had managed to do so through the help of a drug dealing

associate who had paid his rent while he was inside.

With regard to recovery capital other than housing, the majority of interviewees had, at least temporarily, been in employment. This was often short-term, ‘cash-in-hand’ work and nearly always obtained through personal contacts, including family and friends.

I sell fruit... I work on a market now. I love it, mate. Because me mate knows the boss, so... He was just passing one day. I just started helping out. He said “right, you want a job?” Sweet.

Finally, the interviews with Recovery Supports elicited an overriding narrative of being progressively ground down by a relentless series of highly painful, emotionally damaging events. Even the most resilient were clear that, over the course of many years, great damage to their relationship had been done:

Well I suppose it’s just continuously feeling for years that you’re not getting anywhere. And always keep on going in spite of having police in the house and raiding the house... And sort of breaking your heart seeing his life is going by and no changes for him, you know? He’s ah...Like he’s...For anybody of his age I suppose he hasn’t got much you know. Not things he’s achieved.

With regard to the idea of turning points, among those whose situation improved on release it was more often support from a partner or getting work that interviewees’ described as the key influence, rather than sudden, transformative events. Reflecting the prison interviews, this was often in the context of growing older and having tired of their lives of addiction and imprisonment. Negative life events occurred but their impact also tended to be negative. One recovery support described the impact of a double bereavement on a released prisoner:

...his best friend and his auntie died within a space - within a very short space of time. And he was just devastated and he just got drunk [...] those were both the two major people in his life.

Another interviewee described how he began using drugs again after the job centre had told him that he would not get a job.

Discussion and conclusions

This research has added to a large body of work that has demonstrated the limitations of through-care provision in addressing the fundamental disjuncture between life inside and outside prison: both for prisoners with substance misuse problems (Burrows, Clarke, Davison, Tarling, & Webb, 2001; MacDonald, Williams, & Kane, 2012; Mitchell & McCarthy, 2009; Roy, Fountain, & Sundari, 2008; Turnbull, 2008) and the wider prison population (e.g. Maguire & Raynor, 1997; Maguire & Raynor, 2016; Petersilia, 2003). However, our study is the first to do so in the context of the through-care of prisoners within avowedly recovery-oriented prison projects. This seems particularly significant, given the increasing focus on recovery in a number of drug policy strategies around the world and its resonance with reformative or rehabilitative ideals in prison (Lloyd, Page, Liebing et al., 2017), the most recent manifestation of which has been the development of a ‘recovery prison’ in the UK, (Gauke, 2018).

The current study’s findings raise some fundamental questions about this endeavor. While one of the main aims of the DRWs was to support the continuity of recovery journeys into the community, this aspect of their work simply did not materialize. The most glaring problems revolved around accommodation: with very little help offered to the interview sample while they were in prison and an almost complete absence of professional support on release. In the remainder of this article, we will consider some of the issues revolving around the idea of ‘doing recovery’ in prison.

Returning to Cloud and Granfield’s concept of recovery capital, what are the implications of this framework for understanding the role of recovery capital in the DRWs? With regard to social capital, prisoners’ relationships with friends and family are inevitably put under

great strain by incarceration (Brunton-Smith & McCarthy, 2017) and this was borne out in this study, particularly in the accounts given by recovery supports. It was also notable that where members of our process sample were able to find employment or acceptable accommodation on release, in nearly all cases this resulted from their own family, friends and other contacts. Thus, while it is clear that imprisonment diminishes prisoner access to such informal support, where it survives, its importance may be paramount. Physical capital or financial assets were largely absent in the DRW cohort. The small minority that had had any financial resources in the past had lost these over the course of their addiction, long before their imprisonment. Those that had housing tenancies often lost them over the course of their sentence, demonstrating again how recovery capital tends to diminish over the course of a custodial sentence. It should be noted that two of the rare, positive accommodation outcomes were achieved through money that had probably come from supplying drugs. That is two more than was achieved by prison housing services. With regard to human capital, pre-existing mental health problems are frequently exacerbated by imprisonment. Mentally ill prisoners are more likely to have problems with discipline (O'Keefe & Schnell, 2007) and be victimized by other prisoners (e.g. Blitz, Wolff, & Shi, 2008; Travis, Western, & Redburn, 2014). Among our sample, mental health problems were common. On the issue of cultural capital, where therapeutic groups worked well, prisoners often referred to their peers as an important source of support (see Page et al., 2016). Positive views were also expressed about fellowship programmes, such as Narcotics Anonymous, that operated within some of the prisons: although very few reported making any contact with such groups on release.

It is interesting to reflect on the idea of turning points within the context of our sample. When interviewed in prison, a number of the interviewees expressed a sense of being deeply tired of their addiction and the damage it had done to their lives. Some believed that they had now turned the corner, would remain abstinent and would not be returning to prison, with critical moments such as births and bereavements sometimes appearing to be the precipitating factors in these decisions. However, at re-interview, it was clear that for most, this had been a false dawn. There was also little or no evidence of defined turning points after prison. Rather, where more positive paths had been forged it was through employment and support from loved ones. Potentially transformative events such as bereavement were associated with relapse rather than recovery.

At its worst, prison can be seen as a system that makes recovery capital largely unavailable to substance-misusing prisoners, while simultaneously making a range of psychoactive substances readily available. To some extent, DRWs were able to ameliorate this situation but there is nevertheless, we believe, a fundamental contradiction between *recovery* and *imprisonment*. In thinking about how recovery-oriented interventions might best work in prison, there is therefore a sense in which this might most realistically be cast in terms of damage limitation (or, ironically, harm minimisation). If we accept that 'the intensity of intoxicant use may be less important in overcoming dependency than the contextual factors that surround addiction in a person's life' (Granfield & Cloud, 1999, p.178), then the emphasis might best be placed on preventing or reducing the harms caused by imprisonment to these contextual factors. In this regard, clearly the most effective solution would be to prevent incarceration in the first place and there is, of course, a long history of referring substance misusing offenders to drug treatment at arrest and sentencing stages (e.g. McSweeney, Turnbull, & Hough, 2008). However, there may be the potential to revisit this agenda and identify more holistic, integrated treatment approaches that can more effectively reduce substance misuse and offending among this group, and avoid imprisonment. For those that are imprisoned, attempts should be made to prevent the erosion of recovery capital. One way to try to reduce damage to relationships with loved ones is to provide frequent family visits. Recent work has shown how such visits are associated with improved family

relations and a decreased likelihood of reconviction (Brunton-Smith & McCarthy, 2017). Family Support Workers also have an important role to play here, providing advice about family visit procedures, acting as a conduit for information between families and prisoners, and providing emotional support (Boswell, Poland, & Price, 2010). An evaluation of pilot FSWs in four English prisons found positive results in terms of the number of contacts and views expressed in interviews with prisoners (Boswell et al., 2010). Specialist FSWs or 'Recovery Workers' have been funded to work specifically with prisoners with substance misuse problems in some prisons in the UK. Other work to persuade private and public housing agencies to maintain tenancies, partnership working with employers to improve employment skills and opportunities, and the provision of training and educational qualifications also hold promise with regard to reducing the harms of imprisonment.

Whatever can be done to prevent the decay of recovery capital over the course of the prison sentence, some of the most important work needs to start on or near to release. Our research suggests that this is where the real recovery 'journey' (or, more often, free-fall) actually begins. It seems that radical changes are needed here. The prisoners in our study experienced a 'cliff-edge' of unsupported release and there is a pressing need to graduate the reintroduction of prisoners with substance misuse histories into the community: a ladder down the cliff-face. Release on Temporary License or ROTL allows prisoners to be released temporarily into the community for specific purposes, such as employment. However, despite some evidence of the effectiveness of such approaches in reducing recidivism (Cheliotis, 2008), use of ROTL declined quite dramatically in England and Wales in recent years (Strickland & Allen, 2016) and none of our process sample had been on ROTL when interviewed shortly before release.⁶ There may therefore be scope for prisoners on DRW-style programmes where prisoners have shown a strong intention to make changes to their lives on release, to be granted ROTL or other graduated reintroduction approaches such as intermittent custody⁷ (Penfold, Hunter, & Hough, 2006), which allow them to begin working in the community prior to release.

This raises the question of who should be targeted for intensive, recovery-focused approaches to prison through-care. In terms of the DRW target group, many of the DRWs accessed substantial numbers of dependent drinkers who had detoxified in prison and were motivated to address their drinking on release. More problematic was the engagement of opioid dependent prisoners (Page et al., 2016). Given the strong evidence for the effectiveness of OST on release in preventing overdose deaths, there are strong arguments in favour of continuing medication or resuming medication prior to release where there is any likelihood of relapse (e.g. Marsden, Stillwell, Jones, Cooper, & Eastwood, 2017). In this context, prison drug workers may need to adhere more closely to the approach taken by their community-based counterparts. Tailoring interventions to service users' recovery capital is an essential part of assessments for, and triage of, drug-related needs in community services (e.g. NICE, 2007). It is highly unlikely, for example, that a community drug worker would refer a homeless heroin user to an ambitious, abstinence-focused treatment programme. Yet this is effectively what happened in some DRWs. Opiate-addicted prisoners that had been homeless prior to their incarceration entered abstinence-focused treatment and were then released with nothing more than £46 and the chance of finding a dry doorstep or a temporary bed in a night hostel. This argues for prison assessments, triages and interventions which take much greater account of the access individuals have to recovery resources in the outside world, and trying to limit ambitious

⁶ Recent policy changes aim to reverse this decline (HM Prison & Probation Service, 2018).

⁷ Intermittent custody was introduced in the UK through the Criminal Justice Act 2003, and consisted of sentences served partly in prison and partly in the community. An evaluation of nine pilot courts suggested that it would be too infrequently used to warrant national roll-out (Penfold et al., 2006).

abstinence-focused interventions to those opioid using prisoners who are determined to follow this path and have robust recovery capital (histories of employment, stable and secure housing, family support, etc.). For those with more depleted recovery capital, there is a need for combining harm reduction approaches with comprehensive resettlement support.

While the focus of this research has been pilot projects developed within the particularly recovery-oriented policy context of the UK, we think that the fundamental tensions identified above are likely to exist in the majority of penal establishments around the world. It has long been established that people with histories of substance use problems are greatly overrepresented in prison populations around the world (Fazel et al., 2006; Fazel, Yoon, & Hayes, 2017; World Health Organisation, 1988). Some prisoners with such histories have always used their time inside to reappraise their situations and seek to make major changes to their lives: including a determination to become abstinent from alcohol and illicit drugs. This research contributes to our understanding of this particular group and the nature of the provision needed to support them. Previous research has tended to focus on the quantitative outcomes of prison drug treatment or a qualitative understanding of the ‘double commission’ (Nylander et al., 2011) of care and control within prison drug treatment. By contrast, this study’s focus is firmly centred on the transition from prison to the community and demonstrates, in a qualitative sense, how hopes and goals fostered within treatment units inside prison can quickly evaporate on release. However, equally important, it demonstrates how imprisonment fundamentally and systematically erodes those relationships and structural factors known to contribute to the recovery and reintegration of prisoners with a history of substance dependence. We see these as generalizable findings that we hope will resonate with those working in the field across a range of different prison systems.

In conclusion, these interviews have demonstrated a fundamental mismatch between the extent of prisoners’ past and present problems and the level of support they received in the pilot DRWs and in particular, on release. Some DRWs offered good treatment environments, with strong relationships between prisoners and prison staff (Lloyd, Page, Liebing et al., 2017), and many prisoners expressing a strong desire to make long-lasting changes to their lives. However, without proper help on release, it was hard to see how such plans could be realised, and in large part they were not. At a time in the UK when there have been renewed calls for prisons to focus on ‘reform’ (Ministry of Justice, 2016), there is a pressing need to find new ways to prevent or mitigate the damage caused to prisoners’ recovery potential while incarcerated, and, perhaps most importantly, to substantially invest in support on release.

Limitations and areas for future research

As discussed above, these interviews were conducted as part of a larger evaluation of DRWs. The prisoners had therefore been assessed and selected for these projects and the view might be taken that the input they received makes them ‘unrepresentative’ of the wider prison population of prisoners with substance use problems. This is certainly true. However, the aim of this study is to explore the sample’s progression within a recovery-oriented programme. It is not intended to provide findings that are representative of the general prison population.

The sample attrition between prison and the community means that many individual narratives are missing. However, we suspect that, given the chaotic situation of many of our follow-up sample, this attrition has not simply resulted in the selection of the more stable and integrated. Attrition is almost inevitable in any longitudinal study of the transition from prison to the community that does not rely on quantitative data-matching and we regard the considerable variation within our sample to demonstrate that it has had a limited impact on our findings.

With regard to future research, we were unable to follow up the samples from the two women’s prisons. This is a high priority area for future research, given the high level of drug problems and the complex needs of women released from prisons that are often geographically remote from their homes (Grace, Page, & Lloyd, 2016). We are also very keen to see more evaluations of promising through-care programmes that provide substantial support to prisoners on release.

Declaration of interest

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