

AN INVITATION TO CHANGE?

**An Ethnographic Study of a Residential Therapeutic Community for
Substance Use**

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Abstract

Drawing upon the findings of a 31 month ethnographic study this thesis provides a snap-shot of the intricate workings that take place in a residential Therapeutic Community (TC) in the North West of England for individuals with a history of substance use. The thesis identifies and addresses the omission of process based research in the existing literature on TC's for substance use and pays particular attention to how such unique settings provide an alternative way to work alongside those mainstream society deems to be deviant, problematic, worrying, threatening, troublesome, or undesirable in some way or another. The longitudinal dimension of the research allows the study to capture the voices of residents¹ and practitioners to inform a more complete appreciation of the interpretation and implementation of the principles of the TC in practice.

The study offers an unprecedented insight into the innovative design, delivery and intricate workings that takes place in a residential TC. Conducted at a time of great change and uncertainty in the theory and practice of drug policy and service provision – as the implications of Payment by Results (PbR) in the sector take hold - the study captures the tensions at work in realising in practice the theoretical ambitions of the TC and the very real challenges of reconciling increasingly commercial/business orientated decisions within public health models of thinking. In this way the study has the capacity to contribute to ongoing debates about processes associated with an individual's journeys in and out of criminal careers in the desistance literature; and to broader criminal justice policy debates about the increasing marketization of the management and supervision of lawbreakers whose offending behaviour is heavily influenced by substance use.

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Introduction

Approximately 200,000 adults receive help for substance use each year in England and Wales. The majority of these are dependent on a class A substance, usually heroin and/or crack cocaine (84%), which can lead to a variety of problems on an individual and social level that costs the taxpayer approximately £15,400,000,000 per year (National Treatment Agency for Substance Misuse, 2012). In an attempt to reduce the individual, social and economic costs of substance use the government is spending £800 million per year on a variety of alcohol and drug services such as detoxification programmes, substitute prescription programmes, outpatient programmes and residential programmes (National Treatment Agency for Substance Misuse, 2012-2013).

Residential services are a crucial component of the alcohol and drug treatment system in England and Wales (National Treatment Agency for Substance Misuse, 2006). They account for 2% of individuals who engage with alcohol and drug services² but 10% of central funding (National Treatment Agency for Substance Misuse, 2012a). They cater for complex clients with greater care needs (National Treatment Agency for Substance Misuse, 2006; Mistral, 2013) and have received a rebirth of interest, driven by a media-led dissatisfaction with the perceived failures of substitute prescribing policies of the previous two decades (Best, O'Grady, Charalampous and Gordon, 2005; Ashton, 2007; Gyngell, 2011; Yates, 2012).

Residential services are provided by both voluntary and private sector organisations. The National Treatment Agency for Substance Misuse (NTA) has identified four approaches that are commonly used in residential settings: 12-Step programmes;

Cognitive Behavioural Therapy (CBT); faith-based services; and Therapeutic Communities (Davies, English, Stewart, Edginton, McVeigh and Bellis, 2012).

The term Therapeutic Community, or TC as they are colloquially known, has been linked to a range of traditions and approaches that use interpersonal relationships and activities that take place in a purposefully designed social environment or residential setting to promote social and psychological change (Vanderplasschen, Vandeveld and Broekaert, 2014). Although the origins and development of the TC can be traced to two independent traditions: the democratic TC, which specialises in supporting those with moderate to severe personality disorders; and the hierarchical TC, which assists individuals with a history of substance use. The focus of this thesis is the hierarchical TC; and more specifically the residential hierarchical TC.

The term TC can mean different things to different people given its diversity of practice and breadth of clientele (Rawlings and Yates 2001; Autrique, Vanderplasschen, Broekaert and Sabbe, 2008; Stevens, 2013; Perfas, 2014). One of the consequences of this is that the definition of a TC, how it works and for which clients it is most suited remains unclear³ (DeLeon, 1995; Yates, 2008). Although it has been suggested that a hierarchical TC can provide a significant facilitator of the recovery process (DeLeon, 1997) and programme effectiveness in terms of reduced substance use and criminality has been documented (Ogbourne and Melotte, 1977; Wilson and Mandelbrote, 1978; Holland, 1978; DeLeon, Wexler and Jainchill, 1982; Wilson and Mandelbrote, 1985; Condelli and Hubbard, 1994; Page and Mitchell, 1998; Toumbourou, Hamilton and Fallon, 1998), questions such as how and why participation in a TC can facilitate the recovery process remain largely unanswered (Timms, DeLeon and Jainchill, 1994; Rawlings and Yates, 2001; Perfas 2012, 2014).

In addition to this there is a lack of process based research surrounding the TC for substance use, which means that there is a limited insight into how programme components interact on a day-to-day basis in a TC (Berg, 1979; Nielsen and Scarpitti, 1997; DeLeon, 1997, 2000; Lees, Manning, Menzies and Morant, 2004; Zhang, Roberts and McCollister, 2009) and how outcomes, such as reduced substance use and criminality are achieved (Van de Ven and Sminia, 2012).

The purpose of this thesis is to provide an ethnographically based account of the intricate workings that take place in a residential hierarchical TC, paying particular attention to how programme components are operationalised on a day-to-day basis as outcome-based initiatives, such as PbR, were introduced into the sector. To do so, the study explores the organisation, structure and operation of a TC according to the TC perspective (Chapter Two and Chapter Five) and contextualises the day-to-day practices that take place in the setting within a broader social and political landscape (Chapter Six). It includes a rich qualitative analysis of residents' experiences during their time in the TC under study as well as the immediate period following on from their departure (Chapter Seven) and concludes by reflecting upon the adaptations and modifications that have been made to the programme (Chapter Eight).

The longitudinal nature of the study means that the findings are able to provide an intimate insight into the intricate workings that take place in a TC, capture how such occurrences are played out amidst theoretical and political uncertainty and explore the consequences this has on those involved. Ultimately, the aim of the thesis is to provide an in-depth account of a residential TC and explore whether the concept of recovery capital⁴ can provide a comprehensive way in which the work that takes place within

these settings can be better understood by those at the coal face of service delivery and communicated to a wider audience.

To investigate whether recovery capital could be used to open up the design and delivery of TC practices ethnographic fieldwork took place over 31 months, from August 2010 to March 2013 in a residential hierarchical TC for individuals with a history of substance use. Throughout the duration of fieldwork an array of research methods were used to collect data in order to throw light on the issues under study and answer the central research question:

To what extent can the concept of recovery capital be used to explain the work that takes place in a TC for substance use?

As fieldwork was conducted during a time that was characterised by great change and uncertainty for services that provided support for substance users, findings are able to contribute to broader social and criminal justice policy debates. This means that the findings from this study not only provide an in-depth insight into the workings of a hierarchical TC through the application of recovery capital, but an original perspective into how high level policy directives, such as PbR, were translated into practice.

Chapter One

Origins and Development of the Therapeutic Community

Introduction

The origins and development of the Therapeutic Community (TC) can be traced to two independent traditions: the hierarchical TC and the democratic TC. The democratic TC began with the work of Maxwell Jones during the Second World War and was developed at the Henderson Hospital in Surrey during the 1960s (Rawlings, 1998). The democratic TC specialises in supporting individuals with moderate to severe personality disorders, as well as complex emotional and interpersonal issues. Generally speaking, the democratic TC provides a psychosocial approach, which is intended to help troubled individuals understand and, as far as possible, lessen or overcome their psychological, social and/or emotional issues and difficulties (Stevens, 2013). On the other hand there is the hierarchical TC, derived from Synanon, a self-help community for substance users, established by Charles Dederich in 1958 in San Francisco (Rawlings and Yates, 2001). The term hierarchical TC refers to a social psychological intervention which uses self-help and behaviour modification techniques to help individuals address underlying issues and difficulties that surround their substance use.

The purpose of this chapter is to explore the theoretical knowledge and empirical evidence surrounding the history and development of the hierarchical TC⁵. A systematic approach was conducted when identifying and collecting literature in a comprehensive, unbiased and reliable fashion. A bibliographic search of books and manual search of electronic databases was conducted to examine existing research designs, methodologies and findings; measures of effectiveness; and ambiguities worthy of further investigation. The approach was based upon three fundamental principles which

underpin a systematic literature review (Mulrow, 1994; Forward, 2002; Tranfield, Denyer and Smart, 2003; The Magenta Book, 2011). The three principles are: a clearly stated set of objectives with pre-defined inclusion and exclusion criteria; a systematic search that attempts to identify all studies that meet the inclusion criteria; and a systematic presentation of the findings of the included studies.

Within these parameters a wide variety of texts were considered for inclusion. The manual search of electronic databases went on to constitute the main form of literature collection, pulling together all academic information, in print and electronic form, available through the library at Liverpool John Moores University (LJMU). In total 12 electronic databases⁶ were searched using the search terms: therapeutic communit*, substance* or drug* and hierarch* thus identifying 6,694 articles.

A pre-determined exclusion criteria was established before the literature search was conducted in an attempt to keep the findings pertinent to the study in hand. This exclusion criteria consisted of articles written in another language, not available directly (paper or electronic copies) or indirectly (via the inter-library loans service) from the library at LJMU or compared a TC to another alcohol and drug treatment programme.⁷ Therefore of the 6,694 articles identified, 6,577 were excluded as they fell into the pre-determined exclusion criteria. This left 117 articles of which there was 46 descriptive accounts,⁸ 19 follow up studies,⁹ 6 accounts of modified hierarchical TCs (Kaufman, 1979; Hughes, Coletti, Neri, Stahl, Urnann, Sicilian and Antony, 1995; Greenberg, Hall and Sorensen, 2007; Bologna, Bahr and Diaz-Guerra, 2008; Dye, Ducharme, Johnson, Knudsen and Roman, 2009; Vassilev and Groshkova, 2007) and 14 evaluation studies.¹⁰ There were 11 follow up studies of prisoners who participated in a prison-based hierarchical TC,¹¹ three in-programme studies¹² and four critical accounts of the

hierarchical TC.¹³ Four studies explored the relationship between outcomes and individual characteristics,¹⁴ there were six comparative studies¹⁵ (Aaron and Daley, 1976; Simpson and Sells, 1982; Page and Mitchell, 1988; Marcus, 1998; Sorensen, Andrews, Delucchi, Greenberg, Guydish, Masson and Shropshire, 2009; Goethals, Soyez, Melnick, DeLeon and Broekaert, 2011) two large scale studies (Bell and Ryan, 1985; Stewart, Gossop, Marsden and Rolfe, 2000) one explorative study (Condelli and DeLeon, 1993) and one literature review (Rawlings, 1998). All of these spanned over 40 years from 1971-2013 and the majority derived from the United Kingdom and America. However, cases from Italy, Belgium, Spain, Peru and Bulgaria were included.

The Democratic Therapeutic Community

The British democratic TC developed as a result of two experiments known as the Northfield experiments, which took place between 1942 and 1948 at the Hollymoor Hospital in Birmingham. The hospital was designed to rehabilitate soldiers suffering from neurotic disorders, such as anxiety, post-traumatic stress, bereavement and personality disorders (Kennard, 1998).

During this time army psychiatrists were not only faced with hundreds of psychologically traumatised soldiers as a result of the Second World War but also expected to rehabilitate traumatised soldiers to enable them to return to military service. The enormity of the task that faced army psychiatrists saw the focus of interventions carried out at the Hollymoor Hospital shift from addressing patients' needs on an individual basis to addressing the needs of patients collectively (Campling and Haigh, 1999). Between 1942 and 1948 wards at the hospital were transformed into small cohesive communities where mutual support and co-operation was promoted. Non-directive patient-led group discussions were encouraged to develop patient

understanding of personal issues and difficulties, as well as to strengthen patient insight into the strategies and interventions used in the hospital (Kennard, 1998; Campling and Haigh, 1999; Clarke, 2004).

At the same time as the Northfield experiments the Mill Hill Neurosis Unit opened in London to treat soldiers suffering from neurosis and shell shock. Maxwell Jones, clinical lead at Mill Hill, conducted extensive research on the psychological manifestations of soldiers with effort syndrome. Effort syndrome, colloquially known as soldier's heart, is a psychosomatic disorder related to combat fatigue which is considered to be an indication of an anxiety disorder (Bloom, 1997). Jones originally set out to lecture patients on his research findings with a view to improving their neurotic conditions. However, he soon discovered that the most therapeutic aspect of the lecture was the concluding group discussion where patients, who had resided at Mill Hill for some time, taught newer patients about effort syndrome (Campling and Haigh, 1999; Clarke, 2004).

After the Second World War had ended Jones developed a programme at the Belmont Hospital in London for ex-prisoners of war; based on discussions and education in group settings (Bloom, 1997). By the end of the 1960s the Belmont Hospital (now known as the Henderson Hospital) was considered to be a leading centre for the study of neuroses; claiming to specialise in working with individuals who were diagnosed with a moderate to severe personality or character disorder until its closure in 2008 due to changes in government funding (Campling, 2001). The work carried out at Mill Hill not only set the foundations for the work carried out in the Henderson Hospital, but contributed to the development of a social psychiatry movement known as the Philadelphia Association.

The Philadelphia Association was established in 1965 by a group of psychiatrists and psychoanalysts who wanted to bring about a revolution in the diagnosis and ‘treatment’ of mental illness (Campling and Haigh, 1999; Clarke, 2004). It aimed to provide alternatives to traditional ways to work alongside those deemed to be mentally ill, particularly those diagnosed as schizophrenic. The Association’s first venture was the development of a community based project in the east end of London called Kingsley Hall. The Philadelphia Association described Kingsley Hall as a crucible which questioned established ideas about sanity and insanity; and normality and abnormality (The Philadelphia Association, 2007). There were no locks on the doors, patients were free to come and go as they pleased, anti-psychotic medication was not administered and lysergic acid diethylamide (LSD), which was legal when Kingsley Hall opened, was frequently administered to patients and staff to help release inner demons and buried childhood traumas (O’Hagan, 2012).

Kingsley Hall was described as a place that was very much of its time, attracting maverick doctors, hippies and people trying to find themselves, as well as the seriously mentally ill (The Philadelphia Association, 2007). It was part of a greater social upheaval where definitions of authority, family, sexuality and illness were all being questioned (O’Hagan, 2012). Interest in the democratic TC grew during the 1960s and 1970s and an acceptance of its ideals within psychiatry flourished. Liberal open-door psychiatric hospitals became the norm, as mental health professionals recognised the importance of the emotional and social atmosphere of the hospital/programme setting and society became more understanding and accepting of mental illness (Stevens, 2013).

From 1953 to 1957 Robert Rapoport, an American anthropologist, carried out a participant observation study of the Social Rehabilitation Unit at the Belmont (later Henderson) Hospital (Lees *et al.*, 2004). The title of his book – *Community as Doctor* – sums up the fundamental premise of a TC; living in a community can be a healing experience (Rapoport, 1960). Based on his observations Rapoport articulated four themes: democracy; permissiveness; communality; and reality confrontation that characterise the structural organisation of the democratic TC. Democracy is the sharing of decision making between all members of a TC community (staff and residents). Permissiveness is the tolerance of others' behaviour. Communality is the development of a peer community which works together and, reality confrontation calls for continuous feedback from members of the TC about how they perceive and are affected by each other's behaviour. These themes continue to underpin the day-to-day workings of the democratic TC, however, it is important that they are seen as principles in tension with each other rather than absolutes.

“Although it is vital that all community members have a significant voice in decisions that affect their lives, it is important to be realistic and clear about the limits of democratic decision-making and the responsibility of professionals to provide a safe framework for therapeutic work.”

(Campling, 2001:366)

Democratic TCs hold daily community meetings that provide a collective format for confrontation and discussion about an individual's behaviour. They also have small therapeutic groups, which provide a more intimate atmosphere where sensitive matters can be discussed (Rawlings, 1998). Free time is purposively built into the programme as a therapeutic tool as it is claimed that, if progress is to be made, residents need time to work through and digest what they are learning whilst residing in a TC (Rawlings, 1998; Stevens, 2013).

In 1962 Britain's first and only 'democratic prison' opened in Buckinghamshire. Her Majesty's Prison (HMP) Grendon is an experimental psychiatric prison tasked with caring for prisoners whose mental disorder did not qualify them for a transfer to a psychiatric hospital under the Mental Health Act 1959 (Lees *et al.*, 2004). Prisoners in Grendon are not deemed to be suffering from psychosis or classified as legally insane but they are classed as having personal issues that would be responsive to some form of support or intervention (Genders and Player, 1995; Stevens, 2013). Over the years it has been brought more in line with the rest of the prison estate and is now run by a prison service governor. It does however, continue to operate a unique regime. The purpose of Grendon is to assess prisoners whose offending behaviour suggests mental morbidity and explore ways of dealing with these individuals (Lees *et al.*, 2004).

The effectiveness of Grendon has been discussed and documented (Cullen, 1994; Marshall, 1997; Taylor, 2000; Wilson and McCabe, 2002; Shuker and Newton, 2008). Cullen (1994) studied two groups of prisoners in Grendon: those who stayed more than 18 months and those who stayed less. The reconviction rate for the latter group was 50% while the rate for those who stayed for more than 18 months was down to 19% (n = 103 and 47 respectively). Cullen's study had no control group but was included in a replication by Marshall in 1997 who followed a cohort of 700 males for four years after they had completed Grendon, comparing them to a waiting list control group of 142 males who had been referred to Grendon, but for one reason or another had not been admitted. Marshall (1997) demonstrated two main findings. First, compared to a comparator general prison group, Grendon referrals were of a higher risk of reoffending than the general prison population. Second, there was a reduction in reoffending rates for the Grendon group who stayed for more than 18 months of between a quarter and a fifth when compared to the waiting list control group. The same cohort of men were

followed up by Taylor (2000) who replicated these findings and identified a 60% reduction in recall for life sentenced prisoners who resided in Grendon, compared to a risk matched group from the general prison population.

The documented success of Grendon inspired the development of and template for a number of small democratic TC wings located in a number of other prisons: HMP Dovegate; HMP Gartree; HMP Aylesbury; HMP Blundeston; and HMP Send.¹⁶ However, since the emergence of the ‘democratic prison’ and ‘democratic wings’ there has been an interest in, and problematisation of, the relationship between control and care in custodial settings. On one hand it has been suggested that the punitive carceral context holds the ability to undermine therapeutic attempts (Genders and Player, 1995; Cullen, Jones and Woodward, 1997; Wexler, 1997; Rawlings, 1998; Woodward, 2007; Carlen and Tombs 2006, cited in Sim, 2009; and Cullen and MacKenzie, 2011). However, on the other hand, the desirability of prison-based interventions has been discussed; described as visionary spaces where ‘change for the better both for individuals, organisational/relational structures and society might be facilitated’ (Jefferson, 2003:72).

The 1980s were marked by the beginning of a gradual decline in the influence and popularity of the democratic TC in Britain. The arrival of community care initiatives, which relocated mental health provision from institutions to community settings and instigated a number of changes to the management and funding of psychiatric services gradually reduced interest in and support for the democratic TC (Clark, 1984; Campling and Davis, 1997; Campling and Haigh, 1999; Clarke, 2004).

The Hierarchical Therapeutic Community

Charles Dederich (1913-1997) was a member of Alcoholics Anonymous (AA) until his dissatisfaction with the AA model spurred him on to establish his own recovery movement called Synanon.¹⁷ Although Dederich rejected AA's spiritual approach to self-help, he did maintain the AA philosophy that individuals must take personal responsibility for their actions in order to recover from substance use (Borkman, Kaskutas and Owen, 2007).

Dederich argued that Synanon was a learning environment where individuals learned, or relearned, how to live right (Yates, 2012). The most telling clue as to the origins of Synanon lay in its insistence on the AA concept of a dry drunk: the former drinker who continues to behave in ways that are unacceptable and which are the hallmark of a former drinking career (Makela, 1996; Yates, 2012). Abstinence was not a goal of participation in Synanon; it was a serendipitous outcome of overall behavioural change (DeLeon, 2000; Yates, 2012).

Dederich practiced a highly confrontational brand of therapy built on an autocratic, family surrogate model that required a high level of self-disclosure and honesty as well as an unrelenting pursuit of truth surrounding an individual's behaviour, feelings and thoughts (Perfas, 2004). An individual's needs were met through total participation in Synanon and individual roles and responsibilities evolved to serve the maintenance of the Synanon peer community. Every member regardless of rank, function or seniority was first and foremost a Synanon resident. Total identification with the Synanon community was paramount and residents were required to conform to the rules, values, norms and expectations as documented in handbooks that detailed how to behave and

the values that applied to everyday life, from getting up in the morning to relaxing in the evening (Kennard, 1998).

Synanon residents were expected to work their way up the hierarchical structure, which offered positions of increased responsibility as well as opportunities to carry out and manage different aspects of work such as cooking, cleaning and house management. A wide range of methods, such as reward and sanction systems, peer pressure and encounter groups were employed to introduce conformity and commitment to the rules and regulations, although the emphasis placed on conformity in Synanon and early TCs has evoked much criticism (Waldorf, 1971; Sugarman, 1986; Kooyman, 1986, 1993; White, 1998).

In 1964 Daytop Village in Staten Island opened and was designed for probationers with a history of substance use. Although its founders, William O'Brien and Daniel Casriel, were originally supporters of Synanon they became disillusioned due to its authoritarian leadership style and rejection of mainstream society (Kaplan and Broekaert, 2003). Where Synanon moved its residents in the direction of dropping out of mainstream society, Daytop promoted social inclusion and the re-integration of residents back into society once they had completed their programme.

The first generation of hierarchical TCs considered themselves to be drug free (Glaser, 1981; Broekaert, Kooyman and Ottenberg, 1998). However, there was considerable hedging on what was considered to be a drug. Although Synanon banned alcohol, Synanon-inspired TCs such as Daytop Village permitted and even ritualised the social drinking of alcohol as part of an individual's re-integration into mainstream society (White, 1998). Whilst some successfully managed relationships with alcohol, a number

of ex-residents and ex-addicted staff developed problems and eventually sought support for alcoholism (White, 1998).

In 1968, on the other side of the Atlantic, Dr Ian Christie converted a ward of St. James Hospital, Portsmouth into Europe's first hospital-based hierarchical TC. At around the same time Professor Griffith Edwards of the Maudsley Hospital Addiction Unit established the Featherstone Lodge TC and Dr Bertram Mandelbrote created a TC in the Littlemore Hospital Oxford. Hospital-based TCs for substance use were a result of a group of British psychiatrists who had been inspired by visits to Daytop Village and Phoenix House in New York.

By 1969 the number of individuals attending group discussions in Synanon had grown from 500 in 1964 to over 1400 (White, 1998). Its early success witnessed the development of a number of Synanon inspired TCs across America including the Delancy Street Foundation, Topic House Long Island, Phoenix House New York, Gaudenzia House Philadelphia, Gateway House Chicago, Integrity House Newark, Archway House St Louis and Marathon House in Coventry Rhode Island.

The rise in illicit drug use, which occurred during the 1960s grew to epidemic proportions during the 1970s (Plant, 1987). This saw a shift in how substance use was viewed and responded to; abstinence was now the primary goal of alcohol and drug treatment (Stimson and Oppenheimer, 1982). The hard hitting abstinence-based approach provided by the first generation of hierarchical TCs resulted in the emergence of a number of Synanon-inspired programmes throughout the American prison estate. In 1977 a Synanon-inspired prison-based TC called the Stay 'N' Out programme was established in the Arthur Kill Correctional facility for men and in 1979 the Cornerstone

programme was established at the Oregon State Prison for offenders with a history of substance use. A number of studies have since documented the effectiveness of prison-based TCs in terms of reduced reoffending and relapse (Field, 1984; Inciardi, Martin, Butzin, Hooper and Harrison, 1997; Wexler, Melnick, Lowe and Peters, 1999; Martin, Butzin, Saum and Inciardi, 1999; Knight, Simpson and Hiller, 1999).

By the late 1970s completion from Synanon was abolished as Dederich redefined addiction as a terminal disease that could only be arrested by sustained participation in Synanon (White, 1998). This shift marked the beginning of the end of Synanon as it gave way to the development of a community which introduced a greater degree of coercion and a series of loyalty tests that drove out all but the most committed residents (White, 1998). Although essentially inspired by the American movement, European TCs went on to develop their own identity due to a strong opposition to the harsh confrontation of residents and demoralising learning techniques, such as wearing signs and compulsory head shaving that had taken place in Synanon. This dissatisfaction led to the development of a European TC model that provided a more balanced and supportive dialogue between residents and staff (Broekaert, Vandeveld, Schuyten, Erauw and Bracke, 2004; Broekaert, 2006; Goethals *et al.*, 2011; Vanderplasschen *et al.*, 2014).

Although the British hierarchical TC was first established in hospital settings, by the 1970s it had been transferred to residential settings. Alpha House, founded by Dr Ian Christie, was the first residential TC for substance use to open in Britain. It was followed soon after by Phoenix House in London, established by Professor Griffith Edwards. The residential TC identified itself as an abstinence-based programme thus providing a stark contrast to programmes available during the 1970s that sought to limit

the harm that emerged from substance use rather than achieve abstinence. During this time heroin use, which was associated with American jazz music and Hollywood films, was at the centre of British public and political concern (Yates, 2002, 2003). Therefore it is unsurprising that an American programme, such as the hierarchical TC, was integrated into the British alcohol and drug treatment system with relative ease; accounting for approximately half the 250 residential beds in Britain by the end of the 1970s (Yates, 1981).

By this time the population seeking help for substance use had diversified as cannabis, LSD and amphetamine use had become more widespread and more women and adolescents sought help and support for substance use (Yates, 1992). The increased demand for alcohol and drug treatment witnessed a growth in the number of services, such as medically managed detoxification programmes, short-stay residential programmes, outpatient programmes and individual drug counselling; as well as group counselling that was available during the time. The availability of such a range of services saw the hierarchical TC gradually diminish in significance as it was deemed an outdated modality (Yates, 2003). In an attempt to meet the needs and demands of the population seeking alcohol and drug treatment additional services such as medical and mental health services, family therapy services, vocational courses and methadone reduction programmes were gradually incorporated into the TC.

The introduction of medical interventions into the TC were initially greeted with scepticism as the TC perspective views methadone as an ordinary drug and suggests that the provision of substitute medication replaces personal change and the prospect of recovery with stagnation (Broekaert, Vandeveld, Soyez, Yates and Slater, 2006). Despite this negative view of methadone in 1979 Kaufman produced the first report

which suggested that TC based methadone reduction programmes helped individuals initiate recovery from substance use and achieve abstinence. Kaufman (1979) documented the detoxification of 94 admissions over an average of three to four months at the Su Casa TC in New York. He suggested that a TC provided residents with the support and direction required to help them complete detoxification successfully and claimed that the provision of methadone reduced the likelihood of residents leaving prematurely.

The 1980s saw the arrival of, and general public concern surrounding, the HIV/AIDS virus. In an attempt to prevent the virus from spreading alcohol and drug programmes were encouraged to become more user friendly, provide free needles and syringes, condoms, health education and flexible prescribing of methadone (MacGregor, 1994). The shift in public and political interest witnessed a growing emphasis on harm reduction approaches, which subsequently reduced the sphere of influence of programmes practicing a philosophy of abstinence; as was the case with the TC (Broekaert *et al.*, 1998). In an attempt to cater for the changing needs and demands of the population presenting for alcohol and drug treatment the TC was modified once again. Outpatient, short stay and HIV/AIDS orientated programmes were established and additional services such as counselling, family therapy, education/vocational services and mother and baby units were also integrated into a number of TCs.

The 1990s saw the fear of HIV/AIDS subside as public and political interest was re-orientated once again (Hunt and Stevens, 2004; Duke, 2006; Parker, 2007). There was an increasing interest, both publically and politically, on the relationship between substance use and crime. This interest gave way to a presupposed drug-crime link, which advocated that substance use was the catalyst behind most if not all crime (Preble

and Casey, 1969; Ball, Rosen, Flueck and Nurco, 1983; Nurco, Shaffer, Ball and Kinlock, 1984; Johnson, Lipton and Wish, 1986; Nurco, Hanlon, Kinlock and Duszynski, 1998; Goldstein, Brownstein, Ryan and Bellucci, 1989; Chaiken and Chaiken, 1990; Lipton, 1995; Anglin and Perrochet, 1998; Simpson, 2008). Drug interventions such as the Drug Treatment and Testing Order (DTTO, now Drug Rehabilitation Requirement) and the Mandatory Drug Testing (MDT) programme in prisons enhanced the presupposed drug-crime link which elevated interest once again in services that provided abstinence-based programmes (Bean, 2004). At around the same time a number of studies from America emerged, which claimed to provide evidence that participation in a TC could help to reduce substance use and criminal activity (Field, 1984; Wexler, Falkin and Lipton, 1988; Siegel, Wang, Carlson, Falck, Rachman and Fine, 1999).

Field (1984) examined three year outcomes for all inmates who graduated from the Cornerstone programme between 1976 and 1979 comparing them with three control groups: Cornerstone drop outs (less than one month stay); all Oregon parolees with a history of substance use; and a sample of parolees from Michigan. The groups were compared on two measures: the percentage not returned to prison; and the percentage not reconvicted. The three year follow up of Cornerstone graduates showed that they exhibited better post-release performance than any of the comparison groups. Although the Cornerstone graduates had more severe criminal histories 71% were not reincarcerated three years after release compared to 63% of Oregon parolees. Similarly, although slightly more than half the Cornerstone programme graduates were not convicted of any crimes, only 36% of the Oregon parolees were not convicted of any crimes. Programme dropouts fared even worse with only 26% avoiding imprisonment and 15% not convicted of any subsequent crimes.

Wexler, *et al.*, (1988) conducted an analysis of outcome data from the first three years of the Stay 'N' Out programme. Prisoners taking part in the programme were compared to a group of matched prisoners in a milieu therapy based programme,¹⁸ a group counselling programme and a control group of individuals who were not engaged in any service for substance use. Results showed that the arrest rate for males taking part in the Stay 'N' Out programme (27%) was lower than arrest rates for those taking part in milieu therapy (35%), those taking part in group counselling (40%) and the control group (41%). Results also found that there was a strong relationship between time spent in the programme and positive outcomes; parole violations decreased from 50% for those who stayed less than three months to 22% for those that stayed between nine and twelve months.

Siegel *et al.*, (1999) evaluated the Ohio department of alcohol and drug addiction services prison-based TCs for inmates with a history of substance use. The study compared arrests following release from prison among 487 inmates with TC experiences and 242 inmates without. Outcome measures were based on arrest and charge statistics. Controlling for age, gender, ethnicity and education, inmates who spent at least 180 days in a TC were less likely than those with less or no time in a TC to be re-arrested with violent or drug related crimes one year post release. In light of these emerging positive findings and an escalating prison population with a history of substance use, it is unsurprising that a number of context-specific hierarchical TCs surfaced throughout the prison estate in England and Wales during the 1990s.

Prison-based hierarchical TCs are designed to provide intense support and guidance for prisoners with a history of substance use. The programme is typically designed to last between 12 and 18 months and is most suited to prisoners with complex problems,

extensive criminal histories, years of substance use and poor involvement in education and employment. The fundamental purpose of the prison-based TC is to provide an opportunity for prisoners to reflect on their past difficulties by promoting trust, emotional risk taking, self-learning and interpersonal skills essential for life after release (Sugerman, 1986). In the United Kingdom there are currently prison-based TCs for substance use in HMP Portland for young offenders, HMP Holme House, HMP Garth, HMP Wymott, HMP Low Newton and HMP Highpoint.

When the hierarchical TC first emerged the notion that a group of substance users could manage and control their own recovery was greeted with scepticism by mainstream alcohol and drug services (Yates, 2003; Broekaert *et al.*, 2006; Yates, 2012). Despite initial and continuing scepticism from Europe's mainstream alcohol and drug treatment culture the TC has survived the test of time. The programme is a well-established self-help modality in countries such as Italy, Greece, Spain, Portugal, Lithuania, Hungary and Poland; with more than 1,200 TCs across Europe alone (Vanderplasschen *et al.*, 2014).

The European Federation of Therapeutic Communities (EFTC), established in 1981, has become one of the largest and longest-lived recovery networks with members from over 70 organisations in 27 European countries as well as associate members from Israel, Lebanon, Iran, Colombia, USA and Japan (European Federation of Therapeutic Communities, 2013). Members of the EFTC provide prison-based TCs, residential TCs, structured day programmes, peer-led after-care services and street-based advice services. As the EFTC recognises that TCs have been met with scepticism it encourages self-evaluation amongst its members and an active participation in research studies. As a result of this commitment it has organised 15 biennial international conferences to

present and evaluate research into all aspects of the TC and the wider issues of long term recovery from substance use (Yates, Rawlings, Broekaert, and DeLeon, 2006; European Federation of Therapeutic Communities, 2013).

Despite divergent origins, philosophies, clientele and settings the democratic TC and hierarchical TC are considered to be vanguards of new and alternative therapies for individuals who have mental health or substance use issues (Rawlings and Yates, 2001). Since the inception of the TC there has been great debate about whether hierarchical TCs are, in theory and practice, similar to, or significantly different from their democratic cousin (Glaser, 1983; Sugarman, 1984; Lipton, 1998; Lipton, 2010; Vandavelde, Broekaert, Yates and Kooyman, 2014). There is, however, a general agreement that TCs:

“share an encouragement of residents’ active involvement in, and responsibility for, the day-to-day running of the TC; a respect for the social learning and behavioural reinforcement that occurs naturally in the course of communal living.”

(Stevens, 2013:14)

Chapter Two

The Therapeutic Community Construct and Pursuit to Demonstrate Effectiveness

Introduction

Chapter One has provided a detailed insight into how the democratic and hierarchical TCs have developed and progressed since their inception. The purpose of this chapter is to move beyond historical narratives of the programme and explore the theoretical principles and prescriptions, which ought to underpin the day-to-day workings of a hierarchical TC and examine how the application of longstanding assertions creates difficulties for evaluative research.

To do so the chapter has been divided into two parts. The first part provides a concise exploration of traditional TC philosophies and perspectives, while the second explores how the complexity and variety of TCs have had an adverse impact on the movement's ability to define and demonstrate programme effectiveness.

The Perspective, Model and Method

George DeLeon, the first research director at Phoenix House New York, organised the day-to-day workings of a TC into three components (Yates, 2012). The perspective describes the TC view of addiction, the individual, recovery and what is deemed to be right living. The model outlines how a TC is structured and organised and the method describes how the community as method self-help approach is applied to life in a TC.

View of the Disorder

According to the TC perspective, substance use is a disorder of the whole person affecting some, if not all, areas of functioning (DeLeon, 2000). Although substance users cite a variety of reasons and circumstances as to why they use substances, TCs emphasise that individuals must recognise how they have contributed to the problems that they are experiencing and develop coping strategies to manage potential future problems (DeLeon, 2000).

View of the Person

As indicated by the TC perspective, substance users characteristically display a variety of cognitive deficits such as poor awareness, difficulty in decision making and a lack of problem solving skills (DeLeon, 2000). In addition to these cognitive characteristics, substance users commonly display difficulties in how they see themselves in relation to their personal self-worth, as members of society, with self-regulation and how they communicate and manage feelings.

DeLeon (2000) suggests that an individual's anticipated problems with meeting responsibilities, being held accountable for their actions and maintaining consistency creates anxiety and discomfort, which results in avoidance of obligations, through substance use and impedes autonomous functioning. Lying or selectively forgetting the details of obligations becomes a way in which substance users cope with the discomfort associated with irresponsibility and inconsistency.

Although the origins of an individual's experienced and displayed trust issues are multifaceted, they typically reflect social and psychological influences such as histories of unsafe and abusive families, poor parental models of trust and negative socialisation.

The problem is not only in an individual's inability to trust others but the inability to trust themselves and their own feelings, thoughts and decisions (DeLeon, 2000).

View of Recovery and Right Living

DeLeon (2000) suggests that some substance users may have had some form of social functioning, positive community and family ties; however, the abrasive properties of substance use gradually eroded these resources. For these individuals recovery from substance use involves rehabilitation: re-learning or re-establishing their capacity to sustain positive living as well as regaining physical and emotional health. On the other hand, some substance users may have never acquired functioning lifestyles in the first instance, with their substance use embedded in a wider, more complex web of psychological dysfunction and social deficits. For these individuals recovery involves habilitation: learning the behavioural skills, attitudes and values associated with the view of right living for the first time. Despite the various social and psychological backgrounds that substance users have, the fundamental goal of recovery in a TC remains the same: to learn or re-learn how to live without substances.

According to the TC perspective, recovery is a gradual process of multidimensional learning involving behavioural, cognitive and emotional change. Behavioural change refers to the elimination of asocial and antisocial behaviour and the acquiring of positive social and interpersonal skills. Cognitive change refers to gaining new ways of thinking, decision making and problem solving skills; and emotional change refers to the development of skills necessary for managing and communicating feelings.

DeLeon (2000) outlines a number of generic assumptions and beliefs that constitute healthy personal and social living. These assumptions and beliefs are summarised by the phrase 'right living' to describe how and why people change in a TC. Right living means abiding by community rules, remaining substance free, participating in daily groups, meetings, work and therapeutic interventions, meeting obligations, maintaining a clean physical space and basic personal hygiene, taking both personal and collective responsibility and displaying socialised behaviour such as civility, manners, respect and keeping agreements. According to the TC perspective, the daily practice of right living not only provides a positive prototype that can be referred to after separation from the TC, but given time will evolve into a change in lifestyle and identity (DeLeon, 2000).

The Model

Each component of the TC model reflects an understanding of the perspective and is used to transmit community teachings as well as facilitate social and psychological growth of the individual (DeLeon, 2000). Components of the model include: work; staff; peer roles; and programme stages. Although the TC is grounded in self-help it is managed as an autocracy defined by hierarchical community positions and job functions indicative of a resident's level of responsibility.

Work in a TC is used as a fundamental activity to mediate socialisation, self-help, recovery and right living (DeLeon, 2000). Although the work structure is grounded in necessity, with labour required to physically operate the programme, it has profound social and psychological meaning in the self-help recovery process. The work experience in a TC provides an opportunity for substance users to develop a personal and social stake in mainstream life, changing one's perceptions about the future, instilling hope and a sense of possibility, as well as a social and personal identity.

Staff members in a TC are viewed as rational authority. By exercising their power to teach and guide rather than punish and control, staff members model trustworthy authority (DeLeon, 2000). This can serve as a restorative experience for residents who have had past negative experiences with authoritative figures.

Hierarchical TCs have three programme stages: induction, primary and senior. The induction stage is designed to provide new residents with a welcoming, less intense introduction to TC life. The primary and senior stages provide a hierarchically structured environment where residents can learn to express emotions and change behaviour by means of encounter groups and other therapeutic interventions (Rawlings and Yates, 2001). The stages are described in terms of stage-specific activities and typical outcomes and the stage format reframes long-term objectives of change into short term goals that can be defined, perceived and pursued (DeLeon, 2000).

The Method

The term ‘community as method’ refers to the self-help approach used within a TC where it is the community itself that brings about change. Community as method means encouraging residents to use their time constructively by teaching them how to learn about themselves and bring about personal change. These strategies and interventions place demands on the individual by expecting them to participate, behave appropriately and respect the rules of the programme. Being a member of a TC means that as well as conforming, every individual is also expected to monitor, observe and feedback on each other’s behaviour, attitude and personal change.

Everything that happens in a TC is designed to bring about therapeutic and educational change (DeLeon, 2000). The context, activities, people and teachings are organised into nine broad components that describe how the TC can be used to facilitate individual change: member roles; membership feedback; membership as role models; relationships; collective learning formats; culture and language; structure and systems; open communication; and community and individual balance.

Residents are part of the programme 24 hours per day, 7 days a week and are observed in everything that they do: work; leisure; peer interactions; group participation and so on. It is through these observations that a picture can be drawn up of residents' behaviours and attitudes, which need to be challenged and developed. The fundamental assumption that underlies the community as method approach is that residents obtain maximum therapeutic and educational impact when they meet community expectations and use the peer community to change themselves (DeLeon, 2000).

Organisation and Operation

As mentioned earlier, the mechanisms used in a TC have been organised into three components: the perspective; the model; and the method. This reflects the perspective of George DeLeon rather than a position of consensus amongst all TC workers, across all TCs (Clark, 1984; Rosenthal, 1984; Broekaert, Raes, Kaplan and Coletti, 1999; Melnick and DeLeon, 1999; Kaplan and Broekaert, 2003; Perfas, 2012). For instance, Melnick and DeLeon (1999) carried out a survey of essential hierarchical TC elements with 59 directors of TCs through their membership in Therapeutic Communities of America and found that although all programmes subscribed to the same perspective of the person, recovery and right living, differences were apparent in the diverse range of beliefs regarding specific elements of a TC. This suggests that although DeLeon's work is

widely recognised and documented, there is a limited insight and general understanding of how traditional components are applied to everyday life in a TC for substance use. Furthermore, as the components are associated with first generation long-term residential TCs, essential elements of contemporary, modified and adapted TCs are yet to be empirically described and validated (Timms *et al.*, 1994).

The reciprocal determinism¹⁹ between a TC population and context means that therapeutic interventions in one TC may not be transferable, or indeed appropriate, in other circumstances, situations or settings. This is because every aspect of a TCs operation is directly or indirectly related to the programme goals, population and setting (Berg, 1979). While some interventions, such as the encounter group are consistent with the traditional components of a TC, others may only be identified within the context of the community to which it belongs and the peer community receiving it (Broekaert, Vandeveld, Vanderplasschen, Soyez and Poppe, 2002). Positive parenting programmes and family focused interventions are appropriate in family orientated TCs which cater for pregnant women and those with young children. However, such interventions would not be appropriate in prison-based TCs due to the setting in which the programme is based and the population served.

Furthermore, as the social environment of a TC is sui generis the location of an active programme ingredient is a complex, if not impossible task (Berg, 1979; Timms *et al.*, 1994; DeLeon, 1997; Perfas, 2004). DeLeon, Hawke, Jainchill and Melnick (2000) assessed the efficacy of an intervention called the Senior Professor (SP) intervention, to reduce early drop outs in a hierarchical TC. In the SP intervention the most experienced staff in a TC led induction seminars during the first weeks of admission; traditionally the period with the highest rate of dropout.

Two trials of the SP intervention were conducted on separate cohorts admitted a year apart: trial one (20th November 1984 to 30th January 1985) and trial two (1st February 1986 to 31st March 1986). Retention rates between the experimental condition (the on period which consisted of the standard induction procedures plus the SP intervention) were compared to the preceding control condition (the off period which consisted of the standard induction procedures only).

Findings show that the SP intervention significantly reduced the likelihood of early drop out compared with controls. For the combined trials, the 30 day retention rates in the SP condition were significantly higher than in the control condition ($p < 0.00$). There were no significant differences between the two conditions at 180 or 365 days, which suggests that the SP intervention appears to decrease early dropout. For trial one the retention difference between the experimental and control groups was statistically significant at 30 ($p < 0.00$) and 365 days ($p < 0.02$). For trial two only the 30 day difference was significant ($p < 0.08$). No differences were obtained at 180 or 365 days. Every admission was required to attend all routine community activities in addition to the SP intervention. Therefore the interpretation of the interventions' effectiveness and the assertion of the ability of a specific mechanism in a multifaceted programme to produce the outcome intended calls for care in drawing conclusions (Melnick and DeLeon, 1999; Rawlings and Yates, 2001).

Timms *et al.*, (1994) suggest that findings from research conducted in hierarchical TCs are limited in external validity and generalisability due to an array of methodological limitations such as a limited use of control groups, client self-selection issues, retrospective research designs, additional programme and non-programme influences, validation of self-report data and changes in programme design and delivery (DeLeon

and Ziegenfuss, 1986; Melnick and DeLeon, 1999; Johnson, Pan, Young, Vanderhoff, Shamblen, Browne, Linfield and Suresh, 2008).

The Scientific Methods Scale (SMS) designed by Lawrence Sherman and colleagues was devised as a simple scale to measure internal validity using a scale of one to five to summarise scientific rigour (Sherman, Gottfredson, Mackenzie, Eck, Reuter and Bushway, 1998). The scores reflect the level of confidence that can be placed in an evaluation's conclusions about cause and effect, with the score of five indicating the strongest evidence. The highest point on the scale (five) is the use of randomised controlled trials where participants are randomly assigned to a control and an experimental group so that the only difference between the two groups is the presence of the intervention. Comparisons or changes in outcome measures between the two groups can then be made whilst at the same time controlling for other explanatory factors (Sherman *et al.*, 1998).

According to the SMS scale, by using a randomised control group, evaluation studies are able to gather the most credible evidence to confirm that a programme is making some kind of difference to the lives of its participants. However, the heterogeneity of the population served by a TC besides programme adaptation and modification means that establishing a true randomised control group is a complex if not impossible task.

In an outcome study conducted by Inciardi *et al.*, (1997) of the 184 individuals allocated to a control group 56% reportedly received some kind of previous help and support for substance use. Therefore it is possible to suggest that some members of the control group may have received more help and support than individuals allocated to the experimental group. Inciardi *et al.*, (1997) claimed that one of the main problems with

establishing a truly randomised control group was actually finding and establishing one that could be truly considered a control group. Rawlings and Yates (2001) went on to suggest that it is difficult to find groups which can be properly compared, since the critical factor in outcomes may be related to the personality that leads someone to enter a TC, such as motivation and commitment to change.

Without some form of control group inferences about programme effects on outcome are limited (Bale, 1979; Gray, 2009). Holland (1978) conducted a follow up study in an American TC using 193 admissions between July 1968 and June 1974. Three groups were constructed. Group one consisted of those who dropped out within the first nine months. Group two consisted of those who remained programme involved for more than nine months but left prematurely and group three consisted of those who completed the programme. Holland (1978) found an 81% reduction in arrest rates for group two and a 97% reduction for group three. However, definitive conclusions could not be drawn from the findings as the question remains whether those who remained programme involved would have changed even without participation in a TC.

Wilson and Mandelbrote (1985) conducted a ten year follow up study of 61 admissions to the Ley Community in Oxford between 1971 and 1973 using official records. The sample was divided into three groups: short stay (under one month); medium stay (under six months); and long stay (six months and over). The groups were compared with regard to demographic characteristics, history of criminality and history of substance use. The long stay group had a reconviction rate of 15%, the medium stay group a rate of 70% and the short stay group a rate of 85%. Wilson and Mandelbrote (1985) also raise the question whether the success of the long stay group could be attributed solely to their programme involvement due to the lack of a control group.

These findings illustrate how recovery from substance use is not something that can be delivered like a letter; the individual has a significant influence on outcome (Williams, 1990).

The articles upon which this chapter is based rarely describe the sampling procedures that were employed when conducting the research. For those that do, samples were typically generated from a population in a TC at the time of the study (Sutker, Allain, Smith and Cohen, 1978; Wilson and Kennard, 1978; Wilson and Mandelbrote, 1978, 1978b, 1985; DeLeon and Jainchill, 1981-82; Sorensen, Deitch and Acampora, 1984; Page and Mitchell, 1988; Fals-Stewart, 1992; Pouloupoulos and Tsiboukli, 1999) or programme completers and drop-outs (Romond, Forrest and Kleber, 1975; Aron and Daily, 1976; Ogbourne and Melotte, 1977; Holland, 1978; DeLeon, Andrews, Wexler, Jaffe and Rosenthal, 1979; DeLeon *et al.*, 1982).

DeLeon *et al.*, (1982) conducted a five year follow up study with dropouts and graduates from the 1970-1971 residential population in Phoenix House New York, which had a minimum residency of between 18 and 24 months. Composite indices of criminality, substance use and employment described resident status on a four-point outcome scale. Success was defined as an absence of crime and substance use at follow up and improvement represented a positive change over pre-programme status. Graduate success and improvement rates were 31% to 56% respectively but increased by time spent in the programme from less than one month to more than 20 months. Despite the longstanding attention that has been paid to comparing TC graduates and early leavers it is yet to be proven that achieving graduate status influences outcomes (Berg, 1979). A client may drop-out of a TC at 20 months whereas another may graduate from a different TC after six months.

The fundamental aim of evaluative research is to discover whether a programme does what it sets out to achieve, whether or not residents have improved and whether identified improvements are a result of the programme under study (Lees *et al.*, 2004). The articles upon which this chapter is based illustrate some of the difficulties surrounding the TCs ability to draw robust, generalisable conclusions from existing research findings. The discussion has paid particular attention to how the absence of a contemporary framework to guide the design and delivery of TC practices has not only left questions such as how does a TC work, why does it work and who does it work for largely unanswered (Vanderplasschen *et al.*, 2014) but created problems for evaluative research.

Measures of Effectiveness

Time spent in a TC has become one of the best and most consistent predictors of positive outcomes, with substantial attention invested in temporal patterns of retention (DeLeon and Schwartz, 1984; Condelli and DeLeon, 1993) and client predictors of retention (Aaron and Daley, 1976; DeLeon, 1989; Condelli and DeLeon, 1993; Condelli and Hubbard, 1994; Pouloupoulos and Tsiboukli, 1999; Dekel, Benbenishty and Amram, 2004). Findings suggest that the temporal pattern of dropout is uniform across TCs with dropout rates the highest in the first 30 days from admission, declining thereafter with the probability of continuing participation increasing as time progresses (DeLeon and Schwartz, 1984; Condelli and DeLeon, 1993).

Although no individual characteristics have been found that could be used to predict retention; factors such as legal pressure, motivation and readiness to change have been used to predict this. Mandell, Edelen, Wenzel, Dahl and Ebener (2008) found that adults referred by the criminal justice system were more likely to remain in a TC for at least 30

days and DeLeon, Melnick and Kressel (1997) found that motivation and readiness to change persist as significant predictors of short term retention.

Findings also suggest that the longer a client stays in a TC the more likely they are to incur positive outcomes (Ogbourne and Melotte, 1977; Wilson and Mandelbrote, 1978, 1978b; Holland, 1978; Simpson and Sells, 1982; Wilson and Mandelbrote, 1985; Page and Mitchell, 1988; Fals-Stewart, 1992; Condelli and DeLeon, 1993; Condelli and Hubbard, 1994; Toumbourou *et al.*, 1998; Dekel *et al.*, 2004; Fernandez-Montalvo, Lopez-Gonzi, Illescas, Landa and Lorea, 2008; Bankston, Carroll, Cron, Granmayeh and Marcus, 2009). This has not only produced a narrow interpretation of existing findings suggesting that the more exposure an individual has of a TC the more positive change will occur, but fails to recognise the array of inconsistent findings throughout the research. For example, DeLeon *et al.*, (1982) suggest that a four to six month stay in a TC is needed before an absence of opiate use and criminal behaviour can be achieved, whereas Simpson and Sells (1982) suggest that a minimum of 90 days is needed to achieve this. In addition to this, the discussion surrounding the notion of retention fails to recognise that an unplanned discharge from a TC does not necessarily mean that an individual's participation was a failure or ineffective (National Institute on Drug Abuse, 2004, 2008; National Treatment Agency for Substance Misuse, 2009; National Institute on Drug Abuse, 2009).

While retention is a legitimate concern it is not necessarily a conclusive indicator of effectiveness. Although it has been suggested that there is a relationship between time spent in a TC and positive outcomes, there are a number of extraneous factors that can explain equally as well why longer durations of stay may lead to better outcomes. Additional services such as professional counselling and family alliance strategies have

been introduced into a number of TCs to reduce premature drop out and enhance retention rates (DeLeon and Jainchill, 1991). Therefore we cannot be sure whether it is additional support, TC specific interventions or a combination of the two that keep people involved in the programme (DeLeon, 1988, 1991, 2000; Hughes *et al.*, 1995). Furthermore, what may be occurring is a self-selection process of residents who are better disposed to benefit from programme involvement, with those less willing or able to change more likely to leave early (DeLeon and Jainchill, 1986; DeLeon, 1984, 1993, 1994).

Toumbourou *et al.*, (1998) conducted a retrospective quasi-experiment to test the hypothesis that a high level of individual attainment and time in a TC had a linear association with improvements in outcome. 427 ex-residents of the Melbourne Odyssey House TC were stratified according to their highest level of programme participation. Residents who were admitted to Odyssey House between 1984 and 1988 were targeted for follow up and 60% were successfully located and interviewed an average of five to six years after their first entry. Substance use, criminal involvement and employment were used as outcome measures at follow up. Although individual attainment and time spent in Odyssey House had a linear relationship to improved outcomes, individual attainment was a better predictor of outcomes on programme exit; with those who had spent the median time or longer demonstrating worse outcomes on official conviction records and on self-reports of employment compared to those remaining programme involved for less than the median time. These results suggest that individual progress rather than time spent in a TC may best explain improved functioning following exit from the programme. Thus, the level of individual progress on exit is a better predictor of positive outcomes than the actual time spent programme involved.

Although findings suggest that individual progression during TC involvement is a better predictor of positive outcomes, little attention has been invested in exploring the processes that take place on a day-to-day basis in a TC; despite such endeavours being able to shed light on the work that takes place in a TC and how this contributes to an individual's decision to desist from substance use and crime. The omission of process based research has not only left the structure and processes at work in a TC subject to debate and interpretation (Bale, 1979; Bell and Ryan, 1985; Manning, 1989; Kaplan and Broekaert, 2003) but provided little insight into how outcomes, such as reduced substance use and criminal activity, can be achieved as a result of spending time in a hierarchical TC (Ravndal, 2003; Sminia, 2012; Van de Ven and Sminia, 2012).

Research in and around the TC for substance use consist of descriptive accounts²⁰ and follow up studies,²¹ which typically focus on retention, relapse and (re)conviction. The prioritisation of absolute measures such as retention, relapse and (re)conviction not only accentuates negativity, overlooking any personal benefits that may have been gained as a result of participation in a TC (DeLeon, 1984; Strupp, 1988; Hubbard, Marsden, Rahal, Harwood, Cavanaugh and Ginzburg, 1989; Greenberg, 1991; Rhodes and Greenberg, 1994; Hanna and Richie, 1995; Genders and Player, 1995) but introduces an array of conceptual and methodological limitations into an already difficult endeavour to define and measure the effectiveness of participation in a TC

Validity refers to how well a measurement tool measures what it sets out to and how well it reflects the reality that it claims to (LeCompte and Goetz, 1982; McKinnon, 1988; Hammersley, 1990; Del-Boca and Noll, 2000; Gray, 2009). The most obvious and recurring problem with outcome measures such as relapse and (re)conviction is the

fact that such measures cannot provide definitive answers as to whether an individual has reverted back to substance use and/or participated in criminal activity.

The studies that underpin this chapter measured relapse through self-report data, urinalysis and appearance on a drug data base such as the National Drug Treatment Monitoring System (NDTMS), and reconviction through (re)appearance on official databases such as the Police National Computer (PNC) and prison records. Although official databases such as the PNC and NDTMS are able to provide large amounts of numerical data, they provide blunt measures of effectiveness due to the inherent conceptual and methodological limitations which surround these methods of data collection. For example, non-appearance on the NDTMS does not necessarily indicate that an individual has not relapsed. It simply means that they have not presented at a tier three or tier four service, which includes structured community-based services, residential services and inpatient programmes (Public Health England: Healthcare professionals and partners, 2013).

Establishing a reliable measure of criminality also poses difficulty (Holland, 1978; Lloyd, Mair and Hough, 1994) as there is an inevitable discrepancy between the volume of actual crime and the number of recorded offences (Friendship, Beech and Browne, 2002; Gyngell, 2011). Arrest rates, appearance on the PNC and prison records do not necessarily measure criminal activity as an individual may be (re)arrested and/or imprisoned for breaching the terms of their license conditions, or for a crime committed before entering a TC, rather than a new offence. An ex-prisoner may lead a life of crime and never get re-arrested, whereas others may be struggling to stay crime free and get re-arrested for their first minor infringement (Lees *et al.*, 2004).

In addition to the use of official databases self-report data have also been used in a number of articles to explore relapse and (re)conviction (Ogbourne and Melotte, 1977; Wilson and Kennard, 1978; DeLeon et al., 1982; Page and Mitchell, 1988, Pouloupoulos and Tsiboukli, 1999; Kressel, DeLeon, Palij and Rubin, 2000; Dekel *et al.*, 2004; Johnson *et al.*, 2008; Fernandez-Montalvo *et al.*, 2008). There is much scepticism surrounding the use of self-report data, particularly on sensitive issues such as substance use and criminal activity due to perceived negative consequences associated with the admission of certain behaviours, such as cessation of help and support or legal consequences, which may motivate people to conceal the truth (Bale, 1979; Darke, 1998).

In an attempt to increase the validity and reliability of self-report data, with regards to substance use, a number of researchers utilised urinalysis to obtain corroborative information (Ogbourne and Melotte, 1977; Toumbourou *et al.*, 1998; Sorensen *et al.*, 2009). However, the urinalysis that was employed could not detect cannabis, LSD or substances that had been taken several days before the sample was provided. Furthermore, on a broader note, urinalysis cannot assess substance use histories, frequency of use over extended time frames, amounts of substance use or patterns of concomitant substance use (Darke, 1998).

A review of the retention literature conducted by Lewis and Ross (1994) found that terms such as retention, length of stay, time in treatment, completion, graduation, attrition, dropout, discharge against medical advice or against staff advice and expulsion were all used to describe time spent in a TC. In addition to this there were also no standardised definitions of relapse. Ogbourne and Melotte (1977) use the terms sporadic use (those who claimed that since leaving a TC they did not use substances more than

once a week) and regular use (those who claimed that since leaving they had used substances orally more than once a week for the last two weeks). Page and Mitchell (1988) used reversion back to substance use in terms of daily, several times per week, once per week and several times per month. Fernandez-Montalvo *et al.*, (2008) defined relapse as the use of an illegal substance on three or more occasions during a period of two months.

The lack of standardised definitions and reliable measures of outcomes illustrate how the findings presented in this chapter are characterised by conceptual and methodological limitations. This suggests that another way in which the definition and measurement of effectiveness is needed. If we were to conceptualise effectiveness in incremental, rather than absolute measures and look at recovery from substance use in relation to an individual's level of functioning, we see the change process or outcomes assume another form (Perfas, 2012).

After some time in a TC some individuals may return home and demonstrate an increased level of functioning, even though they may not fully abstain from substance use. Others may maintain a job or return to education, minimise their criminal involvement or become involved in productive pursuits while still indulging in occasional substance use. So, if we look at effectiveness in relative instead of absolute terms, the preceding examples represent a significant amount of change (Perfas, 2012). The more we use crude outcome measures to illustrate effectiveness the further we actually become from demonstrating effectiveness of TCs (Rawlings and Yates, 2001).

Vanderplasschen, Colpaert, Autrique, Rappy, Pearce, Broekaert and Vandeveldel (2013) suggest that a broader perspective is required to allow a more accurate evaluation of effectiveness to develop. As the TC has stood the test of time it is possible to suggest that it may not be a case of do they work, but an indication that alternative ways in which effectiveness is defined and measured is needed. This is particularly timely given the current social and political landscape surrounding the TC; characterised by a cost-cutting outcome-driven ethos.

Conclusion

There are a number of conceptual and methodological limitations that surround existing attempts to articulate the work that takes place in a TC and why it is considered to be effective. This is predominately due to the omission of process based research and problems with the criteria used to define and measure effectiveness. These limitations have not only created a limited insight into how the programme operates on a day-to-day basis (Timms *et al.*, 1994; Rawlings and Yates, 2001; Perfas, 2012) but hindered the movements' ability to demonstrate efficacy.

The findings presented in this chapter suggest that an alternative way to explain the intricate workings that take place in a TC could go some way in reducing the implementation gap between what ought to take place and what does take place in a TC and provide a more coherent way in which the relationship between TC interventions, individual progression and outcomes can be understood, communicated and assessed (Bell and Ryan, 1985; Manning, 1989; Nielsen and Scarpitti, 1997; Kaplan and Broekaert, 2003; Lees *et al.*, 2004; DeLeon, 2010). The next chapter will begin to explore whether the concept of recovery capital can be used to explain the intricate

workings that take place in a TC, as well as define and communicate programme effectiveness.

Chapter Three

The Theoretical Framework

Introduction

The theoretical framework that underpins this thesis evolved as findings from the literature review identified issues worth investigation and experience of the setting under study developed. The lack of clarity and insight which surrounds the day-to-day operation of a TC guided the initial aims and objectives of the study; to explore what work takes place in these programmes and how it is understood by those at the coal face of service provision. To move beyond a purely descriptive account of the TC under study and provide a unique contribution to knowledge, a comprehensive review of the hierarchical TC, recovery capital and desistance²² literature was undertaken to establish an empirically informed framework in which the daily workings of a TC may be better understood. The framework was then applied and refined through a 31 month ethnographic investigation in a residential TC.

The longitudinal dimension of the research allows the study to capture the voices of residents and practitioners in the setting under study to inform a more complete appreciation of the interpretation, implementation and consumption of TC principles in practice. It not only provides an unprecedented insight into the intricate workings that take place in a TC, but offers a more coherent way in which the programme can be understood.

The purpose of this chapter is to introduce the theoretical framework that was used for this study. To do so it has been divided into three parts. Part one explores the origins and development of social capital. Part two discusses the literature which surrounds the

concept of recovery capital and the final part draws parallels between the recovery capital and desistance literature to bring together the different themes of the chapter and illustrate how a framework couched in recovery capital principles could go some way to opening up the work that takes place in a TC.

Social Capital: The Origins of Recovery Capital

A bibliographic search of relevant books and manual search of electronic databases was used to explore the theoretical knowledge and empirical evidence surrounding the concept of recovery capital. As the manual search of electronic databases went on to constitute the main form of literature collection an attempt to adopt a systematic approach was made.²³ In total 13 databases²⁴ were searched using the search terms: recovery, recovery capital, drug* and substance*, which in turn identified 11,435 articles.

Of these, 11,410 were excluded as they fell into pre-determined exclusion criteria. These criteria consisted of articles which had an alcohol only dependent sample: articles which covered natural disasters; articles not in English; articles which covered accounting and financial recovery; mental illness; eating disorders; tax incentives; and capital investment as they were not considered relevant to the study. This left 25 articles which span over 13 years from 2000-2013.²⁵

The term social capital is typically used to describe social networks, the reciprocities that arise from them, the value of these for achieving mutual goals and social relationships between people that enable productive outcomes (Szreter, 2000). It was first used in 1916 by Lyda Hanifan, an American school inspector, in a report on rural schools in Virginia.

“In use of the phrase social capital I make no reference to the usual acceptation of the term capital, except in a figurative sense. I do not refer to real estate, or to personal property or to cold cash, but rather to that in life which tends to make these tangible substances count for most in the daily lives of people, namely goodwill, fellowship, mutual sympathy and social intercourse among a group of individuals and families who make up a social unit, the rural community, whose logical centre is the school.”

(Hanifan 1916, cited in Yates, 2012:42)

The concept of social capital can also be traced to the work of Emile Durkheim and his emphasis on being connected in a community as an antidote to anomie and self-destruction,²⁶ as well as Marx’s distinction between an atomized class in-itself and a mobilised and effective class for itself²⁷ (Portes, 1998; Field, 2008). Since the initial introduction of the concept it has accumulated considerable interest across the social sciences through the work of Pierre Bourdieu in France and James Coleman and Robert Putnam in the United States. According to Field (2008) the central theory of social capital can be summed up in two words; relationships matter. In other words, the more people that you know and the more you share a common outlook with them the richer you are in social capital. Generally speaking, people’s networks should be seen as part of a wider set of relationships and norms that allow them to pursue their goals and bind society together.

Bourdieu developed the concept of social capital during the 1980s as part of a wider analysis of the diverse foundations of social order. He described the development of structured sets of values and ways of thinking as forming what he calls habitus, which provided a bridge between subjective agency and objective position (Bourdieu, 1986). Bourdieu suggested that groups were able to use cultural symbols as marks of distinction, both signalling and constituting their position in the social structure. He gave force to this view by using the metaphor cultural capital, pointing to the way in which groups traded on the fact that some types of cultural taste enjoy more status than

others (Field, 2008). Bourdieu emphasised that people's ownership of cultural capital did not just mirror their resources of financial capital but, shaped by family circumstances and school tuition, cultural capital can to some extent operate independently of monetary holdings, and even compensate for a lack of money (Jenkins, 1992; Robbins, 2000; Field, 2008). He saw the positioning of agents in the social field as determined by the amount and weight of their relative capitals and by the particular strategies they adopted to pursue their goals. Bourdieu defined social capital as the:

“sum of resources, actual or virtual, that accrue to an individual or group by virtue of possessing a durable network of more or less institutionalised relationships of mutual acquaintance and recognition.”

(Bourdieu, in Bourdieu and Wacquant, 1992:119)

Gauntlett (2011) suggests that where other writers, such as Hanifan, see social capital as a heart-warming network of social connections, Bourdieu uses it to understand social hierarchies and explain the cold realities of social inequality and exclusion; referring to social capital as a tool in the armoury of the elite, deployed to ensure that the 'wrong' kind of people do not enter their circles (Bourdieu, 1980, 1986). This approach exemplifies how social capital can be exclusionary.

For Bourdieu, the density and durability of social ties were vital: social capital represented an aggregate of the actual or potential resources which are linked to the possession of a durable network (Bourdieu, 1980, 1986). He also acknowledged that the value of an individual's ties depends on the number of connections they can mobilise and the volumes of different capitals possessed by each connection. However, the work of Bourdieu has since been criticised for overemphasising the role of social capital based on kinship and despite his concern to acknowledge agency, in general, his theory appears to be rooted in a relatively static model of social hierarchy (Field, 2008).

For Coleman (1988) social capital was significant, primarily as a way of understanding the relationship between educational achievement and social inequality (Baron, Field and Schuller, 2000). Baum (2000) suggests that Bourdieu emphasizes the role played by different forms of capital in the reproduction of unequal power relations, whereas Coleman takes a more rational approach.

Coleman (1988) went on to extend the scope of social capital from Bourdieu's analysis of the elite to encompass the social relationships of the non-elite groups (Teachman, Paasch and Carver, 1997; Baron *et al.*, 2000). He suggested that social capital can take on three forms: obligations and expectations, which depend on the trustworthiness of the social environment; the capacity of information to flow through the social structure in order to provide a basis for action; and the presence of norms accompanied by effective sanctions (Harper, 2001). Social capital, according to Coleman, represents a resource because it involves the expectation of reciprocity and goes beyond any given individual to involve wider networks whose relationships are governed by a high degree of trust and shared values (Coleman, 1988).

The place of social capital in Coleman's (1994) work occupies space within a wider attempt to grapple with the basis of social order. From rational choice theory he developed a broad view of society as an aggregation of social systems of individual behaviour. In order to reveal the principles of social order Coleman proposed that system-level behaviour must be disaggregated into a grasp of individuals' preferences and their actions. This concept of social capital was, for Coleman, a means of explaining how people manage to cooperate (Coleman, 1994).

Like Bourdieu, Coleman's interests in social capital emerged from attempts to explain relationships between social inequality and academic achievement (Field, 2008). Coleman (1988) was concerned less with evaluating the relative merits of social and human capital as concepts, than with distinguishing between them and exploring their interconnection.

“Social capital is defined by its function. It is not a single entity, but a variety of different entities having two characteristics in common: they all consist of some aspect of social structures, and they facilitate certain actions of actors whether persons or corporate actors within the structure.”

(Coleman, 1988:98)

Coleman's definition of social capital bridged both individual and collective schools of thought as he not only viewed social capital as an asset for the individual, but saw it as build-up of social resources. Social capital therefore, was to be treated as a public rather than a private good (Coleman, 1994). Coleman believed that certain types of social structures were more likely to facilitate individual's choice of action than others. In particular the family was portrayed as the 'archetypal cradle of social capital' (Field, 2008:29). For Coleman, kinship in general represented a societal keystone and he was pessimistic about the prospects for social control being rooted in a more artificial set of arrangements. Even so, his framework allowed for the possibility that some constructed forms of organisation were more likely to promote social capital than others.

Bourdieu's treatment of social capital boils down to the idea that privileged individuals maintain their position by using their connections with other privileged people. Coleman's view is more nuanced in that he discerns the value of connections for all actors, individual and collective, privileged and disadvantaged. However, critiques have described his work as naively optimistic as he predominately sees social capital as benign in its function, providing a set of norms and sanctions that allow individuals to cooperate for mutual advantage with little reference to the 'dark side' of social capital

(Field, 2008). Bourdieu's usage of the concept by contrast, virtually allows only for a dark side for the oppressed and a brighter side for the privileged.

Putnam was later responsible for popularizing the concept of social capital through his study of civic engagement in Italy (Baron *et al.*, 2000; Boggs, 2001); defining the term as a feature of social organization such as trust, norms and networks that can improve the efficiency of society by facilitating coordinated actions (Putnam, Feldstein and Cohen, 2003). According to Putnam (1993) social capital contributes to collective action by increasing the potential costs to defectors, fostering robust norms of reciprocity, facilitating flows of information and acting as a template for future cooperation. Putnam switched his focus to the United States and his message throughout the mid-1990s was a consistent one; America's social capital was in a state of long-term decline and the main culprit in its demise was the rise of television (Putnam, 1993, 1995, 1996, 2000). Putnam also introduced the distinction between two basic forms of social capital: bridging and bonding. Bonding capital tends to reinforce exclusive identities and maintain homogeneity; whereas bridging capital tends to bring together people across diverse social divisions.

From most of the social capital literature, particularly that of Putnam, there is an overwhelming sense that social capital is a societal good (Portes, 1998; Harper, 2001). This assertion overlooks documented examples of its downside, which suggest that the same mechanisms appropriable by individuals and groups such as social capital can have other, less desirable consequences, as there is a possibility that social capital can help reinforce inequality as well as play a part in supporting anti-social and criminal behaviour (Geertz, 1963; Boissevan, 1974; Waldinger, 1999; Portes, 1998, Field, 2008).

Social capital can promote inequality because access to different types of networks is unequally distributed across society (Field, 2008). Everyone can use their connections as a way of advancing their interests, but some people's connections are more valuable than others. Some people find themselves disadvantaged by network poverty while others are in a relatively powerful position as a result of their strong network assets. If it can foster mutual cooperation for the benefit of members, social capital is in principle as likely to promote cooperation for harmful as well as positive ends (Edwards and Foley, 1997; Putnam, 2000; Field, 2008).

Although Bourdieu, Coleman and Putnam are most commonly cited for the basis of discussions on social capital there are many possible approaches to define and conceptualise social capital, which leads to confusion about what constitutes social capital in the first instance. According to Harper (2001) this has been exacerbated by the different words used to refer to the term. These include: social energy, community spirit, social bonds, civic virtue, community networks, social ozone, extended friendships, community life, social resources, informal and formal networks, good neighbourliness and social glue, which have different conceptualizations depending on the theoretical backgrounds that further contributes to conceptual confusion.

All three writers have been criticized for the gender-blindness of their work (Field, 2008). Feminist critics have noted that much civic engagement is highly gendered (Lowndes, 2000; Adkins, 2005) and Coleman's inherently conservative view of the family has significant consequences for his analytical framework (Blaxter and Hughes, 2001). Although Putnam made some effort to pay particular attention to gender as a factor in the creation and decline of social capital, his comments appear to have been

impressionistic and lack the detailed basis of evidence that otherwise underpins his argument (Field, 2008).

There is, however, some consensus within the social sciences towards a definition that emphasizes the role of networks and civic norms in the creation of social capital, in particular the presence of social control and crime levels (Jacobs, 1961). Putnam (2000) suggests that higher levels of social capital, all else being equal, translate into lower levels of crime. This hypothesis has since been re-iterated by Rosenfield, Messner and Baumer (2001) who suggested that crime was a product of weak informal social controls and Cote and Healy (2001) who found that communities characterised by anonymity, limited acquaintance and low levels of civic participation faced an increased risk of crime and violence. Social capital then may be seen as one factor among others that helps to influence the amount of criminal activity in a community.

Across the social capital literature, trust and networks are taken to be two key components of the concept (Coleman 1994; Baron *et al.*, 2000; Putnam, 2000; Harper, 2001). Fukuyama (1995) argues that social capital consists of a system of values, especially social trust, which is the basis of social order. Some consider trust to be an outcome of social capital (Woolcock, 2001) others view it as a component of the shared values, which constitute social capital and some consider it to be both (Cote and Healy, 2001).

Trust is important as it acts as a form of social lubricant promoting confidence, collaboration, communication and cohesiveness (Stevens, 2013). Social relationships tend to be strongest when they rest on a foundation of trust (Granovetter, 1973; Putnam, 1993; Fukuyama, 1995) and reciprocity (Granovetter, 1973; Coleman, 1990; Kolm,

2000; Wolff and Draine, 2004). This is because psychologically one's ontological security, an elemental sense of confidence in the reliability and continuity of one's personal identity and social and material world, is founded on the formation of trusting relationships (Giddens, 1990). Axiomatically, trust is integral to the creation of a therapeutic alliance (Meissner, 1992; Ackerman and Hilsenroth, 2003; Stevens, 2013) and TC (Gale, Realpe and Pedriali, 2008; Cullen and Mackenzie, 2011).

Recovery Capital

The notion of social capital has recently been developed by authors such as Robert Granfield and William Cloud who have applied the concept of capital to recovery-orientated scholarship. They devised the term 'recovery capital' to describe the breadth and depth of internal and external resources that an individual can draw upon to initiate and sustain recovery from substance use (Granfield and Cloud, 1999).

The term was first used in their book *Coming Clean: overcoming addiction without treatment* published in 1999. The book is based on 46 semi-structured interviews with substance users who recovered without any professional help and support; a process known as natural recovery. The authors explored the social context of these individuals' natural recovery and the circumstances that facilitated their recovery from substance use. Since then academics such as White (2008) and Best and Laudet (2010) have developed this concept to describe observed changes in substance user's resilience and robustness of social and emotional circumstances in long-term recovery.

Granfield and Cloud (1999) suggest that the concept of recovery capital can be refined as four individual, though overlapping components which are as follows: social; physical; human; and cultural. *Social capital* is affected by the environmental context in

which an individual is embedded (Cloud and Granfield, 2008; Lyons and Lurigio, 2010) and comes about through changes in relations among persons that facilitate action (Coleman, 1988). Cloud and Granfield (2008) suggest that membership in a social group confers resources and reciprocal obligations, which an individual can use to improve their life. Social capital is an important component of the recovery process as it affects an individual's options, resources, information and available support (Cloud and Granfield, 2008; Best and Laudet, 2010; Lyons and Lurigio, 2010). For instance, when substance users have access to social capital, expectations from family and friends can serve as a valuable resource, whether it is emotional support or access to opportunities that help to facilitate recovery from substance use.

Physical capital includes savings, property, investments and other financial assets (Granfield and Cloud, 2001). Individuals who are considered to be financially stable possess physical capital (Granfield and Cloud, 2001). Substance users who have a moderate level of physical capital have more recovery options than those without financial resources (Granfield and Cloud, 1999, 2001) as they may be able to take leave of abstinence from their job or take an extended holiday to address their substance use. They may also have the ability to temporarily or permanently relocate if they decide that a geographical move is needed in order to recover from substance use.

Human capital covers a wide range of human attributes that provide an individual with the means to function in society (Granfield and Cloud, 1999; Best and Laudet, 2010). It is created by changes in persons that bring about skills and capabilities that make them able to act in new ways (Coleman, 1988). Human capital includes skills such as problem solving, self-esteem and interpersonal skills, educational achievements, physical, emotional and mental health and aspirations; as well as personal resources

such as commitment and responsibility that will help an individual to manage everyday life (Daddow and Broome, 2010).

Cultural capital refers to an individual's attitudes, values, beliefs, dispositions, perceptions and appreciations that derive from membership in a particular social or cultural group (Bourdieu, 1986). It refers to an individual's ability to act in accordance with culturally defined norms, values and expectations. Individuals who use substances but have a stake in societal conformity are said to have a distinct advantage over those who have been socialized to reject them (Granfield and Cloud, 2001). The quality and quantity of recovery capital that an individual has is both a cause and a consequence of recovery from substance use as it can hold substantial implications for the options available to the individual when attempts to desist from substance use are made (Granfield and Cloud, 2008; Lyons and Lurigio, 2010).

The sample upon which the concept of recovery capital is based lacks external validity and generalisability due to the personal and social resources that interviewees possessed before they desisted from substance use and the sampling procedure that was utilised for the study. Interviewees have been described as socially advantaged as they were found to possess a substantial amount of recovery capital. 24% of the sample completed high school, 28% attended college and 13% obtained a postgraduate degree. 26% were employed in a professional occupation, including law, engineering and health care or held managerial positions, 28% owned their own business and 24% were retired. At the time of the interview respondents also claimed to be actively involved in a variety of pursuits associated with religion, education and community life (Granfield and Cloud, 1999, 2001).

Granfield and Cloud (1999) contacted half of the research sample through a snowball sampling procedure, which consisted of a referral chain. Individuals who volunteered to be interviewed were asked if they knew someone who had overcome substance use without professional help and support. If so they were asked to contact the individual and have them call the authors. Snowball sampling is a non-probability sampling procedure that uses a process of chain referrals, where each contact is asked to identify members of the target population (Granfield and Cloud, 2001). Although snowball sampling procedures are able to identify individuals from unknown and potentially large populations relatively quickly and cost-effectively findings are limited in reliability, validity and generalisability (Gray, 2009).

Cloud and Granfield (2008) describe recovery capital as an interval-level variable. Zero is not the beginning; it is a point along a positive and negative continuum. An individual's level of recovery capital rests on the negative side of the zero when their personal circumstances, attributes, values, cognitive processes and behaviour impede upon their ability to desist from substance use. This is known as negative recovery capital (Cloud and Granfield, 2008). There are a variety of factors such as age, mental health, physical health and involvement with the criminal justice system that can have an impact on the level of positive and negative recovery capital that an individual has. For instance, if an individual's mental health is compromised, many of the personal resources that constitute human recovery capital, such as problem solving skills, self-esteem, interpersonal skills and social skills are difficult to develop for a variety of reasons (Cloud and Granfield, 2008; Advisory Council on the Misuse of Drugs, 2012). Interventions to improve the physical and mental health of substance users may improve recovery outcomes. However, the effectiveness of a given intervention may be somewhat limited where serious health damage such as irreversible changes, which

shorten life expectancy and/or limit cognitive functioning has been incurred (Advisory Council on the Misuse of Drugs, 2012). It is therefore not surprising to find that in some instances and for some individuals, continued substance use can be an attractive alternative to the realities of life without substances.

Khantzian's (1985) self-medication hypothesis provides a perfect illustration as to how substance use can be an attractive alternative to a life without substances for those suffering from mental distress and psychological trauma. Khantzian suggests that substance use is an attempt to self-medicate; this occurs when an individual uses un-prescribed substances to alleviate symptoms of mental distress, psychological trauma and/or poor physical health. According to the self-medication hypothesis an individual's substance of choice is not accidental or coincidental. Individuals choose a substance that they feel will provide them with the most relief from their psychiatric distress and help them achieve emotional stability (Khantzian, 1985). For those who do self-medicate substance use becomes a compensatory coping mechanism; a way to treat and mask distressful psychological states and find emotional comfort (Khantzian, Mack and Schatzberg, 1974; Duncan, 1974; Marlatt and Gordon, 1985; Swadi, 2000; Gossop, Stewart, Brown and Marsden, 2002; Litt, Kadden, Cooney and Kabela, 2003; Sugarman, Nich and Carroll, 2010). Recovery from substance use may therefore be unappealing to individuals who use substances as a compensatory coping mechanism (Granfield and Cloud, 2001).

It has been suggested that feeling good naturally is one of the motivating factors as to why people decide to desist from substance use (Granfield and Cloud, 1999; Cloud and Granfield, 2001). Physical activity can provide experiences that reduce stress, improve mood, provide a sense of well-being and help individuals to feel good without the use of

substances. Individuals who are in poor physical health, whether it is related to sheer neglect or a by-product of substance use, have a diminished capacity to feel good naturally due to energy levels, motivation and ability to participate in various physical activities (Granfield and Cloud, 2001). For those in poor physical health the inclination to use substances to merely feel better can represent a continuous form of negative recovery capital (Cloud and Granfield, 2008). For instance, Multiple Sclerosis (MS) sufferers may regularly use cannabis to alleviate some of the painful symptoms of the illness such as spasticity, involuntary muscle stiffness and muscle spasms (Baker, Pryce, Croxford, Brown, Pertwee, Huffman and Layward, 2000; Vaney, Heinzl-Gutenbrunner, Jobin, Tschopp, Gattlen, Hagen, Schnelle and Reif, 2004; Rog, Nurmikko, Friede and Young, 2005). For these individuals desistance from substance use represents a decreased sense of well-being, which is a form of negative recovery capital.

Those in recovery from heavy Class A substance use, notably heroin and/or crack cocaine, typically have a criminal record and a history of involvement with the criminal justice system, such as imprisonment (Advisory Council on the Misuse of Drugs, 2012). Wolff and Draine (2004) suggest that the experience of imprisonment has the potential to alter the attributes of social capital in ways that reduce its ability to improve health and justice outcomes and therefore can create additional barriers when attempts to initiate and/or sustain desistance from substance use are made.

Terry (2003) argues that imprisonment can harden individuals who use substances as it holds the potential to indoctrinate them into a convict code. The code refers to the norms, values, rules, attitude and behaviour that develop amongst prisoners within prison social systems, which help to define a prisoner's image, mould their thoughts,

values, attitudes and belief system (Bowker, 1977). Although this adaptive behaviour is deemed necessary to survive in prison (Terry, 2003), such codes of conduct provide a direct assault on an individual's quality and quantity of social and cultural recovery capital (Cloud and Granfield, 2008). This can increase an individual's level of negative recovery capital as it can lead to a reduction in personal resources, such as interpersonal skills, social resources such as disrupted family ties and an identification with anti-social and/or criminal social networks, and community resources such as reduced employment opportunities, due to stigma, criminal record and a lack of educational and/or vocational skills (Jamieson and Grounds, 2003; Richards and Jones, 2004).

Laudet and White (2008) interviewed 312 recovering persons twice, at a one year interval, between April 2003 and April 2005. Participants were classified into one of four baseline recovery stages: under six months; 6-18 months; 18-36 months; and over three years. The sample group was recruited through media advertisements placed in a free newspaper and flyers posted throughout the local community. 63% of the sample was African American, 85% had no involvement with the criminal justice system, 20% were employed part time, 22% full time, 58% were on benefits and 36% had a job off the records.

Findings suggest that different domains of recovery capital were salient at different recovery stages. Laudet and White (2008) found that twelve-step involvement was a significant predictor of sustained recovery among individuals who had six to eighteen months of recovery at baseline interviews. It was the only predictor of (lower) stress levels at one year follow up interviews among the earliest recovery group. Laudet and White (2008) suggest that this finding is particularly important since stress is often cited

as a perceived trigger for return to substance use (Connors, Tonigan and Miller, 1996; Laudet, Magura, Vogel and Knight, 2004; Laudet and White, 2004).

Laudet and White (2008) claim that recovery is fraught with difficult realisations and situations such as facing consequences of past lifestyle choices, lack of resources, poor housing, physical and mental health and deteriorated social and family ties, all of which imply that the individual is challenged to acquire the skills that are required to cope with stress in a healthy and productive way, that is, without resorting to substance use. Involvement in a twelve-step group may therefore, provide the tools necessary to cope with stress associated with early recovery. For example, the first and second steps²⁸ may contribute to the acceptance that one is unable to desist from substance use on their own and that help of some sort is needed (Laudet and White, 2008). Moreover, hope that things will get better and the belief that, as stated in the Big Book of AA, there is a solution, may contribute to an emergent capacity to tolerate the trials and tribulations associated with early recovery.

Keane (2011) conducted semi-structured interviews with 20 individuals who were in recovery to explore the role of education in developing recovery capital. Interviewees were accessed through participation in a drug programme and were asked to talk about their early school experience, family, home, substance use, engagement with services, experience with education, employment and sustaining accommodation during their recovery. Keane (2011) found that most interviewees' family upbringing and early school experience were set within a social context of poverty and disadvantage, most were early school leavers and some had poor literacy and numeracy skills. Nearly all of those interviewed had experienced repeated episodes of family conflict, often against a background of alcohol use amongst their parents and individual narratives suggest that

they drifted into substance use from various experimental episodes with substances. Official programmes such as methadone detoxification and residential services played a part in their recovery.

Findings from this study suggest that education can play a role in all four dimensions of recovery capital. It can improve: social capital by opening up opportunities to develop new networks of friends outside the confines of formal programmes and self-help groups; physical capital by improving career options and job opportunities, which can improve living standards; cultural capital by exposing people to new values, beliefs and attitudes; as well as human capital, empowering people to look after their health, become a more effective parent, reappraise in-grained negative belief systems, develop achievable goals and improve day to day functioning and personal efficacy (Keane, 2011). Keane (2011) concluded that interviewees were caught in the dilemma of multiple recoveries as they were not just recovering from addiction, but from a lifetime of exclusion, emotional turmoil and a fractured identity.

The sampling techniques used in the above studies have an array of methodological limitations. Granfield and Cloud (2001) used a snowball sampling technique to recruit participants. Laudet and White (2008) recruited the sample group from an urban area in America, populated with individuals who had long and severe histories of poly-substance use. Keane (2011) recruited the sample group from a drug programme, which was dedicated to improving service user's educational attainment. Therefore is it difficult, if not impossible, to determine how representative the sample groups are of the wider recovering population.

The literature search and selection strategy conducted for this chapter identified articles with a number of methodological limitations such as small sample sizes and unvalidated self-report data obtained through semi-structured interviews and focus groups. These methodological limitations hinder the ability to draw reliable, generalisable conclusions from the findings, despite the findings suggesting that the more recovery capital that an individual has, the more likely they are to desist from substance use (Granfield and Cloud, 1999, 2001; Cloud and Granfield, 2001; Dennis, Foss and Scott, 2007; Cloud and Granfield, 2008; White and Cloud, 2008; Laudet and White, 2008; Fox, 2009; Davidson, White, Sells, Schmutte, O'Connell, Bellamy and Rowe, 2010; Lyons, 2010; Lyons and Lurigio, 2010; Keane, 2011).

Parallels can therefore be drawn between the TC and recovery capital literature as they both recognise that recovery from substance use is a gradual incremental process consisting of the accumulation of personal, social and community resources.

Recovery Capital and Desistance from Crime

This discussion draws parallels between the literature, which surrounds the concept of recovery capital and desistance. This is due to the fact that recovery capital has gained recognition in a number of desistance studies that have explored how personal, social and community resources contribute to an individual's decision to initiate and/or sustain desistance from crime (Sampson and Laub, 1993; Farrall, 2002; Giordano, Cernkovich and Rudolph, 2002; Farrall and Maruna, 2004; Ezell and Cohen, 2005; McNeil, 2009).²⁹

Commentary on desistance suggests that it is not an event that happens but a sustained absence of a certain type of event occurring (Laub, Nagin and Sampson, 1998); described by some as a consequence of a new and improved lifestyle (Colman and

Laenen, 2012). Desistance does not fit neatly into linear models of causality as it is an on-going quest for a better life (Laub *et al.*, 1998; Best and Laudet, 2010). It is not an event so much as a gradual movement which can include several turning points (Laudet *et al.*, 2004). For some individuals life events such as finding employment, getting married and maturing are considered turning points (Ezell and Cohen, 2005; Colman and Laenen, 2012). Life events are considered to be important as they can increase an individual's quality and quantity of social capital as they enter into new social relationships (Ezell and Cohen, 2005).

Generally speaking, there are two forms of desistance: *Primary desistance*, a period of short term crime-free lulls; and *secondary desistance*, a process by which an individual assumes a role of non-offender or reformed person (Farrall and Maruna, 2004). Secondary desistance is associated with the re-organisation, by the desister, of who they are and what sort of person they wish to become; it involves the construction of a positive identity and a change in the way offenders see themselves (Laub and Sampson, 2003; Bottoms, Shapland, Costello, Holmes and Muir, 2004; Farrall and Maruna, 2004).

Some of the earliest attempts to explain the process of desistance suggest that individuals make a rational decision to cease offending (Clarke and Cornish, 1983; Shover, 1983; Cromwell, Olson and Avary, 1991; Liebrich, 1993). Although they acknowledge the influence of wider social factors, which may have an impact on an individual's decision to desist from crime, such factors reportedly help the offender to come to a decision to desist rather than constrain decision making capabilities or influence the offender.

Another theory which emerged in the early 1990s was that proposed by Gottfredson and Hirschi (1990) who claimed that individuals who are more likely to offend are often found to be impulsive risk-takers exhibiting low levels of self-control; unable to delay gratification as they are solely focused on the present. As a result such individuals act impulsively based on their feelings and emotions and it is this impulsivity that makes them risk takers and so more likely to engage in criminal activity.

According to Gottfredson and Hirschi (1990) low self-control is the product of ineffective parenting where there are weak attachments between a parent and child; and in families where parents fail to recognise and correct their children's wrong behaviour. This was critiqued by Gibbons (1994) who claimed that it is a general theory of some instances of some forms of crime. This view is also shared by Polk (1991) who suggests that too much crime falls outside the boundaries of their definition for the theory to be of much use.

Sampson and Laub (1993) postulate a theory of age-graded social control, which attempts to explain the development of criminal careers. The central idea behind the theory is the bond between an individual and society, which, according to Sampson and Laub (1993) is made up of the extent to which an individual has emotional attachments to societal goals; is committed to achieving them by legitimate means, believes the goals to be worthwhile and is able to work towards the attainment of such goals.

According to Sampson and Laub (1993) individuals are more likely to participate in crime when this bond is weakened or broken. In addition to this they argue that at various points in an individual's life course formal and informal social institutions help to cement the bond between the individual and society. For example the school, the

family and peer groups influence the nature of the bond between young people and their wider communities, whilst employment, marriage and parenthood operate in a similar way for adults. These institutions and the relationships between the individuals they encourage help the formulation of social bonds, which in turn creates informal social controls. Avoidance of crime is the result of relationships formed for reasons other than for the control of crime. According to Sampson and Laub (1993), changes in an individual's relationship with these various institutions are an inevitable factor of modern life and as such are crucial to understanding criminal activity over an individual's life course.

Whilst much continuity in an individual's life can be observed, key events can trigger changes in an individual's bond to society and pattern of offending. Similarly, because many relationships endure over time they can accumulate resources such as emotional support, which can help sustain conventional goals and conformity (Laub *et al.*, 1998). In contrast to Gottfredson and Hirschi (1990) who see low levels of self-control as an end to the matter Sampson and Laub (1993) argue that levels of criminal propensity are open to influence and these influences are often the result of informal social control. Furthermore unlike rational choice theorists, Sampson and Laub's approach enables one to view desistance as the result of a process which stretches over time.

Giordano *et al.*, (2002) also explored the significance of the bond between an individual and society as they examined how social influences and internal change contributed to an individual's decision to desist from crime. Unlike Gottfredson and Hirschi (1990) and Sampson and Laub (1993), Giordano *et al.*, (2002) postulate a reciprocal relationship between an individual and the environment to which he/she belongs, suggesting that desisters have not only established pro-social bonds but have also

experienced cognitive shifts that have facilitated their desistance. In their cognitive transformation theory Giordano *et al.*, (2002) introduced the concept of cognitive shifts as part of the desistance process.

According to Giordano *et al.*, (2002) the desistance process consists of four steps. The first step is an openness to change; the individual needs to realise that change is necessary and desirable and thus engage in a process of reflection and reassessment. Second is the exposure to a turning point or an opportunity to change. In this context turning points can serve as a catalyst for change. The third step is an insight into the conventional replacement self whereby it is possible for the individual's to see themselves in a new role. The final step is the individual's transformation away from crime and a realisation that their former behaviour is undesirable (Colman and Laenen, 2012). The first two steps focus on an individual's openness and willingness to change, whereas the third and final steps relate to the development of a new identity. According to Giordano *et al.*, (2002) individuals attempting to desist from crime need to have the ability to recognise and show their openness for turning points, which require the desire and ability to change.

Farrall and Maruna (2004) suggest that offenders who have desisted from crime had a desire to feel good about themselves, which was achieved by taking pride in their new roles and pro-social identity. When desisters found themselves praised and trusted by others it led to increases in self-esteem. This suggests that desistance, on an emotional level, is as much about a change in feelings as it is about a change in behaviour, family ties, and employment. This was re-iterated by Bottoms *et al.*, (2004) who found that recent desisters' have an inspiration to live a 'normal life' which consists of a family,

job and safe place to live. This journey towards normality is not automatic but a gradual process of adjustment and change (Douglas, 1984).

Farrall (2002) tracked the desistance of 199 probationers exploring the significance of personal and social circumstances. He found that desistance was related to the probationer's motivations, as well as the personal and social contexts in which various obstacles to desistance were addressed and suggests that the work undertaken whilst on probation was of little direct help to many of the probationers (Farrall, 2002). However, the indirect impact of probation such as naturally occurring changes in employment, accommodation and interpersonal relationships was of greater significance. He went on to suggest that interventions should pay greater attention to the contexts in which they are located, considering social circumstances, as this is the medium through which change may be achieved.

A similar point was made by McNeil (2009) who claims that the process of desistance is one that is produced through the interplay between individual choices and a range of social forces which are beyond the control of an individual. Although offender programmes represent a key mechanism for developing one's capacity for change by building human capital in terms of enhanced cognitive skills or strengthened employability skills, they cannot create or enhance an offender's quality and quantity of social capital.

McNeil (2009) suggests that persistent offenders have limited social capital. They damage ties to friends and family thus forcing them to rely on illicit and criminal networks and therefore damaging which damages their prospects for desistance (Webster, MacDonald and Simpson, 2006; McNeil and Whyte, 2007). Beckett Wilson

(2014) developed this point suggesting that all individuals possess social capital, but desistance and offending are processes in which the balance of licit and illicit social capital differs.³⁰ These findings suggest that efforts to support desistance rest in the reparation and restoration of an offender's social capital (McNeil, 2009); as well as a devaluation of illicit social capital (Beckett Wilson, 2014).

Conclusion

This chapter has outlined the concept of recovery capital and how it has been utilised within the existing desistance literature. It has been proposed that the concept could provide a way in which the intricate workings that take place in a TC can be better understood as well as a way in which effectiveness can be defined and measured.

The literature discussed in this chapter illustrates how recovery from substance use and desistance from crime is an incremental process that consists of an accumulation of personal, social and community resources that help to (re)establish the relationship between an individual and the social world to which they belong.³¹ It is a process characterised by the accumulation of recovery capital that requires an individual to shed their 'old' sense of self, work through their problems and craft a 'new' sense of self and pro-social identity through the accumulation of skills, tools and resources (Laub *et al.*, 1998; Maruna, 2001; Farrall and Maruna, 2004; Farrall, 2002; McNeil, 2009; Beckett Wilson, 2014).

The findings presented in previous chapters suggest that there is a limited insight into how the TC helps individual's recover from substance use and 'spoilt' identities during their time in the programme, as well as the immediate period following on from their departure. With this in mind, it is possible to suggest that the concept of recovery capital

could be utilised to open up the intricate workings that take place on a day-to-day basis in a TC and provide a way in which effectiveness can be defined, measured and communicated. Although the concept of recovery capital has been recognised in the desistance literature and used as a way in which desistance from crime can be understood, this study is the first to apply the concept of recovery capital to the TC for substance use.

The forthcoming chapters will discuss this proposition in further detail; using the concept of recovery capital to explain the day-to-day workings of the setting under study and how processes and practices couched in TC principles contribute to the individual's ability to initiate and/or sustain recovery from substance use.

Chapter Four

Methodology

Introduction

The purpose of this study is to open up the intricate workings that take place in a residential TC for substance use through the application of recovery capital. It is anticipated that this will provide a more coherent and comprehensive way in which the operation of a TC can be understood. As this is the first attempt to synthesis the concept of recovery capital with the TC the central research question which this study seeks to answer is:

To what extent can the concept of recovery capital be used to explain the work that takes place in a TC for substance use?

The main research question necessarily requires a consideration of the following objectives:

Research Objectives

1. To explore the design and delivery of day-to-day practices in a residential TC for substance use.
2. To assess whether recovery capital can provide a theoretical and practical way in which to describe the workings that take place in a TC.
3. To explore the definition and measurement of effectiveness in a TC.
4. To explore the impact of Payment by Results on the setting under study.

To open up the central research question an ethnographic investigation took place between August 2010 and March 2013 in a residential TC. To maintain the anonymity of the setting and population under study the name and precise location of the service

has been omitted. Although anonymity was not requested, given the nature of the information that has been obtained during fieldwork it was felt appropriate to do so. As a result the TC will be referred to as the Mother-ship³² throughout this thesis.

The purpose of this chapter is twofold: to recount the design and delivery of fieldwork which took place over approximately 31 months; and to describe the analytical strategy that was applied to the data that were collected. To do this the chapter has been divided into seven parts. Part one introduces the research design and research methods that were utilised when conducting the fieldwork. Part two explores how access to the setting was obtained and maintained throughout the duration of the fieldwork. Part three provides a concise account of the research setting and population and part four discusses the research sample. Part five explicates the analytical approach that was applied to the data that was generated as a result of the fieldwork, and part six explores the ethical considerations which surfaced as a result of the fieldwork. The final part concludes the chapter with a discussion of the exit strategy that was employed to draw the fieldwork to a close.

Research Design and Methodology

Grounded theory is a naturalistic research design that can be traced to the work of Glaser and Strauss (1967) and their discussion of research methods used during the 1960s. It was initially presented in the book *The Discovery of Grounded Theory* which had three fundamental purposes. The first was to offer a rationale for theory development that was described as being grounded. The second was to suggest the logic for, and specifics of, grounded theory and the third was to legitimate qualitative research as by the 1960s it had sunk to a low status amongst a number of sociologists as it was not believed to be capable of adequate verification (Strauss and Corbin, 1990).

Firmly believing in the inadequacies of logical deduction, which was commonly applied in sociology at the time, Glaser and Strauss (1967) sought to redress the emphasis placed on existing theories and research methods used to construct theories by creating a methodology that could guide qualitative researchers through the theory development process (Locke, 1996; Pettigrew, 2000). By doing so they bridged the gap between empirical data and theory generation (Hammersley, 1989). Generally speaking, theories that are generated via grounded theory evolve inductively through the continuous interplay between data collection and analysis (Glaser and Strauss, 1967; Glaser, 1978; Strauss and Corbin, 1990; Goulding, 1998; Dey, 1999). Creswell (1998:84) suggests that the following assumptions about grounded theory are shared amongst social researchers:

- The aim of grounded theory is to generate or discover a theory.
- The researcher has to set aside theoretical ideas to allow substantive theory to emerge.
- Theory focuses on how individuals interact in relation to the phenomenon under study.
- Theory asserts a plausible relationship between concepts.
- Theory is derived from data acquired through fieldwork.
- Data analysis is systematic and begins as soon as data become available.
- Data collection is based on emerging concepts.
- These concepts are developed through constant comparison with additional data.
- Data collection can stop when no new concepts emerge.
- The resulting framework can be reported in a narrative framework or as a set of propositions.

The initiation of grounded theory research involves the selection of an area of inquiry and a suitable site for the study (Egan, 2002). An area of inquiry can be described in a variety of ways including a specific social phenomenon, a place, location, context or group of people. Grounded theory holds the assumption that it is essential to gain familiarity with the setting under study before attempts to generate theories and generalisations are made (Arnould and Wallendorf, 1994; Huberman and Miles, 1994;

Robrecht, 1995; Wells, 1995; Annells, 1996; Goulding, 1998). It is important that the researcher avoids predispositions and preconceptions as the aim of grounded theory is to produce rich interpretations of reality that can be used to explain and understand a particular setting or gathering of people (Glaser and Strauss, 1967; Strauss and Corbin, 1990; Annells, 1996).

Research designs that are guided by grounded theory do not begin with a precise research question as they tend to emerge inductively from an on-going immersion in a particular setting (Glaser, 1992; Wuest, 1995; Melia, 1996; Charmez and Mitchell, 2001, Charmez, 2006). When conducting fieldwork, guided by grounded theory, an array of research methods are used, such as semi-structured interviews and participant observation to study ordinary events and activities within the setting in which they occur. These methods allow the researcher to immerse him/herself into the setting in an effort to understand what ordinary activities and events mean to those who engage in them (Fetterman, 1998). Thus, the grounded theory research has the potential to produce rigorous and illuminating work (Greener, 2011).

However, like any other research design grounded theory has its limitations. One of the dilemmas surrounding grounded theory is that of generalisability (Johnson, 1990; Goulding, 1998). Research designs guided by grounded theory do not seek to establish representative or generalisable findings. Instead the aim is to collate in-depth information that reflects the behaviour, attitudes and norms of a particular group or culture (Glaser and Strauss, 1967; Glaser, 1992; Wells, 1995; Annells, 1996; Pettigrew, 2000). Therefore the generalisability and external validity of interpretations and theories beyond the phenomenon under study is limited.

Theories that are generated via grounded theory consist of interpretations made from a given perspective as adopted by the researcher (Strauss and Corbin, 1990). This increases the likelihood of researcher bias, which occurs when the researcher carrying out the research influences the findings due to (un)known actions during the research design, delivery and/or analysis of data sets (Pannucci and Wilkins, 2010). Although the likelihood of researcher bias is not exclusive to grounded theory, the array of subjective processes that are utilised to explain a social phenomenon, or build a theory, makes it difficult to detect and prevent such bias (Grimes and Schulz, 2002). This subsequently limits the reliability and validity of the findings generated as a result of this research method.

The challenge for researchers then is to expel threats to reliability as and when they are identified. In an attempt to limit researcher bias a comprehensive breakdown of the research design, delivery and analysis of findings has been provided in the methodology chapter (see Chapter Four). In a further attempt to limit researcher bias the researcher's personal attitudes and assumptions were discussed and challenged by residents and staff in the TC under study, academics, friends and family members throughout the duration of fieldwork and writing up period. These individuals were approached on a regular basis to discuss emerging themes, theoretical connections and general conclusions.

Critiques of grounded theory suggest that it is complex and time-consuming due to the tedious coding process and memo writing that is part of the analysis process (Bartlett and Payne, 1997). The longitudinal nature of fieldwork meant that an incremental analytical process could be applied to the analysis of data. Themes were identified through a constant comparative method, which required on-going comparisons between themes found in the data and emerging theoretical concepts (Glaser and Strauss, 1967;

Hammersley, 1989; Barnes, 1996). This gradual analytical process resulted in a systematic and manageable strategy to analyse the data generated as a result of the fieldwork. As the purpose of this study was to generate a rich insight into the workings of a residential TC, grounded theory was considered an appropriate mechanism to open up the subject area and setting under study.

When in the field methods of empirical data collection and analysis were guided by ethnography.³³ The term ethnography refers to the study of social interactions, behaviours and perceptions, which create a complete description of a particular group of people (Kurz, 1984; Reeves, Kuper and Hodges, 2008a). Ethnographic research involves participation, either overtly or covertly, in people's daily lives for an extended period of time: watching what happens; listening to what is said; asking questions; and collecting whatever data is available to throw light on the issues that are under study (Hammersley and Atkinson, 1995). It also places a strong emphasis on exploring a particular phenomenon; it has a tendency to work with unstructured data and employs an analytical strategy that involves an explicit interpretation of meaning (Atkinson and Hammersley, 1994).

Ethnography places a strong emphasis on observing and analysing behaviour in natural settings (Kurz, 1984; Hammersley and Atkinson, 1995; Reeves, Kuper and Hodges, 2008b) and grounded theory performs best with data generated in natural settings (Glaser and Strauss, 1967; Robrecht, 1995). Generally speaking, grounded theory and ethnography attempt to obtain emic descriptions of behaviour (Belk, Sherry and Wallendorf, 1988; Wells, 1995; Barnes, 1996). Lett (1990) suggests that emic descriptions consist of accounts that are regarded as meaningful and appropriate by the native members of the culture whose beliefs and behaviours are being studied.

Therefore by taking an emic approach to research the researcher allows themes, patterns and concepts to emerge from the data collected.

These fundamental similarities illustrate how ethnography offers a method of data collection that is conducive to inductive theory building (Glaser and Strauss, 1967). Grounded theory and ethnography can provide useful tools when attempts to open up a subject area or setting are made. The application of grounded theory and ethnography provides a means whereby a researcher, having identified a problem or issues worthy of further investigation, can begin to collect data that is organised into various concepts, which then provides the foundations for further data collection (Battersby, 1979).

The definition of the term ethnography has been subject to controversy. For some it refers to a philosophical paradigm to which one makes a total commitment and for others it is a term used to designate a particular set of research methods (Atkinson and Hammersley, 1994; Hammersley and Atkinson, 1995). The definition of ethnography that has been adopted for this study is the study of social interactions, behaviours and perceptions, which create a complete description of a particular group of people (Kurz, 1984; Reeves *et al.*, 2008a).

Fieldwork is an essential component of ethnographic research (Whitehead, 2005) as when in the field a variety of research methods can be employed to study ordinary events and activities within the setting in which they occur. The array of research methods employed during ethnographic fieldwork means that the ethnographer can immerse him/herself in a setting in an attempt to understand what ordinary activities and events mean to those who engage in them; as well as to generate a rich understanding of the environment under study (Fetterman, 1998; Reeves *et al.*, 2008b; Westmarland,

2011). By remaining with a group, community or culture over a period of time, watching behaviour at a variety of times and in a variety of contexts, the ethnographer can begin to understand how public roles are played out by individuals in a particular setting, as well as observe and learn to understand how informal roles develop (Kurz, 1984). This level of rich, in-depth understanding cannot be achieved through a quantitative research design (Greener, 2011).

The gains offered by ethnographic research are bought at the expense of certain methodological limitations such as characteristically small samples, the inability to generalise findings to the wider population with confidence, the relatively long period of time ethnographers spend in the field and the difficulty securing repeated access. Such limitations have subsequently raised questions surrounding the reliability and validity of the findings (LeCompte and Goetz, 1982).

Qualitative research reliability, which equates to the dependability of generated findings, is based on two principles (Burns, 1994; Nurani, 2008). The first is that a study can be repeated using the same research methods as the original study. The second is that a consistent interpretation of findings can be generated using the same research methods (LeCompte and Goetz, 1982). To address the problem of reliability ethnographers can provide a comprehensive description of the research methods employed when in the field as well as a detailed guide as to how the data was analysed. However, these strategies are subject to criticism given that even the most concise description and replication of original research methods may fail to reproduce identical findings; as events which occur in a natural setting cannot be reproduced and people's behaviour cannot be exactly replicated (LeCompte and Goetz, 1982; Nurani, 2008).

Hammersley (1990) suggests that validity is the extent to which an account accurately represents the social phenomena to which it refers. Generally speaking there are two forms of validity: internal validity and external validity. Internal validity is the approximate truth about inferences regarding cause and effect relationships; and external validity is the extent to which findings can be generalised (Gray, 2009). Ethnographic fieldwork employs an array of research methods over an elongated period of time, which provides an opportunity for continual data analysis and comparison to refine constructs and ensure a match between scientific categories and participant reality (LeCompte and Goetz, 1982). The ability to triangulate research methods and cross-reference data heightens the consistency and internal validity of findings. Ethnographic research designs may produce findings that are high in internal validity. However, given the small research samples that ethnographic studies are typically based upon, the external validity of findings and ability to generalise findings beyond the sample group to the wider population is somewhat limited.

Although ethnographic findings are limited in external validity, what they lose in breadth they gain in depth given the qualitative nature of ethnographic research. As the purpose of this study was to generate a rich insight into the day-to-day workings of a TC an ethnographic research design, which was guided by grounded theory was considered to be appropriate.

Gold (1958) outlined a standard typology of research roles that consists of the complete observer, the complete participant, the observer as participant and participant as observer. Before entering the field Gold's (1958) typology of research roles was considered and the decision to adopt the participant as observer role was made. As the participant as observer role utilises formal and informal research methods to study

groups, programmes or organisations (Gold, 1958; Kurz, 1984) it seemed the most appropriate given the nature and purpose of fieldwork.

The participant as observer role has the advantage and disadvantage of the researcher being known. On one hand questions can be routinely asked and if a good rapport has been established with those being observed a wealth of information can be obtained. However, on the other hand, the presence of the researcher can alter the behaviour of those being observed (Kurz, 1984). Although claims have been made that observer caused effects have been somewhat overemphasized (Mulhall, 2002), such effects are an obvious drawback of the participant as observer role.

To overcome observer caused effects a substantial amount of time was invested in the field. Fieldwork was conducted over 31 months and consisted of evening visits, weekend visits, early morning visits and overnight stays. This was done in an attempt to avoid observing an atypical period. Observer caused effects may therefore be mitigated by other components of data collection as well as by the elongated nature of fieldwork

Given the inductive, longitudinal nature of the study, fieldwork consisted of two stages: an explorative stage; and a main fieldwork stage. The explorative stage lasted approximately 10 months. During this stage observations and informal discussions with staff and residents were utilised to open up the subject area and setting. During this stage the researcher purposively adopted the role of a naïve investigator, taking every available opportunity to ask questions about the design and delivery of the programme. This role was adopted in an attempt to avoid interpretation and presumption surrounding the programme, to clarify data that had already been gathered and illustrate ambiguities worthy of further investigation.

Every morning and evening there was a resident-led community meeting. The researcher began each visit in either a morning or evening meeting. This provided an opportunity to make the researcher's presence known to all residents, initiate informal discussions, as well as gain an insight into how the day was intended to run, if in a morning meeting, or how the day had panned out, if in an evening meeting. Attending the community meeting provided an opportunity to engage in informal discussions with new residents, inform them about the fieldwork and provide them with an opportunity to ask questions.

It was not deemed necessary to make a formal announcement about fieldwork in every community meeting as residents were aware that fieldwork was taking place and new residents were spoken to on an individual basis. As fieldwork progressed rapport and familiarity were fostered between the researcher, residents and staff in the Mother-ship. The researcher was frequently referred to as 'the uni girl', which suggested that residents understood the researcher's purpose and role. After every community meeting there was a 15 minute break. This provided an opportunity to employ informal research methods and explore how residents socialised in their free time.

Given the complex nature of the programme and heterogeneity of the population resident in the Mother-ship, explorative fieldwork was vital as it contributed to the elimination of potential observer bias. McKinnon (1988) suggests that there is a temptation to seek meaning immediately after entering the field, which increases the opportunity for observer bias. Such bias is increased as there is too little data to work with, which creates interpretation gaps that are plugged with the researcher's own values, projections and expectations (McKinnon, 1988). As the purpose of explorative fieldwork was to open up the work that took place in the Mother-ship, the urge to seek

meaning and interpretation was somewhat reduced as was the possibility of observer bias.

The explorative stage provided an opportunity to refine research methods which were utilised during the main fieldwork stage. Prior to the explorative phase it was intended that a longitudinal approach, whereby residents would begin the follow up process from the point of arrival through their time in the TC, would be employed. However, as experience of the setting developed it became apparent that a modified longitudinal approach, initiating the follow up process at various programme stages, through a series of key milestone dates would be more appropriate given the high dropout rate during the first 30 days of admission into the service.

After approximately ten months of explorative fieldwork it was felt that the researcher had developed a reasonable understanding of the Mother-ship, established rapport with the population under study and the novelty of an outsider's presence had diminished. Although the explorative stage did not have a definitive end, as the first interview was conducted after ten months in the field, it was felt that the fieldwork had naturally evolved into a more intense form of fieldwork, which consisted of semi-structured interviews, analysis of official documentation and more refined observations and informed discussions guided by the aims and objectives of the study.

During the main fieldwork stage observations and informal discussions continued as did observations in group therapy sessions, staff handovers and community meetings. The researcher addressed residents in a community meeting once again. The nature and purpose of fieldwork was re-iterated, the opportunity to be interviewed was discussed and a further opportunity to ask questions about the study was provided. Residents were

asked to approach the researcher after the meeting if they wished to be interviewed. As and when residents volunteered to be interviewed information regarding their date of birth, ethnicity, gender, programme stage and substance use was recorded on a pre-interview information sheet before an interview date was arranged (see Appendix 2).

The information collected on the pre-interview information sheet provided a useful tool for the researcher. If a resident met the pre-defined sampling criteria an interview was arranged and the follow up process was discussed. After this first interview if the resident was willing to take part, the follow up process was explained in more detail and an approximate date for the next interview was arranged. Where a resident's primary substance of choice was not heroin and/or crack cocaine they were interviewed at a mutually convenient time and thanked for their participation. However, if a resident was detoxing at the time of their expressed interest this was noted and an interview was arranged for approximately one week after they had completed their detoxification programme. Finally, if a resident was not willing to take part in the follow up process they were thanked for their time.

Before each interview was conducted the nature and purpose of fieldwork was reiterated, the content of the interview was briefly outlined (see Appendix 3), respondents were advised that they could ask questions at any time; before, during or after the interview and told that they were free to request a break at any time during the interview. Respondents were then given an information sheet to read (see Appendix 4), which, to avoid discomfort and potential embarrassment, the information sheet was read out loud by the researcher, as it was not taken for granted that the respondents could read. The respondents were then given the opportunity to ask any questions before being asked to read and sign an informed consent form (see Appendix 5), which once

again was read out loud and again were given the opportunity to ask any questions and raise any concerns before being directed to where they were required to sign.

Once full informed consent was obtained respondents were interviewed in a place where they felt comfortable and able to speak openly and honestly. Interviews with residents took place on site in the library, conservatory, ball room and medication room. During the warmer months some interviews took place in the garden. Residents who had completed their programme were asked to come back to the Mother-ship for their follow up interview and all agreed to do so. In an effort to maintain the anonymity of those taking part in the follow-up interview process the Residential Manager agreed that ex-residents could say they were visiting the service as they were passing by if they were questioned by current residents or staff members. A number of interviews took place in the re-entry house and sound-proof rooms in LJMU's library. Where interviews were conducted off site at least two people (a member of staff from the service and a family member) were made aware that an interview was taking place in the community and were given a time to expect either a phone call or text message from the researcher. This system was put in place to maintain the researcher's personal safety.

Interviews were semi-structured and consisted of a number of questions that were clustered together to deal with similar issues. General issues that were covered in interviews included a resident's lifestyle before entering the Mother-ship, why they decided to seek help and support, experience of TCs and expectations for life after programme completion. Interviews covered a range of events and experiences, which could be upsetting, emotive and embarrassing for residents to discuss. Therefore the interview schedule was designed to begin with sensitive and potentially uncomfortable experiences for the respondent such as childhood experiences, educational and

vocational attainment, experience of the criminal justice system, relationships with family and friends and substance use. To conclude each respondent was invited to discuss their hopes and dreams for the future. This was done in an attempt to reduce the likelihood of a respondent leaving an interview feeling disempowered and/or upset about the material that had been covered.

Although there was a generic interview schedule to follow interviews were conducted in an open and relaxed manner, which provided respondents with the time and space to talk about issues that were important to them. The semi-structured nature of interviews meant that the duration and depth of each interview varied as they were based on self-report data. As self-report data are based upon information that a person verbally reveals about themselves; the validity and reliability, together with the evidential status of such data is debatable as respondents ultimately control what they decide to include and exclude in their narrative (Brown, Taylor, Baldy, Edwards and Oppenheimer, 1990; Darke, 1998; Del-Boca and Noll, 2000). Given the array of research methods employed during fieldwork, besides the ability to cross reference interview data with other forms of data, such as observational data and official documentation held in a resident's personal file, the internal validity of self-reported data was heightened.

Note taking took place during each interview, which slowed down the pace of the interview and provided a means for locating important quotations during the analysis stage. This also provided the respondent with a non-verbal cue that something significant had been said (Genders and Player, 1995; Gray, 2009). Interviews were electronically recorded, to ensure that information obtained during each interview was correctly and fully documented, and transcribed using a transcription service. The electronic recording of interviews permitted undivided attention to listening and

understanding what was being disclosed during an interview (Gray, 2009). However, the use of electronic recording was not without its problems as many respondents stated that they felt uncomfortable being recorded.

“Are you messing Helena? You’re not the plod are ya?”

(Dave, Resident, June 2011)

“I hate these. I always seem to end up in trouble when there is one of these around.”

(Melissa, Resident, August 2011)

Any expressed uneasiness required reassurance. The researcher allowed respondents the opportunity to express their concerns and discuss why they felt the way that they did about electronic recordings. This provided an opportunity for the respondent to have his/her opinions and beliefs heard. The researcher then explained the methodological reasons as to why interviews were recorded in a way in which respondents could understand; and measures to maintain anonymity were re-iterated. Despite initial expressed uneasiness all respondents agreed to be electronically recorded during their interview(s).

“Go ‘ed then, let’s have it. For once I’ve actually got nothing to worry about.”

(Dave, Resident, June 2011)

To maintain the anonymity of the population under study information that was able to identify specific residents and staff members has been removed. In the Mother-ship there were a number of unique staff roles such as: residential manager; programme manager; and department co-ordinator. Therefore references to staff members and/job roles, regardless of seniority, have been referred to as staff or staff members through this thesis.

Observations and informal discussions were recorded in the form of field notes. Field notes are an important tool for the ethnographer able to communicate engagement in the field and provide a source from where an array of quotations and empirical evidence can be generated (Bloor, McKagney and Fonkert, 1988; Fetterman, 1998; Mulhall, 2002; Wolfinger, 2002). During fieldwork key words, abbreviations, phrases, unconnected sentences and notations of events were manually recorded. After a period of observation, usually within 24 hours, an expanded account was written using the notions made during fieldwork as a guide. Mulhall (2002) suggests that such reflection could provide a different gloss on the day's events. However, given the elongated nature of fieldwork and the ability to cross-reference observations with other methods of data collection this method of data recording was considered to be appropriate.

When writing up field notes it was imperative to differentiate between actual verbatim and approximate recalls of conversations and interpretations of events. To do so actual verbatim was put in quotation marks, general paraphrasing of informal discussions were left without quotation marks and ideas, thoughts and questions to explore when next in the field were recorded in a different colour pen.

Methodological triangulation is a technique designed to compare and contrast different types of methods to help provide more insight into the phenomenon under study (Reeves *et al.*, 2008b). The triangulation of research methods is a strategy which can be employed during fieldwork to counter threats to reliability and validity (Kurz, 1984; McKinnon, 1988; Reeves *et al.*, 2008b; Gray 2009). Data generated via a range of research methods have a greater chance of covering sufficient events about the phenomenon under study to produce the comprehensiveness required for validity (LeCompte and Goetz, 1982). Although ethnographic fieldwork can become labour

intensive, the longer the time spent in the field the more likely it is that more insight will develop and the ability to negotiate access to events, activities and certain people, which may have been denied on initial entry to the setting will increase (Kurz, 1984). The elongated nature of fieldwork meant that a wide range of internal consistency could be established due to the ability to cross reference data gathered via a range of research methods.

Gaining and maintaining access to the field

In August 2010 an opportunity to visit the Mother-ship arose due to involvement with a prison-based TC, which had come about as a result of voluntary work with a through-the-gate mentoring scheme that provided support to prisoners who intended to reside in the Merseyside area upon release from custody. Albeit unintentionally the mentor role went on to ignite an interest in the hierarchical TC.

Weekly mentor meetings, which took place on the wing where the TC operated not only provided an opportunity to explore the workings of a prison-based TC but provided access to a relatively hidden space and population. The mentor role provided an opportunity to observe how prisoners applied the skills that they had learnt during their time in a TC to cope with life after programme completion, both inside and outside the walls of the prison estate. Nearly six years on the researcher continues to mentor a number of individuals who took part in the prison-based TC where this interest and thirst to understand the intricate workings of the TC for substance use began. It has been a challenging, inspirational and rewarding experience, observing in real time how these men adapted to mainstream prison life and life after release with a 'new' identity and sense of self.

After visiting the Mother-ship this interest and curiosity grew and a desire to conduct research in a residential TC developed. Buchanan, Boddy and McCalman (1988) developed a four-stage model to categorise and organise access to a research setting: getting in; getting on; getting out; and getting back. At the getting in stage researchers are expected to be clear about their objectives, time required in the field and resources. Once access has been granted it is necessary to renegotiate entry to the actual lives of people in the setting under study (getting on). This renegotiation requires basic interpersonal skills and good appearance as well as verbal and non-verbal communication skills (Burgess, 1984). The best strategy for getting out is agreeing a deadline for the closure of the data collection process and the option to return for further fieldwork should be maintained. This means that the researcher must be able to manage the process of withdrawal from the setting under study favourably (Buchanan *et al.*, 1988).

Van Maanen and Kolb (1985) suggest that gaining access to the field is crucial and should not be taken lightly as it is an important first step in ethnographic research. The term gatekeeper is used to describe an individual or group of individuals who have the power to grant or withhold access to people or settings for the purpose of research (Noaks and Wincup, 2007).

Generally speaking there are two types of gatekeeper: formal and informal. Formal gatekeepers provide access to a setting or group of people, whereas informal gatekeepers provide practical assistance and cooperation throughout the duration of fieldwork (Wanat, 2008). For this study there were two formal gatekeepers. The first was the Research Ethics Committee (REC) at LJMU and the second was the Quality Assurance and Clinical Governance Committee (QACGC) of the organisation that

operated the Mother-ship. Although the REC was not responsible for providing direct access to the setting under study, receipt of confirmation was required before fieldwork was allowed to commence. The QACGC was responsible for providing direct access to the TC where fieldwork took place. Due to the ethnographic nature of fieldwork the REC at LJMU and the QACGC were aware that fieldwork might digress from the initial research proposal as time in the field progressed. Full approval was obtained from both formal gatekeepers before explorative fieldwork commenced.

It has been suggested that organisations may be sceptical about outside researchers and may not always welcome academic studies (Okumus, Altinay and Roper, 2006). However, this was not the case with the organisation that operated the Mother-ship. The Head of QACGC not only granted permission to the Mother-ship but provided on-going support throughout the duration of fieldwork, providing information about the service under study and organisation as a whole as and when requested.

Regardless of its form, access is a problem that looms large for the ethnographer (Hammersley, 1992). The negotiation of access is at its most acute during the initial negotiation stage. However, it is an issue which persists in one form or another throughout the duration of fieldwork. Once initial access has been granted a degree of support when in the field is crucial as a gatekeeper's permission to conduct fieldwork will not necessarily guarantee cooperation when in the field (Shaffir and Stebbins, 1980, 1991; Wanat, 2008).

Building trust and rapport is a crucial component of ethnographic fieldwork; it not only contributes to the development of a successful relationship between the researcher and the population under study but ensures access to the field is maintained (Burgess, 1984;

Wasserman and Clair, 2007). This involves a combination of strategic planning, hard work and grasping opportunities when they emerge (Johl and Renganathan, 2010). In an attempt to build trust and acceptance the researcher developed a reputation for being consistent, which was considered an important strategy as ethnographic researchers are expected to show commitment to the setting under study before being trusted with the information that is sought (Johl and Renganathan, 2010). The researcher also arranged a pre-fieldwork meeting with informal gatekeepers (residential manager and programme manager) in an attempt to establish a productive working relationship, acceptance, trust and show respect for the management team in the Mother-ship. Although the QACGC did not deem this necessary, it was felt appropriate to do so. This proved to be a productive strategy as permission was granted to access to the encounter group's³⁴, care plans, residents' personal files and the intranet system was obtained as a result of the pre-fieldwork meeting.

Towards the end of October 2010 explorative fieldwork commenced; once approval from the REC was obtained, access from the QACGC was granted and an enhanced Criminal Records Bureau (CRB now Disclosure and Barring Service) check was acquired. A further meeting was held with informal gatekeepers and the researcher made an announcement in a community meeting to all residents and staff members on shift. The nature and purpose of fieldwork were explained and the opportunity to ask questions and raise any concerns was provided. It was made clear that if anyone had any concerns that they did not feel comfortable discussing in the meeting, they could speak on a one-to-one basis with either the researcher or their key worker who had contact details for the researcher if any issues were to surface. A week elapsed before explorative fieldwork commenced. It was felt that this provided enough time for staff and residents to raise any issues and concerns that they might have in relation to the

forthcoming fieldwork. Within this time and throughout the duration of fieldwork no concerns were raised by staff or residents.

Weekly visits to the Mother-ship were made to develop consistency as well as illustrate the researcher's commitment to the study. Scheduled visits were recorded in the staff and residents diaries to ensure that they were aware of these visits. The researcher also made a conscious effort to dress appropriately, in a smart-casual manner and respected (although did not necessarily agree) the norms, values and practices that occurred in the Mother-ship. When asked to do so, the researcher provided practical assistance on open days; family days; external day trips; and attended TC specific training.

The researcher made it explicitly clear to management, as well as the staff team, that if a resident disclosed anything during informal discussions or interviews, which suggested that they had broken the cardinal rules of the programme they would be informed. The cardinal rules were no substance use and no threats or acts of violence. This commitment was made to ensure the safety of the resident, the peer community, the researcher and staff team, as well as ensure the longevity of fieldwork.

Buchanan *et al.*, (1988) suggests that the best strategy for getting out from the field is agreeing on a deadline for the closure. However, unexpected delays and unanticipated developments that occur during fieldwork mean that an exact closure date is unviable (Okumus *et al.*, 2006). When negotiating access to the Mother-ship the researcher emphasized that the exact duration of fieldwork was unclear. This lack of clarity was due to an array of factors; not only were the aims and objectives of the study not refined at this point, but there was a lack of clarity surrounding how long it would take to

understand the intricate workings that take place in a TC and what would happen during the course of fieldwork.

The Mother-ship

The TC under study is a six month residential abstinence-based programme for 32 men and women over the age of 18 with a history of substance use. Although the service could cater for up to 12 female residents it was unusual to find more than five or six admitted to the service at any one time. The resident population was predominately white males and the age range was between 21 and 62.

Between August 2011 and November 2011 surveys were sent to all residential, community and prison-based services across England and Scotland that were operated by the organisation that ran the Mother-ship. The survey explored substance use, housing issues, education, employment, criminal activity and family relationships to ascertain the profile of the population accessing their services. The study found that there was a 70:30 male-female ratio in residential and community services. 92% of residential clients described themselves as White British and 30% of residential clients had been through the care system. Seven out of ten residential clients came from the most deprived areas in the United Kingdom, a quarter were homeless or living in temporary homeless accommodation before engaging with a service and a third had five or more previous attempts to engage with a service. During the three months prior admission to a residential service the average weekly spending on substances was £599.60 per person. 30% of residential clients claimed to have been in prison more than five times and 60% claimed to have sold illicit substances for profit.

Potential residents are not required to be abstinent on arrival (if agreed prior to admission) as the service includes an integrated detoxification programme, which is monitored by a General Practitioner and supported by a care team who adhere to organisational policies and procedures. Methadone, Benzodiazepine, Buprenorphine, Diazepam and Librium detoxification programmes are available for residents who feel that they cannot achieve abstinence in the community.

The Mother-ship responds to substance use through three programme stages: the welcome house stage; primary stage; and senior stage. The welcome house stage lasts a minimum of four weeks and maximum of eight weeks and is designed to provide a warm welcome to new residents. Welcome house residents have their own timetable; which consists of less intense group sessions and are only expected to participate with the main house programme at specific times such as community meetings.

The primary stage lasts a minimum of twelve weeks and maximum of twenty-two weeks. During the primary stage residents are expected to comply with the rules of the programme, demonstrate a practical knowledge of TCs, display limited personal disclosures in group sessions, set an example for other community members, carry out required house duties and reveal a level of self-awareness and motivation. The senior stage lasts a minimum of ten weeks and maximum of eighteen weeks. At the senior stage residents are expected to take on a greater level of responsibility and use the skills that they have learnt and developed during their time in the Mother-ship to plan for their re-entry into the wider community. Senior residents are also expected to participate in external activities such as voluntary work and engage with external support groups.

Every morning at 8.30am a resident-led morning meeting was held, chaired by the senior house manager, which lasted approximately 30 minutes. An attendance check, which was colloquially referred to as a department check, was carried out and all absences were accounted for. Residents were asked to give a thought for the day; which was recorded on a chalk board by the entrance of the house. The structure of the day was clarified, announcements were made, positive pull ups were announced and something uplifting was done to round up the meeting, such as singing, role play or a game of charades. Before the meeting concluded residents stood in a circle and read the philosophy out loud. The philosophy is a statement of belief about the possibility of change and personal growth that can be found in every TC.

After the morning meeting residents resume their position in the work hierarchy, which is used to test a resident's skill development and personal growth (DeLeon, 2000). There were six work departments in the Mother-ship: the kitchen department; garden department; allotment and recycling department; maintenance department; cleaning department; and house management. Residents were expected to experience all work departments as they progressed through the programme. Each work department, apart from house management, was structured with the following positions: crew member; assistant department head; and department head. House management is structured with two house managers and a senior house manager.

Group sessions were held at 11am for welcome house residents and 1pm for primary and senior residents, referred to as main house residents. There were four types of group sessions: behavioural; orientation; relapse prevention; and encounter group. Behavioural groups are based on Cognitive Behavioural Therapy (CBT) and are designed so that all residents can learn about their past and current behaviour. Welcome house behavioural

groups included sessions on: confrontation; appropriate challenging and rewards; collusion and glorification of the past; responsible concern and rational authority; asking for help; coping with triggers; and using time positively. Main house behavioural groups included sessions on: the onion concept; denial and suppression; glorification of the past; honest;, ideas for a commitment; collusion; Johari's window; anger and loss of control; healing from anger; separation and loss; assertiveness; shame and guilt; blind faith and trust; setting boundaries in relationships; learning to say yes and no in relationships; and self-esteem and self-worth.

Orientation groups were designed to teach residents about generic TC concepts, processes and perspectives. Welcome house orientation group sessions cover: rules and boundaries of the Mother-ship; staff roles; structure; hierarchy; programme stages; self-help and peer support; encounter groups; and role models. Main house orientation group sessions include: view of the person; view of the disorder; view of recovery; view of right living; 'act as if'; and life maps.

Relapse prevention groups consist of structured relapse prevention work using CBT coping skills and strategies. They provide residents with the opportunity to present their relapse prevention plan to the group, receive feedback, and help to evaluate other residents' plans. Group sessions include: high risk situations; safe coping skills; triggers; urges and cravings; managing cravings; refusal skills; saying no positively; high risk situations in relationships; dealing with a lapse; and relaxation techniques.

The encounter group is a significant component of a TC as it provides a community forum where group processes are used to resolve a variety of individual and community issues (DeLeon, 1997, 2000; Rawlings and Yates, 2001; Perfas, 2004, 2012). The

purpose of the encounter group is to challenge negative patterns of behaviour, thinking and feeling so that an individual becomes more aware of themselves and the impact that they have on those around them.

The staff team in the Mother-ship consists of a residential manager, programme manager, a department head, four therapeutic workers, three care workers and an administrative support team. The residential manager is not involved in delivering the programme as she is the interface with external agencies to promote the service. It is the responsibility of the programme manager to ensure that the programme is run correctly and to a high standard. The department head is responsible for the day-to-day running of the work hierarchy and general running of the house.

Therapeutic workers are responsible for delivering behavioural groups, encounter groups and welcome house groups as well as key working residents with each therapeutic worker having a maximum of eight key clients. The frequency of key work sessions for each resident is programme stage dependent. Welcome house residents are entitled to two 30 minute key work sessions per week. However, once in the primary and senior stage of the programme residents, in theory, have at least one key work session every two weeks.

The day care worker is responsible for designing and delivering activities for the residents, dispensing medication and ensuring that appointments with external agencies were facilitated. The night care workers are responsible for delivering the evening programme, which includes community activities, the administration of medication and sleepover duties. The support team manage the administration of the service and are responsible for taking referrals to the service and ensuring that the residents' benefits

are correct. There was an apprentice who graduated from the programme in 2011 working on his employability skills and gaining vocational qualifications whilst in a paid position. There were also a number of volunteers and peer mentors providing support to residents and the staff team on a day-to-day basis.

Re-entry is the final stage of the programme where residents live in semi-independent accommodation not far from the Mother-ship. The re-entry service is a 10 bedded house that is staffed between the hours of 9am and 8.30pm Monday to Friday with out-of-hours checks carried out throughout the week and at weekends. A specific re-entry worker is based out of the house for 19 hours per week. There is also a 24 hour on call emergency service operated through the Mother-ship. In this stage residents' receive their own benefits, which should pay for food, rent and other necessities. Prior to moving to re-entry residents are required to have a deposit of £24.78. This is for two weeks client contribution of £7.39 per week and a £10.00 deposit for house keys.

The main purpose of re-entry is to give residents the chance to ease back into the local community. The structure is less rigid than that in the Mother-ship and greater emphasis is placed on residents taking responsibility for their future. At this stage residents are expected to fill their time constructively with support from the re-entry worker. This is monitored with the help of a weekly planner (see Appendix 6), which is used to help residents examine their motivation and ability to keep going when there is no one directly behind them giving them support and direction.

Residents in the re-entry stage have a fortnightly key work session and regular care plan reviews and there are also weekly groups that focus on relapse prevention and basic life skills. Peer group councils (PGCs) take place once a week, which give residents the

opportunity to explore their progress and receive feedback from peers and staff. Re-entry residents must attend these groups as they are compulsory.

There are four supported housing projects in the area surrounding the Mother-ship that are available for those who have successfully completed the programme but feel that they require further help and support. Each supported house can hold four residents and is part of the organisation's wider recovery model. Supported housing residents have key workers who provide one-on-one support with life skills. Residents can stay in supported housing for up to two years and during their stay will be supported in finding their own accommodation. Once a resident has found their own accommodation they can access the floating support service, which provides one-to-one support for individuals in their own accommodation.

The Research Sample

Alcohol, heroin and methadone were the most common substances used by residents admitted to the Mother-ship, followed by buprenorphine and crack cocaine. Residents who took part in the follow up process consisted of males and females who entered the service (primarily) to address their heroin and/or crack cocaine use. Information regarding a resident's substance use was initially obtained via self-report data and was cross-referenced with information stored on Janus³⁵ for validation.

The decision to track residents who had been admitted to the Mother-ship due to heroin and/or crack cocaine use was made due to the array of individual, social and economic costs associated with the supply and demand of these particular substances. 81% of those who engaged with an alcohol and/or drug service in England and Wales in 2012 were receiving help for heroin and/or crack cocaine use; out of the 197,110 adults

accessing such services 96,343 were receiving help for heroin use and a further 63,199 for heroin and crack cocaine (National Treatment Agency for Substance Misuse, 2012).

As the Mother-ship utilised a series of programme-specific stages a non-proportional quota sampling strategy was employed to ensure that the research sample consisted of residents from all three stages. Non-proportional quota sampling is a purposive sampling strategy, which means that predetermined criteria, guided by the aims and objectives of the study, are set before the sample group is established (Strauss and Corbin, 1990; Gray, 2009). Non-proportional sampling strategies do not strive for representative research samples (Daniel, 2011) and therefore the generalisability of findings is limited.

For this study the pre-determined criteria consisted of two requirements: firstly, the resident must have a history of heroin and/or crack cocaine use; and secondly, the resident must be abstinent at the time of the interview i.e., completed a detoxification programme if applicable. Non-proportional sampling was employed to generate residents from each of the stages and ensure that a small group within the population under study was represented. Once a resident or staff member volunteered to be interviewed an informal discussion, which provided further information about the nature and purpose of fieldwork was had, and a pre-interview form was completed. Pseudonyms were established at this point to ensure that information held on the pre-interview form could not be used to identify respondents.

The pre-interview form not only provided an opportunity to speak to the resident or staff member prior to the interview and break the ice, so to speak, but provided a reference point that could be referred to throughout the duration of fieldwork. The

longitudinal nature of fieldwork required a degree of ongoing critical reflection to keep the study focused. The pre-interview form was a technique that was employed throughout fieldwork to facilitate critical reflection as and when interviews took place, establishing how many interviews had been conducted, with whom and how many were needed. This reference point helped to keep the sampling strategy on track and time in the field productive.

Follow up interviews were carried out with 18 residents; 12 males and 6 females between the age of 32 and 46 and consisted of a series of semi-structured interviews, which were conducted at three milestone dates. Due to the non-proportional sampling strategy seven residents started the follow up process during the welcome house stage, four started during the primary stage and seven started during the senior stage. In total, each respondent was interviewed three times.

Residents who volunteered to take part in the follow up process during the earlier stages of fieldwork were tracked over a longer period of time than those who took part at a later date. The longest follow ups took place over 15 months, with an interview conducted at five month intervals. The shortest took place over 11 months, with a follow up interview conducted at approximately three and a half month intervals. Follow up interviews were conducted with all respondents except for one who died of an overdose during fieldwork.

In addition to the follow up process a number of one-off interviews were conducted with residents, ex-residents and staff members. Interviews were conducted with two males who completed the prison fast track programme³⁶ before admission to the Mother-ship, 6 residents (three male and three female) who had a history of alcohol use,

10 residents (seven male and three female) who elected to leave the programme early and 9 members of staff. In total 81 semi-structured interviews were conducted.

Data Collection and Analysis

Grounded theory approaches collect and analyse data in a gradual sequence. This consists of constant comparisons between results and new findings to guide further data collection (Strauss and Corbin, 1990; Miles and Huberman, 1994). The development and identification of variables does not take place prior to data collection, but instead as part of the data collection process.

Data collected during semi-structured interviews were subject to content analysis, which is a process through which data sets are given meaning. It involves making inferences about data by systematically and objectively identifying certain patterns, characteristics, classes and/or categories within the generated data (Gray, 2009). According to Fetterman (1998) patterns of thought and behaviour generated through ethnographic research should be considered as a form of ethnographic reliability and used to demonstrate internal consistency.

Content analysis was carried out manually and involved successive readings of interview data with the aim of exploring and comparing themes within and between interview transcripts. Although it has been suggested that using computer software packages in the data analysis process can add rigour to qualitative research (Richards and Richards, 1991) computer-based tools are facilitators of data management rather than analytical tools in their own right. Thus, reliance on them without well-examined and reasoned methodological strategies can result in potentially weak and unreliable results (Blismas and Dainty, 2003).

Welsh (2002) suggests that computer software packages add rigour when the data are searched in terms of attributes such as age, gender and ethnicity, as carrying out such a search electronically will yield more reliable results than doing it manually; simply because human error is ruled out. This form of data interrogation is important in terms of gaining an overall impression of the data. However, when it comes to interrogating the data in more detail computer software packages are somewhat limited; mainly because the existence of multiple synonyms can lead to the partial retrieval of information (Brown *et al.*, 1990). Furthermore, as respondents may express themselves in different ways, it becomes difficult if not impossible for computer software packages to recover all responses (Welsh, 2002).

As the Mother-ship accepts referrals from all over the United Kingdom an array of regional dialects are used. In addition to this, as the majority of respondents had a history of imprisonment, a substantial amount of prison slang and street terminology was used within the data that had been collected (see Appendix 1). Although search facilities in computer software packages can add rigour to analytical strategies, as they are unable to detect multiple synonyms a manual analysis of the data was deemed to be the most reliable and productive option. By going through the data personally the researcher was able to achieve a greater familiarity with the findings and uncover themes that, because of wording, may not have been identified by a computer software package.

Residents and staff used metaphors and allegories to describe TC principles and prescriptions, the change process, the challenge system and the detoxification process. The use of multiple synonyms, metaphors and allegories meant that a system of respondent validation was required to ensure that the findings were accurate, credible

and valid. After each interview was transcribed, the researcher would read through the interview, code key words using line by line coding and make a note of the themes that emerged. During the follow up interview, or informal discussions, respondents were asked questions regarding their previous interview to determine whether the concepts that had presented were factual or a misunderstanding on behalf of the researcher. This allowed a respondent to validate a potentially ambiguous comment and add substance to the statement (McGrain, 2010). For example:

“During your last interview you said, “It’s something for that lot in the Ivory tower to worry about, not me. I just let it all go over my head to be honest,” what exactly did you mean by that?”

(Helena, Researcher, August, 2011)

The process of coding highlights problems, issues, concerns and matters of importance to those being studied. Charmez (2006) suggests that coding is not only an important link between collecting data and developing theory but as a connection between linking empirical reality and the researcher’s view of it. Grounded theory advocates using several coding techniques to examine interview transcripts (Strauss and Corbin, 1990). Line by line coding provides a way in which to begin to categorise and sort the data. It is the process of combing data for themes, phrases and key words and marking similar passages of text so that it can be retrieved at a later stage of analysis. Codes can be based on themes, phrases and key words, which appear in the data and are usually given meaningful names that represent the concept underpinning the theme, phrase or key word. Codes are assigned to the respondent’s words and statements to develop concepts, constituting the start of the analytic process.

For this study codes were based on key words pertinent to answering the research question. Although the analytical strategy aimed to provide answers to the aims and objectives of the study, it was also data driven in that it allowed themes and responses,

which had not been anticipated, to emerge. The analytical strategy also paid attention to both qualitative and quantitative aspects of the generated data i.e., both what was said and the frequency of what was being said (Strauss and Corbin 1990, Lees *et al.*, 2004).

The detailed and meticulous process of line by line coding helped to open up the data and interpret the transcripts in new and unfamiliar ways, which helped test the researcher's assumptions. This method of analysis allowed the researcher to go through the interview to firstly get an overall impression, then refer back to specific passages and make notes and comments about what might be taking place. It also provided an opportunity to review the interview again at a later date. Creating a wide-ranging set of initial codes gives the researcher a road map to the data, allowing for further dissection of each interview transcript while understanding the general ideas and concepts within the data (McGrain, 2010). The advantage of this type of coding scheme is two-fold. First, starting with a list of general codes is a good way of providing the researcher with something to work with; and the creation of additional codes means that the coding can become limitless, allowing the researcher to get everything that they can from the data. By remaining flexible throughout the analysis process allows the researcher to create codes when it becomes clear that data will fit into categories.

The next coding phase, which is referred to as focused coding, is considered to be more abstract than line by line coding as it helps to verify the adequacy of the initial concepts developed (Strauss and Corbin, 1990). As phrases and key words were identified, labels which described the content of each passage were recorded. Broad themes comprised: community separateness; peers as role models; a structured day; programme stages; work as therapy and education; the encounter group; emotional growth and awareness training; planned duration of stay; continuity of care; resources, tools; Payment by

Results; client change; outcomes; effectiveness; commitments; re-entry; and the therapeutic alliance.

Two copies of each interview transcript were made. On one of the copies sections that had been labelled were physically cut out. The other copy was saved for future reference. Broad themes were then coded and sorted into piles. Sections of interview transcripts, which had the same or closely related label, were grouped into piles. Each pile was labelled with a phrase that captured the general essence of what was going on in that pile. The purpose of this strategy was to refine, expand or reject initial themes as the analysis progressed.

Each pile was then subject to critical reflection. To do so the following questions were applied to each pile: Does everything in this pile relate to the assigned label? Can some piles be combined? Can some piles be deleted because they do not relate to the research question or have very few pieces of data in them? This left a total of five piles which covered: community as method; emotional growth training; commitments; retention and Payment by Results; and continuity of care. Each of the piles was then given a code. Each pile was then coded accordingly with the categories being: C1 – community as method; C2 – emotional growth training; C3 – commitments; C4 – retention and Payment by Results; and C5 – continuity of care.

The analytical strategy for this study adopted a reflective stance whereby the data collected was subject to a process of constant comparison. Every interview transcript was subject to the initial stage of analysis (line by line coding) once returned from the transcribing service. As fieldwork progressed and further interviews were conducted each interview transcript was revisited for focused coding. The constant comparisons

between collected data, codes, categories and initial findings helped to refine ideas and themes that went on to become a part of the emerging theoretical framework. This reflective strategy was employed in an attempt to minimise coding errors and heighten the reliability of the coding procedure as well as provide a degree of internal consistency when coding data over a prolonged period of time.

The process of coding and developing categories was supported by memo writing. Memos are a set of notes that, if kept continuously, support the researcher by providing a record of thoughts and ideas. They enable the researcher to reflect on the interviews and given codes to enter into a dialogue about the collected data. The memo system for this study was created to improve the reliability and validity of the coding procedure (see Appendix 7). It consisted of a definition and description of each code, as well as an example quotation from an interview transcript, which had already been subject to content analysis.

According to Gibbs and Taylor (2010) memo systems are essential when coding data as they illustrate why data has been coded in the way in which they have. For this study the memo system acted as a reference point, which guided the coding process and analytical strategy. For instance, when a passage was identified as being applicable to an existing coded category a cross-check with the memo system was made to confirm whether or not it fitted into the code definition. If not a new code was created. To demonstrate how statements generated through the memo system validly endorsed the identified themes, a quotation from fieldwork and a related theoretical concept, which it is held to reflect, has been identified and documented.

Data are collected until theoretical saturation is reached, in other words until no new or relevant data emerges regarding a category and relationships between categories are established (Strauss and Corbin, 1990). Theoretical saturation means that additional data collection and analysis efforts do not yield any new findings (Eisenhardt, 1989). It is at this point that the researcher should concentrate on integrating their findings and working out the theoretical contribution to the domain of study.

It was felt that theoretical saturation was reached before Christmas 2012 as no new themes, concepts or ideas were emerging from the data that were being collected. By this time it was also felt that time away from the Mother-ship was needed to concentrate on writing up the findings. Once all loose ties were addressed the exit strategy was put into practice. This provided the researcher with enough time to revisit the field if deemed necessary when writing up the findings.

Ethical Considerations

There are no straightforward solutions to resolve ethical dilemmas, as what is considered ethically defensible depends on a researcher's values and beliefs. There is, however, a code of ethics that preserves the well-being of research participants before, during and after the research experience (Westmarland, 2011).

The REC at Liverpool John Moores University follows the Economic and Social Research Council's (ESRC)³⁷ framework for research ethics, which outlines key principles of ethical research (The Economic and Social Research Council, 2012). The principles cover issues such as informed consent, confidentiality, deception, voluntary participation and avoidance of harm which ensures that research is designed and

delivered in a way whereby the dignity and autonomy of research participants are protected and respected at all times (The Economic and Social Research Council, 2012).

A number of strategies can be incorporated into the design and delivery of research to ensure that it is conducted according to the key principles of ethical research as outlined by the ESRC. However this does not protect the researcher from the unanticipated dilemmas that may surface during one's time in the field.

The principle of informed consent was addressed before, during and after fieldwork was conducted. Measures such as pre-fieldwork meetings with informal gatekeepers were arranged not only to foster cooperation, but to ensure that informal gatekeepers were fully aware of the nature and purpose of fieldwork. It was important that informal gatekeepers had a good understanding of the study, not only enable them in the decision of whether to participate themselves in the study, but because it was likely that residents would approach them with questions relating to the research.

On the first day of fieldwork the researcher made an announcement, during a community meeting, to discuss the nature and purpose of the study, as well as provide an opportunity for staff and residents to ask questions and raise any concerns. Those who volunteered to be interviewed were provided with an information sheet which provided further details of the study, what would happen to the information collected, potential risks and benefits of participation and measures to maintain confidentiality. These strategies were put into place to ensure that full informed consent was obtained.

Once the information sheet was discussed and an opportunity to ask questions was given, respondents were asked to read and sign an informed consent form and create a

pseudonym. As extracts from interviews have been used verbatim, pseudonyms were utilised to maintain the anonymity of respondents. Once full informed consent was obtained respondents were interviewed in a place where they felt able to talk openly and honestly. As some respondents were interviewed more than once, the process of gaining full informed consent was repeated before each interview took place.

To ensure confidentiality all manual data were stored in locked filing cabinets and electronic files were stored on a personal computer protected by a user name and password. Consent forms and interview transcripts were stored separately to maintain the confidentiality and anonymity of respondents. Although it is impossible to ensure complete confidentiality (Ensign, 2003) measures were taken to maintain the anonymity of respondents and the Mother-ship by following confidentiality procedures outlined by LJMU (registered under the Data Protection Act).

Before every interview respondents were made aware that the content of the discussion would remain confidential. It was felt that the discussion surrounding what confidentiality meant was important, not only to ensure that full informed consent was obtained but to avoid the risk of harm and/or feelings of deception on behalf of the respondent if the researcher was to make a disclosure to the staff team. This discussion was required as, with self-report data, material may be divulged to the researcher that is not known by the staff team, which can pose ethical and moral dilemmas. According to Lees *et al.*, (2004) holding this information is neither appropriate nor safe for the researcher or the client.

The most recurring dilemma that occurred during fieldwork was the extent to which it was considered appropriate to interview residents who were detoxing from an addictive substance. The Betty Ford Centre (2010) outlines an array of symptoms such as confusion, altered perceptions, poor short term memory, poor judgement, cognitive decline, drowsiness, sudden mood swings, anxiety and paranoia that are associated with detoxification from alcohol, benzodiazepine, opiates and/or crack cocaine. Issues that surround the inclusion of individuals who are detoxing from substances in research studies have also been recognised in the literature (Wilson and Mandelbrote, 1978; Del-Boca and Noll, 2000).

There were a number of instances where residents suffering from withdrawal symptoms over-reacted to staff direction, became volatile, unpredictable; verbally aggressive and elected to leave because they did not like the thoughts and feelings that were coming back to them; and/or wanted to use substances. As the detoxification programme took place during the first month of admission to the Mother-ship, which is a period of time that is characterised by a high dropout rate anyway, the decision not to conduct interviews with residents during this transitional phase was made. This is not to say that residents who were detoxing were excluded from the study if they wished to participate, as this is not the case. Nor is it a claim that everyone involved in a detoxification programme is unable to make an informed decision. Waiting until a resident had completed their detoxification programme and associated withdrawal symptoms had subsided is an example of an effort to strive for integral, high quality findings, which not only respects a respondent's well-being but limits the ambiguity surrounding an individual's ability to give informed consent. This decision was made to ensure that participants experienced an approach that gave attention to protecting their rights,

sought to achieve consent and respected promises of confidentiality (Noaks and Wincup, 2007).

The ethical principle of informed consent implies a responsibility on part of the researcher to ensure that those involved in the study not only agree and consent to participate of their own free will, but are fully informed about what it is they are consenting to. The collection of informed consent ensures that researchers conduct themselves with honesty, integrity, consideration and respect for their research subjects. Informed consent is therefore considered to be one of the main responsibilities that a researcher has towards their research subjects.

Exit Strategy

Fieldwork ended in March 2013 for two reasons. Firstly, before Christmas 2012 it was felt that a point of theoretical saturation had been reached. Secondly, from a practical point it was felt that time away from the TC was needed to concentrate on writing up the findings. Due to the longitudinal nature of the study the exit strategy was a gradual process. All staff members were made aware that fieldwork was coming to an end and the reasons for this were explained. A meeting with the residential manager and programme manager was conducted to discuss the findings and an opportunity to ask questions and raise any concerns was made. The Head of QACGC were also made aware that fieldwork was coming to an end.

Visits to the Mother-ship, between December 2012 and March 2013 decreased in length and number until fieldwork was eventually drawn to a close. Residents who had taken part in the follow up process were fully aware that, on completion of the last interview, the formal aspect of the study was complete. They were thanked for their time and once

again given the opportunity to ask questions. The researcher's e-mail address was given to each respondent should they decide to withdraw from the study at a later date.

Chapter Five

Organisation, Structure and Operation

Introduction

The purpose of this chapter is to delineate the intricate workings that take place in a residential TC. To explore the subject area the theoretical prescriptions, which underpin each component of the TC model as outlined by George DeLeon (2000) are provided. In addition to this, the first part of the chapter explores how each component was translated into practice in the Mother-ship. To move beyond a descriptive account of the programme the second part of the chapter discusses some of the gaps, tensions and dilemmas between how a TC ought to work and how TC principles and prescriptions were put into practice in the setting under study. To conclude, the final part of the chapter discusses whether recovery capital can contribute to the development of an empirically informed framework, which may go some way in explaining the work that takes place in a TC for substance use.

Components of a TC

As mentioned earlier in Chapter Two, the traditional TC model consists of 14 components: community separateness; a community environment; community activities; staff roles and functions; peers as role models; a structured day; work as therapy and education; phase format; concepts; peer encounter group; awareness training; emotional growth training; planned duration of stay; and continuity of care, all of which outline how a TC should be organised and structured (DeLeon, 2000). To examine the programme under study the traditional TC model is explored on a theoretical and practical level. The theoretical basis of each component is outlined and a description of how it is put into practice provided. There was a considerable amount of

overlap between several components with regards to their theoretical principles and prescriptions, therefore in order to avoid repetition the components peer encounter group, awareness training and emotional growth training have been studied simultaneously, as have the components planned duration of stay and continuity of care.

Community Separateness

Hierarchical TCs have their own names, which are usually generated by the residents. They are located in a separate space or locale from institutional programmes, units or any kind of drug related environment. In residential settings residents are, in theory, removed from outside influences 24 hours per day, seven days a week for several months before earning day out privileges (DeLeon, 2000).

The Mother-ship is located in a large Edwardian house in the North West of England. Male residents live in the main house and female residents live in a separate cottage. Once in the primary stage residents were expected to work their way through a pass system in order to earn day out privileges such as shopping trips and home leaves. They were required to be in the primary stage for a period of two weeks before they were eligible to apply for a local pass through the memo system, which was a way in which residents could make formal requests to the staff team (see Appendix 8). Memos were collected from residents every Tuesday evening by the night care worker and were discussed in a clinical team meeting, which took place every Wednesday afternoon at 1pm to discuss admissions and assessments, family visits, stage moves, community activities, health and safety concerns and funding. All staff members who were on shift were expected to attend the meeting. A community meeting usually followed the clinical team meeting when the memos were returned to the residents and feedback surrounding each decision was provided by a member of staff.

Residents who had a local pass were allowed to visit the local shops once permission had been obtained from a staff member and were also allowed to escort welcome house residents, who were not detoxing from controlled medication³⁸ to appointments within half a mile radius of the service. Once a resident had completed three escorts they were eligible to apply for an independent pass, which would enable them to go to the local town centre; located approximately two and a half miles away from the Mother-ship.

Towards the end of the primary stage residents who had an independent pass were allowed to memo for a commitment, such as voluntary work and college courses in the community. They were expected to attend one commitment for two weeks before they were entitled to memo for another. This process was put in place as residents were expected to prove that they could be trusted in the local community. Commitments were seen as a reward for positive behaviour. If a resident's behaviour was deemed to be deteriorating then they would be temporarily stopped from attending their commitment(s) until it was decided, by staff, that their behaviour had improved. If a resident's behaviour continued to deteriorate they would lose their pass, which meant that they would no longer be able to attend their commitment(s) in the local community. This meant that they would have to begin to work their way through the pass system once again.

Commitments were scheduled for a Tuesday, Wednesday and Thursday afternoon. This was because the encounter group took place every Monday and Friday at 2.15pm. As the encounter group is defined as one of the most important groups in a TC, all main house residents were expected to attend and participate in the group. Welcome house residents were not allowed to participate in the encounter group as it was deemed to be too intense and challenging for those who were 'just through the door'.

Once in the senior stage residents could apply for a full pass, which meant that they were eligible to memo to visit a nearby city centre, which was approximately five miles from the Mother-ship; and overnight home leaves every fortnight. Initially, a one night home leave would be permitted. If all went well and the resident returned to the service when requested and provided a negative urine sample on their arrival they would be permitted to go home for two nights on subsequent home leaves. Permission to go on a home leave was dependant on a resident's behaviour and participation in the programme.

Community Environment

The inner environment of a TC contains communal space to promote a sense of commonality. Signs and pictures in a TC state the philosophy of the programme, the messages of right living and recovery. Cork boards and blackboards identify residents by name, programme stage and job function (DeLeon, 2000).

The Mother-ship had a communal television room where community meetings took place, a games room where social activities were undertaken and a conservatory where daily meals were eaten at set times. There were a number of signs throughout the house which outlined the philosophy.

We are here because there is no refuge finally from ourselves
Until we confront ourselves in the eyes and hearts of others, we are running
Until we suffer them to know our secrets, we can know no safety from them
Afraid to know ourselves we can know no others
Where else but in our common ground can we find such a mirror?
Here at last we can appear clearly to ourselves
Not as a giant of our dreams, nor slaves of our fears, but as people;
A part of the whole with a share in its purpose
Here together we can take root and grow
Not alone as in death but alive in ourselves and others.

(The Mother-ship, 2010)

The philosophy that was employed in the Mother-ship was uniform across all residential TCs that were operated by the service provider and was recited daily by the peer community to conclude every morning meeting. There was a chalk board in the main entrance of the service that was updated daily with a quotation that was in-keeping with the TC view of recovery and right living as well as two white boards, one detailed the work department that each resident belonged to and the other outlined the structure of the day.

Community Activities

To be effectively utilised therapeutic or educational services must be provided in the context of the peer community in a TC. With the exception of individual counselling all activities must be programmed in collective formats, which include at least one daily meal prepared, served and shared by all members of the community, a daily schedule of groups, meetings and seminars, job functions and organised recreational time (DeLeon, 2000).

In the Mother-ship all therapeutic and educational services, except individual counselling and key work sessions, were designed and delivered in a collective format. Breakfast, lunch and evening meals were prepared by residents who worked in the kitchens and set times were put in place to ensure residents and staff came together to share daily meals. Several external services such as an art therapy group, reading group, Tai Chi class, singing group and Hepatitis C support group visited the service to provide weekly therapeutic and educational activities. All of these services were designed and delivered in a collective format.

Every month the residential manager allocated £300 to an activity budget and the staff team selected a resident to be the activity co-ordinator who was expected to liaise with the day care team worker and design an activities time-table. This consisted of in-house entertainment such as pamper nights, DVD nights, charades, discos and BBQs and external trips for example to the bowling alley, a local farm, the museum and cinema.

Staff Roles and Functions

Staff members in a TC are a mix of recovered professionals and traditional professionals. Professional skills define the function of staff members in a TC. However, their generic roles are those of community members who, rather than treatment providers are rational authorities, facilitators and guides (DeLeon, 2000). Brill and Lieberman (1969) suggest that the notion of rational authority is based upon the idea that professional power should be used in a humane and constructive way, which promotes rather than inhibits personal growth and development.

Although all staff members in the Mother-ship were aware of the concept of rational authority, the degree to which they provided a consistent approach, couched in traditional TC principles, varied. The application of the pull-up system illustrates this point. If a resident was deemed to be behaving inappropriately they would be issued with a verbal pull-up, which was an informal way in which residents were challenged about their behaviour. The member of staff issuing the pull-up was expected to ask the resident “can I take you off the floor please?” This provided an indication that a verbal pull-up was about to be issued and both parties involved in the process needed to talk in private. Twenty minutes after the verbal pull-up had been issued that same member of staff was expected to seek out the resident to whom the pull-up had been issued to

check their feelings and ensure that they understood why their behaviour had been challenged.

Although all staff members were expected to issue pull-ups in this manner, the majority felt that they did not have the time to follow up a resident after they had issued a verbal pull up, and/or understand the significance of the follow up process. As a result staff members would issue a verbal pull-up in a way in which they deemed appropriate. This usually consisted of a resident being challenged about their behaviour without being taken off the floor and not followed up to check how they were feeling.

Residents claimed that the inconsistency amongst the staff team enabled them to differentiate between those who were in recovery and those who were considered to be ‘text-book’ professionals. Those who had experience of living in a TC reportedly held onto traditional values and concepts because that was considered to be ‘the right way to do it,’ whereas staff members who were considered to be ‘text-book’ professional were keen to move away from TC traditions as they considered them to be dated and unclear.

Peers as Role Models

Residents who demonstrate behaviour that reflects values and teaching that are in accordance with the TC perspective are viewed as role models. The strength of a TC relates to the quality and quantity of residents considered to be role models as they are expected to maintain the integrity of the community and assure the spread of social learning effects (DeLeon, 2000).

Davidson *et al.*, (2010) suggest that a role model is someone that people can look up to and aspire to be like, who offers support, assistance and encouragement. In the Mother-ship a role model was someone who used the tools of the house, challenged peers in the encounter group and was able to openly express their feelings and emotions. Although the literature suggests that the resolution of problems related to substance use can be mediated by the process of social and cultural support (Longabaugh, Beattie, Noel, Stout and Malloy, 1993; Brady, 1995; Groh, Jason, Davis, Olson and Ferrari, 2007; Litt, Kadden, Kabela-Cormier and Petry, 2007; Beattie and Longabaugh, 1999; Moos, 2008; Christakis and Fowler, 2010), the emphasis that was placed on becoming a role model and supporting other people was somewhat diluted as a resident progressed through the programme stages. This point will be discussed further in the second part of the chapter.

A Structured Day

In a TC each day has a formal schedule of varied therapeutic and educational activities with prescribed formats and routine procedures. Ordered routine activities counteract the characteristically disordered lives of residents and help to distract them from negative thinking and boredom, which are factors that predispose to substance use (DeLeon, 2000).

The Mother-ship had a generic time-table for welcome house residents and main house residents (see Appendix 9). The welcome house time-table provided its residents with a gradual introduction to the programme as welcome house behavioural groups were separate from main house behavioural groups. Community meetings and activities were attended by both welcome house and main house residents thus providing an opportunity for welcome house residents to adapt to being in large group settings. The

welcome house time-table and main house time-table were subject to change if deemed appropriate by the programme manager.

Work as Therapy and Education

Residents are responsible for the daily management of a TC. Peer work roles mediate essential educational and therapeutic effects, strengthen affiliation with the community, provide opportunities for skill development and foster self-examination and personal growth. The scope and depth of peer work roles depend on the setting of the programme and available resources (DeLeon, 2000).

During a resident's time in the Mother-ship they were expected to experience all work departments. Each department was structured with crew members, an assistant department head and department head. The department head was there to supervise other residents in the work department and take overall responsibility for the completion and standards of the work produced. The assistant department head was there to assist the department head in the running of the department. The crew members were directly managed by the assistant department head, who was responsible for allocating and checking chores once they were completed. As a resident progressed through the programme they acquired positions that required more co-ordination and personal responsibility, reporting to staff about the running of their department, residents' behaviours and attitudes.

The notion of hierarchy was somewhat diluted in the TC under study. Rather than a peer work hierarchy (as the traditional model suggests) there was a loosely structured department system, which served to maintain the physical up-keep and daily operation of the service. No department was superior to another and residents were not allocated

jobs based on status or ability. For instance, the role of senior house manager required confidence, relatively good interpersonal and organisational skills and an ability to give direction. Those who lacked confidence, organisational and interpersonal skills would usually be given this position, with another peer to support them, as it was considered to provide a way in which new skills and personal resources could be developed. It would be the responsibility of all community members to support the senior house manager to fulfil their duties. This illustrates how a 'management' department was not about status, rank or superiority; it was a living-learning experience that was no better or advanced than any other job in any other department.

Phase Format

The plan of therapeutic and educational activities that take place in a TC is organised into a series of phases that reflect a developmental view of the change process (DeLeon, 2000). The Mother-ship has three programme stages: welcome house; primary; and senior. The welcome house stage lasted a minimum of four weeks and a maximum of eight weeks with the purpose of providing new residents with a less intense introduction to TC life. The primary stage lasted a minimum of ten weeks and a maximum of twenty weeks with the purpose of providing a safe and therapeutic setting for residents to begin the process of change and learn to care about themselves and others; and the senior stage lasted a minimum of eight weeks and maximum of twenty-two weeks. During this stage residents were expected to take on a leadership role and begin to deal with issues that faced them external to the service.

A resident's progress through the stages was, in theory, dependent on whether or not they had reached the prescribed measures and markers of achievement (see Appendix 10). Progress was reviewed every twelve weeks during a care plan review, which would

provide an opportunity for a resident, their key worker and care manager to discuss what measures and markers of achievement had been reached and what was required enable progression to the next stage.

Hierarchical TC Concepts

In a hierarchical TC there is a curriculum which is both formal and informal that focuses on teaching the TC perspective and view of right living. The concepts of right living and ‘act as if’ (behaving as the person you should be rather than have been) are integrated into groups, meetings, seminars, activities and written work. These activities are intended to heighten awareness of specific attitudes or behaviours and their impact on oneself and the social environment (DeLeon, 2000).

The Mother-ship utilised an array of concepts such as: responsible concern; honesty is the best policy; ‘act as if’; you only get out what you put in; you alone must do it but you can’t do it alone; trust in your environment; to understand rather than to be understood; and you can’t keep it unless you give it away, to promote the TC movement’s view of recovery and right living. The ‘act as if’ concept was incorporated into the phrase ‘act as if, think as if, feel as if, be,’ which was employed when residents were encouraged to behave as the person that they want to be, rather than the person that they have been.

“Acting as if isn’t about pretending to like someone or something, pretending to be someone or masking your true feelings. It isn’t about lying. It is about trying to feel and act, like the person that you want to be, not the person that you have been. The more you focus on being the person that you want to be, the less you focus on the person that you have been. Before you know it two weeks have gone by and the next you’re thinking and behaving like the person you have wanted to become. Change is a process that you have to go through, it doesn’t just happen overnight, it takes hard work and commitment.”

(Bert Flump, Staff, August, 2012)

The ‘act as if’ concept was difficult for residents to comprehend during the first few weeks of their programme. Many felt that it encouraged them to be false or conceal how they were feeling but, as they began to work through their personal problems and the dynamics that surfaced as a result of communal living they could relate to its meaning.

“I thought I had joined a cult when I first landed. It was mad, people asking how you are all the time. Where I’m from if someone asks how you are they are usually after something. I am still getting used to the act as if thing to be honest but I know that it helps you to start actually thinking about what you are saying and doing. In the past I would have just jumped into anything and everything straight away, but now I am thinking before I do or say anything which is a good thing. We are here to change our behaviour at the end of the day so little things like remembering to act as if can help along the way.”

(Mick, Resident, February, 2011)

When residents asked staff to explain the ‘act as if’ concept it became apparent that there was little insight into how and why this particular intervention helped to achieve ‘change’. It was suggested by staff that by encouraging a resident to ‘think before they act out’ they would eventually become the person that they want to be, rather than the person that they have been. This rather limited insight into how and why this concept was considered to be one of the most important interventions in the Mother-ship resulted in residents questioning the legitimacy of this particular programme component.

“It doesn’t make sense to me. They tell you to act as if but half of them don’t know what it even means. If they can’t explain it to me, why should I put my trust in it?”

(Bernie, Resident, January 2012)

This illustrates how a comprehensive framework is needed to not only identify what TC components are implemented on the ground, but why. Although it was not recognised by staff or residents, the ‘act as if’ concept (as well as other interventions that took place in the Mother-ship) provided an opportunity for residents to begin the process of cognitive transformation, which involves a change in one’s ability to focus reflectively on the self (Giordano *et al.*, 2002). Cognitive transformation is the process of how

people learn better cognitive skills to achieve a stronger understanding of what has been happening in their lives and what they can do about it in order to move forwards (Klein and Baxter, 2006). It is about learning to change the way we understand events, change the way we see the world and what counts as information in the first place.

The success of an individual's cognitive transformation will depend upon their ability to successfully shed outmoded beliefs and adopt new beliefs, just like the way in which a snake sheds its skin (Klein and Baxter, 2006). TC concepts, such as 'act as if', were an important component of the programme as they provided a way in which residents could begin the process of de-masking, leaving the 'old' self behind whilst simultaneously beginning to create a 'new' sense of self.

"It's proper hard to drop the mask, I couldn't do it out there. I needed to come to a TC to get away from the madness and be around likeminded people, people who actually give a fuck about me and what I want."

(Lee, Resident, November, 2011)

Peer Encounter Group, Awareness Training and Emotional Growth Training

The encounter group is the main therapeutic tool in a TC. The minimal objective of the encounter group is to heighten a resident's awareness of specific attitudes and behavioural patterns considered to be detrimental to the recovery process. All therapeutic and educational interventions that occur in a TC involve raising an individual's consciousness of the impact of their conduct/attitude, which is known as awareness training. Achieving the goals of personal growth and awareness training involves teaching an individual how to identify, express and manage feelings through the interpersonal and social demands of communal life, known as emotional growth training (DeLeon, 2000).

Group interactions such as those that take place in the encounter group were utilised to raise self-awareness, particularly with regard to a resident's ability to identify and communicate thoughts and feelings.

"I have to sit on me hands in them encounter groups. I get all animated when I'm tryna' get my point across. People say its intimidatin' coz of my size. I've learnt that I have to think about how I express myself so that I'm more approachable."

(Ruthless Toothless, Resident, March, 2011)

"I've got all these emotions coming back to me and sometimes I get overwhelmed. I don't know whether I want to cry or break someone's neck half the time. The encounter group is helping me to tell someone how I feel about something rather than dealing with it the way I used to, which was getting off me head or using me fists."

(The Bear, Resident, October, 2012)

"I used to hate them but I feel confident to talk in them now. If someone asks my opinion they will get it. Don't get me wrong they are horrible at first but they teach you so much. I am more confident now to say how I feel about something or challenge someone if I don't like how they spoke to me or the way they are behaving around the house. There's no way I'd have done that before I come in here."

(Shelley, Resident, April, 2012)

The overarching purpose of the encounter group is to develop a resident's emotional intelligence, which refers to the ability to perceive, control and evaluate emotions. Salovey and Mayer (1990) outline four different components of emotional intelligence: the perception of emotion; the ability to reason using emotions; the ability to understand emotion; and the ability to manage emotions. The importance of developing one's emotional intelligence has been recognised in the desistance literature, which suggests that such skills can help offenders to begin to take responsibility for their behaviour, develop internal controls and seek to change those aspects of their behaviour that are the most damaging to society and themselves (Giordano *et al.*, 2002; Farrall and Calverley, 2006; Knight, 2014).

Planned Duration of Stay and Continuity of Care

The length of time an individual must be involved in a programme depends on their phase of recovery, although a minimum period of intensive involvement is required to assure the internalization of TC principles and prescriptions. After-care services are also an essential aspect of the TC model; whether implemented within the boundary of the programme or separately, the perspective and approach guiding after-care programming must be continuous with that of the TC (DeLeon, 2000).

Although the Mother-ship is based on a six month programme, shorter or longer lengths of stay were considered depending on an individual's need and available funding. All residents were steered towards the re-entry service, which was the final stage of the programme. The fundamental aim of re-entry was to give residents a chance to ease back into the local community with the least possible trauma. The structure was less rigid than that of the main house and more emphasis was placed on the individual taking responsibility for their future. Group meetings, which focused on relapse prevention and life skills, took place once a week to give residents the opportunity to explore their own and each other's progress and ultimately receive feedback from peers and staff.

Rhetoric and Reality: A Tale of Two Halves

The preceding discussion suggests that a number of TC components have been diluted as they are transferred from theory into practice in the Mother-ship. The purpose of this part of the chapter is to build upon these findings by exploring the gaps, tensions and dilemmas surrounding the implementation of interventions couched in TC principles. To do so this part of the chapter has been divided into four sections: maintaining community separateness; peers as role models; a structured day; and planned duration of stay.

Maintaining Community Separateness

DeLeon (2000) suggests that TCs must maintain a social and psychological separateness from the environment in which they are located as it is essential to remove the substance user from the physical, social and psychological surroundings associated with substance use and previous lifestyle choices. A complete chemical and behavioural detoxification is deemed necessary as social, circumstantial and interpersonal pressures in the community could influence a resident's decision to desist from substance use.

The residential nature of the Mother-ship meant that residents were physically separated from the local community for the majority of their time. They were not allowed to have visits from family and friends during the first two weeks of admission to the service and visitors were only permitted to visit on a Saturday or Sunday between 1.30pm and 4.30pm. Residents were not allowed to leave the service during their detoxification programme and were only allowed contact with the local community if they had obtained a pass or were escorted to a health or criminal justice appointment. Residents felt that physical separation from the wider community gave them breathing space from the 'madness' as well as a chance to stop and think about their substance use and lifestyle choices. However, despite being physically separated from the geographical location that they belonged prior to admission to the service, the degree to which they were completely separated from the circumstantial and interpersonal issues that they faced prior to programme involvement was debatable.

“She booked my train ticket to Newcastle last night. She wants me home and said that I don't need six months in here. She is struggling to cope. I need to be there for the bairn. I know leaving is the worst mistake I will make but I got to go man.”

(Robbo, Resident, August, 2010)

“I need to know that my boys are alright. If anything happens to them I will walk. I'd have to, they have been through enough.”

(Shelley, Resident, February, 2012)

The above quotations illustrate how residents' social, circumstantial and interpersonal relationships, particularly with regard to family and friends, influenced their decision to remain programme involved, despite being physically separated from the local community.

The majority of the literature, which explores the role of family ties in desistance from crime and/or recovery from substance use suggests that families can support the change process by providing practical and emotional support, informal social controls, motivation to change and strengthen positive identities (Sampson and Laub, 1993; Laub *et al.*, 1998; Warr, 1998; Maruna, LeBel and Lainer, 2003; Moloney, McKenzie, Hunt and Joe-Laidler, 2009; Jardine, 2014), which is indicative of social capital, (Coleman, 1994; Webster *et al.*, 2006; McNeil and Whyte, 2007; Lyons and Lurigio, 2010). For a number of residents the family unit provided a source of encouragement and support.

“I'd be lost without my folks. They have never touched a drug, proper straight people. They visit me here every week but my mum's got to a point where she has said that if I don't get my shit together I can't come home so I know that this is the last chance saloon.”

(Jon, Resident, March, 2012).

To help residents develop and sustain positive family relationships, which subsequently increase the quality and quantity of social capital that they have to aid the recovery process a mutual support group called Families and Loved ones Accessing Mutual and Emotional Support (FLAMES) was held every month. The group was facilitated by the programme manager and apprentice in a ballroom, which was attached to the female cottage.

Residents were not allowed to attend FLAMES as it was an opportunity for families and loved ones to discuss how having a substance user in the family had affected them and access support from other family members in the group. The group was established as

staff and residents felt something was needed to help family members understand substance use and the work that took place in the setting under study. It was believed that although family members played a crucial support role in a resident's recovery, the lack of understanding that surrounded the change process caused conflict between family members.

It has been suggested that involving the family in a residents programme in a regulated and structured manner is necessary (Perfas, 2014) and in some instances this was the case. However, findings from fieldwork suggest that family relationships are more diverse and complex and in some instances can represent sources of negative social recovery capital.

“I can't remember a time in my life when I was drug free. When I was a kid I was hyperactive. My arl fella couldn't handle me so he put pot in my food to calm me down. Every time I am around him I always end up using something. He's my dad and I'll always love him but he is no good for me. I learnt that in here.”

(Lee, Resident, November, 2011)

“My mum still thinks that I am up to my old tricks. She keeps asking for money because she thinks I can just go out on the graft like I used to and come home with a few hundred pound in my pocket. I keep telling her I'm not doing that, but she isn't having any of it. She just can't get it into her head that I've changed and that's not me anymore. It's so hard coz I am really trying my best to keep my nose clean but when your family have always relied on you to bring home the money and then you're not its hard. It makes me feel proper down if I'm honest.”

(The Bear, Resident, October, 2012)

Multiple substance use amongst family members, family disharmony, parental break-up, bereavement issues, economic difficulties and negative feelings of family members towards substance using relatives are just some of the issues that were raised and discussed with residents during their time in the Mother-ship. For residents who felt that their family could potentially be detrimental to their recovery the physical separateness

provided them with an opportunity to (re)assess what kind of relationship they wanted with their family members and whether or not it was conducive to their endeavours.

The inability of residents to completely separate themselves from the community illustrates how the notion that a spell in residential care can eliminate an individual's social, circumstantial and interpersonal issues, as suggested by DeLeon (2000), which is not only simplistic, but fails to recognise that residential setting can actually heighten the array of social and circumstantial issues that an individual has due to the physical removal of a person from the community with limited access to resources enabling them to liaise with the outside world, such as mobile phones and the internet.

“Being in here is hard especially when you're miles away from home. I've got her ringing me up every day saying me little boy is playing up and she can't handle him. I feel terrible leaving her to pick up the pieces when I know I should be there to help her.”

(Rob, Resident, September, 2011)

The management team acknowledged that community separateness was a key component of a TC, however, it was recognised that complete community separateness would result in the service becoming isolated from the wider community. As a firm commitment to the traditional principles of community separateness could place the Mother-ship on the periphery of the local treatment system, the management team promoted joined-up working with services in the local community; introducing additional services to the programme such as professional counsellors and an advocacy service as well as referring residents to local recovery-orientated services. This was done in an attempt to reduce the likelihood of residents falling through gaps in the local service provision net after they had completed their programme.

Ultimately, the degree to which a resident was separated from the local community depended upon the number of outstanding issues that they had upon admission to the Mother-ship. Residents with ongoing criminal justice issues and/or serious medical conditions were more involved with the local community than residents who did not have such issues. The implementation of community separateness from theory into practice was a delicate balancing act, which involved giving residents physical distance from the community, whilst at the same time maintaining a degree of engagement enabling them to address personal issues. Although this pragmatic approach worked on some levels, there were a number of perceived limitations amongst staff, residents and external care managers, which will now be discussed.

On admission to the Mother-ship the administration team took control of a resident's financial affairs. All benefits were paid directly into a company account and residents were allocated a weekly allowance of either £11.00 or £22.50, depending on contributions to the service and ongoing deductions such as child maintenance and court fines. The residential nature of the programme meant that a resident's weekly allowance was only needed for tobacco and personal toiletries as everything else was provided by the service.

Residents had limited contact with the local community they were not expected to pay any substantive bills and had no tangible responsibility for their benefits yet they were expected to work on their money management skills whilst they were programme involved. On one hand this provided a way in which residents could learn how to budget small amounts of money, whereas on the other hand, it was considered to be a dated process, which limits autonomous functioning.

“For a lot of us money is a massive trigger. The minute there is a bit of money in our pocket we score drugs; fuck everything else, bills, food, the kids; if its pay day and we’ve got money we’re going to get what we need. So if you think about it, it makes sense not to have money in our pocket, especially when we’re detoxing and feeling rough because you’re more likely to get off to make yourself feel better. At first you think “how dare they take my money, its mine, I’m not a child” but if you stick with it you realise that it’s for your own good, you need to learn to walk before you can run. What do we need money for in here anyway? We get all our food and bills paid for. We’re in rehab for Christ sake.”

(Terri, Resident, October, 2011)

“I can’t work on my money issues in here on £11.00 a week. I’m not paying bills and I’m not thinking “I’ve got to put this much away each week for Christmas.” I’m concentrating on my recovery.”

(Neil, Resident, January, 2011)

As time in the programme progressed residents who were initially opposed to the financial system gradually realised that it could provide a way in which they were able to develop their money management skills, albeit on a much smaller scale. These skills and resources were considered vital components of the recovery process by staff and residents alike.

“When you’re in here you are able to fill your tool box with all the tools that you will need for life. Tools like assertiveness, confidence and self-worth that come from within; the things that a lot of us in here have never really had, or lost because of the drugs.”

(Donna, Ex-Resident, February, 2013)

Although interventions in the Mother-ship provided an opportunity for residents to develop the tools and resources that they felt they would need for life after programme completion; it could not, and indeed was unable to, separate residents from all external influences, pressures and strains. It was, however, able to provide a starting point, a safe environment in which old habits could be challenged and ‘new’ ways of dealing with life stressors and community living could be tried and tested.

Peers as Role Models

DeLeon (2000) suggests that role models are one of the principle vehicles of self-help and mutual aid in a TC. During the course of the research it became clear that residents who challenged their peers through the verbal pull-up system and encounter group were considered to be role models by the staff team.

“He’s brilliant isn’t he? He is positive, uses the tools of the house and just loves being here. We need more role models like him.”

(Peanut, Staff, April, 2011)

Residents perceptions of a role model were however somewhat different to the staff team’s perception of a role model.

“I need people who have been where I am to look up to. I feel inadequate otherwise. You may have a thousand tales to tell but you have none from straight society so sometimes you don’t know what to say to straight people. Just because you got clean that doesn’t change.”

(Jade, Resident, August, 2010)

“Role models play a big part in the first bit of your recovery. You all want to get off drugs. I’ve never been around people who wanted to get off drugs before.”

(Mark, Resident, November, 2012)

Residents who were considered to be role models were relied upon by the staff team to conduct tours and talks with visitors, feedback on dynamics between peers, facilitate groups and lead seminars. They assisted the staff team with the day-to-day operation of the programme and were frequently asked to sit with residents who were considered to be struggling because they were experiencing cravings; thinking about leaving and/or struggling to cope with their thoughts and feelings; and provide them with support and guidance. The expectations that were placed on residents who were considered to be role models had a number of adverse consequences.

“It helps to build your self-esteem and self-worth but it can get on top of you coz there’s added pressure. People are always coming to you and sometimes you get bogged down in their issues.”

(The Meercat, Resident, December, 2010)

“You can take too much on board when people ask for advice especially when no one is supporting you and you can’t off-load your pressures. It becomes easier to set yourself up as a target by people less motivated than you or just after earning brownie points.”

(Rocket Dog, Resident, December, 2010)

In addition to the adverse consequences that surfaced as a result of being considered as a role model, it was clear that the significance residents attributed to role models and the kudos that were attached to the status were relatively short lived and typically decreased as time in the programme increased.

“A couple of months ago I would have been thrilled that someone saw me as a role model, but I have realised that it’s just a status in a rehab. I didn’t come here to be looked up to. I came here to get my life straight. You’ve got to be a bit harsh because you’ve got to come first in your recovery.”

(Neil, Resident, June, 2011)

“I am sick of having to be nice to the welcome house and let them basically take the piss because they are new through the door. They are starting to get on my nerves moaning about doing department’s coz they’re detoxing. I just feel like saying to them “stop your moaning and crack on with it, if you don’t want to be here and get your shit together then you know where the door is.” We have to be nice to them just because the staff want them to feel welcomed. If we behaved like they do then we would be encountered and pulled-up left, right and centre. It’s not fair and you find yourself resenting the fact that you have to help these new residents when all they do is take liberties.”

(Rob, Resident, January, 2012)

“Yeah I guess I am classed as a role model in here but that doesn’t mean that I am going to kill myself to be there for all these new people through the door and tread on egg shells. I am a role model because I’ve looked after number one and got stuck into the programme, for me, not because I wanted to be a role model. I couldn’t give a fuck about all these in here. It’s not like I am going to be the best of friends with them when I leave so I’m not gonna kill myself to support every Tom, Dick and Harry that walks through that door am I, especially when half of them are only here for clean time. It’s great being seen as a role model but at the end of the day I have to come first.”

(Paul, Resident, July, 2011)

By the time residents reached the senior stage the time and energy that they once gave to the programme and fellow peers was transferred and invested in the commitments that they had established in the local community. Residents who were considered to be

emotionally and physically disengaging with the programme were described as having their ‘head out the door,’ which meant that being a role model for newer residents was not considered to be a priority. In addition to this, it also became apparent that as residents progressed through the stages a clear lack of empathy developed towards those who were new to the programme. Welcome house residents felt that those further on in the programme had ‘forgotten where they had come from,’ which led to a feeling of resentment towards residents who were further on in the programme.

A Structured Day

The Mother-ship had a rolling time-table, which provided residents and staff with a daily guide of Monday to Sunday from 7am to 11pm. Welcome house residents and main house residents had separate time-tables. Both of these outlined the time a resident was expected to get up and go to bed, the time of community meetings, department checks, group therapy sessions and community activities took place, as well as set meal times. The time-table provided residents and staff with a daily guide but was subject to change. It was modified if it was felt that there were dynamics amongst the residents that needed addressing, there was a limited number of staff on shift, there was a new admission, a discharge and so on. Any adaptation to the daily structure of the programme was made during the morning staff handover. If any modifications were made, the senior house manager was informed and tasked with the responsibility of informing all the residents via the structure board. The daily structure that was in place in the Mother-ship was something that residents claimed to struggle with when they first entered the programme.

“You try riding a bike for 24 hours and see how you feel, you’d be fucked. I have never had structure in my life, even in jail. I just did what I wanted, when I wanted so this is hard for me.”

(Kenny, Resident, December, 2012)

“The structure is hard to get used to when you first come here, but you get used to it. It’s important because it helps to put order back into your life. You need to make sure you have a routine; you’re getting up every morning and you’re busy. Otherwise your mind starts wandering onto other things. I think a lot of it is because we’ve led such chaotic lives that were not used to normality. So when normality comes you’re like fucking hell this is boring.”

(Marie, Resident, January, 2012)

DeLeon (2000) suggests that TCs are highly structured environments. Although the Mother-ship had a daily time-table in place it became apparent that the programme was flexible and responsive to the needs and demands of the peer community. This responsiveness was considered vital by residents and staff but did create a number of problems with regard to the day-to-day operation of the programme.

“The most frustrating thing about working here is that we are responsive and not proactive. We’re like the fire brigade. A lot of our time is diverted by running round putting fires out, coping and just managing to get the job done. I think we need to know exactly what we are doing and we have enough staff to do it. It should be more structured and I know we have a day structure but that is very fluid and that is dependent on members of staff really.”

(Oliver, Staff; August 2011)

The responsive nature of the programme meant that there was a lot of contradiction and misinterpretation.

“A staff member will tell you one thing one day, then something completely contradictory the next. It really tests your patience. Have you heard about the radio saga in the kitchen? Well we got told by ... that ... said we couldn’t have the radio on in the kitchen for health and safety reasons, now the radio has been there for months so we asked [*a staff member*] if she had said it and she said that she hadn’t. Then a few days later we asked another staff member if it was OK to have the radio on because we got told it wasn’t and he didn’t know what we were talking about, considering he is in charge of health and safety I thought he would know about radio gate but he never. It sounds petty but it gets on your nerves when it is happening all of the time and it’s ongoing day after day after day.”

(Ed, Resident, October, 2011)

“I honestly feel like this lot couldn’t organise a piss up in a brewery sometimes. When they get it right its spot on, but sometimes you get told that many different things you just switch off and let everything go over your head.”

(Bri, Resident, September, 2010)

There was also a lack of consistency with regard to the overall structure of the programme. The core day operated Monday to Friday between 9am and 8pm and staff members worked to a rota which consisted of A shifts and B shifts. Staff on an A shift would work between 9am and 5pm whilst those on a B shift would work between 12pm and 8pm. Between Monday and Friday there were at least two therapeutic workers, a day care team worker, programme manager and/or residential manager, as well as a number of students and volunteers working an A shift and one staff member would work a B shift. The night worker would be on duty between the hours of 5pm and 9.30am the following morning.

The fluctuations in staff presence meant that the programme was much more relaxed during evenings and weekends. This meant that residents were less engaged in therapeutic activities due to a smaller number of staff to implement a structure similar to that of a weekday. Reduced staff numbers, besides a loosening of the daily structure, provided residents with a window of opportunity to violate the cardinal rules, norms and values of the TC.

“I always get in trouble of a weekend. I hate them, there’s nothing to do and I have to watch everyone with their families when I can’t see mine, so I act up to get noticed.”

(Kat, Resident, September, 2012)

Although the notion of a structured day had been diluted in an attempt to provide a more responsive environment that catered for the needs and demands of the residents, it inadvertently meant that the programme lacked consistency. This point re-iterates previous findings that suggest a more coherent and comprehensive way in which to understand the intricate workings that take place in a TC is needed.

Planned Duration of Stay and Continuity of Care

The majority of local authorities would fund residents for the full six month programme and this would be agreed prior to a resident's admission to the service. There were, however, a number of local authorities who would only provide funding in four, eight and twelve week blocks due to austerity measures and funding restraints. This meant that key workers would have to re-apply for funding whilst the resident was programme involved. If further funding was obtained the resident would complete the six month programme; if not they would remain programme involved until their funding expired. If their bed had not been booked out to another admission the residential manager would usually allow the resident to stay until their bed space was needed. This illustrates how the amount of time that a resident was programme involved depended on funding rather than theoretical principles and individual need.

"I'm so lucky to have the funding in place that I need. Some of them don't know if they will be here next week."

(Hopper, Resident, July, 2011)

"I haven't even scratched the surface yet and my funding runs out next week. I am petrified about leaving here."

(Cheryl, Resident, May, 2011)

The Mother-ship steered its residents towards the re-entry stage of the programme, which also required local authority funding. As a result, a resident's ability to access the final and arguably, most crucial part of the programme was also dependent on funding availability.

"I am so frustrated. Lee's funders don't fund re-entry so I discussed the price variation with them, you know turn two weeks of main house funding into three months of re-entry funding so he can have the chance to do re-entry and they have refused, said he needs to complete the 24 weeks here for their books."

(Maria, Staff, April, 2012)

There were a number of occasions where the re-entry house was low on client numbers. In an attempt to fill bed spaces residents in the Mother-ship, who were due to complete the programme but could not obtain re-entry funding, were allowed to go to re-entry as a supported housing client. This meant that they were able to reside in the re-entry service as long as they provided a small contribution from their housing benefit. As a result they were able to attend group sessions and have regular one-to-one key work sessions.

Although it was positive to see the service make attempts to widen participation in the TC and re-entry part of the programme, even when local authority funding was not in place, it was obviously driven by financial gain rather than theoretical reasoning and individual need, as it was more economical to have some money coming into the service than none at all. It also became apparent that the continuity of care that the Mother-ship could provide when residents completed the programme was solely dependent on whether or not they were going to locate to the local area and engage with the organisation's recovery model, which consisted of a TC, re-entry service, four supported housing projects and a floating support service.

Residents who completed the TC were steered towards the re-entry stage of the programme. Once a resident had completed this stage they could move into a supported housing project, where they could reside for up to two years and receive weekly support from a key worker. Supported housing residents were not necessarily expected to have completed the TC as referrals were taken from other community projects and prison establishments. Floating support services were available for those who felt that they needed extra support once they had left supported housing and moved into their own accommodation. The recovery model could provide up to five years of support for

individuals who intended to reside in the local area. However, this level of support, or social capital, was not available for those who resided in a different geographical location.

“I’ve realised that this place is brilliant if you live around here but I am going back to Leeds. They know nothing about what is available there so it’s all up to me to sort as soon as I leave here. I feel like going home now so I can start setting everything up that I need to because I am so frustrated about it all.”

(Stevie G, Resident, May, 2012)

Throughout the duration of fieldwork, as localised service provision became more prominent, it became increasingly obvious that such initiatives were doing little more than contribute to existing differential opportunities amongst communities and social inequality that these already vulnerable people were facing on a day-to-day basis.

Conclusion

This chapter has examined how the Mother-ship operates on a theoretical and practical level. It has explored how components of the traditional TC model were put into practice illustrating some of the gaps, tensions and dilemmas which surface as a model based on first generation long term residential TCs was translated into a contemporary six month programme.

The traditional principles and prescriptions, which surround the TC model were somewhat diluted in the Mother-ship. The programme was flexibly structured, the utilisation and importance of role models varied and continuity of care was directed by available funding rather than theoretical rational or individual need. Staff members claimed that the modifications and adaptations that took place were crucial as they provided a way in which the programme was able to remain current and keep up to date with on-going changes in the sector. Diluting traditional TC principles and prescriptions was not considered to be an issue; the inconsistencies, misinterpretation and confusion

that surfaced as a result was, however, a cause for concern amongst staff and residents alike. This re-iterates earlier findings, which suggest that there is an implementation gap between TC principles and TC practices (see Chapter Two).

The lack of clarity surrounding the design and delivery of interventions couched in TC principles meant that staff and residents in the Mother-ship had to find a way in which they could understand and communicate how the programme worked. The terms ‘resources’ and ‘tools’ were utilised by staff and residents to explain the purpose of a TC and how programme involvement contributed to one’s ability to recover from substance use.

“Being in here helps you identify what resources you need to manage out there without drugs. Once you understand what you need, you have to be prepared to do whatever it takes to change and get what you need out of the programme. You need to be able to sit with yourself when you leave here and not feel that you have to block life out or suppress things that you have not dealt with over the years. Let’s have it right, that’s what most of us in here have been doing, no one wants to end up like this; it’s a means to an end.”

(Louise, Resident, September, 2012)

This point re-iterates how an empirically informed framework would help to explain how a TC operates at the coal face of service delivery. A framework, which recognises that recovery is not just about the removal of substance use from a person’s life; it is about providing an opportunity for individuals to build themselves up through the accumulation of resources and tools to give them the confidence of being able to manage life without substances.

Although staff and residents were able to identify what tools and resources the Mother-ship could help individuals to develop and why they were considered to be an important component of the recovery process, there was no comprehensive or coherent theoretical rationale to support these claims.

It is therefore possible to suggest that recovery capital may not only provide a theoretically informed way in which the workings of a TC can be better understood, but an opportunity for the TC movement to engage with broader discussion surrounding the desistance of substance-dependent offenders. In particular the strengths-based approaches that seek to promote 'good lives' as defined by the person him or herself (Burnett and Maruna, 2006; Ward and Maruna, 2007), which can be achieved through the accumulation of resources such as attachments, roles and life situations that are associated with successful social engagement (Farrall, 2004; Ward and Brown, 2004).

Recovery capital may not only provide a better way to understand the work that takes place in a TC, but go some way in bringing the programme into wider discussions about recovery from substance use, desistance from crime and spoilt identities. These assertions deserve further attention and will be discussed in detail in forthcoming chapters. The next chapter will build upon the findings that were presented in the latter part of this chapter paying particular attention to the impact of funding and localised service provision on the day-to-day workings that take place in the Mother-ship.

Chapter Six

A Change in the Tide: Payment by Results in Practice

Introduction

Fieldwork for this study was conducted during a time of great uncertainty as the Coalition Government planned to reorganise the delivery, management and commissioning of alcohol and drug treatment in England and Wales (Her Majesty's Government, 2010b). It was a time that was characterised by great debate, on a social and political level, as services were increasingly marketized and coming to terms with the ethos and often conflicting values of an outcome-based initiative called Payment by Results, colloquially known as PbR.

PbR is a way of commissioning services that offer a financial reward for the achievement of pre-arranged outcomes. It is a key accountability mechanism for the government, which underpins the localism agenda and moves towards greater diversity in the public sector (Mulgan, Reeder, Aylott and Bo'sher, 2010). The primary aim of PbR is to make service providers more accountable for the extent to which they bring about successful outcomes. This means that the Government will only be committed to pay for services that can produce evidenced results (Mulgan *et al.*, 2010).

In addition to PbR the Government outlined plans to re-organise the delivery and management of alcohol and drug treatment services. Under the Health and Social Care Act 2012 local authorities are now responsible for improving the health of their population (Local Government Association, 2011). This meant that the responsibility for public health transferred from the National Health Service (NHS) to local authorities. By April 2013 each local authority had a Health and Well-being Board,

which had strategic influence over commissioning decisions across social care and public health. Statutory board members include a locally elected councillor, a health-watch representative, a representative of a clinical commissioning group, a director of adult social care, a director of children's services and a director of public health. Board members are expected to work together to identify local needs, improve the health and well-being of their local population and reduce health inequalities (Local Government Association, 2011). As part of the re-organisation the National Treatment Agency for Substance Misuse (NTA)³⁹ moved into Public Health England (PHE), which was established to protect and improve the nation's health and well-being and reduce inequalities (National Treatment Agency for Substance Misuse, 2014).

The purpose of this chapter is to locate the Mother-ship within the wider socio-economic landscape and explore whether changes to the sector had an impact on the TC under study. The first part of the chapter explores the broader social and political context within which the programme is located. Part two explores how high-level policy directives, such as PbR, were translated into practice; and part three explores how effectiveness was defined and measured by those at the coal face of service delivery.

A Change in the Tide: Gold Standard or Fools Gold?

The 2010 Drug Strategy *Reducing demand, Restricting supply, Building recovery: Supporting people to live a drug free life* outlines the Coalition Government's approach to tackling substance use in the United Kingdom over the next four years (Her Majesty's Government, 2010b). The Strategy calls for more responsibility to be put on the individual, places more power and accountability into the hands of local communities and advocates whole person approaches to substance use in which an

individual's level of recovery capital is recognised as one of the best predictors of sustained recovery (Her Majesty's Government, 2010b).

To achieve the aims and objectives of the Strategy, the Government outlined plans to reform the way in which programmes that cater for substance users were paid for their services. Prior to the 2010 Strategy, service providers were paid according to the number of clients who engaged with the programme, which created few incentives to support individuals to improve their personal circumstances (Maynard, Street and Hunter, 2011; Roberts and Singleton, 2011). Since the introduction of the Strategy outcome-based payment initiatives, which reward service providers who discharge clients' substance free, have been piloted across England to explore whether interventions that work alongside substance users could be incentivised to support service users into full recovery (Her Majesty's Government, 2010b).

PbR was first introduced to the United Kingdom in 2000 by the Labour Government's NHS plan, which set out to link the allocation of funds to the activities that hospitals undertook (Battye and Sunderland, 2011). This marked a departure from previous funding arrangements in which hospitals were paid according to block contracts, which involved a fixed payment for a broadly specified service (Battye and Sunderland, 2011).

Generally speaking PbR was designed to pay providers on the basis of the outcomes that they achieved rather than the activities undertaken. The fundamental aim of PbR was to improve service quality by offering bonuses to service providers for performance improvement or withholding payments for poor performance, improve transparency around spending by putting a tariff on service user needs and ease pressure on public

spending budgets by staggering payments over longer periods of time (National Council for Voluntary Organisations, 2013).

The 2010 Drug Strategy outlined plans to introduce PbR to the alcohol and drug treatment sector. Pilot schemes were designed to test the assumption that commissioning service providers on an outcome-focused basis would lead to improved efficiency as well as a transparent funding system based on the achievement of high level, long-term and interim outcomes (Department of Health, 2012a).

In April 2011, after a bidding process that involved several Drug and Alcohol Action Teams (DAATs) across England, the Department of Health announced that eight areas had been selected to pilot PbR over a two year period: Bracknell Forest; Enfield; Kent; Lincolnshire; Oxfordshire; Stockport; Wakefield; and Wigan. The PbR pilot scheme aimed to aggregate existing funding streams and align overlapping services to increase available funds for providers (Department of Health, 2012a).

Although a generic PbR model was designed, each pilot area went on to adapt and modify the proposed model, which allowed for considerable local discretion. This meant that each model reflected the needs of the population engaged with services in the local area, the maturity of the local system of support and the different speeds at which each area was expected to achieve full implementation (Department of Health, 2012b).

In an attempt to create a degree of consistency across the eight pilot areas a co-design group, which consisted of representatives from local partnerships in the pilot areas, central government departments such as the Department of Health, the Home Office, Ministry of Justice, Department for Work and Pensions and the NTA, as well as experts

from the field, established a set of high-level outcome measures that spread across four domains. The four domains were: free from drug(s) of dependence; employment; offending; and health and well-being. The domain which covered employment was later removed before the PbR pilot scheme went live in April 2012 (Department of Health, 2012a).

In May 2013 a national service providers' summit was held in London to bring together representatives from the eight pilot areas to discuss their experiences of PbR over the first 12 months. The purpose of the summit was not to revisit the general arguments about PbR but to focus on implementation issues. There was a general consensus amongst service representatives that PbR had been introduced too rapidly and as a result there was still a need to explain the initiative to the workforce and provide support for staff on how it worked and what it meant for their day-to-day work. It was also recognised that PbR placed significant burdens on service providers, commissioners and service users; and data requirements to demonstrate outcomes and confirm payments were more onerous in pilot areas (DrugScope, 2013).

Although the Coalition Government anticipates that the PbR pilot scheme will provide lessons that will help to set the future direction of commissioning for all service providers (Battye and Sunderland, 2011), the introduction of outcome-based initiatives to the alcohol and drug treatment system has been subject to debate and controversy. Those in favour suggest that outcome-based initiatives improve the quality of service provision and create a sense of freedom so that services can focus on outcomes rather than methods (National Council for Voluntary Organisations, 2013). Whereas those in opposition suggest that PbR does not reward providers for supporting people to achieve what they need to achieve as it rewards the production of data that pay particular

attention to the attainment of nationally defined outcomes (Lowe, 2013). It has also been suggested that outcome-based initiatives are punitive as they force providers to shoulder the financial burden of service delivery (Maynard *et al.*, 2011).

Payment by Results: Practice makes Perfect?

Prior to admission to the Mother-ship potential residents were required to complete pre-admission paper work with a member of staff. This included a Circumstance, Motivation, Readiness and Suitability (CMRS) questionnaire, an Outcomes Star questionnaire and a Fast Alcohol Screening Test (FAST) questionnaire. If applicable, a copy of previous convictions was requested before a decision about whether to accept the individual was made.⁴⁰ If offered a place in the Mother-ship pre-admission paper work would feed into a Risk Assessment and Management Plan (RAMP) which, contributed to the construction of a resident's care plan and consisted of a series of short and long term goals that were linked to each ladder of the Outcomes Star (see Appendix 11).

The CMRS questionnaire was a self-administered document that consisted of four scales that explored an individual's circumstances, motivation, readiness and suitability for participation in a TC. The circumstance scale covered external conditions that could potentially influence programme involvement. The motivation scale addressed a prospective resident's reason for change. The readiness scale covered perceived need for help and support, while the suitability scale explored the prospective resident's perception of a TC. The questionnaire consisted of eighteen questions with each response constructed around a five point Likert scale, which ranged from strongly agree to strongly disagree. Respondents were entered into a CMRS database and a CMRS score, from very high to very low, was produced.

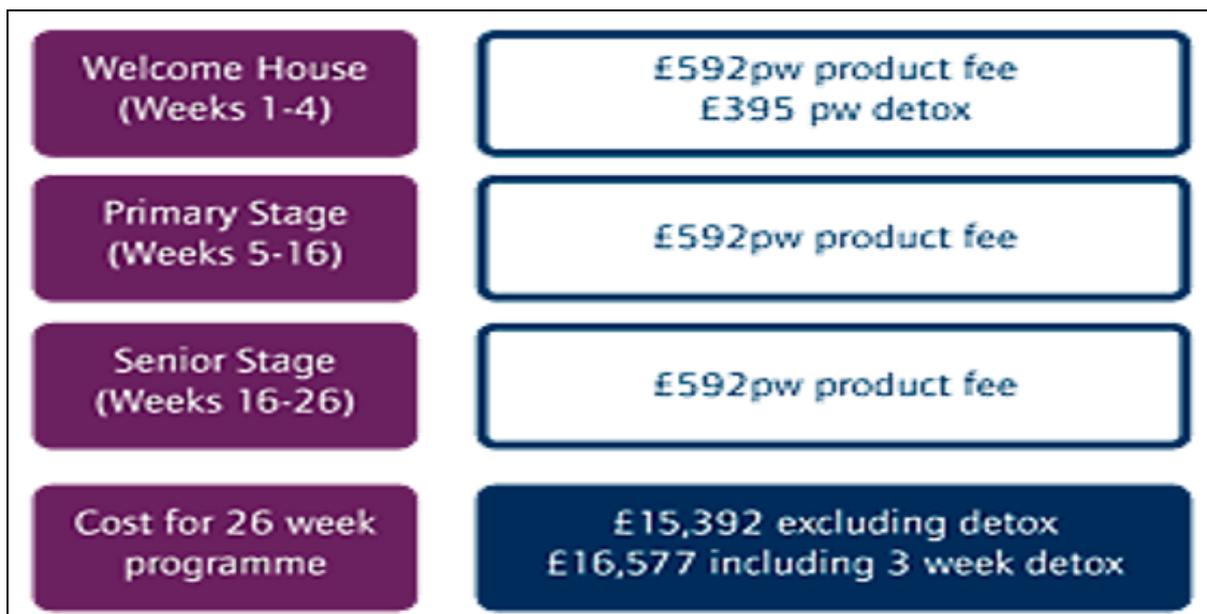
The Outcomes Star questionnaire explored aspects of a prospective resident's life such as physical, emotional and mental health, overdose and self-harm, alcohol related risks, offending behaviour, childcare and individual circumstances such as homelessness, financial circumstances, experience of domestic violence, eating disorders, social isolation, learning disabilities and literacy problems. This was utilised in initial key work sessions to help key workers set short and long term goals with their key client, address areas of need and identify any increase in recovery capital such as increased self-esteem and the ability to exercise more control over impulsive behaviour. The FAST questionnaire was a four item initial screening test that collated information surrounding an individual's alcohol consumption.

Prospective residents were required to submit a copy of their previous convictions for insurance purposes as the service was unable to accept anyone with an arson conviction due to insurance premiums. Individuals with a schedule one offence, which is an offence committed against a child, and/or a conviction of rape and/or sexual assault were accepted as long as they agreed to not discuss previous offending behaviour in groups. Prior to admission the admissions officer liaised with a prospective resident's care manager to ensure that a Confirmation of Funding (CoF) form was obtained. The CoF was a contract between the organisation and a prospective resident's local authority, which provided contact details, invoice details, total cost of the programme and the agreed period of funding.

Throughout the duration of fieldwork the flat fee was £592 per week. If an integrated detoxification programme was required there was an additional charge of £395 per week, which took the total weekly cost to £987. The cost of a 26 week programme was £15,392 without an integrated detoxification programme and £16,577 with a three week

integrated detoxification programme. The flat fee was consistent across all residential TCs operated by the organisation except for a residential service in Yorkshire that provided residential care for pregnant women and women with young children who used substances.

Figure 1: Weekly Flat Fee



From the 1st April, 2011 to the 30th September, 2011 the organisation piloted a PbR scheme, which was available to all new admissions to residential TCs across England. As it was based on voluntary participation care managers were not obliged to participate and could remain on the flat fee payment option.

The organisation's PbR model required a care manager to pay a weekly product fee and a results payment. The product fee was the amount that the service charged for each programme stage. In the welcome house stage 10% of the total fee paid to the service was based on outcomes, in the primary stage 20% of the total fee was based on outcomes while in the senior stage 30% of the total fee was based on outcomes. A

product fee and a results payment were attached to the completion of each programme stage (see Figure 2).

Figure 2: The PbR Model

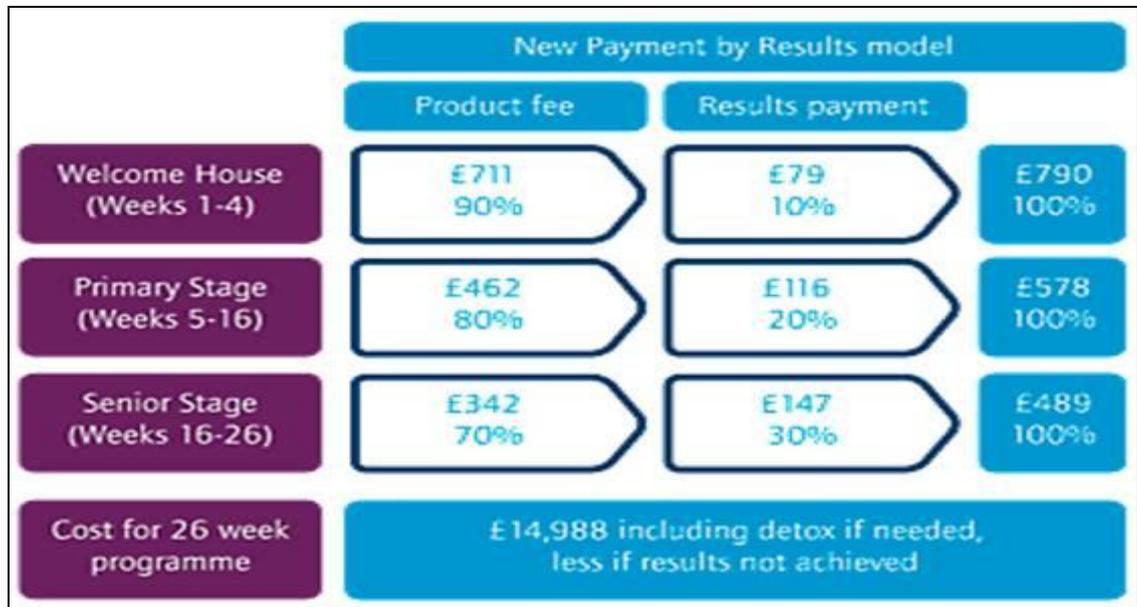
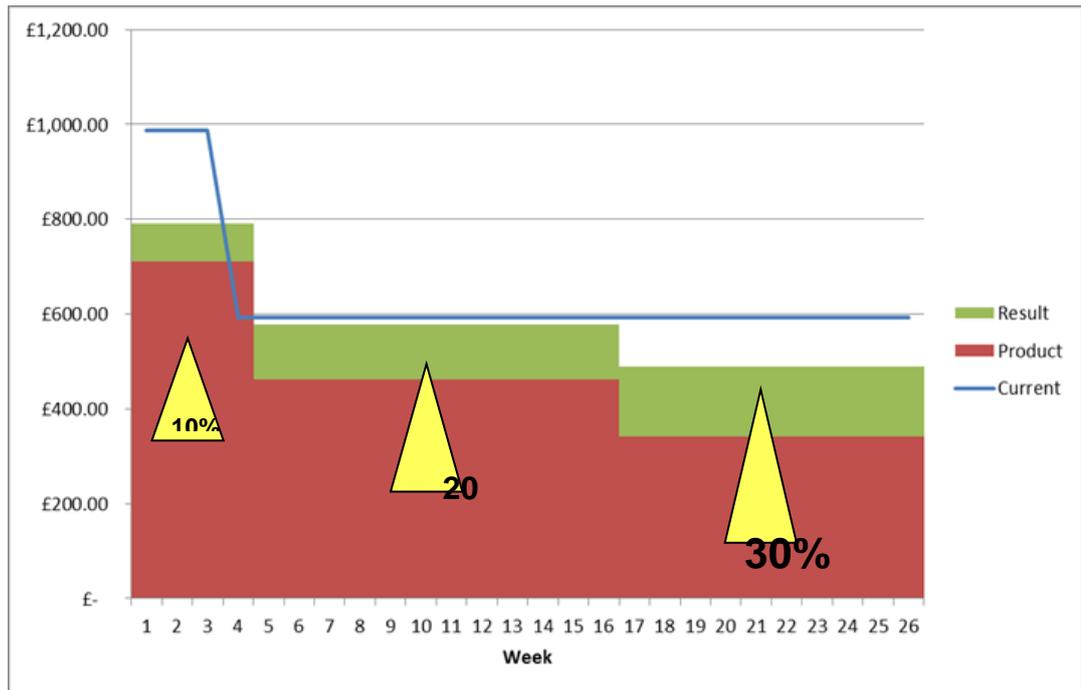


Figure three was used to illustrate how PbR was a cheaper payment alternative when a resident completed the full programme.

Figure 3



The blue line shows the price of the welcome house, primary and senior stage with the flat fee payment option. The red proportion of the graph represents the product fee attached to each of the programme stages. The green proportion of the graph represents the results payment attached to each of the stages and the yellow triangles show the percentage of the total fee that is results based. The organisation claimed that the results payment structure reflected two things: the higher the risk the organisation takes at the beginning of a resident's programme; and the more intensive support received during the welcome house stage.

Residents who were funded by PbR were expected to progress through the stages according to a series of milestone dates that were negotiated prior to their admission to the service (see example 1 and 2 below).

Example 1: Pre-arranged milestone dates

Programme Stage	From	To	Total Weeks
Welcome House	01.08.2011	29.08.2011	4
Primary	30.08.2011	22.11.2011	12
Senior	23.11.2011	01.02.2011	10

Example 2: Pre-arranged milestone dates

Programme Stage	From	To	Total Weeks
Welcome House	17.05.2011	14.06.2011	4
Primary	15.06.2011	04.10.2011	16
Senior	05.10.2011	15.11.2011	6

As a product fee and a results payment were attached to the completion of each programme stage, the admissions worker and care manager would establish specific dates in which a resident was expected to complete each phase by. This agreement was then included on the CoF form. The negotiation of programme progression prior an individual's admission, illustrates how outcome-based incentives such as PbR, are directed by financial gain rather than individual need.

Residents were set a number of specific targets by their key worker that they were expected to achieve during each programme stage. During the welcome house stage residents were expected to have finished their detox, if applicable, completed an initial Treatment Outcome Profile (TOP) form and initial Outcomes Star. During the primary stage residents were expected to have completed an Outcomes Star review at week 16 and achieved a positive direction of travel in at least two ladders of the Outcomes Star. Prior to completion of the senior stage residents were expected to have completed a

final Outcomes Star review at week 26 and positive direction of travel in at least two further ladders from the review Outcomes Star should have been achieved.

The targets attached to each programme stage were the same for flat fee and PbR residents. The only difference was the stringent deadlines given to PbR residents and therapeutic workers within which their targets had to be reached. This was because the service would not receive the results payment if a care manager did not receive a progress report detailing the resident's achievement of the agreed stage-specific targets prior to the pre-arranged milestone date.

The introduction of a high-level policy directive, characterised by fixed deadlines and absolute measures within a setting based on humanistic principles and incremental processes, created an array of adverse consequences. This was primarily due to the contrasting philosophies of PbR and the TC: one based upon standardised measures; and the other based on holistic person-centred approaches. As staff members, particularly therapeutic workers had to balance the needs and demands of their key clients as well as PbR it was felt that PbR contributed little more than a financial dimension to their work load.

“All this has done is add a financial dimension to my work. Not only do I have to think about my client's needs but now I have to think about the financial implications of what I do. If I fail to have paperwork completed and sent by a certain date then we lose out. What happens if I'm off sick or on annual leave? Is it my fault if a report is due in but I wasn't here to do it and we end up losing money?”

(Ringo, Staff, July, 2011)

PbR not only added an oppressive, financial dimension to a therapeutic worker's day-to-day duties, but held the ability to divert attention away from a resident as a human being towards bureaucratic processes, which undermine rather than facilitate genuine individual progression.

“Think about it because PbR is linked to the Outcomes Star it isn’t hard to show that a ressie has improved. Their physical health improves because they aren’t using, they’re eating three meals a day and seeing the doctor every week. They’re not offending because they’re off the streets and stuck in here for six months. Showing that someone has progressed on paper isn’t hard when you think about it so that bit of PbR won’t be the problem, it’s the deadlines. It’s going to be so hard, especially in here because you just never know what’s around the corner.”

(Ringo, Staff, July, 2011)

This re-iterates how financially orientated incentives do not reward service providers for supporting people to achieve what they need to achieve, as the focus of the initiative is on the production of data that demonstrates the achievement of nationally defined outcomes (Lowe, 2013). Thus reinforcing rather than breaking away from the status quo, which surrounds the anticipated outcomes of alcohol and drug treatment.

Incentives such as PbR dehumanise rather than humanise residents as the individual is removed from the epicentre of their programme and replaced by a series of bureaucratic processes such as milestone dates and result payments. The phase move process will now be discussed to illustrate this point.

A phase move was the term commonly used by residents and staff when a resident requested to move to the next programme stage. If a resident requested a phase move the staff team who attended the clinical meeting would discuss whether or not the stages’ measures and markers of achievement had been met. There were a set of guidelines that illustrated the minimum and maximum duration of stay in each stage, which were frequently adapted depending on a resident’s needs, behaviour, progression and available funding. The flexible nature of the guidelines meant that residents would typically memo to request progression onto the next stage of the programme when they themselves felt ready.

This flexibility was, however, somewhat constrained by the financial demands of PbR. Residents who were funded by PbR were given fixed deadlines, which specified when they were expected to move through the stages. Key workers would prompt their PbR clients to memo for a phase move a week before the mile-stone date had arrived and at the next clinical meeting would insist that these residents were moved into the next stage to enable the results payment to be obtained. This illustrates how phase moves, which were in theory a representation of individual progression, were led by a financially-orientated process rather than individual progress.

“We will have to move him up to primary and just tell the community that he is on a probation period. He has to move up today guys.”

(Peanut, Staff, July, 2011)

The financial incentives that were attached to PbR not only transformed individual progression into a financially-driven process but had an impact on the perceived legitimacy of the staff team’s decisions, especially when it came to phase moves.

“I just don’t understand how he has got into seniors. There are people in here who are just through the door who are better role models than him and they’re only in welcome house. It’s a fucking joke.”

(Sim, Resident, September, 2011)

“She is still walking around holding that bottle of juice. It reminds her of her bottle of cider when she was out there. It’s her comfort blanket and she has got to seniors. She’s no senior, she’s a walking relapse.”

(Terry, Resident, May, 2011)

It became apparent that the lack of legitimacy, which surrounded the staff teams’ decision to move residents through the programme had an adverse impact on how the peer community viewed the programme.

“At the end of the day everything comes down to money. From the minute you come through that door to the minute you leave that’s all people think about; money. I know this place has got to make money, but we’re people, and chaotic people at that, half of us don’t even know what you’re on about when you’re talking about funding! All I know is that it plays a big part in the decisions made here. You see it all the time.”

(Sam, Resident, August, 2011)

Residents and staff were aware that funding pressures and austerity measures had an impact on some of the decisions that were made in the Mother-ship, however, there was a varied level of awareness, interest in and understanding of PbR and how it was implemented.

“Oh yeah [*name removed*] mentioned something about that to me in key work but it just went in one ear and out the other. To tell you the truth I’m not assed about all that. That’s something for that lot in the ivory tower to worry about.”
(Craig, Resident, June, 2011)

“It doesn’t affect me and my job so I don’t know much about it to be honest.”
(Eddie, Staff, April, 2011)

“Basically we get paid if someone completes. I’ve not had much to do with it. I think it could be a good thing but I think it will put a lot of pressure on the staff team. It’s not easy to work with people and it’s not easy to say in three months he is going to be cured as it depends on what happens during their programme really.”
(Maria, Staff, April, 2011)

“I’ve heard the word but I don’t really know much about it. I think people have to reach certain targets and when they do they get some kind of retaining money where a referrer pays a service X amount of money. It’s all dependent on that person getting through the programme which is purely financially driven. We could fall down massively because it could take away the integrity of the programme because residents may be kept regardless of their progress and commitment to change because we need them for the money and this will have an impact on other people and how they see it here.”
(Bert Flump, Staff, August 2011)

For those who were aware of PbR there was a mixed bag of interest surrounding the applicability of the incentive.

“He is having a detrimental effect on the community. It’s not right for him here, he is a danger to himself and the community but you know what it’s about don’t ya, money. They just want heads on beds kid, heads on fuckin beds.”
(Ringo, Staff, July, 2011)

“I like it, it’s more structured and you know exactly when you need to have reports in and when clients have to have moved into the next stage.”
(Trio, Staff, June, 2011)

“We are the absolute last line. Everything that everybody else doesn’t want to work with we do. I think all PbR does it give a funder, with an eye on the bank balance, a reason not to pay. I think it lessens the value of what we do if you are getting paid by results. How do you quantify success here?”

(Oliver, Staff, August, 2011)

The varied level of awareness and general reluctance to invest in PbR extended beyond the staff team and residents in the Mother-ship as the scheme failed to attract much take-up during the six month trial period. Nine care managers agreed to provide funding based on the PbR model: six residents in the Mother-ship; two in a service in the south; and one in the North-east. Out of the 9 residents who were funded according to PbR, one completed the programme, two were discharged without completing the programme and one was transferred to another service. The remaining five were still programme involved when the pilot scheme drew to a close.

There was the general lack of appetite from care managers to participate in the scheme as local authorities were content with the way in which funding was obtained and allocated. As the Mother-ship had a number of block contracts with several local authorities the majority of referrers were not able to participate in the scheme. In addition to this, as most local authorities had split funding streams, a stream for detoxification programmes and a stream for residential services, it would have cost authorities more to place individuals in the Mother-ship under the PbR scheme. This was due to the fact that, unlike the flat fee model, the PbR scheme had no separate costing for the detoxification programme. Although the organisation claimed that PbR provided value for money, in practice the scheme could incur higher financial implications for local authorities than the flat fee payment option.

Two further limitations of the PbR scheme emerged during fieldwork. The first was the prioritisation of financial gain over therapeutic integrity; and the second was the theoretical and practical tensions between the aims and objectives of PbR and the TC. Political drives towards defining and demonstrating a polished end product as a result of programme participation provides a stark contrast to the realities of recovery from substance use and indeed the work that takes place in the Mother-ship, which recognises that recovery is an ongoing journey of improvements rather than an accomplished state that can be achieved during a six month stay in a residential service (McLellan, 2010; Best and Lubman, 2012).

Consensus and Conflict: What is Effectiveness?

The introduction of PbR to the Mother-ship brought into sharp focus the notion of effectiveness, which contributed to the discussion about what are considered to be valid, reliable and useful measures of performance and impact.

Defining and measuring effectiveness is problematic as it is a value-laden term that can mean different things to different people. On an organisational level, retention rates, which are the number of residents who complete a TC, were used to define and measure the effectiveness of the Mother-ship. However, the definition of effectiveness on a service level (amongst staff and residents) was much more ambiguous; subject to debate and interpretation. Despite being in the field for over 31 months no robust conclusions or consensus could be reached with regard to what constituted effectiveness on a service level as programme effectiveness was ultimately dependent on each and every individual.

“There are people in here from all different walks of life; you’ve got those who have had everything and lost it, and those who have never had anything to begin with. How you work with people is very much dependent on the life that they have had prior to admission and where they are in terms of their recovery. You have to get to know the person to establish where they are at, assess what problems and issues they have and explore how they are going to use the programme to grow and change.”

(James, Staff, December, 2012)

The emphasis that was placed on retention on an organisational level filtered down into the day-to-day running of the programme. Residents commonly referred to the term ‘heads on beds’ when resident numbers were discussed, or a resident was kept due to retention rates despite them making no visible progress or commitment to the programme.

“When you go over to the portable cabin and the referral board is full of names you know you’re not getting away with nothing coz there is plenty of people waiting for your bed, but if you go over there and the board is looking a bit empty you know you’re more likely to be allowed to come back if you get off for the weekend or go and use. It does my head in that my recovery is based on the names on that board.”

(James, Resident, February, 2011)

“I am sick of funders sending people here who haven’t got a clue about TCs. It’s causing major problems when they arrive and it’s fucking up my retention rates. We can’t afford to keep losing people. If we operate on anything less than thirty-one we lose £11,000 a week. We have all the beds booked out now it’s up to you lot to keep them here.”

(Peanut, Staff, December, 2010)

Although the staff team accepted that retention was an important component of their work, there was a general reluctance to view retention as an indicator of effectiveness.

“I couldn’t believe some of the things that I was seeing when I visited there; seniors swearing in groups and eating biscuits while it’s on, it was ridiculous. I asked staff about it and they just said “yeah that’s what it’s like here.” No wonder they’ve got good retention rates, the resses just aren’t challenged like they are here.”

(Peanut, Staff, January 2011)

Retention and effectiveness are important issues but are not necessarily causally related. The Mother-ship had the poorest retention rates of all residential TCs that were ran by the organisation under study, yet it was considered to be a flagship service as it consistently produced the highest internal audit scores, pioneered a prison fast-track programme, specialised in criminal justice referrals and established a FLAMES support group. This illustrates how retention, albeit an important issue, is not synonymous with programme effectiveness. What was considered to be effective was dependent on the stage of recovery that a resident was at when they were admitted to the service and what they wanted to achieve during their time in the Mother-ship.

“Yeah it is one house, one generic model, but there are thirty-two different programmes going on at any one time in here. People need to get different things out of this programme and because of the way it is designed they are able to do just that. We get people in here straight from the madness needing multiple detox’s and then we get people who have been clean for three years in jail but need the resettlement element of the programme. There’s no one size fits all when it comes to recovery.”

(Peanut, Staff, August, 2010)

“I just need a break from the madness. I’ve come straight off the street haven’t I? I just need a bit of space to think, have a good rest and get off the shit. Once I’ve done that then I’ll start thinking about why I’m here and what I need to work on. At the minute I don’t know what day of the week it is, never mind what my core issues are and how I’m going to work on them.”

(Dave, Resident, May 2011)

“I done the TC in Wymott and have been properly clean for about four years now. Yeah I used drugs but they weren’t my biggest problem. My biggest problem was having no one to turn to, no one to support me when I needed help. The only people who ended up being there for me was people who wanted to use drugs so I’d end up using and committing crime just to be around people and fit in. I’ve come here after release just for the support really and to get some help building my life up around here. Drugs don’t interest me, they never really have.”

(Daz, Resident, October, 2012)

“It’s not about pushing a person into a generic programme in the hope that it will work. It’s about sitting a person down, assessing where they are at, what they need, where they want to be and bringing relevant components of the programme to them. They only have six months here, some of them less, so they need to take what they need from here and grow. We don’t want TC robots by

the end of this; we want happy, productive people who can cope with life without drugs.”

(Ringo, Staff, July, 2011)

The incremental person-centred nature of the programme under study meant that attempts to define and measure effectiveness were a complex task. Attention was therefore invested in ways in which a resident’s progression or ‘journey’ from first assessment to programme completion could be demonstrated. The Outcomes Star⁴¹ provided a way in which key workers could identify what resources a resident entered the Mother-ship with and what underlying and outstanding issues needed to be addressed during their time in the programme to build their capacity to desist from substance use.

The twelve week Outcomes Star review explored whether a resident had addressed issues that were identified in the initial Outcomes Star and explored what issues still to be addressed. The final Outcomes Star review explored a resident’s progress through their time in the programme; identifying what resources they had strengthened as well as areas of the Outcomes Star that they should continue to address upon programme completion. This provided a visual representation of a resident’s quality and quantity of recovery capital from when they entered the Mother-ship, their time in the programme and the immediate period prior to their departure.

“It showed me that I have loads of tools now like support, confidence and self-esteem but it’s up to me to put them into practice.”

(Shelley, Resident, July, 2012)

“It helps you with things like confidence, assertiveness and self-belief; all the things that we will need out there.”

(Jodie, Resident, May, 2012)

“It’s about each individual and their journey through the programme not ticking a box. I do this job because I want to see people change their lives.”

(Maria, Staff, April, 2012)

Rather than focusing on pursuits to define and measure effectiveness staff and residents in the Mother-ship focused on the notion of individual progression as it was deemed to provide a more accurate reflection of the positive movements that took place during a residents' programme, such as the accumulation of resources indicative of recovery capital.

“You find yourself again when you come in here. I completely lost who I was in the madness; the drugs, sex and the beatings what come with it took over me. I didn't like what I'd become and I didn't know who I was when I come in here. I still don't really but I'm getting there. You just gotta use the tools that you learn in here out there. Honesty is one of the best tools you learn from here. You spend year's lying to yourself out there and it's not until you recognise and accept that you were the problem that things start to change.”

(Rachael, Resident, August 2010)

“I convinced myself that I had mental health problems and that's why I was the way I was. It was why I used drugs, it was why I always fucked up, it was why I had no happy memories, it was why I tried to kill myself and everyone around me when I'd had enough, death didn't scare me one little bit. I've spent the last 30 years of my life in prison or a psychiatric unit. I don't think people knew what to do with me. I'm starting to understand myself now I'm off the shit. It's my emotions. I just don't know what to do with them. I've realised that I overanalyse things and live in the past. I try not to feed into my own thoughts anymore coz it leads me to dark places.”

(Kieran, Resident, June, 2011)

“You've got to remember that being a junkie isn't just about the drugs, it's about your whole way of life; how you behave, how you think, how you feel, what makes you tick. You can be clean for years, not so much as have a toot, but you can still be driven by your inner junkie; not bothering to get washed for days on end, not going to the job centre to look for work because you can't be assed and you're feeling sorry for yourself. Recovery isn't just about getting off drugs. That's the easy bit; you will detox lying on your bed. It's everything else that surrounds the drugs that's hard coz you've actually got to work on them.”

(James, Staff, August, 2011)

This point re-iterates earlier findings, which suggest that the individual progression that takes place in a TC is situated within a strengths-based approach focussing upon interventions that attempt to improve an individual's quality of life (Farrall, 2004; Ward and Brown, 2004; Burnett and Maruna, 2006; Broekaert, 2006; Ward, Polaschek and

Beech, 2006; Ward and Maruna, 2007; Raynor, McNeil and Trotter, 2010) through the accumulation of resources indicative of recovery capital.

Conclusion

Although high-level policy directives such as PbR were in their infancy at the time of fieldwork, it was apparent that they did little more than contribute additional pressures and strains to the day-to-day delivery of the TC programme; transforming individual progression into a financially-driven bureaucratic process. The findings that are presented in this chapter illustrate how the theoretical tensions between PbR and the TC created a number of adverse effects as PbR was implemented in the Mother-ship.

In addition to this the chapter discusses the reactions that surfaced as those who worked and resided in the Mother-ship were told, via PbR, what they ought to use to gauge the effectiveness of the work they do. Whether they were organically creating a new definition of effectiveness, or having standardised measures forced upon them, there was a clear sense of uncertainty amongst staff and residents when discussions about effectiveness were had.

In an attempt to move away from the notion of effectiveness those who participated in the Mother-ship adopted a more realistic way in which the change process that residents embarked upon during their time there could be understood. This was founded upon a strengths-based approach, which recognised that an individual's recovery from substance use was based upon their ability to craft a new sense of self, which required the accumulation of resources and tools indicative of recovery capital.

Given the longitudinal nature of the study it is possible to suggest that the concept of recovery capital can go some way to better understand the intricate workings that take place in a TC together with understanding how the commissioning of alcohol and drug treatment can become more inclusive and representative of the work that takes place. If we were to take a more pragmatic, but true to life approach to outcome-based commissioning, based on principles and prescriptions of recovery capital, we would see a much more aligned financial framework emerge that could support and encourage person-centred approaches. The findings that are presented in the forthcoming chapters will re-iterate this point.

Chapter Seven

The Voice of Recovery Capital

Introduction

This chapter utilises a number of personal narratives to illustrate how recovery capital can be used to explain the work that takes place in and around the Mother-ship. Throughout each of the narratives particular attention has been paid to a residents' progression through the TC and re-integration into the local community after programme completion. In addition to this the following discussion will draw upon the accounts that have been provided to re-iterate how absolute standardised measures of effectiveness (such as those outlined by PbR) fail to capture the work that takes place in a TC and what people achieve as a result of participation.

To do so, the chapter has been divided into three parts. Part one utilises recovery capital to explore the lived experiences of five residents⁴² who were tracked during their time in the Mother-ship and the immediate period following on from their departure. Part two pays particular attention to the challenges surrounding those who reside in the Mother-ship as they begin to work their way through past and present problems, develop new ways to make sense of their lifestyle choices and make future plans. To conclude, the final discussion will illustrate how recovery capital can be used as a mechanism to align ideological measures of effectiveness, such as relapse and (re)offending, with the realities of the work that takes place in the TC.

Lived Experiences: A Selection of Biographies

Polkinghorne (1988) suggests that personal narratives have specific plots and events that are ordered to illuminate certain themes. Figures of speech, metaphors, similes and other linguistic devices are used to filter and organise one's personal story and are a form of autobiographical storytelling that gives shape to experience (Gaydos, 2005). A personal narrative is not a simple chronology (Polkinghorne, 1988; Braid, 1996) and following a personal narrative is not a linear process (Braid, 1996). People begin their stories in many different places, usually starting with memories that are less emotionally intense but nevertheless important to self-definition (Gaydos, 2005).

In order to give a voice to those who participated in the study, the following self-narratives, which have been edited and structured by the author,⁴³ have been explored and explained through the application of recovery capital.⁴⁴ Each narrative provides an account of connected events, which describe when residents began to use substances, why they continued to do so and what influenced their decision to enter the Mother-ship.

Michelle

Michelle, originally from Leicester, entered the Mother-ship on the 6th June 2011 at the age of 32 primarily due to her heroin and crack cocaine use. Prior to her admission to the service Michelle completed a two week methadone detoxification programme in a drug dependency unit in the South of England. She was originally given six months funding from her local authority, however, due to a series of events, which unravelled during her time in the service her care manager obtained additional funding which allowed her an extended stay in the main house and re-entry stage of the programme. In total Michelle did nine months in the main house, four months in the re-entry stage of

the programme and at the time of the final interview had been residing in a supported housing project for approximately two months.

Michelle was tracked over a fifteen month period. The first interview was conducted when she was in the primary stage; the last was conducted when she was residing in supported housing. During the final interview Michelle disclosed that she had a lapse in the re-entry stage of the programme and a lapse when she first moved into supported housing. On both occasions she stated that she used a £10 bag of heroin with a male that she had met in the Mother-ship; she did not use crack cocaine as she feared that she would have a relapse as this was her substance of choice. At the time of the final interview Michelle was substance free and claimed to have not committed any criminal offences since she entered the Mother-ship.

The initial interview conducted with Michelle was primarily based on building rapport, which was important given the longitudinal nature of the follow up process. During this first interview she talked about her childhood and adult life up until the time she entered the TC, which provided a clear indication of the quality and quantity of recovery capital that she entered the service with.

“My life for the last twenty-eight years has been about drugs, abuse and sex. It all started around the age of five when I was abused sexually by older boys and staff in a children’s home. It became a normal part of my life; that normal that by the time I was nine or ten I had turned into the abuser and was doing to younger children what I had done to me. When I was twelve I went to live with my mum and her boyfriend. I started to have a sexual relationship with my mum’s boyfriend until he got me pregnant at 13 and I had to have an abortion. Things at home were hard so I ran away and ended up living on the streets. I was on the streets for about two months before I met Susie. She took me into her home and gave me somewhere safe to sleep. Things were good for about three weeks and then one night she introduced me to crack and weed. After I had been using crack for a few weeks Susie told me I would have to start paying for it and that’s when she started making me have sex with men for money.

I was working in brothels by the age of fourteen. I had Nathan at sixteen and Ayesha at eighteen. I carried on using and sold myself throughout both pregnancies as men paid more to have sex with me because I was pregnant. I met Anthony when I was eighteen; at first he was nice but when he found out that I was a prostitute he changed and started selling me to his mates. I ended up having two children to him. By twenty-two I had four kids so I had to start working the streets to fund mine and Anthony's habit. The beatings that I was getting by this point were slowly killing me.

Anthony wanted more children and I didn't. After a fight one night he beat me and raped me with a screw driver. He left me in bed for over a week before taking me to hospital. I nearly died, and because of that night I can't have any more children. He went to jail for what he did to me and I started working for a pimp. I started doing call outs; it went from sex to rough sex and things just got weird. By now I was injecting anything I could put in a pin. I did meet a nice guy called JB but we split up coz I turned into a bully and abused him. I didn't know how to deal with a guy being kind, caring and loving me. By now I wasn't looking after the kids and I was more interested in men, sex, beatings and drugs. In 2010 the kids were taken into care and I went into self-destruct."

(Michelle, Resident, July, 2011)

Michelle's substance use was just one component of a landscape of difficulties which consisted of an early involvement with the care system, childhood abuse, abortion and homelessness, prostitution, domestic violence, rape, physical assault and the adoption of her own children. She clearly had a limited amount of recovery capital; she defined her existence by a catalogue of tragedies, she did not have anything positive to say about her lifestyle or identity and felt that she had very little to live for. In fact, during an informal discussion she said that if she not entered the Mother-ship she would have died as she felt that she was going to either end up being killed or killing herself as a result of the lifestyle that she was living prior to her admission to the TC.

Upon arrival to the service it was clear that Michelle was a broken woman who had completely given up on herself and those around her, which was unsurprising given her previous life experiences. In an attempt to keep herself safe she developed a hard front which she felt stopped people from getting close to her. After several months in the programme Michelle stated that the front, or mask, that she wore was a way in which

she attempted to conceal how vulnerable, fragile, scared and insecure she felt; afraid of being in an unfamiliar environment, scared to confront who she was and what she had done in the past without any substances to numb the pain.

“It’s proper hard when you first come here because you don’t know anyone and you don’t know how it works. I tried to be this big bolshie southerner but people could see right through me. When I arrived I had an eating disorder and my confidence was on the floor. It took me five weeks to talk in a group and eight weeks to eat with the community. I found every day a struggle and even found it hard to come to terms with the fact that people cared about me and didn’t want anything in return.”

(Michelle, Resident, September, 2011)

Michelle had developed more negative than positive recovery capital up until her admission to the service. She stated that she did not enter the Mother-ship for herself; she did it in an attempt to show social services that she was addressing her substance use and lifestyle choices. She felt that she had no reason to leave her lifestyle behind because it was all she had ever known. The only thing that she felt that she had achieved was having children.

As Michelle’s time in the programme progressed she developed a healthier relationship with food, started to trust people and engaged in community life. This shows that she began to develop a degree of recovery capital. Michelle felt that her progress was slow and she was still unsure about whether she wanted to be in the Mother-ship until a young girl with a similar background to herself was admitted to the service and elected to leave within three days of arriving. Michelle felt that seeing someone in a similar position to herself when she entered the TC made her realise how far she had come since her admission and what she had to lose if she decided to leave prematurely. It was at this point that Michelle recognised that she had progressed; she felt that she had gained a degree of self-worth and belief that she could potentially have a better life. This recognition was indicative of a raised level of human recovery capital.

Michelle believed that the challenge system was the most important component of the programme as it compelled her to look at herself and the person she had become.

“Challenging yourself and your peers is the hardest thing to do when you’re in there, but you need to do it coz that’s what will keep you safe when you leave. It’s important because it helps build your confidence and assertiveness so you feel that you can say no and walk away from certain people and negative situations. Challenging yourself to do things differently helps you to develop the tools that you need out here. It massively helped me; it helped me to look closely at myself and confront a few things from my past that I thought I would never talk about.”

(Michelle, Resident, May, 2012)

Michelle believed that the challenge system helped her to develop the skills and tools that she needed for life after programme completion. It provided a way in which she could work through her problems, be challenged by fellow peers and ‘put to bed’ some of the issues from her past. She considered this process to be important as she claimed to ‘hide behind a smile’ and not speak to people about her personal problems and issues even though there was still a number of events she needed to ‘let go of’ in order to be able to move forward with her life.

“When Anthony was in jail I was moved onto a different pimp and my life got very dark. I started seeing men in hotels who used to bring children with them. I got paid to have sex with children while the men watched. At first I refused to do it because I knew that it was wrong; but my pimp dragged me out the room, beat me up to teach me a lesson and gave me a crack pipe; he kept doing it every time I said no. Eventually I just got on the bed and let the child do what they wanted; I knew it wasn’t their first time because they knew what to do. I realised they were just like me when I was a little girl. I had never spoken about this until I came here and challenged myself. I knew this wouldn’t be the end of it but it was something that I felt I needed to do; I needed to get honest with myself and try and leave my past behind me once and for all.”

(Michelle, Resident, May, 2012)

Michelle stated that this was a particularly ‘dark time’ for her. It was a part of her life that had always caused her a great deal of distress and, up until a few months into her programme, felt that it was something that she would never talk about. Michelle eventually felt able and willing to work through this particular part of her life as she believed that the Mother-ship provided a safe and supportive environment where she

could challenge her thoughts, feelings and behaviours, let-go of her mask and face up to her demons without substances.

By residing in the service Michelle was embedded, albeit for a relatively short period of time, within an environment that is rich in social and cultural recovery capital. She believed that because she knew that she would not be judged on her past, she felt able to open up and discuss some of the events that had taken place. This was another important component of Michelle's programme as she felt that belonging to an accommodating network of people helped her to 'turn a corner' as she recognised that she did not like the person that she had become and felt confident that she could create a better life if she gave herself the opportunity to do so.

During the final follow up interview, 15 months after first meeting Michelle, she was asked to sum up what she had learnt during her time in the programme.

"I still struggle some days with my bad attitude, my behaviour, trusting people and things from my past. I fought everything when I was in there because I didn't think that I was worth it. I packed my bags at least once a week, wanting to run away when things got hard. Looking back, I realise that I've learnt that I don't need to rely on men to look after me and I don't need drugs to keep my head together. I am starting to genuinely believe that I am worth a new and happy life. It has helped me to be more confident and have self-esteem and self-respect. I know I can be a good person given half a chance. I am still scared; I'm scared that I am going to fall flat on my face and I'm scared because everything is just so uncertain at the minute. I don't know where my life is going and I don't know if people will accept me and my past."

(Michelle, Resident, September, 2012)

The accumulation of tools and resources such as confidence, self-esteem and self-respect, that are indicative of human recovery capital, were important to Michelle. She felt that the biggest obstacle that was in the way of sustained recovery was herself; learning to trust her own judgement and believing that she could leave her past behind and build a better future. Recognising that she had the ability to be a 'better person' was

important to Michelle, as was the knowledge that she had the tools required to enable her to create a new sense of self.

Despite the personal progress that Michelle made during her time in the TC her narrative was characterised by fear and uncertainty. Initially she feared what the programme entailed. As she became more involved in the programme she feared that she had left it too late in her life to change and upon completion there was a fear that she would not be able to shed her old identity and be accepted beyond the recovering community.

Marie

Marie, originally from Wallasey, entered the Mother-ship on the 17th August 2011 at the age of 34 due to a history of heroin and crack cocaine use. She completed a six month programme in the main house and just over two months in the re-entry stage of the programme before she was asked to leave. The first interview was conducted with Marie when she was in the welcome house stage and had completed her methadone detoxification programme. The final interview was conducted when she was re-admitted to the TC for a three week stand-alone detoxification programme in November 2012, once she was substance free and displaying no visible withdrawal symptoms. Just like Michelle, Marie felt that the Mother-ship provided an opportunity for her to get to know who she was without substances.

“When you come into a TC you can find yourself and get to know who you are without substances. You might not like what you find but it is all part of the process of moving away from the person that you have become. It’s not about dwelling on things; it’s about letting wounds heal once and for all. Counselling and getting honest with yourself is a major part of it because most of us want to get away from our feelings and emotions. I find it hard to let people in and will stop people getting close. I’ve got a major armour suit on and I know it’s got to come off bit by bit, but I’m worried about what is going to be left at the end of it all.”

(Marie, Resident, October, 2011)

The follow up process with Marie took place over a 15 month period. During this time she completed a six month programme in the Mother-ship, progressed to the re-entry stage of the programme and was asked to leave.

“When I was in re-entry I thought that because my drug of choice was heroin it was alright to drink on my home leaves. I’d go through a litre and a half maybe two of vodka to myself but I wasn’t drinking socially, I was just looking for a head-change and I knew I was because I was getting cravings for gear. Not being honest with myself was one of the things that sent me on a downward spiral. I was getting arrested for being drunk and disorderly. I felt like I’d let myself down. I didn’t think it would have that much of an effect on me but it did. I just didn’t feel proud of myself any more, especially after being arrested. I’d done so well in here and I felt like I had actually done something good for once in my life, but once all that started happening it was like all that positive stuff was gone.”

“When I was coming back to re-entry I was in a room with [*name removed*] and she was using gear. I should have fed back but I was that negative I thought fuck it and used with her. We ended up getting kicked out and we continued to use to the point where I was hooked again. My habit this time round was worse than last time. I’d gone from being up here, to right down there. I think that was one of the first times that I’ve ever felt proud of myself because I had actually achieved something. I was getting somewhere in court with my kids and then it was just like Marie you’ve done it again, as quickly as that. I just felt like I was dead selfish, well I was selfish wasn’t I.”

(Marie, Resident, October, 2012)

Marie was not asked to leave the re-entry service because she had lapsed but because of her reluctance to be honest with herself, her peers and the re-entry worker about how she was feeling, what was happening on her home leaves and her roommate; who was using substances in the service.

Marie recognised that a failure to be honest with herself and those around her contributed to her eventual relapse. She was aware that she could speak to her peers, the re-entry worker or even her previous key worker from the Mother-ship but she decided not to as she felt that she needed to maintain the ‘bolshie’ image that she had created for herself prior to her admission to the Mother-ship.

“Coming back has made me realise things about myself and where I went wrong in my last programme. I wasn’t challenged; I made sure of it, but I know that’s no good for me. I put on this big bolshie front because I’ve had to be like that but it doesn’t do me any justice. Well, it gets me what I want but I end up losing out in the long-run because I can’t get where I need to be. That was the way I’ve learnt to live and it’s hard to just put that aside.

I used all the tools in the house, like the pull-up system and the encounter group, but to the point where people would say I’m not going there with her because if I hit her with a pull-up or an encounter she’s coming back with ten. Looking back on my first time in here I would be stricter with myself for a start. I’d be honest but totally honest to the point where I’m not trying to get away with things or trying to be clever.”

(Marie, Resident, November, 2012)

Just like Michelle, Marie also believed that being challenged was an important component of the programme. Although she recognised that the challenge system was important, due to the uncomfortable feelings that coincided with the process she claimed to ‘manipulate the system’ so that she would not be confronted about her behaviour as frequently as she felt that she should have been.

Marie acknowledged that she developed the tools and resources that she needed during her time in the Mother-ship, but failed to apply them to the situations she encountered during her home leaves. Therefore, although she accumulated components of human recovery capital, such as self-awareness, she lacked tools and resources such as the ability to challenge herself and be honest about her thoughts and feelings.

“The programme helps to get you off drugs but it is all about challenging yourself at the end of the day; changing your way of thinking and changing the way you behave. It’s to get you used to challenging things so you’re ready for when you go out there. I didn’t realise that until I left and went to re-entry; when you’re in hard situations that’s when you need to use the tools that you pick up in here. I didn’t use them and I don’t know why; I thought I was alright when I obviously wasn’t.”

(Marie, Resident, November, 2012)

Although Marie's relapse started with a craving for heroin she stated that the reason she continued to use substances after she was asked to leave the re-entry service was because she felt that she had lost all the skills and tools gained during her time in the Mother-ship. Her relapse was predominately due to a perceived depletion in recovery capital. She felt ashamed, upset and disheartened. She also lacked self-respect and her self-esteem was at an all-time low. According to Marie her relapse was not about substance use per se, it was about her inability to manage and communicate how she felt. This re-iterates how resources indicative of human recovery capital are a vital component of the recovery process.

“Recovery is about getting your life back. Getting back to the person you always was. Obviously staying off drugs is important but to me it's about getting my self-worth and self-respect back. Knowing where I want to go and being the best person that I can be.”

(Marie, Resident, November, 2012)

Although the content of each resident's narrative varied, the belief that recovery was not about substance use per se is a consistent theme throughout the findings. Recovery was about looking at the person that they had become, getting honest about their thoughts, feelings and behaviours and challenging themselves and others to enable them to develop and build upon the tools and resources required to diminish their use of substances.

Marie's narrative illustrates how although the Mother-ship provided an opportunity for residents to initiate their recovery, it was ultimately the individuals' responsibility to take what they needed from the programme and apply the skills and tools that they had learnt during their time in the service to life in the wider community. The Mother-ship provided an invitation to change; an opportunity for residents to accumulate recovery capital. The uptake and application of recovery capital was however dependent on the resident.

T-Bone

T-Bone, a 35 year old male originally from Manchester was one of the first residents to complete the prison fast-track programme. Upon release from prison he resided in the Mother-ship for four weeks. He then moved on to the re-entry service for five weeks before spending several months in supported housing. He was interviewed approximately 30 months after leaving the Mother-ship during which he stated that he was put into the care of his local authority at the age of 8. He was taking LSD and cannabis by the age of 10 and by 16 he was selling and using heroin. By the time he was 21 the revolving door of drugs, crime and prison were in full-swing. He initially engaged with a TC in 2008 during which he felt that he learnt where he was in life and where he wanted to be.

“I think of it like climbing a tree; everyone does it differently and everyone goes to a point where they feel comfortable to let go of the masks, preconceptions, beliefs and cultures that kept them in addiction as you know that you’re not going to get persecuted for doing it.”

(T-Bone, ex-resident, January, 2013)

As the majority of T-Bone’s TC experience was prison-based he felt that his ability to explore emotional issues were somewhat limited. This was due to the fact that discussions about emotions and feelings within a hyper-masculine environment were considered to be signs of vulnerability and weakness. Although he suggested that he would have liked to have worked on his emotional well-being, given the context of the TC he felt unable to do so. The negative impact of imprisonment on the accumulation of recovery capital has also been documented elsewhere (Terry, 2003; Cloud and Granfield, 2008).

“Emotions were difficult for me to deal with, especially in prison because you’re locked behind your door at the end of the day. Doing the prison TC means that you don’t get to work on your emotions coz your opening yourself up for abuse if you do. Well you can talk about them, but you have to realise that you won’t be on the TC forever and there will come a point when you have to go back onto the big side where you will be seen as weak. That’s the last thing you want in them places, especially if you have a long stretch ahead of you.”

(T-Bone, ex-resident, January, 2013)

T-Bone illustrates a degree of self-awareness, which is indicative of human recovery capital. He recognised that he needed to work on his ability to identify, manage and communicate how he felt, but due to the context in which the TC operated, he felt unable to do so. This created a degree of frustration for T-Bone but, as he was aware of what he needed to do in order to sustain recovery from substance use, he felt that he was able to work through his problems in his own way; which at the time was through written work from his key worker. So, although he felt that he could not verbalise how he was feeling and what was troubling him, he still attempted to work on his emotional well-being.

Upon arrival to the Mother-ship he instantly obtained a role model status as he had already completed eighteen months of a TC. At the time this was something that he felt positive about as he felt good being able to help staff deliver groups and provide a source of support for his peers. However, in hindsight he recognised that this left him feeling unable to work on his ability to identify, manage and communicate his own thoughts and feelings.

“When I came here I had the opportunity to look at my emotions but I didn’t because I fell into the role model role. My girlfriend’s Nan died not so long ago and I couldn’t show any empathy. I was numb and didn’t feel a thing; I didn’t even feel sorry for my girlfriend and what she was going through. I just went through the motions. I feel as though I am massively disadvantaged but at least I am aware of stuff like this now and I will talk about it with people close to me and try my best to work on it. Being honest about it is massive for me because in the past that wouldn’t have happened; I would have thought it was a sign of weakness to talk about stuff like that but I’ve left all that macho bravado in the past. It did nothing but get me into trouble anyway.”

(T-Bone, ex-resident, January, 2013)

This point re-iterates how becoming a role model could incur a number of adverse consequences for residents in the Mother-ship (see Chapter Five for a more detailed discussion). As T-Bone was considered to be a role model he did not want to discuss his emotional well-being as he was considered to be a strong peer whom staff and residents relied on. This had an adverse impact on the quality and quantity of recovery capital that he accumulated during his time in the TC. Despite his ongoing difficulties with emotions T-Bone felt that he was much more self-aware, which for him was important as it was a sign of personal progression.

“I am content with who I am now. I know that I don’t need to be the big I am or the guy that people fear. Respect comes when you respect yourself and I can take care of myself now in a positive way. There are lots of skills that I learnt in there but being content with who I am was definitely the biggest thing that I’ve learnt. Recovery doesn’t mean happiness or sadness; it’s about doing the right thing for the right reason, knowing your capabilities and being brave enough to walk away from something that you can’t accept. It’s about becoming you again; the person you were before the drugs. The most important and most helpful thing that you learn during your time in here is recognising your own barriers and breaking them down, letting people in and dropping the masks.”

(T-Bone, ex-resident, January, 2013)

This quotation re-iterates how recovery from substance use is an incremental process that is influenced by one’s ability to work through past and present problems, leave the old sense of self behind whilst simultaneously crafting a new identity (see Chapters Two, Three, Five and Six). Although T-Bone felt that there were outstanding issues, which he needed to work on, his sense of self-awareness provided him with the skills

and resources that he felt he needed to manage his insecurities, particularly around his emotional well-being and establish ways in which he could build tools and resources to help develop this particular life skill.

James

James, originally from Nottingham, entered the Mother-ship on the 13th January 2011 at the age of 41 due to a history of heroin and crack cocaine use. During the initial interview with James he disclosed that he was regularly smoking cannabis by the age of 16 and by the time he was 23 was smoking heroin as a way in which to come down off crack cocaine, speed, ecstasy and amphetamine. In 1998 he received a custodial sentence for supplying a class A substance during which his relationship broke down and his father died. He was released in 2001 and ended up spending a substantial amount of years on a methadone script.

“Looking back I think I would have been better off just smoking gear. I could drink 300mls of methadone a day, set fire to myself, put a ciggie out on myself and when people asked if I was OK I would say yes because I wasn’t on smack.”
(James, Resident, March, 2011)

James completed a six month programme in the TC during which he lapsed twice. He progressed to the re-entry stage of the programme for three months and supported housing for approximately four months before securing his own accommodation. James was tracked over a period of 15 months and the first interview was conducted when he was in the senior programme stage; the last was conducted when he was residing in his own accommodation and had become a care team worker in the Mother-ship.

“At first I hated it here and thought that I’d joined a cult. The evening meeting freaked me out; some kid got up and started dancing round so straight away I started thinking about train times and hatching an escape route. Fear pulls you away from here as you are moving away from everything that you know. You know how to operate in addiction, you don’t have to try. But operating a pro-social life after a twenty year gap is like learning English again. Your detox is going to happen without any effort, you can lie on your bed and it will happen

it's not very nice but it will happen. It's the bit after that that's hard and needs effort so I don't know why we're so scared of the detox."

(James, Resident, July, 2011)

Upon reflection James felt that honesty, being able to trust and challenge himself was an integral component of his recovery, as it provided a way in which he was able to accumulate skills and resources indicative of recovery capital.

"Through doing the programme I have learnt that I am not this uncaring, unfeeling shell of a man that I thought I was. I've never laughed as much in my life as what I have in here. I have a different laugh now, it sounds different because it comes from within. I still believe that honesty is threaded through every fibre of this place; your recovery depends on it. I know that I still have emotional issues to deal with but it was my choice to keep them in. I was an emotional cripple but I am getting better.

I've realised that apathy is a massive enemy to me because it can get you back into the fuck it mind set. If that way of thinking takes over you're just an addict without the drugs, your inner junkie comes out with all the irrational thoughts and behaviour that comes with it. I know I could have and should have challenged myself more when I was in here but I'm working on that now. I am aware of what I have to do now, the blinkers are off and I'm not prepared to lie to myself any more. I've had enough of all that."

(James, Resident, September, 2011)

James believed that he did not work on himself as much as he could have done during his time in the Mother-ship. He felt that this was due to the fact that he was not ready to look at the 'skeletons in his cupboard' and confront certain things from his past. After programme completion James stated that he continued to look at himself and eventually reached a point in his life where he felt ready and able to confront issues that he felt unable to do so in the Mother-ship. For James the accumulation of tools and skills such as self-awareness, self-reflection and personal honesty were significant components of the recovery process both during and after programme completion as they provided a way in which he was able to continue to work on himself and manage social and economic issues as and when they occurred.

The following quotation illustrates how the accumulation of tools, indicative of cultural and human recovery capital, helped James to manage difficult situations after programme completion without the need to revert to substance use.

“I went for the job here and got it. I knew my CRB would take a while but it has been months now. The dole are on my back saying that I need to look for work, even though I keep telling them that I have a job, I can’t afford any shopping so I have been coming here for my meals and to be honest I am really struggling to get by. I have learnt so much from this place, mostly how to cope with adversity and hard situations without getting off my head. I have learnt that the past will never leave you, you just got to accept it, keep good people around you and crack on. Just coz you got the monkey off your back, it doesn’t mean the circus has left town.”

(James, ex-resident, April, 2012)

Parallels can be drawn between Marie and James’ narrative. They both suggest that although the Mother-ship provided them with the opportunity to develop the tools and resources they would need for life after programme completion, it was ultimately up to them to put them into practice. James utilised his tools to deal with the challenges that life brought his way, whereas Marie initially reverted to her habitual coping mechanism. The narratives that have been presented in this chapter illustrate how engaging with a programme like the Mother-ship is the beginning of an end, rather than a standalone end of story event.

Eddie

Eddie, a 39 year old male, five years into his recovery from heroin and crack cocaine use, was a care team worker in the Mother-ship. Prior to his employment in the TC he had served a lengthy indeterminate custodial sentence for a violent offence, which was reportedly the catalyst behind him seeking help and support.

“I had only been home from a long custodial for 31 days before I ended up receiving another lengthy sentence. It was then that I realised that my life had to change; either that or I was going to die in prison. I entered a TC in HMP [*name removed*] in 2006 but I went for all the wrong reasons. Yeah I was generally sick of the life that I was living but I had ulterior motives; I wanted my parole and the TC was the best way that I could make sure that I got it.

I completed the programme in 2007 and during this period my thinking actually changed. It raised my awareness and helped me become more emotionally stable because everything was either regression or breakdown with me. It took time but I actually started believing in some of the philosophies. It wasn't rocket science, it was a simple programme but it was something that I'd never really sat down and assessed before."

(Eddie, Staff, March, 2013)

Eddie felt that the TC helped him to manage his thoughts and feelings more productively. This was important to him as feeling unsure or unable to express how he felt typically resulted in violence, criminal activity and/or substance use. This behaviour was a life-long coping mechanism for Eddie; a way in which he attempted to 'save face' rather than be judged, laughed at or criticised.

"By doing the TC I learnt that I would come across chaotic because I couldn't handle how I was feeling. I couldn't cope with arguments or disagreements and that's why I always resorted to my fists or drugs. I was a proper proud man so I wouldn't have anyone tell me that I was wrong or out of order, even if I was, I just wouldn't have it. My ego wouldn't let me. Now, I will sit back and think about something before I decide what to do. I still feel like my emotions build up from time to time but I can recognise this now and remove myself from situations that make me feel uncomfortable or will put me in a compromising position."

(Eddie, Staff, March, 2013)

The TC helped Eddie to develop the quality and quantity of recovery capital that he had to call upon to aid his recovery from substance use, as the programme provided a way in which he could begin to understand his thoughts, feelings and behaviours. Despite being five years into his recovery Eddie felt that he was still developing a new sense of self and putting his life back together. The following quotation illustrates the incremental nature of the recovery process.

"My life's a bit like a jigsaw as I still feel as though I am putting all the pieces back together. I'm becoming more stable and recognising my place in society. I don't feel I have to tread the line anymore; I don't feel that I have to justify myself or try to exonerate myself. For some reason I always felt guilty if something went wrong. Even if it wasn't me I'd question myself, even though I knew that I had no part in it because I knew deep down that people would be looking at me because I had criminal tattooed on my head. I've always wanted a home, with heating and food in my cupboards but I feared I would never get the chance and would always be kept on the edge of society. I have a small circle of

good, pro-social friends now that take me for who I am, warts and all. They don't judge me and they just accept me for me. This is a massive thing for me because I don't have to pretend to be something that I'm not anymore, I can just be me."

(Eddie, Staff, March, 2013)

The feelings of vulnerability and insecurity that Eddie discussed were predominately due to a belief that he would not be accepted by mainstream society. Eddie felt that if society was not willing to give him another chance, then his recovery options such as tools and resources indicative of physical and social recovery capital were limited. He felt that although he had worked on himself he was still judged by his past, notably his criminal convictions and a lack of socially desirable attainments such as good educational achievements and an employment history. This, according to Eddie, had an impact on his self-esteem and self-belief but was something that he felt he was able to manage without the use of substances because he had worked on himself, his insecurities and his relationship with society during his time in the TC.

The findings that are presented in this part of the chapter illustrate how the concept of recovery capital provides a way in which the processes that take place in a TC can be better understood. The application of recovery capital throughout each narrative also provides a way in which the study can contribute to on-going debates about what is needed on an individual, social and economic level to support the work that takes place in settings like the residential TC. Although participation in the Mother-ship enabled residents to work through their individual problems and perceived need for substances, recovery is not something that happens behind closed doors. It is a highly personal yet social issue that is mediated by the processes of social and cultural support. This point will be discussed in further detail in the concluding chapter.

Recovery Capital and PbR: The Beginning of an End?

This part of the chapter explores in further detail some of the challenges surrounding those who reside in the TC under study as they confront past lifestyle choices and recognise the impact of certain life events upon their recovery options, both during and after their participation in the Mother-ship. The findings that are presented here re-iterate how the recovery process is not about substance use per se; it is an ongoing quest for a better life that consists of a number of personal and social improvements. With this in mind, it is suggested that the individual progress that takes place in settings like the Mother-ship should be recognised (through the application of recovery capital) on a political level and integrated into outcome-frameworks that drive forward high-level policy directives such as PbR. Thus creating a social and political framework that demonstrates a commitment to support and accurately represent the work that takes place in settings like the Mother-ship.

Regardless of a residents' background it was apparent that the abrasive properties of substance use left behind a residue, which initially hindered an individual's expectations and perceived ability to create a new sense of self. This residue created a recovery barrier; it affected the way in which residents saw themselves, their ability to desist from substance use and the way in which they viewed society. It provided a source of negative recovery capital, which was particularly prominent during the first few weeks of admission to the programme.

“All I know is drugs and crime. I'm in my 50s and I haven't got a clue about the real world. It's sad when you sit down and think about it, but it's even worse knowing that you want to change your life around but you have no idea where to start or what path to take. It is seriously overwhelming.”

(Tommy, Resident, September, 2011)

This residue is formally known as *habitus*, which derives from the Latin verb *habere* and means to have or to hold (Swartz, 2002). *Habitus* has been defined as a durable, transposable system of definitions (Bourdieu, 1990). Dispositions of *habitus* are acquired informally through the experience of social interactions by processes of imitation, repetition, role play and social participation (Bourdieu, 1990). *Habitus* generates perceptions, expectations and practices that correspond with the structuring properties of socialisation. An individual's *habitus* is a residue of his or her past that functions within the present to shape his or her perceptions or thought patterns (Swartz, 2002).

An individual's *habitus* has a significant role in the formation of emotions, as people develop emotions based on what they are exposed to and what they experience (Harre, 1986, 1995; Parkinson, 1996, 1997; Parkinson, Fisher and Manstead, 2005). They are signals that provide information about a person's attitudes, values and belief system, as well as clues as to how people take care of themselves (Thornton, 1987). When it comes to expressing how we feel and what we feel we tend to resort to habitual coping mechanisms; exhibiting responses that one has been permitted to show (Armon-Jones, 1986; Thornton, 1987). When residents first entered the TC displays of anger, such as verbal outbursts, walking out of group sessions and self-harming were re-occurring events when feelings of frustration, vulnerability and/or uncertainty surfaced.

"I am really trying but when I feel like I don't understand something I just get angry. I know that emotion alright; I seem to have spent most of my life angry for one reason or another."

(Paul, Resident, February, 2011)

"One of the groups really got me thinking today. I started welling up and there was no way I was going to cry in front of everyone. So I just eye balled one of the lads who I knew still had a bad jail head on and we ended up having words. I'd rather have a barney than cry in front of people. It was proper random but I'd rather do that than have this lot think I'm weak. I know I have to change the way I'm thinking but I'm not ready to do it just yet, especially in groups. I have

started talking about things with my key worker like but I'm still not ready to put my shit out there, it will take a lot to get me to do that kid."

(Dave, Resident, July 2011)

Expressions of anger were frequently utilised by residents in an attempt to avoid talking about issues requiring them to face uncomfortable emotions such as guilt and shame that could leave them feeling vulnerable and exposed. This outward emotion was a useful resource for residents as it provided a way in which they could 'keep people at arm's length' and reportedly prevented them from getting hurt. This coping mechanism was something that residents felt kept them safe 'in the madness' and as a result was considered to be particularly hard to let go of as it invoked feelings of insecurity and vulnerability. This habitus provided a source of negative recovery capital as it hindered a residents' ability to identify, manage and communicate how they felt.

"Learning about your emotions is the key to recovery because you haven't had them for years. You can't have them when you're doing what you're doing in the madness. You can't feel guilty when you're robbing someone; you just got to learn to be numb."

(Oliver, Staff, August 2011)

The ability to regulate ones emotional well-being was considered to be particularly important for residents as many claimed to 'use on their feelings', which meant that they would revert to substance use if they experienced emotions that made them feel uncomfortable. This coping mechanism subsequently had an adverse impact upon a resident's ability to manage and communicate their thoughts and feelings.

"I want to be a person in the real world having a real life. I want to be able to laugh, cry, scream at the top of my voice and not worry that I am going to be judged. I know what I want and I don't want a life that seems so easy to step into. I am terrified that I am going to slip and disappear through the cracks of life again that's all. I am full of fear; fear of the unknown I guess. I am trying to leave 40 odd years of crime and chaos behind me and behave in a completely new way, express myself differently and deal with situations differently but I haven't got a clue how to go about it. I know where I want to be, I just don't know how to get there."

(Carl, Resident, October, 2010)

“If you ask them how they are feeling you either get “I’m OK” or “Me heads fell off,” when you ask them what they mean they usually look at you completely blank. I don’t know how many times I have told them that OK isn’t an emotion.”
(Oliver, Staff, December 2010)

Although the majority of residents did not enjoy the process of being challenged they recognised that it provided a way in which they could attempt to create a new sense of self and move away from their existing habitus, in particular the use of substances as a primary coping mechanism.

“I never thought about my behaviour and attitude until I came here. Probably because I didn’t care to be truthful, it was my way or the high way. Since I have moved to primary I think I have been encountered every week about how my behaviour is affecting people in the community. I really didn’t think I was that bad ya know so this has really has made me more aware. I still make mistakes and react sometimes, but I can honestly say that for once in my life I am starting to think before I speak or act. I think about how people will perceive me and how they will feel about what I am saying or doing. It is proper hard though because I have never had to do this before, being like this would have had me walked all over on the streets.”

(Mick, Resident, February, 2011)

“It just makes you become dead aware of yourself and your environment. You need to be aware of how you behave, think and feel as well as the impact that your behaviour can have on others around you. When you have lived a life like us in here awareness wasn’t something that you particularly needed or was bothered about.”

(Kenny, Resident, January, 2013)

The challenge system provided a way in which residents could begin to engage in the process of cognitive transformation, which involves a change in one’s ability to focus reflectively on the self (Gordiano *et al*, 2002). A cognitive transformation is said to have occurred when an individual no longer sees their previous behaviour and/or coping mechanisms as positive, viable or even personally relevant (Gordiano *et al*, 2002).

“Being in here has taught me that I’m not just a smack head. I’m actually an alright geezer. I have to leave my past behind me now because if I keep looking back I will get distracted and lose sight of what I want and need to do with my new life. I have to remember that the person from my past isn’t me anymore so I have to stop associating myself with who I was and be the person that I have always wanted to be.”

(Dick Dastardly, Resident, September 2010)

“Don’t get me wrong when I first got out of jail I loved doing all the promotion stuff, talking about my past and that, but now I’m less forthcoming with it all. I have completely moved on. I have kids and a wife to think about now. It would be unfair of me to keep dragging up my past. I’d be mortified if my kids went into school and all their mates knew their dad used to be on smack. It’s my past and I’m at a point in my life now where I want to leave it alone because it was so long ago. I just don’t see all of that as a part of who I am today. I am a professional drugs worker and that is all people need to know, because that’s who I am.”

(Oliver, Staff, August 2011)

Although the environment to which one belongs can provide a scaffold that makes possible the construction of significant life changes, it is the individual themselves who must attend to these new possibilities, discard old habits and begin the process of crafting a different way of life (Meisenhelder, 1982; Lakoff, 1987; LeDoux, 2003; Mayer and Salovey, 1997 cited in Knight, 2014). In other words, the individual must be able to integrate their pasts, present and perceived future into a personally appealing replacement self to replace the one that must be left behind (McAdams, 1994; Paternoster and Bushway, 2009). This consists of the reorganisation and understanding of information in a new light (Erikson, 1959; Epstein and Erskine, 1983; Waldorf, 1983; Shover, 1985; Biernacki, 1986; Denzin, 1987; Burnett, 1992; Leibrich, 1993; DiClemente, 1994; Graham and Bowling, 1995; Adams, 1997; Maruna, 1997).

Crafting a different way of life and replacement self, began with a process of self-reflection, which required a resident to work through past and present problems, deal with suppressed or surfacing emotions and become more self-aware.

“You can find yourself again when you come in here. I didn’t know who I was when I first come here. The only thing I knew was that I didn’t like what I’d become. I still don’t really know who I am but I’m slowly getting there. Honesty is one of the best tools you learn from being here because you spend years lying to yourself when you’re in the madness. If you are not honest you will just find yourself in high risk situations all the time and before you know it you will be back to square one.”

(Rachael, Resident, August 2010)

The process of self-reflection was poignant for a number of residents; especially those who were in their mid to late 40s as they felt that they had left it too late to change their habitus due to the degree of negative recovery capital they had accumulated as a result of their substance use and lifestyle choices.

“I’m nearly fifty and I’ve never had a job. Who’s going to employ me now? I’ve left it too late; all I know is drugs and crime. Yeah I’m substance free, but that’s about it. I’ve got fuck all going for me in the real world.”

(William, Resident, April, 2012)

“I’m at a point now where I’m thinking that it’s just too little too late. I haven’t got enough time, I’m too old and to be frank girl I don’t think that I have it in me anymore, I give up on myself a long time ago. My issues are like a dead body that has been buried for years. It’s better to leave them alone and keep it buried; once you start to take away the soil the stench is awful and all you see is dirty, rotten flesh. Some things are just better left undisturbed, you get me?”

(Lea, Resident, December, 2010)

In addition to the feeling that they had left it too late to desist from substance use there was a noticeable increase in the amount of physical health problems amongst residents who accessed help and support later on in life. There were a number of instances where residents found out that they had irreversible health damage and began to seek specialist help and support for the first time during their time in the Mother-ship.

“It’s only through being in here that I have started to look at my health problems and the impact that they are having on my life. There is no way that I would have gone to the doctor’s when I was on the streets. There’s no way you would find someone like me sat in a doctor’s waiting room, everyone looking at me thinking she’s only here to get drugs. No thanks. I’d rather score, get off my head and crack on. I’ve only been here for a few weeks and already I am starting to realise that my health is important, and if I don’t start sorting my shit out I’m going to end up in a box 10 feet under. I’m getting too old for all this. It’s a young man’s game.”

(Pat, Resident, August, 2010)

“I found out that I had Hep C just as I got clean and started to get my shit together. I know a lot of people who have had the treatment and it’s ruthless. I really want to get treated but I am scared that I will feel so bad that I will end up using to take away the pain. I obviously don’t want to do that so I have been putting off going for treatment. I know I need to do it but at the minute I am OK and I am clean, that’s my priority. I am going to have to put off the treatment until I am a lot stronger as a person. I’m just not ready to put myself in situations like that at the minute.”

(Jay, Resident, January, 2012)

The above quotations illustrate how the process of recovery was bitter-sweet for some residents and that the success of one’s desistance from substance use was influenced by the amount of positive and negative recovery capital that they had to call on during and after participation in the TC. The processes that took place in the Mother-ship provided a way in which residents could begin to deconstruct their existing habitus (which may have directly and/or indirectly influenced their substance use) and let ‘old wounds heal’ whilst simultaneously creating ways in which positive recovery capital could be accumulated.

The findings that have been presented in this chapter illustrate some of the challenges and complexities that surround those who embarked upon their recovery in the Mother-ship during fieldwork. The concept of recovery capital has been applied to the journey of Michelle, Marie, T-Bone, James and Eddie to explore and explain how interventions couched in TC principles aid desistance from substance use. The ‘residents’ voice’ has been utilised throughout this chapter to re-iterate earlier findings, which suggest that standardised definitions and measures of effectiveness overlook the complex and varied nature of the work that takes place at the coal face of service delivery in a residential TC (see Chapter Two and Six).

Conclusion

The narratives that have been presented in this chapter were characterised by a web of complexities, hardship and anger; anger towards the situations that residents found themselves in and anger towards themselves for being unable to identify, manage and cope with the challenges of life without the use of substances. Although it was believed that the service provided residents with an opportunity to accumulate recovery capital, there was an overwhelming sense of fear (negative recovery capital) amongst residents as they began to engage in the process of self-reflection and cognitive transformation. A fear that they had left recovery too late, a fear that they had not done enough work on themselves during their time in the programme, a fear that they would be unable to let go of entrenched values, attitudes and beliefs that are synonymous with the drug sub-culture and create a 'new' sense of self. This fear, albeit initially expressed as anger, was a poignant theme throughout the findings presented in this chapter.

The longitudinal nature of fieldwork meant that the gradual change in people's perceptions and indeed willingness to discuss emotions perceived as weak or vulnerable were captured in real time as the research progressed. This therefore means that the findings present a detailed insight into the process that take place in a TC as they unfolded, paying particular attention to how residents not only made sense of their biographies up until participation in the programme, but reflected upon their own histories and behaviours up until the point of admission. This insight illustrates how the emphasis that was placed on individual progression rather than programme effectiveness provided a more accurate representation of the work that takes place in and around a TC.

In addition to this the findings that are presented in this chapter re-iterate how absolute measures such as relapse, (re)offending and retention do little more than hold onto an ideological commitment that an individual's relationship with substances, and in some instances crime, will disintegrate after a given time in a residential TC. Rather than maintaining the status quo, the integration of recovery capital into a framework that underpins high-level policy directives such as PbR, would go some way in aligning standardised definitions and measures of effectiveness with the work that takes place in the alcohol and drug treatment field, providing a more true-to-life representation of the processes that take place on the ground.

Chapter Eight

Moving with the Times

Introduction

This penultimate chapter reflects upon how the TC under study has adapted and modified since the service opened its doors and addresses the question, where now for the residential TC? To do so the chapter has been divided into three parts. The first explores how a programme, which originates from a different substance use landscape has adapted and modified to meet the needs and demands of a heterogeneous population. The second part discusses whether contemporary changes to the sector pose a threat or opportunity for the Mother-ship and the third and final part of the chapter reflects upon the findings from parts one and part two and discusses whether the TC can continue to revise its approach without compromising the unique qualities of the programme.

Adaptation and Modification

The service opened in 1987 as a residential rehabilitation programme, which was designed to last for at least twenty-four months. Initially prospective residents were only accepted if they were free from all mind and mood altering substances, which include both licit and illicit substances. This meant that prospective residents had two choices if they decided to enter the Mother-ship; either complete a detoxification programme in the community before admission to the service, or abruptly give up substance use on admission without any prescribed substitute medication, a process colloquially referred to as going cold turkey. Like all first generation TCs across Europe and America there was no integrated detoxification programme as the service aimed to provide a drug-free environment. In addition to this, the Mother-ship did not accept individuals who were

alcohol dependent as the programme was designed to cater for those who primarily used opiate-based substances.

Up until the mid-1990s residents were expected to contribute their housing benefit to the service. However, a change to the way in which alcohol and drug treatment was funded meant that prospective residents were expected to obtain local authority funding before they were given a start date. The way in which local authorities funded services like the Mother-ship varied; some covered the full cost of the programme, whereas others only part funded the programme. This meant that those who were from a local authority that part funded were required to provide a compulsory contribution to the service to cover the full cost of their programme. This could range from £10 to £60 a fortnight and would be taken directly from their benefits or private bank account by the finance officer.

In 1993 an opiate detoxification programme was integrated into the Mother-ship which enables those who feel unable to achieve abstinence in the community to do so during the first few weeks of their programme. A general practitioner who specialises in detoxification regimes visits the service once a week to oversee these regimes and prescribe medication such as sleeping tablets and pain relief to ease withdrawal symptoms. On one hand the introduction of an integrated detoxification programme illustrates an attempt to widen programme participation, but on the other hand it creates a number of theoretical and practical tensions which will be discussed in further detail throughout this chapter.

Over the years funding for residential services has become tighter and more difficult to obtain. Since the Mother-ship opened the duration of the programme has been shortened from 24 months to 18 months, to 12 months, to 9 months to 6 months by 2000. In addition to this an alcohol detoxification programme was integrated into the service in 2005. These adaptations and modifications were just some of the ways in which the service attempted to increase programme participation and ensure the literal survival of the TC. The next part of the chapter will discuss the impact of these adaptations and modifications on the intricate workings that take place in the Mother-ship.

A Changing TC Ethos

The introduction of a detoxification programme to the TC was seen as both a threat and opportunity. For some the introduction of a reduction programme provided a way in which the service could widen programme participation, as people who felt unable to engage with a detoxification programme in the community could now do so within a residential setting. However, for the majority of those who worked and resided in the Mother-ship the introduction of a medically managed programme into a self-help community created a number of adverse effects.

Perfas and Spross (2007) suggest that integrating a medically managed detoxification programme into a TC requires a variety of adjustments that challenge the status quo of the programme, thus creating a cultural conflict for the 'drug-free' self-help philosophy. In other words the integration of a reduction programme into the TC, which originally emerged due to dissatisfaction with the medical 'treatment' model, means that a number of compromises have to be made in order to accommodate both medical and TC principles and practices.

According to those who participated in this study the compromises that took place were unbalanced, as the needs and demands of ‘medical issues’ associated with the detoxification programme were prioritised over TC principles and day-to-day TC practices; detox surgeries would run over scheduled time-slots, which meant that residents would miss entire group sessions and disruption would occur as residents were called to see the doctor. In addition to this, doctors would prescribe opiate-based medication (despite being asked not to do so by the programme manager), which had an adverse impact on the day-to-day workings that took place.

“It’s getting out of hand. The doctors are making all kinds of demands and paying no attention to how we do things in a TC. It’s causing havoc. Half of the community are on opiate-based medication all of a sudden and the doctors pick and choose when they turn up which is disrupting the group sessions. We are all going to have to sit down and try and come to some sort of compromise.”

(April, Staff, December, 2012)

“We are meant to be working on their behaviour yet we are letting resident’s pop pills whenever they feel that they can’t cope. They must think we were born yesterday, we’ve been exactly where they have been, we’ve manipulated doctors, we’ve tried every trick in the book to get a head change when things got hard.”

(Bert Flump, Staff, March, 2011)

In addition to this there were a number of residents who were admitted to the service for a stand-alone detox; which meant that they were funded for a period of two to three weeks to enable them to complete a reduction programme in a residential setting. Due to the short period of time that they were programme involved there was a general reluctance to participate in the programme.

“Look I didn’t come here to do your cleaning and sit in your shit groups. I came here for a break from the madness and to get off the methadone, that’s it. So there is no point in trying to get me to get involved because I won’t. I am doing a stand-alone detox so if I want to lie in my bed all day I will.”

(Greg, Resident, March, 2013)

“He is refusing to get out of bed again. He said he doesn’t see the point in getting up because he is feeling rough and will be leaving in a few days anyway.”

(Adam, Resident, November, 2012)

Although residents who entered the Mother-ship for a stand-alone detox were expected to participate in the programme there was a general reluctance and, in some instances, a complete failure to get involved in day-to-day activities, which at times, had an adverse impact on the community.

“When people come here who aren’t here for the right reasons and are here to just ‘get clean’ negativity can spread like wild fire. All it takes is one person to rebel and before you know it the community is in uproar; people are selling out to each other, cliques are forming, people can’t be assed, people use and the sense of community just disappears.”

(Oliver, Staff, January, 2011).

The presence of an integrated detoxification programme not only divided opinion amongst staff and residents, but had an impact upon the willingness and ability of residents to participate in the programme. Although all residents were expected to participate in the programme during their residency there were a number of residents who despite having six months funding, felt that they did not have enough time to work on themselves because they decided to do their detoxification in-house.

“When I first came here I did a Librium detox because I had a problem with drink, that lasted a few days and then I started my methadone detox. I went from 60mls to 0mls in a few weeks which was really quick but it got it out the way. The worse detox was the last one, my benzo detox. I will always remember that detox every time I am craving because I am determined that I will never go through that again. All in all, my detox’s took about three months; it was shit because my emotions were all over the place. I couldn’t get my head into anything for the first three months. I think you should either do your detox before you come here, or try and get more funding to do a longer programme because you don’t take anything in when you’re detoxing, half the time you’re just battling with yourself to stay.”

(Liz, Resident, November, 2010)

Residents who undertook multiple detoxification regimes stated that they would have preferred to do their detox externally or have more funding so that they could be programme involved for a longer period of time. This was due to the fact that they felt that they could not work on their core issues while they were suffering from withdrawal symptoms.

“I think 6 months isn’t enough for people when they come here needing multiple detox’s, they just about get off substances and then they are off, six months done. If I had my way people would come here after they had detoxed so that we are hitting the ground running and we can work really intensely with them for 6 months. You can’t do that when people are detoxing because they are all over the place, one minute they’re happy, the next they hate everyone and everything. You can’t work on emotive core issues with someone who is unstable and withdrawing because it could send them down the path.”

(Oliver, Staff, December 2010)

The tensions and dilemmas which surround the detoxification programme were further compounded by the use of prescription medication. Traditionally the only medication that was dispensed in a TC was those required for on-going medical conditions, such as diabetes. This was because substances can be used to avoid the challenges of ordinary living through the provision of a chemical safety blanket (DeLeon, 2000). There were a number of occasions where residents, particularly those in welcome house, would utilise prescribed medication to ‘fix their feelings’ and experience an altered state of mind, colloquially referred to as a ‘head change’ because they felt unable to manage their thoughts and feelings.

“I’ll be honest with you when I first come in here I manipulated the doctor to get as much opiate-based pain killers and sleeping tablets as I possibly could. I was craving like mad and had all these suppressed emotions coming back to me that made me think that I needed something, anything to take the edge off, even if it was for a few hours. I needed a head change I guess.”

(Marie, Resident, November, 2011)

“She is still using codeine for toothache that she had four months ago. She deserves an Oscar for the performance that she puts on when she is in with the doctor. I have told her that she needs to let go of her old behaviours because if she doesn’t she is going to leave here still relying on them.”

(Bert Flump, Staff, November, 2010).

The term old behaviours was utilised by staff and residents when a resident was deemed to be resorting to old behavioural traits, such as using substances to diminish uncomfortable emotions rather than work through them. It was felt by staff and residents alike that the ability for residents to obtain prescription medication in-house provided them with an opportunity to maintain old behaviours, particularly during the welcome house stage, rather than begin to try new way of dealing with their thoughts and feelings.

“I have always used something to help me get by. It’s all I know and sometimes, well most of the time; it is all that I want. Everyone rinses the doctor in here. What do you expect, we are all junkies trying to get clean and you have someone sat in front of you who has the power to give you what you want. All you have to do is play the game and it’s yours. Manipulating the doctor is easier than facing your demons.”

(Ellie, Resident, May, 2012)

Residents who were deemed to be displaying old behaviours were challenged in behavioural groups and key work sessions. However, staff members were (at times) uncomfortable with this process as they were unable to decipher between a genuine need and want of substances.

“The situation with prescription medication is hard. On one hand we have to challenge residents over their pill popping antics because if we don’t they will go through here relying on chemical fixes to cope. There are some residents who blatantly play the game, and you feel comfortable challenging them because deep down they know what they are doing. But then there are a handful of residents that you have to be really careful with because they are on pain relief, opiate-based mind, for serious health conditions. Even though we do challenge them, albeit in a much more round-a-bout way, there is a part of me that thinks that one day someone is going to put in a complaint or something, The worst thing that they ever did was condone the use of prescribed drugs in here.”

(Ringo, Staff, June, 2012)

This illustrates an uncomfortable balance between the TC philosophies and medical practices that took place in the Mother-ship. The following quotation provides a further illustration of how the amalgamation of contrasting philosophies and practices created a

window of opportunity for residents to manipulate the processes that took place in the Mother-ship and hold onto old behaviours.

“Meds are an absolute nightmare to control in here. There was one lad who was blatantly using gear and got away with it for weeks because he was on codeine. Its opiate based isn’t it so there was no point testing him because he always comes up positive for opiates. He was challenged about it for weeks and eventually he admitted using, but it was too late, by then he was leaving here a walking relapse. I wouldn’t be surprised if he developed a habit in here before he left.”

(Bert Flump, Staff, August, 2012)

In addition to this all members of the care team, especially the night care worker, felt that the presence of medication in the Mother-ship had an adverse impact on the duties that they were expected to perform. Although the time-table incorporated four 30 minute slots for medication dispensing this was not considered to be enough time, especially when the service was operating at full capacity and the majority of residents required medication. This meant that the dispensing of medication would run over its scheduled time allocation and disrupt group sessions. After the doctor’s surgery had commenced there would be a large quantity of medications to be accounted for, which was a particularly lengthy administrative duty.

“We can be in that meds room all night some nights, if we’re not dispensing meds we’re logging them in. Fridays are the worst, you come in at 5, do tea time meds; you finish them about 7 and start logging in meds before bed time meds at 10. I can spend my entire shift in here some nights and its soul destroying, I have no contact with the community which ultimately means they can get up to no good and get away with it because I have to be back in the meds room at 7.30am to start dispensing morning meds. So if they have done something that they shouldn’t, like go off project and have a drink, they probably won’t get caught unless someone feeds back.”

(Bert Flump, Staff, August, 2012)

The introduction of detoxification regimes and prescribed medication to a programme that is founded upon a philosophy of abstinence created a number of adverse consequences on a theoretical and practical level. It created an array of theoretical contradictions as well as a window of opportunity for residents to hold onto old

behaviours. Although residents were challenged if they were deemed to be using substances as a chemical fix, this somewhat misses the point and forces our attention to why and how these processes are not working on the ground, rather than towards opening up a discussion about whether there is a place for pharmacological interventions in a non-medical setting such as the TC.

The findings that have been presented in this chapter illustrate how the TC under study is a hybrid of two juxtaposed concepts; a philosophy of abstinence couched in TC principles and a treatment model, which utilises initiatives steeped in a philosophy of harm reduction such as the prescription of substitute medication. This part of the chapter has illustrated how the adaptations and modifications that are taking place in TCs like the Mother-ship are not only diluting but jeopardizing the movements' unique qualities. The next part of the chapter will build upon this discussion with particular reference to PHE.

Swimming against the Tide

The findings that are presented in this part of the chapter provide an insight into how the adaptations and modifications that were made to the Mother-ship, in preparation of the shift towards PHE, contributed to the array of tensions and dilemmas that were already felt, particularly by staff in the TC.

In addition to PbR the Coalition Government outlined plans to re-organise the delivery and management of the alcohol and drug treatment system. On a national level the responsibility for public health, which includes the commissioning of alcohol and drug services was to move back to local authorities; and on a national level the NTA was to move into an executive agency of the Department of Health called Public Health

England (United Kingdom Drug Policy Commission, 2008; National Treatment Agency for Substance Misuse, 2012-2013; DrugScope, 2013). The formation of PHE came as a result of the re-organisation of the NHS, which was outlined in the Health and Social Care Act 2010. According to the Department of Health this new system embodies localism, with new responsibilities for local government within a broad policy framework set by the Government to improve the health and well-being of their populations.

The shift to PHE meant that by the 1st April, 2013 all local authorities were allocated a ring fenced budget, a share of £5.2 billion, which they could choose how to spend based on the needs of their population. As the budget for service providers has been transferred to Directors of Public Health, employed by local authorities, providers are now expected to compete for the ring-fenced budget against an array of services in other areas of health care (Boyd, 2012). Directors of Public Health will oversee services as well as play a key local leadership role around the delivery of public health outcomes and also work with local partnerships such as Police, employment and housing services and prison and probation services to increase the drive towards recovery (Boyd 2012; United Kingdom Drug Policy Commission, 2012).

The PHE outcomes framework *Healthy lives, healthy people: Improving outcomes and supporting transparency* (2010) sets out a vision for public health, desired outcomes and indicators that help to understand how public health is being improved and protected (Her Majesty's Government, 2010a). It focuses on three high-level outcomes across the public health system: increased healthy life expectancy; reduced differences in life expectancy; and healthy life expectancy between communities. Indicators of effectiveness are grouped into four domains covering the full spectrum of public health

which are: improving the wider determinants of health; health improvement; health protection; public health; and preventing premature mortality (Department of Health 2013-2016). The outcomes reflect a focus not only on how long people live but how well they live at all stages of life (see Appendix 12).

DrugScope (2013) recognises the potential that PHE might offer as bringing alcohol and drug policy into the broader public health remit could potentially create scope to develop new opportunities for innovative local approaches. However, until the new systems are in place it is difficult to gauge how they will operate, how the local public health budget will be allocated and how services will be commissioned. Given the ongoing cuts to local authority budgets there is a risk that the shift of responsibilities could result in disinvestment in services, which could have an adverse impact upon vulnerable individuals, families and communities.

Findings suggest that the adaptations and modifications that were taking place in the TC in order to prepare the service for the imminent shift towards PHE exacerbated the contradictions and compromises that were already at work within the service. Interventions such as harm minimisation groups, sexual health groups, increased emphasis on relapse prevention groups and first aid training, which specifically focused on what to do in the event of an overdose, were all introduced into the weekly timetable despite providing a stark contrast to the philosophy of abstinence, as maintained by the TC movement. Although staff and residents enjoyed the groups, there were a number of tensions with regard to the messages that these groups were giving residents; TC behavioural groups worked with residents to develop coping strategies so that they did not revert to substance use and harm minimisation groups helped residents to

minimise the harm to themselves and others if and when they use substances after programme completion.

Building upon the findings that have been presented in Chapter Six it is possible to suggest that PHE's prioritisation of localised service provision will compound rather than alleviate differential opportunities amongst communities, particularly with regards to support for substance users, thus contributing to the postcode lottery, which persistently bifurcates between the haves and the have not's.

“I wish I could give my funding to someone in here. Funding is dead easy to get where I'm from, my care manger is always asking if I need more time in here. Some people are leaving here next week who just don't want to go but they have to because their funding has run out.”

(Hopper, Resident, July, 2011)

It is therefore possible to suggest that the emphasis that has been placed on localised funding for residential services since the 1990s could be further exacerbated by PHE's emphasis on localised service provision; creating little more than a heightened prevalence of differential opportunities between communities and contributing to future decisions to shorten the programme duration of TCs once again. This was a cause for concern amongst a number of staff members. It was believed that interventions such as counselling, key work sessions and group therapy sessions that invite residents to open up 'old wounds' and talk about their core issues, could have a detrimental impact on residents if they were not programme-involved for a sufficient amount of time; as they would be unable to work through their problems and 'put them to bed.' On the other hand, other staff members were more receptive to the potential changes and believed that it could be a way in which the programme could respond to the changing needs and demands of the population that resided in the Mother-ship.

“I couldn’t leave my wife for six months. It’s not fair to expect her to pick up all the pieces yet again, look after the kids, pay the mortgage, work and run the house.”

(Ben, Resident, August, 2010)

“If we keep them here longer than six months they will stagnate. There are only so many groups that you can sit in and there is only so much that you can take from the challenge system. Sometimes you just have to let them bite the bullet and give life a go in the real world. We can’t protect them in here forever; they have to learn to stand on their own two feet without drugs and crime to prop them up.”

(Bert Flump, Staff, August, 2012)

The various rules and regulations that surrounded the way in which local authorities funded alcohol and drug treatment not only had an impact on the length of time that residents were programme-involved, but upon the availability of after-care services and support for residents upon programme completion.

“There are loads of services around here to keep you out of trouble when you leave here. There’s nothing like this where I’m from so I’m going to stay round here. Boredom is a massive trigger for me and my old mates don’t help situations, I can’t expect them to stop doing drugs and whatever else just because I have. I just have to leave that part of my life behind now, move on and accept that this is my new home now.”

(Ste, Resident, December, 2011)

The differential level of available after-care services amongst local communities meant that a large proportion of residents felt that relocating to a different area provided them with an opportunity to maintain their new sense of self and drug-free identity. Although key workers placed a great deal of emphasis on residents relocating to the area in which the Mother-ship was located so that they could have a fresh start, other members of staff were not of the same opinion.

“Why would you want to relocate them here, yeah there’s loads of services but that’s because there’s a massive drugs problem.”

(Eugene, Staff, March, 2011)

“We’re adding to the area’s problem. We’re bringing some of society’s most problematic people together. Think of all the drug dealers from around the country that we have brought together to form relationships and networks which they can use to populate the area with even more drugs. Think about all the resses who have relocated here, relapsed and are now committing crime in the local area to fund their habit. So when this place doesn’t work for someone and it all goes wrong what have we done at the end of the day, we have brought a shit load of problems to our doorstep.”

(Oliver, Staff, May, 2012)

Although relocation was seen as a way in which residents could leave their old identity behind and access a wide range of recovery-orientated services, it was also deemed to hinder one’s ability to leave the old sense of self behind as they would always be reminded of why they relocated to the area. This not only illustrates how the social structure to which one belongs can be constraining (Giddens, 1984), but provides an early indication that PHE’s emphasis on increasing healthy life expectancy amongst communities through the provision of localised service provision, is ill-thought through and counter-productive.

PHE claims to be able to bring alcohol and drug policy into the broader public health remit but it is still not clear how this ambition will be operationalised. It is also not clear how PHE’s priorities will help to combat some of the social pressures and constraints that prevent people accessing help and support for substance use in the first instance.

“It’s hard for women because although you know that you need help, you don’t necessarily want to go out and get it, because if you do you are shooting yourself in the foot. Social services can use it against you and assume that because you have a drug problem you are a bad mum and you run the risk of the spot light being put on you and your family. That’s probably why you don’t get many women wanting to come in here, because they don’t want to admit that they need help.”

(Louise, Resident, December, 2012).

This raises the question how PHE will increase a healthy life expectancy for all given the plethora of personal and social issues that have and continue, to ensure that certain members of society, such as women, find it difficult to engage with services like the

Mother-ship, due to a fear of losing custody of their children, a fear of criminal prosecution and a fear of negative attitudes from service providers, family and friends (Beckman and Amaro, 1986; Marsh, D'Anno and Smith, 2000; United Nations Office on Drugs and Crime, 2004; Green, 2006; McAlpin, 2006; Lester and Twomey, 2008; National Treatment Agency for Substance Misuse, 2010).

In order to genuinely improve healthy life expectancy across communities more should be done in addition to the rebranding and promotion of already available health-orientated services. Emphasising the role of health in recovery individualises the problem and diverts the attention away from the impact of poverty and structural disadvantage onto health and personal well-being (Gillies, Tolley and Wolstenholme, 1996; Muntaner and Lynch, 1999). This is unsurprising as encouraging people to engage with already existing health services is cheaper than attempting to reduce poverty and social inequality.

Rather than inventing strategies that advocate victim blaming, economic and social regeneration of communities would go some way to reduce social inequalities and differential opportunities (Campbell, 2000). Although raising human recovery capital, such as an individual's sense of self-worth and self-efficacy can go some way in helping people to take control of their health and well-being (Bandura, 1996). The creation and maintenance of good health and well-being is also dependent on structural opportunities and wider social forces, such as accommodation and employment (Campbell, 2000).

Conclusion

Although the adaptations and modifications that were made to the Mother-ship were seen as a way in which the programme could remain current, there was an array of inadvertent tensions, contradictions and compromises as medical interventions were implemented within the setting. This not only created a number of adverse consequences on the ground, but raised the question how far can TC traditions be diluted before a TC loses its originality.

Given the breadth and depth of this study it is possible to assert the following. Firstly, there are some TC principles and prescriptions that should continue to stand the test of time if it is still to be considered a TC. Although there is a need to adapt and modify day-to-day interventions to ensure the programme remains current and relevant within an increasingly competitive market, a TC must retain and celebrate its traditional components after all they are the ingredients that make a TC a TC (see Chapters Two and Five).

Secondly, the main cause for concern that has faced the TC for the last three decades and will continue to do so if different ways in which to open up these settings are not explored is its ability to demonstrate the importance of the work that takes place in these settings on an individual and social level. Rather than re-inventing the wheel the TC movement would benefit from an empirically informed framework that could contribute to new ways in which effectiveness can be defined and measured, rather than conforming to standardised outcome measures that are defined by high-level policy directives providing a true to life representation of the work that takes place in a TC where people who have participated in a programme directed by financial incentives rather than individual need initiate and sustain their recovery from substance use.

Conclusion

This study provides a detailed insight into the intricate work that takes place in a residential TC for substance use. To move beyond a purely descriptive account of the setting the concept of recovery capital was utilised to provide a way in which the day-to-day activities that take place in a TC could be better understood. The following discussion will draw upon recovery capital to bring together the findings that have been presented throughout this thesis. To do so, particular attention will be paid to the aptitude of recovery capital to address a number of the challenges surrounding the operation of a programme that, in practice, is characterised by theoretical ambiguity. In addition to this, as fieldwork took place during a time that was characterised by political upheaval, the findings offer a first-hand account of how on the ground a series of fundamental changes to the commissioning and management of alcohol and drug services took hold in the setting under study (see Chapter Six).

The day-to-day workings that take place in the Mother-ship were somewhat detached from traditional TC concepts as outlined by DeLeon (2000), which reportedly underpin all activities that take place in a TC (see Chapter Five). Although the evolution of the programme has contributed to the ambiguity, which surrounds the practices that take place in settings like the Mother-ship, the most controversial and disputed alteration to date is the introduction of a medically managed detoxification programme. The strengths and limitations surrounding the integration of a medical intervention within a self-help community that utilises a psycho-social⁴⁵ approach to substance use have been discussed in Chapter Eight. This point has however been raised once again as it captures an inherent and live dilemma for the TC.

The Mother-ship, just like any other TC for substance use, claims to provide an abstinence-based programme, which advocates that recovery from substance use is a gradual process that consists of multi-dimensional learning involving behavioural, cognitive and emotional change. Although the utilisation of the term abstinence may be socially and politically desirable, it contradicts the philosophies, principles and practices that take place in a TC, which work towards incremental person-centred progress.

Abstinence and recovery are not synonymous or necessarily indicative of the same thing. As opposed to simply stopping using a specific substance, recovery is a multifaceted process that is as varied as the people who embark upon it. The term abstinence puts a focus on what someone is not doing, rather than what they are doing, or hope to do in the future. The philosophy of abstinence opposes the practices that take place on the ground in a TC, which are more aligned with principles and prescriptions of harm reduction.

“It’s a lapse, not the end of the world. I think we should keep him because we can work with him and he wants this chance. He has made loads of progress since he has been here. I thought this place was about the person, not the substance.”

(Oliver, Staff, March, 2012)

This point illustrates the presence of an implementation gap between the TC in theory and the TC in practice (see Chapter Two). It also suggests that there is a longstanding contradiction within the TC movement, which advocates abstinence from substance use (in theory) despite providing a programme that, on the ground, is steeped in philosophies of harm reduction.

Harm reduction refers to policies, programmes and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive substances (Harm Reduction International, 2015). Harm reduction

targets the causes of risks and harms associated with substance use rather than the use of substances per se (Hunt, Ashton, Lenton, Mitcheson, Nelles and Stimson, 2003). It is a pragmatic response to substance use based upon humanistic values that promote respect and dignity for all members of society (including substance users in need of help and support), which seeks to reduce the negative consequences of substance use. Although the principles that are associated with harm reduction provide a stark contrast to the theoretical assertions of 'abstinence', which surround the TC, they provide a more accurate representation of the work that takes place at the coal face of service delivery. This therefore raises the question whether the TC should adopt and embrace philosophies of harm reduction on both a theoretical and practical level. Although this is something that requires further attention, drawing upon the findings that have been presented throughout this thesis, it is possible to suggest that recognising harm reduction philosophies on a more formal basis would go some way in aligning TC theory and practice.

The importance attached to the reduction of negative consequences of a given behaviour has been recognised in the literature (see Chapter Three). For the last decade or so the desistance literature has been re-orientated away from deficit-orientated approaches⁴⁶ towards strengths-based approaches that offer a more positive recognition of individuals' strengths and goals (Ward, 2002a; 2002b; Andrews, Bonta and Wormoth, 2011; Stephens, 2012). At the epicentre of strengths-based approaches is a belief that an individual's well-being and risk of future (re)offending are inextricably linked. According to advocates of strengths-based approaches, the best way to reduce (re)offending is to help individuals to manage aspects of their life that elevate risk (Gendreau, 1996; Andrews and Bonta, 1998; Ward and Brown, 2004; Burnett and Maruna, 2006; Ward and Maruna, 2007). The best way to lower risk is to equip

individuals with the tools that they need to live a more fulfilling life (Ward and Brown, 2004). This suggests that parallels can be drawn between the contemporary desistance literature and the practices that take place in and around the Mother-ship.

With this in mind, it is possible to suggest that TCs like the Mother-ship are based upon a strengths-based approach to recovery couched in principles of harm reduction. The processes and practices that take place on the ground help to reduce the likelihood of residents reverting back to substance use through the accumulation of recovery capital. The programme is a holistic intervention that is led by individual need (although increasingly under threat due to the emergence of an outcome-orientated framework) rather than risk factors.

“When you come in here it’s as if you have an empty tool box. It is up to you to do the programme and make it work for you, taking what you need from it so that you get all the tools that you need ready for when you go out there. Tools are things like confidence, self-esteem, assertiveness, and all the things that can help keep you safe when you leave here.”

(Jon, Resident, August, 2011)

If the TC movement was to utilise the concept of recovery capital, on both a theoretical and practical level, it would provide an empirically informed framework that would not only help to define what people can achieve during their residency, but why interventions couched in TC principles are an important component of the recovery process (see Chapter Seven). Rather than relying upon metaphors, similes, allegories and dated concepts to describe the processes and outcomes of programme participation, the application of recovery capital would provide a grounded framework that is much more aligned with the practices that take place in a TC, as well as the achievements that are made during and after a residents’ time in the programme.

It is important to note that it is not suggested that we should simply disregard traditional TC concepts. Rather, as a contribution to this debate it is proposed that the findings presented in this thesis go some way to opening up a wider debate about existing TC concepts and their relevance to the contemporary TC for substance use. The findings presented could also invite further discussion about how the concept of recovery capital can be utilised alongside revisited TC concepts and explain what takes place in settings like the Mother-ship; and offer a rationale as to why.

The utilisation of recovery capital would not only provide a more grounded representation of the processes that take place in a TC, but a more accurate reflection of the outcomes that are achieved during and after programme completion. Outcomes may include tools such as an improved ability to function autonomously without the use of substances (human recovery capital), the erosion of criminal values, attitudes and beliefs (cultural recovery capital), an improved ability to manage money (physical recovery capital) and a more positive relationship with family and friends (social recovery capital). Although such outcome measures do not quite fit with the longstanding, but ill-informed, socially and politically desired outcomes of reduced (re)offending, retention and relapse they provide a much more realistic representation of the work that takes place within the alcohol and drug treatment sector, in particular the residential TC.

“It can be hard to explain what you learn in a TC. People think it is a soft option the minute you start talking about feelings and that, but it is one of the hardest things that you can do. Well I think so anyway. All I know is that it was the start of my new life.”

(T-Bone, ex-resident, January, 2013)

“What did I get out of this place? My life! I don’t care how they write it down or make it look good for them, but that’s exactly what I got by being here.”

(Michelle, Resident, December, 2011)

“Yeah I was a junkie who committed crime, but that doesn’t define who I am and what was going on for me back then. People tend to forget that you have needs when you’re in the madness.”

(Eddie, Staff, March 2013)

The use of absolute standardised measures to define and measure effectiveness, which rather ambitiously indicate that some form of end-state has been reached provide a further illustration of the contradictory philosophies and practices surrounding the TC (see Chapter Two and Seven). Staff and residents in the Mother-ship believe that recovery is an incremental process, which consists of the accumulation of personal and social skills and resources. Not a once in a lifetime event whereby people are somehow ‘fixed’ simply because they have participated in a TC for a given period of time. The service provides a safe and supportive environment in which residents can begin to learn about themselves, their relationship with others and work through past experiences and ongoing issues that may have influenced, directly and/or indirectly, their use of substances. Participation in a TC like the Mother-ship is the beginning of an end, not a standalone end of story event.

“I know that I have a lot of work still to do on myself. You can’t come in here and expect everything to just be OK the minute you walk out the door. You can’t expect to never think about using drugs again just because you have been in here. You have to be realistic with yourself, and that is what this place has helped me to do. I can’t escape the fact that I’ve got a colourful past and a problem with substances but what I can do is prove to myself and, anyone else for that matter, that that isn’t me anymore. It’s probably something I’m going to be working on for the rest of my life, but I am ready for it. In fact I think I’m looking forward to it. I have to make a go of it this time because I doubt I’ll get funding again for somewhere like this.”

(Charlie, Resident, January, 2011)

The above quotation illustrates how even a removed and supposedly sanitised environment like the residential TC finds itself subject to the pressure of the wider social and political landscape. During fieldwork it became apparent that the traditional, ideological vision of the TC was fundamentally compromised by an array of very real practical, social and political pressures. The introduction of PbR introduced an

uncomfortable balance between financial gain and individual progression whereby an individual was removed from the epicentre of their programme, marginalised and overlooked as financial gain was prioritised (see Chapter Six). The prioritisation of bureaucratic processes not only dehumanised residents and their programme progression, but raised questions about the legitimacy of the programme and staff decisions. On a number of occasions residents questioned the legitimacy of staff decisions, particularly with regard to programme progression, admissions and discharges. This not only had an impact upon a resident's perception of the programme, but the way in which staff members were viewed.

“It makes me angry when they blatantly do things for money. You feel that you have a price tag on your head sometimes and that is just as bad, if not worse than the other labels that I am trying to get away from.”

(Steve, Resident, May, 2012)

This could, and indeed did, have a detrimental impact on the working relationships and inter-personal bonds between staff and residents in the service. The ability of bureaucratic processes to fracture relationships between staff and residents not only jeopardised the perceived legitimacy of the work that took place in the Mother-ship, but hindered the development of positive working relationships, which as the literature suggests, are important components of the recovery process (Orlinsky, Ronnestad and Willutzski 2004; Meier, Barrowclough and Donmal, 2005; Lebow, Kelly, Knoblock-Fedders and Moos, 2006; Gibbons, Nich, Steinberg, Roffman, Corvino and Babor, 2010; Hartzler, Witkiewitz, Villarroel and Donovan, 2011; Urbanoski, Kelly, Hoepfner and Slaymaker, 2012).

The prioritisation of financial gain over individual need raises a number of ethical and moral issues; notably whether it is a fair and just way in which to provide vital life changing and indeed lifesaving services for some of the most vulnerable and complex

members of society. Although the PbR scheme piloted in the Mother-ship was relatively short-lived and lacked uptake, the findings that were generated provide an intimate insight into what the future will hold for the TC as and when outcome-based initiatives dominate residential funding streams.

In addition to the introduction of PbR the emergence of business-orientated decisions within a public health model of thinking also raised a number of moral dilemmas. This is predominately due to the fact that putting localised health-orientated mantras at the forefront of the political agenda distracts attention away from the social pressures and differential opportunities that exist between communities, which prevent people from accessing help and support for substance use in the first instance (see Chapter Eight).

All of a sudden we have witnessed the term ‘local community’ become an all-purpose solution to a range of social problems, which seems rather contradictory given that for many people it is their relationship with the community that compounds existing problems and ongoing issues. Although the Mother-ship provides a more just approach for substance users, prioritising individual progression rather than punishment, criminalisation and marginalisation as justice has something to do with equalising unequal social situations (Sullivan and Tifft, 1998), more ought to be done in order to tackle the social and structural hurdles that affect the recovering community during and after participation in a TC (see Chapter Eight).

Although the Mother-ship provided a platform for residents’ to develop aspects of recovery capital there were some components that were dependent upon an individual’s relationship with the community. Generally speaking, the accumulation of physical and social recovery capital is influenced by wider structural opportunities such as

employment, educational attainment and validation as a proper member of society (Farrall *et al.*, 2010 cited in Shapland, Bottoms, Farrall, McNeil, Priede and Robinson, 2012). This illustrates how recovery from substance use is not a process that takes place behind closed doors in a residential setting away from the public eye. It is a social issue that requires an array of social policy responses rather than criminal justice responses.

The findings that have been presented in this thesis are usefully thought out as: parallels; process; and progress. *Parallels* can be drawn between the TC for substance use, desistance, recovery capital and harm reduction literature to provide a more coherent way in which to explore the organisation of a setting such as the Mother-ship; and explain how and why a TC provides an environment that is conducive to recovery. The term *process* is significant as it illustrates how alternative ideas and interventions, like the hierarchical TC, can also find themselves undermined by the influence of the wider social and economic inequalities and an ever changing socio-political climate. The ethos and application of the term *progress*, rather than effectiveness, not only dominates the findings, but illustrates how detached current definitions and measures of effectiveness are from the realities of the work that takes place in on the ground and the individual achievements that residents make during and after their time in the Mother-ship. As the discussion in Chapters Two and Eight suggest, the utilisation of the term *progress* is more reflective of the work that takes place in a TC as ‘effectiveness’ is relative and can be contrary to nationally defined measures of effectiveness.

The thesis has sought to advance the case for using recovery capital to provide a more comprehensive way in which to interpret the operation of TCs at the coal face of service delivery. The application of the framework here, to make sense of the experience of one situated TC, helps determine the dynamism of the inputs, process and outcomes of TC

interventions. More than simply addressing gaps in research knowledge about the workings of TCs, the generated data shed light on the practical, political and social factors (and on occasions hurdles) that shape the delivery and realisation of theoretically informed policy ambitions.

The findings that are presented here have substantial political implications as they are able to engage with wider criminal justice and social policy debates about the marketization of the management and supervision of substance users and lawbreakers whose offending behaviour has been heavily influenced by substance use. They discuss some of the adverse consequences that have surfaced as outcome-based initiatives began to shape the delivery and management of the alcohol and drug treatment field; illustrating how such incentives hold the ability to suffocate personal progression and transform environments based on compassion and care into a bureaucratic financially-driven conveyor belt. In addition to this, it has been suggested that the concept of recovery capital could go some way in helping to align PbR, as well as other administrative frameworks, with the outcomes that are obtained during and after participation in a TC.

Utilising the concept of recovery capital as a foundation for outcome-based commissioning would not only go some way in creating and implementing a more aligned and grounded measure of effectiveness, but contribute to ongoing debates which urge politicians, commissioners and society as a whole to confront issues such as stigma, differential opportunities, social inequality and structural disadvantage that deeply affect members of the recovering community; and indeed other marginalised groups on a daily basis, which inhibits their ability to de-mask and create a new sense of self.

The findings that are presented in this study provide a progressive and alternative way in which the practices and processes that take place in a TC can be explained and communicated to a wider audience. The application of recovery capital would not only go some way in developing a better insight into the daily operation of a TC, but contribute to the development of a consistent framework that can accurately reflect that work that takes place within a TC; regardless of the population being served or the context in which the programme is located. In addition to this, the thesis contributes to the longstanding debates that surround the definition and measurement of TC effectiveness. Rather than maintain the status quo, it is suggested that the provision of a more open-ended but representative outcomes-framework, steeped in principles of recovery capital, could go some way in aligning political incentives with the realities of the work that takes place on the ground within TCs like the Mother-ship.

End Notes

¹ The term resident is used by those in the TC under study when referring to service users/clients.

² In 2012 it was estimated that there were 120 residential services, with a further 18 private hospitals providing alcohol and drug treatment in the United Kingdom. The majority of these had a minimum length of stay of less than six months (70.2%, n = 85) with just over half of these (n = 48, 56.5%) offering programmes with a minimum length of stay between three and six months. Those offering programmes of more than 12 months accounted for only 6% of the services (n = 7) (Davies *et al.*, 2012).

³ For the purpose of this thesis a hierarchical TC has been defined as an environment in which people with problems, primarily related to substance use, live together in an organised and structured way in order to promote change. A TC forms a miniature society in which residents and staff, in the role of facilitators, fulfil distinctive roles and adhere to clear rules all designed to promote the transitional process in which the individual is the protagonist principally responsible for achieving personal growth and upholding the welfare of the community (Ottenberg, Broekaert and Kooyman, 1993). This definition has been adopted as it has been used since 1991 by the European Federation of Therapeutic Communities (EFTC) to broadly identify what a hierarchical TC should consist of (Rawlings and Yates, 2001).

⁴ Recovery capital is the sum total of personal, social and community resources that can be used to facilitate an individual's decision to initiate and sustain recovery from substance use (Granfield and Cloud, 1999). Although the concept is still in its infancy it has gained prominence in the United Kingdom, and was recognised in the 2010 drug strategy as one of the best predictors of sustained recovery (Her Majesty's Government, 2010b:18).

⁵ Although the focus of this thesis is the hierarchical TC a short exploration of the origins and development of the democratic TC has been provided for informative purposes.

⁶ Academic Search Complete, Applied Social Science Index and Abstracts, International Bibliography of the Social Sciences, IngentaConnect, JSTOR, MetaPress, Oxford Scholarship Online, PsyncINFO (EBSCO), Sage, Science Direct, SwetsWise and Web of Science.

⁷ Residential settings, such as the TC, routinely respond to the needs of a population which is significantly more damaged than that seen by comparable community-based programmes which inevitably has an impact on respective outcomes (Yates, 2008).

⁸ The descriptive accounts identified were as follows: Davidson, 1976; Sutker *et al.*, 1978; DeLeon and Jainchill, 1981-1982; Glaser, 1981; Yates, 1981; DeLeon and Schwartz, 1984; Sorensen *et al.*, 1984; DeLeon, 1985; Carr-Gregg, 1985; DeLeon and Jainchill, 1986; DeLeon and Ziegenfuss, 1986; Sugerman, 1986; Manning, 1989; Yates, 1992; Kooyman, 1993; Cullen *et al.*, 1997; DeLeon, 1997; Broekaert *et al.*, 1998; Kennard, 1998; Marcus, 1998; White, 1998; Melnick and DeLeon, 1999; DeLeon *et al.*, 2000; Broekaert *et al.*, 2001; Melnick, DeLeon, Thomas and Kressel, 2001; Rawlings and Yates, 2001; Broekaert *et al.*, 2002; Yates, 2002; Kaplan and Broekaert, 2003; Tsiboukli and Wolff, 2003; Yates, 2003; Lees *et al.*, 2004; Perfas, 2004; Ward, 2005; Broekaert 2006; DeWilde, Broekaert and Rosseel, 2006; Eliason, 2006; Yates *et al.*, 2006; Borkman *et al.*, 2007; Autrique *et al.*, 2008; Mandell *et al.*, 2008; DeLeon and Wexler, 2009; Bunt, Muehlback and Moed, 2011; Yates, 2012; Perfas, 2012; Stevens, 2013.

⁹ The follow up studies identified were as follows: Collier and Hijazi, 1974; Romond *et al.*, 1975; Holland, 1978; Wilson and Kennard, 1978; Wilson and Mandelbrote, 1978; DeLeon *et al.*, 1979; DeLeon, Wexler and Jainchill, 1982; Simpson and Sells, 1982; Field, 1984; Wilson and Mandelbrote, 1985; DeLeon, 1991; Fals-Stewart and Schafer, 1992; Bleiberg, Devlin, Croan and Briscoe, 1994; Condelli and Hubbard, 1994; Toumbourou *et al.*, 1998; Dekel *et al.*, 2004; Fernandez-Montalou *et al.*, 2008; Johnson *et al.*, 2008; Bankston *et al.*, 2009.

¹⁰ The evaluation studies identified were as follows: Ogbourne and Melotte, 1977; Berg, 1979; DeLeon, 1984; Strupp, 1988; DeLeon, 1989; DeLeon, Melnick, Kressel and Jainchill, 1994; Cancrini, DeGregoria and Cardella, 1994; Rhodes and Greenberg, 1994; Timms *et al.*, 1994; Wexler and Love, 1994; Hanna and Richie, 1995; Broekaert *et al.*, 1999; Lloyd and O'Callaghan, 1999; Ravndal, 2003.

¹¹ The follow up studies of prisoners who participated in a prison-based TC identified were as follows: Wexler *et al.*, 1988; Genders and Player, 1995; Eisenberg and Fabelo, 1996; Graham and Wexler, 1997; Inciardi *et al.*, 1997; Nielson and Scarpitti, 1997; Wexler *et al.*, 1998; Knight *et al.*, 1999; Martin *et al.*, 1999; Siegel *et al.*, 1999; Zhang *et al.*, 2009.

¹² The in-programme studies identified were as follows: Fals-Stewart, 1992; Kressel *et al.*, 2000; Small and Lewis, 2004.

¹³ The critical accounts identified were as follows: Waldorf, 1971; Bale, 1979; Rosenthal, 1984; Clark, 1984.

¹⁴ The studies that explored the relationship between outcomes and individual characteristic were as follows: DeLeon, 1988; DeLeon *et al.*, 1997; Pouloupoulos and Tsiboukli, 1999; Wildlitz, Dermatitis, Galanter and Bunt, 2011.

¹⁵ The six comparative studies that were included compared outcomes of clients in two or more hierarchical TCs.

¹⁶ To date, there are 538 places in prison-based democratic TCs which equates to less than 1% of the prison population (Stevens, 2013).

¹⁷ An important difference between TCs, AA and 12-step programmes is the fact that TCs do not define substance use as a disease. On the contrary, rooted in humanistic approaches, characterised by a belief in individual growth and human potential, the development of the TC has been regarded as a reaction against the medical model of addiction (Troyer, Acampora, O'Connor and Barry, 1995; Vanderplasschen *et al.*, 2014). TCs do not refer to the concept of a 'higher power' as the AA does in four of its twelve steps (Galanter, 2007).

¹⁸ Milieu therapy is a type of in-patient therapy which involves the prescription of particular activities and social interactions according to an individual's emotional and interpersonal needs.

¹⁹ Reciprocal determinism is a term used to describe how a person's behaviour influences and is influenced by the social environment (Bandura, 1986).

²⁰ Descriptive accounts provide qualitative information about the population or phenomenon under study and can be used to guide clinical programme planning (Lees *et al.*, 2004; Gray, 2009). Of the 46 descriptive accounts identified there were 37 accounts of TC components and five descriptive accounts of the TC population (Sutker *et al.*, 1978, Sorensen *et al.*, 1984; DeLeon and Jainchill, 1991; Melnick *et al.*, 2001; Ward, 2005). There were two descriptive accounts of the origins and development of the hierarchical TC (Glaser, 1981; DeLeon, 1985) and two discussions of the social impact of TCs (DeLeon and Jainchill, 1981-1982; Sugerma, 1986).

²¹ Follow up studies involve participants being studied over a period of time with data collected at given intervals, usually a period before and after programme involvement. Of the 19 follow up studies identified: seven explored the relationship between relapse and length of programme involvement (Collier and Hijazi, 1974; Simpson and Sells, 1982; Field, 1984; DeLeon, 1991; Bleiberg *et al.*, 1994; Toumbourou *et al.*, 1998; Johnson *et al.*, 2008) while five explored the relationship between criminal convictions and length of programme involvement (Romond *et al.*, 1975; Wilson and Mandelbrote, 1978; Holland, 1978; DeLeon *et al.*, 1979; Wilson and Mandelbrote, 1985). Three explored the relationship between relapse, criminal convictions and length of programme involvement (DeLeon *et al.*, 1982; Dekel *et al.*, 2004; Fernandez-Montalvo *et al.*, 2008). One explored the relationship between relapse, criminal conviction and productivity (Condelli and Hubbard, 1994); one looked at neuro-cognitive functioning and length of programme involvement (Fals-Stewart and Schafer, 1992) and two looked at impulsivity and length of programme involvement (Wilson and Kennard, 1978, Bankston *et al.*, 2009).

²² Research in and around the concept of recovery capital was still in its infancy when the literature review was conducted for this study. It was however, recognised in a number of desistance studies which explored how personal, social and community resources contributed to an individual's decision to desist from crime (Sampson and Laub, 1993; Farrall, 2002; Giordano *et al.*, 2002; Maruna and Farrall, 2004; Ezell and Cohen, 2005; McNeil, 2009). This meant that a review of the desistance literature was required.

²³ See Chapter One for further details on the systematic approach that was employed when collecting literature for this study.

²⁴ Academic Search Complete, Applied Social Science Index and Abstracts (ASSIA), International Bibliography of the Social Sciences (IBSS), IngentaConnect, MetaPress, NetLibrary, Oxford Scholarship Online, PsycINFO, SAGE Journals Online, ScienceDirect, SwetsWise, Web of Science, Wiley Online Library.

²⁵ Of the 25 articles identified there were 16 descriptive accounts (White, 2000; Brown University Digest, 2001; White, 2007; Hser, Longshore and Anglin, 2007; Laudet, 2007; The Betty Ford Institute Consensus Panel, 2007; Radcliffe and Stevens, 2008, Cloud and Granfield, 2008; White, 2008; White and Cloud, 2008; Laudet, 2008; Cluley, 2009; Fox, 2009; Davidson *et al.*, 2010; Lyons, 2010; Lyons and Lurigio, 2010). Three follow up studies (Dennis *et al.*, 2007; Laudet, 2007; Laudet and White, 2008). Five studies which employed a single semi-structured interview with individuals at various stages of recovery (Granfield and Cloud, 2001; Cloud and Granfield, 2001; Keane, 2011; Best, Gow, Knox, Taylor, Groshkova and White, 2012; Terrion, 2012) and one focus group study (Groshkova, Best and White, 2013).

²⁶ Durkheim was particularly interested in the way that people's social ties served as a thread from which a society wove itself together (Durkheim, 1933).

²⁷ Marxism gave rise to a variety of attempts to explain the strength and weakness of solidarity amongst the oppressed. Marx in particular sought to distinguish between what he called a class in-itself, defined by its objective economic circumstances and a class for itself whose members were subjectively aware of their common situation and determined to do something about it (Field, 2008).

²⁸ According to AA an individual's recovery is contained in twelve-steps. The first step is admitting powerlessness over substances; the second step is coming to rely on a power greater than oneself (Alcoholics Anonymous, 2014).

²⁹ In an attempt to gather as much information as possible on recovery capital a review of the desistance literature, which specifically mentions the term capital or resources was conducted. The electronic library at LJMU was searched using the search terms desistance and recovery which identified 79 titles from within 13 electronic databases. Of the 79 titles there were; 61 academic journals, four conference papers, ten books/book chapters, three dissertations and one magazine extract. 49 journal articles, four conference papers, three dissertations and one magazine extract were excluded as they discussed topics that were not relevant to desistance from crime or the accumulation of capital or resources, and/or were not available electronically or via the inter-library loan service at LJMU. This left 22 titles in total; 12 journal articles (Shover, 1983; Laub *et al.*, 1998; Giordano *et al.*, 2002; Bottoms *et al.*, 2004; Farrall and Maruna, 2004; Farrall, 2004; Burnett and Maruna, 2006; Webster *et al.*, 2006; Ward and Maruna, 2007; McNeil, 2009; Colman and Laenen, 2012; Beckett Wilson, 2014) and 10 books or book chapters (Clarke and Cornish, 1983; Douglas, 1984; Gottfredson and Hirschi, 1990; Cromwell *et al.*, 1991; Liebrich, 1993; Sampson and Laub, 1993; Farrall, 2002; Laub and Simpson, 2003; Ezell and Cohen, 2005; McNeil and Whyte, 2007).

³⁰ Social capital can range from positive (socially legitimate, promoting cohesion, law abiding) to negative (socially illegitimate, often self-serving and illegal) described respectively as licit and illicit social capital (Beckett Wilson, 2014).

³¹ Sullivan, 1953; Sampson and Laub, 1993; DeLeon, 1997; Granfield and Cloud, 1999; DeLeon, 2000; Granfield and Cloud, 2001; Farrall, 2002; Giordano *et al.*, 2002; Farrall and Maruna, 2004; Ezell and Cohen, 2005; Dennis *et al.*, 2007; Cloud and Granfield, 2008; Laudet and White, 2008; White and Cloud, 2008; Fox, 2009; McNeil, 2009; Best and Laudet, 2010; Davidson *et al.*, 2010; Lyons, 2010; Lyons and Lurigio, 2010; Keane, 2011; Colman and Leanen, 2012.

³² The term Mother-ship was utilised as this was how the TC was referred to by staff and ex-residents. It became apparent that the term captured the symbolic significance of the TC in the lives of residents and ex-residents as it was considered to be a place that they could go back to if they felt that they were in need of guidance, advice and support. When we think of a mother we think not just of care and love, but an obvious sense of unconditional support. Symbolically then, the term Mother-ship evokes a sense that people remembered, and felt able to seek support, advice and guidance both during and after their time in the programme.

³³ As grounded theory and ethnography are naturalistic forms of enquiry they are compatible approaches to data collection and theory generation (Glaser and Strauss, 1967; Battersby, 1979; Ingersoll and Ingersoll, 1987; Brewer, 2000; Pettigrew, 2000). Ethnography entails observing and analysing behaviour in naturally occurring situations (Longabaugh, 1980) and grounded theory performs best with data that have been generated in natural settings (Robrecht, 1995).

³⁴ The encounter group that takes place in the Mother-ship was attended by two staff members and all residents. Students and volunteers are not permitted access to the encounter group due to the sensitive nature of the discussions that take place. As the encounter group is an important TC component access to the group was negotiated with the management team and granted as long as field notes were not taken during the group.

³⁵ Janus is the data base that is used in the Mother-ship. It stores information on each resident such as admission and funding information, harm reduction information, Treatment Outcome Profile (TOP) information, Outcomes Star and care plan progress and results from random drug tests which is submitted to the National Drug Treatment Monitoring Service (NDTMS).

³⁶ The prison fast track programme is designed for newly released prisoners who have completed a prison-based TC.

³⁷ The ESRC was founded in 1965 and is one of the largest research councils in the United Kingdom. The ESRC receives most of its funding from the Department of Business, Innovation and Skills and provides funding and support for research and training work in social and economic issues.

³⁸ Some prescribed medicines, such as morphine and methadone, are controlled under the Misuse of Drugs legislation. They are typically referred to as controlled medicines or controlled drugs because stricter legal controls apply to how they are stored, produced, supplied and prescribed (National Health Service Choices, 2014).

³⁹ The NTA was created as a specialist health authority in 2001 to improve the availability, capacity and effectiveness of drug treatment in England. The NTA's role was to ensure services, delivered on both public health and criminal justice agendas, reflected the interests of the Department of Health (National Treatment Agency for Substance Misuse, 2014).

⁴⁰ If the potential resident was in the community when the referral to the Mother-ship was made the care manager would be responsible for sourcing a record of previous convictions, which were usually obtained from a previous probation officer or solicitor. If a potential resident was serving a custodial sentence at the time of their referral the prison officer/CARAT worker who referred the prisoner would be responsible for obtaining a copy of previous convictions from the prisoner's offender supervisor.

⁴¹ The Outcomes Star was established in 2001 to explore ways in which the homeless sector could improve its delivery of services by setting, measuring and learning from the outcomes of their work (Burns, Graham and MacKeith, 2006). The Outcomes Star is an approach to measuring change when working with vulnerable people. The understanding that lies beneath the Outcomes Star is captured in the journey of change which is a scale that outlines the key steps in the transition from dependence to independence (DiClemente, 2003). The Outcomes Star approach outlines a resident's journey from first assessment to independent living. The journey is defined in ten steps, within which there are three turning points: wanting change and accepting help, actively taking part and more self-motivated (Burns *et al.*, 2006). The Outcomes Star had ten ladders which cover: motivation and taking responsibility, self-care and living skills, managing money, social networks and relationships, drug and alcohol use, physical health, emotional and mental health, meaningful use of time, managing tenancy and accommodation and offending. In theory each ladder helped residents to identify where they were, what problems they had, where they would like to be and what steps they needed to take to get there (Burns *et al.*, 2006).

⁴² For the purpose of anonymity their names have been changed and pseudonyms used.

⁴³ See Chapter Four, for a more detailed discussion about how data was analysed, edited and structured throughout this thesis.

⁴⁴ The following residents were chosen as their narratives illustrate some of the personal, social and economic difficulties that surround an individual's decision to desist from substance use.

⁴⁵ The term psycho-social is used to emphasise the close connection between psychological aspects of the human experience and the wider social experience. Psychological effects are those that affect different levels of functioning including cognitive (perception and memory as a basis for thoughts and learning), affective (emotions), and behavioural. Social effects concern relationships with family and community networks, cultural traditions and economic status. The use of the term psycho-social is based on the idea that a combination of factors are responsible for an individual's well-being. The term directs attention towards the totality of peoples experiences rather than focusing exclusively on the physical or psychological aspects of health and well-being, and emphasises the need to view these issues within the interpersonal contexts of wider family and community networks in which they are located (Martikainen, Bartley and Lahema, 2002).

⁴⁶ The risk-need-responsivity (RNR) model has been widely regarded as the premier model for guiding offender assessment and treatment. The RNR model underlies some of the most widely used risk-needs offender assessment instruments, and it is the only theoretical model that has been used to interpret the offender treatment literature. Recently, the good lives model (GLM) has been promoted as an alternative and enhancement to RNR. GLM sets itself apart from RNR by its positive, strengths-based, and restorative model of rehabilitation (Andrews, Bonta and Wormoth, 2011).

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Appendix 1: Glossary of Definitions

Abstinence	Choosing not to engage in certain behaviour, or not giving into a desire or appetite.
Aftercare	Support and advice offered to an individual once they have completed a programme.
AA	Alcoholics Anonymous, an international organisation that provides support groups for individuals trying to overcome alcoholism.
Approved premises	In the United Kingdom, approved premises, formerly known as probation or bail hostels, are residential units which house offenders in the community.
Banged up	A commonly used slang phrase that is used when someone has received, or is serving, a custodial sentence.
Base	A street name for a range of drugs formally known as amphetamines.
Big Book (AA)	Alcoholics Anonymous: the story of how many thousands of men and women have recovered from alcoholism is a book generally known as the Big Book (Alcoholics Anonymous, 2014). It is a basic text which describes how to recover from alcoholism, primarily written by one of the founders of AA, Bill Wilson. It is the originator of the seminal twelve-step treatment method which is used to treat alcoholism with a strong spiritual and social emphasis.
Blind Faith	Is a belief in something that we cannot see and because we cannot see it we say it is blind.
Bairn	A phrase that is typically used by those from the north-east when referring to a baby or young child.
Cash in hand	A street term that is used when an individual who receives state benefits works illegally and receives a cash in hand payment for doing so that they do not declare to the department of work and pensions.
CBT	Cognitive Behaviour Therapy, developed to help people make practical changes in their thoughts (cognitions) and actions (behaviours) in order to improve how they feel. It is a way of talking about how you think about yourself, the world and other people and how what you do affects your thoughts and feelings.
Clean	A street term that is commonly used when an individual, who has previously used substances, is abstinent or has been abstinent for a given period of time.
CMRS	Circumstance, Motivation, Readiness and Suitability.

Cock of the landin'	Cock of the landin' is a street term that is typically used to describe male prisoners who are considered to be at the top of the pecking order due to previous offending behaviour, status and reputation.
CoF	Confirmation of Funding.
Cold turkey	A street term that is commonly used to describe the abrupt and complete cessation of taking a substance to which one is addicted.
Commitment	A term used by residents when referring to a voluntary, educational or vocational activity in the local community.
Common Ground	A term used to describe a foundation for mutual understanding.
Convict Code	The Inmate Code, or Convict Code, refers to the rules and values that have developed amongst prisoners inside prison social systems.
Core Issue(s)	A term commonly used in Therapeutic Communities to describe deep, underlying emotional imbalances which usually develop in response to traumatic events.
Crack head	A street term that is used to describe someone who is addicted to crack cocaine.
Cravings	An intense desire for a particular experience.
CRB	Criminal Records Bureau, now known as the Disclosure and Barring Service (DBS) produces two levels of checks: a standardised disclosure; and an enhanced disclosure. A standard check will detail every conviction, including spent convictions, cautions, warnings and reprimands which are recorded in central records, or it will state that there is no such information held. An enhanced check will detail all criminal information as above, as well as any information which, in the opinion of a Chief Police Officer, might be relevant for the purpose and ought to be included in the certificate. Additionally this level of disclosure will provide clarification as to whether the applicant is banned from working with children or vulnerable adults.
Custodial	A street term that is used when someone has received a custodial sentence.
DAATs	Drug and Alcohol Action Teams.
DTTO	Drug Treatment and Testing Order, introduced to the United Kingdom in 2000 as a community sentence that aimed to break the link between substance use and crime. DTTOs have since been phased out and the Drug Rehabilitation Requirement (DRR) was introduced in April 2005.
EFTC	European Federation of Therapeutic Communities.
ESRC	Economic and Social Research Council.
Fambo	A street term that may be used when an individual is referring to a family unit.
FAST	Fast Alcohol Screening Test.

Feedback	A phrase that is used by staff and residents to describe a process whereby residents will feedback information to staff about a fellow peers attitude and behaviour.
FLAMES	Families and Loved ones Accessing Mutual and Emotional Support.
Frosty Jack	A brand of Cider.
Gear	A street term that is used when talking about Heroin.
Get me head into it	A term that was frequently used by residents when they were making a tentative effort to change their thoughts, feelings and behaviours.
Gettin off me head	An expression that was frequently used by residents when they were discussing previous substance use.
Glorification of the past	This occurs when a resident retells stories from their past about substance use and crime, in a positive light.
Going down	A street term that was used when an individual received a custodial sentence.
Grafting	A street term that is commonly used when reference to drug dealing or criminal activity is made.
Harm reduction	Harm reduction, or harm minimisation, is an umbrella term which is used to describe a range of public health policies that are designed to reduce the harmful consequences associated with substance use and/or other behaviours and practices.
Head change	A street term that was used when staff and residents in the Mother-ship were discussing the effects of substance use.
Heads out the door	A phrase that was used when residents were seemingly not interested in the programme.
Higher Power	A term associated with Alcoholics Anonymous when referring to a power greater than the individual.
HMP	Her Majesty's Prison
High risk situation	An occurrence, situation, group of people and/or behaviour that could lead to substance use.
Inside	A street term that was commonly used to refer to individuals who were serving a custodial sentence.
IPP	Indeterminate Sentence for Public Protection, introduced by the Criminal Justice Act 2003. Generally speaking an IPP has the same structure as a life sentence, the same criteria for parole, the same limitations on the offender and the same difficulties in that a prisoner has to prove that (s)he is no longer a danger to the public if they are to stand any chance of release. The IPP was abolished in accordance with the Legal Aid Sentencing and Punishment of Offenders Act 2012 and from December 2012 no more IPPs could be handed out. Although a welcomed move, it is not retrospective as it does not affect those currently serving IPPs.

Ivory tower	This phrase was used by staff and residents to suggest that management teams were detached from the realities of service provision.
Jail head	A phrase used by staff and residents when an individual entered the TC straight from prison and displayed behaviour that was synonymous with the convict code.
Jail stories	A phrase that was used when residents discussed criminal behaviour, previous convictions and experiences of imprisonment.
Jail swerve	A phrase that was used when residents entered the Mother-ship so that they could avoid a custodial sentence.
Jug	A street term for prison.
Junkie	A street term that was used to refer to an individual who used a substance such as Heroin.
Just through the door	A phrase that was commonly used to refer to residents in the welcome house stage.
Johari's Window	A group that was used in the Mother-ship to help residents better understand their relationship with themselves and those around them.
Lapse	A brief or temporary use of substances after a period of abstinence.
LJMU	Liverpool John Moores University.
LSD	Lysergic acid diethylamide, a synthetic crystalline compound with powerful hallucinogenic properties.
Main house	A term that was used when reference to primary and senior residents were made.
MDT	Mandatory Drug Test.
Mother-ship	A name given to the TC under study by staff and residents. See footnote 31 for a detailed explanation of this term.
MS	Multiple Sclerosis, a chronic disease of the nervous system, affecting different parts of the brain and spinal cord, resulting in typically scattered symptoms.
NHS	National Health Service.
NTA	National Treatment Agency for Substance Misuse.
NTDS	National Drug Treatment Monitoring System.
Out there	A phrase commonly used by staff and residents when references to the wider community were made.
Overdose	A term that is used when someone has used a dangerous or excessive amount of a particular substance.
PbR	Payment by Rules.
PGCs	Peer Group Councils, informal, time-tabled sessions that provided the opportunity for residents to come together and discuss any issues or concerns.
PHE	Public Health England.
Picked up the foil	A street phrase used when someone referred to Heroin use.
Pin	A street term for needle or syringe.

PNC	Police National Computer.
Pot	A street term for Cannabis.
Psychosis	A term used to describe a severe mental disorder in which thought and emotions are so impaired that contact is lost with external reality.
QACGC	Quality Assurance and Clinical Governance Committee.
RAMP	Risk Assessment and Management Plan.
REC	Research Ethics Committee.
Relapse	Resuming the use of a substance after a period of abstinence.
Resident(s)/Ressie	A term used when referring to clients in the Mother-ship.
Score	A street term used when an individual had obtained, or was about to obtain substances.
Send him down the path	A phrase used by staff and residents when referring to an event that could result in a resident electing to leave the programme under study early.
Smack	A street term for Heroin.
SMS	Scientific Methods Scale.
SP	Senior Professor Intervention.
Straight	A street term used to describe individuals without a criminal record or history of substance use.
Stretch	A street term used when referring to a custodial sentence.
TC	Therapeutic Community.
The madness	A street term used when reference to the drug subculture was made.
The Onion Concept	Ultimately this is about identifying and understanding the layers of an individual's character; layers of defences and images that have been put in place in attempt to protect them from being vulnerable and allows others to see only what they want them to see. It is about identifying and accepting core issues and encouraging individuals to replace negative layers with positive ones.
Tools of the house	A phrase used when referring to therapeutic interventions that took place in the Mother-ship.
Tooter	A street term used by residents and staff when referring to a device used to smoke heroin or crack cocaine.
TOP	Treatment Outcome Profile
Trigger	A stimulus associated with the preparation, anticipation or actual use of substances.
Urge	A strong desire or impulse.
Usin me fists	A street term used when acts of physical violence were referred to.
Weed	A street term for Cannabis.
Wing it	A phrase used by staff and residents when someone was deemed to be making things up as they went along.

Appendix 2: Pre-interview information sheet

Background Information

Gender: _____

D.O.B: _____

Ethnicity: _____

Primary substance of choice: _____

Secondary substance of choice: _____

Contact details: _____

<i>[Pseudonym here]</i>	1st interview	2nd interview	3rd interview
Date			
Programme stage			

Appendix 3: Interview question schedule

Resident interview question schedule

1. Tell me a bit about how you came to be here?
 - Lifestyle prior admission
 - Alcohol and/or drug use
 - Educational achievements and employment history
 - Criminal justice involvement
 - Perceptions and expectations of a TC
2. Have you tried any other programmes for substance use? Which ones, when, what did you think of them?
3. How did you hear about the Mother-ship?
4. Why did you join the Mother-ship? What do you think of the programme?
5. How long have you been in the programme? What are your plans after the programme?
6. In your own words can you describe a TC?
7. Have you found any tools of the house to be particularly useful and/or inspirational? Why/why not?
8. Have you found any aspects of this programme particularly frustrating? Why/why not?
9. If you could make any improvements to the programme what would they be?
10. How would you describe your role/position in the community?
11. Do you think that having a role/position in the community has helped your recovery? Why/Why not?
12. Is there a down side to having a role/position to live up to in the community?
13. Do you think that it is important that everyone pulls their weight in the community? Why/Why not?
14. In your opinion, what role does the staff team play in the community?
15. Do you think that any improvements can be made to the level of staff involvement in the community?
16. Do you think that the support between yourself and your peers differs from the support between yourself and the staff? How/Why?
17. What does recovery mean to you?

18. What do you hope to get out of this programme?
19. In your opinion what would you say helps someone when they are in a TC?
20. In your opinion is there anything that can hold your progression back?
21. Are role models important? How important are they? Why?
22. Does being around people in a similar position to you help you understand more about addiction/recovery?
23. If you had to pin point one thing that you have learnt or value from the Mother-ship so far what would it be?
24. Can you describe the Outcomes Star to me?
25. How do you think it will help you when you leave here?
26. If you could change one thing on the star what would it be and why?
27. In your opinion what do you think a 'successful' graduate from the Mother-ship is?
28. In your opinion how should we measure effectiveness?
29. Are there any other measures of effectiveness that can be used?
30. What are your plans for after here?
31. What are your hopes and fears for the future?

Interview Schedule: Staff and Volunteers

1. Tell me a bit about yourself and how you came to work/volunteer here?
2. Have you worked in any programmes? If so, which ones? What did you think of them?
3. How long have you worked here and why did you decide to work here?
4. What are the good aspects of working here?
5. What are the frustrating aspects of working here?
6. If you could change any aspect of the programme and/or day to day running of the programme what would it be and why?
7. What does the term therapeutic community mean to you?
8. What role should a staff team play in a therapeutic community?
9. In your opinion, what role does the staff team play in the community?
10. What do you think of the current staff team?
11. What pressures do the staff team face on a day to day basis?
12. Would you make any improvements to the current staff team? If so what, and why?

13. In your opinion, what role would you say that you play in the staff team, both formally and informally?
14. Do you feel as though you get enough support? Could it be improved?
15. What is the greatest pressure that faces you and the staff team on a daily basis?
16. Do you feel as though you have enough training opportunities? If not why not and what would you like to see put in place?
17. Have you heard of Payment by Results? What does it mean? What do you understand by the term?
18. How has it been implemented here?
19. What are your thoughts on PBR? What are its strengths and weaknesses?
20. What do you think of the outcome measures of reduced reoffending and substance use and accommodation?
21. How would you measure effectiveness of a therapeutic community?
22. What are the strengths of residential programmes?
23. What are the limitations?
24. What improvements could be made to a TC?

Appendix 4: Participant information sheet



Therapeutic Communities: An Invitation to Change.

Participant Information Sheet

You are being invited to take part in a research study. Before you decide it is important that you understand why the research is being done and what it involves. Please take time to read the following information and ask if there is anything that is not clear or if you would like more information. Take your time to decide if you want to take part or not.

1. What is the purpose of this study?

This study aims to look at the identity of residents in a TC and why the community is important to people recovering from substance use.

2. Do I have to take part?

It is up to you; if you agree to take part you will be given an informed consent form to read and sign. After signing the consent form you are still free to withdraw from the study at any time and without giving a reason. This decision will not affect your rights in any way.

3. What will happen to me if I take part?

The fieldwork will last for approximately 24 months. The researcher will be observing every day events and activities that happen in the community. If you decide to be interviewed you will be asked to sign an informed consent form once you clearly understand what the research involves. All interviews will be private and confidential, and last between 90-120 minutes.

4. Are there any risks/benefits involved?

The interview will look at your experience of substance use and participation in a TC. You will be free to leave at any time and leave questions that you do not feel comfortable answering. However the interview will allow you to freely and safely express your opinion.

5. Will my taking part be kept confidential?

All information will be kept in confidence. Names and information that could be used to identify somebody will be removed. Quotes and extracts will be represented by a made up name.

Contact Details of researcher:

Miss H Gosling
C/o Professor G Mair
School of Law,
Liverpool John Moores University
John Foster Building, 98 Mount Pleasant, Liverpool, L3 5UZ

Appendix 5: Participant informed consent form



Therapeutic Communities: An Invitation to Change.

Informed Consent Form

- I confirm that I have read and understood the information provided for the above study. I have had the opportunity to consider the information, ask questions and have had these answered clearly.
- I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason and this will not affect my rights.
- I understand that any personal information collected during the study will be anonymised and remain confidential.
- I agree to take part in the interview and I understand that parts of our conversation may be used verbatim in future publications or presentations but such quotes will be anonymised and represented by a pseudonym.

Name of Participant: _____

Date: _____

Signature: _____

Pseudonym: _____

Contact Details of Researcher:

Miss H Gosling

C/o Professor G Mair

School of Law, Liverpool John Moores University

John Foster Building

98 Mount Pleasant, Liverpool, L3 5UZ

H.Gosling@2006.ljmu.ac.uk

Appendix 6: Example re-entry planner

Name: Ian Jones

Week beginning: 01.01.2010

Day	Morning	Afternoon	Evening
Monday	Aftercare group (Computers) 10.00-12.00	Drug awareness course 14.00-15.00	Clinical group in re-entry house 18.30-19.30
	Aftercare group (lunch) 12.00-13.00	Key work appointment 16.00-17.00	Local gym 20.00-21.00
Tuesday	Progress to Work appointment 09.00-10.00	College (English and Maths course) 12.00-16.00	Re-entry house
	CVS to explore voluntary work opportunities 10.00-11.00		
	Bidding on properties 11.30-12.00		
Wednesday	Conservation Therapy programme (CTP) 09.00-16.00	CTP 09.00-16.00	Workshop in re- entry house 18.30-19.30
Thursday	Aftercare group (photography) 10.00-13.00	Drama group 14.00-16.00	House meeting 17.00-18.00
			Local gym 19.00-20.00
Friday	College (English and Maths Course) 09.30-12.00	Aftercare group (Computers) 13.00-15.00	Re-entry house
		Shopping 15.00-17.00	

Appendix 7: Memo coding system

Category	Code	Definition of code	Description of code	Example quote
Community as method	C1	The term community as method refers to the self-help approach used in a TC. Community as method means teaching community members to use life within the TC to learn about themselves and bring about change (Rawlings and Yates, 2001).	The code covers the following broad themes: TC concepts, work as therapy, programme stages, a structured day, peers as role models, staff as community members, community activities, community environment, refocus, responsive environment and self-help.	I know it's a lot about community in here, but for me it was more about me, and mending my ways and changing my behaviours. (Neil, Resident, June, 2011)
Emotional growth training	C2	Achieving the goals of personal growth and socialization involves teaching individuals how to identify feelings, express feelings appropriately and manage feelings constructively through the interpersonal and social environment (Rawlings and Yates, 2001).	This code covers the following broad themes: awareness training, encounter group, client change, personal, social and community resources, and tools.	I need to take my mask off. I know it is something I need to do while I have the chance. (Marie, Resident)
Commitments	C3	As residents progress through the programme under study they are allowed to set up three commitments per week in the local community which are allocated to a Tuesday, Wednesday and Thursday afternoon.	This code covers the following broad themes: community separateness and consistency.	This place can only really help people who live round here or are moving here. (Stevie G, Resident, May, 2012)
Retention and PbR	C4	Retention refers to the emphasis that is placed on keeping residents programme involved for the planned duration of time (usually 6 months).	This code covers the following broad themes: therapeutic alliance, heads on beds, funding, effectiveness, programme completion, positive transfer, client outcome and PbR.	It's all about heads on beds at the end of the day. (Ringo, Staff, July, 2011)
Continuity of care	C5	Aftercare services are an essential component of a TC model. Whether implemented in the boundaries of the main programme or separately as in residential or non-residential half-way houses or ambulatory settings the perspective and approach guiding after-care programming must be continuous with that of a TC. The views of right living and self-help recovery and the use of a peer network are essential to enhance the appropriate use of vocational, educational, mental health, social and other typical after-care or re-entry services (Rawlings and Yates, 2001).	This code covers the following broad themes: planned duration of stay, re-entry, uncertainty, services in local area, relocating and conflict moving back to old area.	When I leave here I am going to re-entry and I think it is going to be a bit of a struggle for me, but I'll deal with that when it comes. (Michelle, Resident, November, 2011)

Appendix 8: Example resident memo slip

HOUSE MEMO

To the clinical meeting:

From:

Date:

RE:

Position in the programme:

.....

.....
Cost Implications:

Transport Implications

.....

CLINICAL RESPONSE

Appendix 9: Weekly Time-table

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
7.00	Community Wake-up					8.00	
7.30	Department check / Breakfast					8.30	
7.45	Medication					8.00	
8.30	Morning Meeting / Needs of Community / Department Jobs Allocated					9.00	
9.00	9:00am – 11:30 am Departments (Primary / Senior Residents)					9:30 -10.30 TC Awareness 10:30Memos / Departments	9:30 - 10:30 Business Forum 10:30 Memos / Departments
	9:00am to 9:30am – Staff Handover						
	WH Support Group (9:00am – 10:00am)		WH Support Group (9:00am – 10:00am)		WH Support Group (9:00am – 9:30am)		
	9:30 am to 11:30am – Key working				Literacy with embedded employability group (9:30am – 11:30am)		
11.30	Department Check / Break						
11.45	NHS Inspire Group (MH and WH)	MH / WH- Behavioural Group	Educational Group MH & WH	MH / WH- Behavioural Group	Small group PGC's MH & WH	Lunch / Dishpan / Community Clear up / Room Jobs 12:00pm – 1:15pm Department Check	
12.45	Department Check / Lunch (12.45pm – 1:15pm)						
1.00	Staff Handover 1:00pm until 1:15pm					Staff Handover 1:00 - 1:15pm	
1.15	Dishpan (1:15pm – 1:45pm) / Break 1:45pm – 2:15pm					Medication 1:15pm – 1:45pm	
1.30	Medication – 1:15 pm – 2:00pm / Department Check at 2:00pm						
2.15	Mock / Encounter Group Staff De- brief after Encounter 3:15pm – 3:30pm	MH / WH Orientation Group Peer With Staff	Client Led Activity Staff Meeting 2:15pm – 4.15pm	Seminar / Drama Group MH & WH	Mock / Encounter Group Staff De-brief after Encounter 3:15pm – 3:30pm	1:30pm – 4:30pm Community Activity / Family Visits	
3.15	Department Check / Tea Break						
3.30	Seminar / Debate Care Team led MH & WH	PGC'S WH & MH Separate	Community Projects MH & WH	Gender PGC'S (MH& WH Gender Specific)	Introduction to Administration Skills (3:30pm – 5:00pm) Staff Debrief 3:30pm – 4:00pm	5:15pm – 6:30pm Department Check / Dinner/ Dishpan	
4.30	Department Check / Freshen Up				Completions / Community Projects		
	Staff De- brief	Staff De - Brief	Staff De - Brief	Staff De - Brief			
5.00	Dinner / Dishpan						
6.00	Medication						
6.30	Pull Ups / Push ups and Outcomes with staff						
7.00	Evening Meeting						
7.30	Calm and Create/ Life story	AI's Reading Group	Life Story / Activity	Expert Patient Programme	Community Wrap All Residents	Activity	TAI CHI Class
8.30	Personal Calls / Free time					8.30	
10.00	Community Check In / Tea Break					10.00	
10.00	Medication					10.15	

Appendix 10: Measures and Markers of Achievement

Welcome House Measures and Markers of Achievement

Welcome House	<ul style="list-style-type: none"> • Minimum of 4 weeks, maximum of 8 weeks
Markers of achievement	<ul style="list-style-type: none"> • Has understood the purpose of the TC, its philosophy and expectations • Established some trusting relationships with staff and/or recovering peers • Completes an assessment of self, circumstances and needs • Begins to understand the nature of the addictive disorder and the demands of recovery • Makes a tentative commitment to the recovery process • Has a firm commitment to remain through the primary stage of the programme • Complete detox (if applicable)
Measures of achievement	<ul style="list-style-type: none"> • Completion of all required groups and set assignments • Monitor of progress against care plan goals agreed with key worker and care manager against Outcomes Star • Completion of care planned goals • Develop relapse prevention and harm minimisation plan • Tasters of departments • Preparation of life story

Primary stage Measures and Markers of Achievement

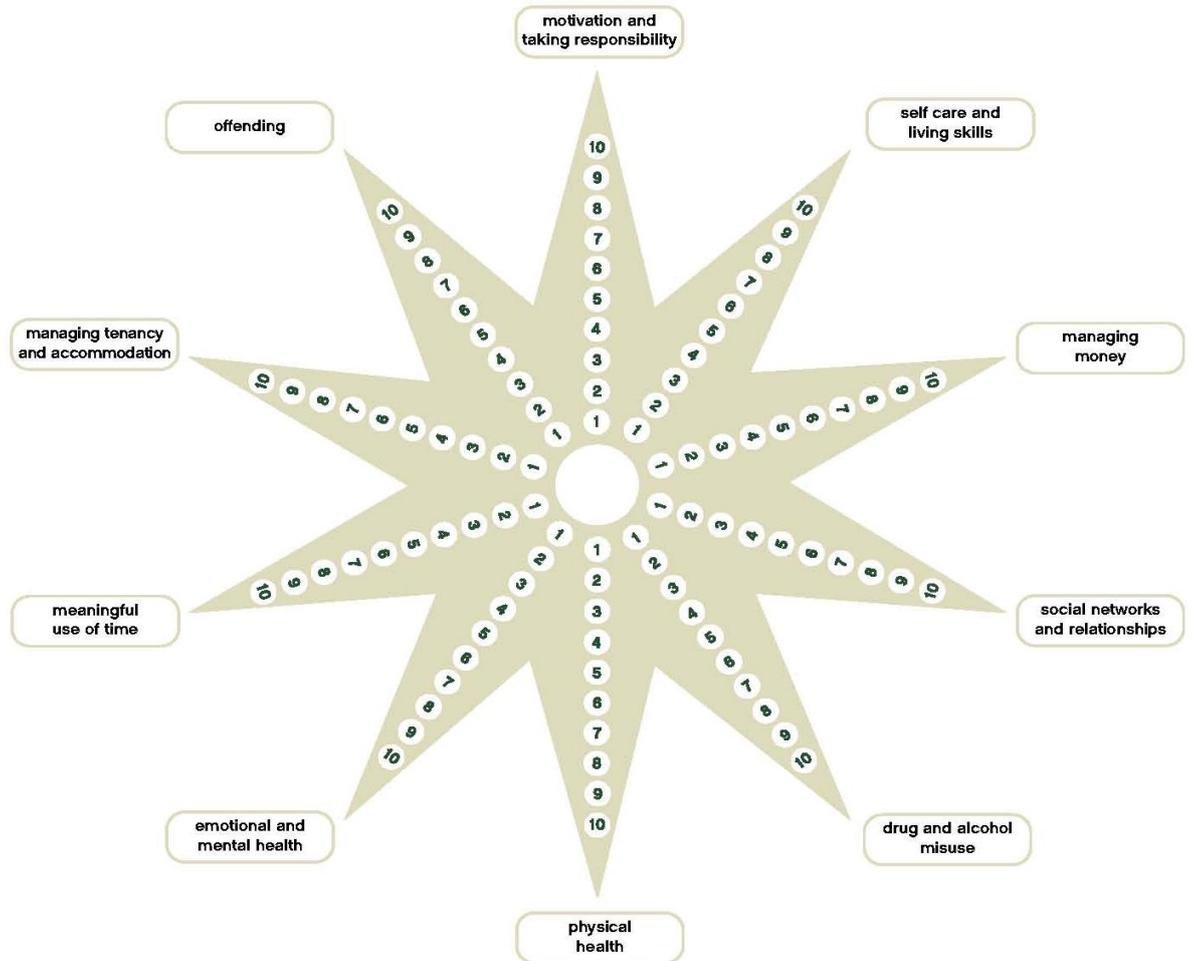
<p>Primary stage</p>	<ul style="list-style-type: none"> • Minimum 12 weeks, maximum 22 weeks
<p>Markers of achievement</p>	<ul style="list-style-type: none"> • Identifies oneself as a community member • Acts as if – understand and complies with the programme, participating fully in daily activities • Displays a practical knowledge of the TC • Displays limited personal disclosure in groups and in one-to-one sessions • Group and communication skills are not fully acquired • Carries out allocated house duties • Sets an example for other community members • Greater personal freedom • Key attitudes reflect acceptance of the programme • Personal growth evident in adaptability to job changes, acceptance of staff as rational authorities and ability to contain negative thoughts and emotions • Self-awareness is manifest in identification of characteristic images • Reveals a higher and more stable level of self-esteem • Carries out allocated house duties
<p>Measures of achievement</p>	<ul style="list-style-type: none"> • Completion of all required groups and set assignments • Completion and presentation of life story in the first or second week • Completion and presentation of a comprehensive relapse prevention and harm minimisation plan • Monitor and progress against care plan goals agreed with key worker and care manager measured by the Outcomes Star • Attendance at primary stage care plan review • To have demonstrated role modelling, budding and involvement in encounters as needed • Work in departments

Secondary stage Measures and Markers of Achievement

<p>Secondary stage</p>	<ul style="list-style-type: none"> • Minimum 10 weeks, maximum 18 weeks
<p>Markers of achievement</p>	<ul style="list-style-type: none"> • Elevated status in the social structure evident in privileges and house functions • Established role model in the programme, provides leadership in the community • Accepts full responsibility for his/her behaviour, problems and solutions • Carries out allocated house duties • Reveals elevated self-esteem based on status and progress through programme duration • Acquired group and communication skills and is expected to assist facilitators in group processes • Carries out allocated house duties
<p>Measures of achievement</p>	<ul style="list-style-type: none"> • Monitor of progress against care plan goals agreed with key worker and care manager, measured by the outcomes star • Completion of care plan/re-entry plan groups • Preparing exit plans and developing links with external agencies and providers • To have demonstrated role modelling, buddying and involvement in encounters as needed • Attendance at senior care plan review • Work in departments

Appendix 11: The Outcomes Star

The Outcomes Star



Appendix 12: PHE Outcomes Framework

