

A qualitative exploration of UK prisoners' experiences of substance misuse and mental health difficulties, and the Breaking Free Health and Justice interventions

## ABSTRACT

This qualitative study explored prisoners' lived experiences of substance use and mental health difficulties and aimed to examine perceived links between these two areas and how they might be associated with recovery during engagement with the Breaking Free Health and Justice (BFHJ) treatment programmes. Interviews were conducted with 32 prisoners receiving treatment for substance use in North-West England. Emerging from prisoners' interviews were themes relating to difficult life experiences from childhood into adulthood; how these experiences played a role in the emergence of their multiple and complex difficulties; treatment experiences; and how their current involvement with the criminal justice system acted as a catalyst for positive change, including engagement with the BFHJ programmes. This study identified the roles of substance use and mental health difficulties in the lives of participants, how their multiple and complex difficulties might be addressed, and provided insights into prisoners' interpretations of their life experiences.

## INTRODUCTION

The published literature demonstrates that substance misuse and mental health difficulties are prevalent within the offender population. Although estimates may vary between countries, it is estimated that as many as 50% of offenders in the European Union (World Health Organisation, 2007) and the same proportion within UK prisons (Budd et al., 2005; Fazel et al., 2006; Prison Reform Trust, 2011; Singleton et al., 1999) may be dependent on drugs or alcohol. Outside of Europe, studies have suggested that prevalence of substance misuse within the Australian prison population may be slightly higher than in Europe at around 55% (e.g. Butler et al., 2011) and in the USA, some estimates are even higher at around 70% (e.g. Mumola & Karberg, 2004).

For many offenders, their substance misuse is tied in with their offending, with substance use identified as a criminogenic factor that predicts offending and recidivism (Andrews et al., 2006; National Treatment Agency for Substance Misuse, 2009). For example, use of mephedrone (Brookman & Edwards, 2014) or crack cocaine and alcohol have been suggested to be implicated in violent crime (Gilchrist et al., 2003; McMurrin, 2006; Young et al., 2011), whilst heroin and crack cocaine have been suggested to be related more to acquisitive crime (Hall, 1996; Sigurdsson & Gudjonsson, 1995; Young et al., 2011).

Whilst the links between substance use and offending are well established in the literature there is still some uncertainty around the relevance of mental health difficulties to specific kinds of criminal offences, particularly violent crimes (Vinkers et al., 2011). Although up to 45% of prisoners with identified substance dependence may have comorbid mental health issues such as anxiety or depression (Department of Health, 2009), the precise mechanisms by which substance misuse, mental health difficulties and offending may be associated with one another are still uncertain (Guest & Holland, 2011; Hamilton, 2014; Torrens et al., 2015). However, a number of causal mechanisms have been suggested, although there is still some disagreement in the literature.

One such mechanism is described by the 'self-medication' hypothesis (Bolton et al., 2009; Khantzian, 1997; Robinson et al., 2011) which states that individuals with mental health issues use substances as a means of coping with their mental health difficulties, for example, when a socially anxious individual uses alcohol to help them cope with social situations, or an individual with depression uses opiates to alleviate their low mood. It has been suggested that substance use may directly cause, or at least exacerbate, pre-existing mental health difficulties, such as the evidence which suggests that certain strains of cannabis may elicit psychotic symptoms in some individuals (Moore et al., 2007), or that consumption of alcohol may be related to severity of depression (Boden & Fergusson, 2011). Another alternative mechanism is that there may be some other common, underlying factor that increases vulnerability to the occurrence of both mental health and substance

use issues, such as chronic stress (Brady & Sinha, 2005) or certain personality traits such as neuroticism (Kotov et al., 2010).

The literature would therefore indicate that the relationship between substance use and mental health is a complex one, which in order to untangle, may require examination from childhood onwards. Substance use and mental health difficulties may start in late childhood and early adolescence (Deas & Brown, 2006), often alongside significant childhood adversity (Grella et al., 2005; Johnson et al., 2006). Moreover, earlier substance use may increase likelihood of later substance dependence (Chen et al., 2009), with these difficulties also playing a role in the emergence of offending behaviour into adulthood (Wiesner et al., 2005). Researchers and clinicians remain divided regarding whether or not substance use is an independent cause of mental health problems and vice versa (Burns, 2013; Mathews et al., 2013; McLaren et al., 2010; Seddon, 2010; Tripp et al., 2015; Wahlstrom et al., 2015) and the extent to which substance use leads to crime also remains in contention (Seddon, 2010). Moreover, such correlation studies tend to be specific to population, circumstance and measures thus rarely lead to robust interventions (Tripp et al., 2015; Wahlstrom et al., 2015).

The co-occurrence of substance misuse and mental health difficulties is often referred to as 'dual diagnosis', although, some have suggested that as a concept, dual diagnosis may not capture the full range of multiple and complex difficulties such individuals may experience (Guest & Holland, 2011) and therefore the range of needs that should be recognised and addressed in interventions for dually diagnosed individuals (McSweeney & Hough, 2006; Rutherford & Duggan, 2009). Such multiple and complex needs may include coming from a background of high social and economic deprivation, having been removed from biological parents and becoming a 'looked after child' within the care system, and having experienced periods of homelessness (Rosengard et al., 2007). However, dual diagnosis as an all-encompassing definition of these multiple complex needs, within the remit of substance misuse and mental health difficulties, is widely accepted, and regardless of direction of

causality between substance use and mental health difficulties what is clear is that these issues are prevalent within the offender population.

Traditionally, substance use and mental health difficulties have been treated separately, with treatment services and interventions being commissioned and designed separately to address one or the other (Tiet & Mausbach, 2007). However, due to the limitations of such parallel approaches, and given the causal links between these two areas of difficulty, integrated substance misuse and mental health treatment interventions have been recommended (Hughes et al., 2008). However, despite changes in the perceptions of best treatment for dual diagnosis difficulties, there would appear to still be an absence of evidence-based interventions that allow both substance use and mental health difficulties to be addressed simultaneously.

In an attempt to resolve this need for dual diagnosis treatments, a novel treatment programme for substance-involved, dually diagnosed offenders has been developed, Breaking Free Health and Justice (BFHJ). The programme has recently been introduced throughout a number of prisons in the North West of England, and is based on a programme previously developed for community settings, for which there is now a growing evidence-base (Davies et al., 2015; Elison et al., 2013; Elison et al., 2014b; Elison et al., 2014a; Elison et al., 2015a, 2015b; Hogan et al., 2015). The programme incorporates evidence-based techniques taken from cognitive-behavioural therapy (CBT) (Beck et al., 2001; Beck, 2011) alongside 'mindfulness' approaches (Marlatt et al., 2008; Marlatt et al., 2010), and is appropriate for individuals with substance misuse difficulties and those who are dually diagnosed (Davies et al., 2015; Elison et al., 2013; Elison et al., 2014a; Elison et al., 2014b; Elison et al., 2015a).

The BFHJ programme is delivered using a group and one-to-one key-working intervention referred to as 'Pillars of Recovery' (PoR), and a computer-assisted therapy (CAT) intervention referred to as 'Breaking Free Online' (BFO). Recently, the BFHJ programme has been delivered as part of a prison to community throughcare initiative in the UK, 'Gateways', which is intended to improve continuity of care for prisoners by providing

psychosocial interventions to address substance use in prison followed by support post-release, including support with accommodation and employment. 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).

Initial evaluation of BFHJ as part of Gateways have indicated that prisoners that use the programme experience significantly reduced consumption of, and severity of dependence to, both drugs and alcohol, along with improved quality of life and significant improvements in aspects of psychosocial functioning related to substance use recovery (Elison et al., 2015c). The BFHJ programme is intended to support prisoners to strengthen their resilience and build 'recovery capital' (Best & Laudet, 2010; Cloud & Granfield, 2008), defined as the 'sum of resources an individual has at their disposal to facilitate their recovery' (Best & Laudet, 2010: pg 5). This concept is underpinned by the notion that the more resources, or 'recovery capital', an individual possesses the more likely they are to overcome their substance misuse-related problems. There are four components of recovery capital. These are social capital, referring to the amount of supportive relationships an individual may have; physical capital, referring to tangible items such as property and money; human capital, referring to an individual's aspirations, skills and positive health; and cultural capital, which is made up from a person's beliefs, values and attitudes which link to social conformity (Cloud and Granfield, 2008). Accordingly, those who have access to these kinds of resources have a greater capacity to terminate substance misuse than those who do not have such access.

Yet, as Cloud and Granfield (2008:1977) also acknowledge, there might be situations where recovery capital might be regarded as 'negative'. In other words, it is possible that personal circumstances, individual attributes, behaviours, values, etc., may 'actually impede one's ability to successfully terminate substance misuse and keep people trapped in the world of addiction'. Drawing on in-depth qualitative interviews conducted with prisoners as part of the BFHJ evaluation (the findings of which are not the focus of this paper, but are reported

in full in Alison et al., 2015c), the study reported in this paper attempts to explore in detail prisoners' understanding of the links between their substance use, offending and mental ill health, and explore some of the past personal experiences of prisoners that may, in Cloud and Granfield's (2008) terms, be regarded as negative recovery capital that prevent individuals from overcoming their substance-misuse.

## METHOD

### Design:

This study adopted a qualitative approach based on thematic analyses of data generated by in-depth, semi-structured interviews with substance-involved offenders in UK prisons currently receiving treatment for substance misuse and comorbid mental health issues.

### Participants

The present study is based on interviews with 32 adult prisoners who had completed the BFHJ treatment and recovery programme in prison. All participants were recruited via participating prisons in the North West of England, within which the BFHJ programme was being delivered. The only inclusion/exclusion criteria were that potential participants had to have taken part in the BFHJ programmes as part of their substance use recovery whilst in prison, and were willing to take part in an interview about their experiences.

Participants were informed of the interview study by staff facilitating the BFHJ programme in prisons. Then, if there were any prisoners who were willing to take part in an interview, prison staff contacted the lead author (SE) who then visited each prison and conducted interviews with prisoners. Before each interview was conducted, each prisoner had the aims of the study explained to them and ethically approved informed consent procedures were completed. No honorarium or other incentive was provided for participation in either the BFHJ programme or the interview study. Included in the sample were 29 male participants and 3 females, who were all White-British and had an average age of 35.5 years (range 23 – 56 years). A total of 21 participants had left school years without having attained any

qualifications, although six reported having attended college and five reported having attended other training programmes such as apprenticeship schemes.

Although for the purposes of this study ethical approvals were not sought to obtain data from the Ministry of Justice surrounding participants offences and sentences, as part of the interview, participants were asked if they would be willing to provide this information, although it was not compulsory for participants to divulge this information. In terms of their sentences, prison sentences ranged from six months in duration to 12 years, with an average of 3.18 years. The prisoners who participated in this study had between one month and eight years left of the sentence, with an average of 15 months. The primary offences for participants were: 13 had committed robbery and other acquisitive crimes, eight had been charged with drug dealing and a further eight had been charged with violent offences such as assault. A total of three participants reported they would rather not divulge what their offence was when they were interviewed.

In terms of substances used by participants, the most commonly used substance was heroin, which 16 of the participants reported having had a dependency to, and a total of 12 participants were currently prescribed methadone for opiate dependence. Cannabis and crack cocaine use were also common with 13 and 10 participants reporting these respectively. However, poly substance use was the norm rather than the exception in the group, as can be seen in Table 1, which provides a breakdown of the substances prisoners reported having some kind of misuse difficulty with.

Table 1: Substances used by participants

| Substance     | Number of participants reporting use |
|---------------|--------------------------------------|
| Heroin        | 16                                   |
| Cannabis      | 13                                   |
| Methadone     | 12                                   |
| Crack cocaine | 10                                   |

|                               |   |
|-------------------------------|---|
| Alcohol                       | 8 |
| Amphetamine                   | 6 |
| Powder cocaine                | 6 |
| Benzodiazepines               | 5 |
| Ecstasy                       | 4 |
| Novel psychoactive substances | 2 |

Although formal psychiatric diagnostic data for the sample were not available, of the principal mental health issues reported by participants during their interviews, nine reported depression, eight reported anxiety, six reported paranoia and psychotic symptoms, four reported insomnia, and one participant reported they had previously attempted suicide. A total of four participants did not specify any one particular mental health issue.

#### Procedure

Semi-structured interviews were conducted with participants on a one-to-one basis with the lead author (SE) within a number of prisons in the North-West of England. Ethical approval to conduct this study was granted by the Ministry of Justice National Offender Management Service on the 18.06.2014 (Ref: 2014-143), who provided permission for the lead author to gain access to the participating prisons. Before entering the prisons to conduct interviews, the lead author was required to complete a week-long Ministry of Justice prison induction and receive training on best-practice approaches to working within the prison setting. Interviews were conducted in prison healthcare centres, in a private individual room, and participants were escorted from their cell to the healthcare centre by a prison officer. There were no prison officers or healthcare staff present during each interview; only the participant and lead author were present in each interview. However, a prison officer and member of healthcare staff were on hand in the next room should there be a need for assistance.



Appropriate data protection standards were followed in order to maintain participant confidentiality; all audio recorded interviews files were transcribed in such a way that no participants identifiable information was available in transcripts, and all hard copy data were stored in secure, locked facilities. Participants were given pseudonyms for the purposes of reporting interview findings.

The interview schedule included open-ended questions to allow participants to elaborate on their answers, and was designed to gather participants views on a number of topics. These included their current sentence and the events that lead to it, their substance using history and the precipitating factors participants felt may have led to this, including life events. Additionally, interviews enquired as to participants past and present mental health, and previous and current support and treatment they have received for both their substance use and mental health difficulties. For the purposes of the more formal evaluation of the BFHJ programme (reported in Elison et al., 2015c), interviews also contained questions about participants views of this new treatment programme and how they feel it may have benefited them, and also ways in which they thought it could be refined and improved. Interviews lasted for approximately 20 – 30 minutes and were audio recorded using a digital Dictaphone.

## Analysis

All audio recordings of interviews were transcribed verbatim and thematically analysed in accordance with a narrative approach in order to capture not only the stories that prisoners told about their substance use, mental ill health and offending, but also the manner in which they made sense of their life experiences. An important point to note here is that the authors' intention was not to seek objective truth about the relationship between substance use, mental ill health and offending, but to capture prisoners' own understanding of their lived experiences (Josselson, 2011). In order to achieve this aim, and because multiple narratives were available, the process of analysis adopted involved making comparisons between different respondents by creating categories and codes with which to compare similar sections of different narratives. The categories and codes were then used to identify similarities and differences between the accounts told.

## FINDINGS

Findings from the interviews are conceptualised to illustrate participant's experiences of their substance misuse and mental health difficulties throughout their lifetime, and how these experiences may be associated with their current life situation, in which they are receiving treatment for substance misuse in prison. In doing so, four distinct themes emerged from the data, each identified by prisoners as key periods or events in their life stories:

- 1) Experiences from childhood into early adulthood;
- 2) The emergence of multiple and complex difficulties;
- 3) Experiences of treatment
- 4) Criminal justice system involvement as a catalyst for positive change

- 1) Experiences from childhood into early adulthood:

Consistent among the prisoners interviewed was the recounting of experiences from childhood, with early substance use appearing to be common amongst the individuals participating in the study. Most reported that they first started experimenting with, and then using on a regular basis, a number of substances from early adolescence:

*"When I was about 13, not using heroin, just using drugs like weed first. Then as I got a little bit older, I started going raving, so I started taking speed and ecstasy, and all the rave drugs. And, then I also took them my sister, she was like a role model to me, and she ended up on heroin"*

Jane, Female, aged 16 years

However, some participants reported that they started using substances before adolescence, with one particular participant reporting that they began experimenting with a wide range of substances from the age of 10 upwards:

*When I was 10 I started using cannabis, solvents, aerosols and things like that. 12, diazepam, magic mushrooms, ecstasy, cocaine.*

Frank, Male, aged 38 years

Along with recounting their earliest substance use experiences during interviews, some participants also provided explanations for this early substance use, with some suggesting that their substance use served as a coping mechanism to enable them to deal with difficult, distressing and, at times, traumatic early life experiences. For example, several participants described being abused as children.

*"I had a lot of stuff that had gone on, in my childhood, like, abuse and stuff like that, violence, you know, the usual"*

Maurice, Male, aged 40 years

What is of note in Maurice's case is the language he uses to describe the abuse he experienced. From this quote it can be seen that he reflects on this violence by framing it as 'the usual', and therefore in some way commonplace or 'normal', providing an invaluable insight into the kind of psychosocial world he may have inhabited since his early years. Links were also made between Maurice's traumatic past life experiences and his current mental health state. In his interview he described how he was experiencing distressing intrusive memories of past abuse, and that this was affecting his current mental health:

*"Well, things were starting to come back to me, yeah. Because, a lot of it I blanked out 'cause they put me through some pretty dire situations there. So, more things have been coming back to me all the time. I've been struggling to deal with it"*

Maurice, Male, aged 40 years

In addition to abuse, another common experience described by participants was involvement with the care system from a young age, which for many was a life experience that has played a significant role in their life and development:

*"I was brought up in the care system, so I think that played a big part in my life"*

Helen, Female, aged 43 years

The childhood experiences recounted by participants indicate that they may not have been simply experimenting with substances as children, but instead may have been using them as a means of coping with painful affective states. In such cases the painful affective states being experienced, and potentially medicated against, may not necessarily be a result of diagnosable mental 'illness' but could be appropriate and expected human emotional response to particularly distressing or painful life events and experiences.

2) The emergence of multiple and complex difficulties:

The negative life experiences participants recalled in their interviews appeared to continue to occur from childhood and into adulthood and, for some, it was these adult experiences that appeared to have contributed to the chains of events that led them to their current situation; attempting to overcome substance misuse difficulties within the criminal justice system. However, although for most participants their multiple and complex difficulties could be traced back to childhood, it was in adulthood that many experienced events that set them firmly on the course of substance misuse and the offending behaviours that often occur alongside it:

*"I'd lost my partner. I lost my home, I lost everything. I was on methadone, but when I lost him, I ended up...I was doubling my gear, but I ended up doing gear more, and I went onto crack - I'd never touched crack - all my life, even though I'd been offered it, 'cause I knew if I played about with it, I'd end up in prison. Anyway, everything got on top of me, and I ended up taking it and ended up on a robbery charge and was brought here [prison]"*

Sally, Female, aged 40 years

It was also during adulthood that participants identified themselves as first experiencing significant mental health difficulties, with some of the individuals interviewed reporting that their substance use acted as a means of coping with these mental health issues:

*“I was drinking at work. Well, I was drinking, just to stop the anxiety attacks that I was getting, on a nice level, you know, I couldn't be drunk in my job. I think they called me a functioning alcoholic”*

Raymond, Male, aged 46 years

For other participants, substances provided a means of escape from the reality of the circumstances they found themselves in, and were described as a coping mechanism, rather than medicating against mental health symptoms per se:

*“The drugs seem to take you a step away from the reality side of things, the consequence isn't, it's yours”*

Max, Male, aged 49 years

Once participants had begun to be dependent on substances to enable them to cope with the life circumstances and mental health difficulties they were experiencing, many reported that it was at this point that they found themselves involved in the chaotic lifestyle typified as revolving around the acquisition and use of substances:

*“I was homeless for a while. I didn't realise I was on self-destruction, because I'd got into substances at an early age. I'd get out, go to score, grafting, I ended up, almost by choice...I had a flat, just never went back to it, it took me too long to get there and then get back to town to make money the next day. I just ended up staying in squats, in this, crack dens, I wasn't a human being at all”*

Max, Male, aged 49 years

Some participants recalled that it was perhaps at this point that their substance use, rather than serving the purpose of acting as a coping mechanism for their life difficulties and mental health issues, was actually directly causing their mental health to suffer. For example, one participant was able to identify that the specific kinds of mental health issues he experienced at any one time were closely related to the substance he was using during that period:

*“Well, I'd only been out [of prison] for six weeks, but getting out and having to cope out there, it deteriorated fast, rapidly. Then I started misusing amphetamines - my mental health is, paranoia, depression and anxiety. So, all of them tallying into amphetamine use, and then diazepam abuse, and then cannabis abuse”*

Frank, Male, aged 38 years

However, what was evident from the life stories recounted by participants is the complex nature of the relationship between substance use and mental health. Some participants, when reflecting on this relationship, described it as something far more nuanced than simply substance use causing mental health issues, or vice versa. For example, as one participant described:

*“Every time I did drink, I'd always been very depressed. I'd always been suicidal, or end up in fights - pretty nasty when I drink. I think it played a big part. I think it's all been mixed in together. 'Cause if I hadn't had drunk then I wouldn't have got sectioned”*

Helen, Female, aged 43 years

Regardless of the directionality of the relationship between substance use and mental health, it was clear from the interviews conducted that the mental health difficulties faced by participants had a significant impact on their lives. Different participants described their mental health difficulties in different ways, so for example one participants described them in terms of a more general, pervasive, low mood:

*“It just makes you...feel depressed. It just makes you feel down all the time. That's why you don't give a shit, you know”*

Jon, Male, aged 26 years

Whereas some participants described these their mental health difficulties less in terms of low mood and more specifically in terms of a feeling of isolation and loneliness:

*" I don't know where I am, I just kind of drift off to this lonely place I don't even know, I don't think it's a very good place anyway"*

Michael, Male, aged 33 years

For some participants, their mental health difficulties were described in somatic terms, with one individual recalling how his anxiety made him feel physically:

*"It feels like someone's standing on my chest. It's like pressure...and that's what it feels like. I mean, I can feel myself at times, like, twitching, you know. I feel anxious, and I used to be so quite relaxed"*

Raymond, Male, aged 46 years

And for one participant, their mental health issues became so difficult to cope with that they attempted suicide, following several inpatient psychiatric admissions:

*"I tried to commit suicide. I've been sectioned four times, never got help, was just thrown out of the hospital"*

Helen, Female, aged 43 years

### 3) Experiences of treatment

Some of the information participants provided was around the various mental health and substance misuse treatments and sources of support they had either attempted to access, or had accessed previously, with mixed success. In recognition of their mental health and substance misuse difficulties, one of the most commonly accessed treatments was medication but many of the participants felt that these medications were not beneficial:

*They put me on Temazepam, and they put me on Sertraline antidepressants. In September, here, I was attacked by a prisoner, and they put my anti-psychotic up to 100 mil. And, I was totally different. Six weeks ago I said to them, "I'm not taking them anymore, I've had enough"*

*of these. I'm sick and tired of taking tablets that I feel are making me worse." It was like I felt more anxious, nervous and shaking a lot"*

Sally, Female, aged 40 years

Even though most participants were offered medication, the kind of treatment they actually wanted to access was psychosocial rehabilitation and detox. Because it was often incredibly difficult to access such professional support, some participants reported that they had had failed attempts to try to detox themselves, sometimes with the support of a family member or friend:

*"I tried everything to get off it. I tried locking myself away. My dad tried locking me away, keeping me away from everything. He even bought me sleeping tablets to get me through it, but I ended up finding them, and taking them all. I was just spiralled well out of control, and that's it, my life's just been chaos since"*

Jane, Female, aged 35 years

Such difficulties accessing support appeared to be a common experience amongst the participants, with one individual describing how the treatment system was not designed in such a way as to make it possible for people to access the support they really needed:

*"I felt like I'd been moved from pillar to post within the system. Trying to get hold of some recovery, latch onto recovery, but I found that everything was being pulled from underneath me"*

Charles, Male, aged 37 years

Some prisoners reported that the lack of support and treatment available through the conventional healthcare system impelled them to commit crime in order to be convicted so they could access the increased support offered to substance users involved in the criminal justice system:



*"I even said to them, I said, "Listen, if you aren't gonna help me to come off it, I'm not gonna come back to probation, and I'm gonna just keep breaching it until I go to jail, and then I'll do my detox then. 'Cause you're not gonna help me." They didn't, so I ended up committing a crime"*

Joseph, Male, aged 23 years

#### 4) Criminal justice system involvement as a catalyst for positive change:

Most of the participants interviewed had a long history of involvement with the criminal justice system, but for most, their current involvement in the criminal justice system was acting as a catalyst for positive change, in the form of engaging with treatment services for their substance misuse and mental health difficulties. For example, many participants had been in young offender institutes and reported having spent most of their adult life in prison:

*"I've been in Borstals and stuff. From the age of 13. I've just been like, locked up. I have spent time out there, but...not long. I think the longest I've been out there is about ten months"*

Tom, Male, aged 34 years

Yet, despite reports that the criminal justice system presented opportunities to get support for their substance use, many had continued to use substances throughout their times in prison. The short-term sentences that had been served by many of the prisoners interviewed rarely presented as an opportunity for individuals to interrupt his or her substance use:

*"Every other sentence I've done, and I've done quite a few, I've done about 20 years in the system altogether if you add them up. And I've spent most of them off my nut. I wasn't bothered, I didn't care, the years went past like minutes"*

Max, Male, aged 49 years

However, prisoners' expressions about their current sentence were much more positive. As all the participants were interviewed as part of a wider outcomes evaluation of the Breaking Free Health and Justice treatment and recovery programme, many reported that the reason their current sentence had been so beneficial was because of their involvement with the programme. A number of therapeutic benefits were reported, related to better understanding of their substance use and mental health difficulties and the underlying reasons for these issues:

*"Mainly knowing that behind every time I take a drug, no matter what it is, there's an underlying reason, and you never ever, no matter what anybody says to you - when people take drugs there's always a reason there has to be, and it's not plain like a lot of things. It's something deep down, and that shocked me"*

Robert, Male, aged 33 years

Some participants reported that whilst engaging with the Breaking Free Health and Justice programme during their current sentence that the intervention strategies contained within the programme enabled them to think and feel better than they had previously:

*"I just, sort of, feel like I've got more life in me. I feel that I'm achieving something again. I'm thinking about what I can achieve again when I get clean. And, I'm just thinking more positively. My thinking's changed. The whole way I see things has changed, and I'm feeling properly again"*

Charles, Male, aged 37 years

Despite the therapeutic benefits of engaging with the Breaking Free Health and Justice programme, and the progress most of the participants had made in overcoming their substance use and mental health difficulties, many expressed a number of anxieties about leaving prison and re-entering the community following the end of their current sentence. For most, the challenges that their new-found sobriety would face beyond the prison gate was something they spent a great deal of time thinking about and many felt that the coping skills

and tools they had acquired whilst engaging with the Breaking Free Health and Justice programme would enable them to cope with these challenges despite their anxieties:

*“Yeah, very frightened of the outside world, but it's a healthy fear. You know, it's healthy in the fact that, I feel like I've got the tools, and the knowledge from what I've been doing to go forward. When I get out, paramount, the Recovery Capital, so obviously I can start that prior to release from here, put things in place for when I get out”*

Greg, Male, aged 24 years

But for others, their anxieties around their release from their current sentence were related to more practical matters such as securing accommodation, as they were concerned that it was these challenges that could have a significant impact on their ability to maintain their recovery. One participant was worried that if he had to go and live back in his old home town he would be drawn back into substance use and committing crimes to fund this:

*“I don't know what to do. Go home, and then what? Go home. Go home back to the North East, and I'll end up getting out, and I'll end up down there, and what have I got down there? Nothing. What'll I end up doing down there, grafting and all that all over again”*

George, Male, aged 29 years

Indeed, most participants had previous experiences in which they were released with no secure accommodation and had quickly relapsed into a substance use and offending lifestyle:

*“I was released, no accommodation, no fixed abode from here in June of '13, and then I had nowhere to go, so they stuck me in a hostel, 6 weeks later, living in hostel surroundings, it was the same circle, so it was either use drugs or sell drugs. And, I went to using them and then selling them, and that's what I'm in for now”*

Frank, Male, aged 38 years

Many participants felt that the solution to this issue was to secure a place in a rehabilitation facility or other therapeutic residential setting such as abstinence housing for when they were released to the community following the end of their current sentence. This continuity of care beyond release was described by many participants as being central to their continued recovery, and some were already planning to access such continued support via the Gateways 'through-the-gate initiative'<sup>1</sup>:

*"I'd like some sort of abstinence house, something like that. I've been looking at the, Through the Gate [Gateways] project. You know, being taken from the gate, taken to the house, with other like-minded people who all want the same. I think that's the road I wanna go down"*

Tom, Male, aged 34

For some participants, recovery and the process of rehabilitation was described as a complex and ongoing process, with one recognising that past experiences had contributed to substance misuse and mental health difficulties and that, despite the progress made whilst serving their current sentence, there was still some way to go on their recovery journey:

*"When I go out in February, I'm going straight back into rehab. I've already got my bed booked. I know I need to go there, I know there's still a lot from my past that I've got to work on. A lot has happened"*

Helen, Male, aged 43

Common throughout the themes identified is the importance of the development of 'recovery capital' to overcome and address the problems associated with substance use.

## DISCUSSION

This study sought to explore prisoners' experiences of substance use and mental health issues via a qualitative approach, in order to understand the associations between these

---

<sup>1</sup>Gateways provides a new pathway approach to tackling substance misuse and supports offenders to achieve sustainable recovery by providing treatment and support via BFHJ within prison, which can then be continued upon release to the community. In addition to BFHJ, all offenders accessing Gateways are also provided with a peer mentor to meet them at the prison gate, and support to secure accommodation back in the community, in addition to help with finances, employment etc

two areas of difficulties and contribute to the literature around the nature of 'dual diagnosis' (Guest & Holland, 2011; Hamilton, 2014). Rather than focussing purely on the substance misuse and mental health difficulties of prisoners, this study also attempted to make sense of these difficulties through understanding their relations to the experiences and events that have occurred in their lives, the other multiple and complex needs substance-involved prisoners might have (Rosengard et al., 2007), and how these issues may have impacted on their ability to terminate their substance misuse in the long-term.

The findings revealed that substance use, mental health difficulties and offending feature as significant issues in the lives of prisoners and that these issues are related to each other in complex ways. Unlike previous research that has attempted, but failed, to identify the direction of the relationship between substance misuse, mental ill health and offending, this study sought to disentangle this relationship through the subjective experiences of prisoners. While mental ill health and offending were clearly prevalent and acknowledged by prisoners as problems during adulthood they were not necessarily identified as a causal explanation for their substance use. Rather, explanations for substance use were framed within the difficult and, often, traumatic events experienced during childhood with some prisoners suggesting that substances were used as a coping mechanism. Early childhood adversity such as abuse and neglect were reported by many of the prisoners interviewed. This finding is consistent with the literature suggesting that for infants and children growing up in such rearing environments, the impact on their developmental outcomes can be profound. Studies have demonstrated that children reared in environments in which they are exposed to multiple, cumulative stressful life events, particularly in the first few years of life, may be at a significantly increased risk of developing difficulties with substance misuse from later childhood onwards (Enoch, 2011). This is in addition to affective, behavioural and cognitive difficulties (Anda et al., 2006; Peleg-Oren & Teichman, 2006), and poorer physical and mental health outcomes in adulthood (Wickrama et al., 2005).

Although there has been a decline of substance use among 11-15 year olds in recent years, during the early 2000s lifetime use of substances were reported by up to 18% of children aged

11-15 (Health and Social Care Information Centre, 2014) and of those aged 15-16 in 2011 the figure was 27% (Hibell et al., 2011). Figures such as these led some researchers to contend that substance use among young people had become normalised (Parker et al., 2002; Parker, 2005) and that life course transitions, such as work commitments, parenthood and becoming more aware of the longer term health consequences of substance use, would lead many to eventually abstain from substance use (Williams, 2013). However, what appears to separate the participants of this study from those who experiment and transition out of substance use, are their early childhood and adolescent experiences, and the multiple stressors and sources of adversity they have faced, which may be linked with their substance use. Multiple stressors and sources of adversity throughout the life-course were reported by prisoners as having contributed to their substance use. Prisoners in the study had experienced bereavement, homelessness, and often as a result of these difficulties, periods of ill mental health. They conceptualised their mental health difficulties as being reactions to these life events rather than in terms of diagnosable mental 'illness' or 'disorder', and described their mental health difficulties in terms of the subjective, experiential qualities of them.

Many of the prisoners interviewed also reported that they had experienced significant difficulties in accessing support for both their mental health and substance use difficulties, with many reporting that their current prison sentence had provided them, for the first time, an opportunity to address their difficulties and begin the process of recovery. As with mental health, access to evidence-based psychosocial interventions for substance misuse is limited throughout the sector despite the evidence-base demonstrating that these sorts of approaches can be as effective (NTA, 2010; Whiteley et al., 2012). Furthermore, access to truly integrated mental health/substance use ('dual diagnosis') interventions may be even more restricted (Drake et al., 2007; Hamilton, 2014).

Consistent throughout the findings presented in this paper was prisoners' lack of access to 'positive' recovery capital. The experiences of many of the prisoners interviewed, including childhood adversity, such as abuse and neglect, the emergence of multiple and complex difficulties in adulthood including but not limited to homelessness, bereavement and mental

ill health, and negative experiences with treatment services illustrate the differential capacities individuals may have for overcoming substance misuse related problems. Referred to as 'negative' recovery capital the issues identified by prisoners in this paper emphasise the complexity involved in not only leveraging recovery capital to enhance the capacity of individuals to overcome substance misuse related problems but transferring negative recovery capital into positive recovery capital. The resources connected to the individual human traits with which persons are born, the individual qualities that they acquire over time, and the environmental and social structural spaces which they occupy can be collectively construed as resources of recovery capital but if negative, as illustrated in this paper, may also threaten the cessation of substance misuse.

It is critically important, therefore, for those responsible for treating substance misuse to understand the implications of the differential capacity persons have for overcoming substance misuse related problems and to develop programmes and initiatives that can help to alleviate the effects of 'negative' recovery capital. The anxieties prisoners had about their release and concerns about their abilities to cope with returning back to environments in which they had previously used drugs and alcohol and engaged in criminal activity demonstrates how the needs of this population extend far beyond their substance use and mental health. Alongside concerns about securing accommodation, prisoners reported financial worries, lack of education, training and employment opportunities, significant interpersonal problems with family, in addition to their substance use and mental health issues. This set of multiple and complex, inter-related difficulties means that intervention approaches need to be multi-faceted and nuanced, capable of addressing multiple areas of need simultaneously. They also require truly collaborative, inter-agency working, as no one agency would have the necessary skills, knowledge and resources to address the multiple areas of need prisoners have. However, such inter-agency working requires differences in ethical and professional outlooks to be negotiated, which can sometimes be difficult (Williams, 2009).

A key driver behind the current lack of treatment options for dual diagnosis interventions, or interventions that address the multiple and complex issues presented by prisoners, results partly from the separate commissioning of mental health and substance misuse services. The separate funding streams for both mental health and substance misuse provision means that commissioned healthcare providers have different budgets to operate within and targets to achieve. This difference in service provision will often result in competing focuses for operational and budgetary management at the expense of prisoners requiring intervention from both healthcare services. Therefore mental health services may assess prisoners as being inappropriate for their service until the identified causal drugs or alcohol issue is addressed. On the other hand a substance misuse service may assess a prisoner as being inappropriate for treatment until they have addressed the causal mental health difficulty. Therefore many prisoners can be at risk from falling between the gaps in service provision. Therefore, the implementation of the BFHJ interventions, which have already shown some success for individuals experiencing difficulties with both mental health and substance misuse in terms of supporting them to strengthen their resilience and build recovery capital (Elison et al., 2015c), may provide an opportunity to engage and treat this particular population and their multiple and complex needs.

Although this study has provided valuable insights into the difficulties many substance-involved prisoners face, participants in the study was a self-selecting group of UK prisoners, so it cannot be assumed that experiences and views reported in the interviews are representative of the entire prisoner population, either in the UK or globally. Additionally, in this study participants were asked to reflect back on their past experiences of the associations between their mental health difficulties, substance use and offending. Such qualitative recollections of autobiographical experiences may be considered by some researchers to be unreliable and overly subjective (Gardner, 2001; Nunkoosing, 2005), although many others perceive this inherent subjectivity within qualitative approaches to be its central strength (Braun & Clarke, 2006; Neale et al., 2005).



Certainly, the qualitative approach taken in this study has provided some unique insights into the lived experiences of substance-involved prisoners in the UK, and specifically the ways in which their early life events, mental health issues, substance use and offending may be linked. However, more work is needed in order to unpick the precise ways in which these areas of difficulty may be causally related. It seems highly likely that these causal mechanisms may have some commonalities across individuals, but may also have some relations that may be unique to each individual person that experiences them.

## REFERENCES

- Anda, R. F., Felitti, V. J., Bremner, J. D., Walker, J. D., Whitfield, C., Perry, B. D., . . . Giles, W. H. (2006). The enduring effects of abuse and related adverse experiences in childhood. *European Archives of Psychiatry and Clinical Neuroscience*, *256*(3), 174-186.
- Andrews, D. A., Bonta, J., & Wormith, J. S. (2006). The recent past and near future of risk and/or need assessment. *Crime and delinquency*, *52*(1), 7.
- Baird, C., Fox, P., & Colvin, L. (2014). Gabapentinoid Abuse in Order to Potentiate the Effect of Methadone: A Survey among Substance Misusers. *European Addiction Research*, *20*(3), 115-118.
- Beck, A. T., Wright, F. D., Newman, C. F., & Liese, B. S. (2001). *Cognitive therapy of substance abuse*: Guilford Press.
- Beck, J. S. (2011). *Cognitive behavior therapy: Basics and beyond*: Guilford Press.
- Best, D., & Laudet, A. (2010). *The potential of recovery capital*. London: RSA.
- Boden, J. M., & Fergusson, D. M. (2011). Alcohol and depression. *Addiction*, *106*(5), 906-914.
- Bolton, J. M., Robinson, J., & Sareen, J. (2009). Self-medication of mood disorders with alcohol and drugs in the National Epidemiologic Survey on Alcohol and Related Conditions. *Journal of affective disorders*, *115*(3), 367-375.
- Brady, K. T., & Sinha, R. (2005). Co-occurring mental and substance use disorders: the neurobiological effects of chronic stress. *American Journal of Psychiatry*, *162*, 1483-1493.
- Brookman, F., & Edwards, J. (2014). *The Links between Mephedrone Use, Violence and other Harms in South Wales*. University of South Wales.
- Budd, T., Collier, P., Mhlanga, B., Sharp, C., & Weir, G. (2005). *Levels of self-report offending and drug use among offenders: Findings from the Criminality Surveys*: Home Office London.
- Burns, J. K. (2013). Pathways from cannabis to psychosis: a review of the evidence. *Frontiers in psychiatry*, *4*.
- Butler, T., Indig, D., Allnutt, S., & Mamoon, H. (2011). Co-occurring mental illness and substance use disorder among Australian prisoners. *Drug and alcohol review*, *30*(2), 188-194.
- Butzin, C. A., Martin, S. S., & Inciardi, J. A. (2005). Treatment during transition from prison to community and subsequent illicit drug use. *Journal of Substance Abuse Treatment*, *28*(4), 351-358.
- Butzin, C. A., O'Connell, D. J., Martin, S. S., & Inciardi, J. A. (2006). Effect of drug treatment during work release on new arrests and incarcerations. *Journal of Criminal Justice*, *34*(5), 557-565.
- Chen, C.-Y., Storr, C. L., & Anthony, J. C. (2009). Early-onset drug use and risk for drug dependence problems. *Addictive Behaviors*, *34*(3), 319-322.
- Cloud, W., & Granfield, R. (2008). Conceptualizing recovery capital: Expansion of a theoretical construct. *Substance use & misuse*, *43*(12-13), 1971-1986.

- Davies, G., Elison, S., Ward, J., & Laudet, A. (2015). The role of lifestyle in perpetuating substance dependence: A new explanatory model, The Lifestyle Balance Model. *Substance Abuse, Treatment, Prevention and Policy*, 10(2).
- Deas, D., & Brown, E. (2006). Adolescent substance abuse and psychiatric comorbidities. *Journal of Clinical Psychiatry*, 67, 18.
- Department of Health. (2009). The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system. London: Department of Health.
- Drake, R. E., Mueser, K. T., & Brunette, M. F. (2007). Management of persons with co-occurring severe mental illness and substance use disorder: program implications. *World Psychiatry*, 6(3), 131-136.
- Elison, S., Davies, G., & Ward, J. (2015a). An outcomes evaluation of computerised treatment for problem drinking using Breaking Free Online *Alcoholism Treatment Quarterly*, 33(2), 185-196.
- Elison, S., Davies, G., & Ward, J. (2015b). Sub-group analyses of a heterogeneous sample of service users accessing computer-assisted therapy (CAT) for substance dependence using Breaking Free Online. *Journal of Medical Internet Research*, 2(2), e13.
- Elison, S., Humphreys, L., Ward, J., & Davies, G. (2013). A Pilot Outcomes Evaluation for Computer Assisted Therapy for Substance Misuse- An Evaluation of Breaking Free Online. *Journal of Substance Use*, 19(4), 1-6.
- Elison, S., Ward, J., Davies, G., Lidbetter, N., Dagley, M., & Hulme, D. (2014a). An outcomes study of eTherapy for dual diagnosis using Breaking Free Online. *Advances in Dual Diagnosis*, 7(2), 52-62.
- Elison, S., Ward, J., Davies, G., & Moody, M. (2014b). Implementation of computer-assisted therapy for substance misuse: a qualitative study of Breaking Free Online using Roger's diffusion of innovation theory. *Drugs and Alcohol Today*, 14(4), 207-218.
- Elison, S., Weston, S., Davies, G., Dugdale, S., & Ward, J. (2015c). Findings from mixed-methods feasibility and effectiveness evaluations of the "Breaking Free Online" treatment and recovery programme for substance misuse in prisons. *Drugs: Education, Prevention and Policy*, 1-10.
- Enoch, M.-A. (2011). The role of early life stress as a predictor for alcohol and drug dependence. *Psychopharmacology*, 214(1), 17-31.
- Fazel, S., Bains, P., & Doll, H. (2006). Substance abuse and dependence in prisoners: a systematic review. *Addiction*, 101(2), 181-191.
- Gardner, G. (2001). Unreliable memories and other contingencies: problems with biographical knowledge. *Qualitative Research*, 1(2), 185-204.
- Gilchrist, E., Johnson, R., Takriti, R., Weston, S., Beech, A., & Kebbell, M. (2003). *Findings 217: Domestic violence offenders: characteristics and offending related needs*. London.
- Grella, C. E., Stein, J. A., & Greenwell, L. (2005). Associations among childhood trauma, adolescent problem behaviors, and adverse adult outcomes in substance-abusing women offenders. *Psychology of Addictive Behaviors*, 19(1), 43.
- Guest, C., & Holland, M. (2011). Co-existing mental health and substance use and alcohol difficulties – why do we persist with the term "dual diagnosis" within mental health services? *Advances in Dual Diagnosis*, 4(4), 162-172.
- Hall, W. (1996). Methadone Maintenance Treatment as a Crime Control Measure *BOCSAR NSW Crime and Justice Bulletins* Sydney, New South Wales Bureau of Crime Statistics and Research.
- Hamilton, I. (2014). The 10 most important debates surrounding dual diagnosis. *Advances in Dual Diagnosis*, 7(3), 118-128.
- Health and Social Care Information Centre. (2014). Smoking, Drinking and Drug Use Among Young People in England - 2013

- Hibell, B., Guttormsson, U., Ahlstrom, S., Balakireva, O., Bjarnason, T., Kokkevi, A., & Kraus, L. (2011). The 2011 ESPAD Report: Substance Use Among Students in 36 European Countries.
- Hogan, L., Elison, S., Davies, G., & Ward, J. (2015). Effectiveness of the Pillars of Recovery group and keyworking program for service users with a dual diagnosis of substance dependence and concurrent mental health problems: An initial outcomes evaluation. *Journal of Groups in Addiction & Recovery, 10*(2), 125-140.
- Hughes, E., Wanigaratne, S., Gournay, K., Johnson, S., Thornicroft, G., Finch, E., . . . Smith, N. (2008). Training in dual diagnosis interventions (the COMO Study): Randomised controlled trial. *BMC Psychiatry, 8*(1), 12.
- Johnson, R. J., Ross, M. W., Taylor, W. C., Williams, M. L., Carvajal, R. I., & Peters, R. J. (2006). Prevalence of childhood sexual abuse among incarcerated males in county jail. *Child Abuse & Neglect, 30*(1), 75-86.
- Josselson, R. (2011) 'Narrative Research', in F.J. Wertz, K. Charmaz, L.M. McMullen, R. Josselson, R. Anderson, and E. McSpadden (2011) *Five Ways of Doing Qualitative Analysis*. New York: The Guildford Press.
- Khantzian, E. J. (1997). The self-medication hypothesis of substance use disorders: a reconsideration and recent applications. *Harvard review of psychiatry, 4*(5), 231-244.
- Kotov, R., Gamez, W., Schmidt, F., & Watson, D. (2010). Linking “big” personality traits to anxiety, depressive, and substance use disorders: a meta-analysis. *Psychological bulletin, 136*(5), 768.
- Marlatt, G., Bowen, S., Chawla, N., & Witkiewitz, K. (2010). Mindfulness-based relapse prevention for substance abusers: Therapist training and therapeutic relationships. In Z. Segal, S. Hick, & T. Bien (Eds.), *Mindfulness and the therapeutic relationship*: The Guilford Press.
- Marlatt, G. A., Bowen, S., Chawla, N., & Witkiewitz, K. (2008). Mindfulness-based relapse prevention for substance abusers: Therapist training and therapeutic relationships. *Mindfulness and the therapeutic relationship, 107-121*.
- Mathews, M., Tesar, G. E., & Muzina, D. J. (2013). Schizophrenia and Acute Psychosis.
- McKay, J. R. (2001). Effectiveness of Continuing Care Interventions for Substance Abusers: Implications for the Study of Long-Term Treatment Effects. *Evaluation Review, 25*(2), 211-232.
- McKay, J. R. (2009). Continuing care research: What we have learned and where we are going. *Journal of substance abuse treatment, 36*(2), 131-145.
- McLaren, J. A., Silins, E., Hutchinson, D., Mattick, R. P., & Hall, W. (2010). Assessing evidence for a causal link between cannabis and psychosis: A review of cohort studies. *International Journal of Drug Policy, 21*(1), 10-19.
- McMurrin, M. (2006). Drug and alcohol programmes: concept, theory and practice. In C. Hollins & E. Palmer (Eds.), *Offending Behaviour Programmes: Development, Application and Controversies* (pp. 179-207). Chichester: John Wiley & Sons.
- McSweeney, T., & Hough, M. (2006). Supporting offenders with multiple needs Lessons for the ‘mixed economy’ model of service provision. *Criminology and criminal Justice, 6*(1), 107-125.
- Moore, T. H., Zammit, S., Lingford-Hughes, A., Barnes, T. R., Jones, P. B., Burke, M., & Lewis, G. (2007). Cannabis use and risk of psychotic or affective mental health outcomes: a systematic review. *The Lancet, 370*(9584), 319-328.
- Mumola, C., & Karberg, J. (2004). Drug use and dependence, State and Federal prisoners 2004. In B. o. J. Statistics (Ed.). U.S. Department of Justice: Office of Justice Program.
- National Treatment Agency for Substance Misuse. (2009). Breaking the link: The role of drug treatment in tackling crime. In NHS (Ed.). London.
- Neale, J., Allen, D., & Coombes, L. (2005). Qualitative research methods within the addictions. *Addiction, 100*(11), 1584-1593.
- NTA. (2010). Routes to Recovery: Psychosocial interventions for drug misuse. In T. B. P. Society (Ed.), *A framework and toolkit for implementing NICE recommended treatment interventions*. UCL: London: Centre for Outcomes, Research and Effectiveness (CORE).

- Nunkoosing, K. (2005). The problems with interviews. *Qualitative health research, 15*(5), 698-706.
- Parker, H. (2005). Normalization as a barometer: Recreational drug use and the consumption of leisure by younger Britons. *Addiction Research & Theory, 13*(3), 205-215.
- Parker, H., Williams, L., & Aldridge, J. (2002). The Normalization of 'Sensible' Recreational Drug Use: Further Evidence from the North West England Longitudinal Study. *Sociology, 36*(4), 941-964.
- Peleg-Oren, N., & Teichman, M. (2006). Young Children of Parents with Substance Use Disorders (SUD): A Review of the Literature and Implications for Social Work Practice. *Journal of Social Work Practice in the Addictions, 6*(1-2), 49-61.
- Popovici, I., French, M. T., & McKay, J. R. (2008). Economic evaluation of continuing care interventions in the treatment of substance abuse recommendations for future research. *Evaluation Review, 32*(6), 547-568.
- Prison Reform Trust. (2011). Bromley Briefings Prison Factfile. London.
- Robinson, J., Sareen, J., Cox, B. J., & Bolton, J. M. (2011). Role of self-medication in the development of comorbid anxiety and substance use disorders: A longitudinal investigation. *Archives of General Psychiatry, 68*(8), 800.
- Rosengard, A., Laing, I., Ridley, J., & Hunter, S. (2007). A Literature Review on Multiple and Complex Needs. Edinburgh: Scottish Executive Social Research.
- Rutherford, M., & Duggan, S. (2009). Meeting complex health needs in prisons. *Public health, 123*(6), 415-418.
- Schifano, F. (2014). Misuse and Abuse of Pregabalin and Gabapentin: Cause for Concern? *CNS Drugs, 28*(6), 491-496.
- Seddon, T. (2010). Drugs and Crime. In J. Barlow (Ed.), *The Implications of Research, Policy and Practice*. London: Jessica Kingsley Publishers.
- Sigurdsson, J. F., & Gudjonsson, G. H. (1995). Personality characteristics of drug-dependent offenders. *Nordic Journal of Psychiatry, 49*(1), 33-38.
- Singleton, N., Farrell, M., & Meltzer, H. (1999). Substance misuse among prisoners in England and Wales. London: Office for National Statistics.
- Stein, D. J., Phillips, K. A., Bolton, D., Fulford, K., Sadler, J. Z., & Kendler, K. S. (2010). What is a mental/psychiatric disorder? From DSM-IV to DSM-V. *Psychological medicine, 40*(11), 1759-1765.
- Tiet, Q. Q., & Mausbach, B. (2007). Treatments for patients with dual diagnosis: a review. *Alcoholism: Clinical and Experimental Research, 31*(4), 513-536.
- Torrens, M., Mestre-Pintó, J., & Domingo-Salvany, A. (2015). Comorbidity of substance use and mental disorders in Europe. Portugal: EMCDDA,.
- Tripp, J. C., McDevitt-Murphy, M. E., Avery, M. L., & Bracken, K. L. (2015). PTSD Symptoms, Emotion Dysregulation, and Alcohol-Related Consequences Among College Students With a Trauma History. *Journal of dual diagnosis, 11*(2), 107-117.
- Vinkers, D. J., de Beurs, E., Barendregt, M., Rinne, T., & Hoek, H. W. (2011). The relationship between mental disorders and different types of crime. *Criminal Behaviour and Mental Health, 21*(5), 307-320.
- Wahlstrom, L. C., Scott, J. P., Tuliao, A. P., DiLillo, D., & McChargue, D. E. (2015). Posttraumatic Stress Disorder Symptoms, Emotion Dysregulation, and Aggressive Behavior Among Incarcerated Methamphetamine Users. *Journal of dual diagnosis, 11*(2), 118-127.
- We Need to Talk Coalition. (2013). We still need to talk: A report on access to talking therapies. London: Mind.
- Whiteley, C., Mitcheson, L., & Hernen, J. (2012). The Contribution of Clinical Psychologists to Recovery-orientated Drug and Alcohol Treatment Systems. In T. B. P. Society (Ed.). Leicester: BPS.
- Wickrama, K. A. S., Conger, R. D., & Abraham, W. T. (2005). Early Adversity and Later Health: The Intergenerational Transmission of Adversity Through Mental Disorder and Physical Illness.

*The Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, 60(Special Issue 2), S125-S129.

- Wiesner, M., Kim, H. K., & Capaldi, D. M. (2005). Developmental trajectories of offending: Validation and prediction to young adult alcohol use, drug use, and depressive symptoms. *Development and psychopathology*, 17(01), 251-270.
- Williams, I. (2009). Offender health and social care: a review of the evidence on inter-agency collaboration. *Health & social care in the community*, 17(6), 573-580.
- Williams, L. (2013). *Changing Lives, Changing Drug Journeys*. London: Routledge.
- World Health Organisation. (2007). *Health in prisons: A WHO guide to the essentials in prison health*. Copenhagen: Denmark: The Regional Office of the World Health Organisation.
- Young, S., Wells, J., & Gudjonsson, G. (2011). Predictors of offending among prisoners: the role of attention-deficit hyperactivity disorder and substance use. *Journal of Psychopharmacology*, 25(11), 1524-1532.