Using the ‘recovery’ and ‘rehabilitation’ paradigms to support desistence of substance-involved offenders: Exploration of dual and multi-focus interventions

ABSTRACT

The links between substance use and offending are well evidenced in the literature, and increasingly, substance misuse recovery is being seen as a central component of the process of rehabilitation from offending, with substance use identified as a key criminogenic risk factor. In recent years, research has demonstrated the commonalities between recovery and rehabilitation, and the possible merits of providing interventions to substance-involved offenders that address both problematic sets of behaviours. This review paper therefore provides an overview of the links between substance use and offending, and the burgeoning literature around the parallel processes of recovery and rehabilitation. This is provided as a rationale for a new treatment approach for substance-involved offenders, Breaking Free Online (BFO), which has recently been provided as part of the Gateways throughcare pathfinder in a number of prisons in North-West England. The BFO programme contains specific behaviour change techniques (BCTs) that are generic enough to be applied to change a wide range of behaviours, and so is able to support substance-involved offenders to address their substance use and offending simultaneously. This dual and multi-target intervention approach has the potential to address multiple, associated areas of need simultaneously, streamlining services and providing more holistic support for individuals, such as substance-involved offenders, who may have multiple and complex needs. Recommendations are

provided to other intervention developers who may wish to further contribute to widening access to such dual-focus programmes for substance-involved offenders, based on the experiences developing and evidencing the BFO programme.

INTRODUCTION

The recent Department of Health report by the UK Chief Medical Officer has revealed problematic drug and/or alcohol use to be a major public health concern (Davies, 2012), with alcohol misuse alone estimating to cost society £17 – 22 billion annually in health and broader social harms (McManus et al., 2009). In terms of illicit drugs, the most recent Crime Survey for England and Wales (CSEW) estimates that between April 2014 and March 2015, 8.6% of 16 – 59 year olds living in the UK had used an illicit drug within the last 12-months, which translates to approximately 2.8 million people (Home Office, 2015). Figures from the Manchester University National Drug Evidence Centre (NDEC) estimate that in the period 2013 – 2014, 193,198 individuals aged 18 and over were in contact with structured drug treatment services, and that 27% of these individuals accessed treatment within criminal justice settings (Public Health England, 2014).

There may be multiple reasons why many individuals access treatment for substance misuse within criminal justice settings, although one of the most significant maybe the fact that in the UK, possession of most psychoactive substances of use and misuse, is a criminal offence. In this way, UK law could be suggested to criminalise, and therefore stigmatise, substance users (Lloyd, 2010;

Stevens, 2011), regardless of whether they might be dependent on these substances or not, with some commentators suggesting that the drug criminalisation issue is used as a tool by political parties to win public votes (MacGregor, 2013).

However, despite the political issues, the links between substance use and criminal behaviour are supported by the research literature (Bennett et al., 2008; Hough, 2002; Schroeder et al., 2007). High levels of crime committed by substance users during periods of use (Ball et al., 1983; Bennett et al., 2008; Bennett & Holloway, 2009; Best et al., 2001; Goldstein, 1985; Gossop et al., 2000; Inciardi, 1979; McGlothlin et al., 1978) indicate that the two behaviours often co-occur. The association between substance use and offending is illustrated further by the high prevalence of substance use among prisoners. Research suggests that approximately 50% of offenders entering prison may be dependent on alcohol or drugs (Budd et al., 2005; Fazel et al., 2006; Prison Reform Trust, 2011; Singleton et al., 1999) and substance use has been identified as a key criminogenic factor that predicts offending and recidivism (Andrews et al., 2006; National Treatment Agency for Substance Misuse, 2009).

Although the links between offending and substance use are well-documented, there are as yet unanswered questions around the precise casual mechanisms between the two sets of behaviours, and subsequently, there is still a paucity of knowledge and application around the most effective intervention approaches that might be employed to address substance-related offending. Given the steadily increasing prison population in England and Wales and the extent to which prisons have

become overcrowded (Hardwick, 2015; Warmsley, 2005), it may be useful to understand how substance-involved offenders may be most effectively rehabilitated to help them achieve recovery from their substance misuse and desist from engaging in drug- and alcohol-related offending. With recent data suggesting that substance-involved offenders make up around 64% of the UK prison population (Ministry of Justice, 2013a), if even a proportion of these offenders are supported to achieve substance misuse recovery and rehabilitation from offending, this could have a significant impact on the size of the UK prison population and reduce public expenditure on drug and alcohol related harms and criminal justice costs (Crane & Blud, 2012; Gossop et al., 2005; Hiller et al., 1999; Lurigio, 2000). This could be likely even if the links between substance use and offending are not directly causative, or are more tenuous than the literature would suggest.

Over the past 20 years the UK Government has introduced a range of drug treatment initiatives to various segments of the criminal justice system to divert substance-involved offenders away from crime and into treatment. These initiatives have been introduced from the first point of contact with the CJS through to sentence and beyond. Arrest referral schemes (Edmunds et al., 1999) have evolved from a motivational focus on referral to treatment to a fundamentally more coercive approach of drug-testing on charge (Home Office, 2004a) and even drug testing on arrest in many areas (Home Office, 2011). The government focus on diversion extends into court sentences with offenders receiving custodial sentences being offered a number of treatment interventions. The introduction of Counselling, Assessment, Referral, Advice, and Through care Services or CARAT Schemes (Harman & Paylor, 2005) saw for the first time in UK prisons an intensified focus on

breaking the links between drugs and crime.

The CARATS approach was further bolstered by the development of Integrated Drug Treatment Systems (Marteau et al., 2010) and more recently the establishment of Drug Recovery Wings (NOMS, 2014). Investment in treatment also extended to community sentences with the introduction of Drug Treatment and Testing Orders or DTTO's (Hough et al., 2003) evolving to become a more flexible sanction when Drug Rehabilitation Requirements (DRR) and Alcohol Treatment Requirements (ATR) in 2005 (Ashby et al., 2011). To assist in joining up treatment interventions within the criminal justice system, the government introduced the Drugs Intervention Programme (DIP) where Criminal Justice Intervention Teams attempted to strengthen continuity of care from arrest to sentence to aftercare provision (Skodbo et al., 2007). The role of drug and alcohol treatment in rehabilitation from offending has therefore played a significant role within successive governments attempting to address so-called drug-related crime.

Most recently, the UK government's 'Transforming Rehabilitation' (TR) agenda (Ministry of Justice, 2013b), has stated that it aims to reduce reoffending rates through providing effective throughcare between prison and community settings and appropriate support via probation services to rehabilitate offenders, a feat that was never fully realised through the DIP and IDTS initiatives. As part of TR, as of February 2015, the enactment of the Offender Rehabilitation Act (ORA) has extended the period of mandatory probation supervision to all short-term sentenced prisoners (UK Parliament, 2015) opening up a significant opportunity for interventions to be provided to address the key risk factors that may lead to reoffending. One of the principal risk factors for reoffending that the TR agenda has identified as a focus of intervention is substance use (Ministry of Justice,

2013b).

This discussion paper therefore draws on the current evidence-base surrounding the links between substance use and offending and the causal mechanisms between these two sets of behaviours, to suggest a new approach to providing intervention within the criminal justice sector to address both substance use and offending simultaneously. The literature around the dual processes of substance use recovery, and rehabilitation from offending is first explored, with the similarities and differences between these two apparently related processes discussed. Then, a novel approach to providing interventions for substance-involved offenders is described, the Breaking Free Online (BFO) computer-assisted therapy (CAT) treatment and recovery programme. The main principle underpinning the BFO programme is to provide specific intervention techniques that are generic enough to dually address both the psychosocial causal factors of substance use and the offending, and indeed as will be seen, these underlying casual factors maybe common across both sets of behaviour.

The links between substance use and offending

The statistics around substance-involved offenders and the proportion of the prison population they represent, strongly supports the hypothesis that substance misuse and offending often co-occur (Budd et al., 2005; Jones et al., 2007; Phillips, 2000; Young et al., 2011). Indeed, some researchers have argued that substance misuse is a primary “criminogenic” factor – that is, a facet of offending behaviour (Weekes et al., 1999). As many as 64% of the prison population having used drugs in the

four weeks prior to their sentence (Ministry of Justice, 2013a), and 14% of male and female prisoners having been convicted of a drugs-related charge (Ministry of Justice, 2015b), the links between substance misuse and offending would appear to be uncontroversial. However, unravelling the causal links between substance misuse and offending is complex.

A number of mechanisms have been proposed to account for the links between substance use and offending, including the notion that drug use directly leads to crime (Goldstein, 1985), with different substances having been suggested to be associated with difference forms of offending. For example, use of crack cocaine and alcohol has been suggested to increase the likelihood of being violent (Gilchrist et al., 2003; McMurran, 2006; Young et al., 2011), whilst heroin and crack cocaine are related to acquisitive crime (Hall, 1996; Sigurdsson & Gudjonsson, 1995; Young et al., 2011).

Previous research has demonstrated that many illicit drug users may engage in acquisitive crime in order to generate the income necessary to fund an often expensive drug habit (Gossop et al., 2000; Stewart et al., 2000). However, more recent research has suggested that although this might be the causal link between substance use and offending for some, for others this might be an oversimplification. For example, many individuals may get drawn into dealing illicit drugs in order to fund a habit, rather than engaging in acquisitive crime (Lyman, 2013) and there may also be gender differences, with male substance-involved offenders being more likely to engage in drug dealing, and females more likely to be involved in prostitution to fund drug habits (Home Office, 2004b; Young et al., 2000).

There is also the suggested link between substance use and the enactment of violent offenses, particularly when under the influence of drugs such as crack cocaine (Lundholm et al., 2013). A significant proportion of violent offences might also be associated with alcohol consumption, with as many as 20% of violent crimes having been committed in or around a pub or nightclub (Office for National Statistics, 2013). Alongside this evidence are data suggesting that around a third of accident and emergency admission may be alcohol-related with this figure rising to 70% during peak times (Drummond et al., 2005). In addition, many domestic violence cases would appear to be associated with alcohol misuse (Galvani, 2010), and although estimates vary, as many as 73% of perpetrators of domestic violence may have committed violent offences whilst under the influence of alcohol (Gilchrist et al., 2003). Further complicating the picture is the consideration of intent and whether violence is a bi-product of intoxication and circumstances, or whether alcohol is consumed to directly influence a criminal act through providing the offender with the confidence to enact a crime (Haque & Cumming, 2003).

Although it would appear from the research cited that there may be clear, linear associations with various kinds of drug and alcohol use and specific criminal offences, in more recent years research has demonstrated that these associations may not be linear, and instead, may be mediated by other multiple, complex factors (Rosengard et al., 2007). For example, many individuals who have difficulties with substance use and offending, have often experienced multiple sources of disadvantage, such as being involved in the care system from early childhood (Aarons et al., 2001; Vaughn et al., 2007), parental and intergenerational substance use (Donovan & Molina, 2011; VanVoorst & Quirk, 2003) and offending (Farrington,

2012), social and economic deprivation (Hannon & DeFronzo, 1998), childhood neglect and abuse (Anda et al., 2014; Nikulina et al., 2011) and developmental and learning difficulties and negative experiences of the education system (Lochner, 2004).

Each of these sources of disadvantage has been associated individually with both substance use and offending, although there is now a growing evidence-base for 'cumulative disadvantage' (Dannefer, 2003; DiPrete & Eirich, 2006; Sampson & Laub, 1997), in which multiple sources of adversity experienced from early childhood, significantly influence life-course trajectories. This has led to the hypothesis that instead of substance use and offending being necessarily linearly associated with one another, these multiple sources of disadvantage may act as common factors underlying both (Bramley et al., 2015; Seddon, 2000). This would indicate that targets for interventions to address substance use and the offending behaviour often related to it, may lie in these multiple sources of disadvantage, and that it may be these sources of disadvantage that would benefit from direct intervention as opposed to substance use and offending per se.

Targeting interventions in order to address the possible, common root-causes of substance use and offending could open up possibilities for development of interventions that are capable of addressing both substance use and offending simultaneously. The UK Ministry of Justice until recently, had a suite of such programmes accredited by the Ministry of Justices Correctional Services Accreditation and Advice Panel (CSAAP) that were designed to do this, although many of these were recently decommissioned due to their financial costs resulting in

the reduction of offenders starting accredited programmes dropping by 76% in five years (Ministry of Justice, 2015a). Subsequently, availability of evidence-based interventions to address both substance use and offending across the England and Wales prison estate is inconsistent, with many prisons not being able to provide such interventions at all. For those prisons that do provide specific substance use and offending interventions, often the interventions provided do not have an evidence-base to support their effectiveness, and even for those interventions initially accredited by CSAAP, in the longer-term, results from effectiveness research have been disappointing (Maguire et al., 2010; The Prison Drug Treatment Strategy Review Group, 2010). Additionally, when prisoners are transferred between prisons, often the support that may be in place in one prison, is not available for them in the prison they are transferred to, and neither does there appear to be appropriate interventions that can cross the prison to community divide, and are therefore capable of providing genuine continuity of care (The Prison Drug Treatment Strategy Review Group, 2010). This is despite the fact that continuity of care was laid out as a key priority of the National Partnership agreement between NOMS, Public Health England (PHE) and NHS England around co-commissioning and delivery of healthcare services in prisons in England (NOMS, 2015).

When interventions are available for substance-involved prisoners, they are often offered in such a way that substance use and offending are addressed separately by different parallel intervention streams, delivered by different professionals, and do not intersect to address or reflect that reality of the prisoner's situation. Substance misuse practitioners provide support to prisoners for their drug and alcohol use, often

in the form of unstructured keyworking, whereas Offender Managers will deliver structured offending programmes. The difficulty with this kind of delivery approach, is that it may be difficult for these different kinds of professionals to gain a full understanding of how a prisoners substance misuse and offending might be related, and may not have received the appropriate training to be able to offer support and intervention for both aspects of difficulty. This can result in a system which intervenes on substance misuse and offending in a disconnected and fragmented manner (The Prison Drug Treatment Strategy Review Group, 2010).

Recovery and rehabilitation: Two parallel processes

In order to further understand the potential of intervening on common underlying factors that moderate both substance use and offending, it may be useful to examine the literature around the processes of substance misuse recovery and rehabilitation from offending, and reflect on the parallels between these two processes. Understanding the commonalities between these two processes may also provide further support for the proposal that for substance-involved offenders, these two processes may be inextricably linked, and therefore, for interventions for such offenders to be effective, they need to adequately address both their recovery from substance use, and their rehabilitation from offending, simultaneously.

A recent literature review by the UK charitable organisation, Revolving Doors Agency, has revealed some of the ways in which substance use recovery and rehabilitation from offending share commonalities (Terry & Cardwell, 2015). Along with recovery from mental health issues, which was also included in the review,

substance misuse recovery and rehabilitation from offending are processes characterised by an initial decision to change ones behaviour, which is then followed by considerable effort to maintain this change in the face of challenges such as stigma and social exclusion. Multiple attempts at maintaining this change is often required, as slips, lapses, and relapse are often the rule rather than the exception, though many people do succeed in making lasting changes despite such setbacks (DiClemente et al., 2010), with this being facilitated by the building of assets such as skills and support networks, and a process of fundamental identity change and finding new meaning for one's life.

Examination of the academic literature reveals a number of models that have been proposed that seek to provide systematic, evidence-based explanations of the dual processes of substance misuse recovery and rehabilitation from offending, with these theories also facilitating identification of intervention targets and appropriate intervention techniques. One of the most influential of these has been the 'Central Eight' model of major criminogenic risk factors (Andrews et al., 2006), which describes how multiple risk factors may be associated with increased risk of offending. The risk factors identified within the model include history of anti-social behaviour, anti-social personality pattern, anti-social cognitions, anti-social associates, family and/or marital issues, difficulties at school and/or work, leisure and/or recreation issues, and substance abuse. These risk factors also provide targets for intervention, with the model stating that by intervening to reduce the impact of these eight factors, risk of offending can be also be subsequently reduced.

Closely aligned with the ‘Central Eight’, the ‘Risk-Needs-Responsivity’ model (RNR: Andrews et al., 1990; Bonta & Andrews, 2007) seeks to outline the process by which the main criminogenic risk factors outlined in the big eight may facilitate assessment and treatment of offenders. This process involves matching intensity of interventions with assessed offender risk level, by targeting identified criminogenic factors, and by matching the intervention approach, strategies, and choice of treatment techniques to the mode and style of the offender (Andrews et al., 1990). The RNR model is empirically supported within the research literature (Polaschek, 2012; Taxman et al., 2013; Ward et al., 2007) and as with many offender programmes, the types of interventions that this model recommends are informed by cognitive-behavioural therapy (CBT) principles (Marshall & Marshall, 2012). Interventions informed by RNR principles tend to be highly structured and manualised, and delivered by trained professionals within rehabilitation institutions.

An alternative to the RNR model is the ‘Good Lives Model’, also known as GLM (Ward & Brown, 2004), which takes a largely humanistic, assets-based approach to rehabilitation. Influenced by the so-called ‘positive psychology’ movement (e.g. Gable & Haidt, 2005; Seligman, 2002), the GLM places emphasis on enhancing human assets, through skills acquisition, building support networks, and enhancing wellbeing, rather than focusing on rectifying deficits. The GLM takes a pragmatic approach to building resources that facilitates positive change, such as stable accommodation, and having a fulfilling means of occupying oneself such as employment or education. Within the GLM, risks are still considered, but are conceptualised as being embedded and inextricably linked to complex systems,

within which an individual's lifestyle and behaviours are influenced by environmental factors such as social and economic circumstances.

What the RNR and GLM models have in common is that both describe the process of rehabilitation and abstinence from criminal behaviour, a process that is referred to in the literature as 'desistance' (Maruna, 2001; Maruna & LeBel, 2010; McNeill, 2006). Desistance provides an approach to offender management that puts *processes* of offender change, rather than the *methods* used to attempt to instigate offender change, at the centre of rehabilitation (Bushway et al., 2003). Desistance has been conceptualised as a complex process that occurs over time, and involves not only changes in behaviours, but also attitudinal changes and changes in life circumstance and identity (Bushway et al., 2003; Healy, 2010; McNeill, 2006). This frames desistance as a dynamic process, postulated to comprise two distinct stages; 'primary desistance' and 'secondary desistance' (Farrall & Maruna, 2004).

Within the research literature, the process of desistance has been conceptualised as involving a complex interplay of social/environmental factors, such as life course changes associated with employment or relationship status (Sampson & Laub, 2003), in addition to more subjective/agency factors, such as shifts in identity or attitudes (Colman & Vander Laenen, 2012; LeBel et al., 2008; Maruna & LeBel, 2010). Fundamental cognitive changes around such things as the desirability of offending behaviour, openness to change and motivation, have been suggested as being central to the desistance process (Giordano et al., 2002). Primary desistance refers to the absence of offending behaviour, which can involve temporary periods of offending abstinence. Secondary desistance involves longer-term abstinence from

offending and fundamental identity change, with the individual no longer identifying themselves as a ‘criminal’ (Marsh, 2011; Opsal, 2012). This process of identity change has been suggested as central to not only desistance from offending (Best et al., 2008) but also during recovery from substance use (Best et al., 2015). As individuals begin to associate more with non-offending, non-substance using social networks, and associate less with their old social networks, this facilitates a process of identity change, as they begin to identify more with their new social networks and the non-offending, non-substance using activities these new networks engage in (Best et al., 2015).

Alongside this growing literature around the identity and other changes that occur during the process of desistance from crime during offender rehabilitation, so too recovery has increasingly become accepted within the substance misuse sector as a realistic treatment outcome (Best et al., 2010; Giles et al., 2005; Laudet, 2014; White et al., 2012). As with desistance, the process of recovery from substance use may occur naturally alongside changes to social and situational circumstances, such as beginning a new relationship or moving to a new area (Granfield & Cloud, 2001), in addition to more internal, subjective changes occurring during the recovery process, such as ‘maturing out’ of substance use across the life course (Klingemann et al., 2010).

The growing literature around substance misuse recovery has subsequently lead to the concept of ‘recovery capital’, which is conceptualised as the internal and external resources that any given individual may have that can facilitate their recovery from substance misuse (Best & Laudet, 2010;

Burns & Marks, 2013; Peele & Brodsky, 1991). In many ways, the concept of ‘recovery’ from substance misuse has much in common with the concept of ‘rehabilitation’ from offending, with recovery and rehabilitation interventions sharing many features. The concepts of rehabilitation and recovery are now largely accepted within the substance misuse and criminal justice sectors, with government policy and treatment approaches now being framed within the rehabilitation/recovery paradigm (Duke, 2013).

The UK Drug Policy Commission (UKDPC) Recovery Consensus Group defines recovery as being “*characterised by voluntarily-sustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society.”* (UKDPC, 2008). This definition recognises the role of harm reduction, whilst emphasising the importance of aspiration to fulfil a healthy lifestyle through personal responsibility. It is worth noting the origins of the UKDCP definition, as described by the Betty Ford Institute Consensus Panel who describe recovery as “a voluntarily maintained lifestyle characterized by sobriety, personal health, and citizenship.” (Betty Ford Institute, 2007).

Despite attempts to reach consensus around what constitutes ‘recovery’, there is still ongoing debate as to what recovery entails, and equally, what ‘recovery capital’ is formed of. Seminal work conducted by Cloud and Granfield (2008) defines recovery capital as being composed of four separate components. *Social capital* refers to the resources an individual has available to them through membership of a social group or network of people, and the interpersonal and social support that comes from other

members of the group or network. *Physical capital* refers to economic or financial resources available to an individual that may facilitate the process of recovery, through funding professional treatment such as residential rehabilitation. *Human capital* refers to the attributes an individual has internally such as skills, knowledge and mental health that enable the individual to be able to function effectively and facilitate the process of recovery. Finally, *cultural capital* refers to the cultural norms such as value, beliefs and dispositions, that come from membership to a specific cultural group, and which influence social functioning. Recovery can be facilitated by increasing capital in these four areas (Best & Laudet, 2010).

Informed by the concept of recovery capital, more recently, the concept of 'rehabilitation capital' has been proposed (O'Brien et al., 2014). Rehabilitation capital describes, much like recovery capital, the various internal and external resources an individual might have and is able to acquire, that will enable them to achieve progress in their rehabilitation. The concept is based around the NOMS seven pathways to reducing reoffending approach, which seeks to address the key barriers to rehabilitation and resettlement (e.g. Gojkovic et al., 2011). These pathways include support with finding accommodation, with securing education, training and employment opportunities, with addressing and physical or mental health issues, in addition to any issues with drugs and alcohol.

Other pathways include providing support with financial issues such as social security benefits and debt management, and support with addressing any relationship difficulties including those with children and other family member. The final pathway is associated with addressing difficulties with thoughts, feelings and

behaviours. The seven pathways subsumed within the concept of rehabilitation capital appear to be aligned with both the risks for offending identified by the RNR model (Bonta & Andrews, 2007)and the assets that the GLM refers to as being facilitators of rehabilitation from offending (Ward et al., 2009).

The implications of recovery and rehabilitation capital for services

The concepts of both recovery and rehabilitation capital essentially describe the importance of building assets that help to facilitate recovery and rehabilitation, and so increasingly, substance misuse recovery services, and offender rehabilitation approaches, seek to build these assets. If the assets related to recovery and rehabilitation are essentially equivalent, then for substance-involved offenders, there may now be an opportunity to provide interventions for offenders to build assets to support both their substance misuse recovery and rehabilitation from offending. Therefore, this last section now describes a potential approach to delivering such dual recovery-rehabilitation interventions within services, which not only seek to build the assets described by recovery and rehabilitation capital, but also help to mitigate risks of substance misuse relapse and reoffending. Additionally, the potential of this new approach to provide genuine continuity of care is also discussed, along with how the current treatment system might be modified to make it more amenable to providing dual-focussed, recovery-rehabilitation interventions.

When exploring novel approaches to providing interventions to offenders, the principal concern has been for some years now, ‘what works’ (McGuire, 1995), and ensuring that intervention approaches are evidence-based and effective. However, the research evidence around what works has indicated that although evidence-

based intervention is a vital component of rehabilitation support approaches, to focus solely on ‘treatment’ and clinical outcomes may be overly reductive. It would appear that the process of rehabilitation, and the multiple changes to the person that occur within it, is too complex a process of transformation to occur directly as a result of intervention (Hough, 2010). Rather, though evidence-based intervention may play a central role, for the process of rehabilitation to be successful and enduring, several sources of support to address the multiple and complex difficulties offenders experience, may need to be provided in tandem (McSweeney & Hough, 2006; McSweeney et al., 2008). Additionally, it may not be sufficient to provide interventions that focus on changing the individual, especially given the evidence in the literature that would suggest that offending and substance use may, at least in part, be a result of social and economic inequalities (Marmot et al., 2010). Therefore, any rehabilitation approaches may also need to focus on changing the environment an individual inhabits, in addition to providing psychosocial and behavioural intervention (Carlen, 2013).

In accordance with these principles, a novel intervention programme for substance-involved offenders has been delivered across the North-West of England prison estate, as part of a pathfinder initiative alongside the introduction of resettlement prisons within the Transforming Rehabilitation (TR) agenda. This initiative, called ‘Gateways’, is intended to deliver support to substance-involved offenders following release to the community for matters such as accommodation and employment, in addition to one-to-one mentoring from an ex-offender with lived experience of substance use recovery and rehabilitation. Gateways is also intended to improve continuity of care for prisoners by providing psychosocial intervention to address substance use in prison that can be continued upon release to the community.

Providing continuity of care for substance misusers when transitioning between settings has been demonstrated to be cost-effective and reduce relapse and recidivism (Butzin et al., 2005; Butzin et al., 2006; McKay, 2001, 2009; Popovici et al., 2008).

The psychosocial intervention provided as part of Gateways, Breaking Free Online (BFO), incorporates evidence-based behavioural change techniques (BCTs: Michie & Johnston, 2013; Michie et al., 2013), techniques from cognitive-behavioural therapy (Beck et al., 2001; Beck, 2011) and approaches such as 'mindfulness' (Marlatt et al., 2008; Marlatt et al., 2010). The BFO programme is appropriate for individuals with substance misuse difficulties, in addition to those who are dually diagnosed (e.g. Davies et al., 2015; Elison et al., 2014; Elison et al., 2015a). BFO is designed to support prisoners to strengthen their resilience and build their 'recovery capital' (Best & Laudet, 2010), through supporting prisoners to develop a range of coping skills and tools based on principals of CBT and mindfulness, and has been demonstrated as effective in a number of populations receiving support for substance misuse in community settings (Elison et al., 2014; Elison et al., 2015a, 2015b). The BFO programme also encourages users to engage in mutual aid and other positive non-offending, non-substance using activities in order to facilitate the building of supportive social networks, which may facilitate the process of identity change for individuals using the programme (Best et al., 2008; Best et al., 2015).

The BFO programmes is delivered as computer-assisted therapy (CAT) intervention via the MoJ 'Virtual Campus' (VC) a web-based learning environment provided to prisoners across the prison estate, and has become the first offender healthcare programme to be provided on VC platform. The intervention programme has also

been developed to contribute to delivering genuine continuity of care, as all offenders can continue to access BFO regardless of their location. Therefore if prisoners are transferred between prisons, or released to the community, they can continue to access the same interventions. Initial quantitative outcomes have indicated that engagement with BFO in the prison setting is associated with significant improvements to offenders quality of life, severity of substance dependence and other aspects of substance misuse recovery (Elison et al., 2015c).
Additionally, the clinical content of the programme is informed by a set of evidence-based, generic BCTs (Michie & Johnston, 2013; Michie et al., 2013) that although are appropriate for addressing the behavioural and psychosocial determinants of substance misuse, are also appropriate for addressing the behavioural and psychosocial determinants of offending. In this way, BFO is able to address substance use and offending simultaneously, allowing offenders to identify the links between their substance use and offending, whilst allowing the practitioners that deliver the programme to have a full understanding of each offender's circumstances.

However, there are still many challenges within the Health and Justice commissioning environment to overcome, with the TR agenda aiming to reduce prison population, reduce reoffending rates and make significant financial savings. However, it is hoped that further attempts will be made by the government to co-commission and integrate health and offending interventions (NOMS, 2015).

Dual-focussed CSAAP accredited programmes such as BFO, that have the capability to provide offenders with evidence-based, effective support for their multiple and complex difficulties, will become the norm rather than the exception.

Concluding thoughts and recommendations for innovative service provision

This paper has discussed the important links between substance use and offending and the advantages of developing innovative interventions to support offenders to achieve substance use recovery and rehabilitation from offending simultaneously. Given the significant role substance use plays as a risk factor for offending, it seems intuitive that if any intervention to address offending in substance-involved offenders is to be effective, it needs to address not only the offending behaviour, but also the substance use associated with it. Unfortunately, very few interventions have been developed to date, and so this final section provides some recommendations for intervention developers who may have wish to contribute to filling this gap in effective services, based on the experiences developing and evidencing the BFO programme.

Much of the research conducted by Breaking Free has included considerable input from substance involved offenders themselves (Elison et al., 2015c; Elison et al., 2016) in order to gain detailed insights into their own accounts of the links between their substance use and offending, and therefore ensure that the clinical content of BFO is as appropriate for meeting their needs as possible. This has also involved gaining as understanding around how their wider multiple and complex difficulties are associated with substance use and offending. Gaining such insights from the

offender population has informed decisions around potential intervention targets, which may encompass behaviours and issues that on first glance may not be obviously associated with the main targets of the intervention, i.e. substance use and offending. Often the prevailing assumptions about the lived experiences of substance-involved offenders can be inaccurate or incomplete, and so it is only through speaking to offenders themselves that the complexity of their life experiences, and therefore the specific needs, can be most fully understood. Because many offenders face such a wide ranging set of multiple and complex difficulties, interventions may benefit from having a broader scope than the main intervention targets they intended to address, so that they also support offenders to make changes to additional areas of their lives. For example, the authors' own research has highlighted the concerns many offenders have in terms of their abilities to organise secure accommodation and employment following their release back to the community, and the potentially damaging impact on their sustained rehabilitation and recovery if they are not able to organise these things (Elison et al., 2016). Therefore, an intervention to support substance-involved offenders may benefit from the inclusion of generic intervention techniques, such as goal setting and problem solving approaches, that can be appropriate for supporting multiple kinds of behaviour change, and can enable offenders to make such wider changes to their lives.

Given offenders do face such a wide range of multiple and complex difficulties, they require the support of a correspondingly wide range of professionals, if they are to be achieve successful recovery and rehabilitation. Professionals from health and social care, education and offender management often work to support the same

individuals, but rarely work closely with each other, meaning that silos can be created. However, in order to support offenders to make changes to multiple areas of their life in order to achieve sustained recovery and rehabilitation, there may be significant benefits to professionals being given to opportunity to engage in genuine crossdisciplinary working in the delivery of interventions. A very good example of this was identified by the authors in their own research. As BFO is a CAT programme and is therefore delivered on Virtual Campus (VC), education teams who are the custodians of this digital resource played a vital role in supporting offenders to access it, and worked closely with the substance misuse teams in doing so. By combining the expertise of both sets of professionals, offenders not only benefited from the clinical content of the programme in helping them to overcome their substance use, but also benefited from developing IT skills and becoming digitally included. Developing such digital skills is beneficial in helping offenders to access education, training and employment opportunities, and therefore, enhance their chances of achieving sustained rehabilitation from offending.

Such ‘joined-up care’ would also benefit from happening not only in the prison environment, but also across prison and community settings, in order to provide offenders with interventions that are able to follow them on their journey through the criminal justice system. One of the major advantages of BFO, and technology-enhanced interventions more broadly, is that they have the capabilities to deliver this continuity of care across settings. Indeed, one of the key reasons why BFO was delivered as part of Gateways, was the fact that it would allow offenders to access their personal account for the programme whether they were in custodial or community settings. Therefore, interventions to support offenders to sustain the

gains they have made in terms of their recovery and rehabilitation in prison, would benefit from being able to follow an offender through the prison gate when they are released.

Indeed, emerging technologies have the potential to play a central role in delivering effective interventions to support substance-involved offenders to achieve successful recovery and rehabilitation as the sector evolves through the 21st Century. Digital technologies have the capabilities to deliver interventions to meet the full spectrum of multiple and complex needs offenders experience, from substance misuse, to other areas of health and social care, to financial management, to education. The authors hope that the current reforms to the criminal justice sector make delivery of therapeutic technologies a priority, to enable offenders to access effective interventions to support them to not only overcome the multiple and complex difficulties they face, but to do so in an integrated, coherent way.

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