Post-release Alcohol Use in Victoria

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BA (Hons)

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Abstract

The problems and challenges experienced by individuals transitioning from prison into the wider community are well documented by academics and policy makers. However, research has largely overlooked the post-release experiences of individuals with Alcohol Use Disorders (AUDs), which constitutes a significant gap in the literature. Drawing on the responses contained in thirty-six interviews of post-release support workers (n=16) and forensic counsellors (n=20), who work for Non-Government Organisations (NGOs) in Metropolitan Melbourne and Regional Victoria, this thesis responds to this gap by providing an in-depth analysis of post-release alcohol misuse and the associated challenges and difficulties it poses for individuals exiting prison. This thesis also identifies and examines the post-release support services and alcohol treatment programs available to releasees and, in doing so, considers the extent to which these support services promote the building of capital resources in conjunction with factors identified as being desistance and recovery focused.

The thesis also sheds light on how drinking problematically after release complicates and impedes the processes of desistance and recovery. In particular, the findings reveal that post-release alcohol misuse is a “massive” problem, which presents significant challenges for releasees intending to pursue a desistance and recovery lifestyle.

This thesis aims to stimulate discussion and debate among Victorian policy makers, Correctional authorities and those in the Alcohol and Other Drug (AOD) treatment sector to address post-release alcohol misuse in its own right, considering the social and personal harms associated with its use.
Declaration

This thesis contains no material which has been accepted for the award of any other degree or diploma at any university or equivalent institution and that, to the best of my knowledge and belief, this thesis contains no material previously published or written by another person, except where due reference is made in the text of the thesis.
Dedication

This thesis is dedicated to my beautiful grandchildren Harvey Thomas Kirtley and Charlie Ava Kirtley who were born as I approached the end of this long journey. The joy and love you brought into my life spurred me on to reach the finish line. I look forward to spending more time with you both and simply being ME.

Acknowledgements

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My sincere thanks to the staff at the five Non-government organisations that assisted me with the recruitment of participants and for making what could have been an arduous task relatively easy. Also, to the post-release support workers and forensic counsellors who willingly and candidly shared their knowledge and expertise in the field of post-release alcohol misuse.

The completion of this degree would not have been possible had it not been for the unconditional love, support and encouragement of my incredible family. To my husband Dan, my deepest gratitude for reading innumerable drafts of this thesis and for your encouragement and understanding at having a wife often preoccupied with her studies. I wish to thank my wonderful sons, Nick, Christian and Jeremy and my amazing daughters-in-law, Stacey and Vicki. The enduring support, interest and encouragement you have displayed not only in my studies, but in all my endeavours, have buoyed me throughout the years this has taken to complete. To my eldest son Nick, had it not been for your gentle persuasion and reassurance, all those years ago, that I was capable of returning to study, I would not be writing this today. Estoy eternamente en deuda con usted.
## Abbreviations

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<tr>
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<tr>
<td>AA</td>
<td>Alcoholics Anonymous</td>
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<td>ABI</td>
<td>Acquired Brain Injury</td>
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<td>ABS</td>
<td>Australian Bureau of Statistics</td>
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<td>ACSO</td>
<td>Australian Community Support Organisation</td>
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<td>AFL</td>
<td>Australian Football League</td>
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<td>AIC</td>
<td>Australian Institute of Criminology</td>
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<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
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<td>AOD</td>
<td>Alcohol and Other Drugs</td>
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<td>AUD</td>
<td>Alcohol Use Disorder</td>
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<td>AUDIT</td>
<td>Alcohol Use Disorders Identification Test</td>
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<td>CJS</td>
<td>Criminal Justice System</td>
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<td>CTT</td>
<td>Cognitive Transformation Theory</td>
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<td>COATS</td>
<td>Community Offenders Advice and Treatment Service</td>
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<td>DUMA</td>
<td>Drug Use Monitoring Program in Australia</td>
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<td>EOC</td>
<td>Episode of Care</td>
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<tr>
<td>FARE</td>
<td>Foundation for Research and Education</td>
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<td>GLM</td>
<td>Good Lives Model</td>
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<tr>
<td>GP</td>
<td>General Medical Practitioner</td>
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<td>MI</td>
<td>Motivational Interviewing</td>
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<td>NGO</td>
<td>Non-Government Organisation</td>
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<td>NRL</td>
<td>National Rugby League</td>
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<td>RNR</td>
<td>Risk-Needs-Responsivity</td>
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<tr>
<td>SAMHSA</td>
<td>Substance Abuse and Mental Health Services Administration</td>
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<td>TAP</td>
<td>Transitional Assistance Program</td>
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<td>WHO</td>
<td>World Health Organization</td>
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Introduction

Alcohol has been recognised as Australia’s worst drug problem for more than 50 years. It has maintained the title despite successive waves of so-called drug epidemics involving marijuana, heroin, cocaine, speed and, most recently, ice.

Only alcohol is the true epidemic. No other drug has come close to causing as much death, illness, violence and lost productivity as alcohol. Yet it remains to some extent behind the lace curtains, almost a taboo subject, a blind spot in the national conversation. (Paul McDonald, Chief Executive Officer, Anglicare Victoria 2015)

Most criminological studies that address any form of substance misuse largely fail to produce findings that distinguish alcohol from other drugs. In scholarly literature and official documents, alcohol is frequently conflated with illicit drug use under the term Alcohol and Other Drugs (AOD), or subsumed under the generic term of substance misuse. This oversight is concerning given the overwhelming evidence of the escalating health and social harms caused by alcohol misuse and the suggested causal relationship between harmful or hazardous alcohol consumption and a range of serious offending behaviours.

In light of this gap, this thesis set out to examine what rehabilitation programs were offered in the prison setting for people who entered prison in Victoria with an Alcohol Use Disorder (AUD). It soon became apparent that the Victorian prison system offers very little in the way of treatment programs that specifically target alcohol misuse, and that an unknown, but substantive proportion of prisoners will exit prison, and return to the wider community with unresolved alcohol problems.

Responding to the gap in criminological literature, this thesis has three central aims. First, to seek an in-depth understanding of the needs and issues that releasees with alcohol problems face while transitioning from prison to the Victorian community. Second, to identify and examine the post-release support and treatment services available to releasees
with AUDs. And third, to examine the extent to which post-release support and treatment services promote the building of capital resources and employ a service delivery model that is desistance and recovery focused.

The above aims were achieved by conducting interviews with 36 post-release support workers and forensic counsellors who provide services to released prisoners with alcohol problems in Metropolitan Melbourne and Regional Victoria. The interviewees’ clients were predominantly male parolees, who at the time of the interviews were, or had recently, received post-release support and/or alcohol treatment services from Non-Government Organisation (NGO) professionals. The scope of this thesis does not adequately address alcohol misuse among women or indigenous releasees who are likely to have different needs and face different challenges following release from prison. This was simply because the interviewees’ client cohort had few women or indigenous clients. In addition, the clientele of the participants did not include prisoners with AUDs on straight release receiving support or alcohol treatment services. Accordingly, this thesis provides a qualitative in-depth analysis of the challenges and the transition process faced by male parolees with an AUD upon release from prison in Victoria. The thesis provides an important contribution to post-release research, as it represents the first Victorian study to examine alcohol, independent of other drug types, in the post-release environment.

**Research Questions**

As will be discussed in Chapter Two, there is a significant body of research that demonstrates the potential harms of alcohol misuse. According to the Foundation for Alcohol Research and Education [FARE], (2014, p. 2) each year in Australia, alcohol is responsible for approximately 5,500 deaths and in excess of 157,000 hospital visits, making alcohol misuse
“one of our nation’s greatest preventative health challenges”. The link between alcohol and crime is not a new phenomenon. Research suggests that there is a strong nexus between alcohol misuse and criminality (Dingwall, 2006; Sweeney & Payne, 2011, WHO, 2002a), including, but not limited to, homicides (Dearden & Payne, 2015), and domestic (Cussen & Bryant, 2015), and public violence (Drugs and Crime Prevention Committee, 2006). Despite this, there has been no in-depth qualitative study conducted in Victoria that seeks to address alcohol misuse, independent of other drug types.

Accordingly, the overarching aim of this thesis is to examine the issues associated with post-release alcohol misuse. In doing so, this research considers the many complex challenges and multi-faceted needs that releasees with AUDs face after exiting prison.

Bearing in mind the participant group restrictions outlined above (male releasees on parole), this thesis contributes to post-release scholarship by answering the following key research questions:

1. To what extent is alcohol misuse a problem for individuals transitioning from prison to the wider community? If so, in what ways is it problematic?
2. What post-release support and treatment services are available to released prisoners with AUDs in Victoria? To what extent do these services address their needs?
3. To what extent do post-release support and treatment services enhance the potential for releasees with AUDs to initiate a desistance and recovery pathway?

In addition to answering these primary research questions, six supplementary questions have been developed to guide and inform the research. These include: What post-release non-treatment support services are available to individuals with AUDs; and what post-release
alcohol treatment services are available to individuals with AUDs? Are there identifiable barriers that prevent individuals receiving effective post-release services to adequately address their needs? What is the service delivery approach adopted by support workers and forensic counsellors in the provision of services to released prisoners with AUDs? What role does a therapeutic alliance between worker and client play in Victoria? And does the service delivery approach adopted by support workers and forensic counsellors promote the building of social and human capital resources? If so, how?

Victoria was chosen as the case study jurisdiction for several reasons. First, and most importantly, the extent to which post-release alcohol misuse is a problem for individuals exiting prison in Victoria has not been the focus of prior research in this state. Instead, alcohol misuse has been subsumed under the generic terms of either substance or AOD use; therefore, whether or not it poses a problem for some released prisoners is largely unknown. Second, no previous Victorian studies have investigated the post-release needs of transitioning individuals with AUDs and whether or not their needs are adequately addressed through post-release services. Similarly, no previous Victorian studies have examined the ways in which the delivery of post-release services may promote a desistance and recovery trajectory. This research, therefore, is the first such study to seek an understanding of the impact of alcohol misuse and available services in the Victorian post-release environment.

**Thesis Overview**

Chapter Two presents the theoretical frameworks of desistance and recovery upon which this thesis is based. The frameworks contain common elements considered important in the processes of desistance from crime and recovery from alcohol misuse. Key factors of the frameworks are identified and discussed, including the importance of building a strong
therapeutic alliance between releasees and post-release service providers, and the essential role that the building of social and human capital resources plays in the promotion of a desistance and recovery lifestyle.

Chapter Three reviews the literature on alcohol misuse and places it in both contemporary and historical contexts. This is done in order to provide a current understanding of how alcohol misuse results in some individuals having ongoing contact with criminal justice systems (CJSs). The chapter commences with a brief history of offender rehabilitation principles and practices from the birth of the modern prison up to the 1970s, to place the current study in its historical context. This historical synopsis focuses specifically on the changing ideologies of reformative and rehabilitative practices that aimed to change the behaviours of offenders and problem drinkers to transform them into law-abiding members of society. This chapter also examines a range of literature and statistical data to present a broad overview of the social, personal and economic harms associated with alcohol misuse in a contemporary global, Australian and Victorian context (1980s-today). The review considers two key issues contained in the literature that provide a current understanding of how alcohol misuse leads many individuals into contact with CJSs; the alcohol and crime nexus; and prisoner populations with AUDs. This chapter also includes an examination of alcohol specific treatment programs that are available in Australian and Victorian prisons. Pathways out of Victorian prisons are then explored together with an overview of the role of NGOs in the delivery of post-release services. Addressing these topics is crucial in the context of this study as there is a paucity of research in contemporary literature that examines alcohol independent of other drug types.

Chapter Four details the qualitative methodological approach employed to carry out this research. The key research questions guiding this study are restated, along with a
discussion of the methods utilised in the collection, coding and analysis of data. Ethical considerations relevant to this research and potential limitations of the study are also discussed.

Chapter Five draws on the research data to examine the nature and extent of alcohol misuse among individuals transitioning from prison to the wider Victorian community. The extent to which alcohol misuse is a problem in the post-release environment is discussed, together with the specific ways alcohol misuse complicates and negatively impacts the transitional process. Consideration of the social and cultural acceptability and the legality and accessibility of alcohol in contemporary society is then presented in the context of how these factors can have negative social and health consequences for releasees with AUDs. This chapter also presents a discussion of how misuse of alcohol is implicated in a variety of offending behaviours.

Chapter Six examines the many and complex non-treatment needs that releasees with AUDs have after exiting prison, including those associated with reuniting with family, and physical and mental health. The range of non-treatment transitional support services provided by NGOs is also discussed, together with the extent to which these services are available and accessible to transitioning prisoners with an AUD. A key focus of this chapter is housing, as it is widely acknowledged that many ex-prisoners have great difficulty in sourcing suitable, safe and stable housing. This chapter thus provides an in-depth discussion of the types of housing options available to releasees with AUDs and the limited and largely unsatisfactory nature of the accommodation options available to them. This is a significant discussion, as previous studies have neglected to examine the role of post-release alcohol misuse and if, or how, it limits transitioning prisoners from obtaining safe and secure housing.
Chapter Seven extends the discussion of the support available to released prisoners with an AUD by mapping the landscape of treatment programs and strategies that forensic counsellors utilise to assist individuals in the recovery process. It begins with a brief discussion of the extent to which releasees have access to relevant treatment for alcohol misuse while in prison. It is necessary to present an overview of what support and treatment for alcohol misuse is available in Victorian prisons as this forms a basis for understanding the importance of providing alcohol specific programs in the post-release environment. This is followed with an analysis of the alcohol specific programs available to releasees and the strategies employed by forensic counsellors in the clinical setting. Attention is also drawn to the important role of forensic counsellors and how they employ Motivational Interviewing techniques, as well as goal-setting exercises, to address client ambivalence and to encourage behavioural change. Importantly, this chapter examines the emphasis placed on assisting clients to develop a sense of personal agency, recognising that it is the individuals who are the ultimate decision-makers in driving the change. Throughout the chapter, any discernible elements of the treatment process that draw a parallel with characteristics of a desistance and/or recovery theoretical framework are acknowledged and discussed.

Chapter Eight examines the extent to which capital resources are generated through a strong therapeutic alliance in the post-release support and treatment setting. It examines three factors deemed crucial in the processes of desistance and recovery, namely the development of social capital, human capital resources and a strong therapeutic alliance. This is achieved by drawing on the extant literature and the findings discussed in Chapters Six and Seven, to critically analyse the extent to which these important factors are fostered in the delivery of post-release support and treatment services.
Chapter Nine considers the main findings of the research resulting from analysis of the data and an overview of the contribution the research makes to the field. The potential for future research is also considered.

**Key Definitions**

Throughout the thesis, a number of key terms involving alcohol misuse are used. In order to ensure clarity and consistency, the most important terms are defined below.

No single definition exists to adequately define the broad spectrum of alcohol consumption patterns that constitute AUDs. The term AUDs forms part of the title of a screening tool *The Alcohol Use Disorders Identification Test* (AUDIT), developed by the World Health Organization (WHO), as a simple screening method for excessive alcohol consumption and to broaden the range of available screening assessments to include harmful and hazardous drinking patterns (Babor, Higgins-Biddle, Saunders, & Monteiro 2001, p. 2). The term AUDs is used in scholarly literatures and official documents to describe a broad range of alcohol consumption patterns resulting in a number of significant health-related and social harms (Graham, 2007; HM Inspectorate of Prisons, 2010; Room, 1978, 1996).

Under the rubric of AUDs, a range of terms contained in the WHO’s, *Lexicon of alcohol and drug terms* (WHO, 1994) will be used throughout this thesis to describe AUDs in varying degrees of severity. These include:

---

1 The Alcohol Use Disorders Identification Test (AUDIT) is a screening tool developed by the WHO for identifying persons with hazardous and harmful patterns of alcohol consumption. It is a 10-item questionnaire covering the domains of alcohol consumption, drinking behaviour, and alcohol related problems (p. 791). Screening for excessive alcohol consumption requires individuals to respond to a series of questions relating to their pattern of alcohol consumption. Each response is allocated a score ranging from 0 – 4. Scores of 8 or more indicate an individual’s alcohol consumption is at hazardous or harmful levels with the possibility that the individual is alcohol dependent. Whereas individuals who returned AUDIT scores of 20 or above clearly warrant further evaluation and treatment for alcohol misuse (Babor, Higgins-Biddle, Saunders, & Monteiro, 2001; Saunders, Aasland, Babor, De La Fuente, & Grant, 1993).
**Harmful Use**: A pattern of psychoactive substance use that is causing damage to physical and/or mental health. Harmful use commonly, but not invariably, has adverse social consequences.

**Hazardous Use**: A pattern of substance use that increases the risk of harmful consequences for the user. In contrast to harmful use, hazardous use refers to patterns of use that are of public health significance despite the absence of any current disorder in the individual user.

**Alcohol Misuse**: Use of a substance for a purpose not consistent with legal or medical guidelines. The term is preferred by some to abuse in the belief that it is less judgmental.

**Drinking Problem**: Drinking resulting in problems individual or collective, health or social. A problem drinker is a person whose drinking has resulted in health or social problems.

While the above terms provide an indication of the health and social harms associated with excessive alcohol consumption, they do not quantify at what levels of alcohol consumption these harms may occur. According to the NHMRC (2003, p. 4), in Australia, a standard alcoholic drink “is any drink that contains 10 grams of alcohol”, for example a 100ml serve of wine, 30mls of spirits or a 285ml glass of full strength beer (p. 20). Australian alcohol guidelines are endorsed by the NHMRC and recommend for males: no more than 4 standard drinks per day on average; no more than 6 standard drinks on any one day; and there should be one or two alcohol-free days per week (NHMRC, 2003, p. 6). For women, the NHMRC (2003, p. 6) recommends: no more than 2 standard drinks per day on average; no more than 4 standard drinks on any one day; and there should be one or two alcohol-free days per week.
Conclusion

This chapter has outlined the purpose and scope of this research, including highlighting the gaps in the literature and the contribution this study intends to make to the field. This chapter has also provided an overview of the key and supplementary research questions, and defined important terms.

The next chapter examines the extant literature pertaining to desistance and recovery that provides the foundation for this research and will be drawn on and critiqued throughout the analysis chapters.
Chapter Two

Theoretical Frameworks: Desistance from Crime and Recovery from Alcohol Misuse

The problems and challenges experienced by individuals transitioning from prison into the wider community are well documented by academics and policy makers. However, research has largely overlooked the post-release experiences of individuals with Alcohol Use Disorders (AUDs), which constitutes a significant gap in the literature. This thesis seeks to fill this gap by drawing on elements of two theoretical frameworks: a desistance-focused model of offender rehabilitation and a recovery capital paradigm. Both frameworks identify factors deemed important in the processes of desistance from crime and recovery from alcohol misuse. It is important to note that a desistance-focused model is currently in the developmental stage (Maruna, McNeill, Farrall, & Lightowler, 2012). In contrast, the principles and practices associated with a recovery capital model are increasingly recognised as effective guidelines for the planning and delivery of programs that target Alcohol and Other Drugs (AOD) misuse or dependency (Advisory Council on the Misuse of Drugs, 2013; Best, 2010; Edinburgh Alcohol and Drug Partnership, 2012; McHugh, 2013; United Nations Office on Drugs and Crime, 2008).

The core principles of both theoretical frameworks formed the basis for the collection of data, and the coding and analysis phases of this dissertation. These frameworks are ideally suited to this thesis as they contain many common elements considered important in the processes of desistance from crime and recovery from alcohol misuse. This chapter commences with an overview of existing theoretical explanations of desistance and recovery. Key definitional and conceptual issues are also discussed. The chapter concludes with a discussion of a desistance-focused paradigm and a recovery capital model of rehabilitation.
Defining Desistance

Desistance from crime, or why some people cease offending and others do not, has increasingly been a focus of contemporary criminological research and debate. A growing body of desistance literature has emerged, contributing to an understanding of which factors are considered important in supporting the desistance process (Glueck and Glueck, 1950, 1968, 1974; Bushway, Piquero, Broidy, Cauffman, & Mazerolle, 2001; Caverley & Farrall, 2011; Farrall, 2002; Farrall, Bottoms, & Shapland, 2010; Farrall & Maruna, 2004; Healy, 2010, 2013; Healy & O'Donnell, 2008; Laub & Sampson, 2001, 2003; LeBel, Burnett, Maruna, & Bushway, 2008; Maruna, 2001; Maruna & LeBel, 2010; McNeill, 2002, 2006, 2012; McNeill, Batchelor, Burnett, & Knox, 2005; McNeill & Weaver, 2010). Despite expanding scholarly interest in the topic, no single definition of desistance exists in the literature that clearly and concisely defines the term. In the main, it is the definitional ambiguities that exist in relation to the meaning and measurement of the concept that have hindered scholarly consensus on a definition. Piquero (2004, p. 103) argues that, “[a]lthough the study of desistance has captured the imagination of many criminologists, theoretical and methodological problems have plagued sustained research attention”. Similarly, Kazemian (2007, p. 8) asserts that a “substantial degree of variability in the conceptualization of desistance has led to disparate results regarding the causes and correlates of desistance from crime”.

For some scholars, desistance is defined as the termination of offending and considered to be a distinct event that marks the abrupt cessation of a criminal career (Glueck & Glueck, 1940, 1950; 1968; Hirschi & Gottredson, 1983; Shover, 1996). Others regard desistance as an on-going process during which the frequency and variety of criminal activity decreases (Bushway et al., 2001; Bushway, Thornberry, & Krohn, 2003; Laub & Sampson,
For example, Maruna (2001, p. 17) maintains that desistance is not a discrete event that happens abruptly, but is “the sustained absence of a certain type of event (in this case crime)”. The preceding discussion reveals how scholars are conflicted between understandings of desistance as an end-state and desistance as an ongoing process. The following section contrasts desistance as the termination of criminal activity with desistance as a process to provide a clear distinction between the two terms.

**Desistance as the Termination of Criminal Activity**

Some scholars view desistance as the termination of offending and consider it to be a distinct event (Farrington & Hawkins, 1991; Gottfredson & Hirschi, 1990; Shover, 1996). Maruna (2001, p. 22) acknowledges this contention suggesting that “the criminal career literature traditionally imagines desistance as an event – an abrupt cessation of criminal behaviour”. Hirschi and Gottfredson (1990; 1983) view desistance as the termination of offending. They maintain that desistance occurs “when a set period of time elapses without an offense having been committed” then the offender “is said to have abandoned his criminal career” (Hirschi & Gottfredson, 1983, p. 578). Shover (1996, p. 121) also supports the termination paradigm stating that desistance is “the voluntary termination of serious criminal participation”. In contrast, Maruna (2001, p. 23) argues that if termination is considered to be the moment at which an individual commits their last crime, then, at that instant, they are both an offender and a “desister”, which he maintains is not possible. Furthermore, defining desistance as the termination of offending also suggests that there is an identifiable point in time when an individual can be said to have relinquished their offending lifestyle. If this is so, it raises a key question: How much crime-free time needs to pass for an individual to be considered a “desister”?
The issue regarding what period of time needs to pass without the commission of an offence, before an offender can be labelled a “desister”, is highly contested in the desistance literature. Shover and Thompson (1992) maintain that desistance has been achieved when no arrests, convictions, or term of imprisonment have occurred in the 36 months after exiting prison. Conversely, Farrington and Hawkins (1991), in their study of the onset of offending during childhood versus the initiation of offending during adolescence or early adulthood, determined desistance to have occurred when there was an absence of convictions between the ages of 21 and 32 among the cohorts studied. Other scholars argue that studying desistance over a specified time period, rather than over the lifespan, may produce findings of “false desistance” in which an individual may reoffend after the time period of the study has elapsed (Brame, Bushway, & Paternoster, 2003; Kazemian, 2007). Importantly, Kazemain, 2007:9 demonstrates how desistance literature utilises differing types of data (self-reports or official records) to measure desistance often produced inconsistent results (see also Massoglìa and Uggen, 2007). According to Loeber, Farrington, Stouthamer-Loeber and White (2008) as only a proportion of offenders are arrested, convicted and prosecuted the use of official records to measure desistance cannot definitively determine that cessation from criminal activity has occurred. The use of self-report data to measure desistance has its own limitations as offenders must be capable of, and willing to, self-report their offending behaviour (Payne, 2007). Moreover, according to Maruna (2001, p. 156), defining desistance as a termination point ignores the fact that offenders commonly “zig-zag between crime and non-crime, and they frequently make the claim that they are going straight … only to relapse into crime and drugs”. Thus, unless desistance is studied retrospectively, for example, following the death of an individual, it is difficult to envisage how a definitive declaration that a person has desisted from crime can be made. McNeill (2012, p. 6) also asserts that “the
‘mere’ absence of offending does not in and of itself signal progress towards long term or permanent desistance from crime or … long-term compliance with the law”. In addition, defining desistance solely as the absence of criminal activity fails to take into account the social and personal contextual factors such as access to secure housing or the availability of drug and alcohol treatment, which (as will be further discussed in the analysis chapters) may be important in initiating and maintaining a desistance lifestyle.

**Desistance as a Process**

In line with Maruna (1997, 2001), other scholars suggest that desistance is a gradual process that occurs over time (Bushway et al., 2003; Farrall, 2002; Farrall & Maruna, 2004; Healy, 2010, 2013; Laub & Sampson, 2001; Maruna, 1997; McNeill et al., 2005; Ramstad, 2009) and is characterised by periods of lapse and relapse (Maruna, 2001). One of the earliest references to desistance as a process is contained in Fagan’s (1989) research into family violence. He suggests that desistance is “a process of reduction in the frequency and severity” of offending, “leading to its eventual end when ‘true desistance’ or ‘quitting’ occurs” (1989, p. 380). Contemporary researchers increasingly conceptualise desistance as a process, as opposed to a distinct event (Bottoms & Shapland, 2011; Bushway et al., 2001; Bushway et al., 2003; Farrall & Bowling, 1999; Laub & Sampson, 2001; Maruna, 2001; Maruna, Immarigeon & LeBel, 2004; McNeill, 2006). For example, Maruna, Immarigeon and LeBel (2004, p. 18) contend that “any diminution in the level, seriousness or heterogeneity of criminal activity may mark a step in the process that will lead to the cessation of criminality … desistance is a process that occurs over time, rather than as a switch that comes on or goes off”. Similarly, Bushway et al., (2003, p. 133) consider desistance to be “a developmental process that unfolds over time rather than a static state that is achieved”. Desistance as a process is further expounded by Bottoms and Shapland (2011) who assert that individuals
who aspire to desist from crime need also to learn how to incorporate pro-social activities and behaviours into their daily lives.

**Differentiating between Termination and a Process**

Laub and Sampson (2001) sought to clarify the disparity surrounding the definition of desistance by differentiating between the termination of offending and the concept of desistance as a process. They proposed that:

[T]ermination is the time at which criminal activity stops. Desistance, by contrast, is the causal process that supports the termination of offending. While it is difficult to ascertain when the process of desistance begins, it is apparent that it continues after the termination of offending. In our view, the process of desistance maintains the continued state of non-offending. (Laub & Sampson, 2001, p. 11)

In this sense, scholars assert that desistance is best understood as a gradual process because most persistent offenders experience “significant crime-free gaps” during the course of a criminal career, before re-offending occurs (Bottoms & Shapland, 2011; Maruna, Immarigeon, & LeBel, 2004). Others also view desistance as a process of desistance because a desistance trajectory is punctuated with periods of “‘to-ing’ and ‘fro-ing’, of progress and setback, of hope and despair” (McNeill & Weaver, 2010, p. 17). An understanding of desistance as a process is also offered by Maruna et al., (2004, p. 18) who maintain that “any diminution in the level, seriousness or heterogeneity of criminal activity may mark a step in the process that will lead to the cessation of criminality … desistance is a process that occurs over time, rather than as a switch that comes on or goes off”.

Conceptualising desistance as an ongoing process is similar to how some individuals perceive recovery from alcohol misuse. Narratives used by members of Alcoholics Anonymous (AA), an abstinence oriented twelve-step recovery program, commonly refer to
themselves as recovering alcoholics even decades after their last alcoholic drink, implying that recovery from alcohol misuse is an ongoing process that requires the maintenance of abstaining from all forms of alcohol consumption. This narrative is important in the context of this thesis because it adopts an understanding of both desistance and recovery as processes, rather than terminating events. This is primarily because it is not a focus of this research to determine if desistance and recovery have occurred, as this would have required a longitudinal study conducted over an extended period that the timeframe allocated for this thesis could not accommodate. In addition, by adopting an understanding of desistance and recovery as processes, this research recognises the sometimes precarious and non-linear nature of desistance and recovery which are frequently punctuated by periods of ambivalence and vacillation (Burnett, 2004b), resulting in achievements and setbacks. This thesis also recognises that the processes of desistance and recovery are unique and individualised journeys, therefore the factors influencing these processes will combine in diverse ways, unique to each individual.

**Primary and Secondary Desistance**

A further advancement towards a conceptual clarity of the term desistance was offered by Maruna and Farrall (2004) through their categorisation of the term into primary and secondary desistance. The identification of desistance into two distinct phases parallels the work of Lemert (1948, p. 27) and his division of deviance into “two sharply polarized or even categorical phases” of primary and secondary deviation. Lemert (1948) argues that primary deviation emerges from an individual’s initial foray into deviant behaviour such as excessive alcohol consumption (p. 28); whereas secondary deviation relates to behaviour that becomes “incorporated as part of the ‘me’ of the individual” (1951, p. 75). According to Maruna and
Farrall (2004), desistance can be categorised into two identifiable phases – primary and secondary (2004). In their seminal article, ‘Desistance from Crime: A Theoretical Reformulation’, Maruna and Farrall present an understanding of the difference between primary and secondary desistance, stating:

Primary desistance … could be expected to occur only sporadically, for short periods – a week here, two months there. Secondary desistance, on the other hand, involves a more sustained pattern of demonstrable conformity – a measurable, reflective and more self-conscious break with previous patterns of offending. (Maruna & Farrall, 2004, p. 174)

In the main, contemporary studies focus on secondary desistance and little attention has been paid to the stage of primary desistance – for a comprehensive discussion of primary desistance see Healy (2010, 2012) and Healy and O’Donnell (2008). Maruna et al. (2004, p. 19) argue there is little theoretical merit in studying primary desistance as most offenders experience crime-free gaps in their criminal careers and research attention therefore should focus on secondary desistance that involves the study of the process by which offenders attain and maintain a long-term non-offending lifestyle. However, not all scholars reject the worth of studying primary desistance. West (1963, p. 3), in his study of recidivists incarcerated at Wadsworth prison, emphasised the value of studying “crime-free periods” in a criminal career, stating:

‘Crime-free periods’ occurred for some offenders during times of ‘sheltered circumstances, such as residence in an institution, periods of military service, or … the establishment of a relationship with some stronger personality, someone able and willing to provide continuous sympathy and practical support …’ (West, 1963, p. 50)

Commenting on West’s findings, Bottoms, Shapland, Costello, Holmes and Muir (2004, p. 371) assert that even temporary lulls in offending behaviour should form “an integral part of
the study of desistance”. In contrast to the contention of Maruna et al. (2004) – that research should focus on the stage of secondary desistance – this thesis, in line with Healy (2012), posits that much can be gained by studying the stage of primary desistance. A period of incarceration is most likely to be an alcohol-free period for most prisoners, the time immediately following release therefore presents a window of opportunity for intervention, or as McSweeney, Bhardwa and Webster (2009, p. 48) suggest, “a treatable moment” for providing support and/or treatment for those at risk of resuming harmful drinking habits which may result in further offending.

As this thesis focuses on the temporal space in which individuals are transitioning from prison to the wider community, it is the stage of primary desistance that will be explored. Examining this period of transition will provide a valuable insight into the extent that support services and/or treatment for alcohol misuse precipitate behavioural change in some individuals that may, in turn, lead to long-term desistance from crime and recovery from alcohol abuse.

**Theories of Desistance**

Although scholars often disagree on how desistance should be defined and operationalised, several theories have emerged to explain why some people desist from crime and others do not. Each theoretical perspective attributes a number of salient factors as contributing to desistance, and these will be examined below.

**Age and Maturational Theories**

Early desistance studies focused on the relationship between age, maturation, and offending to explain why some people desist from crime, while others do not. The defining feature of
these theories is that desistance from crime is solely attributed to the age/maturation process. That is, as individual’s age and reach a certain a level of maturity, the rate of offending decreases (Glueck & Glueck 1940, 1950; 1968; Gottfredson & Hirschi, 1990; Laub & Sampson, 2001). One of the earliest theories offered to explain the link between ageing, maturation and desistance emerged from the research of Harvard criminologists Eleanor and Sheldon Glueck (1974; 1940, 1950; 1968). Their central argument is that offending rates decline naturally when individuals reach a certain level of emotional and intellectual maturity regardless of their age, and that desistance is a normative part of the maturational process. Glueck and Glueck (1974, p. 149) argue that “the physical and mental changes which enter into the natural process of maturation offer a chief explanation of improvement of conduct with the passing of years”. Their maturational reform thesis asserts that maturation/ageing is the primary reason for a reduction in, or the cessation of delinquency, stating “the physical process of maturation offer the chief explanation of this improvement in conduct with the passing of the years” (Glueck & Glueck, 1940, p. 264).

Accordingly, they defined maturity as “the development of a stage of physical, intellectual, and effective capacity and stability, and a sufficient degree of integration of all major constituents of temperament, personality and intelligence, to be adequate to the demands and restrictions of life in organised society” (Glueck & Glueck, 1974, p. 170). In addition they assert that as individuals mature, they become more accountable for their actions by understanding that “crime does not lead to satisfaction” (Glueck & Glueck, 1974, p. 170). For these scholars, individuals reach a certain level of physical, emotional, and intellectual maturity at different stages of life and reaching adulthood is no guarantee an individual has sufficiently matured to attain a desistance lifestyle. Conversely, they suggest individuals who persisted in crime and delinquency lacked an appropriate level of maturity,
whereas those who desisted from offending were deemed to have attained maturational adequacy. However, this approach has been criticised for implying that offending and delinquency is linked to immaturity, whereas a pro-social lifestyle indicates individuals are sufficiently emotionally and intellectually mature (Laub & Sampson, 2003).

Although Glueck and Glueck maintain that ageing and maturation are the primary reasons for the decline in offending behaviours, they briefly acknowledge the role of mediating socio-structural and contextual factors such as educational opportunities, finding employment and being part of a stable family, as contributing to a decline in delinquency. In contrast, contemporary explanations of desistance, in the main, exclude the role of maturation and ageing in the process of desistance. Instead, they emphasise the role of socio-structural factors, which are external to the individual, and internal, subjective factors to explain why some people desist from crime and others do not.

**Social Bonds Theory**

Arguably, the leading advocates of the Social Bonds Theory are John Laub and Robert Sampson (2001, 2003; 2005). The main tenet of their theory is that strong social bonds such as marriage, being a good parent, having stable employment, or participating in conventional activities, are major influences towards the attainment of a desistance lifestyle, on the basis that these factors act as informal social controls (Hirschi, 1969; Laub & Sampson, 2001, 2003; 1993; Shover, 1996). Although Sampson and Laub (1993) acknowledge ageing and maturation are involved in desistance, they argue that it is not the ageing process per se, that promotes desistance, but it is the development and strengthening of social bonds and the value individuals place on those bonds as they age and mature that promotes desistance. They suggest that the strengthening of social bonds is similar to an “investment process … as the
growth in social bonds grows, the incentive for avoiding crime increases, because more is at stake” (Laub & Sampson, 2003, p. 41).

**Turning Points**

According to Laub and Sampson (2001), social bonds such as a stable marriage, employment or military service may produce a “turning point” in the life-course and, therefore, foster the desistance process. Elaborating on the role of turning points in the desistance process, Sampson and Laub (2005, p. 18) maintain that investing in conventional norms “reorders short-term situational inducements to crime and over time, redirects, long-term commitments to conformity”. This suggests life events that strengthen social bonds, in turn increase informal social control, and therefore promote desistance. Importantly, it is the extent to which individuals are emotionally attached to, and value conventional norms, that can act as a turning point for giving up crime. For example, it is not whether an individual is married that increases the likelihood of desistance, it is the value placed on the relationship that creates a strong social and emotional bond resulting in informal social control (Farrall, 2002; Laub & Sampson, 2001). Maruna (2001, p. 121) supports this contention stating that:

> Going straight … does not seem to be about defiant rebels turning into diligent working stiffs. Instead, defiant rebels are able to find social roles or occupations that can provide them with the same sense of empowerment and potency they were seeking (unsuccessfully) through criminal behaviour.

Others argue that a strong attachment to a spouse or partner is likely to reduce time spent with criminal peers (Giordano, Cernkovich, & Rudolph, 2002; Warr, 1998). For example, Warr (1998, p. 204) asserts that “changes in peer relations appear to account for the effect of marriage on desistance”. When a marriage is valued, an individual is more likely to spend time with their spouse engaging in pro-social activities than with their criminal peers in a criminogenic environment. Marriage, therefore, is only likely to act as a catalyst for
behavioural change if it generates a valued and strong social bond to one’s spouse or partner. Although the strength of social bonds is considered an important facet in the process of desistance, the social contexts in which those bonds are formed and strengthened also must be considered.

**Social Context**

The importance of addressing the social context in which desistance occurs is emphasised by scholars (Bottoms et al., 2004; Farrall, 2002; McCulloch, 2005; McNeill, 2002; Weaver, 2012; Weaver & McNeill, 2007). Weaver and McNeill (2007, p. 1) argue that recognition of a person’s social context must be a key consideration for anyone supporting an individual in the desistance process. They suggest that supporters of the change process need to focus on assisting with the development of “new networks of support and opportunity in local communities”, rather than attempting to ‘fix’ a person’s perceived deficits (Weaver & McNeill, 2007). Bottoms et al. (2004, p. 377) also acknowledge the importance of attending to the social context of individuals’ lives arguing that: “… desistance cannot be considered outside the social context in which it occurs”. McNeill (2002) strongly suggests that the workplace, the place of residence and the environment in which socialising occurs are crucial factors that must be considered if a desistance lifestyle is to be initiated and maintained.

**Housing**

After release from prison, obtaining safe and stable housing is considered one of the most difficult challenges ex-prisoners face. Post-release housing – a social context in which desistance takes place (Farrall, 2002) – has generated much discussion and raised concerns among scholars (Baldry, McDonnell, Maplestone, & Peeters, 2003, 2004, 2006; Borzycki &
Baldry, 2003; Bottoms et al., 2004; Farrall, 2002; Halsey, 2007, 2010; Hinton, 2004; McNeill, 2002; McNeill et al., 2005; Ogilvie, 2001; Petersilia, 2003; Social Exclusion Unit, 2002; Travis, Solomon, & Waul, 2001; Williams, Poyser, & Hopkins, 2012; Willis, 2004). Acknowledging the importance of the social context of housing, Halsey (2007, p. 1220), argues that housing is not simply about the shelter aspect but includes “both physical attributes (bricks, mortar, plumbing, heating and so forth) and psychical dimensions (the ability to cultivate a meaningful sense of place through time)”. Other scholars suggest that released prisoners who cannot access safe and stable housing are less likely to successfully integrate into the wider community (Baldry et al., 2006; Ogilvie, 2001) and are more likely to reoffend and return to prison (Baldry, 2007; Baldry et al., 2004, 2006; Burnett & Maruna, 2004; Farrall, 2002; Visher, La Vigne, & Travis, 2004).

After release from prison, those who are homeless, transient, reside in boarding houses, hostels, or live with family or friends who condone criminal behaviour, are highly likely to find these social contexts significant barriers to desistance. A highly transient lifestyle (moving more than twice in a three-month period) is common among released prisoners and increases their risk of returning to prison (Baldry et al., 2003, 2006). Highly transient individuals are also likely to engage in problematic drinking or other forms of substance misuse (Baldry et al., 2003). Accommodation in hostels or boarding houses is considered inappropriate for many ex-prisoners as these establishments are often frequented by people with alcohol and/or drug issues, mental health problems and regularly house ex-prisoners (Willis, 2004). While some ex-prisoners stay with family or friends after release, those who cannot have extremely limited options available to them. In some cases, returning to live with family or friends produces its own set of problems, as some families consider criminality and alcohol misuse an accepted way of life. According to Visher (2004), prisoners
frequently return to families in which three or more members have an alcohol problem and where a close family member has either been convicted of a crime or is serving a prison sentence. Such environments are considered to be a trigger for relapsing into pre-prison patterns of heavy drinking (Binswanger et al., 2012), which for some released prisoners will increase their risk of reoffending and returning to prison. This suggests that without secure and stable housing and avoiding problematic alcohol consumption, taking the initial steps towards desistance will be extremely hard for some ex-prisoners to achieve. The challenges created by housing and accommodation options upon release, is a key focus of Chapter Six.

Although socio-structural theory is widely drawn on by scholars (Bottoms et al., 2004; Farrall, 2002; Laub & Sampson, 2001; LeBel et al., 2008; Maruna, 2001; Uggen & Kruttschnitt, 1998; Uggen, Manza, & Behrens, 2004; Warr, 1998) to explain the process of desistance, the theory is not devoid of criticism. Maruna (2001, p. 31) argues that Sampson and Laub construct turning points as “‘events’ that can be sequentially ordered”. In contrast, he argues that “stable marriages and labor force attachments … require constant care and feeding” and are therefore better understood as “social constructions or processes than as stable conditions or events”. Sampson and Laub (2005, p. 33) concur with this critique and acknowledge that their earlier works tended to “conceptualize turning points in terms of singular, sometimes rare events (e.g., serving in the military during wartime)” and agree that “many important life events are repeating in nature”. Perhaps the strongest critique of socio-structural theories, particularly the earlier work of Sampson and Laub, is directed at their lack of consideration of the role subjective factors play in the desistance process. Maruna (2001, p. 25) proposes that there is “nothing inherent in a situation makes it a turning point”, and suggests a consideration of the role of identity and personal agency needs to be included in desistance research, in order to understand why people make the choices they make.
While socio-structural and contextual explanations for why desistance occurs make a valuable contribution to desistance scholarship, they do not adequately explain why changes or turning points in the life course promote desistance for some but not for others. This short-fall is addressed, to some extent, by a large body of research that examines the role of subjective factors in the process of desistance.

**Subjective Factors and Desistance**

To address the perceived shortcomings of socio-structural theories, several scholars stress the importance of understanding the role of subjective, cognitive, and identity factors in the desistance process (Bottoms, et al., 2004; Burnett & Maruna, 2004; Farrall, 2005; Farrall & Caverley, 2006; Farrall, Hough, Maruna, & Sparks, 2011; Giordano et al., 2002; LeBel et al., 2008; Maruna, 2001; Maruna & Farrall, 2004). Broadly speaking, subjective theories of desistance strongly assert that a positive correlation exists between internal psychological factors and desistance from crime. These theories argue that internal changes, such as developing a sense of personal agency, cognitive changes, or a change in self-identity, are important influences in whether or not individuals desist from crime.

Throughout the literature, the subjective elements of hope (Burnett & Maruna, 2004; Farrall et al., 2010; Healy, 2010; LeBel et al., 2008; McNeill & Weaver, 2010) and motivation (Healy & O'Donnell, 2008; LeBel et al., 2008; Maruna & LeBel, 2010; McNeill et al., 2005; McNeill & Whyte, 2007; Roberts, 2004) are frequently cited as being crucial factors in the promotion of a desistance lifestyle. LeBel et al. (2008, p. 132) consider the subjective factors of motivation, hope, self-efficacy and self-perception as essential factors in the desistance trajectory. LeBel et al. (2008) suggest that hope is more than a vague concept and, in the process of desistance, it denotes the imagining of future goals and a belief that
desired goals are achievable. Farrall (2005) draws on elements of existential thought to explain how the role of subjective factors such as feelings, emotions and motivations contribute to desistance. In contrast, other scholars stress the importance of an optimistic rather than a pessimistic mindset (Bandura, 2001; Farrall, 2002; Maruna, 2001) for desistance to be achieved. Regardless of which specific subjective factors are considered fundamental in desistance trajectories, they all contain the overarching theme of the individual being an active agent in driving the process of behavioural change.

**Personal Agency**

The subjective element of personal agency is deemed to be a salient factor in the process of desistance (Adams, 1997; Bottoms et al., 2004; Healy, 2010, 2013; McNeill et al., 2005; McNeill & Weaver, 2010; Paternoster & Bushway, 2009; Vaughan, 2007; Weaver & McNeill, 2007). However, noting the role of personal agency in the process of desistance is not new. During the 1980s, Fagan (1989, p. 380) stressed the role of personal agency in the process of desistance stating that “desistance implies a conscious behavioural intent to reduce the incidence of violence”. The importance of agentic factors was further highlighted in Farrall’s (2002) study of individuals on probation, in which he noted that individuals who were optimistic about desisting from crime were more likely to achieve their goals than those who had a pessimistic outlook regarding the attainment of a non-offending lifestyle.

Despite being a term used frequently in desistance studies, there is no agreed definition of the term ‘agency’ in criminological literature. Broadly speaking, the term implies that individuals who believe they have the capabilities to achieve specific goals through their own volition and determination have a sense of personal agency. McNeill et al. (2005, p. 3) view agency as “an active process” in which “the ability to make choices and
govern one’s own life is first discovered then exercised”. A more comprehensive definition of personal agency is offered by renowned psychologist Albert Bandura (2001, p. 2) who states that:

To be an agent is to intentionally make things happen by one’s actions. Agency embodies the endowments, belief systems, self-regulatory capabilities and distributed structures and functions through which personal influence exercised, rather than residing as a discrete entity in a particular place. The core features of agency enable people to play a part in their self-development, adaptation, and self-renewal with changing times.

Implicit in Bandura’s definition of agency is the notion that the individual acts as a change agent, believing that through his/her actions and motivations behavioural change is achievable. This thesis adopts an understanding of personal agency in line with Bandura’s definition, as it emphasises the importance of the individual being an active participant in facilitating change.

**Cognitive Transformation Theory (CTT)**

CTT (Giordano et al., 2002) has contributed significantly to desistance scholarship by providing a nuanced understanding of how individuals’ cognitive changes contribute to the attainment and maintenance of a desistance lifestyle. CTT proposes that four interacting “cognitive shifts” need to occur for individuals to attain and maintain a desistance lifestyle. The first, and perhaps the most important cognitive shift, is “openness to change”. This occurs when individuals believe that change is both desirable and possibly coupled with a willingness to change (Giordano et al., 2002). The second shift requires the ability to recognise and access “hooks for change” that are available in the social environment. Giordano et al. (2002, p. 1000) propose “hooks for change” are the “scaffolding” that make significant life changes possible. By necessity, this change entails rejecting a criminal
lifestyle and embarking on a pro-social way of life. However, the acknowledgement that change is possible is of itself not sufficient for the process of change to occur. Individuals must also be sufficiently motivated to drive the change process. The third cognitive shift entails a person envisioning a “replacement self”, for example, perceiving themselves as a non-offender now, and in the future (p. 1002). This change in self-perception is generated by “hooks for change” that are available in the social environment. For example, a strong commitment to an intimate relationship or obtaining a job that is valued may operate as “hooks for change” that can foster desistance (Giordano et al., 2002). The fourth cognitive shift, termed “the capstone” (Giordano et al., 2002, p. 1002), requires a transformation in cognition from believing that offending is an acceptable way of life to the belief and understanding that offending behaviours are not consistent with societal norms and values.

The four cognitive shifts that underpin the CTT are evident in the narrative of a female respondent in a study by Giordano et al. (2002) who stated:

I have chosen to grow up, keep a job, keep a home, stay out of trouble, given up drugs and alcohol, and raise my son; and the rest of them are still, you know, floating around, drinking, losing homes, not working …

This example clearly situates the individual as an active agent in the change process, as she chooses to pursue a more pro-social lifestyle, which demonstrates her “openness to change”. Furthermore, she identifies “hooks for change” in her environment through the opportunity to become a good mother, provide a home for her son and seek employment. These hooks for change then provided the catalyst for the respondent to envision a “replacement self” by imagining herself as a good mother as opposed to an offender. The fourth cognitive shift, a change in attitudes towards offending, is evident in the respondent’s narrative, as she states she no longer wants to be like “the rest of them”.

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The four cognitive shifts that underpin CTT clearly require individuals to have a strong sense of personal agency to act as their own change agent. Adams (1997, p. 335) asserts that “lasting changes in criminal behaviour rarely come about as a result of passive experience, and such changes are best conceptualised as the outcome of a process that involves significant participation by the offender, who, in many respects acts as his or her own change agent”. Similarly, McNeill & Weaver (2007) assert that people who desist from crime develop a sense of personal agency, whereby a belief that they can govern their own lives is realised, and pro-social choices are made that consequently assist individuals in resisting the criminogenic pressures of their environment. While this thesis does not draw specifically on the core principles of CTT, it provides a nuanced understanding of the important role that agency, motivation and hooks for change play in the promotion of a desistance lifestyle, and thus is important to acknowledge in a discussion of desistance and recovery.

**Narrative Scripts and Identity**

A change in self-identity (self-perception) is considered by some scholars to be an important subjective component of the desistance process (Farrall, Hough, et al., 2011; Giordano et al., 2002; LeBel et al., 2008; Maruna, 2001; Maruna, Lebel, et al., 2004; Vaughan, 2007). Self-identity is created by the internal narratives individuals generate to create an image of their present and future selves. The role of self-narratives in desistance research came to prominence largely through Maruna’s (2001) insightful publication, *Making Good: How Ex-Convicts Reform and Rebuild their Lives*. According to Maruna (2001, p. 40), “[t]he narrative identity can be understood as an active information processing structure, a cognitive schema, or a construct system that is both shaped by and later mediates social interaction”. Maruna
(2001, p. 38) analysed and compared the views and self-perspectives of two groups of individuals he categorised as “persisters” (those who continued to engage in criminal activities) and “desisters” (those who attempted to “go straight”). The two cohorts were matched in terms of age (average age 30 years old), educational qualifications, and criminogenic backgrounds.

Studying the narratives of these two groups, Maruna (2001, p. 8) was able to “to identify the common, psychosocial structure underlying these self-stories, and therefore to outline the phenomenology of desistance”. Two distinct narratives emerged from the data: a “condemnation script” and a “redemption script” (Maruna, 2001, pp. 75, 85). A condemnation script emerged from the narratives of those who persisted in offending. The narratives of “persisters” were overly pessimistic and fatalistic in nature. Additionally, their stories lacked a language of agency, as they believed they had no control or choice over the trajectory their lives would take. In interviews with people suffering from chronic alcoholism, Singer (1997, p. 39) discovered a similar fatalistic narrative regarding their prospects of recovery. He claimed:

Convinced that failure, relapse and death are his inevitable fate, the chronically addicted man chooses to say ‘I might as well do the damage to myself before life does it to me.’ At such moments the individual turns his capacity for self-mastery against himself. His only sense of control is the harm he can do to his body and to those people who still love him … There are two avenues to sense of agency that any individual can travel – one is the independence gained by success, the other the freedom of total loss.

In contrast, a “redemption script” formed the basis of the narratives of Maruna’s “desisters” in which a new, optimistic, sense of self emerged. A redemption script is created when individuals “re-narrate their past lives in order to make those histories consistent with who they are in the present and [who they] want to be in the future” (Farrall, Hough, et al., 2011,
This entails choosing to reject a criminal lifestyle and constructing a self-narrative that replaces their self-identity as a criminal with a new personal identity in which they perceive themselves as a non-offender. Maruna (2001) also discovered that the desisters exhibited a strong sense of agency, evident in their belief that they could take control over their lives. However, not all scholars agree that a reformulation of identity is necessary for desistance from crime to occur. Bottoms et al. (2004) argue that if a change in self-identity is a necessary component for desistance to be achieved, then individuals who do not offend for extended periods of time, without a change in self-identity, cannot be considered to be genuine desisters. Maruna (2001) contends that a change in self-identity rarely occurs early in the desistance process but is closely aligned with the stage of secondary desistance. In contrast, this thesis argues that the roots of identity change are likely to be embedded in the early stages of desistance when individuals are supported in the transition from prison to the community. Paternoster and Bushway (2009) suggest that individuals have both a sense of who they are at the present time and envisage a future positive “possible self” (Markus & Nurius, 1986; Oyserman, 1990). Imagining a future self encompasses “what a person hopes to become, expects to become, and fears that he or she might become” (Oyserman, 1990, p. 141). Foreseeing a positive possible self may promote factors deemed important in the process of desistance, such as a sense of optimism and hope for a better future. A future-oriented self may also provide a platform for lasting behavioural change to occur. Paternoster and Bushway (2009, p. 1114) suggest that believing in a positive future self can produce a motivational “roadmap” whereby future goals and aspirations are defined and a plan can be formulated as to how these goals can be achieved. An aim of this thesis is to gain an understanding of whether released prisoners transitioning from prison to the community have either a pessimistic or optimistic view that behavioural change is possible.
Obtaining this understanding will provide an important insight into the how releasees in Victoria view their post-release prospects for behavioural change.

**Integrating Structure and Agency**

The preceding discussion highlights how strong social bonds, social contexts and subjective factors are considered to be instrumental in the process of desistance. However, within the last decade, a new discourse has emerged in desistance studies, arguing that desistance is more likely to occur as a result of the interplay between social/structural and subjective factors (Bottoms et al., 2004; Farrall, 2002; Farrall & Bowling, 1999; Farrall, Sharpe, Hunter, & Calverley, 2011; Giordano et al., 2002; Maruna, 2001; Maruna & Farrall, 2004). These scholars argue that any explanation of desistance must incorporate both subjective and social/structural variables. Structural theories focus on external events in the life-course such as securing employment (Weaver, 2012), obtaining stable housing, and having a regular income (Burnett, 2007). The importance of addressing agentic factors in desistance studies is supported by Maruna (2001). He suggests that “subjective changes provide the phenomenological understanding of how ex-offenders go legit (and stay that way) …” (Maruna, 2001, p. 34). Farrall (2002) asserts that a desistance pathway may be triggered by structural turning points suggesting that the acquisition of something, such as employment or a stable marriage, then generates a subjective re-assessment of their offending behaviour. Furthermore, he proposes that “external factors influence internal states and vice versa” (Farrall, 2002, p. 367). Similarly, Maruna et al. (2008) maintain that individuals make conscious decisions to enter into marriage or seek employment, and if these social bonds contribute to successful desistance, it is important to understand the role conscious decisions play in individuals remaining employed or staying married.
Other scholars acknowledge that strong social bonds are necessary elements if offenders are to change their behaviour and adopt non-offending lifestyles, but they argue social bonds are only beneficial in the desistance process if they are considered meaningful and, therefore, subjectively valued (Burnett & Maruna, 2004; Giordano et al., 2002; LeBel et al., 2008; Lippens & Crewe, 2009). Contemporary research proposes that social factors in the desistance process only become significant as a result of underlying internal change processes (Lloyd & Serin, 2012). However, scholars emphasise that individuals must not only be aware of when opportunities for change exist, but they must also possess the necessary skills and capabilities to access and utilise transformational opportunities (Giordano et al., 2002). The interplay of internal and external factors highlights the non-linear and multifaceted nature of the desistance process. McNeill (2006, p. 47) states that:

… desistance resides somewhere in the interfaces between developing personal maturity, changing social bonds associated with certain life transitions, and the individual subjective narrative constructions which offenders build around these key events and changes. It is not just the events and changes that matter; it is what these events and changes mean [emphasis in original] to the people involved.

Combining structural and agentic factors into an integrated framework has contributed to a broader understanding of desistance by examining and explaining how alterations in one’s socio-structural contexts, together with a change in subjectivities, enhances the likelihood of some people desisting from crime. Nonetheless, desistance theories have attracted some scholarly criticisms. Porporino (2010, p. 61) stated recently that: “[d]esistance theory and research, rich in descriptive analysis of the forces and influences that can underpin offender change, lacks any sort of organised framework”. McNeill and Weaver (2010, p. 6) similarly contend that, “[o]ne of the problems with desistance research, is that it is not readily translated into a straightforward model for practice …”. Regardless of these criticisms,
scholars increasingly argue that a desistance-focused framework be used to inform offender rehabilitation programs and practices. In the context of this research, this thesis draws on an integrated theory to seek an understanding of how the interplay between socio-structural and subjective processes may contribute to individuals taking the initial steps towards desistance and recovery when transitioning from prison to the community with an AUD.

**A Desistance-Focused Model of Rehabilitation**

Increasingly, scholars advocate for offender rehabilitation programs to be desistance-focused rather than offence-focused (Farrall, 2002, 2004; Maruna, Immarigeon, et al., 2004; McCulloch, 2005; McNeill, 2002, 2006, 2012; McNeill et al., 2005; Ward & Maruna, 2007; Weaver & McNeill, 2007). Farrall (2002) argues that if offender support services adopted practices that were desistance-focused, rather than offence-focused, support workers, forensic counsellors, case managers, and parole officers may feel they have the authority to address a broader range of challenges that many ex-prisoners face when exiting prison. Farrall’s (2002) study of 199 probationers and their probation officers revealed the probationer’s level of motivation and recognition of social contexts were more important in fostering desistance than the supervision process itself. Conversely, probation officers interviewed for the study were primarily concerned with probationers’ risk of reoffending and little attention was given to their social and personal contexts (Farrall, 2002). Whereas, four decades ago the need to tailor interventions to address the needs of ex-prisoners within the contexts of their environment was posited by Bottoms and McWilliams (1979, p. 174), who stated that providing “help maybe more crime-reducing than treatment”.

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One of the strongest arguments for developing offender rehabilitation programs that are desistance focused, as opposed to offence-focused, is offered by McNeill (2003, pp. 156-157) who argues:

[b]eing offence-focused might in some senses tend to accentuate precisely those aspects of an offender’s history, behaviour and attitudes which intervention aims to diminish. It may also tend towards identifying the problem as one of individual malfunctioning. Being desistance-focused, by contrast, implies a focus on the purpose and aspiration of the intervention rather than on the problem that precipitates it. It tends towards recognizing the broader social contexts and conditions required to support change. Thus where being offence-focused encourages practice to be retrospective and individualized, being-desistance focused allows practice to become prospective and contextualized.

Despite widespread interest in a desistance-focused model of offender rehabilitation, there is no practice model currently in existence. However, it is significant that a two-phase research project, the Desistance Knowledge Exchange Project (DesKE) was undertaken in 2011 by criminology scholars Fergus McNeill, Steven Farrall, Shadd Maruna and Claire Lightowler (2012), in conjunction with project partners, the National Offender Management Service for England and Wales, the Probation Board for Northern Ireland and the Community Justice Division of the Scottish Government, to produce an outline of a desistance-model practice framework (see Maruna et al., 2012). The two-phase project aimed to stimulate discussion and debate among key stakeholders, including academics, service providers, ex-offenders and policy makers to consider how reintegration and supervision policies can incorporate practices that are more desistance-focused in their service delivery approach (Maruna et al., 2012). The first phase involved the production of a documentary titled The Road from Crime, featuring the life story of Alan Weaver, a former prisoner, now Probation officer in Scotland, and his personal journey of turning away from crime. The second phase consisted of a number of workshops, with each group limited to “40-50 invitees” to discuss,
from their own perspectives, how and why some people desist from crime (Maruna et al., 2012, p. 48). Notwithstanding the nascent work being undertaken to develop a desistance-focused model of service delivery, some strong themes emerged indicating that some core components of a desistance paradigm have been identified. These are: the importance of crafting a strong therapeutic alliance (worker client relationship), and the need for individuals to develop social and human capital resources. The significance of these elements is outlined below.

**Therapeutic Relationship**

The importance of developing a strong therapeutic relationship between worker and client resonates strongly throughout the desistance-focused literature (Bazemore & Erbe, 2011; Bottoms & McWilliams, 1979; Burnett, 2004a; Healy, 2010, 2012; Maruna et al., 2012; McNeill et al., 2005; McNeill & Weaver, 2010; Rex, 1999; Weaver & McNeill, 2007). Four decades ago, Bottoms and Williams (1979) argued for the development of a strong therapeutic alliance in which goals and tasks are collaboratively defined between the client and worker, rather than predetermined by the worker/therapist. This notion is also supported contemporarily by (Best, 2010). McNeill (2006, p. 46) explains:

> Put simply, the implication is that offender management services need to think of themselves less as providers of correctional treatment (that belongs to the expert) and more as supporters of desistance processes (that belong to the desister).

Several core components of a strong therapeutic alliance are highlighted throughout the literature. Carich, Wilson and Carich (2010, p. 192) maintain the worker/client relationship needs to be based on “rapport … empathy, respect and warmth; encouragement/reward (reinforcing positive responses); being directive to a degree; and encouraging hope”.

Similarly, McNeill et al. (2005, p. 22) acknowledge the importance of establishing a
therapeutic relationship that is built on a “... mutual understanding and agreement about the nature and purpose of treatment ...”. They also argue for an approach that is “person-centred, collaborative and client-driven (taking the client’s perspective and using the client’s concepts)” (McNeill et al., 2005, p. 22). Others suggest that a strong therapeutic alliance is as important as the program content itself in promoting behavioural change (Best, 2010; Burnett, 2007; Burnett & McNeill, 2005; McCulloch, 2005; Rex, 1999). Smith (2004, p. 44) states that:

Research as well as intuition suggest that the quality of the relationship between helper and helped ... matters, perhaps as much as the content of the intervention, as a predictor of success or failure of efforts to help people change.

Accordingly, a key aim of this thesis is to draw on the perceptions and experiences of support workers and forensic counsellors to gain an understanding of the importance they place on the role of developing a strong therapeutic alliance in the delivery post-release services. The factors considered salient in developing a strong therapeutic alliance are examined in Chapter Eight.

**Social and Personal Contexts of Desistance**

McNeill (2002) argues that a desistance-focused model of offender rehabilitation should aim to address the needs of each individual within their social environment, as ex-offenders are a heterogeneous group who exit prison and return to the wider community with a diversity of challenges and needs. He expands on this notion by asserting that “this requires ... interventions be focused not solely on the individual person and his or her perceived deficits”, but also take into account “the broader social contexts and conditions required to support change” (McNeill, 2002). Criticism has been directed at some structured treatment
programs, specifically those employing cognitive-behavioural techniques, for having an overt focus on the negative aspects of an individual’s behaviour, and neglecting to recognise a person’s strengths, capacities and motivation to change (McNeill & Whyte, 2007). Research proposes that services and programs should employ a “person centred” (McNeill & Whyte, 2007, p. 163) approach in which planning, goal setting and decision-making is a collaborative endeavour, rather than exclusively professionally directed (Department of Health Victoria, 2012). According to McNeill and Whyte (2007, p. 163), when planning and goal-setting is a collaborative venture the client is likely to feel he/she is “someone with potential and worth”. This also requires a focus on the “purpose and aspiration” of the intervention as opposed to accentuating the negative aspects associated with offending behaviours (Farrall, 2002, p. 30). This approach is in contrast to offence-oriented programs that emphasise the negative aspects of a person’s behaviours and have an overt focus on the risk of reoffending.

Farrall (2002) suggests that effective rehabilitation practices need to address the environmental, social and personal contexts of each individual as well as their risk for reoffending. Farrall’s (2002) study in which he tracked 99 probationers revealed that desistance could, in the main, be attributed to two main factors. First, how motivated probationers were to initiate change; and second, changes in their social contexts relating mainly to successfully re-establishing family relationships and accessing employment. However, while Farrall (2002) acknowledges that the risk of reoffending needs to be addressed in program settings, he argues that risk is better addressed by attending to the personal and social needs of individuals, such as assistance with employment or family reunification rather than focusing on the factors that may lead to re-offending. Other scholars support Farrall’s premise and propose that programs should assist individuals to develop both human capital (individuals’ capacities and skills) (Farrall, 2004; Maguire & Raynor, 2006)
and social capital (strengthening the social relationships that generate opportunities) resources (Farrall, 2004; McCulloch, 2005; McNeill, 2009, 2012).

Proponents of a desistance-focused model argue that the more capital resources an ex-offender has to draw on, the more likely he/she is to desist from crime. Farrall (2002) suggests that support services need to consider what resources people need in their lives to assist in the desistance process and then help them achieve these aims.

**Social Capital**

During the past decade, the importance of building social capital resources in the process of desistance occurs repeatedly in contemporary criminological literature (Brown & Ross, 2010; Coleman, 1988; Farrall, 2002, 2004; McNeill, 2002, 2009; McNeill et al., 2005; McNeill & Weaver, 2010; McNeill & Whyte, 2007). Broadly, social capital relates to the changes in personal relationships and social networks that in turn facilitates actions (Coleman, 1988). Hagan and McCarthy (1997, p. 229) suggest that social capital:

… originates in socially structured relations between individuals, in families and in aggregations of individuals in neighbourhoods, churches, school and so on. These relations facilitate social action by generating a knowledge and sense of obligation, expectations, trustworthiness, information channel norms and sanctions.

Social capital resources are generated when individuals build, or re-build, pro-social relationships with family or friends or other community members who are likely to support the individual in the process of behavioural change. Furthermore, social capital resources are generated through the development of relationships with those who adhere to pro-social norms, as opposed to remaining embedded in relationships with individuals who engage in anti-social or offending behaviours. However, building social capital will be difficult for
some, as their offending behaviours, often spanning many years, have resulted in estrangement from previously supportive family members and friends. Some offenders therefore will return to their communities with little or no social support systems on which to draw. In these cases, the establishment of a strong therapeutic relationship between support worker and/or counsellor may be crucial if positive behavioural change is to occur. Burnett contends “it is quite possible for the practitioner to become a ‘significant other’, albeit in an obviously circumscribed way” (Burnett, 2004a, p. 183). This contention is further supported by Burnett and McNeill (2005, p. 234) who argue that “for people who are without the basic means and opportunities to lead reasonably comfortable and fulfilled law-abiding lives, it is likely to be more urgent to provide interventions that mobilise ‘social capital’”. Without the genuine support and encouragement of their support worker or counsellor, it is highly unlikely that some individuals will have the motivation, skills or capacities to change their behaviours or take the initial steps towards a desistance lifestyle.

It is important to note that some researchers separate ‘social capital’ into two distinct categories, namely “bonding social capital” and “bridging social capital” (Lyons & Lurigio, 2010; McNeill, 2009; McNeill & Weaver, 2010; Weaver & McNeill, 2011); both categories of social capital will be addressed in the analysis chapters. Bonding social capital refers to the pro-social ties individuals have with family and close friends, whereas bridging social capital relates to pro-social relationships with acquaintances or workmates or members of the wider community (McNeill, 2009; McNeill & Weaver, 2010; Weaver & McNeill, 2011). Moreover, individuals who have access to social capital (pro-social relationships) can utilise these resources to generate opportunities that build stocks of human capital.
Human Capital

At a basic level, social capital and human capital appear to be separate concepts, however they are inextricably related. Coleman (1988, p. 100) describes the relationship between human and social capital stating: “social capital … comes about through changes in the relations among persons that facilitate actions”. Human capital refers to the “motivation, skills, knowledge, resources and qualities of the individual [emphasis in original] that he or she might need to develop and deploy in the process of desistance” (McNeill, 2009, p. 43). McNeill and Whyte (2007, p. 159) assert stores of human capital … “in ordinary circumstances, facilitate access to education, employment and other valued social goods and resources”. Human capital resources are “created by changes in persons that bring about new skills and capabilities that make them act in new ways” (Coleman, 1988, p. 100). Farrall (2002, p. 216) suggests that building knowledge and skills enables individuals to apply for jobs, maintain employment and achieve successes at work. Professionals who work closely with released prisoners are ideally positioned to assist them to develop human capital resources. Assisting individuals to access short courses, to develop thinking skills, or participate in courses that enhance problem-solving abilities, contributes to the attainment of human capital. Importantly, Farrall (2002) asserts that providing information and education on AOD harm minimisation practices also contributes to building human capital stores.

However, the relationship between building human capital and accessing employment opportunities is somewhat tenuous. Research suggests a large proportion of former prisoners experience significant difficulties gaining meaningful employment after release from prison (Visher, Debus, & Yahner, 2008). This is due in part to the reluctance of some employers to hire a person with a criminal record (Visher, Yahner, & La Vigne, 2010) as some believe people with a criminal history are not trustworthy and may cause trouble in the work place
(Gideon & Hung-En, 2011). In addition, many ex-prisoners have minimal education qualifications and have little or no work skills or experience which limits their post-release employment options (Gideon & Hung-En, 2011; Visher et al., 2008). These and other factors, including poor health and alcohol or drug misuse make securing employment difficult for released prisoners (Gideon & Hung-En, 2011; Visher et al., 2008). The preceding discussion highlights some of the difficulties ex-prisoners face in building human capital skills in relation to gaining employment. However, an environment in which released prisoners receive social supports or treatment for alcohol misuse provides an opportunity for building human capital resources.

The period in which support or treatment services are provided to ex-prisoners also presents a platform for building human capital resources. McNeill and Whyte (2007) suggest that the strength of the relationship between worker and client is an important source for building human capital. They suggest a relationship built on collaboration rather than a rigid, worker-directed relationship enables both parties to make significant contributions towards the achievement of positive behavioural change. This type of relationship has the propensity to build an individual’s stock of human capital in two ways. First, it enables the client to develop a sense of personal agency by participating in treatment planning and goal setting in conjunction with the professional worker. Second, a key task of post-release workers is to address any perceived obstacles that may impede the change process. Therefore, addressing problems that may arise in a collaborative, rather than a directive manner, is likely to generate confidence and enhance the motivation of the client to overcome obstacles should they occur (McNeill & Whyte, 2007).

Not all scholars, however, support a desistance-focused rehabilitation framework. Following a review of the desistance literature, Wormith, Gendreau and Bonta (2012, p. 113)
argue that they remain unconvinced that desistance-focused programs will contribute anything to the rehabilitation of offenders. It should be noted, however, that the criticisms of a desistance focused model proffered by Wormith et al. (2012) are drawn from the work of other scholars. Their first critique of the model is that the operational definition of desistance is vague – drawn from the work of Maruna and Le Bel (2010). The second critique suggests that “by its very nature, it lacks experimental control and there is no cogent theory to explain it” (Wormith et al., 2012, p. 113) – drawn again from the work of Maruna, Le Bel et al. (2004). It is somewhat surprising that Wormith et al. (2012) offer such a strong criticism of a desistance-focused paradigm, as the theoretical framework is still in the developmental stage and therefore has not been empirically evaluated.

Although theories of desistance are extensively drawn on in criminological research to explain why some people cease offending and others do not, explanations of desistance do not explain how these theories may be applicable to offenders with AUDs. However, a close reading of the extant recovery literature reveals that there are several common factors that scholars argue are important if desistance and recovery trajectories are to be initiated. These include: the motivation and the will to undertake behavioural change; the importance of personal relationships and pro-social influences; and the value of a strong therapeutic alliance. To understand how to best support released prisoners with AUDs, this thesis will draw on some common factors considered influential in promoting desistance and recovery and consider the ways in which support workers and forensic counsellors assist ex-prisoners accumulate social and human capital resources. These issues will be primarily addressed in Chapter Eight.
Recovery

There is no consensus among scholars, or professionals in the drug and alcohol sector, as to what the term recovery means, nor how best to assist individuals on a recovery journey. This lack of consensus poses key questions for consideration. How should recovery be operationalised? Does recovery mean total abstinence from alcohol or drugs, or can recovery also be understood as harm minimisation? White (2007, p. 229) argues the term is characterised by a “conceptual fuzziness” throughout the literature and leaves a crucial question unanswered: when is the “state of recovery … achieved, lost and reacquired?” (White & Kurtz, 2006). Nonetheless, two distinct discourses of what constitutes recovery emerge from the literature: recovery as total abstinence and recovery as harm minimisation.

Defining Recovery

Attempting to add some conceptual clarity to the term recovery, The Betty Ford Institute Consensus Panel (2007) convened to address the question, “What is recovery?” and to develop a working definition of the term. The panel suggested that recovery from substance abuse is: “a voluntarily maintained lifestyle characterized by sobriety, personal health and citizenship”.

A similar definition is offered by the Center for Substance Abuse Treatment (2005) which suggests:

Recovery from alcohol and drug problems is a process of change through which an individual achieves abstinence and improved health, wellness and quality of life.

Whilst these definitions of recovery provide a broad understanding of what the term recovery means they do not explain the resources one needs to employ to achieve an improved quality of life.
A more comprehensive definition of recovery is presented by the United Nations Office on Drugs and Crime (2008) that states:

Recovery is a continuum process and experience through which individuals, families, and communities utilize internal and external resources to address drug dependence and substance abuse problems, actively manage their continued vulnerability to such problems, and develop a healthy, productive and meaningful life.

Throughout this thesis, recovery will be understood in line with this latter definition for three important reasons. First, this thesis adopts an understanding of recovery as a process. It recognises, as does the process of desistance that pathways to recovery involve periods of ambivalence, lapses and relapses. Second, the definition provides the latitude to view recovery as having either an abstinence or a harm minimisation focus. Third, it highlights the role of internal and external factors in the process of recovery and places individuals as active agents in the process of behavioural change.

**Recovery as Abstinence**

Historically, recovery from alcohol misuse or dependency was understood as abstinence from all forms of alcohol. Contemporarily, some scholars also associate recovery with an abstinence model (Amodeo, Kurtz, & Cutter, 1992; Biernacki, 1986; McGovern & DuPont, 1999). Similarly, the fellowship of Alcoholics Anonymous (AA), a mutual-aid recovery group, strictly adheres to the notion that recovery from alcohol addiction requires abstinence (AA, 1939). This idea of recovery as total abstinence encompasses a disease model of addiction. The abstinence and disease models assert that problematic alcohol use is a progressive disease; therefore the ingestion of even a small quantity of alcohol can lead to a loss of control (AA, 1939). The belief that recovery from alcoholism can only be achieved by
abstinence grew largely out of the testimonials given by early members of AA who drew on their experiences of relapse. They argued that maintaining an abstinent lifestyle was the most successful method of staying sober. An abstinence model of recovery, also known as the Minnesota Model\(^2\) (McGovern & DuPont, 1999, p. 8) defines recovery from alcohol misuse or addiction as:

… abstinence from the use of all addicting drugs (for example, people addicted to alcohol were not considered clean and sober if they used marijuana or cocaine and vice versa) …

However, some scholars and professionals in the addiction field advocate for a definition of recovery that also encompasses a harm minimisation approach to addressing the problems associated with problematic alcohol consumption (Ambrogne, 2002; Saladin & Santa Ana, 2004). A harm minimisation framework considers recovery to be a process often spanning many years characterised by alternating periods of relapse into alcohol misuse and periods of abstinence.

**Recovery as Harm Minimisation**

Despite the historical adherence to an abstinence model of recovery, a number of scholars and professionals in the AOD sector argue that a definition of recovery should acknowledge that recovery also includes the adoption of harm minimisation principles; also known as a harm reduction approach (Wodak, 2009). In relation to alcohol misuse, the terms controlled drinking, risk-reduced drinking and moderate drinking are used in discussions of a harm minimisation framework (Ambrogne, 2002). A harm minimisation approach aims to reduce the personal and community harms associated with problematic alcohol consumption by

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\(^2\)The Minnesota model was developed in a state mental hospital in the United States during the 1950s. It was created by integrating a state hospital program and an Alcoholics Anonymous recovery program.
assisting individuals to manage their drinking behaviours, rather than setting a goal of abstinence. The philosophy recognises that merely reducing or managing one’s alcohol consumption patterns is, of itself, unlikely to produce long-term behavioural change and acknowledges that individuals’ socio-economic and environmental factors that may impact on family life, employment and successful integration into the wider community, also need to be considered for beneficial outcomes to be realised (Center for Substance Abuse Treatment, 2005).

Whether recovery is defined as total abstinence or harm minimisation, both models recognise that recovery is an ongoing process that requires either continual maintenance (abstinence) or reduction (harm minimisation). While both models address an individual’s alcohol consumption pattern, both have the broader goal of seeking a better quality of life. Best and Laudet (2010, p. 2) suggest:

… the essence of recovery is a lived experience of improved life quality and a sense of empowerment; that the principles of recovery focus on the central ideas of hope, choice, freedom and aspiration that are experienced rather than diagnosed and occur in real life settings rather than in the rarefied atmosphere of clinical settings.

Alex Wodak, a leader in the Australian addiction treatment field, suggests that total abstinence from alcohol may not be an achievable goal, or a viable option, for all people with AUDs (Wodak, 2009). Although he supports a harm minimisation approach, he maintains that abstinence remains the most effective method of reducing the harms associated with alcohol misuse or dependency (Wodak, 2009). Laudet (2007) endorses a harm minimisation approach and contends that recovery from substance abuse entails much more than the experience of abstinence. He contends that recovery involves individuals living a “‘bountiful new life’, an ongoing process of growth, self-change, and reclaiming the self” (Laudet, 2007,
p. 243). However, the achievement of a “bountiful new life” is unlikely to emerge from treatment or support systems that primarily focus on the symptoms and pathology of AOD misuse.

A number of scholars emphasise the importance of employing a holistic approach when delivering AOD treatment and support services (Laudet, 2008; McLellan & McKay, 2009; McLellan, McKay, Forman, Cacciola, & Kemp, 2005). A holistic approach entails not only assisting individuals to overcome their alcohol misuse, but also considers a person’s physical and mental health status, their family and cultural needs, and economic and social needs as part of any intervention (Department of Health Victoria, 2012). This is important because a key aim of this thesis is to seek an understanding of the needs of released prisoners with alcohol problems and the approach adopted by professional workers who support individuals making the transition from prison to the community.

Pathways to Recovery

There are many pathways that individuals can take in recovering from AOD misuse or dependency. Some achieve “natural recovery” (Center for Substance Abuse Treatment, 2005; Granfield & Cloud, 2001) from AOD misuse problems without the support of clinical treatment or the assistance of mutual aid groups, such as AA. Research suggests that those who recover without the assistance of formal treatment or mutual aid groups are highly likely to have received valuable support from their social networks of family, friends or members of the wider community (Granfield & Cloud, 2001). Conversely, individuals without supportive social networks may find it extremely difficult to initiate and maintain their recovery journey without the support of “accessible, available and affordable quality drug dependence treatment and rehabilitation services” (United Nations Office on Drugs and Crime, 2008).
Having access to treatment is for some a crucial step in facilitating a recovery journey. Research suggests that the availability and accessibility of good quality treatment can be a vital step in the recovery process (Advisory Council on the Misuse of Drugs, 2013). Treatment programs and support services that embrace a recovery-oriented perspective recognise that the accumulation of recovery capital must be incorporated as part of an individual’s pathway towards recovery. For example, the inability to access safe and stable housing will for some be a barrier to the recovery process. As Deleon (2007, p. 87) states:

… the potential benefits of social services … depend upon the timing of their delivery in the recovery process. For example, early in recovery, social services … can provide incentives for engagement in treatment. Later in recovery, provision of housing and vocational and educational training can promote continued involvement in the recovery process.

**Recovery Capital**

The concept of *recovery capital* is a recent edition to criminological, addiction and recovery literatures. Granfield and Cloud’s (1999) book, *Coming clean: Overcoming addiction without treatment*, introduced the concept to describe a wide range of resources that individuals can accumulate over time to increase the prospect of recovering from AOD misuse or dependency. Recovery capital is a rehabilitation philosophy that seeks to address the complex and multi-faceted needs of individuals with AOD problems rather than simply focusing on the pathology and symptoms of AOD misuse (Welsh Government, 2013). Cloud and Granfield (2008, p. 2) define “capital” as:

a body of resources that can be accumulated or exhausted … [h]ow much and what types of resources a person accumulates and/or exhausts hold significant implications for the options available to that person.

A Treatment Process Model manual (Best, 2010), based on the principles of recovery capital has recently been produced in Lanarkshire as a guideline to assist service providers support clients in their recovery journeys. The manual draws on evidence-based psychosocial interventions and principles that foster client engagement in the treatment process. Cloud and Granfield (2008) argue that positive treatment outcomes are more likely when individuals are supported to develop and strengthen their social capital, human capital, physical capital and cultural capital resources.

Four Categories of Recovery Capital

The overarching aim of utilising a recovery capital model is to produce positive outcomes across the spectrum of people’s lives. Cloud and Granfield (2008, p. 1983) define recovery capital as: “[t]he sum total of one’s resources that can be brought to bear on the initiation and maintenance of substance misuse cessation”.

Expanding on this definition, Dennis, Foss and Scott (2008, p. 587) define recovery capital as:
resources that can be accumulated throughout time (e.g. health, mental health, housing crime free [status], employment strong family and social relations, and life satisfaction) as abstinence is sustained.

These, and other examples of recovery capital are classified into four major categories: social capital (opportunities that arise from the formation of supportive personal relationships which in turn may lead provide opportunities for building human capital); human capital (physical and mental health, employment and skills development); physical capital (financial capital and accommodation); and cultural capital (values, beliefs, attitudes) (Advisory Council on the Misuse of Drugs, 2013; Cloud & Granfield, 2008; Granfield & Cloud, 1999). The recovery capital perspective, although a recent addition to the addiction and recovery literature, is arguably gaining prominence among scholars and professionals in the recovery field as the preferred AOD treatment model. It is a strengths-based, holistic treatment paradigm that draws parallels with a desistance-focused model of rehabilitation, which also prioritises the generation of social and human capital resources in the change process. Both conceptual frameworks advocate strongly for a holistic focus in supporting and treating individuals with AOD problems as opposed to simply targeting the risk factors associated with reoffending and substance misuse. For individuals attempting to recover from any form of substance misuse, the accumulation of recovery capital is considered crucial in facilitating the change process and fostering a motivation to change.

Social Capital

Social capital refers to the total sum of resources each individual has as a result of their supportive relationships and obligations to the groups to which they belong (Cloud & Granfield, 2008; 1999). Social capital is strengthened through building positive relationships with people and groups who are supportive of an individual’s recovery journey. In turn, these
support networks may provide individuals with opportunities to build sources of human capital such as obtaining a job or providing access to safe and stable housing, which are considered important foundational elements for a recovery journey. For individuals with AUDs, social capital resources are expanded or limited by the social and situational contexts in which they are embedded. Best and Lubman (2012, p. 3) assert in the process of recovery from any form of substance misuse “other people matter”.

The central tenet of social capital maintains that belonging to a social group, for example, family, friendship, community or a self-help recovery group, provides individuals with opportunities and support mechanisms to assist them in making positive behavioural changes in their lives. For example, having a supportive family or life partner, who do not have alcohol problems, or being a caring parent are factors that can contribute to one’s stores of social capital. Those seeking to change their drinking behaviours, who value their membership of a particular group, adhere to the expectations of others. The obligations and responsibilities associated with belonging to a particular group can therefore provide the stimulus and opportunities to improve recovery outcomes (Advisory Council on the Misuse of Drugs, 2013).

**Human Capital**

Human capital represents a range of human characteristics that enable individuals to function effectively in society. Cloud and Granfield (1999, p. 181) describe the attributes associated with human capital as:

… all the personal characteristics an individual possesses that can in turn be utilised by individuals to enhance the likelihood of recovery from substance misuse.
Specifically, human capital resources refer to the “knowledge, skills, educational credentials, health, mental health, and other acquired or inherited traits essential for optimal negotiation of daily life” (Cloud & Granfield, 2008, p. 1974)

Cloud and Granfield (1999) pay particular attention to the role of mental health as a human capital resource. They assert that mental health problems such as impaired cognitive functioning, depression, emotional instability, persistent impulsivity and other negative mental health states can be precipitated by, or result from, AOD misuse (p. 182). On the other hand, they contend that individuals who do not suffer from any form of severe mental illness, and do who not have diminished cognitive abilities, are more likely to have a positive disposition and a sense of self-esteem and self-awareness, which are important factors in aiding the recovery process.

As previously discussed providing access to programs that enhance employment or vocational skills can build human capital resources. However, Farrall (2002) argues that despite one’s best intentions, if the prevailing social and economic circumstances do not encourage the employment of ex-prisoners, no amount of skills training will enhance the likelihood of obtaining employment. Despite this, individuals who have social capital resources in the form of supportive families, friends and social networks may be able to seek assistance in obtaining employment through these resources.

**Physical Capital**

The concept of physical capital refers to the extent to which an individual is financially secure, which in turn may enable access to a greater range of support mechanisms and treatment options. Coleman (1990, p. 301) suggests:
… physical capital is created by changes in materials to form tools that facilitate ‘production’; human capital is created by changes in people that create the skills and capabilities that make them able to act in new ways and to do new things.

Physical capital includes income, savings, property, investments, and other material assets that can be drawn on to increase their recovery options (Cloud & Granfield, 2008). For individuals in recovery, the more physical capital they possess, the more choices they have in obtaining support and assistance for their recovery from substance misuse. For individuals who lack safe and stable accommodation, the level of physical capital they possess will largely determine the housing options available to them. Individuals with high levels of physical capital will have the means to seek accommodation in the private rental market, whereas those with little physical capital will have limited housing options, possibly restricting them to accommodation in hostels, boarding-houses or remaining homeless on the streets.

Physical capital, however, not only refers to the accumulation of tangible assets but also to the challenges released prisoners face in relation to the management of their money (Bath & Edgar, 2010). Regardless of whether income is derived from a salary or from welfare payments provided by the government, individuals need the ability to manage their money to build physical capital. This includes effectively budgeting to meet their basic obligations such as paying rent or buying food (Bath & Edgar, 2010). People without even basic money management skills (human capital) are, therefore, highly unlikely to build any meaningful form of physical capital resources, which are considered necessary elements of a recovery journey.

Having sufficient physical capital also provides options for those seeking treatment for alcohol problems. Those with physical capital resources are likely to have private health
insurance, which provides access to professional treatment in the private health sector rather than waiting for a treatment placement in an often overcrowded public health system.

**Cultural Capital**

Cultural capital represents cultural and societal norms, and the extent to which a person’s belief and value systems enable them to adopt pro-social behaviours and adhere to dominant social norms. Cloud and Granfield (2008, p. 1974) contend that “[c]ultural capital embodies cultural norms and the ability to act in one’s interest within these norms to meet basic needs and maximize opportunities”. Changing belief and value systems is not an easy task for people who have a history of alcohol misuse. The beliefs and values of these individuals are likely to be entrenched in behaviours embedded in a lifestyle where alcohol misuse is commonplace (Keane, 2011). In the context of recovery capital, cultural norms refer to conventional pro-social norms that enable individuals to achieve social inclusion in mainstream society. Central to building cultural capital are the elements of hope, encouragement and empowerment (Welsh Government, 2013, p. 4). According to the Substance Abuse and Mental Health Services Administration (SAMHSA) (2012, p. 4), “recovery emerges from hope” and hope can be fostered by families, peers, friends or support networks, that is, fellowship recovery groups or treatment professionals. Critcher (1976, pp. 168-170) explains the way that cultural experiences can determine how individuals respond to both the obstacles and opportunities they encounter:

A person or close social grouping is situated in relation to the structures of society: they circumscribe present experience, and are the limits of any foreseeable future. We are not saying that being at the wrong-end of these structures – in poor housing, with little educational opportunity, the most soul-destroying jobs, and low income – gives rise on every occasion to crime, or if these structural constraints were removed then crime would largely cease. People do not respond to their environment in such a crude way. They create,
and have created … ways of thinking and acting which embody ideas, beliefs, values, notions of right and wrong. These we call cultures.

The process of recovery from AOD misuse entails building stores of recovery capital in several domains of an individual’s life. Elements of recovery capital pertaining to the social, human, physical and cultural resources that a person can utilise in the recovery process are inter-related and changes in one area may impact on other areas of their lives. It is important to note that while physical capital and cultural capital are elements of a ‘recovery capital’ model of rehabilitation, they are not a focus of this research as they are not key factors associated with a desistance-focused model. Social capital and human capital remain a focus of this study, as they are the two ‘capital’ factors considered important in both models. However, building recovery capital resources are not the only factors deemed salient in the process of recovery. A recovery-oriented system of care also stresses the importance of a therapeutic alliance in the treatment setting.

**Therapeutic Alliance**

The context of treatment, the relationship between the client and the worker is seen as an important predictor of positive treatment outcomes (Best et al., 2010). Problematic alcohol or drug consumption in the post-release environment is one of the strongest predictors for breaching parole orders and returning to prison (Kirby, McSweeney, Turnbull, & Bhardwa, 2010) It is, therefore, important that ex-prisoners are encouraged and assisted to engage in alcohol treatment services to promote behavioural change. As noted, a collaborative approach is preferable to a relationship in which the counsellor or support worker sets goals for the client to achieve. Best et al. (2010, p. 35) argue that a strong therapeutic relationship is more
likely to develop when “a set of shared goals and objectives that will inspire and motivate the client to seek recovery goals …” are part of the planning process.

Conclusion

The two theoretical frameworks presented in this chapter emphasise a number of factors deemed crucial in the promotion of a desistance and recovery journey. Both theories argue for the development of strong pro-social attachments to others who in turn, are likely to be supportive of individuals desire to change their behaviours. The importance of structural (external) factors, for example, suitable housing and stable employment; and subjective (internal) factors, for example, personal agency, hope and motivation are also important in initiating desistance and recovery lifestyles. The literature on desistance-focused and recovery capital models of offender rehabilitation principles and practices suggests the two frameworks contain similar elements. Both models advocate for interventions that address the needs of ex-offenders in the contexts of their social and personal environments by helping them to develop social and human capital resources. Another common factor of both models pertains to the importance of a strong therapeutic alliance between the support worker and their client. It is also worth noting that contemporary thought, in the main, views both desistance and recovery as processes and not discrete events.

Although considerable conceptual overlaps are evinced between the models, a review of the literature has failed to reveal any existing research studies that have integrated both conceptual frameworks into one model. This thesis will draw on the core elements of both frameworks and employ those factors as the basis for presenting the data collated in this research. It is important to note, however, that this study does not intend to develop an integrated theoretical model of the two conceptual frameworks, as work is still underway to
develop a desistance-focused paradigm. Drawing on the core elements of both frameworks will provide a clearer understanding of what factors need to be addressed and prioritised by support and treatment service providers to deliver positive outcomes for individuals who transition from prison to the community with an Alcohol Use Disorder (AUD). This thesis will also make a contribution to existing desistance and recovery literatures by positioning post-release alcohol misuse as a topic for discussion and debate among policy makers, academics, program developers and the wider AOD sector.

The next chapter reviews the literature on alcohol misuse and places it in both contemporary and historical contexts. This is done in order to provide a current understanding of how alcohol misuse results in some individuals having ongoing contact with CJSs. This chapter also examines a range of literature and statistical data to present a broad overview of the social, personal and economic harms associated with alcohol misuse in a contemporary global, Australian and Victorian context (1980s-today).
Chapter Three

Literature Review – Setting the Context

The history we are studying is not like a ladder, on which each rung marks a clear division between one stage and the one above. It is more like a river, arising from several tributaries, some of which, owing to the operation of changing climatic factors, tend to grow more powerful, while others show signs of drying up; yet, all are adding their respective flow to the main stream. (Sellin, 1958, p. 586)

This chapter reviews the literature on alcohol misuse and places it in both contemporary and historical contexts. This is done in order to provide a current understanding of how alcohol misuse results in some individuals having ongoing contact with criminal justice systems (CJS). Establishing this link is crucial in the context of this study as there is a paucity of research in contemporary literature which examines alcohol independent of other drug types. This chapter thus draws on a wide range of literature including government reports, policy documents, statistical data and peer-reviewed research to examine the role of alcohol misuse in the post-release environment. It sheds light on the nexus between alcohol misuse and crime, and provides an estimate of the proportion of individuals who enter prison with an Alcohol Use Disorder (AUD). This chapter also presents a brief history of offender rehabilitation theories and concepts to demonstrate how offender rehabilitation ideologies have changed over time. This is important for the purposes of this research for two reasons. First, an understanding is needed of previous approaches to the rehabilitation of offenders and the reasons why they have largely failed. Second, reflecting on the shortcomings of past reformative and rehabilitative efforts can provide the basis for the design and implementation of more effective rehabilitation practices and programs by avoiding the mistakes of the past. Rotman (1990, p. 21) emphasises the importance of gaining insights into the historical practices of rehabilitation:
Historical scrutiny … throws light on the redemptive contributions of rehabilitation. Despite its failures and distortions, the idea of rehabilitating the criminal offender is related to the faith in the human capacity to change for the better.

What to do with offenders and how to rehabilitate them to become law-abiding, pro-social members of society have been topics of conjecture and debate among reformers, politicians, correctional administrators and academics for over 200 years (Cullen & Gendreau, 2000; Garland, 1990; Morris & Rothman, 1995; Raynor & Robinson, 2005; Robinson & Crow, 2009; Rotman, 1990). At several points in history, various principles and practices have been utilised for punishing, reforming, treating or rehabilitating offenders with AUDs. Broadly, these can be categorised as penal discipline, religious teaching, medical interventions and psychologically based programs (Robinson & Crow, 2009; Rotman, 1990). Rotman (1990) suggests the roots of offender rehabilitation ideologies can be traced back to antiquity (1050 BC). However, the history of offender rehabilitation presented in this chapter will commence with the inception of the Penitentiary in the early nineteenth century because this era heralded the birth of the modern prison and saw a significant change in society’s response to crime and criminality (Garland, 1990). The advent of the penitentiary system brought a shift away from physical punishment to incarceration, coupled with the belief that imprisonment would perform the function of rehabilitation by changing the character and behaviour of offenders (Robinson & Crow, 2009; Rotman, 1990). Thereafter, the ideological changes in rehabilitation theories and concepts up to, and including, the present time will be discussed. Although it is beyond the scope of this thesis to provide a comprehensive history of offender rehabilitation, the historical overview presented draws on successive models namely: the Penitentiary model; the Progressive era – Medical model; the ‘Nothing Works’ era; and two contemporary rehabilitation models, the Risk-Needs-Responsivity (RNR) and
the Good Lives Model (GLM). The discussion of these models also documents how the terms ‘drunkard’, ‘inebriate’, ‘alcoholic’ or ‘alcohol misuser’ have evolved in historical rehabilitation discourses, notably, variances in the terms used to depict prisoners and offenders with AUDs. The terms ‘drunkard’ and ‘inebriate’ are used interchangeably throughout the literature in the Penitentiary and early Progressive era and are supplanted by the words ‘alcoholic’ and ‘alcohol misuser’ from the late Progressive era through to the present time.

This chapter is presented in six sections. Section one presents a brief history of offender rehabilitation principles and practices from the birth of the modern prison up to, and including, the 1970s with a focus on the methods and practices employed to change the behaviour of offenders with alcohol problems. Section two explores the contemporary models of offender rehabilitation – the RNR and the GLM. Section three then provides a broad understanding of the social, personal and economic harms associated with alcohol misuse in the global, Australian and Victorian contexts. Section four examines the nexus between alcohol and crime to provide an overview of the perceived relationship between alcohol and a number of offending behaviours. The fifth section presents an estimate of the current proportion of individuals in Australian prisons with an AUD by drawing on data contained in surveys of Australian prisoner populations carried out since 2003. This section acknowledges the difficulties that exist in accurately depicting the number of prisoners with an AUD – a fact that is also noted throughout the thesis more generally. The final section presents a discussion of the two pathways out of prison in Victoria – parole or straight release – together with an overview of the post-release services available to Victorian releasees. These topics provide a relevant background to the study by positioning the research within the social, personal and economic harms associated with alcohol misuse. Ultimately, this chapter
provides insight into how the current situation in relation to post-release services for those with an AUD has evolved and sets the foundation for the subsequent analysis chapters examining the adequacies of those services.

**Historical Rehabilitation Practices: The Pennsylvania and Auburn Systems**

A contemporary understanding of prison-based alcohol and drug rehabilitation programs did not exist until the 1980s (Valle & Humphrey, 2002). The idea of reforming criminal offenders into law-abiding and productive members of society emerged with the inception of two Penitentiary systems in early nineteenth century America. In New York and Pennsylvania during the 1820s, two competing systems of penitentiary regulation were developed and implemented. Commonly referred to as the Pennsylvania and Auburn systems, both models shared similar ideologies for the reformation of criminal offenders through daily regimes of hard labour and religious instruction, but utilised solitude in different ways (Cullen & Gendreau, 2000; Rothman, 1995; Rotman, 1990). The Pennsylvania model, also known as the separate system, confined prisoners in their own cells day and night, to work, eat and sleep; in contrast, the Auburn model, referred to as the silent system, focused on solitude only at night and prisoners worked and ate together during the day, albeit in total silence (Rotman, 1990, p. 35). During the same era, Britain also utilised penitentiaries as reformative institutions, similarly believing that any changes in prisoners’ criminality could only be achieved by strict adherence to a regime of hard work, religious education and night-time solitude (Robinson & Crow, 2009).

Both systems emphasised the perceived rehabilitative benefit of solitude, believing it was a crucial step in reforming criminals in two salient ways. First, by confining convicts in single cells, they would not be further corrupted by other prisoners. Second, being isolated,
the prisoners would be compelled to reflect inwardly, enabling “God and conscience to speak” (Schneider, 1979, p. 739). During this period, prisoners were considered to be largely uneducated and unsanctified, and religious instruction was deemed critical in assisting them to interpret the “inner and divine voices” which would augment the reformative process (Schneider, 1979, p. 739).

Scholars suggest the notion of utilising prisons as a reformatory, rather than a punitive measure, resulted largely from the work of Quaker and Penal Reformer, John Howard, and his condemnation of the death penalty and other cruel penal practices (N. Johnston, 2009; McGowen, 1995). As a frequent visitor to prisons, correction houses, and asylums in Britain and Europe, Howard chronicled the state of squalor, overcrowding and violence evident in these institutions. He reported his findings to the British Parliament and other penal reformers (N. Johnston, 2009; Schneider, 1979). Consequently, Howard’s written works and intense lobbying for penal reform greatly influenced the introduction of Britain’s Penitentiary Act of 1779, which officially situated rehabilitation alongside deterrence as a key aim of imprisonment. In addition to his concern for prisoners’ health and safety, Howard was troubled over the state of prisoners’ moral and spiritual welfare (Schneider, 1979). A devout Christian, Howard steadfastly believed in the power of religion as a reformatory mechanism:

[r]eligion will … have a strong influence in correcting the morals of men, and I am no less persuaded, that it is religion alone which can effectually accomplish so great and so desirable a work. (cited in Schneider, 1979, p. 725)

The notion of changing prisoners’ criminal propensities and morals through religious instruction, created a profound shift in penalogical thinking, from a harsh punitive focus to one that included notions of reform and behavioural change. The idea of utilizing imprisonment as a reformatory mechanism, rather than using imprisonment as a purely
punitive response to crime and criminality, forms the central component of what is referred to as the “rehabilitative ideal”, a term introduced by Allen (1959) into correctional discourses in the mid twentieth century.

Within the penitentiary era literature, the ‘drunkard’ features prominently in penal populations in both America and Britain. Historical documents reveal that in America, drunkards accounted for the large majority of the convicts confined in penitentiaries:

In the State Prison of Auburn six hundred and seventeen convicts, who with reference to their former habits, may be classed as follows, namely: intemperate persons five hundred and sixty six; moderate drinkers one hundred and thirty two; under the influence of spirits when their crimes were committed, three hundred and forty six; discharged during the past year one hundred and thirty three of whom ninety five had been drunkards. (American Temperence Society, 1835, p. 46)

Drunkards also constituted a large percentage of British penitentiary populations as described in the following excerpt from a prison report, _circa_ 1850:

With few exceptions the unhappy beings that generally become inmates of your prison are neglectors of Public Worship and Sabbath-breakers, and on their own showing, seventy per cent are drunkards. (Great Britain House of Commons, 1850, p. 59)

It is worth considering the description of ‘inebriates’ as “unhappy beings” in the preceding quote. Throughout the literature, the “drunkard” is primarily portrayed in a negative light and characterized as sinful or evil (Garton, 1987). In contrast, depicting the “inebriate” as an “unhappy being” suggests some members of nineteenth century society held a more humanitarian and sympathetic view of the drunkard’s plight. During this era, the problem of drunkenness in the Australian colonies was also widely discussed and debated (Davies, 2011). Historical records show that in Victoria, “drunkenness was a problem in the colony from its very first years as shown on the first page of the Register of Drunkards from 1842,
which records evidence and Melbourne Court of Petty Sessions proceedings against offenders found drunk” (cited in Davies, 2011, p. 2).

Rotman (1990, p. 21) asserts that these early rehabilitative endeavours embodied the core notion of “transforming a purely vindictive penal reaction into a constructive venture” by incorporating “a measure of social or moral improvement to the arid panorama of mere punishment”. Through strict adherence to the principles of obedience and hard work, as well as undertaking spiritual reflection and repentance, the Penitentiary model of offender rehabilitation aimed to transform criminal offenders into law-abiding citizens. However, a major shortcoming of the Penitentiary system of reformation was that there was no incentive for offenders to change their ways, as a fixed period of confinement was conferred at the time of sentencing (Rotman, 1990). A further criticism related to the long periods of solitude undertaken by prisoners, which was viewed by some as counterproductive to the reformatory process, as Reynolds (1834, p. 17) asserted:

The solitary confinement plan, is an unwise, unfeeling and ruinous innovation … it adds to the terror of such places; evinces a cruel recklessness of the feelings and personal comfort of the prisoner; and has the effect to convince him that the government is not his friend … it destroys his confidence … and creates in him a disposition for revenge, which will eternally battle all efforts for his reformation.

The Penitentiary model of reforming criminals and drunkards focused primarily on precipitating the moral and Christian renewal of individuals. Furthermore, the Penitentiary was deemed to be the solution to the problems of increasing rates of crime and drunkenness plaguing nineteenth century societies which were undergoing the process of industrialization (Garland, 1990). Societal problems associated with drunkenness were specifically attributed to rising numbers of lower class citizens living in city slums, considered to be breeding grounds of inebriety, prostitution, corrupted workers and criminality (Lewis, 1988).
Drunkenness was identified as the cause of many social problems and rising poverty rates in early nineteenth century societies. For example, Marteau (2006, p. 32) suggests that “[c]riminality, sloth, violence and licentiousness” were all directly linked to alcohol consumption. This view is also supported in an article published in the *Sydney Morning Herald* in 1869 which attributed 90 per cent of the crime, poverty and misery in Sydney to drunkenness (cited in Lewis, 1988, p. 392). By the early nineteenth century, disillusionment with the Penitentiary’s ability to reform prisoners contributed to the emergence of Progressive era reforms. Reforms included the introduction of indeterminate sentences, parole and probation. Furthermore, the overtly punitive approach of criminalising individuals with alcohol problems during the Penitentiary era gave way to the adoption of a medical model that aimed to treat and cure offenders of their affliction. The role of religion as a reformative penal instrument has remained a feature of the correctional rehabilitation landscape over time as evinced by several ‘faith-based’ rehabilitation programs offered in some prisons today (Cei, 2010; Daggett, Camp, Kwon, Rosenmerkel, & Klein-Saffran, 2008; Dodson, Cabage, & Klenowski, 2011; Hewitt, 2006; Sumter, 2006).

**Progressive Era – Medical Model: The Inebriate**

The Progressive era spanned from the late nineteenth century through to the mid-twentieth century. It encompassed the introduction of penal reforms and practices to address crime and criminality that dramatically transformed the CJS. These reforms stemmed largely from disillusionment with the Penitentiary model’s ability to prevent crime and reform offenders. New penal reforms included the introduction of juvenile courts, probation, and importantly, the introduction of indeterminate sentences (Cullen & Gendreau, 2000; Raynor & Robinson, 2005; Robinson & Crow, 2009; Rothman, 2002; Rotman, 1990). The aim of introducing
indeterminate sentences was to provide individualised treatment for prisoners and thereby enhance their prospects of rehabilitation. A hallmark of indeterminate sentencing was the introduction of “marks of commendation” (Cullen & Gendreau, 2000; Rotman, 1990, p. 38), a system of incentives allocated to prisoners on satisfactory completion of set tasks. Accumulation of marks of commendation enabled prisoners to work towards, or earn, early release from prison through parole. It was hoped that through their own volition, prisoners would develop a solid work ethic and acquire pro-social habits that would remain with them after release from prison. In Victoria, indeterminate sentences were introduced through the adoption of the Indeterminate Sentences Act 1907 and became operational in 1908 (Provan, 2007, see also Finnane & Myrtle, 2011). The Act “regulated the detention and control of habitual criminals, and established reformatory prisons in Victoria (where prisoners were detained at the Governor’s pleasure)” (Provan, 2007, p. 2).

Some scholars also suggest the implementation of indeterminate sentences stemmed largely from an innovative experiment in the Australian penal colony of Norfolk Island – undertaken by Captain Maconochie in 1840 – where convicts transported from Britain were serving long-sentences (Hirst, 1995; Rotman, 1990, 1995). Maconochie believed the aim of punishment should be the reformation of offenders, facilitated by instilling in them notions of individual responsibility and self-discipline. The hallmark of Maconochie’s new measures was the move from fixed-term sentences to the introduction of indeterminate sentences, enabling possible early release from prison through reform. The core principles of this “new scientific approach” to punishment incorporated:

A carefully planned mark system, progressive classification, meaningful academic and industrial education, intense religious instruction and positive

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3 Although the discussion surrounding the introduction of ‘indeterminate sentences’ does not fit within the timeline of the Progressive era, it is included to expand on the discussion of penal reforms and practices to address crime and criminality that dramatically transformed the CJS.
reinforcement and mild discipline, as opposed to traditional ‘brute force’, were proposed as a means of increasing prisoners’ opportunities, enhancing self-esteem and, ultimately, fostering rehabilitation. Parole was recommended to ease the offender’s transition into society and prevent relapse. (cited in Pisciotta, 1983, p. 615)

Towards the end of the nineteenth century “the use of indeterminate sentence [sic], parole, probation and juvenile justice became increasingly common” and was “aimed at specific populations such as juvenile delinquents, ‘inebriates’, ‘defectives’ and ‘the insane’” (Drabsch, 2006, p. 20). It is worth noting, however, that during the time the new reforms emerged, inebriety was widely viewed as “a self-inflicted sin or vice punishable as a crime” (Garton, 1987, p. 2). Moreover, Progressive era societies held the belief that inebriety was the social evil of the time and associated it with several serious social and personal harms linking it to crime, insanity and death, and it was also considered a major contributor to poverty, child-neglect and family breakdowns and violence (Davies, 2011; Garton, 1987; Lewis, 1988). Indeed many of the harms attributed to inebriety in the Progressive era are similar to the social and personal harms associated with alcohol misuse today, including violence (Dingwall, 2006; Drugs and Crime Prevention Committee, 2006, 2010; Laslett et al., 2010; Singleton, Meltzer, Gatward, Coid, & Deasy, 1998); child abuse and neglect (Johnson, 2004; Laslett et al., 2010; Morgan & McAtamney, 2009); and domestic violence (Graham, 2007; Horrocks & Kelly, 2011; Kershaw, Nicholas, & Walker, 2008; Laslett et al., 2010; Morgan & McAtamney, 2009; National Offender Management Service, 2006; People, 2005; Victoria Police, 2009).

During the Progressive era, understandings of crime and criminality were not based on scientific knowledge but on the philosophical principles of classical criminology (Cullen & Gendreau, 2000). Classical criminology views crime as resulting from the rational choices made by individuals, following the consideration of the costs and benefits of their actions
(see Cornish & Clarke, 1987). Despite the inebriate being viewed as a criminal type and therefore warranting punishment through imprisonment, some elements of society increasingly began to perceive them as suffering from an illness and therefore requiring medical treatment to cure their sickness.

A profound change occurred in how criminality and the offender were viewed and understood during the late nineteenth century. This period witnessed the introduction of a “new criminology” through the adoption of “scientific methods” to study crime and criminality and the intricacies of human behaviour (Garland, 1985, pp. 9-10). The introduction of a scientific standard for the gathering of knowledge relating to crime and criminality was a seminal moment in the disciplines of law and criminology. It altered the ways in which crime and offending were viewed, and provided the impetus for medical professionals to enter into the realm of the legal profession. Garland (1985, p. 129) maintains that “‘criminality’ was a social problem demanding a ‘scientific’ solution and its investigators were committed more to that solution than to any single or coherent theory of human behaviour”. During the Progressive era, the convergence of CJS reforms and medical science was described by Cullen and Gendreau (2000, p. 116) as a “marriage of the new penology” and “positivist criminology” which ascribes biological or psychiatric explanations for the causes of crime and criminality. Moreover, the emerging belief in pathological explanations of crime saw the implementation of what is termed the “medical model” of offender rehabilitation practices in which the causes of criminality are diagnosed and a “cure” is provided in the form of psychiatric or other medical interventions (Cullen & Gendreau, 2000; Rotman, 1990).

Historical records reveal the idea of reforming the inebriate through therapeutic treatment, rather than imprisonment, gained momentum among doctors, politicians, the
clergy, social reformers and criminal justice professionals (Commonwealth Bureau of Census and Statistics, 1916; Davies, 2011; Room, 1988). A number of psychiatrists and other medical professionals were increasingly perturbed regarding the significant number of insanity cases that appeared to be alcohol-related (Lewis, 1988). Consequently, inebriety was considered “a physical cause of insanity like trauma, syphilis and menstrual disorders” (Lewis, 1988, p. 393). As a result, the belief that inebriety could be treated and cured was also adopted within the penal system. For example, in New South Wales, the Comptroller of Prisons recommended the imprisonment of inebriates be abandoned. He argued that allowing the habitual drinker, “in his weakened state” to associate with “professional malefactors” in prison not only “swells the ranks of prisoners but certainly tends to lower his self-respect” (Commonwealth Bureau of Census and Statistics, 1916, p. 839). Instead, he favoured medical treatment in a hospital setting for prisoners suffering from inebriety.

By the beginning of the twentieth century in Australia, treatment of inebriates in a medical setting was endorsed through the introduction of the Inebriates Acts of 1900 and 1909, which sanctioned the confinement of inebriates for extended periods of time. Shortly thereafter, Inebriate Acts were passed in all Australian states enabling drunkards to be committed to government run institutions and undergo medical treatment for their habitual drunkenness (Commonwealth Bureau of Census and Statistics, 1916).

In Victoria, during the same period, Herbert Booth, the Commandant of the Salvation Army, urged the government to act and address the issue of habitual drunkenness through treatment protocols, as he believed the practice of imprisoning inebriates was fruitless. Booth equated drunkenness with mental illness as he asserted in the following statement:

[t]he habitual and chronic drunk is as powerless and as mentally unhinged, by the temptation presented to him at the entrance of the drinking saloon, as is any maniac. Why does society reserve all its remedial measures for one class
of its weaklings, while it has no better system for the other than the ever-recurring police cell? (cited in Davies, 2011, p. 2)

Booth’s contention clearly demonstrates the prevailing idea that drunkenness was an illness, requiring treatment; rather than sinfulness, or criminality requiring punishment.

In Britain, a similar view of the drunkard as sick and requiring medical treatment for inebriety also came to prominence. The concept of inebriate reformatories was advanced largely as a result of pressure from the Society for Promoting Legislation for the Control of Habitual Drunkards (Hunt, Mellor, & Turner, 1992, p. 113). Two prisons, one at Warwick and the other at Aylesbury, were re-assigned as state inebriate reformatories under the Inebriates Act of 1898 and commenced providing some basic rehabilitation for habitual drunkards mainly in the form of “prayers and piecework” (Hunt et al., 1992, p. 119).

Two eminent physicians of the early twentieth century, Benjamin Rush and Thomas Trotter, contributed significantly to the ideology of drunkenness as an illness through their conception of alcoholism as a disease. However, they held different views on what was the most effective curative measure. Rush maintained “the alcoholic’s inebriety was beyond his control, as autonomous as a convulsive movement in the body” (Lewis, 1988, p. 393). He argued that the inebriate required treatment in an asylum. On the other hand, Trotter concurred with the disease ideology arguing that the role of treatment should be the attainment of abstinence (Lewis, 1988). These philosophical understandings of the need to treat offenders for their drunkenness, demonstrate how the “medical model” of offender rehabilitation principles and practices emerged in penal and correctional discourses (Cullen & Gendreau, 2000; Rothman, 2002; Rotman, 1990). Framing the inebriate through a medical lens in Progressive era discourses generated a revolutionary ideology – the disease concept of alcoholism, which still holds sway today. This is particularly the case for proponents of the
fellowship of Alcoholics Anonymous (AA) that steadfastly adheres to the notion that the
disease of alcoholism can only be arrested through abstinence (Bond, Kaskutas, & Weisner,
2003; Lewis, 1988).

The Habitual Drunkard

The habitual drunkard was a significant problem for CJSs worldwide. According to Bewley
(1967), in the mid-twentieth century, prison populations around the world contained large
numbers of individuals incarcerated for alcoholism. For example, in the United States over 50
per cent of the inmates held in county jails were there because they were chronic alcoholics
(p. 241). While the literature examined pays little attention to specific types of crimes
committed by inebriates in the Progressive era, they were characterised as the “undeserving
poor” (Garton, 1987)\(^5\). They were primarily viewed as being morally deficient and lacking in
self-control. This was seen to diminish their capacity to manage or change their habitual
drunken behaviour (Garton, 1987, p. 43). What the literature also reveals is that drunkenness,
especially among the lower classes, was considered a crime and a “national vice”, resulting in
overcrowded “poor houses, lunatic asylums … hulks and … gaols” (MacLeod, 1967, p. 216).
Consequently, control of inebriate offenders remained in the domain of CJSs with local
police agencies arresting individuals for public drunkenness, and the courts imposing
sentences of imprisonment.

\(^5\) Garton’s article explores the social construction of habitual drunkenness as a sin or vice punishable as a crime. In addition, the article clearly charts the transition from the perception that habitual drunkenness was a sin to its being considered a disease not a vice.
Medical Treatments

Throughout the Progressive era, a range of medical treatments were developed and prescribed for what was considered to be the “inherited illness” of habitual drunkenness. According to Garton (1987), there was a perceived connection between mental illness and drunkenness, deemed to be the result of a biological predisposition that made certain individuals highly susceptible to the toxicity of alcohol. Consequently, a diverse range of medical treatments was administered to inebriates in an attempt to cure them of their disease. Although the medical model appeared to be underscored by more humane practices than previous models of isolation and hard labour, this was not necessarily the case. For example, in Britain and America, anti-toxins were administered to alcoholics to eradicate their craving for alcohol. A widely accepted cure for drunkenness involved injecting inebriates with “bichloride of gold”, as it was claimed that it “counteracted the function of alcohol” (Garton, 1987, p. 47). This practice was initially carried out at the Keeley Institute in America and, thereafter, was adopted by institutions in New Zealand and Victoria (Garton, 1987). Other medical practitioners preferred to treat inebriety through hypnosis, which was deemed to “counter the psychic craving for stimulation amongst depressed and anxious individuals” (Garton, 1987, p. 48).

Medicine and the Law

The conflation of medicine and law during this era is succinctly articulated in a brochure advertising the Instituto de Criminologia, a psychiatric annex to the National Buenos Aires Penitentiary. The brochure describes the institute as a “laboratory and a clinic to gather the basic elements to prepare the future transformations of criminal law” (cited in Rotman, 1990,
Three central elements, “criminal etiology, clinical criminology and criminal therapy” – terms that clearly demonstrate a synthesis between criminal law and medical science – were referred to as “the application of the positive method to the study of social and individual pathology”.

In the mid-twentieth century, the practice of imprisoning alcoholics was still widely followed and some viewed incarceration as a treatment for drunkenness as it provided a period of compulsory sobriety (Bewley, 1967). According to Bewley (1967), a range of medical treatments and interventions were prescribed for imprisoned chronic alcoholics. The physical complications associated with alcoholism were treated with vitamins and tranquillisers. Group therapy, hypnotherapy and conditioned reflex therapy were also employed in conjunction with doses of Emetine or Apomorphine. This treatment regime was claimed to have provided up to 50 per cent “permanent cures” among those treated (Bewley, 1967, p. 246). Despite the initial enthusiasm surrounding the effectiveness of conditioned reflex therapy as a cure for drunkenness, further tests among chronic imprisoned alcoholic cohorts found it to be comprehensively unsuccessful. However, the introduction of Antabuse therapy and its use of Disulfiram, which causes the drinker to have an adverse reaction to alcohol if consumed, held great promise as the “certain method of interrupting the alcohol pattern” (Bewley, 1967, p. 245). Several deaths from adverse Antabuse-alcohol reactions led to restrictions in prescribing it for prisoners: “the drug should not be prescribed unless it is possible first to arrange a test in circumstances where the reaction can be controlled and resuscitative measures are available” (Bewley, 1967, p. 245).

Such examples demonstrate how the beliefs in a medical cure for the imprisoned alcoholic dominated ideologies through the first half of the twentieth century. Strong criticism has been levelled at the ‘medical’ methods purported to rehabilitate offenders during
this era. Rotman (1990, p. 102) argues that the use of chemicals to “control and/or recondition the offender” were “therapeutic abuses” disguised under the misnomer of rehabilitation.

The Nothing Works Era

During the 1970s, the long held belief that imprisonment could rehabilitate and change offenders’ criminal and drunken propensities declined rapidly following the publication of Robert Martinson’s controversial essay “What works? Questions and answers about prison reform” (Martinson, 1974). Martinson and colleagues, Judith Wilks and Douglas Lipton undertook a review of correctional programs on behalf of the State of New York to address the general question, “what works” in rehabiliting offenders (Martinson, 1974). They reviewed 231 criminal justice treatment programs operating between 1945 and 1967. Drawing on this data, Martinson published the “what works” paper, in which he claimed that “nothing works” in correctional treatment. He explained:

With few isolated exceptions, the rehabilitative efforts that have been reported so far have had no appreciable effect on recidivism”, and in reference to specific types of rehabilitative programs he stated, “[w]hat we do know is that, to date, education, and skill development have not reduced recidivism by rehabiliting criminals. (Martinson, 1974, pp. 25,28)

Martinson’s seminal contention that “nothing works” became the dominant theme in penal and correctional discourse from the mid-1970s through to the 1990s. The extent to which Martinson’s article contributed to the decline of the rehabilitative ideal as a correctional aim is articulated by Palmer (1992, p. 28), who stated, “rarely if ever did a research article have as powerful and immediate impact on corrections … [w]ithin a year, the view that essentially no approach reduces recidivism was widely accepted”. Similarly, Garland (2001) suggests the
rejection of the rehabilitative ideal as a correctional philosophy in the 1970s was a salient occurrence in the history of penology and corrections, as it promoted the shift to a more punitive CJS with an emphasis on “getting tough” on crime and criminality. This was pursued through the introduction of mandatory and determinate sentences; intensive and electronic monitoring in the community; and the transformation of some prisons into boot camps (Cullen, Latessa, Burton, & Lombardo, 1993, p. 71).

Martinson’s contention, however, was not the only factor that added momentum to the ‘nothing works’ doctrine. The volatility of the social, correctional and political climates throughout America and Britain strengthened the belief that offender rehabilitation programs were futile. For example, the 1970 Attica prison riot in America, in which 39 prisoners died, was described as “the bloodiest one-day encounter between Americans since the Civil War” (King, 2007, p. 337). Ten years after Attica, a violent outbreak at New Mexico’s Penitentiary, resulting in the death of 33 staff members and prisoners was attributed to prisoners who were “high on home brew” (King, 2007, p. 337). Furthermore, in several American states, there was widespread unrest and violence associated with the American Civil Rights Movement and this, together with the Watergate political scandal, fostered a belief that that the government had lost the ability to control violence and dissent and to restore social order (Cullen & Gendreau, 2000).

Martinson’s assertion that “nothing works” did not go unchallenged. Palmer (1975, p 150) re-analysed Martinson’s data and found more positive results in relation to the effectiveness of rehabilitation programs than Martinson reported in his findings:

[R]ather than ask, ‘What works for offenders as a whole?’ we must increasingly ask ‘[w]hich methods work best for which types of offenders, and under what conditions or in what types of settings’.
Other scholars attributed Martinson’s findings to his choice of methodology which they suggested affected the validity of his findings (Andrews et al., 1990a; Cullen, Cullen, & Wozniak, 1988; Gendreau & Ross, 1987; Palmer, 1975). Martinson employed a qualitative, narrative approach to review a large number of correctional programs individually. Robinson (2009) suggests this methodological approach may have concealed the true nature of the programs’ treatment effects. Furthermore, Gendreau and Andrews (1990, cited in Hollin 1999, p. 362) argue that utilising a narrative approach to review such a large number of studies makes it extremely difficult to draw a strong conclusion about the effectiveness of rehabilitation programs.

Perhaps the most surprising rebuke of the nothing works contention came from Martinson himself. In an article published in the Hofstra Law Review in 1979, he recanted his earlier contention that nothing works and suggested instead that “[s]ome studies showed an effect, others did not” (Martinson, 1979, p. 243). He added “treatments will be found to be ‘impotent’ under certain conditions, beneficial under others, and detrimental under still others” (Martinson, 1979, p. 243). Unfortunately, Martinson’s retreat from his previous claim that “nothing works” had little immediate effect on correctional rehabilitation ideologies as both political conservatives and liberals had widely accepted Martinson’s assertion as definitive proof of what they already knew; “that the correctional system was … morally and pragmatically bankrupt” (Cullen & Gendreau, 2000, p. 123).

The outcome of the nothing works era was the re-endorsement of a punitive response to the issue of crime and criminality, in which the purpose of sentencing was defined as “just deserts”. According to Pallone and Hennessy (2003, p. 10), the belief that “correctional institutions should (once and for all) redefine themselves as places whose purposes are to deter and incapacitate, in short, to punish in precise and inflexible fashion” gained credence.
Consequently, the terms “just deserts” and “get tough” became the dominant mantras of correctional systems in western nations through to the late 1990s, and unfortunately continue to persist today (Cullen et al., 1988; Cullen & Gendreau, 2000; Gendreau, Goggin, Cullen, & Paparozzi, 2002; Rotman, 1990). This can be seen in the “get tough on crime” discourse of Victoria’s former coalition government, who articulated a policy intended to “‘fix the problems’ in law and order” (Tomazin, 2011).6

**Nothing Works to What Works**

One of the first scholarly challenges to the notion that nothing works can be found in Gendreau and Ross’ publication, *Effective Correctional Treatment: Bibliotherapy for Cynics* (Gendreau & Ross, 1979). They suggest that when assessing the effectiveness of correctional programs, the focus should be on establishing what works as opposed to determining what does not work. The question of what works in correctional treatment was further advanced by the work of several Canadian criminologists who claimed:

> [W]hat works, in our view, is the delivery of appropriate correctional service, and appropriate service reflects three psychological principles: (1) delivery of service to higher risk cases, (2) targeting of criminogenic needs, and (3) use of styles and modes of treatment (e.g. cognitive and behavioural) that are matched with client need and learning styles. (Andrews et al., 1990a, p. 369)

Scholars continued to empirically examine why some correctional rehabilitation programs worked and others did not (Andrews, Bonta, & Hoge, 1990b; Andrews et al., 1990a; Bonta & Andrews, 2007). As a consequence of their perseverance, two new theoretical frameworks of offender rehabilitation emerged: the RNR model which focuses primarily on risk assessment.

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6 The government had almost 30 law-and-order policies it said it would implement within its first term of office. Among them: recruiting an extra 1600 police and 100 transit officers; the deployment of 940 protective service officers on train stations; abolishing suspended sentences; minimum sentences for serious crimes such as murder and drug trafficking; banning violent drunks from entering licensed premises; and outlawing bikie gangs.
and offender management, and the GLM which gives primacy to addressing individuals’ human needs by assisting them develop the capacities required to enhance their overall well-being. Both frameworks form the basis of contemporary offender rehabilitation programs delivered in Western jurisdictions (Bonta & Andrews, 2007; Cullen, 2005) (Andrews et al., 1990b; Andrews et al., 1990a; Gendreau & Ross, 1979; Gendreau & Ross, 1990; Ward, 2002a, 2002b; Ward & Maruna, 2007; Ward & Stewart, 2003a).

**Risk-Needs-Responsivity Model (RNR)**

The RNR model has contributed significantly to the landscape of offender rehabilitation since its emergence in the 1990s (Bonta & Andrews, 2007). It consists of three core principles: risk, needs and responsivity. Bonta & Andrews (2007, p. 11) explain these principles as “the risk principle speaks of who should be treated (the higher risk offender), the need principle speaks to what should be treated (criminogenic needs) and the responsivity principle helps determine how to treat” (emphasis in original). Research suggests that when RNR principles are meticulously adhered to, re-offending rates can be reduced from between ten and sixty per cent, with higher percentages attributed to community-based programs (Gendreau, 1996; Hollin, 1999). Notwithstanding its suggested empirical strength, the RNR framework has drawn scholarly criticism. The most notable criticism is that it has a narrow focus through its concentration on managing risk (Ward & Maruna, 2007) by targeting “factors that predict criminal behaviour, [and] not on factors that predict desistance” (McNeill, 2012, p. 11). Further criticisms suggest that the model overlooks the issue of client motivation in its core values and also disregards the importance of a therapeutic alliance (client/practitioner relationship) in the delivery of programs (Polaschek, 2012).
An additional criticism of the RNR model relates to the lack of discussion regarding the role of personal agency and self-identity in the rehabilitation process (Ward & Maruna, 2007). In part, this criticism is levelled at the RNR’s use of “avoidant goals” rather than a focus on “approach goals” in program settings. “Avoidance goals are those concerned with the modification, reduction or elimination of experiences, states of affairs and characteristics, while approach goals are concerned with the realization of these factors” (Ward & Maruna, 2007, p. 101).

Despite the criticisms levelled at the RNR model, there has been no suggestion that the concept should be abandoned or replaced in its entirety. Ward and Maruna (2007, p. 132) suggest the RNR model could be enhanced by incorporating elements of the GLM by utilising its strengths-based approach and “shift[ing] the focus away from criminogenic needs and other deficits, and instead asks what the individual can contribute to his or her family, community and society” (Ward & Maruna, 2007, p. 24). Ward and Maruna (2007) suggest that employing the principles of the GLM, which promotes the strengths of individuals, is a more effective model of rehabilitation rather than the risk-focused RNR paradigm. There is some evidence that the core principles of the GLM form part of the Corrections Victoria Offender Management Framework (2010a) which states in part:

The aim of the offender management system is to motivate offenders to engage in and continue with programs and services, identify offenders’ issues, coordinate and prioritise their access to appropriate programs.

The preceding aims are consistent with the strengths-based approach prescribed by the GLM. However, the extent to which the services delivered to ex-prisoners in Victoria are consistent with these aims is unknown. This thesis aims to address this gap in the knowledge base by
examining the nature of and the approach adopted in the delivery of support services and treatment programs to released prisoners with AUDs.

The Good Lives Model (GLM)

Conceptualised by Tony Ward and colleagues, the GLM of offender rehabilitation is a human needs, strengths-based theory that emphasises positive skills development rather than focusing on individuals’ deficits such as their criminogenic needs (Birgden & McLachlan, 2004; Raynor, 2004; Ward, 2002b; Ward & Brown, 2004; Ward & Eccleston, 2004; Ward & Stewart, 2003a, 2003b). The GLM is premised on a holistic treatment perspective that considers offenders’ preferences, strengths and primary goods in the context of their environment and identifies the capabilities and resources needed to achieve their desired goals. The GLM has two primary goals: to assist individuals obtain primary goods and to reduce the risk of reoffending. Advocates of the GLM argue that by assisting offenders to develop the “internal (capabilities) and utilise external conditions (opportunities and supports)” (Ward, 2002b) to achieve primary human goods, offenders are more likely to function in pro-social and meaningful ways, enabling them to lead “good lives” (Birgden, 2002, 2008; Ward, 2002a; Ward & Gannon, 2006). In addition, the acquisition of primary goods that are personally valued helps individuals to create a sense of who they are and determine what and who is important in life (Ward, Yates, & Willis, 2012).

The GLM has attracted less scholarly criticism than the RNR model, as it is a more recent theory of offender rehabilitation. However, it has been criticised for its lack of

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7 Ward and Brown (2004, p. 247) describe primary human goods as: “(1) life (including healthy living and optimal physical functioning and sexual satisfaction), (2) knowledge, (3) excellence in play and work (including mastery experiences), (4) excellence in agency (i.e. autonomy and self-directedness, (5) inner peace (i.e. freedom from emotional turmoil and stress), (6) relatedness (including intimate, romantic and family relationships) and community, (7) spirituality (in the broad sense of finding meaning and purpose in life), (8) happiness, and (9) creativity”.

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empirical validity, as the effectiveness of the model has not been widely examined (Andrews, Bonta, & Wormith, 2011; Cullen, 2012). Despite the assertion that the GLM lacks empirical substantiation, its main principles have been used as the basis for a number of offender rehabilitation programs in western jurisdictions (see Gannon, King, Miles, Lockerbie, & Willis, 2011, p. 153; Purvis, Ward, & Willis, 2011a; Ward, 2011b).

The following statement by The Network of Alcohol and Other Drugs Agencies (NADA) demonstrates how support for the GLM’s holistic, strengths-based treatment model is gaining support among professionals in the area of substance abuse treatment:

> It is essential to treat ex-prisoners with drug and alcohol issues holistically, as with any client. This requires staff to utilise a range of models and interventions specifically targeting individual client needs. People don’t develop drug dependence in isolation from other problems – all drug issues are complex and inter-connected. Risk-taking behaviour associated with drug use means clients of drug and alcohol services already have an elevated level of significant health problems. There may be some ex-prisoners who need specialist treatment programs. These may be due to mental illness, brain damage or disability. (No Bars, 2011b)

Although the RNR and the GLM models of rehabilitation will not specifically inform this research, they are important in that they provide a broad understanding of the foci of contemporary rehabilitation practices currently delivered in Victorian correctional system. This thesis will instead be informed by the theoretical frameworks of desistance-focused and recovery-capital models of rehabilitation, which were presented in the previous chapter.

**Alcohol – A Global Concern**

In many countries – notably, including all Western nations – alcohol is a legally and socially sanctioned substance enjoyed by many individuals in a range of settings. Alcohol plays a major role in the culture and traditions of many societies and is often an integral part of

The Harms of Alcohol Misuse

The excessive consumption of alcohol can adversely affect a person’s physical and mental health, and result in alcohol dependency. The World Health Organization (WHO) (2011) ranks harmful alcohol consumption among the top five global risk factors for disease, disability and death. In 2012, harmful alcohol consumption was attributed to 5.1 per cent of the global burden of disease and injury. It was also aligned with an estimated 3.3 million, or 5.9 per cent of all global deaths (WHO, 2014, pp. 49-50). Alcohol consumption is considered to be a causal factor in more than 200 chronic health conditions and injuries (WHO, 2015) including some cancers, epilepsy, cirrhosis of the liver, cardiovascular disease and poisonings, as well as injuries resulting from acts of violence and traffic accidents (WHO, 2011; 2014; Crombie, Irvine, Elliott, & Wallace, 2007; Room, 1996). Significantly, problematic alcohol consumption affects not only the individual drinker but can also negatively impact on the lives of those around the individual, including family members, spouses/partners, friends/acquaintances and employers, to name a few, through the drinker’s limited capacity to satisfactorily fulfil social roles. Furthermore, any diminution in a person’s ability to adequately carry out their social roles may have consequences for society as a whole by requiring the attention and resources of healthcare systems, welfare agencies and CJSs to intervene and provide support and/or services to both the drinker and others impacted by their alcohol misuse. Baumberg (2006), estimates that the global economic burden of alcohol misuse is somewhere between $210 billion and $650 billion annually. This is
comprised of $40 – $105 billion for health costs; $55 – $210 billion for premature mortality; $30 – $65 billion for absenteeism (at work, school etc.); up to $80 billion for unemployment; $30 – $85 billion for CJS services (police, prisons, courts); and $15 – $50 billion for criminal damage expenses (p. 541). Despite alcohol being a legal substance, the health, social and economic impacts of alcohol misuse globally are substantial and wide ranging.

**Alcohol – An Australian Concern**

Alcohol misuse is a major concern in Australia. The FARE (2014, p. 2) reports that the harms associated with alcohol misuse in Australia are substantial and associated with more than 5,500 deaths and in excess of 157,000 hospital visits each year. In addition, alcohol is considered to be a leading cause of illness and disability in Australian society (Australian Institute of Health and Welfare [AIHW], 2012b). Drawing on data collected from various agencies including the Australian Bureau of Statistics, Australian criminal justice agencies and peer reviewed publications, Manning et al. (2013) disaggregated the economic and social costs of alcohol-related problems in Australia, and estimated that the cost of alcohol-related problems in Australian society sits at around $14.35 billion per year. Of this total figure, they estimate that approximately 20.6 per cent ($2.95 billion) are expenses related to CJS services. These services are broken down into: 38 per cent policing costs; 8 per cent child protection and support services costs; 21 per cent prison costs; 1 per cent insurance administration costs; 3 per cent court costs, and 29 per cent to organisations that address societal violence, such as *The White Ribbon Campaign.⁸* In addition to the direct costs to CJSs, Manning et al. (2013) found the economic burden of alcohol misuse to Australian society included $1.686 billion

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⁸ White Ribbon is the world’s largest movement of men and boys working to end men’s violence against women and girls and to promote gender equity, healthy relationships and a new vision of masculinity. White Ribbon Australia, as part of this global movement, aims to create an Australian society in which all women can live in safety, free from violence and abuse (White Ribbon Foundation (Australia), n.d.).
(11.7 per cent) in costs to the health system; $6.046 billion (42.1 per cent) to lost productivity; and $3.66 billion (25.5 per cent) to the costs associated with traffic accidents. While significant, these figures do not include the “intangible” costs of harms to others caused by alcohol misuse, such as a monetary value of “pain and suffering, and more generally a diminished quality of life” (Laslett et al., 2010, pp. 8, 178).

The extent to which alcohol misuse is a growing problem in Australian society is further evidenced in the number of alcohol-related “treatment episodes” delivered to individuals by health professionals. Significantly, Australians are now seeking professional treatment for alcohol misuse or dependency in greater numbers than for illicit drug use. During the 2010-11 period, 150,500 “treatment episodes” were delivered to individuals seeking help for Alcohol and other Drug (AOD) issues. Of these, 47 per cent (n=68,200) of individuals sought treatment for alcohol (AIHW, 2012b, p. vii). These figures highlight the enormity of alcohol misuse among the Australian population, with individuals seeking treatment for alcohol problems in numbers almost equal to treatment episodes for all other drug types combined (AIHW, 2012b). This highlights the importance of access to treatment programs and support services for alcohol misuse, if the personal, social, and societal harms associated with harmful or hazardous alcohol consumption are to be minimised. This also highlights the significance of this thesis in considering these issues in the context of offender re-entry from prison into society.

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9 A “treatment episode” for AOD use is defined as: “The period of contact, with defined dates of commencement and cessation, between a client and a treatment provider or team of providers in which there is no change in the main treatment type or the principal drug of concern, and there has not been a non-planned absence of contact for greater than three months” (Australian Institute of Health and Welfare, 2012b).
**Alcohol – A Victorian Concern**

In Victoria, during the 2010-11 period, alcohol was the most common drug of concern among individuals seeking government-funded specialist AOD services, with over half of all clients (56 per cent) seeking assistance for alcohol misuse (Heilbronn, Killian, & Lloyd, 2011, p. 2). Moreover, the detrimental impact that alcohol misuse or abuse has on individuals, and the wider Victorian community, is emphasised in the *State of play: alcohol in Victoria* report (FARE, 2014). This report draws on the most recent available data from Victoria Police, the AIHW, and the Turning Point Alcohol and Drug Centre, to provide a broad understanding of the social and personal harms attributed to problematic alcohol consumption throughout the Victorian community each year. Among other factors, the report found that there were significant impacts on medical services including 21,460 treatment episodes in which alcohol was the principal drug of concern (2012-13); 8,349 ambulance attendances in Metropolitan Melbourne in which alcohol was identified as a contributing factor (2011); and 29,694 alcohol-related hospital admissions (2010-11). It also reported that there were multiple social impacts including 6,768 alcohol-related assaults (2010-11); 14,015 family incidents involving alcohol (2012-13); 1,932 serious or fatal road injuries during high alcohol hours (2010-11); and 1,214 alcohol-attributable deaths in Victoria, which accounted for 3.4 per cent of all Victorian deaths in that year (2010).

This report highlights a number of prominent concerns relating to alcohol misuse, including the link between alcohol and reported incidents of domestic violence. *The Victorian Drug Statistics Handbook: Patterns of drug use and related harm in Victoria for the period July 2010 to June 2011* similarly notes this problem, identifying that of the 40,892 family violence incidents recorded on the Victoria Police LEAP database (Heilbronn et al., 2011, p. 88), alcohol was recorded as “definitely” involved in 29 per cent of incidents (n=11,732) and
deemed “possibly”\textsuperscript{10} to have been involved in a further 18 per cent (n=7,253) (Heilbronn et al., 2011, p. 88). The authors of the report maintain however that caution must be exercised in accepting these statistics at face value, as they are formed from the subjective assessments of the police officer at the time the incident was reported (Heilbronn et al., 2011).\textsuperscript{11} The link between alcohol and violent behaviour in the context of family and intimate partner violence is also recognised by the WHO, which identifies alcohol as a contributing role in many incidents of youth violence, sexual assaults, domestic and intimate partner violence, child abuse and personal injuries (WHO, 2002a).

\textbf{The Alcohol and Crime Nexus}

Despite the overwhelming evidence of the serious harms and consequences related to problematic alcohol consumption, it is important to note that the majority of people who drink alcoholic beverages do not suffer any serious adverse consequences. According to Room, Bondy and Ferris (1995), the majority of individuals who drink excessively, report no negative social consequences related to their drinking behaviour. Furthermore, Dingwall (2006) suggests that drinking alcohol can have positive effects for some by reducing anxiety in certain social settings, therefore acting as a social lubricant that enhances interaction with others. While these findings are valid, for some individuals, alcohol misuse has serious social and legal ramifications, by operating as a contributing factor in a range of offending behaviours. This can lead to engagement with CJSs and, for some individuals, leads to arrest, conviction and a term of imprisonment.

\textsuperscript{10} When recording incidents of domestic violence, the reporting officer determines whether alcohol was definitely or possibly involved in the incident (Heilbronn et al., 2011, p. 88).

\textsuperscript{11} The total of family incidents involving alcohol on the LEAP database (Heilbronn et al., 2011) for the period 2010-11 is 18,985. In contrast, FARE lists 14,015 incidents of family violence involving alcohol for the period 2012-13. There is limited information available to explain the disparity in these figures, as there is nothing to indicate that there has been a drop in alcohol related family violence between 2010/11 and 2012/13.
Over the past several decades, the relationship between alcohol and crime has attracted the attention of governments, criminal justice agencies, health authorities and local communities in many parts of the world. Much research suggests there is a strong relationship between alcohol consumption and crime (Dingwall, 2006; Engineer, Phillips, Thompson, & Nicholls, 2003; Forsyth, 2006; Heilbronn et al., 2011; Kramer, Gately, & Kessell, 2009; McSweeney et al., 2009; National Expert Advisory Committee on Alcohol, 2001; Sweeney & Payne, 2011; WHO, 2002a). Despite the relationship between alcohol and criminality, the Prime Minister’s Strategy Unit (2004) argues that it is difficult to establish a direct causal link, as not all individuals who drink to excess, or are alcohol dependent, commit criminal offences, and the majority of those who do commit offences when under the influence of alcohol have only a single encounter with CJSs.

However, a large body of literature indicates that there is a causal link between alcohol misuse and a wide range of offending behaviours, including: minor and serious assaults (Dingwall, 2006; Drugs and Crime Prevention Committee, 2006, 2010; FARE, 2014; Lanarkshire Alcohol and Drug Partnership, n.d.; Laslett et al., 2010; Singleton et al., 1998); child abuse and neglect (Johnson, 2004; Laslett et al., 2010; Morgan & McAtamney, 2009); domestic violence (Ashby et al., 2011; Graham, 2007; Kershaw, Nicholas & Walker, 2008; Laslett et al., 2010; Morgan & McAtamney, 2009; National Offender Management Service, 2006; People, 2005; Victoria Police, 2009); and serious or fatal car accidents (FARE, 2014; Laslett et al., 2010; The National Centre on Addiction and Substance Abuse, 2010; Valle & Humphrey, 2002; Vicroads, 2010).

The extent of alcohol-related violence is a major concern for governments. In 2003, a United Kingdom Home Office study (Budd, 2003) examining the role of alcohol in acts of violence and the findings contained in British Crime Surveys, stated that alcohol was a
contributing factor in a large percentage of violent offences committed in England and Wales between 1996 and 2000. Informed by interviews with victims of these violent acts, the report estimated that perpetrators were under the influence of alcohol at the time of committing the offence, at the rate of 41 per cent in 1996, 41 per cent in 1998, and 40 per cent in 2000. The presence of a relationship between alcohol consumption and acts of violence is also noted in statistics on homicides committed in Australia. The findings contained in the Australian Institute of Criminology’s research into Domestic/family homicide in Australia show that between 2002 and 2012, alcohol was more prevalent in both domestic/family and non-domestic/family homicides than the use of illicit drugs (Cussen & Bryant, 2015). Alcohol had been consumed by both victims and offenders in 30 per cent n=379 of non-domestic/family homicides and in 22 per cent (n=239) of domestic/family homicides (range: 28 per cent [intimate partner]; 1 per cent [filicide]; 13 per cent [patricide]; 46 per cent [siblicide] and 28 per cent [other family members]) (Cussen & Bryant, 2015, p. 6). Furthermore, results contained in the findings of the National Homicide Monitoring Program reveal that in Australia between 2000 and 2006, 47 per cent of recorded homicides were alcohol-related (Dearden & Payne, 2009). Research also indicates that some homicide victims have elevated levels of alcohol in their bodies at the time of death. For example, a study by Darke and Duflou (2008), investigating the prevalence and circumstances of psychoactive substances amongst homicide victims in New South Wales between 2000–2006, estimated that in 60 per cent (n= 438) of 729 homicides, alcohol had been consumed by both the perpetrator and the victim prior to the offence taking place. In addition, they found that in 19 per cent (n=141) of recorded homicides, only the victim had consumed alcohol and in 21 per cent of recorded homicides (n=150), alcohol was consumed by the offender only. This study implies that
alcohol consumption by the perpetrator, the victim, or both, plays a role in some cases of homicide.

Further to homicide, it is estimated that between 41 and 70 per cent of violent crimes in Australia are committed by someone under the influence of alcohol (Drugs and Crime Prevention Committee, 2006, p. 157; National Expert Advisory Committee on Alcohol, 2001). In recent times, state governments and CJSs have voiced their concern regarding the extent and frequency of alcohol-related violence involving young adult males (Department of Health Victoria, 2008; Victoria Police, n.d.). Of particular concern are the number of alcohol-related physical assaults including that take place in and around clubs, bars and entertainment precincts on Friday and Saturday nights, with some of these incidents resulting in the death of the victim (Sweeney & Payne, 2011). Statistical data discloses an increase, over time, in alcohol-related assaults across Victoria. The Victorian alcohol statistics series drew on seven secondary data sources to produce results for all Victorian Local Government Areas (LGAs), regions and the state overall (Matthews, Jayasekara, & Lloyd, 2011). Between 2000 and 2010, alcohol-related assaults in Victoria showed a significant rate of increase from 4,818 in 2002-01 to 6,083-7,023 in 2009-10 (Matthews et al., 2011, p. 26). These figures demonstrate an increase of 25.6 per cent in alcohol-related assaults across Victoria during the decade in which the data was collected (Matthews et al., 2011).

In addition to these violent crimes described, post-release alcohol misuse has also been associated with the death of victims where the perpetrator and/or the victim had been intoxicated during the commission of an offence. Recently, the link between alcohol and violence has attracted widespread attention in Victoria and other Australian states, following the death of several young men as a result of a king-hit or one punch attacks. A study of the National Coronial Database conducted by Pilgrim, Gerostamoulos, and Drummer, (2014)
found that between 2000 and 2012, at least 90 Australians died as a direct result of a single punch to the head – commonly referred to as a “one punch” attack (Dow, 2014); a “coward’s punch” or a “king hit” (Pilgrim et al., 2014). These acts of violence have attracted intense media coverage and provoked public outrage leading to calls for tougher penalties for the perpetrators (Flynn, Halsey & Lee, 2016). It is somewhat ironic that there is such a strong media and political response and focus on some crimes involving alcohol, for example, the “one punch” attack, yet there remains a minimal focus on the bigger picture issues of alcohol-related offending, particularly in regards to assisting prisoners with AUDs in prison or post release. There has also been a dramatic and highly politicised response to “one punch” fatalities involving alcohol, with very quick legislative changes introduced in NSW and Vic in response to these offences.

In NSW, the mandatory minimum sentence for a fatal one-punch attack is eight years; in Victoria it is ten years. Of the 90 one punch fatalities identified by (Pilgrim et al., 2014), 24 occurred in Victoria. The tough law and order response to “one-punch” attacks indicates that the role of alcohol in the commission of serious acts of violence is being recognised by lawmakers. However, the introduction of mandatory minimum sentences for “one-punch” attacks has been criticised as a largely reactive rather than a pro-active response (see Flynn, Halsey, & Lee, 2016). The President of the NSW Bar Association, Phillip Boulton, SC, called the new laws a “knee-jerk legislative response when emotions are running high” (Patty, 2014). Being interviewed for the Sydney Morning Herald, Boulton went on to say “[r]ather than simply proposing reactive changes to the criminal law on the run, the government needs to look at liquor industry reform to strengthen restrictions on the availability of alcohol” (Patty, 2014; see also Flynn et al., 2016 and Quilter 2014, for a discussion on one punch laws).
While the recent focus on the role that alcohol plays in the commission of “one punch” fatalities is an important step in recognising the serious harms associated with alcohol misuse, the link between alcohol misuse and other serious violent offences, for example, domestic violence has not received the same attention. This is despite alcohol misuse being cited as a contributory factor in nearly 30 per cent of family incidents that Victoria Police responded to during the 2010-11 period (Heilbronn et al., 2011). Given the established link between alcohol misuse and domestic violence, it is vital that any treatment programs for alcohol misuse, whether administered in-prison or in the community, have the breadth to comprehensively address the link between alcohol and domestic violence for those who have a propensity to become violent when intoxicated. Importantly, Flynn et al. (2016, p. 186) argue other factors such as “personal and interpersonal, situational and sociocultural dimensions that intersect with alcohol misuse” must also be carefully considered before attributing sole causation to alcohol in the case of “one-punch” attacks or indeed, other forms of violence in which alcohol consumption has been identified as a contributor.

Further evidence of a relationship between alcohol and offending is noted in the findings of the Drug Use Monitoring in Australia program (DUMA), which collects quarterly information regarding drug and alcohol use from individuals detained at police stations or watch-houses at nine locations across Australia (Australian Institute of Criminology [AIC], 2009; Payne & Gaffney, 2012). Commencing in 1999, the DUMA program is the largest survey of police detainees conducted on a regular basis across Australia. The core aim of the DUMA program is “to provide an evidence base for creating policy on issues relevant to drugs and crime” (Sweeney & Payne, 2012, p. 2). Drug use (excluding alcohol) is assessed through the use of “urinalysis”, which is collected voluntarily from detainees. Conversely, data on alcohol consumption is obtained from “self-reported” data as urinalysis does not
detect alcohol in a person’s system (Sweeney & Payne, 2012, p. xiii). Self-reported data is
gathered from detainees’ responses to questions regarding their recent and long-term use of
alcohol, and whether alcohol had been consumed in the 48 hours prior to their arrest. During
the 2009-10 period, a total of 7,575 detainees were interviewed through the DUMA program
(Sweeney & Payne, 2012, p. xi). Of those, 45 per cent (n=1884) indicated alcohol
consumption or illegal drug use was a factor in their offending (Sweeney & Payne, 2011).
Significantly, a higher percentage of detainees (41 per cent) attributed their offending to
alcohol consumption, than to the use of illegal drugs at (32 per cent).

Information collected through the DUMA program is valuable as a resource for
researchers and criminologists as it is one of the few data sources available in Australia that
provides information regarding alcohol and offending independent of other drug types.
Furthermore, it provides an initial insight into how alcohol misuse can lead to contact with
CJS agencies for some individuals.

It should be noted however, that the relationship between hazardous or harmful
alcohol consumption and any form of criminality is multifaceted and complex, and variables
such as personal, social, cultural and environmental factors will frequently determine which
individuals are more likely to engage in alcohol-related offending (Jones & Hoffman, 2006;
Morgan & McAtamney, 2009). Irrespective of this, the serious nature of some offending
behaviours in which alcohol is considered to be a contributing factor, for example, domestic
violence, homicide (FARE, 2014; National Expert Advisory Committee on Alcohol, 2001) or
child abuse and neglect (Johnson, 2004; Laslett et al., 2010; Morgan & McAtamney, 2009)
suggests that some individuals who offend, while under the influence of alcohol, will come
under the scrutiny of CJS agencies which may result in arrest, conviction and a term of
imprisonment.
Prisoner Populations with AUD’s

An alternative way of gauging the proportion of individuals with AUDs who have contact with CJSs is by examining surveys of prisoner populations that, in part, seek to ascertain whether prisoners were engaged in harmful or hazardous drinking patterns prior to entering prison. Since the 1980s, a number of overseas studies suggest that the proportion of prisoners who engaged in hazardous or harmful patterns of alcohol consumption, prior to entering prison, has remained high (see Heather, 1981, 1982; HM Inspectorate of Prisons, 2010; HM Prison Service, 2004; Hollin, 1983; Singleton, Farrell, & Meltzer, 2003; Singleton et al., 1998). For example, in 1997, a study examining the psychiatric morbidity of prisoners, conducted by the UK Office for National Statistics, found that alcohol was the most prevalent substance use disorder among the prisoners surveyed (Singleton et al., 1998). Of the respondents surveyed, 63 per cent of sentenced males (n=1121), 58 per cent of males on remand (n=1250), 30 per cent of sentenced females (n=584) and 36 per cent of females on remand (n=187), self-reported engaging in episodes of hazardous drinking in the twelve months prior to their imprisonment (Singleton et al., 1998, p. 129). Notably, 30 per cent of those surveyed returned Alcohol Use Disorders Identification Test (AUDIT) scores of 16+ which signifies severe alcohol dependency (Singleton et al., 2003, p. 150).

A more recent study, based on the responses of 13,000 prisoners in England and Wales between 2004 and 2009, and 72 prison inspection reports completed between 2006 and 2009, suggests that 13 per cent of prisoners sampled reported having an alcohol problem upon entering prison (HM Inspectorate of Prisons, 2010). This figure rose to 19 per cent in

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12 The Alcohol Use Disorders Identification Test (AUDIT) has been developed from a six-country WHO collaborative project, as a screening instrument for hazardous and harmful alcohol consumption. It is a 10-item questionnaire which covers the domains of alcohol consumption, drinking behaviour, and alcohol-related problems (Singleton et al., 2003).
the 2008-2009 sample, with young adults (30 per cent) and women (29 per cent) reporting the highest levels of alcohol-related problems (HM Inspectorate of Prisons, 2010, p. 5). However, according to the former HM Chief Inspector of Prisons, Anne Owers, these figures are likely to underestimate the full extent of the problem, as many of those with AUDs do not perceive they have an alcohol problem or are reluctant to admit consuming alcohol in harmful or hazardous quantities (HM Inspectorate of Prisons, 2010).

**Prisoners with AUDs in Australia**

Estimating the number of individuals in Australian prisons with an AUD is problematic, as prisoners with AUDs have not been the focus of Australian studies. Some understanding of the extent to which individuals enter Australian prisons with an AUD can be gained from statistical data contained in government reports outlining the health of Australian prisoners. The findings of a report produced by the Australian Institute of Health and Welfare, suggests that in 2010 a large percentage of Australian prisoners had an AUD. The study was informed by data collected as individuals entered prison and from those visiting prison clinics over several two week periods during 2010 (AIHW, 2010). The findings indicate that 58 per cent of prisoners reported drinking alcohol at hazardous levels in the twelve months prior to entering prison. A higher percentage of males (59 per cent) than females (54 per cent) identified their alcohol consumption as being in quantities deemed to be hazardous to themselves and/or others. Moreover, Indigenous prisoners, both male and female, were found to be the group at greatest risk of alcohol related harm with 73 per cent of them identifying harmful use, compared to 48 per cent of non-Indigenous prisoners (AIHW, 2010, p. x).
Alcohol and Indigenous Prisoners

Indigenous Australians constitute only 2 per cent of Australia’s population aged 18 years and over (Australian Bureau of Statistics [ABS], 2012), yet they make up 27 per cent (n=9,264) of the national prisoner population (ABS, 2014). Indigenous prisoner populations vary across states and territories with the Northern Territory having the largest Indigenous prisoner population at 86 per cent and Victoria the lowest at 8 per cent (ABS, 2014). No single determinant can be identified as leading to the over-representation of Indigenous Australians in the prison system. However, it is well documented that a range of complex and interrelated historical, social, and structural factors contribute to the disproportionate number of Indigenous Australians imprisoned in Australia (AIHW, 2008). Scholars suggest the over-representation of Indigenous Australians in Australia’s prison system stems, in part, from the continuing historical impact of colonialism and dispossession which has resulted in their marginalisation from mainstream society (Kahn, Hunter, Heather & Tebbutt, 1990; No Bars, 2011c). This historical legacy has resulted in inequitable access to many essential public services such as health-care, education and employment for indigenous Australians. Moreover, the effects of colonisation and dispossession are identified as being central to the alcohol misuse and violence that currently exists in many Australian indigenous communities (Aboriginal and Torres Strait Islander Women’s Task Force on Violence, 2000; Cunneen & Libesman, 1995). Indigenous Australians experience health and social problems as a result of alcohol misuse at a disproportionately higher rate compared to that of non-indigenous Australians (AIHW, 2008). The phenomenon of alcohol misuse among Australia’s indigenous population cannot be understood without consideration of the historical context in which alcohol was introduced to Australia’s indigenous population. According to Langton (1993, p. 196) from the arrival of the First Fleet:
Alcohol was used to engage Aboriginal people in discourse, attract Aboriginal people into settlements, in barter for sexual favours from Aboriginal women, [and] as payment for Aboriginal labour and to incite Aboriginal people to street fight as entertainment.

Similarly, Cunneen and Libesman (1995) argue the phenomenon of alcohol misuse in indigenous communities is related to the colonial legacies of dispossession; the erosion of traditional culture in some communities; and boredom, due to the lack of adequate educational opportunities and suitable employment. Scholars suggest one determinant in the overrepresentation of Indigenous people in Australian prisons relates to the high levels of substance abuse amongst indigenous populations (Joudo, 2008; Saggers & Gray, 1998), with alcohol misuse being the main focus of concern (Putt, Payne, & Milner, 2005). It is important to note that overall alcohol consumption among Australia’s Indigenous population is lower than that of non-indigenous Australians, although many of those who regularly drink alcohol do so in hazardous or harmful quantities (Cunneen & Libesman, 1995; Langton, 1993). Moreover, research suggests that a strong relationship exists between alcohol misuse by Indigenous Australians and offending behaviours (see Snowball & Weatherburn, 2006). Indigenous offenders are 1.5 to 3.8 times more likely to be under the influence of alcohol when committing an offence than their non-indigenous counterparts (Dearden & Payne, 2009). In addition, on entering prison, they are more likely to report having consumed alcohol in a harmful or hazardous manner (59 per cent) compared to their non-indigenous counterparts (39 per cent) (AIHW, 2012a, p. ix). Although the relationship between alcohol misuse and offending among Australia’s indigenous population is a major concern, it will not be a topic of specific focus for the current study because, at the time of conducting fieldwork, Victoria had the lowest indigenous prisoner rate (8 per cent) in Australia (ABS, 2014). In addition, the support workers and forensic counsellors who participated in the research had
very low numbers of Indigenous clients, thereby rendering any attempts to discuss the research in the context of Indigenous releasees not generalisable. However, where themes have emerged in the data relating to alcohol misuse among indigenous ex-prisoners and their access to post-release alcohol support and treatment services, a brief discussion is presented.

**Victorian Prisoners with AUD's**

A significant proportion of individuals enter Australian (and hence Victorian) prisons with an AUD. A Victorian prisoner health study conducted in February 2003 found that of the 186 prisoners who completed the (AUDIT) questionnaire, 41 per cent returned scores of 8+, which suggests problematic alcohol consumption or possible alcohol dependency (Deloitte Consulting, 2003, p. 44). The study indicates that at the time the survey was conducted, a sizeable percentage of Victoria’s prisoner population had moderate to severe alcohol problems. It was the first study undertaken in Victoria to assess the health status of Victorian prisoners and has not been replicated to date. Therefore, the current extent to which prisoners in Victoria enter prison with an AUD is unknown. Consequently, this research is significant, as it will shed some light on the numbers of prisoners experiencing AUDs based on the data collected from those working directly with releasees in Victoria.

**Prison-based Alcohol Rehabilitation Programs**

Despite evidence from international and Australian studies highlighting the large proportion of prisoner populations who have an AUD, research suggests that prisoners are highly unlikely to receive appropriate treatment for their alcohol problems while incarcerated, as prison-based support for substance misusing offenders has primarily focused on programs for illicit drug users (Duke, 2005; Fitzpatrick & Thorne, 2010). Research suggests that at every stage of the custody process, from reception to release, prisoners with alcohol problems are
less likely to be appropriately screened for alcohol misuse or dependency; are less likely to be assessed for withdrawal symptoms which may require medical attention; and are less likely to be provided treatment or interventions in custody that address their alcohol problems, than those who use illicit drugs (HM Inspectorate of Prisons, 2010). This is despite the fact that research suggests prisoner populations contain more individuals with AUDs than those with illicit drug problems (Jones & Hoffman, 2006; Singleton et al., 1998).

Furthermore, in-prison rehabilitation programs that are developed primarily for illicit drug users may not be suitable, or effective, in addressing issues associated with alcohol misuse. As stated in the Alcohol Treatment/Interventions Good Practice Guide published by HM Prison Service (2004, p. 61):

Drug awareness courses should not be extended to cover alcohol, as the awareness raising issues are quite different due to the legality of alcohol. There is also no evidence to suggest that drug prevention education is effective in preventing alcohol misuse. (emphasis in original)

Australian statistics support the contention that the majority of individuals who enter prison with an AUD are unlikely to have access to an appropriate treatment for their alcohol problems while in prison. Findings contained in the Health of Australia’s Prisoners (2012a) survey reveal that of 387 discharges who self-reported drinking alcohol at harmful or hazardous levels prior to entering prison, only 12 per cent (n=48) reported having accessed an alcohol treatment program while in prison (AIHW, 2014b).

**Prison-Based Alcohol Treatment Programs in Australia – 2004**

Australian prisoners with AUDs are also unlikely to receive appropriate treatment for their alcohol problems, as prison-based programs for those with alcohol-specific problems are scarce. In 2004, across all Australian states and territories, 30 substance abuse programs were
offered (Howells, Heseltine, Sarre, Davey, & Day, 2004); yet only eight of these contained
the word alcohol in the program title. Five programs were listed as being for AOD users and
only three were available specifically for those with AUDs. These included two programs
located in Victoria: (1) an Alcohol and Driving Education program (12 hours); and (2) a
program titled Alchemy: Alcohol Education and Reduction (20 hours). The third program
offered was in the Northern Territory – the Alcohol Treatment program (20 hours) (Howells
et al., 2004, pp. 40, 95, 101). It is important to note that these three programs were of 20
hours duration or less, which is well short of suggested best practice for AOD treatment
programs that recommend better outcomes are realised when overall treatment duration is in
excess of three months (National Institute on Drug Abuse, 2014). Hser, Longshore and
Anglin (2007, p. 516) support this contention by suggesting that brief interventions are not
ideal for treating people with a history of substance misuse.

**Prison-Based Alcohol Treatment Programs in Australia – 2009**

In 2009, the number of substance abuse programs offered in the Australian prison system was
reduced to 24 (Heseltine, Day, & Sarre, 2009, p. 28). Of these, four programs contained the
word alcohol in the program title and three of these targeted AOD users. This meant that in
2009, only one program in the entire Australian prison system was listed as having an
alcohol-only focus. The program, provided in the Northern Territory, was the Alcohol
Treatment Program of 20 hours duration noted in the previous section (Heseltine et al., 2009).
The absence of alcohol-specific programs within the Australian prison system is a serious
concern in light of the large body of extant literature suggesting that a significant proportion
of Australia’s prisoner population entered prison with an alcohol problem. Furthermore, it
suggests that the provision of programs for prisoners with AUDs is not a priority for CJS policy makers.

Despite the limited number of alcohol-specific programs offered in Australia’s prison system in 2004 and 2009, many of the programs offered were categorised as being for substance abuse or AOD use. As no information is available in the public domain regarding the content of these programs, it is difficult to gauge the extent to which prison-based rehabilitation programs directly address the needs of alcohol misusers. Problematically, this demonstrates how alcohol is frequently conflated with illicit drugs in the literature, which limits our understanding of how CJSs and post-release treatment services respond to the needs of prisoners with AUDs. This again highlights the importance of this research, which will shed light on the difficulties experienced by those exiting prison with an AUD.

**Prioritising Prisoners with Illicit Drug Problems**

Although much has been written about prison-based substance abuse rehabilitation programs for offending populations (Department of Human Services Victoria, 2009; HM Inspectorate of Prisons, 2010), the primary focus of these discourses is on programs and interventions for prisoners whose criminality is directly linked to illicit drugs (Duke, 2005; HM Inspectorate of Prisons, 2010; Home Office, 2004; McMurran, 2006a; Prison Reform Trust, 2004). This is understandable considering the relationship between illicit drugs and offending is implicit, as under criminal law, the possession, use, trafficking or manufacture of certain drug types is illegal (see Makkai & Payne, 2003). A direct causal link is therefore established between illicit drugs and criminality.

A critical reading of the literature indicates that the lack of in-prison programs that directly address alcohol misuse is due mainly to limited funding. Overseas, and in Australia,
government funding is directed primarily towards delivery of prison-based programs for illicit drug users, with only minimal funding allocated for alcohol treatment programs (Alcohol Concern, 2007; Auditor General Victoria, 2003; Duke, 2003; Fitzpatrick & Thorne, 2010; Heseltine et al., 2009; The United Kingdom Anti-Drugs Co-ordinator, 2002). Consequently, the majority of prison-based substance abuse programs are developed to address those prisoners whose offending is primarily associated with illicit drugs, or for prisoners who have a poly-drug use problem (Fitzroy Legal Service, 2013). The dearth of programs that specifically address issues associated with alcohol misuse was highlighted in the findings of a study examining alcohol-specific interventions in the CJS in the South West of England (Fitzpatrick & Thorne, 2010). Informed by data collected from interviews and focus groups with over 100 commissioners, managers, front-line workers and prisoners, the study found:

Across the criminal justice pathway … alcohol interventions are under-resourced. Inadequate provision at all stages of the offender pathway is further exacerbated by misalignment between health and criminal justice objectives and a lack of equivalence between alcohol and drug service commissioning. (Fitzpatrick & Thorne, 2010, p. 17)

Of concern is the suggestion that the lack of prison-based programs for alcohol misuse may encourage prisoners to fabricate a drug dependency in order to access support from programs developed for illicit drug users. One prisoner reported that:

… you have to cheat your way in by saying you smoke dope or whatever. You want an honest treatment programme. Lying to get into treatment is not how it should be. (cited in, Fitzpatrick & Thorne, 2010, p. 9)

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13 Poly-drug use refers to the use of more than one drug. Users often have a primary drug of choice (e.g., alcohol, marijuana, speed or heroin) but will use one or more drugs to top up, come down or as a substitute.
Although this is the opinion of only one respondent, it is a powerful statement that re-affirms the findings of existing research that prisoners are highly unlikely to receive appropriate support or treatment for alcohol misuse while incarcerated. This has major implications for prisoners exiting custody and returning to life in the wider community. If prisoners have not had access to alcohol-specific treatment programs while in prison to help them develop the capacities and skills required to avoid resuming harmful or hazardous patterns of drinking on release, they may be at higher risk of resuming pre-prison problematic drinking patterns, which for many, was associated with their offending.

To date, the literature demonstrates the adverse effects of alcohol misuse on the lives of individuals and society at large. The significant legal ramifications associated with alcohol misuse are also substantiated. These issues provoke a number of questions that this research seeks to answer. For example, to what extent is alcohol misuse a problem for those transitioning from prison to the wider community? What support and/or treatment services are available to address the needs of releasees with an AUD? To what extent are post-release support and treatment services accessible to releasees with alcohol problems? To what extent is post-release alcohol misuse a barrier for addressing and resolving the multiple needs of released prisoners? Shedding light on responses to these questions is important as it is acknowledged that exiting prison is for many, a stressful and difficult experience. For individuals with alcohol problems, the experience of transitioning from prison to the wider community may be all the more challenging if timely access to support services and alcohol treatment programs is not readily available. This thesis thus provides an important contribution to the existing data by generating new knowledge in this area.
Transitioning from Prison to the Community

The experiences of individuals transitioning from prison to the community, has increasingly been the focus of criminological research in the contemporary era (Baldry, 2007; Baldry et al., 2003; Borzycki, 2005; Borzycki & Baldry, 2003; Halsey, 2007; Rosenfeld, Petersilia, & Visher, 2008; Travis et al., 2001; Visher & Travis, 2003). This is largely due to the acknowledged multifaceted and complex range of challenges and difficulties many ex-prisoners face in attempting to integrate into the wider community following a period of incarceration, together with increased likelihood of reoffending, re-arrest, and re-imprisonment if successful integration is not achieved (Victorian Ombudsman, 2006). For individuals with alcohol problems, the transitional experience may be rendered more difficult while attempting to avoid resuming harmful or hazardous alcohol consumption (Kinner, 2006). Research suggests that post-release problematic alcohol consumption may also impede individuals’ attempts at community integration, and increase their risk of re-offending (Payne, 2007; Pew Centre on the States, 2011; Social Exclusion Unit, 2002).

The following quote from the Victorian Department of Justice (2015b) acknowledges that transitioning from prison into the wider community can be a taxing time for many individuals:

Many prisoners experience significant challenges in reintegrating after their release from prison. These challenges can be compounded by social disadvantage and complex needs related to drug and alcohol abuse, mental illness, acquired brain injury, homelessness and unemployment.

Post-release challenges and difficulties faced by many ex-prisoners are often the result of multiple forms of disadvantage and social isolation that characterised their pre-prison lives. These include, a history of problematic alcohol or drug consumption, a lack of suitable and stable housing, unemployment, financial hardship, poverty, mental and physical ill-health
issues, and a lack of family and other social support networks (Baldry et al., 2003; Borzycki & Baldry, 2003; Drabsch, 2006; Hinton, 2004; Ogilvie, 2001; Sarnos, Hearnden, & Hough, 2000; Social Exclusion Unit, 2002, Visher, La Vigne, & Travis, 2004). Although the transitional experience of ex-prisoners has been the focus of many studies, the role of alcohol misuse in the post-release environment has been largely overlooked, and it is this gap, this research seeks to fill.

A search of Australian scholarly literature revealed there is a dearth of studies addressing the role of alcohol misuse in the post-release environment. Only one Australian study provides some data on post-release alcohol misuse independently from other drugs. The study (Kinner, 2006), *The Post-Release Experiences of Prisoners in Queensland*, analysed the experiences of released prisoners in relation to their patterns of drug and alcohol use, health and some aspects of their social-economic status. The findings of the study were informed by a small cohort of released prisoners in Queensland, comprising 108 males and 52 females (Kinner, 2006).

Participants were interviewed four weeks prior to release from prison and, on average, at 34 days post-release, and again at 120 days post-release. Overall, the study found that individuals who consumed alcohol at harmful or hazardous levels prior to imprisonment were more likely to adopt the same drinking patterns post-release (Kinner, 2006). In comparing prisoners’ pre-release intentions or expectations to consume alcohol post-release, and the outcomes at 34 days and 120 days post-release, the study provided some valuable and insightful information for gaining an understanding into the patterns of alcohol misuse among released prisoners. Prior to release, 60 per cent of male (n=108) and 60 per cent of female (n=52) participants indicated they had arranged or intended to consume alcohol after exiting prison. Furthermore, 66 per cent of males (n=108) and 62 per cent of females (n=52) implied
they expected to do so. At 34 days post-release, 79 per cent of males (n=61), and 57 per cent of females (n=30) reported alcohol use within the preceding four weeks. The results also showed that at 34 days post-release, 16 per cent of males (n=108) and 3 per cent of females (n=52) were drinking daily. At 120 days post-release, the findings indicated a significant increase in alcohol consumption with 80 per cent of males (n=51) and 65 per cent of females (n=26) consuming alcohol. Of these, more than 50 per cent of males and 20 per cent of females were drinking alcohol at levels deemed to be hazardous or harmful. The qualitative data provides some information on a range of post-release challenges faced by the participants, but it does not provide an explanation of what, if any, specific post-release experiences contributed to their consumption of alcohol at risky levels. The study’s findings revealed that 19.6 per cent of participants (n=150) were re-imprisoned. However, the data did not provide details of whether alcohol misuse was a contributing factor among those who returned to prison.

Although the sample size of Kinner’s (2006) study is small, and therefore the findings cannot be generalised to the wider ex-prisoner population, the research is highly significant on two levels. First, it highlights the disparity between prisoners’ pre-release intentions to drink or misuse alcohol after release and the realities of post-release life in the community. Second, it makes a notable contribution to Australian criminological scholarship providing valuable information regarding the extent to which alcohol misuse is a problem for individuals in the post-release environment. However, the study does not explain the specific ways in which post-release alcohol misuse is a problem for some releasees, nor does it address what support and/or treatment services are available to individuals transitioning from prison to the wider community. These are significant gaps in the literature, which this study seeks to address. In order to fill these gaps, this research focuses on the perspectives of post-
release support workers and counsellors tasked with assisting individuals during the transitional phase.

**Alcohol – A Hidden Category**

Perhaps the dearth of studies investigating alcohol misuse in the post-release environment can be attributed, in part, to the difficulty researchers’ face in attempting to separate alcohol from other drugs in the existing literature. Most studies that address any form of post-release substance misuse, in the main, fail to produce findings that distinguish alcohol from other drugs. In scholarly literature and official documents, alcohol is frequently conflated with illicit drug use under the term AOD use (Auditor General Victoria, 2003; Department of Health Victoria, 2012; Drabsch, 2006; National Treatment Agency for Substance Misuse, 2012; Sarno, Hearnden, & Hough, 2000) or subsumed under the generic term of substance misuse (Day, Casey, Ward, Howells, & Vess, 2010; National Treatment Agency for Substance Misuse, 2009; Pallone & Hennessy, 2003; Travis et al., 2001; Visher et al., 2010). The frequent oversight to separate alcohol misuse from illicit drug misuse in scholarly and other literatures is surprising given the overwhelming evidence of the escalating health and social harms caused by alcohol misuse and the suggested causal relationship between harmful or hazardous alcohol consumption and a range of serious offending behaviours. For example, Borzycki (2005) argues, untreated drug issues, whether or not identified as linked to an individual’s offending behaviour, are likely to contribute negatively to a range of post-release issues such as social isolation, homelessness, financial difficulties and health issues. Borzycki’s contention is a further example of how drug types are frequently conflated under the rubric of a single term (drug issues), which makes it problematical for researchers seeking to examine specific drug types in particular contexts.
The Cycle of Imprisonment

Following the completion of a prison term, some individuals with AUDs successfully integrate into the wider community and are not re-incarcerated. Nevertheless, the high rate at which many return to prison, often within a relatively short period of time, is alarming. According to Payne (2007, p. xi), between 35 and 41 per cent of Australian ex-prisoners will be re-incarcerated within two years of exiting prison. A similar pattern of re-incarceration exists in Victoria. A study examining the temporal patterns of re-imprisonment among a cohort of released Victorian prisoners (n=3,352) in the 2002-03 period, found 35 per cent (n=1,162) were re-incarcerated for offending within two years of release (Holland, Pointon, & Ross, 2007). Furthermore, the study found that individuals were more likely to return to prison in the first few months after release with 40 per cent re-incarcerated within the first six months and 70 per cent within the first twelve months of release (Holland et al., 2007, p. 6).

These patterns of repeated incarceration are what Halsey (2010, p. 7) terms the “incarceration-release-reincarceration machine” to describe the cycle of imprisonment and release that characterises the lives of many offenders. The high rate, at which individuals are re-imprisoned, implies that efforts to rehabilitate offenders with AUDs, and prisoners in general are not succeeding. This outcome suggests that post-release support services and treatment programs may be crucial in determining whether or not individuals with AUDs can avoid resuming harmful or hazardous alcohol consumption and initiate a desistance from crime lifestyle.¹⁴

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¹⁴ It is important to note that the statistical data presented above is reflective of Victoria’s prison population generally and does not relate specifically to those prisoners with AUDs.
Discharges from Prison in Australia

The precise number of prisoners who exit the Australian prison system each year has been difficult to assess, as historically Australia’s correctional systems have not provided yearly release data. Nevertheless, in 2001, Baldry et al., (2003, p. i) estimated the number of discharges from Australian prisons to be in excess of 44,000 annually. However, a recent study by Avery and Kinner (2015, p. 315) drawing on data obtained from the ABS, estimated that 33,751 prisoners were released from Australian prisons during 2011/12. This is 15 per cent more than the number of prisoners incarcerated as at 30 June 2012 (n=29,383).

In Victoria, the Department of Justice and Regulation produces statistical data on prisoners discharged from Victorian prisons. In the 2013/14 financial year, 6,496 prisoners were discharged, an increase of 15.6 per cent from the 2009-10 year (Department of Justice & Regulation Victoria, 2015a). It should be noted that there are two pathways out of prison in Victoria: individuals are released either on parole or on straight release\textsuperscript{15} (Department of Justice Victoria, 2009). It is important to have a clear understanding of the number of prisoners who exit Australia’s prisons annually, in order to provide a basis for informed post-release policy development and service design (Avery & Kinner, 2015).

Prisoners on Parole

Those who exit prison on parole are conditionally released to serve the remainder of their sentence in the community. Parolees remain under the supervision of a Community Corrections Officer and must adhere to the conditions of their parole for the duration of their sentence. According to the Department of Justice Victoria (2014):

\textsuperscript{15} Straight release is a term used to describe those individuals who exit prison without any restrictions or any form of community supervision requirement.
The purpose of parole is to promote public safety by supervising and supporting the transition of offenders from prison back into the community in a way that seeks to minimise their risk of reoffending (in terms of frequency and seriousness) while on parole and after they complete their sentence.

Some parolees may have a mandated alcohol treatment order attached to their parole conditions, if alcohol misuse is deemed a risk factor for re-offending (Corrections Victoria, 2008). For these individuals, alcohol treatment programs are brokered or delivered through the Community Offenders Advice and Treatment Service (COATS) which is part of the Australian Community Support Organisation (ACSO), a non-government community based support agency that provides services to individuals who have had, or are at risk of having contact with the CJS (Corrections Victoria, 2008; Department of Human Services Victoria, 2009). COATS, is funded by the Victorian government and is the sole body responsible for coordinating community based drug and alcohol services for released prisoners. Through COATS, individuals on parole who are required to undertake treatment or counselling for alcohol problems are provided with “priority” access to treatment with specialist treatment providers (Corrections Victoria, 2008, p. 9).

**Prisoners on Straight Release**

Those prisoners on straight release who have an AUD are not eligible for the same priority access to alcohol treatment or support programs as those on parole. Although prisoners on straight release can voluntarily seek counselling or treatment services for alcohol misuse through the Step OUT\(^{16}\) program brokered through COATS (Department of Human Services Victoria, 2009), they first need to be aware of the existence of such services. It is suggested that the lack of information regarding the availability of AOD services for ex-prisoners “is

\(^{16}\) Step OUT is an Intensive Post Prison Drug and Alcohol Treatment Service for individuals released without condition.
one of the greatest barriers” to seeking treatment (Victorian Auditor-General, 2011, p. 19). The implications for prisoners with alcohol problems on straight release are disturbing, as they are solely responsible for sourcing and seeking treatment for their alcohol misuse from a treatment sector that is deemed difficult to access and navigate (Victorian Auditor-General, 2011, p. vii). Moreover, difficulties arising from an inability to source and access treatment and support for an AUD may contribute to some released prisoners drinking in a harmful or hazardous manner, as a way of coping with the stressors associated with exiting the highly controlled prison environment.

As discussed, very few prisoners are able to access in-programs that specifically address alcohol misuse, consequently, they will not have developed the strategies and skills required to avoid misusing alcohol when transitioning from prison into the wider community. On release, some individuals may therefore be highly vulnerable to using alcohol as a coping mechanism (Binswanger et al., 2012; Travis et al., 2001; Wills, Sandy, & Yaeger, 2002; Zamble & Quinsey, 1997). The use of alcohol as a post-release coping mechanism was highlighted in a study conducted by Binswanger, Nowels, Corsi, Glanz, Long, Booth and Steiner (2012, p. 4), who explained:

Participants described an overwhelming urge to use drugs and alcohol to cope with the frustration, ‘numb out’, and ‘forget about’ the daily stressors of the transition period, citing easy availability combined with pressure from old friends and new acquaintances to ‘party’.

As this quote suggests, ex-prisoners are often confronted with a raft of difficulties and challenges when transitioning from prison into community life and many require post-release assistance and support to address or overcome these challenges. Those who misuse alcohol as a way of coping with the challenges associated with re-entering the community will most
likely need urgent access to support and treatment services in order to avoid alcohol-related offending.

**Post-Release Support for Releasees with Alcohol Problems**

The availability of, and timely access to post-release support and treatment programs for individuals with an AUD is critical if a pro-social lifestyle is to be attained. It is argued that in the hours, days and weeks following release from prison, individuals are at a high-risk of relapsing into misusing alcohol (No Bars, 2011b). This can lead to anti-social, or more serious forms of offending behaviours, and once again result in re-establishing contact with CJS agencies (No Bars, 2011b; Rosenfeld et al., 2008). According to Travis, Solomon and Waul (2001, p. 18):

> The ‘moment of release’ from prison, and the hours and days that follow, may be quite pivotal to the transition back to community life. There are multiple hurdles – many of a largely logistical nature – that could be overcome relatively easily with appropriate planning. Systematic attention to small but significant details, important at the moment of release, such as the time of day prisoners are released, whether they have identification, arranging for housing, treatment, jobs, and family reunification immediately upon release could help ease their transition from prison to community.

In Victoria, the importance of accessing pre and post-release services to assist with the transition process is noted in The Deputy Commissioner’s Instruction 7.3. titled *Parole Assessment* (Deputy Commissioner Corrections Victoria, 2015):

> Pre-release preparation provides the opportunity for prisoners to prepare for their release and have access to information and support on return to the community, in order to reduce the likelihood of their re-offending.

Additionally, the Victorian Ombudsman reported that research presented by health professionals indicates that the initial post-release period is critical in terms of the health and wellbeing of those released from prisons (Victorian Ombudsman, 2014).
Post-release Service Provision

In Victoria, prior to release, all sentenced prisoners are offered support through the Transitional Assistance Program (TAP). The program refers exiting prisoners to services such as housing support services, drug and alcohol services and also provides information regarding employment services, legal assistance and Community Correctional Services (Department of Justice & Regulation, 2013). However, a report from the Victorian Ombudsman (2014, p. 24) has demonstrated the difficulties transitioning prisoners have in accessing post-release services through the TAP program:

In 2013-2014, 4,489 sentenced prisoners were released from Victorian prisons. Of this number, placements for Intensive Transitional Support programs were only available to 695 prisoners.

These figures demonstrate that not all releasees will have access to appropriate post-release service provision, which prior research suggests they will need in order to integrate into the community and live pro-social lives. This research seeks to supplement this finding by considering access to services and treatments specific to exiting prisoners with an AUD.

The Role of Non-Government Organisations (NGOs)

The primary source of post-release support and treatment programs in Victoria is provided by NGOs (see Department of Justice & Regulation, 2013). NGOs provide a broad range of transitional assistance services to parolees and those on straight release, although the range of services offered varies by organisation. Broadly, the areas of support and services offered by NGOs address many of the psychological, physical and social needs of released prisoners. These include: assisting with employment and legal services, financial advice, advocacy, social support, family support and assisting with a range of welfare needs, including help
with finding housing or sourcing emergency accommodation. Clients are also assisted with obtaining personal identification documents, and with re-establishing relationships with children and partners (Borzycki, 2005, p. 5). Some NGOs also provide or broker programs that address AOD misuse through counselling, education harm reduction and/or relapse prevention and programs. The role played by NGOs in the provision of post-release support and treatment services is of critical importance, for releasees who may find the transition from the highly controlled environment of prison to the self-regulated external environment challenging without appropriate support. The support of NGO professionals is vitally important to releasees who would otherwise find it difficult to break the cycle of re-arrest, re-conviction and re-incarceration that has characterised their lives (Borzycki, 2005).

**Conclusion**

This chapter presented a history of concepts and approaches employed in the rehabilitation of offenders with a specific focus on those with alcohol problems. Understanding the evolution of rehabilitation from punishment through treatment is important as a basis for understanding what has been tried before and the success or failure of each method. This chapter revealed that offender rehabilitative methods have moved from using silence, isolation, Christian renewal and punishment as reformative practices through to medical interventions including drugs, to the contemporary models which advocate risk management and psychologically based interventions.

This chapter also provided a broad understanding of the social, personal and economic harms associated with alcohol misuse in the Australian and Victorian contexts. It examined the nexus between alcohol and crime to present an overview of the perceived relationship between alcohol misuse and a number of offending behaviours. Although it is
difficult to accurately depict the current proportion of individuals who, through alcohol misuse, come into contact with Australian criminal justice agencies, estimates were offered by drawing on data contained in surveys of prisoner populations, the DUMA program and scholarly research. The chapter also presented a discussion of the pathways out of Victorian prisons and an overview of post-release services provided by NGOs. In doing so, this chapter highlights the gaps in the existing literature, and the ways in which this research will seek to contribute to post-release criminological research with a focus on the services and pathways for releasees with an AUD in Victoria. The next chapter presents the methodology employed in this thesis.
Chapter Four

Methodology

In Victoria and Australia generally, there is a paucity of research examining alcohol misuse in the post-release environment. As discussed in the previous chapters, significant numbers of individuals enter prison with alcohol problems, yet they have limited access to alcohol-specific rehabilitation programs while incarcerated. These prisoners are, therefore, highly likely to leave prison with little or no support for their alcohol problems. This places these individuals at risk of resuming problematic alcohol consumption after release, which for many was associated with their offending behavior.

This research seeks to examine the role of alcohol misuse among individuals transitioning from prison to the wider Victorian community. As outlined in the Introduction, this is achieved by exploring three key research questions (re-stated below) drawing on desistance-focused and recovery-oriented theoretical frameworks:

(1) To what extent is alcohol misuse a problem for individuals transitioning from prison to the wider community? If so, in what ways is it problematic?

(2) What post-release support and treatment services are available to releasees with Alcohol Use Disorders (AUDs) in Victoria? To what extent do these services address their needs?

(3) To what extent do post-release support and treatment services affect the potential for releasees with AUDs to initiate a desistance and recovery pathway?
In order to examine the key questions driving this research, a qualitative design methodology was adopted utilising semi-structured interviews conducted with post-release support workers and forensic counsellors employed by NGOs in Victoria.

This chapter details the steps taken to conduct this study including the rationale of employing a qualitative methodological approach, the process for gaining access to the research participants, and the methods employed for the collection, coding and analysis of data. Ethical considerations relevant to this research and potential limitations of the study are also discussed.

**Research Strategy**

A primary goal of this study was to obtain the professional perspectives of post-release support workers and forensic counsellors who provide transitional support and alcohol treatment programs to individuals exiting prison with an unresolved Alcohol Use Disorder (AUD). A qualitative research methodology, employing in-depth interviews was deemed the most effective strategy to fulfil this task as support workers and forensic counsellors have the “knowledge of, or experience with, the problem of interest” (Rubin & Rubin, 2012, p. 3), which in this study is post-release alcohol misuse. A robust definition of qualitative research is offered by Denzin and Lincoln (2005, p. 3):

Qualitative research is a situated activity that locates the observer in the world. It consists of a set of interpretative, material practices that make the world visible. These practices transform the world. They turn the world into a series of representations, including field notes, interviews, conversations, photographs, recordings, and memos to the self. At this level, qualitative research involves an interpretative, naturalistic approach to the world. This means that qualitative researchers study things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them.
At the most basic level, qualitative research is considered to be any research findings that are not produced through the quantification of data (Strauss & Corbin, 1998). The aim of conducting qualitative research, as argued by Ritchie and Lewis (2003, p. 22), is to gain “an in-depth understanding of the social world, by learning about people’s social and material circumstances, their experiences, perspectives and histories”. Corbin and Strauss (2008, p. 1) similarly suggest that a qualitative approach is conducted to “elicit meaning, gain understanding and develop empirical knowledge”. A qualitative method was chosen for this study as this research is concerned with gaining a nuanced understanding of the professional perceptions, insights and experiences of those who work closely with released prisoners who have an AUD.

**Semi-Structured Interviews**

Three types of interviews are available to the social researcher for the collection of data: the structured interview, the semi-structured interview, and the unstructured format (May, 2011). Having considered each type of interview format, this research employed a semi-structured interview model for the collection of data because they provide the framework for a flexible, open-ended exchange to take place in the interview setting. This approach provides the opportunity for new topics to be explored resulting from the responses given to particular questions (Holstein & Gubrium, 2001). According to May (2011, p. 131), “interviews yield rich insights into people’s biographies, experiences, opinions, values, aspirations, attitudes and feelings”. Along the spectrum of interview typologies, semi-structured interviews are situated between the quantitative structured interview that employs surveys or questionnaires for the collection of data, and the unstructured interview that relies on interviewees talking about a topic in their own words and within their own frame of reference (May, 2011;
Ritchie, 2003). Importantly, the semi-structured format provides researchers with the flexibility to explore key issues and themes with participants and to elicit responses “more in their own terms than the standardised interview permits” (May, 1993, p. 93).

**Probes**

It is the element of flexibility afforded by semi-structured interviews that made this approach most appropriate for this research. A semi-structured model enables predetermined questions to be posed to each interviewee but also permits the latitude to probe beyond the given responses for additional information and engage in a dialogue with the participant (May, 2011; Ritchie, 2003). Probes were used during all interviews to seek clarification of an answer or to encourage the participant to elaborate on their response. The following exchange provides an example of how probes were used during an interview to encourage the participant to elaborate on one word responses. The bold typeset indicates a probed question:

**Researcher:** Has alcohol misuse posed a problem for any of your current or recent clients?

**Participant:** Yes

**Researcher:** Can you explain how alcohol misuse has been a problem for some of your clients?

**Participant:** Gone back inside.

**Researcher:** Can you provide me with an example of how alcohol misuse contributed to the client being re-incarcerated?

**Participant:** A guy was going to AA [Alcoholic Anonymous] meetings. He was sober and clean from all drugs and substances and he decided one night, after having an argument with his partner, ‘That’s it, I’m going to get myself drunk’. He got himself drunk and ended up in a blackout where he couldn’t remember what he did. Got himself into a fight and, I think he was on parole, he breached and ended up straight back in jail where he started.
As this exchange demonstrates, the ability to probe for further responses was invaluable in eliciting more elaborate and meaningful responses from the participants.

**Active Interviewing**

As evidenced from the preceding excerpt, another strength of employing semi-structured interviews is that they enable an “active interviewing” style to evolve between the researcher and the interviewee (Holstein & Gubrium, 2001; Maxfield & Babbie, 2011, p. 285). According to Holstein and Gubrium (1995, p. 16), “active interviewing is a form of interpretive practice involving respondent and interviewer as they articulate ongoing interpretive structures, resources and orientations …”. The aim of “active interviewing” is not to “dictate interpretation, but to provide an environment conducive to the production of the range and complexity of meanings that address relevant issues, and not be confined by predetermined agendas” (Holstein & Gubrium, 1995, p. 17). I employed this “active interviewing” approach during the fieldwork to elicit broader and more insightful responses. This was particularly valuable when interviewing some participants who had a tendency to respond in a relatively brusque manner. Accordingly, an interview schedule (see Appendix F) was developed and used as a thematic guide and not necessarily followed verbatim. Participants were thus provided with the latitude to discuss issues, not only pertinent to the question asked, but to expand the discussion to address related issues based on their responses. This conforms to McNamara’s (2009) “general interview guide approach” which aims “to ensure that the same general areas of information are collected from each interviewee … this provides more focus than the conversational approach, but still allows a degree of freedom and adaptability in getting information from the interviewee”. For
example, in responding to the general question which asked for an overview of what the role of a transitional support worker involves, the following response was offered:

I’m allocated clients [by my manager]. I have a small caseload where I’ll work with them. One goal that all clients have is working on a housing strategy. But any other goal they identify, we can assist with. So that might be legal-related stuff, health-related, mental health, family relationships. Anywhere that we can try and give them a bit of support that might help stabilise where they’re at, I guess lead to a better housing outcome. So that’s pretty much it. It’s usually client-led, but housing always plays a part in it. (Participant 6)

The preceding reference to goals being “client-led” prompted me to say, “I know I’m jumping off on a side-track here [but] when working with clients do you use an approach goal or avoidance goal strategy”? The participant responded:

There are clients that their focus – particularly the ones that have that Corrections link; [who] come with a lot of avoidance goals that they want to work on. For me, having worked in the Corrections background, as well as the welfare side of it, I’m happy to work with either. But I do tend to like approach goals, that counteracts, sometimes, that – I shouldn’t say completely negative, but the more negative focus that sometimes Corrections based clients can have. But yeah, I think it’s a better way, I feel it’s a more positive way for someone to be approaching change. (Participant 6)

This dialogue demonstrates how “active interviewing” occurred during the interview process and the beneficial outcomes it had in providing data that would not necessarily have been elicited by adhering only to the pre-prepared questions. This experience also supports Holstein and Gubrium’s (1995) contention that interviews should not adhere strictly to a set agenda but should be free-flowing in a conversational style.

**Building Rapport**

Scholars suggest building a rapport between the researcher and the participant is important because “[w]ithout rapport, even the best-placed questions can fall flat and elicit brief,
uninformative answers” (Leech, 2002, p. 665). Furthermore, Leech (2002) emphasises that building rapport with interviewees involves more than simply putting respondents at ease. It entails “convincing people that you are listening, that you understand and are interested in what they are talking about, and that they should continue talking” (Leech, 2002, p. 665).

Maxfield and Babbie (2011, p. 285) further argue that:

Great interactions in an interview can be similar to great social exchanges in a regular life. Of course, you do not need to take your participants home or become overly intimate with them. Instead, think about the basics of good conversations. Using your existing social abilities to help establish rapport … can be a great benefit to your research.

Taking the time to establish rapport with interviewees was considered vital in creating a reciprocal and supportive environment for interviews to take place within the context of this research. Thus before each interview, the nature of the project was broadly outlined together with some of the themes that would be explored. Some interviewees explained that they felt nervous, as they had not participated previously in a research interview. To alleviate their anxiety, I explained that they were the expert in the room and my task was simply to draw on their valuable knowledge, insights and experiences. This supports Leech’s (2002) contention that if researchers already knew everything about a certain topic, conducting face-to-face interviews would be unnecessary. Positioning respondents as the experts in the interview setting was made possible by utilising a semi-structured format whereby interviewees were able to inform, and at times guide the research.

**Participants – Access**

NGO support workers and forensic counsellors were chosen as interview subjects for this thesis because they work closely with transitioning prisoners to provide advice, guidance,
assistance, advocacy and support, or treatment services in the post-release environment. They therefore have fundamental knowledge of the needs, difficulties and challenges faced by individuals with alcohol problems who are transitioning from prison to the wider Victorian community. For the purpose of this research, the following definitions of support workers and forensic counsellors were developed based on responses to the first question posed to all interviewees: “Can you tell me about your role as a support worker/forensic counsellor and what it entails”? A support worker is understood as being a person working in a professional capacity for a NGO, who has the primary responsibility for providing non-treatment support services to releasees transitioning from prison to the Victorian community. This role involves addressing an array of releasees’ post-release needs that include advice regarding “legal and financial matters, family disconnection issues, social isolation” (Participant 3). Support workers also act as brokers or advocates by “linking [releasees] into necessary supports in the community” such as “housing and substance abuse [services]” (Participant 3). A forensic counsellor is understood to be a person working in a professional capacity for a NGO who provides “drug and alcohol counselling … specifically [to] clients who are involved in the justice system, either on corrections orders or on parole” (Participant 24). However, it is important to note that there is no definitive demarcation line between the two roles, as explained by Participant 1, who is a support worker said: “I take on a bit more of a counselling role, I guess, post-release, because, unfortunately, a lot of the [treatment] programs that we want to refer them to have huge waiting lists”. Forensic counsellors also provide non-treatment support and advice to their clients as one treatment professional explained, it’s “not just looking at their drug and alcohol problems, we’re looking at them as a whole person … from a social and emotional wellbeing point of view, and their mental health as well” (Participant 30).
Gaining access to individuals to participate in qualitative research can be difficult and time consuming (Noaks & Wincup, 2004). Identifying potential interviewees within organisational structures is problematic as they form part of what Atkinson and Flint (2001, p. 100) term, “hard-to-reach or hard-to-identify” populations. The problem of access is further compounded when “gate-keepers” are relied upon to provide contact information for, or to disseminate information regarding the nature of the research to potential participants. Jupp (2006, p. 126) defines a gate-keeper as:

The person who controls research access. For example, the top manager or senior executive in an organisation, or the person within a group or community who makes the final decision as to whether to allow the researcher access to undertake the research.

Post-release support workers and forensic counsellors form part of the “hard-to-identify” populations as they work within large NGOs and, therefore, their contact details are not readily obtainable in the public domain. Consequently, the most difficult, and time consuming task in the recruitment process, was to obtain the contact details for the person (gatekeeper), within each NGO who had the authority to permit research to be conducted. Early in the research process, a total of ten NGOs were contacted by email and/or telephone to participate in this study. One NGO declined to participate indicating that as they were a relatively small organisation it restricted their capacity to participate in research projects. Another four NGOs did not respond to my request for “gatekeeper” contact details despite several follow-up phone calls and emails. The remaining five agencies provided an email address for the person who was responsible for authorising research access. Once the gatekeeper within each NGO was identified a letter of introduction (see Appendix A) was sent, together with a copy of the explanatory statement (see Appendix B) that outlined the
purpose of the study, what the research involved, discussed possible benefits and risks to participants and addressed issues of confidentiality, anonymity and storage of data.

A letter requesting signed permission to conduct interviews with post-release support workers and forensic counsellors within the organisation was also forwarded (see Appendix C). This letter also sought the gatekeeper’s assistance in promoting the proposed research by circulating a recruitment flyer to relevant employees within the organisation (see Appendix D). In all five instances, I received a signed letter of permission to conduct interviews with employees of these NGOs. From this point on, the recruitment of participants was more straight-forward, as I started to receive contact from professionals within these NGOs who were willing to participate in the interview process. When individuals contacted me indicating their willingness to participate, I emailed a copy of the explanatory statement and consent form (see Appendix E), and asked them to nominate a convenient date and time for the interview to be conducted.

**Participants – Details**

A total of 36 semi-structured face-to-face interviews were conducted with support workers (n=16) and forensic counsellors (n=20), in Metropolitan Melbourne (n=24) and Regional Victoria (n=12) from 5 NGOs.
### Table 1: Interview Participants

<table>
<thead>
<tr>
<th>PROFESSIONAL CATEGORY</th>
<th>METROPOLITAN MELBOURNE</th>
<th>REGIONAL VICTORIA</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>SUPPORT WORKERS</td>
<td>14</td>
<td>2</td>
<td>16</td>
</tr>
<tr>
<td>FORENSIC COUNSELLORS</td>
<td>10</td>
<td>10</td>
<td>20</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>24</strong></td>
<td><strong>12</strong></td>
<td><strong>36</strong></td>
</tr>
</tbody>
</table>

The participant cohort was comprised of 28 females and 8 males. The interview process took place over a six-month period commencing in November 2013 and concluding in May 2014. All interviews were digitally recorded, with the permission of each participant, and ranged from 28 to 80 minutes. Interviews were conducted at the business premises of each interviewee at an agreed date and time. Before commencing each interview, I provided each participant with a brief overview of the nature and purpose of the research and asked if they had read and understood the explanatory statement. All indicated they had. I explained to all interviewees that their participation was voluntary and that they could terminate the interview or withdraw from the study at any time without having to provide a reason for doing so. Voluntary written consent was obtained from each participant prior to the commencement of the interview. Prior to commencing taping, all interviewees were asked if they had any questions or concerns regarding the interview process. No concerns or questions were raised.

On completion of the interviews each person was thanked for their time and presented with a $50 voucher redeemable at supermarkets or a large department store. I decided to do this as the potential interviewees had heavy caseloads with most working days taken up with back-to-back appointments with clients. In recognition of their busy schedules, the vouchers...
were offered as a token of my appreciation for their willingness to participate in the interview process. I was told that at one of the NGOs, all interviewees elected to ‘pool’ their vouchers and purchase food and/or clothing for their disadvantaged clients. There was no evidence that the provision of gift vouchers impacted on the responses given or the quality of the data collected.

**Research Location**

Interviews were conducted at several locations in Metropolitan Melbourne and Regional Victoria. As flagged in the Introduction, Victoria was chosen as the location for this research for several reasons. First, and most importantly, the extent to which post-release alcohol misuse is a problem for individuals exiting prison in Victoria has not been the focus of prior research in this State. This research, therefore, is the first study conducted in Victoria to seek an understanding of the impact of alcohol misuse in the post-release environment. Previously, alcohol misuse has been subsumed under the generic terms of either substance misuse or Alcohol and Other Drug (AOD) use; therefore, whether or not it poses a problem for some released prisoners is largely unknown. Second, no previous Victorian studies have investigated the post-release needs of transitioning individuals with AUDs and whether or not their needs are adequately addressed through post-release services. Third, no previous Victorian studies have examined the ways in which the delivery of post-release services may promote a desistance and recovery trajectory.

**Data Coding**

Each interview generated a large amount of data, which was transcribed verbatim by a professional transcription service. On receipt of the written text, each transcript was read and
re-read to familiarise myself with the story being told and to identify emergent themes present in each interview. The data was then transferred to Nvivo9, a qualitative data analysis software program, for thematic coding. The first step involved utilising Nvivo’s “node” function to identify broad themes that drew on the subject matter contained in the key research questions. From these “parent nodes” themes, sub-categories or “child nodes” were created which identified specific topics that related to the broad theme. For example, housing was identified by many support workers and forensic counsellors as a “need” their clients frequently sought assistance with. During the interviews, the general topic of post-release housing led to discussions around what type of housing/accommodation was available to releasees with alcohol problems. During the coding process, the broad theme of housing became a “parent node” and forms of available housing/accommodation became “child nodes”. This process continued until all relevant themes were identified and coded. Coding in this manner provided data that was structured and readily accessible to commence the process of analysing the data, which is set out in the analysis chapters.

Ethics

Approval to undertake this research was obtained from the Monash University Human Research Ethics Committee (MUHREC) in August 2013. Due to the professional status of participants, the issues of confidentiality and informed consent were important aspects of this study. The names of all interviewees were de-identified by assigning each participant a number to safeguard their privacy and confidentiality.

17 Nodes are created to gather and store data about specific themes, places, people or other areas of interest. Interviews, focus groups, articles or survey results can be coded to a node. The Nvivo “node” is hierarchical. The program enables broad categories or “parent nodes” to be created as well as sub-categories or “child nodes” which contain more specific topics (QSR International, 2012).
Confidentiality and the privacy of participants has been further strengthened, as it was agreed that the names of participating NGOs would not be identified in this study or any other works or publications arising from this project. Originally, the intention was to list the NGOs who supported the research in the introduction of this thesis. However, during the course of the interviews, two participants from two different organisations requested that the NGOs they work for not be identified. They expressed concern because each worked within a relatively small team, in what is a specialised sector, thus any reference to specific geographic locations or specific facilities increased the possibility of them being identified. For these reasons, I have de-identified any references to the names and locations of the NGOs who participated.

Limitations

While this study provides an in-depth and nuanced analysis of issues relating to post-release alcohol misuse, there are several potential limitations that must be acknowledged. At the outset, a core aim of this thesis was to gain a broad understanding of the post-release experiences and needs of parolees and those on straight release with AUDs. However, the inability of some NGOs to participate in this research proved to be a significant limitation to the findings presented. Significantly, the agencies that were not able to participate included those that provide support and treatment services to individuals on straight release. Consequently, the study has only presented the post-release experiences and needs of those who exit prison in Victoria on parole.

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18 Leaving prison on straight release means that these individuals re-enter the community without the monitoring and reporting requirements that parole would otherwise demand (Victorian Ombudsman, 2014).
While conducting the research, two respondents offered views as to why those on straight release rarely form part of their clientele. Participant 16 suggested that they do not seek post-release support because:

They’re not accountable to anybody … on one level you’ve got [parolees] where they’re stitched up to within an inch of their life and they have absolutely no choice, and over here you have a group that has no monitoring and no support at all.

An alternate reason was suggested by Participant 36 who stated, “the statistics show that straight releasees don’t engage in treatment post-release … [they] only seek assistance after they have relapsed”. Both comments show the problems that are associated with the absence of post-release support for those who do not have “conditions” attached to their release. This would have been a useful point of comparison to make with parolees, particularly in relation to the accessibility, legality and social acceptance of alcohol use where there is no monitoring in any sense of the releasees use of alcohol. This is a significant limitation of this research and an area of importance to be considered in future studies. As the interviewees indicated they had little or no contact with individuals on straight release with alcohol problems, the experiences and needs of this group cannot be reflected in the study’s findings.

A further limitation pertains to the number of participants recruited. Thirty-six support workers and forensic counsellors were interviewed. I had originally anticipated conducting a higher number of interviews, but, as explained above, because I was reliant on potential participants making direct contact with me after receiving the recruitment flyer from the “gatekeeper” in each NGO, it is unclear how many potential participants chose not to participate. The sample was therefore comprised of only those NGO professionals who were interested in participating and their perceptions may not have been typical of all post-release support workers and forensic counsellors in the Victorian AOD sector.
Further limitations of this research are that it does not adequately capture the post-release experiences of alcohol misuse of women or indigenous releasees, who are likely to have different needs and face different challenges on exiting prison. Again this is because the NGOs that participated in the research had a predominantly male clientele. While women and Indigenous releasees with AUDs can access transitional services in Victoria – through the ReConnect\textsuperscript{19} transitional program – the NGOs that deliver these services declined to participate in the interview process, thus the experiences of these groups are not reflected in the findings of this study.

\textbf{Conclusion}

This chapter provided an overview of the methodological processes and procedures adopted for the collection and analysis of data for this research. Having presented the literature review and theoretical framework underpinning the thesis, the following chapters discuss the research findings, starting with an analysis of the broad range of problems facing Victorian releasees with an AUD.

\textsuperscript{19} ReConnect provides targeted (up to four weeks) and intensive (up to twelve months) post-release reintegration outreach services for serious violent or sex offenders, Aboriginal and Torres Strait Islander prisoners, women prisoners and prisoners with high transitional needs. It is designed to provide responsive, tailored and flexible support (Department of Justice and Regulation Victoria, 2015b).
Chapter Five

Mapping the Landscape – The Problems Associated with Post-Release Alcohol Misuse

The problems and challenges experienced by individuals transitioning from prison into the wider community are well documented by academics and policy makers. However, the specific impact of alcohol misuse on the transitional experience of ex-prisoners has been largely overlooked in prior research and, as a result, the nature and extent of the problem is often unknown. This chapter aims to fill this gap by drawing on the interview data to examine the extent to which alcohol misuse is a problem in the post-release environment, and to analyse the specific ways alcohol misuse complicates and negatively impacts the transitional process. A discussion of the social and cultural acceptability and the legality and accessibility of alcohol in contemporary society is then presented in the context of how these factors can have negative social and health consequences for releasees with an Alcohol Use Disorder (AUD). This chapter also examines the link between alcohol misuse, the propensity to reoffend and possible re-incarceration.

Post-Release Alcohol Misuse

As a central aim of this research is to better understand the nature and extent to which alcohol manifests as a problem in the post-release environment, support workers and forensic counsellors were asked if alcohol misuse or abuse was a problem among their clients who were transitioning from prison to the community. For some individuals, alcohol was the primary drug of choice. For others, alcohol was a problematic component of poly-drug use.
Approximately 72 per cent (n=26) of interviewees indicated that alcohol misuse was a significant problem among their clients. Words such as a “massive issue”, and “huge”, were offered to explain the magnitude of the problem. The following responses typify how support workers view the problem of post-release alcohol misuse:

I’ve been in this sector since 2007 [and] it’s always been a massive issue. That’s, pretty much, the first word that comes to mind. (Participant 2)

Another respondent affirmed this contention stating:

It is huge. And they don’t understand the addictive process. They don’t understand the brain chemistry. Or, they choose not to understand it. But they’ve often, too, got alcohol related brain injury which makes it very difficult because that, too, effects impulse control and a whole range of other issues. (Participant 25)

One interviewee identified how alcohol misuse has a negative impact on some individuals in the transitional environment:

Generally speaking, most people who come out – and I’m generally talking about men … most of them will go on to go back into their alcohol use. Some don’t, but generally speaking the majority do and they’ll get out of jail, off they go to the pub and then the whole cycle starts again. (Participant 17)

This comment reflects the gendered nature of the interviewees’ client cohort. The Non-Government Organisations (NGOs) who participated in the research were providing post-release services predominantly to male releasees, with females only making up a small portion of their clientele. However, where relevant, the respondents who provided examples of female clients are analysed and discussed.
The above comments suggest that alcohol misuse is a considerable problem for many transitioning prisoners, particularly in relation to perpetuating the offending cycle. This is a significant contention given that, as already noted, the alcohol misuse among transitioning prisoners has not been the focus of previous research conducted in Victoria. Furthermore, as discussed in Chapter Two, it has previously been difficult to ascertain the extent to which alcohol misuse is a problem among criminal justice system (CJS) clients, or ex-prisoners, as prior studies, in the main, conflate alcohol and illicit drugs under the terms substance abuse or Alcohol and Other Drugs (AOD) use. Participant 19 supported this concern, claiming, “it [alcohol] gets lumped in with every other drug … there’s not a lot of alcohol-specific work” done in the prison setting. One respondent acknowledged the “really good support … volunteer groups like the Prison Fellowship … [and] AA [Alcoholic Anonymous]” do with “people who are problematic alcohol users” (Participant 14). The same participant lauded the work that Caraniche (a specialist psychology company that delivers AOD treatment programs through the Victorian Department of Justice) offers in providing drug and alcohol counselling to Victorian prisoners. However, she said the programs “are very, very scarce because of [limited] funding” (Participant 14). Reflective of most addictions and disorders left untreated, it was suggested by Participant 35 that individuals who enter prison with an AOD are unlikely to change their drinking patterns once released “if they haven’t had much treatment inside to talk about relapse prevention and controlled drinking strategies”.

It is perhaps unsurprising that support workers report alcohol misuse to be a “massive” problem among releasees, as prior research indicates many individuals enter prison with an AUD (AIHW, 2012b). As noted in Chapter Three, 41 per cent (n=186) of Victorian prisoners surveyed in 2003 were found to have moderate to severe alcohol problems (Deloitte Consulting, 2003). In light of the fact that the data suggests there are very few programs in
Victorian prisons that specifically target alcohol misuse, it is likely that some prisoners will exit prison without the skills or knowledge to avoid returning to harmful or hazardous patterns of drinking. On this basis, it can be argued, that the shortage of alcohol specific treatment programs in the prison setting, contributes to the significant proportion of released prisoners who resume drinking at harmful or hazardous levels.

The lack of attention given to alcohol misuse, among current and post-release prisoner populations, was suggested by some respondents to result from CJS’ primary focus on illicit drugs and associated harms. Participant 6 explained, “there’s a perception that the people who are in custody mostly will be there for things like Heroin or Ice, but there are a large percentage of people that have found themselves in custody for alcohol-related stuff”. This view was similarly reflected in the comments of Participant 17, who claimed “I think it’s a shame that people don’t take alcohol [as] seriously as … [other] drug[s] … [as alcohol misuse] can be a travesty in some situations”. The contention that alcohol is “less serious” than drug use reflects the findings of prior research suggesting that CJSs prioritise issues associated with illicit drug misuse (Fitzpatrick & Thorne, 2010; Heseltine et al., 2009; HM Inspectorate of Prisons, 2010; Howells et al., 2004; G. Jones & Hoffman, 2006), despite alcohol misuse being the predominant form of substance misuse among individuals prior to incarceration in Australia (AIHW, 2012a).

The failure to acknowledge the seriousness of post-release alcohol misuse emerged as a common theme among the interviewees and was frequently attributed to a focus on illicit drugs and associated harms. Participant 30 explained:

… [W]e’re concentrating recently on Ice and all of these other drugs. I suppose because they’re more out there. But alcohol is so much more insidious … it’s still our number one problem. It’s still our number one reason for presentation to any drug and alcohol service.

The inattention given to alcohol misuse was demonstrated by another interviewee who stated:
… it [alcohol] just doesn’t get the same sort of attention as [if] they’re a drug user. I’m not sure why that is. As soon as its drugs there’s a bit more attention … paid, whereas alcohol, it’s kind of, okay, we might send them to a counsellor but there’s not that same sort of feeling of urgency. (Participant 7)

In explaining the effects of this prioritisation, one participant identified post-release alcohol misuse as a greater problem among her client group than that of illicit drug use:

I would say that alcohol is probably the biggest issue, rather than any other illicit drugs. I found it, for my clients, to be the hardest issue and it’s the issue that’s caused the most problems for my clients; alcohol rather than Heroin or Cannabis or anything else. (Participant 2)

This interviewee’s suggestion that alcohol is a bigger issue than illicit drugs was similarly expressed by another support workers interviewed, who said:

It’s a socially accepted substance and it’s not illegal and people grow up with it. Alcohol is something that people view as being okay. Drugs don’t touch the stuff but alcohol’s a drug … but … it’s a different type of concept but look, alcohol from my perspective … is a big issue. (Participant 33)

This view is also in line with existing Australian research conducted between 2009-2010, which found individuals detained by police on Friday and Saturday nights were more likely to be intoxicated by alcohol than affected by illicit drugs (Sweeney & Payne, 2011). According to Michael Thorn (2014), Chief Executive of the Foundation for Alcohol Research and Education, alcohol is “Victoria’s true epidemic”, with more health and social harms being attributed to alcohol misuse than to the drug, Ice, which has gained much media and political attention in recent times (Thorn, 2014). These findings reflect the data considered in Chapter Three that Victorians seek treatment for alcohol problems in greater numbers than for any other drug type (AIHW, 2012b).
While alcohol misuse appears to be acknowledged by those dealing directly with ex-prisoners and in the research exploring prevalence of AUDs and AODs, its lack of recognition in treatment programs is concerning. Several reasons were offered by interviewees to explain why alcohol misuse is such a significant problem for many releasees, including the legality and affordability of alcohol, together with its ready availability. As Participant 24 noted, “quite a substantial amount” of her clients drank alcohol problematically following release from prison and suggested “a myriad of factors contributes to that”. She claimed, “the fact that it’s legal … available so readily, and so socially acceptable, [are] factor[s] that plays into that” (Participant 24).

The ease with which alcohol can be accessed was suggested by Participant 2 to be a contributory factor as to why many of her clients resume problematic drinking after exiting prison:

> Well the biggest problem with alcohol is how easily accessible it is. So anyone can see a number of bottle shops anywhere between their house and the train station that they need to frequent, or it’s a social thing that people go to the pub to meet their friends, or whatever. So, if they’re firstly wanting to connect with other people or trying to get from their house to somewhere else, it’s in their face, so that’s a big issue. So people who have that issue, walking around is simply the first problem.

Participant 9 also spoke of the accessibility and affordability of alcohol:

> Sometimes guys will get an emergency payment getting out of prison so they’ve got a bit of cash and all you have to do is walk across the road to get your alcohol. This ready availability distinguishes alcohol from illicit drug use and is a key factor underpinning the prevalence of alcohol misuse in the immediate post-release period.
Alcohol – A Legal Substance

The legality of alcohol and its acceptance in social contexts diminishes both the perception and social acceptance of its potentially deleterious and criminogenic effects. This view was expressed strongly by two interviewees, both of whom identified the social acceptability of alcohol as making it difficult for some releasees to avoid drinking in a harmful or hazardous manner. Participant 19 explained:

Because of the legality [and] because of the socialisation and cultural acceptance of alcohol … that does make it a harder issue, or a different issue to deal with than illicit substances, particularly when you’re talking about people that have some sort of dependence or [regularly use alcohol]. The thing that people often talk about [and] … they find difficult, is the fact that it’s in their face. They go to a party and people are drinking. Or it’s a celebration, you go to a family dinner, you drink. It’s just – it’s a cultural thing; it’s part of what we [society] do.

The cultural acceptance of alcohol was similarly reflected in the comments of another support worker who argued that this view exists “not only for people trying to reduce their alcohol use, but people being brought up in this society, where they’re potentially going to have alcohol problems”. She went on to state this was “because they’re sort of brought up and socialised into a society where drinking to levels that are problematic, are not only accepted but … normalised and even promoted in a lot of ways” (Participant 33).

The acceptance of, and even the promotion of a drinking culture in Australia, is evident in the many alcohol marketing and advertising campaigns that associate the consumption of alcohol with “personal, social, sexual and business success” (Australian Drug Foundation, 2012). In Australia, sporting clubs and organisations are key recipients of alcohol sponsorship, and through this, alcohol companies can promote their brand on static and electronic signage, on sporting grounds, and logos on sporting uniforms (Australian National Preventative Health Agency, 2014, p. 33). Sponsorship of major sporting codes or
clubs also provides alcohol companies with the opportunity to widely advertise their products during live television broadcasts of major games. For example, a study by Jones, Barrie, Chapman, Corr, and Davoren (2013, p. 7) examining the amount and type of alcohol promotion during the live television broadcasts of the semi-finals and grand final of the Australian Football League (AFL) and the National Rugby League (NRL) in 2012, found the promotion of alcohol to be “ubiquitous” during the six games analysed. During the three NRL games, there was a total of 30 minutes and 40 seconds of alcohol promotion per match, totalling 18 per cent of the live broadcast. According to Jones et al. (2013, p. 7), during the AFL games, each match contained 20 minutes of alcohol marketing, equating to 17.7 per cent of broadcast time. The lucrative benefits of alcohol companies entering into sponsorship agreements with major sporting codes and teams cannot be overestimated particularly in terms of product exposure to vast audiences. However, associating alcohol with sporting prowess is contradictory by nature, as it shrouds the potential health harms associated with alcohol consumption within the positive image of sport and performance capability.

**Alcohol – Embedded in Australian Cultural Life**

Alcohol is a part of Australian cultural life and is the norm in many social interactions. A common view among the participants was that in Australian society, alcohol is part of “…Australian culture … and it is just normalised behaviour to sink one drink after another at a rapid rate” (Participant 18). In this way, the social and cultural acceptance of alcohol is seen as an endorsement of its use, despite the negative consequences it has for some individuals. This argument was strongly made by Participant 17, who claimed:

…”the thing is about alcohol, it is part of our culture, it’s embedded – we have a drinking culture here in Australia and I think that often anecdotally – so I can only speak anecdotally from what people tell me, but one of the things that
happens when you get – when you come out of prison, is that it’s like a big celebration time and people will tend to go to – even if they’re injecting drug user or – will tend to go towards alcohol thinking that’s a safer drug and it’s okay to go and get – to get really pissed, but that can obviously lead to mayhem. I think the problem is that – because it’s a legal drug people don’t perceive it as dangerous and that includes people who use other drugs and it’s okay – and because it’s socially okay to be – drunkenness is socially okay, then that’s – then for them, that’s okay as well. Sometimes I think when we’re looking at harm reduction stuff we need to be looking a lot with harm reduction with alcohol as well, not just with injecting drug use. That’s across the general population but with people coming out of prison I think that’s really important too. I have actually sat in some programs in prison and I haven’t really heard much about alcohol mentioned because it’s the legal one. I would think that in those settings you would be thinking about, well, your day out of prison what are you going to be doing? Are you going to be going to the pub? Are you going to be going to get [drugs] – but it’s more likely you’re going to commit a crime if you’re intoxicated as well. If you’re intoxicated you’re going to be picked up by the cops. Are you going to be okay getting picked up by the cops because of course once you’ve had a – you’ve got a criminal record you’re more likely to be pursued by the police. It’s all those sort of things and I think it’s – yeah, I just think it’s complicated.

As this quote suggests, the social and cultural acceptability of drunkenness, in conjunction with the legality of alcohol, places releasees with AUDs at risk of drinking to the point of intoxication. Consequently, they are more likely to reoffend while their inhibitions are lowered due to their inebriated state. The reference to in-prison programs largely ignoring alcohol, which is attributed to its legality, is important as it evidences the relative lack of focus on alcohol as a drug. It also points to the likelihood that in the immediate post-release period, the potential for celebration leading to inebriation may result in commencement or continuation of a cycle of alcohol abuse and offending.

**Drinking to Celebrate**

One of the key themes emerging from the data in relation to why post-release alcohol misuse or abuse is such a significant problem among releasees is the cultural tradition of drinking to celebrate certain milestones. Overwhelmingly, participants identified “celebrating release
from prison” as one of the main reasons why their clients returned to problematic drinking. One interviewee asserted that for some clients it occurs “on the first day” of release and drinking alcohol is something they have planned to do as a celebration when they get out of prison (Participant 4). Expanding on this view another support worker stated:

I guess they get encouraged, in a way, to somewhat celebrate because they’re out of prison. Of course, they’re out of prison, they’ve turned over a new leaf and hopefully starting a new life, but I think the celebrating aspect of it instantly in people’s minds is go and have a drink. That’s what you do when you’re celebrating, isn’t it? So a lot of them have the, I’m out now, I’ll go and party and have a drink, type of thing. I guess the only way to stop that would be education. I guess it’s an Australian sort of thing, though people seem to associate drinking with celebration. I don’t know if people really have the knowledge or skills or even would think that, well, if you’re not drinking then are you really celebrating? It seems to be an assumption that we have, and what the clients have as well, they want to celebrate being out, so that pretty much means they will be needing or wanting to drink. (Participant 5)

Another respondent identified alcohol as the first drug likely to be encountered and consumed by some released prisoners, “when they come out of prison that is normally the first drug they are given, because they’re celebrating the release” (Participant 29). The omnipresence of alcohol in social settings was also recognised as making it extremely difficult, if not impossible, for individuals who have an AUD to avoid it. As Participant 4 explained:

… for people who have issues with alcohol, [they] go to a family barbeque, people are drinking and Christmas time, people are drinking … I always found with alcohol and drugs that people are not going to be mulling up heroin at a barbeque but everyone will be drinking and it’s always advertised everywhere. So it’s always in people’s faces.

The impact of embedded drinking in celebration culture is problematic for some releasees who have a propensity to misuse alcohol, as it makes it difficult for them to avoid contact with alcohol in social settings. This will be all the more deleterious if they have not had access to appropriate treatment for alcohol-misuse in prison, which should incorporate
education and prevention strategies to cope with exposure to the availability of alcohol and assistance with drinking in moderation or abstaining.

**Drinking to Cope on the Outside**

In addition to drinking alcohol to celebrate release from prison, some releasees misuse alcohol to self-medicate, in order to temper what respondents often described as emotional pain. As one interviewee posited: “we’re talking about men who are mostly in a lot of emotional pain … they’re really traumatised, and alcohol helps medicate them” (Participant 3). Consistent with previous research (Binswanger et al., 2012; Department of Justice Victoria, 2012), some interviewees attributed their clients’ post-release alcohol misuse as a means of coping with the loneliness and social isolation that some experience following release. Participant 2 said following release her clients often have:

> Feelings of being alone and having nowhere to turn, so that then allows clients to have the opportunity to have an excuse of, oh, I’ve got nowhere to turn to, I’ll turn back to the bottle, so that’s quite a common thing.

A similar contention was offered regarding how the use of alcohol enables some individuals to socialise with others:

> … [for] people whose primary drug has been alcohol … it’s very difficult to have been in a system where there is no alcohol and to come out and have 24 hour bottle shops and gambling places that serve very cheap alcohol and to be socially isolated … The pub with the alcohol provides that. So that’s quite challenging for those people. (Participant 16)

While recognising some of the situational contexts that might lead to alcohol consumption, participants were also asked to provide examples of their clients’ post-release alcohol consumption patterns. One respondent suggested that for those who drink problematically it
will be “casks of wine, it will be beer, it will be mixed drinks” (Participant 3). The same respondent explained how one of her clients could list the amount of alcohol they consume on certain days:

I’ve got a client who tells me. I had four cans on this day, six cans on that day, and 27 on this one. I can’t remember what I did that night. I’ve lost everything. My wallet and my key pass and my Medicare card, all over again. I need keys. I can’t get into my flat. All over again. Over and over.

Another interviewee alluded to the culture of binge drinking that was common among post-release individuals. For those who engaged in binge drinking she contended that, “you’re talking four litre casks of wine and things like that a day” (Participant 21). This binge drinking behaviour was similarly identified by Participant 25, who explained:

They go back to drinking and try to drink as much as they were [before prison and] they end up spastic basically … One of the guys I saw this week, he’s got a severe mental illness [and] he started [drinking] from the moment he got out of prison … Two days later he can remember being helped around at home, people moving him because he was that drunk. It [led] to other drug use and [he] nearly overdosed. I think it’s … the culture, it’s everywhere, it’s on every corner street. We watch the footy; we go to a five year old’s birthday party and we take the Esky with us.

Participant 35 went onto state that this is even more problematic for releasees “if they haven’t had much treatment inside to talk about relapse prevention and controlled drinking strategies and all those sorts of things”.

Substituting Alcohol for Illicit Drugs

Being a legal substance, and widely available, also makes alcohol a viable option for released prisoners who would otherwise prefer to take illicit drugs but may not be able to easily access
their drug of choice. Interview participants suggested that alcohol misuse was a problem even among those who were primarily illicit drug users. As one support worker stated:

I guess it’s … the easiest option post release because it’s a legalised substance. And it’s usually associated with the celebration of, perhaps, getting out. I think, sometimes for lack of a better term … a client switches the witch for the bitch … Sometimes instead of using illicit substances they move on to alcohol because they might have conquered that area in their life and they’ve stopped using that, but then before you know it they’re drinking to replace the other substances. (Participant 5)

Participant 2 similarly observed that:

Clients who have a different substance use issue … they’ll turn to alcohol because of its accessibility. So if someone wants to use something else, hey, alcohol is here, I may as well use that in the meantime, before I can get my other stuff … it’s horrible.

These comments again demonstrate the link between ease of availability, Australian drinking and celebratory culture, and problematic/harmful alcohol use. This suggests that if problematic drinking patterns are to be addressed, Victoria needs to adopt a more collaborative government and community partnership during the immediate post-release period and where possible, during the serving of their sentences, to assist releasees to avoid resuming harmful or hazardous drinking patterns upon existing prison.

**Alcohol as a Component of Poly-Drug Use**

A key concern identified from the interview data was the role of alcohol as a component of poly-drug use, particularly in relation to prescription medications. As Participant 18 explained:

For me, alcohol is a primary concern, given that it is … a legal substance. However, the fact that alcohol leads to loss of inhibitions and can result in
poor choices … which, in turn, can result in [the] use of illicit substances. One thing leads to another. I have particularly seen alcohol is a huge problem when combined with Benzos. They have a few drinks and they think it is a good idea to pop a couple of Zannies, or whatever. And then they just completely – they lose it, and they will reoffend.

The problems associated with mixing alcohol and prescription drugs were further highlighted by Participant 15 who suggested:

[They go] hand in hand, the alcohol and the Benzos … the Valium, and the Xanax. It just seems to be such a lovely relationship, because that’s just the way it is. Because the Benzos, and especially the Valium, will enhance the effects of alcohol and put them in that space, that headspace where they feel calm and relaxed.

Asking how their clients were able to obtain such a variety of prescription medications, the same participant responded:

They’re supplied on the street. There’s a huge market out there for it, huge. They only pay $5.90 for a packet of Valium 30s, but I could sell them for $15 each, depending on the street.

The adverse effects of mixing prescription drugs and alcohol were further highlighted by Participant 15 in the following example:

So I think it’s like a ratio for every – it’s like a 1:6; for every Valium tablet [taken, with] one glass of alcohol … it’s six times the effect for a longer period of time. That’s why you see them with their eyes all droopy and their lip droopy, and they’re just walking around, shuffling along, trying to maintain their balance, because of that. It’s very popular.

The preceding comments highlight the pervasive role of alcohol when mixed with prescription medications. Mixing the two substances can lead to amplification of the effects of alcohol and increasing level of intoxication, which may also result in a loss of inhibitions precipitating reoffending.
Health and Social Harms

During discussions surrounding the poly-drug use of some clients, several respondents referred to the health and social harms their clients experienced as a result of their problematic drinking. As one interview participant asserted: “they end up getting quite ill from how much they drink” (Participant 8). Others identified the serious physical injuries and even deaths that occurred and attributed [them] directly to their clients’ abuse of alcohol. In one case, Participant 12 spoke of the death of a client that resulted from bouts of heavy drinking, where the client “asphyxiated – they’ve died on their vomit”.

A further example of how alcohol misuse can have fatal consequences was given by Participant 15 who said:

… We had an overdose death last week. Overdose alcohol and Heroin. He was one of my clients. He overdosed on Wednesday. Took him to hospital. He was a former Heroin user. He injected Heroin and was drunk at the time and his heart stopped. He must have … stopped getting oxygen to his brain and they don’t know for how long … They put him on a life support machine … He was 29.

Other clients were purported to have suffered serious “head injuries” after “falling over, [and] getting hit by cars” while intoxicated. Further to physical injuries, some interviewees spoke of clients who developed “liver damage” resulting from of long-term alcohol misuse; while others noted the number of their clients who had an Acquired Brain Injury (ABI) caused by sustained alcohol abuse or, stemming from being involved in acts of violence while intoxicated. Despite these examples of the serious physical and health harms associated with alcohol misuse, it was suggested that alcohol misuse was being overlooked by policy makers and the prison system as a serious health issue. As Participant 1 explained, “they’re obviously not treating alcohol issues as a health problem, that’s a huge problem, I mean, that’s bigger picture stuff”.
The serious health harms and fatalities, attributed to post-release alcohol misuse in these examples reflect existing international research that aligns prolonged alcohol misuse or abuse with serious health harms (Crombie et al., 2007; Room, 1996; WHO, 2002b, 2004), and death (WHO, 2011). The detrimental impact that alcohol misuse has on some post-release individuals suggests that they may be exiting prison without having been rigorously assessed for their risk of resuming drinking at harmful or hazardous levels, or without the knowledge of how to access support or treatment services in the community. It is, therefore, vital that pre-release processes are implemented to ensure prisoners are accurately screened for AUDs prior to release and, if necessary, individuals are linked in with primary healthcare or treatment professionals in order to minimise their risk of health harms.

Reoffending and Re-incarceration

Drawing on the work of scholars (Dingwall, 2006; Engineer et al., 2003; Forsyth, 2006; Kramer et al., 2009; McMurran, 1996, 2005; Sweeney & Payne, 2011; WHO, 2002a) who suggest a link exists between alcohol and crime, this study seeks to explore the nexus between post-release alcohol misuse, reoffending and re-incarceration. To explore this issue, interview participants were asked if they could provide examples of any current or former clients who had reoffended and subsequently been re-incarcerated as a direct result of their alcohol misuse. Respondents readily provided examples of cases where their clients had reoffended and/or been re-incarcerated following episodes of drinking. Offences committed among the interviewees’ client groups ranged from “driving under the influence” (DUI), to being “drunk and disorderly”, to engaging in acts of “alcohol fuelled violence”, “sexual assault”, “family violence”, “stalking” and “theft”. In several instances, the commission of
these offences resulted in re-incarceration. In discussing alcohol and re-offending, one interviewee maintained:

I’ve got clients who are at risk of being locked up every month because of their alcoholism and their ABI caused by alcohol, because they’re constantly in the city being disruptive, drunk and disorderly. (Participant 5)

Others discussed how clients being “drunk and disorderly” in public was a common occurrence. Examples of this behaviour included public disorder offences:

… like urinating in public, cursing at the general public, that kind of stuff. They get arrested by the police and then it’s a breach of the bail and then they go back in. (Participant 9)

Some interviewees spoke of the more serious nature of offending behaviours that their clients engaged in. One interviewee described a sexual assault committed by one of her clients when he was drunk: “[He] was drunk [on public transport], and sexually assaulted a young girl while pressing her against the wall of the [carriage]” (Participant 2). Participant 27 offered a further example of a link between serious sexual offending and alcohol misuse: “I do have one person at the moment who’s a sex offender, and his offences are related to alcohol”.

Several interviewees mentioned the role of alcohol misuse or abuse in the commission of other serious offences, particularly acts of violence. In fact, a strong theme of offending behaviour that emerged from the interview narratives was that of alcohol fuelled violence. As one respondent commented:

When they’re using alcohol … the violence comes along with that … they go to the pub and have a few drinks and then someone [looks] at [them] differently and [they] get into an altercation … That’s the scenario I’ve heard many times before. (Participant 5)
One interviewee spoke of a current client who was often taken into custody for several hours or over the weekend for alcohol fuelled violence. She explained that when he was drinking he was unable to control his aggressive behaviour and on one occasion he “assaulted the police when they came to arrest him”. She said that after “a couple of drinks … he would just turn into this horrible aggressive person … all of his custodial sentences were for violent offences he committed whilst intoxicated” (Participant 6).

Continuing the theme of the alcohol fuelled violence, respondents linked alcohol misuse with incidents of “family violence” and “stalking”. The following examples were offered by a forensic counsellor in a Regional Victorian centre:

I’ve been seeing recently a lot of men who have been going to prison for breaches of intervention orders, and so family violence is landing them in jail, and of course behind the family violence is alcohol … they reoffend because they’ll get a skin-full again and it happens again. But the next offence may not be breach of an intervention order or assault; it may be stalking, because once they’ve got a skin-full they start sending text messages. (Participant 25)

The preceding discussion highlights the role played by alcohol in the commission of various offences leading to social harms, reoffending and reincarceration. However, as Flynn et al. (2016) argue, a myopic focus on the effects of alcohol in relation to offending oversimplifies and ignores the complex interaction of a number of social and cultural factors which can combine to produce offending behaviours.

Conclusion

This chapter has mapped the landscape of problems associated with post-release alcohol misuse and in doing so has revealed that alcohol misuse is a significant problem for some individuals while transitioning from prison to the wider community. This chapter thus fills a gap in existing literature by shedding light on post-release alcohol misuse in its own right, as
opposed to it being subsumed under the term substance misuse or AODs. This is a significant finding as this study is the first in Victoria to qualitatively examine post-release alcohol misuse independent of other drug types. For many ex-prisoners with AUDs, the considerable problems associated with post-release alcohol misuse stem, in part, from the fact that alcohol is a legal substance and, therefore, readily available and easily accessible. This, together with its social and cultural acceptability, makes it often an irresistible option for releasees with AUDs, and even for some individuals whose preference is for illicit drugs. The ease with which alcohol can be obtained often results in releasees drinking to celebrate release from prison or as a way of coping with the stressors of dealing with life outside the prison walls. Also of concern is the ready availability of prescription drugs, which when taken with alcohol “amplifies the effects of alcohol” and, while this type of poly-drug use may produce feelings of being “calm and relaxed”, this type of intoxication may lead to a loss of inhibitions resulting in reoffending.

The data clearly demonstrates that, for some, alcohol misuse is linked to a range serious of offending behaviours including sexual assaults, serious acts of violence and, in some cases, leads to the death of the victim. The findings in this chapter are important as they fill gaps in existing literature by focusing on the numerous harms associated with post-release alcohol misuse and the negative consequences they can have on individuals and wider society. If the harms associated with post-release alcohol misuse are to be reduced, serious consideration must be given by policy makers, correctional authorities and academics to maintaining the focus on post-release alcohol misuse as a topic in its own right, rather than continuing to conflate alcohol with illicit drugs in research and policy documents.

The next chapter advances the discussion of post-release alcohol misuse by mapping the landscape of the needs of releasees with AUDs.
Chapter Six

Mapping the Landscape - Post-Release Non-Treatment Needs

The previous chapter presented the problems that post-release alcohol misuse poses for many ex-prisoners in the transitional period. This chapter expands on that discussion by mapping the landscape of the non-treatment needs and supports required by many individuals exiting Victorian prisons with Alcohol Use Disorders (AUDs). It is widely acknowledged that releasees face many challenges and have multiple needs that will often require assistance from post-release support workers to ease the transition process. However, what is unclear is whether and to what extent post-release alcohol misuse impacts on individuals receiving adequate support services to address their post-release needs. This is a gap in the literature that this chapter aims to fill by drawing on the professional perspectives of Non-Government Organisation (NGO) support workers to examine the range of needs and non-treatment support services available to releasees with AUDs.

The chapter commences with a discussion of the immediate and basic needs that releasees have after exiting prison together with needs associated with reuniting with family and having their physical and mental health needs met. The range of non-treatment transitional support services provided by NGOs will also be discussed, together with the extent to which these services are available and accessible to transitioning prisoners with an AUD.

As discussed in Chapter Two, it is widely acknowledged that many ex-prisoners have great difficulty in sourcing suitable and stable housing. The chapter provides an in-depth discussion of the types of housing options available to releasees with AUDs and the limited and largely unsatisfactory accommodation options available to them. This is a significant discussion as previous studies have neglected to examine the role of post-release alcohol
misuse and if, or how, it limits transitioning prisoners from obtaining safe and secure housing.

**Post-Release Challenges and Needs**

Prior research has widely explored and documented the challenges, difficulties and needs that ex-prisoners experience as they transition from prison to life in the wider community (Baldry, 2007; Baldry et al., 2004, 2006; Borzycki, 2005; Borzycki & Baldry, 2003; No Bars, 2011a; Ogilvie, 2001; Visher & Travis, 2003). The needs of transitioning prisoners are multi-faceted and complex, and many require assistance with a variety of challenges they confront after exiting prison. These include: addressing their immediate and basic needs, linking them in with health care providers and services, and assistance with finding employment or accessing skills development programs to enhance their prospects of securing a job. Finding stable and secure accommodation poses great difficulties for many releasees and they frequently need the assistance of a support worker to find suitable accommodation or to advocate on their behalf in applying for public housing. For transitioning prisoners with an AUD, often the most urgent need will be to access professional treatment and support for their alcohol problems. This topic will be discussed in depth in the next chapter. It should be noted, that during all interviews, the participants were asked to consider the questions focusing specifically on their current or former clients whose sole or primary substance misuse problem related to problematic alcohol consumption as opposed to illicit drug use.

**Immediate Needs**

Scholars maintain that transitional support services should commence at the moment of release to assist and support exiting prisoners with some of the challenges they may face in
adjusting to life outside the structured and controlled environment of prison (Rosenfeld et al., 2008; Travis et al., 2001). During the interviews, it became clear that it is not unusual for prisoners to walk through the prison gates and have no-one to meet them to provide transportation to their accommodation. Meeting a new releasee at the moment of release was described by Participant 1 as one of the “most rewarding” aspects of her job:

Most men will come out of prison with a plastic bag, not many belongings in it, walk out the front gates, there’s no-one to greet them, they have to wait for a bus in the middle of nowhere … It must be a really hard, awful experience. … I think it’s a privilege to spend the first day out of prison with someone … We usually take them to accommodation, make sure they’re settled in … [it’s] really important for someone to be contactable … so we’ll go and get them a mobile phone.

The importance of meeting individuals on release was similarly identified by Participant 14:

Probably the most productive thing that you can actually provide someone is that practical support in picking them up … I honestly believe that … knowing … there is someone there to say, you actually matter, you matter, we’re here, we’ll take you to your accommodation, we’ll get you some food, we’ll go and get your medication … we’ll give you a list of some … AA meetings. I just think that’s priceless. That can set someone up on the right course.

In addition to meeting exiting prisoners, and providing transportation on the day of release, support workers also identified a range of immediate and basic needs that must be addressed. One common example provided was the absence of personal identification. Respondents commented that they are frequently asked by clients how to obtain a “copy of their birth certificate” (Participant 4) and how to “get their Centrelink set up” to enable their unemployment benefits or pension payments to be processed (Participant 7). The participants also identified that many releasees seek information on how to purchase and use a “Myki
Card” in order to navigate Victoria’s public transport system. Interviewees were also frequently asked to explain to their clients “how the internet works” as they were often told by government agencies “to lodge things or print forms off online” (Participant 7). Information and assistance with rudimentary tasks such as “what to buy at the supermarket” and how to “manage their money” were also common requests (Participant 3). Although completing such simple tasks is a straightforward exercise for most people, these quotes suggest that many transitioning prisoners are ill-prepared and ill-equipped to undertake even the most basic of tasks.

**Basic Needs**

Participant 1 raised the importance of individuals attending to their “basic life needs” after release from prison:

… A mantra I use with my clients is that in those first few weeks … you’ve got to take it day by day, you’ve got to meet those basic needs … if you’re on parole … your priority is to get to all your appointments, to abide by all your conditions, to have a roof over your head and to have somewhere to sleep.

However, encouraging clients to focus on their basic needs in the days and weeks following release is problematic, as ex-prisoners often lack the organisational skills needed to accomplish seemingly simple tasks. As one interviewee stated, “just being organised to meet … their post-release appointments” poses difficulties for some clients, as “a lot of them don’t know how to be organised. They wouldn’t think to buy a diary to jot it all down” (Participant 7).

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20 Myki is a reusable smart card that permits travel on Melbourne’s trains, trams and buses, V/Line commuter train services and buses in Seymour, Ballarat, Bendigo, Geelong, the Latrobe Valley and Warragul (Public Transport Victoria, 2015).
The same support worker asserted that helping her clients to develop basic life skills was one of the most difficult tasks associated with her job. She remarked, “if they’ve been in prison for a long time [and] had not developed basic life skills prior to being incarcerated … it’s a gap in their needs … I can’t seem to fill as a case worker” (Participant 7). She suggested that that “life skills workshops” need to be developed and made widely available to ex-prisoners to fill the “gap” that exists in post-release services. This echoes the findings of prior research that suggests ex-prisoner populations in Western jurisdictions often lack basic life skills required to live independently, for example, cooking and cleaning; effective management of their time in order to keep appointments, for example, with Corrections or NGO professionals; and as a group, they often lack interpersonal skills that will be required to effectively engage with government agencies, service providers and members of the general community (Borzycki, 2005; Borzycki & Baldry, 2003; Social Exclusion Unit, 2002; Travis et al., 2001; Visher et al., 2004).

Providing support and assistance to ex-prisoners in the hours, days and weeks following release from prison echoes the research of scholars who argue that post-release support should commence from release (Rosenfeld et al., 2008; Travis et al., 2001). Furthermore, contemporary research asserts that without the provision of support in the hours, days and weeks following release from prison, individuals are at a heightened risk for reoffending, rearrest and returning to prison (National Research Council, 2008, p. 52; Rosenfeld et al., 2008; Travis et al., 2001). This is demonstrated in the recommendations of the National Research Council’s (2008, p. 82) study, which notes that if a desistance lifestyle is to be encouraged, it is vital that “major support” is available to prisoners at the time of release. While providing support at the time of release is a common view, previous studies argue that planning for release prisoners should commence at the time they enter the prison
system and continue during the prison term, extending to the post-release period through a model of service delivery, known as “through-care” (Baldry, 2007; Borzycki, 2005; Borzycki & Baldry, 2003).

**Through-Care**

Existing research argues that effective pre-release planning is required to equip prisoners with the skills needed to address some of the difficulties they may face after exiting prison (National Research Council, 2008), which in turn can increase prisoners’ prospects of successfully transitioning from prison to the community. Borzycki and Baldry (2003, p. 2) suggest that preparation for release is most effective when the principles of Through-care are diligently applied. A model of Through-care advocates for continuity of support and treatment for prisoners that commences in the custodial setting, continues during the period of incarceration, and extends into the post-release environment. The post-release component of Through-care is important as it enables individuals to build on any rehabilitative achievements they may have accomplished while in prison (Baldry et al., 2003; Borzycki, 2005). For example, during their time in prison, individuals are likely to experience “improvements in their physical and/or mental health” (AIHW, 2014b, p. 1). This conforms to the broader literature that suggests time spent in prison is a “potential window of opportunity” for an improvement in health status (Rogers & Pilgrim, 2014, p. 148). Therefore, it is vital that pre-release planning includes linking prisoners in with primary health care services post-release to ensure continuity of medical care.

Corrections Victoria also acknowledges the importance of planning for a prisoner’s release. As previously discussed in Chapter Three, the Transitional Assistance Program (TAP) is “offered to all sentenced prisoners who are nearing the end of their sentence”. The
TAP “involves an assessment of the individuals’ transitional needs followed by a series of targeted referrals and information sessions and referrals to assist with these needs” (Department of Justice Victoria, 2013). However, during the interviews, when the topic of pre-release planning was raised, support workers indicated that they saw little evidence of effective pre-release planning in Victorian prisons. Participant 22 described the pre-release assessment process she had witnessed as nothing more than a “tick and flick” exercise, as opposed to a thorough individualised assessment of prisoners’ post-release needs. She said she had seen “assessors who have just ticked the boxes. No talking about different things. I’ve seen assessors go in and go … male, female, drink, yes, no, tick, tick”. Similarly, another interviewee described her experience of pre-release planning as a “tick and flick” exercise. She said: “I’m not a tick and flicker”, and argued that:

There needs to be something put in place … I was seeing guys that hadn’t been seen for months. Their release dates were up three, four months ago. People just didn’t have the time or capacity to see them. No wonder they’re aggressive when they come out. So would I if I’d done my time and still was in there three months later. (Participant 8)

The same respondent was particularly critical of the lack of pre-release preparation provided to her clients and claimed that inadequate pre-release planning is “setting [her clients] up to fail” (Participant 8). She said the “unfortunate thing is they [her clients] don’t come out fully armed” with even the basic skills or knowledge to adjust to life outside prison. She was critical of the process and ineffectiveness of pre-release planning and support provided in prisons:

A lot of the times they’re not even allocated a case worker straight away, or they will come out of prison and say I don’t know, I’ve got a Link Out worker, but I haven’t met him yet. My biggest gripe with the system is I’ve had a lot of guys that lived in [Melbourne’s South-East before they went to prison] and following release they now live [in one of Melbourne’s inner suburbs]. They’re expected to attend their Corrections appointments … and their drug
and alcohol consult in [a South-Eastern suburb]. I said, one, where do they get the money from [to get to the South-East] and two, you’re setting them up to fail. The system is setting them up to fail. Organise this before they come out, organise something within the area [where they live]. I’m constantly ringing up [Corrections] saying, ‘Hey, you’re setting these guys up to fail; you’re just going to say they’re not attending appointments. They can’t attend appointments, they’ve got no money, they don’t know how to get there, why should they have to travel two hours in one direction to attend a nine o’clock appointment?’ I believe the system is setting them up to fail.

It is clear from these concerns that more consideration needs to be given to the arrangements made for their post-release commitments to enable them to comply more readily with Corrections requirements. As evident in Participant 8’s example, a person’s inability to travel across town to attend appointments is essentially “setting them up to fail” by creating financial and logistical barriers that they might struggle to overcome in the post-release period. This mirrors Halsey’s (2010) assertion that parole compliance conditions, even those that are less stringent, can result in parolees’ failure to comply, as they have not been required to exercise the same degree of personal agency over their actions while incarcerated. Halsey (2008, p. 243) argues that:

To expect people whose lives have been characterised by the structural inability to assume responsibility for non-trivial relationships and events for extended periods to suddenly turn this situation on its head overnight because they are now formally ‘free’ to do so, surely rates as one of the most bizarre and unrealistic social experiments in penal practice.

Participants also observed the challenges relating to pre-release planning, including the unavailability of “a private space” in the prison setting for support workers to meet with their clients to identify and discuss their post-release needs. Participant 1 explained:

… providing a service like mine [is difficult] within the prison system. [Prisons] work in a very different framework to what we do and we’re constantly facing barriers. Access to our clients, something as simple as that, having a private space within the prison to meet with them and to go through
these sometimes very personal issues with someone … puts [clients] at a great risk [because] if I’m going out to see them and it’s perceived that they’re getting special treatment … it puts them at a huge amount of risk … It’s an ongoing issue.

It is important to note that although several respondents were critical of the absence of appropriate pre-release planning available to their clients, these are the opinions of only a small number of support workers and, therefore, caution should be exercised in generalising these findings to the wider support worker network. Having said this, the support workers’ criticisms of the lack of appropriate pre-release planning for their clients reflects the findings of the recently published discussion paper by the Victorian Ombudsman, who was tasked with investigating the rehabilitation and transitional services for prisoners in Victoria (Victorian Ombudsman, 2014). The investigation was prompted by the rise in Victoria’s prisoner population, concerns regarding the high rate of recidivism and the cost of both these factors to the Victorian community (Victorian Ombudsman, 2014). The investigation found that due to the rapid increase in prisoner numbers there was a “backlog in assessment [which] affected the availability of programs and support both before and after release” (Victorian Ombudsman, 2014, p. 2).

**Physical and Mental Health Needs**

The absence of comprehensive and individualised plans to address prisoners’ post-release needs may negatively impact not only their efforts to settle into the wider community, but may be detrimental to their health and well-being by neglecting to link them with vital post-release health-care services to address their physical and mental health needs. Research suggests that releasees are more likely to experience difficulties settling into the community after exiting prison if they have health related problems (Visher & Malik-Kane, 2007). Prior
research notes that transitioning prisoners have higher rates of physical and mental health problems than the general population (Borzycki, 2005; Borzycki & Baldry, 2003; Corrections Victoria, 2008; Petersilia, 2003; Travis et al., 2001), including high rates of co-occurring disorders\(^{21}\). It is therefore likely that some individuals will need to access primary health care services shortly after exiting prison. For transitioning prisoners with alcohol problems, access to a General Medical Practitioner (GP) and/or a Mental Health professional may be crucial in order to sustain any health gains acquired in prison while abstaining from alcohol, and to prevent any further health harms from developing. As discussed in Chapter Two, the delivery of appropriate post-release support may serve as a “treatable moment” for those at risk of resuming harmful drinking habits (McSweeney et al., 2009). Respondents suggested that their clients often needed urgent access to primary health care services after release to continue and maintain any health benefits they gained from prison health services. However, as one support worker stated, “it can take time for them to get connected up with different services, [especially] if they are new to the area” (Participant 2). Therefore, it is critical that these ex-prisoners are connected with appropriate community-based medical service providers prior to release.

**Post-Release Health Care**

It is acknowledged that a strong correlation exists between imprisonment and poor health with prisoners requiring primary health care services at a higher rate than the general population (Borzycki, 2005; Petersilia, 2003; Travis et al., 2001). As a group, prisoners have been shown to have high levels of physical and mental health needs, communicable diseases, alcohol and illicit drug misuse and poor dental health (Borzycki, 2005). While a period of

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\(^{21}\) Co-occurring disorders are defined as “both a substance use disorder and a co-occurring mental health Disorder” (The National Centre on Addiction and Substance Abuse, 2010).
incarceration can present the opportunity to address some of a prisoner’s health issues, on release, they will require linking in with community-based health services to maintain any health benefits they gained while in prison. However, participants indicated that individuals with health needs are often released from prison without information as to where they can access primary health care services. This is problematic for releasees who resume drinking at harmful or hazardous levels, as they may be at a heightened risk of having alcohol-related seizures and will therefore require urgent medical attention. Participant 2 explains:

[For those who’ve] got a massive issue with [alcohol], you can’t not have it; otherwise you can have seizures and all the rest of it. So, it’s like saying: ‘Well, have a little bit, but not heaps, even though you’ve got an issue with it, so then you can get these things addressed’ – it’s such a fine balance that these people, who[se] lives have been turned upside down, how are they supposed to address them? Whereas with things like Heroin, you can get put on Methadone, you can walk into a clinic and have all your support needs addressed, whereas if you smell like alcohol, if you are stumbling, any of these sorts of things, all of our clients tick all those boxes, they’ll say, ‘Hey, look, get out of here; come back when you haven’t been drinking,’ but if you haven’t been drinking, you’re too busy having a seizure and the ambulance has been called, so it’s a Catch 22.

Releasees who cannot return to live with family or friends often find themselves living in an area that is unfamiliar to them. This in itself presents a barrier to accessing primary health care services:

If they’re new to an area, they might not know what’s around and how to get linked into things, referrals from places, from their GP; do they have a GP yet? Probably not. (Participant 2)

Continuing the theme of accessing post-release primary health care, one respondent explained that if they are living in an unfamiliar area they are often reluctant to go and see a GP, even though that is the first step required in order to in access specialised health services:
[If they have] come to a completely new area, they don’t want to go to a GP. There are services out there but they haven’t got a clue. Getting an appointment to see a psychologist or a counsellor requires you first to go to a GP and that’s a double appointment to get a few counselling sessions for free. You have to actually get a mental health plan to be able to access [a mental health professional]. So they need a joint appointment, they need a Medicare card. Quite often they don’t have a Medicare card; they’ve misplaced it, or never had one. All sorts of issues. How do they get there? They don’t want to be sitting around because they’re quite paranoid after coming out. They think they’re labelled with a prisoner on their head. They won’t sit in a waiting room for three hours and then sit at a double appointment to have an assessment done. Most of them will go and seek some sort of medication, buy some pills off the street to buy themselves some time if they don’t want a drink. So they’re just replacing that with the alcohol, it’s replacing one [substance] with another. (Participant 8)

This suggests that some prisoners are being released from prison without a comprehensive pre-release plan that includes linking them in with primary health services. This was confirmed by Participant 8, who stated: “Nine out of ten [ex-prisoners I see] wouldn’t have seen a GP”.

Sourcing a GP is therefore the first health care task releasees often need to undertake, as they are the base for individuals to obtain referrals to specialised practitioners such as mental health services. The importance of obtaining the services of a “good GP” was similarly identified by Participant 5:

If a client’s got a good GP then the GP can then refer to psychological services if they need, or get mental health reviews done, all those sorts of things.

In relation to those releasees who have resumed drinking at harmful or hazardous levels, finding a GP takes on a particular urgency, as one interviewee maintained:

Alcohol has a terrible impact on your health, on your brain, on your nervous system and on all your organs. It’s detrimental, really detrimental, to [your health]. (Participant 17)
However, finding a GP is not straightforward as it may appear. For example, in describing one Melbourne Metropolitan suburb where ex-prisoners regularly source cheap accommodation, Participant 11 noted that the local GPs do not provide a flexible approach to accommodate releasees’ needs, for example, bulk-billing. She explained:

We have a number of GP services around [here] who say, ‘No’, they don’t do bulk billing or anything like that because they don’t want our client group.

Even if an ex-prisoner finds a GP, to obtain a referral to a specialised service such as a mental health professional, creates another set of challenges. It is widely acknowledged that as a group, prisoners have high rates of mental illness and co-occurring disorders (Corrections Victoria, 2008). These disorders are (understandably) also prevalent among the ex-prisoner population, as one interviewee explained:

Mental health is another story. I would say nearly all of our clients have some kind of either self-reported or diagnosed mental health issues like depression or anxiety … [or] schizophrenia. (Participant 20)

Another interviewee claimed that mental illness was a “real big issue” among his client cohort:

I have a client [who] since the age of 16 [has been] on treatment orders through alcohol and drug abuse. Was released from a psych ward … and he was starting to hear voices and things were getting bad for him. I’m trying to link him in with the mental health service that we have to go through on this side of town and they wouldn’t have anything to do with him until he lost it. That just seems to be the way it is that he had to have a psychiatric episode for them to pick him up. But things got that bad … and he was eventually taken to hospital and they finally picked him up. (Participant 4)
The same respondent attributed the difficulty some of his clients have in accessing timely mental health care to the protracted mental-health assessment process which stops short of actually providing treatment:

"Often we go through ... [the] PATH Primary Mental Health Team but that will only be an assessment and recommendations. So it’s left up to you [the support worker or forensic counsellor] to try and ... link them in with some type of mental health service. It takes time. (Participant 4)"

Acquired Brain Injuries (ABIs) were also common problems experienced by the respondents’ clients, although not all had a received a clinical diagnosis as one participant explained:

"They [clients] don’t necessarily have to be diagnosed with an ABI, but through the assessment process, there are, indicators that come out whether there is a chance they may have an ABI, such as having used alcohol for 10 or plus years on a daily basis; that’s certainly a huge ABI risk indicator. (Participant 1)"

This issue was raised by another interviewee who described the alcohol misuse and mental health nexus as follows:

"It’s the whole chicken and the egg thing about mental health. [Has] drinking or using substances brought on the mental health [problems], or have they been using these [substances] to hide or eclipse the fact that they’ve got a mental illness that’s never been picked up? (Participant 9)"

These quotes suggest that physical and mental health needs are common among ex-prisoners with AUDs. Although access to adequate health care services may be available in the prison setting, this research demonstrates that prisoners in Victoria are exiting prison without being provided with the contact information of primary health-care providers in the area in which they plan to live. This is concerning as prior research strongly suggests that releasees with
untreated medical conditions are likely to find the transitional experience more difficult than those without health-related concerns (Visher & Malik-Kane, 2007).

**Family and Employment**

As noted in Chapter Two, employment and having strong ties to family are two key factors suggested to enhance the likelihood of successful community integration and desistance from crime. However, in the course of conducting the interviews, it became apparent that the issues of employment and family reunification were largely absent during discussions of the post-release needs. From the point at which I identified the absence of these issues in the discussions, the remaining interviewees were asked how important they considered employment and family reunification to be in fostering a successful transition from prison.

Participant 12 acknowledged the importance of family support for releasees, stating that:

... I think family is incredibly important for all of us [that sense of] being connected ... but a lot of the guys we work with are not very connected to family.

The same interviewee suggested that some clients had tenuous relationships with their family and received only “conditional support”. He explained:

Some guys … have got conditional family support, which is families having some boundaries [as] over the years and years [they have experienced] a lot of drama [relating to offending behaviours]. (Participant 12)

Although scholars suggest that a supportive family is an important element in promoting a smooth transition from prison and promoting a desistance lifestyle (Farrall, 2004; Sampson & Laub, 1993), Participant 1 summed up the general opinion of respondents indicating that most of their clients “very rarely” had family support.
Several reasons were provided as possible explanations for why most clients were disconnected from their families. Participant 3 spoke of one client whose family had “cut him off after dealing with matters that had gone on for a number of years”. Another interviewee cited alcohol misuse as the reason why several of her clients had no post-release family support. She said, “their alcohol intake or alcoholism [caused] their relationship bust-up … they burnt all their bridges” (Participant 17). Another stated that:

Guys just don’t have families, so whether they’ve been wards of the state, [or their] families are living in other areas of Australia … you get guys who do a geographic … [they] come to Victoria, get locked up, get released … [They’ve] got nothing. (Participant 12)

Linked to an absence of family support, post-release employment needs were similarly absent from the narratives of the participants. When asked about the importance of ex-prisoners gaining employment, Participant 19 argued that:

I personally think it is one of the biggest issues … [Employment] is one of the best ways to help people start dealing with not only alcohol or drug use, but other issues going on in their lives. It’s absolutely essential.

Participant 19 went on to claim that when talking with clients about their future goals, “it [employment] is one of the big goals” frequently mentioned. However, he also spoke of the difficulties ex-prisoners have in finding employment due to the lack of skills or an employment history. He said, “people that come out of prison have [a history of] unemployment … that often continues for long periods of time”. Participant 8 also suggested that the stigma associated with having a criminal record prevented some ex-prisoners from seeking employment:

Nearly all jobs these days ask for a Working with Children check or police check. Some things you can get away with depending on what the crime was,
but it’s really limiting their field. The only ones [ex-prisoners] that seem to really get anywhere are the ones that can [work for themselves] … so they’re not required to get a police check.

The only other source of employment for those with a criminal record involves basic manual labour or work in a processing plant. One interviewee in a Victorian Regional centre explained that some of her clients had secured work in a food-processing factory as these industries “will employ people with a criminal history” (Participant 25). However, she stated, “its God-awful work, but that’s how they [the factory owners] get employees”.

Although gaining post-release employment was considered an important factor in initiating a desistance trajectory and community integration, support workers explained that during the first few months following release, their clients are usually so busy attending appointments to fulfil their parole requirements (Participant 27), or had more urgent needs to attend to such as finding suitable housing accommodation, that seeking employment was “so far down the track on their list of priorities that they wouldn’t even … be thinking about it” (Participant 2). This is problematic because as noted in Chapter Two, having stable and meaningful employment is considered a major influence in the attainment of a desistance lifestyle on the basis that these factors operate as informal social controls (Hirschi, 1969; Laub & Sampson, 2001, 2003; Sampson & Laub, 1993; Shover, 1996). In addition, Farrall (2002) asserts that a desistance pathway may be triggered by structural turning points suggesting that the acquisition of something meaningful such as employment or a stable marriage generates a subjective re-assessment of their offending behaviour.

**Housing/Accommodation**

After exiting prison, all individuals need a place to live. If a comprehensive exit plan has not been undertaken (including a person’s accommodation needs), any attempt to integrate into
community life is likely to be challenging. Obtaining safe and secure housing is identified in the literature as one of the most difficult challenges faced by ex-prisoners and one of the most difficult needs to fulfil (Baldry, 2009; Baldry et al., 2006; Borzycki & Baldry, 2003; Social Exclusion Unit, 2002; Visher et al., 2004). In line with existing scholarly research, interviewees argued that finding appropriate post-release housing for their clients was a major challenge, primarily due to the shortage of public housing stock across the state and the scarcity of other forms of “safe” accommodation. Finding safe and secure housing was rated by several respondents as the most important, yet the most difficult, issue facing newly released prisoners. It is important to note that research suggests those exiting prison with an unresolved drug or alcohol problem more often require assistance with finding housing/accommodation than those without a substance misuse problem (Williams et al., 2012). The difficulty in finding suitable accommodation for releasees with an AUD was noted by one support worker who spoke of a client she had worked with for two years. She stated:

I have worked with one client solidly for two years. Moved him about 15 times [during that] period. He’s now living in a motel in [the Western suburbs], unable to move into any kind of supported residential services as he’s been, pretty much, blacklisted. Because when he drinks, he’s abusive. He’s verbally and physically abusive and no one wants to take him. (Participant 5)

In this case, it is also the client’s ongoing alcohol abuse and anti-social behaviour when intoxicated that precludes his ability to obtain a more suitable form of accommodation. The participant further explained: “from my experience, without that, the housing is not going to work, the family relationships will break down. Everything … generally falls by the wayside if there’s nothing in place to address the alcohol issues”. Participant 17 similarly noted that
finding suitable housing for her clients was one of the most important, yet most difficult tasks to accomplish for her clients:

The first problem is housing … that’s the biggest thing … but there isn’t any housing … it’s really hard to get housing … If you’re coming out of an institution and you have not got a place to go then that must be … absolutely terrifying … especially if you’ve been institutionalised for a while and you’ve had everything done for you, you’ve been fed, dressed, your routine has been dictated and to come out and to be unsure where you’re going to be sleeping, or sleeping in hotels or some sort of crisis accommodation … I think that’s really tough.

In addition, Participant 1 claimed the uncertainty surrounding where individuals are going to live after exiting prison is “[w]ithout a doubt … the biggest source of anxiety and stress for anyone exiting prison”. This speaks to Halsey’s (2007) contention that even minor delays in finding post-release housing can be extremely stressful for releasees.

Public Housing

Prior to release, many prisoners believe they will be able to apply for, and obtain, public housing that would be “their housing for life” (Participant 5). However, applications for public housing cannot be lodged while a person is in prison. As Participant 9 explained, “prison is deemed [to be a] suitable accommodation” and, therefore, does not constitute a housing crisis situation, making them ineligible to be prioritised for an Office of Housing property. Furthermore, if a person was on a waiting list for public housing prior to imprisonment they are removed from the list once they enter prison and their application needs to be reinstated post-release (Participant 9). Support workers also spoke of the “extensive” waiting list in Victoria to “obtain public housing” and that people often wait “several years” for public housing.
As at September, 2014, there were 34,618 people in Victoria waiting to access public housing (Council to Homeless Persons, 2014). In Victoria, only 3.4 per cent of all housing stock is allocated for social housing. This is the lowest percentage of social housing stock available in any state or territory in Australia with the national average being 5 per cent (Council to Homeless Persons, 2014). However, certain individuals are prioritised for public housing placements. The majority of the interviewees’ clients are single males under 55 who are not prioritised for public housing in Victoria. Participant 10 stated that single males under 55 “go to the bottom of the list” in terms of housing priority and primacy goes to the aged, the sick and individuals with children. She explained:

A man [who is] single is not a priority for housing. You’ve got young mothers, elderly people, sick people [who] would be way above them on the waiting list … I know guys who’ve been on the waiting list for two to three years.

Also commenting on the waiting period to obtain public housing, Participant 8 asked, “how long is a piece of string?” stating that she knew of ex-clients who had been waiting for public housing for “12 [to] 15 years”. The long waiting list for public housing has a negative effect on the mental well-being of some clients. Participant 5 commented that although most of her clients “do have hope for the future … there’s periods throughout the whole process where they do lose hope. They lose hope when they find out that they’re not going to get housed for years. I’ve had some that have become incredibly depressed around knowing that”.

The contention that some releasees “lose hope” when they realise there is no safe, long-term housing available to them could become a barrier to those wanting to pursue a desistance lifestyle. As discussed in Chapter Two, hope is an important subjective element in the process of desistance and is a trait commonly seen in those individuals who become desisters, as opposed to persisters, who have a pessimistic outlook about their future
prospects. With public housing not readily available to the majority of the interviewees’ clients, very few alternate housing/accommodation options are available to them. Unless releasees can return to their own home, or can stay with family or friends, post-release housing/accommodation is often limited to temporary placements in crisis accommodation or transitional housing facilities; residing in rooming\(^{22}\) houses or private hotels; or being homeless. This creates additional problems for transitioning prisoners with alcohol problems as many temporary accommodation facilities, including crisis accommodation, house individuals who regularly misuse or abuse alcohol (Harris, 2003).

**Parole and Housing**

In order to be paroled, prisoners must have their accommodation pre-arranged and approved by the parole board (Department of Justice & Regulation, 2013). This was noted by Participant 8 who remarked, “[b]asically it’s trying to locate some sort of accommodation or a crisis facility that can take the guys when they get a release date, [be]cause if they’re allowed to be released they must have an address to go to”. However, due to the shortage of suitable housing/accommodation, some individuals remain in prison past their release date while attempting to find somewhere to live (Participant 8). The difficulty in obtaining housing for those scheduled to be released on parole was noted by Participant 23 who stated:

They have to have an address to get out of jail – so [Corrections] just write down an address or they’ll link them into a boarding house and write down that address. [But if] it’s not suitable accommodation they’re going to be off and drinking and running amok.

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\(^{22}\) Interviewees used the terms “rooming houses” and “boarding houses” interchangeably and did not identify any differentiating features between the two terms.
Not having suitable accommodation on exiting prison places those on parole with an AUD at risk of breaching their conditions of parole, especially if they have an alcohol abstinence order attached to their parole conditions. As Participant 5 argued, “if you release someone back into the community with no supports … they’re going to end up on the street doing exactly what they would have been doing pre-incarceration”.

**Crisis Accommodation and Transitional Housing**

After exiting prison, those who can secure a placement in a NGO crisis facility can stay there for 12 weeks, providing they meet regularly with their support worker and are willing to “[start] looking at their life and address some of the things that are going on” (Participant 2). NGO crisis facilities enable releasees to live in a supportive environment where regular meals are provided, their rooms are serviced by cleaners, and staff members are on the premises 24 hours a day to provide assistance if required (Participant 9). One respondent suggested that this “can be a really great place for people to stabilise their life” and to start addressing “some of … [their] psychosocial issues” (Participant 2). Unfortunately, for some ex-prisoners, their problematic drinking and disruptive behaviour leads to their eviction from the facility. As one support worker explained:

[I had one client who was] … extremely vocal, extremely demanding, drinking excessively, was yelling at staff, yelling at other residents and then at night would go door-knocking to see if he could get money off other residents. I think he … lasted three weeks and got evicted, came back through the system after being on the streets for a little while, lasted about a week, similar behaviour but escalating … seemed to be more vocal, seemed to be constantly affected, seemed to have even less respect, had the attitude that jail’s not so bad, that he knows lots of people in there and he felt safe, didn’t have to pay rent, that his behaviour was acceptable there. He came through only a week ago. Each time he’s come he’s been on a behavioural contract which says, if you breach the guidelines, bang, you’re gone. We’ve put up with your nonsense so many times. This time he literally – he should have been outed on his first day because he came straight out of prison to us, was supposed to
meet with his caseworker within the hour. He did not come back to the facility until the next day; when he did, he was so intoxicated we could do nothing with him. Did not attend appointments, became vocal, became demanding, he was evicted three days later. (Participant 8)

After 12 weeks in a crisis facility, “the natural progression” is to go into transitional housing, “which are shared residential facilities, where people can remain for up to 12 months, providing they continue to work closely with their support worker and abide by the general tenancy rules of the facility” (Participant 2). However, a key concern raised by support workers was that their clients were being “stuck” in transitional housing due to the unavailability of public housing. This was a problem identified by Participant 5, who claimed “some people are staying [in transitional housing] longer, because there’s nowhere else to go after that”. Concerned that suitable forms of housing were not available to their clients, following a period spent in transitional housing, support workers from one NGO met with representatives of the Ministry of Housing in early 2014 “to get a bit of a picture about what is going on” with public housing availability (Participant 5). They were advised by a representative of the Ministry of Housing that:

… within the inner metro area, they’ve housed one under 55 single male in the last year … So I’m telling my clients that right now because they’ve had this false hope, this understanding that they would move on, and within six months they’ll be moving into a single bedroom, yeah, and that would be their housing for life. But it’s just not happening. There’s not enough places. (Participant 5)

The same participant was asked to explain what happens to her clients due to the lack of public housing. She said, that “some stay there, [others] get frustrated and move on, on their own, and then things will potentially get a bit wobbly, the potential to fall apart again, end up homeless”.
Some releasees who cannot access suitable housing have no other alternative than to return to where they were living prior to being incarcerated, which, in some circumstances, may encourage a return to problematic drinking. Participant 30 said:

They often returned to the same [pre-prison] circumstances, the same house where alcohol is rife. Its daily life and they haven’t got a hope. They just haven’t got a hope, because what are you going to do? If you can’t beat them, you join them.

It is clear from the participants’ comments that the lack of availability of suitable social housing is a major factor in releasees achieving a desistance lifestyle. For some, not being able to access suitable housing contributes directly to their renewed alcohol abuse and related offending.

**Rooming Houses**

In cases where accommodation in a crisis or transitional facility is not available, Participant 3 suggested, “usually our clients will go into rooming houses”. She explained that there are two streams of rooming houses; those that are owned and operated by “private landlords, others that are community managed and come under the jurisdiction of the Department of Housing, and [the landlords] tend to be a little more flexible … and understanding about client issues” (Participant 3). However, the same respondent emphasised that “any rooming house, private or public, [is] by nature … a shared environment and essentially an unsuitable form of accommodation for her clients”. She explained: “I work with guys who find it really, really difficult to share, and so there are fights. They lose their accommodation or are at risk [of being evicted]. They might get a warning. They will get a second warning, [then] they’re out”.
Another interviewee spoke of how boarding house accommodation was commonly the only housing option available to transitioning prisoners. She explained, “they [her clients] don’t want to go back there [to a boarding house] but they’ve identified that it’s probably going to happen”. She went on to suggest that living in boarding house accommodation increases:

[t]heir likelihood of re-offending … I just feel sad for them because I think … what hope have [they] got? [They’re] stuck in the same cycle. Something has got to change somewhere and I guess that comes down to more suitable accommodation places being made available”. (Participant 21)

One support worker argued that “boarding houses are [an] inappropriate” form of accommodation for her clients and that “they don’t want to do boarding houses – they’ve been in and out of boarding houses” (Participant 6). Supporting the contention that boarding houses are not suitable for some clients, Participant 1 stated, if “you’ve got someone with alcohol issues … living in a rooming house that can feel really unsafe … [and] maybe someone’s security blanket is to just drink themselves to sleep … there certainly isn’t appropriate housing out there”.

Some rooming houses were considered unsuitable and unsafe forms of post-release accommodation for a number of reasons. These largely revolved around a series of key safety issues relating to lack of compliance with fire safety standards; personal safety issues relating to violence and often aggression; and exposure to people with “full on” substance abuse issues. One support worker described some establishments as “real [sic] dodgy ones”, suggesting many of these were unsafe to live in as they did “not meet any of the criteria of the Residential Tenancies Act 1997 (Vic)” and often had “no proper fire exits, wouldn’t have safety blankets, [and] they’re overcrowded” (Participant 9). She described the tenants who often live in these houses as “an eclectic mix” of “foreign nationals that have come from a
war torn country, single parent[s], males [just released from prison]” and people with “full on” substance misuse issues. She argued that boarding houses are “not a good environment for a male with an alcohol issue getting out of prison”. In addition to the contention by some support workers that rooming houses are an “inappropriate” type of accommodation for their clients, like public housing, these options are also not readily accessible. Participant 6 claimed that there is a waiting list to get into some boarding houses and that “[t]he boarding houses that we use, their wait lists have closed”. This echoes Halsey’s (2007, p. 1225) assertion that some forms of post-release accommodation are “dangerous place[s]” for parolees, as they can be occupied by the kinds of people who would be more inclined to engage in anti-social behaviours, including acts of violence.

The inappropriateness of this form of housing for those with an AUD is further demonstrated by the experience of Participant 2’s client, whose request for a rooming house accommodation was refused on the basis that he had a history of alcohol misuse. Participant 2 explained that one of her clients, who had a “criminal history” and “issues with alcohol”, was “denied” accommodation in a rooming house because he was intoxicated when he met with his prospective landlord. The landlord rang the support worker to explain why he could not offer her client accommodation stating:

‘We’ve already got too many people who are drinking here; we don’t want … more people who are adding to that’ … Also the aggression and the violence and some of the things that go along with that … [He said], ‘Look, he’s not welcome. If we get rid of some of the other people who are [here], we are okay to have him, but we just simply can’t do that’. (Participant 2)

This quote highlights the difficulties and complexities support workers face in trying to source any form of suitable post-release accommodation for their clients who continue to drink problematically after release. The data shows that rooming house accommodation is
often unavailable to some clients due to their continual misuse of alcohol. Yet even when rooming house accommodation is accessible, they are often unsafe environments and counter-productive to individuals wanting to initiate a desistance and recovery lifestyle.

**Negative Health Consequences**

The largely unstable and unsafe environment of some rooming houses has the propensity to have negative health consequences for some residents. This was borne out in an example of a support worker’s former client who was staying in a NGO crisis facility, yet at the time, was pressuring her to find him accommodation in a rooming house. The client was also suffering from progressive liver failure as a result of his long-term abuse of alcohol. Deeply concerned for his health and well-being, the support worker explained why she would not assist her client move into a rooming house. She stated:

I had an older gentleman who had liver failure. He required constant checks by a nurse. We’d have to remind him to eat, we’d have to take food to him, and we’d have to remind him to shower. We used to have to get our personal care assistant to assist him with his health needs, because he was very unwell. He just wanted to go to a rooming house, and whilst we’re client-driven, my duty of care meant that I couldn’t with good conscience, refer him to a housing service such as that. He’d be dead in there within two weeks. So there’s that. It limits where you can refer, and that’s the only kind of housing that’s really available for some of our guys. (Participant 6)

The detrimental effects that living in a rooming house environment can have on a person’s physical and mental well-being were reinforced by Participant 6, who suggested that rooming houses often accommodate:

People who are at risk, in terms of their physical health [and] their substance use issues. There might be mental health issues, very vulnerable and erratic people ... [R]ooming houses, as much as they’re not stable, they’re not safe, and they’re not something I would consider long-term stable housing; often that’s all there is. So it puts people who are really, really sick at massive risk.
And … alcohol is the big one, because they [people who misuse alcohol] tend to be quite isolated, and [stay] in their own room drinking; and if they’re not eating, their health will deteriorate really quickly.

Furthermore, roaming houses are often unsafe and unstable places in which to live, as they are often occupied by residents with complex issues, including those with chronic alcohol and drug issues and people with a mental illness (Harris, 2003). In addition, police are called on to settle “daily disturbances” that occur between residents or to investigate incidents of stolen property (Harris, 2003, p. 4). This is hardly a suitable environment for those leaving the highly controlled and structured environment of prison and onto a hazardous roaming house environment in which highly vulnerable people are often their co-tenants. The insecure nature of many roaming houses makes some releasees reluctant to reside in this type of accommodation. Participant 1 spoke of the unwillingness of some clients to accept accommodation in a roaming house:

No-one wants to leave … prison and [go] into a roaming house … being too scared to fall asleep because there are drunken, drug-affected people everywhere … People say, ‘I don’t want to go in there’ – that’s a big one when I assess people with just alcohol use. Don’t want to go into a roaming house where there’s drug users, and then there’s the fear component. So, again, appropriate accommodation so you’ve got a chance to attend to business, if you like, ‘cause there’s a lot of things people need to do when they’re exiting prison. (Participant 14)

Conversely, another respondent suggested that “a lot of guys” indicate they will accept accommodation in a roaming or boarding house providing “it’s a dry house” (Participant 14). As the term “dry house” suggests, alcohol is not allowed on the premises. The aim of a dry house is to enable releasees to gradually transition from the prison institutional setting to living independently in the wider community (Petersilia, 2003). While the benefit of providing post-release “dry houses” is obvious, and has been the topic of discussion among
members of the Alcohol and Other Drugs (AOD) sector, these alternate forms of post-release accommodation remain unrealised. As Participant 1 explained:

This is something in the past that there’s always been a lot of talk about – developing a dry house or a halfway house for people, [but] going down that pathway; it’s never happened. The government will never pour money into it, and it’s what people are asking for.

This thesis contends that the provision of dry houses is a significantly unmet need in Victoria that merits consideration by policy makers who seek to reduce re-offending and re-incarceration rates. It is difficult not to conclude that it would be advantageous for policy makers in government to give serious and careful consideration to allocating funding for the establishment of dry houses for releasees with AUDs. The provision of accommodation in dry houses would provide ex-prisoners with a space to consider, and focus on, their employment or skills training options, and to develop prosocial activities as well as starting to repair any fractured relationships with family or friends. The interviewees’ responses strongly suggest that rooming houses available to releasees with AUDs are highly unsuitable living environments for those wanting to initiate a desistance and recovery lifestyle, thereby strengthening the need for dry house accommodation options.

**Private Hotels and Caravans**

Although Participant 6 suggests rooming house accommodation is often “all there is” for her clients to live in, other interviewees described less suitable forms of accommodation, such as caravans and private hotels. Participant’s spoke of how some clients were restricted to living in private hotels that are little more than “flop houses” or caravan parks due to the unavailability of more suitable forms of accommodation. Although these types of accommodation are usually cheap, they may pose a threat to personal safety and may even
promote reoffending. Participant 21 offered an example of how alcohol misuse and unsuitable post-release accommodation can lead to reoffending in relation to a former client. The client was renting a caravan that was situated on his landlord’s property. The client considered the accommodation to be so unsuitable that he “burnt the van down”. Participant 21 reiterated the conversation she had with her client regarding the circumstances that led to his offending. The client said:

‘Well, the guy was a prick’. He said, ‘his [vans] weren’t two bob to live in … they had no windows in some of them’, and I said, ‘Look, I understand that but you can’t go burning people’s [property] down’. And he said, ‘Yeah, yeah, I know, I fucked up, fucked up’ … I don't believe he would have committed that offence if he had [been placed in] suitable accommodation, which he has now. He said [if] he had been in a decent house with windows and doors … he probably wouldn’t have done it, pissed or not.

This example demonstrates how unsuitable post-release housing, in conjunction with alcohol misuse, can spark anger and frustration in some people that result in criminal activity. Importantly, this also highlights how alcohol misuse and unsatisfactory accommodation can interlink and become a barrier to anyone wanting to initiate a desistance trajectory.

An example of accommodation in a private hotel is the “Gatwick” in St. Kilda, an inner Melbourne suburb. A cash payment of $60 will secure a one-night stay in a double room or $260 will provide one week’s accommodation. In 2008, the “Gatwick” was featured in an article titled “Inside the notorious Gatwick Private Hotel” in Melbourne’s Sunday Herald Sun newspaper (Campbell, 2011). In this article, the Gatwick was described as “Melbourne's biggest and most notorious flophouse” that emits a “smell” that is “a mixture of sweat, alcohol, vomit and tobacco”. Commenting on the residents he observed at the Gatwick, Campbell (2011) said that “[m]ost [were] drunk”. It is also an unsafe environment in which to live. Campbell (2011) was told by a local policeman that “the Gatwick is a very
dangerous place … [t]he last murder there didn’t make the papers”. Participant 2 stated that in the main, her clients reject these types of premises as a housing option saying, “[h]ey, look, I’d rather sleep under a bridge than go there” (Participant 2).

Transitioning prisoners who have unresolved alcohol problems, and who cannot access more suitable forms of accommodation, are likely to find it significantly more difficult to desist from crime or abstain from alcohol if they are forced to accept this type of accommodation. This supports Willis’ (2004) contention that some forms of boarding house accommodation can be detrimental, as they are often occupied mainly by people with substance abuse problems, mental health issues and can also be a point of concentration for ex-prisoners. Exposure to these factors can constitute a temptation to drink problematically, which can lead to anti-social behaviour and violence and re-offending. This is all the more problematic given some releasees’ awareness of the increased risks posed by living in such rooming houses and private hotels.

**Being Homeless**

For releasees who find private hotel, rooming houses or even caravans unacceptable forms of accommodation, often the only remaining option or outcome is homelessness. In Victoria, there are three tiers of homelessness based on minimum community housing standards (Harris, 2003). These are Primary homelessness\(^23\), Secondary homelessness\(^24\) and Tertiary

\(^23\) Primary homelessness relates to “people without conventional accommodation, such as people living on the streets, sleeping in parks, squatting in derelict buildings, using cars or railway carriages for temporary shelter, or living in impovished dwellings” (Harris, 2003, p. 3).

\(^24\) Secondary homelessness refers to “people who move frequently from one form of temporary accommodation to another, including people using various types of emergency accommodation (such as hostels, night shelters, and refuges); people residing temporarily with other households (because they have no accommodation of their own) and those using boarding houses on an occasional or intermittent basis” (Harris, 2003, p. 4).
homelessness. The issue of post-release homelessness was raised by several respondents. The homeless status of some clients was attributed to the unavailability of other forms of suitable housing/accommodation. For others, it was a personal choice. Releasees who do not have suitable accommodation pre-arranged prior to leaving prison are highly vulnerable to being homeless. Participant 2 describes the process by which, in the absence of suitable accommodation, releasees end up being homeless:

They’ll get a couple of nights or a week, or up to two weeks in a rooming house once they’re released from prison. [During] … that time, [they will have to] go to an access point and say, ‘Hey, look, I’m homeless, I need to find somewhere to go’ … they will get put on the list, the same as everyone else. So with that list, what happens is they take it on a day-by-day basis. If you attend there [on] Monday morning at 9:00 am then they’ll have to call around the different housing places that people can go to and say, ‘what places have we got?’ If there’s nowhere, then there’s nowhere. If there’s crisis accommodation, hotel accommodation, or rooming houses, people can then decide whether or not to take up those options. (Participant 2)

Due to the difficulty in finding suitable post-release accommodation some clients suggested they would rather return to prison than be homeless. As Participant 5 claimed:

I had a client say to me the other day, I’m homeless, you know. If I have to go back [to jail] I will … because it’s a roof over my head and three meals a day, and it ain’t that bad, it’s like a holiday. But that’s him convincing himself that … life is better [in jail as opposed to] the tough situation that he’s in right now.

For others, remaining homeless is a personal choice and tied into their alcohol misuse. Participant 3 explained that she had:

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25 Tertiary homelessness is defined as “people who live in single rooms in boarding houses on a medium to long-term basis. Residents of private boarding houses often do not have a separate bedroom and living room; they do not have kitchen and bathroom facilities of their own; their accommodation is not self-contained, and they do not have security of tenure provided by a lease” (Harris, 2003, p. 4).
Worked with a number of clients, who absolutely will not pay a cent towards rent, because they’re so married to alcohol, and so they will choose to live under [a] bridge … because they refuse to pay rent.

For this cohort of releasees, alcohol has become their primary need and it seems that only free accommodation would satisfy them, thereby leaving them with the maximum amount of funds to purchase alcohol.

**Housing in Regional Victoria**

Thus far, the discussion of post-release housing options in Victoria has centred mainly on the situation in the Melbourne Metropolitan area. However, the lack of suitable housing is particularly problematic in Regional Victoria, as one interviewee explained:

[In Regional Victoria] housing is probably the biggest thing that we come across from people coming out of prison if they haven’t got any family or support. They usually stick them in a men’s shelter or a guest house and most of them would prefer to be in jail than over in [those] place[s]. They are a melting pot of drugs and alcohol. So to be expecting a client to not use in that environment is a joke really, and I don’t know why it’s not addressed, I can’t see how you can release them into the community in[to] that sort of situation. (Participant 35)

In two Victorian Regional centres, support workers discussed how some releasees had been given “tents” to live in due to the lack of more suitable forms of housing/accommodation. In one case, it was suggested to a client that the “tent” could be pitched on a local oval (Participant 25). In the other, the client was directed to the “local riverbank” (Participant 31). Suggesting that tents were highly unsuitable as a form of accommodation and may encourage a return to problematic drinking, Participant 25 stated, “for God’s sake … of course you’re going to drink … to keep warm and to put up with living [outdoors]”.
Participant 6 echoed the frustration of several support workers in relation to the “limited housing options” available to releasees claiming:

[It’s] frustrating … not having the ability to recommend somewhere for safe, stable, sustainable housing, which is just such a basic human need. And you just see the impact that it has on people’s lives, not having that safe, solid base to work from. It can be really frustrating the first time you meet someone, where they’ve been in the system for 20 years, they know how limited it is. To have to say to them, ‘Look, I hear what you’re saying about all of these things; I can only offer you rooming house, because … you’ve got to build that rental history before anyone will consider taking you anywhere else’. But I think with a lot of guys, if you are up front, and don’t sit there making them feel like they’re going to get an amazing [house] in the suburbs straight off; they’ll … say, ‘Look, I appreciate you’re honest. I knew that was how it was’. And just acknowledging their frustration with the system, and not adding to it by going, ‘I know it’s really crap. It’s such a crappy system’.

Ultimately, the importance of releasees with alcohol problems having access to safe, secure and stable housing was summed up by Participant 1 who claimed:

If they have that appropriate housing support, with that, hand in hand comes their drug and alcohol treatment and support and counselling that they need, because they realise that there’s a direct link between their alcohol use and returning … to prison. They have that sort of insight and [while] they have all the best intentions in the world when they’re exiting that they’ll never drink … they know very well that [if they do] they’ll end up back in prison. But … there’s no real support for them.

Unquestionably, in Victoria there is a lack of suitable, safe and secure housing for ex-prisoners in general, and specifically, for those with AUDs. Post-release housing options for individuals with alcohol problems are highly unsuitable, at times unsafe, and do not provide security of tenure. In light of the lack of public housing stock across the state, together with the lack of transitional housing for ex-prisoners, other forms of available post-release accommodation, for example, boarding houses, private hotels, tents, caravan park accommodation or homelessness, are highly unsuitable and unstable forms of housing and are
social contexts that make desisting from crime or recovery from alcohol misuse virtually impossible. This view supports scholars who argue that greater emphasis needs to be placed on the social context in which decisions about desistance occur.

These are significant findings as no previous Victorian studies have provided an in-depth qualitative analysis of the relationship between alcohol misuse and post-release housing, nor the ways alcohol misuse may impact on ex-prisoners’ ability to obtain suitable, safe and secure post-release housing. It is important to note that despite the best efforts of support workers to source suitable post-release housing/accommodation for their clients; the shortage of public housing stock and other forms of suitable accommodation is for some a significant structural barrier to initiating a desistance and recovery lifestyle.

**Conclusion**

This chapter mapped the landscape of the multiple and complex non-treatment needs that many releasees with AUDs have after exiting prison. These individuals have a vast array of needs that span from immediate and basic needs such as needing assistance with transportation from prison and help sourcing some form of personal identification to enable them to apply for unemployment benefits or other forms of welfare assistance. These needs extend through to longer-term needs such as assistance with family reunification and assistance sourcing primary health care services. Health-care is often a critical need where life-threatening conditions are involved. Access to a “good” GP is, therefore, essential to ensure timely access to appropriate specialist health-care providers. However, this is not the case in some locations as some GPs are reluctant to accommodate ex-prisoners, for instance, by providing bulk-billing. Releasees are also more likely than not to be in need of help with finding employment or enrolling in skills training courses and finding somewhere to live.
Ex-prisoners are often not well-equipped or skilled enough to obtain these basic needs on their own and, consequently, often require significant support from NGO service providers to re-establish themselves with the basic requirements to enable access to services such as obtaining a copy of their birth certificate. Planning for release and the arrangements for Correction’s compliance requirements are frequently not completed in a manner that provides for a seamless and smooth transition from prison to the community. The difficulties ex-prisoners have sourcing adequate primary health care services and meeting their Corrections obligations clearly shows that the principles of Through-care – that is, effective pre-release planning – are not being adhered to across the Victorian prison system. This strongly suggests that effective pre-release planning is not being undertaken and, therefore, Victorian prisoners with AUDs are being released into the wider community without adequate preparation for the challenges that they will face on returning to society. In line with Participant 8, I argue that for many releasees the lack of effective pre-release planning is effectively “setting them up to fail”.

Support from family and friends, is more often unavailable than available and, therefore, support workers and forensic counsellors are the only people that some ex-prisoners can turn to for support in the post-release environment. Releasees with AUDs often lack the basic skills, either pre-existing to their imprisonment and/or exacerbated by their time in prison. Additionally, as this chapter has shown, there is little or no attempt made by Corrections to prepare prisoners for release by providing basic training in social and life skills.

It is well documented that accessing safe, secure and stable housing is a continuing problem among ex-prisoner populations. However, what has previously been unknown is, if and how post-release alcohol misuse limits individuals with AUDs from obtaining adequate
support services. As this chapter has argued, housing is a particularly problematic factor for ex-prisoners with AUDs. The more unsuitable forms of post-release housing/accommodation which include rooming houses, private hotels, caravans, tents and ultimately homelessness, all present significant challenges to those releasees who desire to embark on a desistance and recovery lifestyle. As argued throughout this chapter, unsuitable forms of post-release housing also present difficulties for those who wish to abstain from drinking or limit their alcohol intake, as they may find themselves exposed to others who are consuming alcohol excessively and therefore may face peer pressure to do likewise in order to fit in socially. In addition, individuals who continue to drink in a harmful or hazardous manner and engage in anti-social behaviours are highly likely to be evicted from their accommodation, which places them at risk of sliding down the accommodation tree into more unsuitable forms of accommodation.

Such issues are amplified in Regional Victoria where the availability of suitable, or any, form of post-release accommodation is significantly less than in the Melbourne Metropolitan area. Viewed collectively, these issues represent significant barriers for any ex-prisoners with AUDs who choose to adopt a pro-social lifestyle, and are ongoing challenges for NGO support workers and forensic counsellors.

The next chapter builds on the discussion of the non-treatment needs and post-release supports available to released prisoners with an AUD, by examining treatment programs and strategies forensic counsellors utilise to assist individuals in the recovery process.
Chapter Seven

Mapping the Landscape – Post-Release Alcohol Treatment Services

Twenty-eight years ago, I woke up in a jail cell following my last alcoholic blackout. I had been arrested for disorderly conduct and resisting arrest. I am alive and sober today only because I had access to addiction treatment that turned my life around. (Former US Congressman Jim Ramstad, 2009)

From my experience, without [access to treatment] the housing is not going to work, the family relationships will break down. Everything ... generally falls by the wayside if there’s nothing in place to address the alcohol issues. (Participant 5)

The previous chapter provided a discussion of the multiple challenges and complex range of needs that releasees with Alcohol Use Disorders (AUDs) have when exiting prison. This chapter extends the discussion of the supports available to released prisoners with an AUD, by mapping the landscape of the treatment programs and strategies forensic counsellors utilise to assist individuals in the recovery process. In Victoria, there is a paucity of research that examines what programs are available to releasees who require treatment for alcohol misuse and the strategies used in the delivery of these programs. This constitutes a gap in the literature that the chapter aims to fill by drawing on the interview data to examine what alcohol treatment programs are available and accessible to transitioning prisoners with an alcohol problem, together with the strategies employed by counsellors in the delivery of these programs.

The chapter begins with a brief discussion of the extent to which releasees have access to relevant treatment for alcohol misuse while in prison. It is important to provide a broad understanding of what support and treatment for alcohol misuse is available in Victorian prisons as this forms a basis for understanding the importance of alcohol specific programs in the post-release environment. This discussion is followed by an analysis of the
alcohol specific programs available to releasees and the strategies employed by forensic counsellors in the clinical setting. The chapter also draws attention to the important role of forensic counsellors and how they employ motivational interviewing techniques and goal-setting exercises to address client ambivalence and to encourage change. Importantly, an emphasis is placed on assisting clients to develop a sense of personal agency, recognising that it is the individuals who are the ultimate decision-makers in driving the change process. Throughout the chapter, any discernible elements of the treatment process that draw a parallel with characteristics of a desistance and/or recovery theoretical framework are acknowledged and discussed.

By presenting a discussion of these issues, this thesis sheds light on an important yet largely hidden area of post-release research: the availability of treatment programs for alcohol misuse. By examining alcohol treatment programs and strategies in their own right, as opposed to those that target substance misuse, or Alcohol and Other Drugs (AOD) use, this research constitutes the first qualitative study conducted in Victoria that provides an in-depth analysis of post-release rehabilitation programs that are tailored for alcohol misusers.

Before presenting a discussion of the post-release alcohol treatment models strategies delivered to transitioning prisoners, it is important to note that forensic counsellors found that parolees mandated to undertake post-release counselling for their alcohol problems were highly unlikely to have received sufficient or appropriate treatment while in prison. They were, therefore, exiting prison ill-equipped to navigate the complexities associated with transitioning into the wider community where drinking alcohol is a normal and widely practised social activity. One participant stated she was “dumfounded” (Participant 22) by the lack of alcohol specific treatment services offered in Victorian prisons:
The guys that I assess in prison, I ask them, what drug and alcohol treatment have you … done here in prison? I had one guy – this guy who killed this person – and he’d only done the 40-hour drug and alcohol [course] for the whole six years he was in prison. That was it. And [I was] just sitting there … dumbfounded. (Participant 22)

The shortage of in-prison programs that specifically target alcohol misuse is not limited to Victoria but is evident throughout the Australian prison system. As stated in the report, *Alcohol and other drug treatment services in Australia 2010–11*:

It appears that just over 1 in 10, (12 per cent) of prison dischargees accessed an alcohol treatment program while in prison. The proportion was similar for males and females (12 per cent and 13 per cent respectively), even though almost twice the proportion of males, were at high risk compared with females (58 per cent and 31 per cent). (AIHW 2012a, p. 94)

This mirrors the contention presented in Chapter Three that suggests individuals who enter prison in Victoria with an AUD are highly unlikely to have access to treatment of sufficient duration to adequately address the complexities involved in alcohol misuse or abuse.

**Post-Release Treatment Programs and Strategies**

A fundamental aim of this research is to shed light on what post-release treatment is available to individuals with an AUD in the transitional period. This aim was approached by asking forensic counsellors: “What treatment models do you employ in the clinical setting to address alcohol misuse or abuse among post-release forensic clients?” The data reveals that forensic counsellors utilise a number of treatment models when working with clients who present with alcohol problems. A summary of treatment models employed by forensic counsellors in Victoria was offered by Participant 16, who explained:
I assess and help plan treatment pathways and provide counselling, relapse prevention, single intervention work as well as case co-ordinate [for] those people who might [want] to go into residential programs.

Other treatment options available to transitioning prisoners with an AUD include residential rehabilitation and support from AA – discussed below. While not specifically a treatment model, the use of ‘alcohol bracelets’ that some Victorian parolees are mandated to wear is also discussed.

**Motivational interviewing (MI)**

It is well established that a person’s level of motivation is an important factor if behavioural change is to occur (Laudet, Becker, & White, 2009; McMullan, 2009; McNeill et al., 2005). MI is a counselling technique commonly employed by AOD counsellors when working with forensic clients (McMullan, 2009). MI was conceptualised by Miller (1983, p. 153) during an eight year period working with problem drinkers. The concept emerged as an alternative to coercive and confrontational methods frequently employed by therapists to solicit clients’ behavioural change (Miller, 1983; Miller & Rollnick, 2002; Rollnick & Miller, 1995). MI is defined by Rollnick and Miller (1995, p. 325) “as a directive, client-centred counselling style for eliciting behaviour change by helping clients to explore and resolve ambivalence”. Importantly, the word ‘directive’ does not mean the therapist determines what goals a client should pursue. Instead, it refers to a “quiet and eliciting” approach that “is essential to MI, and the spirit of the approach is distinguished from the techniques” (Burnett, 2007, p. 7).

MI is a collaborative, person-centred initiative that utilises the process of goal-setting to strengthen individuals’ motivation to encourage behavioural change. Counsellors work collaboratively with clients to identify attainable goals, rather than employing an overly directive or coercive approach to achieve change. The importance of a collaborative
client/counsellor relationship in promoting behavioural change is addressed in the next chapter when the role of a therapeutic alliance is discussed. Miller (1983) suggests that MI techniques are ideal for working with clients “mandated” to undertake treatment for their alcohol misuse as well as for individuals with “less severe” alcohol problems (p. 153).

Ambivalence

A central tenet of MI is to counteract client ambivalence towards changing their behaviours. Indeed, ambivalence to change is a characteristic commonly noted among offending populations and AOD misusers. MI’s primary aim of counteracting client ambivalence has important implications for initiating both desistance and recovery pathways. As discussed in Chapter Two, the process of desistance is frequently punctuated by periods of ambivalence and vacillation (Burnett, 2004b) resulting in achievements and setbacks. Also noted in Chapter Two is the importance that scholars place on the need for individuals to strengthen their motivation to counteract ambivalence and drive the change process (Healy & O'Donnell, 2008; LeBel et al., 2008; Maruna & LeBel, 2010; McNeill et al., 2005; McNeill & Whyte, 2007; Roberts, 2004). In this way, ambivalence to behavioural change is also a characteristic of the recovery process. The process of recovery from alcohol misuse, or any substance misuse problem, is often punctuated by periods of ambivalence, lapses and relapses (Hser et al., 2007; Moos & Moos, 2007; Saladin & Santa Ana, 2004).

As noted in Chapter Four, the majority of the client cohort, serviced by forensic counsellors, is mandated to attend an alcohol treatment program as a part of their parole conditions. Miller (1983) argues that MI is a suitable strategy for working with mandated clients, and this was noted by some participants in relation to the optimism of their clients, especially at the beginning of a treatment program. As one interviewee explained:
Some people come in here [and] because it’s the start of an episode of care … [they] are optimistic. [But] it could be a different story in a couple of months’ time … and that’s a problem. (Participant 19)

Another similarly stated that:

Some clients … do have hope for the future, depending … at what stage of the game you get them … they do want to make changes in their lives. Some not, and usually they’re the ones that drop off and disengage. (Participant 5)

Despite optimism being detected in the demeanour of some parolees, the interview data strongly suggests that the majority of parolees who were mandated to attend an alcohol treatment program were ambivalent and pessimistic about their prospects of achieving change. One participant explained:

The vast majority are pessimistic. They come out, they’ve got all kinds of parole conditions, or they come out and they’re just lost and they don’t know where to go, where to turn, what to do, they’re meant to try and get a job, what do you put on a resume; I’ve been in prison for 20 years, please give me a job. I have no skills. That’s what a lot of them are up against. So it’s pretty tempting, I guess, to turn to alcohol with your old drinking buddies. (Participant 8)

The same participant continued:

I had one client who had a long history of alcohol abuse and he told me that he had foetal alcohol syndrome. I’ve not confirmed [it] – I didn’t see any medical information about it, but I’d have to imagine that it’s true, and he was telling me that all of his family are alcoholics, he is as well, he was always drunk when I saw him. I think I saw him sober once – he wasn’t here for very long. And he’d get really emotional saying, well now that he’s out of prison he’s celebrating so he’s drinking, he’s drunk. If he goes to see his mother they’re going to drink together. If he goes to see his brother, they’re going to drink together. And going to appointments for him was just not possible. He definitely wasn’t positive about his future at all. I think his sort of thinking was he’d come out, drink, see a few friends, probably get done for drunk and disorderly, violate his parole and go straight back in.
Ambivalence and pessimism among parolees was also noted by Participant 20, who claimed:

Clients who are on parole often talk about just feeling like they’ve got no control over their lives and they can’t plan for the future. Especially if they have started parole and they’ve got a year or two stretching out in front of them of just doing the same thing; of having Corrections tell them where they’ve got to be on any given day.

These quotes demonstrate that some releasees feel overwhelmed by the challenges they confront after exiting prison and cannot envisage a future where alcohol misuse and offending is not part of their lives. Those who feel “lost” or believe they have “no control over their lives” will arguably be pessimistic and despondent about their ability to change their behaviours. This, in turn, is likely to generate a negative self-narrative of themselves. This view supports Maruna’s (2001) contention that individuals who have a pessimistic view of their future generate a “condemnation script” and are more likely to be “persisters” and continue their offending and anti-social behaviours. The quotes also suggest that those who feel they have “no control” over the trajectory of their lives exhibit a lack of personal agency which is considered to be a crucial element for the initiation of desistance and recovery journeys. As discussed in Chapter Two, a lack of personal agency and a pessimistic outlook on life are considered barriers to initiating a desistance and recovery lifestyle. Addressing these barriers is often the first issue counsellors need to contend with in the clinical setting. In order to do this, forensic counsellors commonly reported utilising the MI technique of goal-setting to address client ambivalence and pessimism and to foster, or instil a sense of personal agency in their clients.
**Personal Agency**

Encouraging clients to develop a sense of personal agency during the treatment process emerged as a strong theme throughout the interviews. Participants reported that empowering their clients to develop a strong sense of personal agency is the key to generating a sense of optimism, whereby clients believed change is possible. One participant explained how personal agency is promoted by enabling individuals to choose their own treatment pathway:

> It is the individual’s decision whether or not they want to pursue abstinence or take [a harm minimisation] approach. As a counsellor, I would never say, ‘You do it,’ obviously, they [the clients] are the masters of their own [destiny] … they are the ones who make the decisions. (Participant 20)

The same respondent further stated:

> Rather than try and stop something bad, it’s [more about] changing the trajectory into a more positive pathway. Because I feel … when clients are mandated to attend drug and alcohol treatment, they think that they’re going to have someone [saying] you shouldn’t be drinking, and that’s not what I want to do. I want to give them a positive experience so that if they do need more support in the future they’re more likely to come back as well.

**Addressing Ambivalence through Negotiation**

When meeting with clients for the first time, forensic counsellors frequently expressed the need to use negotiating skills in order to address client ambivalence. This was demonstrated by Participant 27’s claim: “We have to negotiate and do a lot of work around resistance to get them to agree to [attend] even [a few] sessions”.

The interview data suggests that ambivalence to attend counselling sessions was commonly exhibited by parolees, despite attendance being a condition of their parole order. One interviewee reported a typical example of client ambivalence:
It’s usually pretty evident if they … just don’t want to be there. What I usually do is negotiate with a client at the first session. I’ll straight out say to them, ‘You don’t want to be here, do you?’ ‘No.’ ‘Your dad dragged you here?’ ‘Yep.’ So I negotiate with them. ‘All right. So can we negotiate? Okay. So you’ve told me about your drinking. What are your goals around that? You want to keep drinking, fine. So how about if we do maybe three or four sessions, we’ll look at some harm minimisation. We might look at a few of your triggers and stuff like that.’ That’s it. I just straight up negotiate with them. (Participant 5)

As this example demonstrates, even when clients are ambivalent about attending counselling and “just don’t want to be there”, negotiating with clients, and encouraging them to articulate and plan their own treatment pathway can positively encourage the development of personal agency. For this reason, within the Victorian AOD sector, the strategy of goal-setting has a strong focus on the development of personal agency. As Participant 16 explains:

First of all, [the treatment goal] that’s the client’s decision. If they want to reduce their alcohol consumption … to what they might consider manageable, [and] reduce the amounts or the frequency when they drink, then we would look at some planning, drink diaries and we would review that in counselling. Whether [I think] that’s going to work or not is immaterial. I do often think this is not going to work; however, to try to tell people that would be a waste of time because it’s not their perception, so we would work with that. Invariably we will end up where I know we’re going to end up which is having the conversation about … you are unable to bring it back to manageable levels, what do you think that’s about and then we might talk about, I wonder what would happen if you stopped drinking all together. Other people do want abstinence. Sometimes people want abstinence from one drug but not another and we also get that in a home base withdrawal service. Some want to stop heroin use but [are] okay with alcohol use. I want to stop my benzodiazepines but my alcohol use is okay. So we would start with that.

The importance of enabling clients to set their own treatment goals, as a form of building desistance and recovery capabilities, was similarly commented on by another counsellor, who claimed:

There’s no one … approach [that works for all clients]. It’s the client that directs me as to what approach I’m actually going to use with them. It’s
always strength-based. It’s always client driven [and] solution-focused … Because clients are looking for ways to keep out of prison we’re looking at … what are the solutions to that? (Participant 24)

Another respondent likewise explained the importance of enabling clients to set their own treatment goals:

‘Cause that’s how you help instil hope and help them reflect on their lives and [their] past mistakes. Rather than being the person that says, yep I’ll do it all for you, it’s far more empowering for them to work out what they need to do to help their circumstances. And usually – proven that that’s what works. You do everything for them then they’ll become co-dependent on you and they haven’t learnt anything in the process. (Participant 5)

The words “hope” and “empowering” in Participant 5’s statement are congruent with subjective factors deemed important in the desistance process. As noted in the theoretical framework discussion in Chapter Two, developing a sense of personal agency is considered vital in the process of desistance. Empowering clients to identify their future goals and work out how they themselves think they can achieve them, enables individuals to drive the change process, which in turn, fosters a sense of personal agency. Moreover, encouraging clients to plan their own treatment goals draws a parallel with what Paternoster and Bushway (2009) term a “motivational roadmap”, which is essentially a blueprint that individuals can construct to identify their future goals and aspirations, together with the steps they need to take to reach their goals.

**Fostering Hope**

Hope is an important element in the processes of desistance (Burnett & Maruna, 2004; Farrall et al., 2010; Healy, 2010; LeBel et al., 2008; McNeill & Weaver, 2010) and recovery (Best, 2010; Best & Lubman, 2012; SAMHSA, 2012). Le Bel et al. (2008) suggest that hope is
more than a vague concept, and that in the process of desistance, it denotes the imagining of future goals and the aspiration and belief that desired goals are achievable. Similarly, hope is deemed to be a salient factor in the process of recovery. As Best and Laudet (2012) argue, having hope for a better future is part of the lived experience of the recovery process in which individuals not only address their drinking behaviour, but develop hope that a better future is possible. According to the SAMHSA (2012, p. 4) “recovery emerges from hope”.

It is important to note that when encouraging clients to set their own goals, forensic counsellors are not passive bystanders. In fact, they play a crucial participatory role in goal-setting exercises. This was clearly outlined by Participant 19, who claimed:

Being able to give advice is incredibly important … but doing it in a way that makes the client understand it’s their [goals] they want to achieve.

This once again demonstrates the important role of forensic counsellors in the treatment setting, as they help clients to identify and set achievable goals which, in turn, are likely to give individuals a sense of hope for a more positive future. In order to assist clients in setting their goals, forensic counsellors commonly utilise the MI technique of goal-setting to address client ambivalence and pessimism in order to strengthen clients’ intrinsic motivation to drive the change process.

**Motivating Indigenous Clients**

During the interviews conducted in the Melbourne Metropolitan area there was no evidence of Indigenous releasees seeking treatment for post-release alcohol misuse. However, in Regional Victoria, Indigenous people formed part of the respondents’ client cohorts. One interviewee spoke of the difficulties associated with motivating Indigenous clients due in part to the historical legacy of grief and loss that underscores their lives. She stated:
[They come in] all fired up and we build on that motivation but things can happen. For many who are chronic drinkers there is a theme of grief through their history. It may be the tiniest trigger of loss or grief that will set them back into that spiral of resuming drinking. So, addressing that grief and loss maybe a very important one. [F]or example in the indigenous community, our clients may be really intent – I’m not going back on the grog, but then someone dies, and we all know about the drinking that goes on as part of the grieving process, the wake and all of that. [T]hey can try very hard but they get drawn into that vortex of culture versus their greater understanding of what’s going on and then their biomedical responses kick them in the backside and they’re back on the cycle. (Participant 25)

This quote echoes the work of the Aboriginal and Torres Strait Islander Women’s Task Force on Violence (2000) and that of Cunneen and Libesman (1995) discussed in Chapter Three, that directly links much of the alcohol misuse and violence evident in Indigenous communities today to the historical legacies of colonisation and dispossession.

**Addressing Ambivalence through Goal-Setting**

Goal-setting is a core strategy of MI that seeks to counteract ambivalence by strengthening clients’ intrinsic motivation to encourage behaviour change. The data shows that forensic counsellors frequently rely on goal-setting exercises to address ambivalence and, in the process, to encourage clients to develop a sense of personal agency. Participant 5 stated, “motivational interviewing is … the key counselling tool [that] most [forensic counsellors] use within the Victorian Drug and Alcohol sector”. She explained that “to get your AOD core competencies you need to be au fait with motivational interviewing [techniques]”. This is a key consideration as the philosophical base of motivational interviewing centres on identifying and promoting a person’s strengths and capacities rather than focusing on risk factors associated with re-offending (Farrall, 2002) or alcohol misuse (Hser et al., 2007).
The preceding discussion indicates that those who work in the Victorian AOD sector place a strong emphasis on identifying and developing a person’s strengths and capabilities that they can utilise to drive the change process. This is in contrast to managing risk and largely being “offence-focused” which are key elements of the Risk-Needs-Responsivity (RNR) model of rehabilitation. Adopting a strengths-based focus is a key component of the Good Lives Model (GLM) of offender rehabilitation, which argues that change is more likely to occur when rehabilitation programs focus less on individuals’ prior offending, and instead consider the strengths and capabilities of the individual and how these attributes can be used to initiate change.

**Motivating Factors that Drive Change**

Forensic counsellors provided examples of the factors some clients use as motivational tools to engage with the treatment process. Participant 19 explained, “there’s two broad areas … internal and external” reasons clients give for wanting to change their behaviours. The same participant suggested the biggest external motivator “is family. It’s either family, or there’s relationship breakdowns … the most common is kids”.

The importance of family and children as external motivators for individuals wanting to change was described in the following example:

I think family is often more motivating. That’s just through my experience and because they’ve had that time, particularly in prison, to think well, had I not got pissed that night, I wouldn’t have hit my wife and she wouldn’t have an AVO on me. So now, once I’m out, I need to rebuild that relationship with, hopefully, my wife and we can reunify. But more importantly, for the children. So I think they identify after the fact where they’ve stuffed up and it’s more so for the children. (Participant 21)
It was common for clients to cite both extrinsic and intrinsic factors that provided the motivation to consider changing their behaviour:

What I’ve noticed is family/children have a huge impact on the desire to change. For some, the effect that alcohol has on the brain, and when they start to see deficits within themselves that’s when they, kind of, start to go, holy shit, this is actually affecting my brain and my capacity to function in the world. But usually it’s family. (Participant 5)

A father’s desire to be involved in his children’s lives, together with his age, was an example provided by another respondent for her client’s motivation to change. She explained:

One of my clients, who I successfully closed, had reconnected with his children. He was in his 50s and he was thinking, I can’t do this anymore, plus, his children were young teenagers at that point, and he said, “If I don’t become a part of their life now, I’m never going to.” So those were the two driving factors for him. (Participant 2)

Frequently cited internal factors for wanting to change related to being “sick of the lifestyle” and deteriorating health. Although internal factors alone were less commonly cited as motivating factors for wanting to change, one counsellor stated:

Internal motivation is less common – but [it’s] normally the one that’s actually most beneficial for making change. But more often than not, the internal stuff is people just going, ‘You know what, I’m sick of it. I’m sick of the lifestyle. I’m sick of feeling crap. I’m sick of all the things that come along with it. I’ve just had enough. And I don’t want to do this anymore’. And I think that’s quite often when you see the most effective change starting to happen. (Participant 19)

Deteriorating physical health relating to liver damage caused by excessive and prolonged drinking was the reason another respondent gave for a client being motivated to change his behaviour. She said:
One client comes to mind. He is a young man. He has reduced his drinking. He was drinking, I guess, up to two to three bottles of wine a day and had liver damage. Now he is only drinking – one to two times a week, having four to five drinks – standard drinks each time. And this particular gentleman was plagued by such chronic abdominal pain. He was also on transitioning hormone replacement therapy. (Participant 18)

These excerpts suggest, as predicted, that motivational factors are vexed, multifaceted and individualised. However, it is clear that a common theme of family and health concerns strongly influences some clients to pursue a recovery lifestyle. Moreover, being motivated to engage in the treatment process, as a means of reconnecting with one’s children can act as “turning point” in the desistance process by creating a valued social and emotional attachment that acts as a form of informal social control (Farrall, 2002; Laub & Sampson, 2001).

**Choosing a Treatment Pathway**

In the first instance, forensic counsellors need to ascertain what the client hopes to achieve through attending counselling sessions for their alcohol problems. One participant explained how she assists her clients to commence the process of choosing and planning their treatment goals by explaining the difference between the approaches of harm minimisation and abstinence. She claimed:

I … explain how harm minimisation is more directed towards people who want to continue [to drink] but do it safer. And relapse prevention is more directed towards people who are committed to abstinence. (Participant 24)

Explaining the difference between harm minimisation and abstinence approaches to clients clearly has benefits in assisting them to make informed treatment goal choices as not all
clients will understand the meaning of the term harm minimisation. One forensic counsellor explained:

> When I start talking about harm minimisation it’s like, ‘Oh, what’s that? What’s that?’ But once they start to realise what it is, it’s like, [they say] ‘Oh, okay. Oh. That’s cool’. (Participant 24)

The same counsellor continued:

> Once a client tells me where they’re at with [their drinking], and [if they indicate] they’re not ready to stop drinking. Then I say, ‘Okay, how about we do some harm reduction stuff’. A lot of … times clients aren’t aware of what harm reduction is. So what I do then is, I sit with the client, and I explain to them what harm reduction means. That … it’s not necessarily a change in your pattern of use. It’s just tweaking it to make it as safe as possible for yourself. We’ll discuss the Australian guidelines for alcohol consumption a little bit. But then the main thing really, that I discuss with them are some strategies that they can put into place, that can assist them in [minimising harm]. (Participant 24)

Discussing the concept of harm minimisation as an alternate goal to abstinence with transitioning prisoners is arguably beneficial in the promotion of recovery and desistance trajectories. First, it has the propensity to encourage the development of personal agency by enabling individuals to set treatment goals they feel are achievable. This mirrors Bandura’s (2001) contention that change is more likely to occur when an individual is an active participant in facilitating change, that is, choice encourages active participation. Second, it may provide the opportunity for a change in cognition, which Giordano et al. (2002) refer to as a “hook for change” or “turning points” (Hser et al., 2007; Maruna & Roy, 2007; Sampson & Laub, 2005), by presenting individuals with a treatment option, about which they were unaware, that may act as the catalyst for motivating individuals to drive the change process.

One respondent explained that the overarching treatment philosophy within the Victoria AOD sector is harm minimisation. She said, “for people who are still actively
drinking a lot of alcohol … we’ll always look at harm reduction, that’s the primary purpose of what we do” (Participant 20). This emphasis importantly underlines the value placed on harm minimisation by forensic counsellors, recognising that not all individuals pursue, or are capable of achieving, a goal of abstinence.

This view is further evidenced by another counsellor, who explained the rational for a harm reduction focus:

[We] work [towards] harm minimisation with the goal of abstinence but [the] majority of clients don’t want to aim for abstinence because that basically prevents them from any socialisation … with family and friends which … isolates them. At the end of the day, it is the individual’s decision whether or not to pursue abstinence or take a [harm minimisation] approach. (Participant 35)

However, it is important to note that forensic counsellors do not operate solely within a narrow treatment paradigm but employ a “holistic approach” in the treatment setting. As one counsellor explained:

I try and [take] a holistic approach where alcohol is one of the issues, mental health is another issue, [physical] health is an issue. [I] try and put whatever I can in place – like a multifaceted approach – [I] try to deal with all those issues that are going to compound the alcohol use. (Participant 4)

Another respondent, who also employs a holistic approach in goal-setting exercises, spoke of the importance of being “strengths-focused”, explaining:

I’m strengths-focused because that’s … how I like to work. I feel if I provide a space for my clients to set personal goals that they can achieve, that may or may not be related to their alcohol use or their offending behaviour … that’s a really positive thing in their life. (Participant 20)

One respondent spoke of the importance of being cognisant of the “capacity” of each person. She said that acknowledging an individual’s strengths is:
Incredibly important for me. [It’s an] an understanding of where the client’s at, and also their capacity. Sometimes we get fixed on what they should be doing, forgetting what they’re capable of. If you’ve got this expectation you’re always going to think they’re not doing well when you forget to look at their strengths. (Participant 5)

In a similar vein, another counsellor spoke of the importance of identifying a person’s strengths and drawing on those strengths to set small goals:

[I’d say] ‘Okay, you’ve got one goal this week. What would you like to do?’ It could be the fact that they’ve got to meet their child from school one day. ‘Okay, how are we going to go about that?’ And it’s setting those tiny little goals, but when they come in next week [I’d say] ‘Yes. Did you, [or] didn’t you? (Participant 29)

Collaborating with clients in setting small goals not necessarily associated with their alcohol problems, but which they feel are achievable helps individuals to develop a sense of agency and self-efficacy and provides a positive framework for the planning of more significant goals related specifically to their recovery from alcohol misuse, for example, harm minimisation or abstinence.

**Harm Minimisation Strategies**

As alluded to in the previous sections, a harm minimisation approach aims to reduce the personal and social harms associated with problematic alcohol consumption by assisting individuals to alter their drinking behaviours. This is achieved by encouraging individuals to reduce the amount of alcohol consumed or by managing their drinking, rather than setting a goal of abstinence. Individuals who choose to continue drinking are often receptive to the idea of minimising harms that alcohol has inflicted on their lives as opposed to pursuing a goal of abstinence. Participant 13 explained, “Some clients … are happy to consume alcohol … that’s what they want to do … as a worker, it [is] my duty of care to try and ensure they do
it safely”. These strategies do not seek to negate all harms associated with problematic drinking but aim for “less” harm (Participant 13). This participant continued:

If they are spending $10.00 on five litres of wine, its most probably got very, very poor chemicals in there. So I … encourage them to buy – to get [better] quality [wine], and that would ensure less harm. Not no harm, but less [harm]. I also try to recommend to reduce the intake. If a person is drinking five litres a day, try to reduce to four … so reduction is always, always on the table. (Participant 13)

A recurring harm minimisation technique that emerged from the data, and one that several forensic counsellors utilised, was to suggest to clients that they periodically drink water when consuming large amounts of alcohol. One participant explained she suggests to her clients that they:

Drink water in-between every few alcoholic drinks. I [also] advise them [not] to drink a soft-drink, ‘cause that’s got sugar in it, and it’s going to dehydrate you even more. So [I] tell them that maybe every third drink you have, just quickly knock down a glass of water. And I explain to them that drinking a litre of water at home, after you have been drinking all night, doesn’t really help. Because you’re already dehydrated, and the point is to keep hydrated throughout the whole thing. And I also tell them that it helps with the hangover … because a hangover is related to dehydration. (Participant 24)

Another respondent spoke of the “great outcome” achieved with one client who adopted the strategy of drinking water periodically during a drinking session:

We’ve had a great outcome – I’ve been working with a guy who has been released from prison; alcohol is his key drug. I’ve been working with him around … harm minimisation. [He has] two beers, then … a bottle of water because it’s going to make [his] grog last longer. For him it’s not about harm minimisation. For him it’s about making his grog last longer. (Participant 22)

In this situation, the client achieves the outcome of harm minimisation. Even though his goal is to continue drinking and make his alcohol last longer, the counsellor has successfully
motivated the client to adopt a harm minimisation strategy by using a solution-focused approach to enable the client to achieve his own goal (his alcohol lasts longer).

The topic of water consumption also emerged in discussions of ways to reduce the potency of alcohol. One respondent explained:

Watering down alcohol is also good … because once they (clients) pass a certain level of drunkenness; it’s just a matter of that movement. And having the drink there … the smell, the taste – there’s a lot more to it (drinking), I’m sure. (Participant 13)

A further example of potency reduction was given by one participant:

If you’re drinking heavy beer, and you’re drinking is causing problems in your marriage and you’re abusing your children and you can’t stop drinking, can we look at maybe reducing it by starting to drink light beer, just to start that process of the reduction cycle because we know the client’s not going to [stop drinking] immediately. (Participant 28)

Other harm reduction strategies utilised by forensic counsellors include encouraging clients to plan how much alcohol they intend to consume and to practice refusal skills. One participant explained:

If you know you’re going out for a big night, just having a bit of a plan in your head, ‘All right, I’m going to stop drinking at 12 o’clock’. Or, ‘I’m only going to have half a dozen tonight’. Or just having some sort of idea, so that you’re responding rather than reacting in the situation. Also things like being aware of the time you started drinking, so that you can look at the clock and go, ‘Oh, shit. Its 5 o’clock in the morning I’ve been drinking for the last seven hours’. Things like that … Being able to just rehearse to yourself how you can say no if you want to say no, to decline a drink if you don’t want one anymore. That’s really important, ‘cause a lot of times people feel very uncomfortable saying no. And there is so much peer pressure. So I just tell people to think of something that’s a really comfortable sentence for them to say, whatever that may be. It doesn’t matter, whatever works for them. So being able to practice some refusal skills. That’s really, really important … if the client takes nothing but this one, I’m happy with that. (Participant 24)
These examples demonstrate how counsellors work collaboratively with clients in setting goals to minimise the harms associated with alcohol misuse.

During the interviews, I asked several forensic counsellors whether alcohol harm minimisation strategies produced positive outcomes. The following quote encapsulate the opinions of those who responded to the question:

Obviously [individuals] might be a little bit out of control, and [they’ll] just have a massive binge one night. But I think that these things [harm minimisation strategies] stay on board. And over a period of time, once clients start practicing [these strategies] … they can see that there are benefits … that it actually works. (Participant 24)

The examples demonstrate how forensic counsellors primarily work within a harm minimisation framework, which is a guiding principle of the Community Correctional Services Alcohol and Drug Strategy (Corrections Victoria, 2008).

During discussions relating to harm minimisation practices, some respondents in Regional Victoria indicated that a harm minimisation approach is often the preferred treatment option for Indigenous clients. One counsellor spoke of the importance of assisting Indigenous clients to develop “other interests” in order to refocus them away from their alcohol misuse:

If we can solve some of the problems like housing, like getting them gainful employment, or even back into school, then [their] alcohol problem diminishes, because they’ve got other interests. But if they’re sitting around all day, and they’ve got nothing better to do, than [to] sit down with their bros and drink. So that’s where harm minimisation or the harm reduction and looking at ways to divert them from wanting to drink. (Participant 30)

**Abstinence**

Not all transitioning prisoners choose to adopt a harm minimisation treatment approach. Some believe that striving for abstinence is the only option available to them if behavioural
change is to occur. Participant 19 explained that she has a number of clients who say “I can’t do that, [reduce or manage their drinking] cause they have one drink, and they say they can’t stop … so their treatment goal [by default] would be abstinence”. According to one forensic counsellor, it is not uncommon for clients who identify abstinence as a treatment goal, to claim they are going to give up alcohol immediately (Participant 29). In recognition of the non-lineal nature of most recovery journeys, the same respondent explained to one client who said “I’m going to give up alcohol” that:

‘It’s like a ladder. This is where you start, this is where you want to be, but you see all these rungs between?’ I often say to them, ‘If you want to catch a bus, you’re not magically going to be there on the bus,’ I said, ‘How many steps does it take? How many steps does it take to make a cup of tea?’ It clicks. Small goals. We go through small goals. (Participant 29)

This data again demonstrates the importance of the role of the counsellor in assisting the client to set goals that are achievable. Writing on how to implement a solution-focused approach when treating problem drinkers, Insoo and Berg (1992, p. 41) argue that identifying “the first small steps the [client] needs to take rather than [focusing on] the end of journey” is vitally important.

Relapse Prevention

Setting goals with clients who choose to pursue an abstinence lifestyle focuses on relapse prevention strategies. It is important to note, that the terms “lapse” and “relapse” are often used in substance abuse literature, but have markedly different meanings. A lapse occurs when an individual “slips” occasionally into previous drinking habits but returns to pursue their treatment goals (Queensland Government, 2013); whereas a relapse occurs when a person returns to problematic alcohol misuse and continues drinking in that manner, rather
than returning to their treatment goals (Queensland Government, 2013). The importance of working closely with post-release clients to identify “triggers” that may result in a relapse was mentioned by one participant who said, “we’ll look at things like triggers, which is very important, especially if someone is just coming out on parole. There’s going to be a lot of triggers out in the community” (Participant 24). Another participant explained:

It’s just trying to help them [the clients] understand and change [the] behaviour that … starts the day off. [They] need to be pushing back [the first drink]. Maybe the first step is to make it [the first drink] after lunch or try get your jobs done … occupy yourself with something else. It’s maybe identifying those cravings then, once they do come on, try to distract themselves. It’s not just that easy just to say stop drinking. (Participant 35)

The risk of relapse among those transitioning from prison into the wider community was noted by one counsellor who said:

I’ve actually had a number of clients who have identified alcohol as their primary substance, who are reporting that they haven’t had a drink for some time. I had one guy, he was released just before Christmas and managed to somehow make it through Christmas and New Year. So with him, it was … a lot about relapse prevention. We spend a lot of time identifying triggers for cravings and triggers for wanting to have a drink and talking about ways you might cope with those situations. He was really honest about finding [it] really difficult. But he’d done really well. We did a lot of reinforcing in terms of [talking about] distracting himself from wanting to have a drink. (Participant 20)

These examples draw on elements of a commonly used relapse prevention strategy known as the “Four D’s” which educates individuals on how to distract themselves from the urge to have a drink when they experience cravings. Acknowledging that lapses and relapses often

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26 The strategy of the Four D’s entails: Delay – the client is encouraged to delay the decision to use. Cravings come in waves and will pass; Distract – the client engages in an activity such as reading, going for a walk, practice relaxation techniques, and the craving or urge to use will pass; Deep Breathing – the client is encouraged to practice deep breathing exercises when they have a craving or urge to use; Drink a glass of water – the client has a glass of water (Queensland Government, 2013, p. 12).
form part of the recovery journey, one forensic counsellor explains to his clients the importance of not losing hope if a lapse or relapse occurs:

If you have a lapse, don’t lose hope, don’t lose that optimism. ‘Cause you learn from it, you get stronger, you come back and you have a go at that cycle. And you’re better prepared the next time around. And you don’t go right back to the start. It’s easier to take action, get back into that maintenance stage after the first time. (Participant 19)

In addition to educating clients on relapse prevention strategies within the treatment setting, counsellors commonly encouraged their clients to attend Alcoholic Anonymous (AA) meetings on a regular basis as a form of relapse prevention. The extent to which releasees attend and benefit from AA as part of their recovery journey will be discussed later in this chapter.

Episodes of Care
In the Victorian AOD sector, post-release treatment for alcohol problems is delivered by forensic counsellors through an “episode of care” (EOC). An EOC involves six, one hour counselling sessions (Participant 20). If a single episode of care fulfils the mandated condition of an individual’s parole order, but the client indicates they would like to undertake further counselling, Participant 20 explained that “we can re-episode them for another six sessions … provided our team leader [approves the extra sessions]”. However, when the topic of an “episode of care” was raised, respondents argued six sessions was inadequate to address the multiple and highly complex issues associated with alcohol misuse. One counsellor suggested the limited treatment time allocated to their clients was linked to funding issues. She stated:

It’s money. What you’re looking at is Department of Health funds … X amount for an episode of care, and if you’re taking [a] longer time [with a
client], you’re stopping the next person coming in [which generates] funding. So their funding figures go down … that’s basically what it is. All the time it’s about … stats, you’ve got to have those stats [which] goes against everything we stand for. As counsellors, it really gets us. (Participant 29)

Another respondent commented on the limitations of an EOC and the prevalence of “exiting” clients early for non-attendance:

The problem with episodes of care in terms of after-care that we provide like counselling consultancy and continuing care, there is so much demand for that that they’re often exited way too early. They’re excited because of non-attendance. We need an assertive outreach model but unfortunately the funding doesn’t allow an assertive outreach model because it would become way too expensive to be doing. And a lot of them, particularly long-term drinkers, will require support for a long, long time. (Participant 25)

Critical of the limited time-frame that constitutes an EOC, another counsellor equated six sessions with a brief intervention stating:

I guess in the forensic team, if you were going to use one term [to describe an EOC] you’d be talking about [a] brief intervention because that’s essentially what it is because we have really limited time … it’s much harder to … create change in only six sessions. (Participant 20)

One counsellor spoke of the inability of her clients to “meet significant goals” within a six session time-frame:

You can’t meet significant goals in less than six sessions, and even then they’re really basic. There are some organisations that will see people for six sessions … because that’s an episode of care and we are driven by episodes of care, we have to meet so many episodes of care a year and … it’s public money, it’s taxpayers’ money, I think we’ve got to find the balance between the fact that we’re paid to do a job and to see as many people and support as many people as we can. I don’t have a problem with that, but it is sometimes a fine balance because if I have a therapeutic alliance and I’m seeing someone on an ongoing basis, those goals can change and the plans can change and

27 In this context the term brief intervention used by the counsellor was a reference to the brevity of the intervention.
sometimes it’s all too hard and they’ll [the clients] disappear on me and then they’ll pop up again. My manager is always saying, will you close that episode and open another episode. I tend to see it as all part of the same episode, to be honest. So in my world, how long is a piece of string? I have an alliance with a human being and I’ve travelled between different AOD organisations and some of my old clients pop up again when they relapse. (Participant 16)

As noted in Chapter Three, best practice standards for AOD interventions recommend that programs be no less than three months in duration, and that better outcomes occur with longer durations of treatment (National Institute on Drug Abuse, 2014). Applying this recommendation to the six session model delivered to AOD clients in Victoria, it is clear the Victorian model falls well short of recommended best practice standards required to foster behavioural change.

It is important to note that the Victorian AOD sector has undergone a major reform with the aim of “transforming it from a series of multiple, complex, episodic transactions to one that supports people to make positive changes in their lives when they decide to seek help for an alcohol or drug problem” (Department of Health Victoria, 2012, p. 5). Implementation of these reforms commenced on 1 September 2014 (Department of Health Victoria, 2014a), after the interviews for this thesis were concluded. Prior to the introduction of the reforms, counsellors spoke of their hope that the six session model would be reconfigured to extend the duration of an episode of care. One respondent said, “I’m really glad they’re reviewing … episodes of care … because six sessions is often not enough time” (Participant 27). The same counsellor went on to say she was:

… quite excited about some of the ideas around being a little bit more person centred for forensic people, because I feel that the six session model – a lot of people either need more or less. Getting them to attend six sessions – getting them to attend four sessions is like pulling teeth. And we have to negotiate, do a lot of work around resistance to get them to agree to do four sessions. It’s a condition of their Order. And then you’ve got other ones with deeper issues who need more than six sessions; six sessions isn’t enough. So I’m hopeful
and fairly optimistic that the reforms are going to give [us] the opportunity to be able to work in that way.

However, to what extent the duration of an episode of care has been extended within the new reform structure remains unclear. A fact sheet published by the Victorian Department of Health, detailing the funding model for the provision of AOD treatment services under the sector reforms, does not make explicit reference to what constitutes an episode of care for adult non-residential services (Department of Health Victoria, 2014b). Instead, the fact sheet refers to “a ‘course’ of the particular treatment type involved that is modelled on an average number of sessions or length of support required”. The paper further states, “to ensure that complex and high needs clients are provided with care that meets their needs, separate ‘standard’ and ‘complex’ products will apply to counselling and withdrawal treatment streams” (Department of Health Victoria, 2014b, p. 2). However, what constitutes “an average number of sessions” is not specified in the fact sheet. Therefore, the extent to which the new reforms provide the latitude for treatment with a forensic counsellor to continue until behavioural change occurs, remains uncertain.

Within the Victorian AOD sector an episode of care refers not only to counselling sessions but also includes “time spent in a withdrawal unit or a residential rehabilitation facility” (Participant 20). This means that for individuals who require medical support to withdraw from alcohol, or who are assessed as needing more intensive treatment in a rehabilitation facility; forensic counsellors can request in-patient placements for their clients.

**Alcoholics Anonymous**

Although AA is not specifically a treatment protocol delivered by forensic counsellors, they commonly encourage clients who choose a goal of abstinence to engage with the fellowship
and attend regular meetings. In the main, however, respondents suggested that attending AA did not appeal to the majority of their clients. Participant 28 said, “[I] have a few clients attending AA … it’s the ones that are really ready to change because they’re sick and tired of being sick and tired”, that embrace the AA philosophy. They identify that their [drinking] has got them to a place where they now want to change it. Another participant suggested that in the two years she has been working in the sector, only a few clients have been willing to try the AA program (Participant 2). Clients were more likely to attend AA and embrace its core philosophies if they had “done it in prison”; whereas, “the ones that haven’t [attended AA sessions in prison], they’re a bit negative … because they hear that it’s a religious based program” (Participant 4). The perceived religious element of AA and having to declare that you are an alcoholic were reasons clients gave for not wanting to attend AA meetings:

Some people believe in a higher power and some people don’t. Some people don’t like to listen to other people’s problems. Some people don’t like to talk about their problems. (Participant 9)

The requirement to identify as an alcoholic at AA meetings was another reason counsellors gave for their clients’ unwillingness to attend:

For someone to attend AA they would have to identify themselves as being an alcoholic, and there’s a lot of people with alcohol related offending who don’t view themselves as alcoholics and abstinence is just not an option for them. (Participant 33)

Similarly, Participant 34 noted:

It’s [AA] right for some and not for others … they’re just not going to be part of it at all. Other people don’t identify that they fit the mould, they’re all different, that’s not me, I wasn’t behaving like that, I’m just a drink driver. (Participant 34)
Although the data reveals very few transitioning prisoners saw affiliation with AA as a viable option for their recovery journey, one forensic counsellor spoke of the social benefits he considered AA has to offer. The counsellor explained:

For a couple of clients who did give it [AA] a try it was able to link them in with other people. They weren't alone trying to deal with their problems. People in AA had experienced a lot of the issues that they’ve experienced and [are] going to experience. It was real beneficial. (Participant 4)

While this example highlights the social benefits of attending AA meetings, one counsellor suggested that the majority of releasees she had treated in both Metropolitan and Regional Victoria considered AA to be a “waste of time” and “old hat” (Participant 22). Individuals who reside in the Melbourne Metropolitan area, and choose to attend AA, have easy access to AA meetings as they are held on a daily basis in many suburbs. On the contrary, in Regional Victoria accessing AA meetings is difficult. One respondent explained, “cause we’re regional, people have to travel quite some distance for an AA meeting” (Participant 36).

While it is beyond the scope of this thesis to examine the disparity between the availability of treatment services in Metropolitan Melbourne and Regional Victoria, the geographic distances in Regional Victoria are an obstacle to timely access to the support provided by AA thereby presenting a structural barrier to recovery.

**Alcohol Bracelets**

During the interviews, several participants spoke of the increasing use of alcohol bracelets as a parole condition for individuals who have an alcohol abstinence requirement attached to their parole. One counsellor said, “I haven’t seen many before but they’re starting to come through a bit more on parole orders now” (Participant 34). In Victoria, the judiciary is able to mandate parolees to wear ankle bracelets “that monitor their blood-alcohol content through
sweat molecules” and if alcohol is detected, “a silent alarm is triggered for corrections authorities” (Johnston, 2013, p. 3).

Counsellors held conflicting views regarding the advantages and disadvantages of fitting parolees with alcohol bracelets to detect any alcohol consumption. One counsellor spoke of the pros and cons of fitting individuals with an alcohol bracelet:

I suppose when you compare and contrast someone’s human right to not be controlled around their substance misuse, and compare and contrast that [to] when they do drink they go out and beat someone up or put someone in hospital or crash a car or offend in a way in which they’ve done in the past – [fitting them with an alcohol bracelet] makes sense … would be for the greater good.

Another participant expressed a view that fitting someone with an alcohol bracelet could be counterproductive in some circumstances, especially for someone who has not disclosed their alcohol misuse to all family members. She explained the difficulty one female client experienced trying to reconnect with her family as a result of having to wear an alcohol bracelet:

Her major concerns are the indignities, the lack of privacy and she hasn’t told her nieces, for example, who are very close to her, they’re part of her family, and they go away at Christmas time. Her family as part of her recovery is very much looking at drawing her back into some family activities and holidays at the beach with [her nieces]. [Being fitted with an alcohol bracelet] … means everyone, of course, is going to [see it] and ask what it is. So it means if she does wear it, holidays are going to have to change as a result. She can’t explain when she goes away with them why she’s not going in the water or why she can’t wear shorts. It’s less about levity than it is about the quality of life that one would hope someone trying to re-integrate back into the community can start to experience, because … if she re-integrate[s] she’s less likely to offend. She’s considered all of the possibilities about lying and saying she has a job and going down [to the beach] in the evening [when] people won’t see it in the dark. (Participant 16)
The same participant suggested that for this client, being mandated to wear an alcohol bracelet was encouraging her to be “devious … which is not a behaviour we’re trying to encourage her to embrace in order to fit into the community” (Participant 16). The interviewee also held the view that by her client being forced to wear an alcohol bracelet the pressure placed on her to not drink was “external” and prevented her client from taking responsibility for her own behaviour. She said:

My concern is what happens when she gets off parole because all of the pressure has been external, there’s no gradual stepdown development into her own autonomy to start taking responsibility [for her drinking]. The brain isn’t going to get that to practice its good plasticity and develop slowly without some guidelines, and I think that’s a shame because if we could do that within the parole period, she’s probably got a better chance in the longer term of remaining crime-free. (Participant 16)

These examples raise several concerns regarding the fitting of alcohol bracelets to enforce alcohol abstinence. While it may be argued that this type of electronic monitoring device is less punitive than imprisonment, it arguably prevents the client from reconnecting socially with her family members and her peers. Throughout desistance and recovery literature, the importance of reconnecting with family and developing pro-social relationships is strongly emphasised as a means of promoting behavioural change. However, for this woman, wearing an alcohol bracelet is clearly a structural barrier to her effectively reconnecting with her family and, in fact, is encouraging devious behaviour as she grapples with how to hide the device from family members while participating in social activities. Furthermore, research suggests that individuals are more likely to engage with, and remain in treatment when they are permitted to take responsibility and control over their treatment options (Ambrogne, 2002). This thesis argues that for some releasees, alcohol bracelets are a punitive response and of little rehabilitative value as they remove the opportunity for
individuals to exercise their personal agency. They also diminish the opportunity to work collaboratively with their counsellors in choosing a treatment strategy that is most appropriate and achievable in addressing their alcohol misuse. Furthermore, enforcing sobriety through the wearing of an alcohol bracelet is more likely to leave the individual at risk of resuming drinking in a harmful or hazardous manner, after the device is removed, as has they will not have developed effective avoidance or harm minimisation strategies.

**Availability and Accessibility of Support and Treatment Programs**

A core aim of this research was to examine the extent to which support and treatment services were available and readily accessible to releasees with alcohol problems. AOD treatment agencies, funded by the Victorian government, are required to provide parolees with “an appointment within two days of their release” from prison (Participant 24). As discussed in Chapter Three, individuals are considered to be at an increased risk of re-offending in the hours and days following release from prison. In this context, there is a heightened risk of resuming pre-prison alcohol misuse for those who did not receive appropriate treatment and support for their alcohol problems while in prison. The policy requirement of providing an appointment within two days of release indicates recognition of the vulnerability of those exiting prison on the part of corrections administration. Participant 24 noted that in her experience, parolees were waiting “a few weeks” to access a treatment service, as there was “a bit of an influx of clients” due to the AOD sector tendering and reform process then being undertaken (Participant 24). Another respondent explained further:

> We have record numbers of organisations refusing service because they haven’t got the staff. They’re actually obligated by the Department to take them through a retainer and they’re actually saying, no, we’re not taking them. We’re in a power load of shit. (Participant 23)
In relation to the research, examining the availability and accessibility of post-release support and treatment services was rendered problematic, as the interviews were conducted from November 2013 until April 2014 in the period leading up to the roll-out of reforms to the Victorian AOD sector, which were due to commence in July 2014.

Expanding on the discussion surrounding the new reforms and why there were delays in allocating appointments to some clients, one counsellor reported:

The issue we’ve got at the moment with treatment services is because of the way funding is being organised in tenders, we’ve seen a lot of people reluctant to take on [new clients] … because they’re not sure if they’re going to have jobs in another couple of months. So they’re putting a lot of treatment on hold, which then puts our clients more at risk. We haven’t heard about tenders. No treatment agencies have heard as yet. (Participant 21)

The uncertainty surrounding which agencies would be granted tenders to deliver AOD support and treatment services under the new reforms, resulted in some professionals “jumping ship” because of job insecurity. One support worker explained:

People are jumping ship [and] getting out of the drug and alcohol sector because they don’t know what’s going to happen [after the roll out of the new reforms] … so they’re saying, we don’t know if we’re going to have a job, we’re going to go and get a job elsewhere. (Participant 22)

The topic of staff shortages was also raised by a participant from Regional Victoria:

A huge issue in the country (Regional Victoria) is worker retention and the availability of workers. We’ve had a huge issue here in [name supplied] … we’ve gone through workers [they] move on or burn out or get a better offer because drug and alcohol workers are paid appallingly. Our last worker who [left] was fan-bloody-tastic … [she] was offered a job in [another] sector where she was being paid significantly more and she didn’t have all the uncertainties of the sector restructure as well. (Participant 25)
In addition to counsellors leaving the sector due to the uncertainty of job tenure in the post-reform era, it was also suggested that in both Metropolitan Melbourne and Regional Victoria there are, “record numbers of organisations refusing service because they haven’t got the staff” (Participant 22). The same respondent summed up the situation during the AOD tendering process stating, “it’s reached dire straits at the moment. We’re having treatment agencies refusing to take referrals” (Participant 22). As a consequence, clients were either denied a treatment place or had to wait for a place to become available. Even though agencies are funded to provide AOD treatment services in a timely manner, one counsellor suggested some agencies have “pretty much gone, nup, [we’re not taking any new clients] and that’s to do with all of the reforms” (Participant 22). Another counsellor said, “because of the retendering, we’re getting longer waiting lists … because [treatment agencies] don’t know if they’re going to be open [after the reform roll-out]. We’re fighting this losing battle at the moment because nobody’s being told what they’re getting funding wise” (Participant 21).

It is evident that the “retendering” process created a significant structural barrier to some individuals to gaining access to AOD treatment services. Participant 25 suggested that in addition to the “retendering” process, access to treatment in one Regional Victorian centre was further hindered by the difficulty in replacing a counsellor who had left the organisation. She went on to say that this created “a huge waiting list” for treatment services which resulted in “people falling through the net” (Participant 25). The lack of timely access to treatment services is most concerning, as prior research emphasises the importance of releasees having support in the days and weeks following release, which is the time when they are most vulnerable to reoffending and, as the data suggests, drinking problematically.

I posed the question, “What is available to support the growing number of clients who are waiting to gain access to treatment?” The general opinion of forensic counsellors was
summarised by one respondent who stated that in Regional Victoria “it’s a crisis … we have nothing to offer [them]” (Participant 22). Another participant explained:

I need to get them into treatment this week … while they’re presenting. But if it’s three weeks, four weeks down the track, who knows where they are by that stage? They may have been kicked out of their accommodation … or they may have moved on. They may have been reasonably sober at this stage but in another couple of weeks they won’t be. (Participant 25)

In addition to the difficulties releasees encountered in trying to access alcohol counselling services, respondents from both Metropolitan Melbourne and Regional Victoria suggested that finding residential rehabilitation placements for their clients was problematic. This was also attributed to the retendering and reform process being undertaken.

**Residential Rehabilitation**

Residential rehabilitation services were reported to be in similar short supply as stated by Participant 23:

Rehab is usually at least a three month wait. [But] because of the retendering, we’re getting longer waiting lists … because rehabs don’t know if they’re going to be open after 1 July [2014]. So if they’re taking someone in for a three month course, they are starting to [close their books] at the end of March [2014] because they can only take them for three months. So that’s another issue. So it’s kind of like we’re fighting this losing battle at the moment because nobody’s being told what they’re getting, funding wise. (Participant 23)

Not all respondents spoke of the availability and accessibility of support and treatment services in the context of the impending reforms. Some spoke more generally about the availability of post-release services and were quick to point out that there was a distinct lack of appropriate programs for individuals whose primary or sole substance misuse problem was
related to alcohol. The following response offered by one forensic counsellor summed up this issue:

In terms of alcohol … unless it’s specifically related to their offences, or the person identifies that it’s been a big problem for them, it’s never going to be a priority. And the reality is that even if they say, ‘I have a huge drinking problem’, the chances of them getting into a long-term supported program, are so minimal. And so it’s being left [to] people, like Corrections officers, who may have done an Alcohol and Other Drugs course. Or in the case of me, no background in it whatsoever, job trained. So you do the best that you can with what you’ve got, and it’s about trying to get people into treatment. So if … they’ve done their two courses [EOC] or treatment per order; if they get to the end of that, and they don’t have any other support, it’s trying to find them support. And it’s just – it’s not out there. (Participant 6)

The following quote affirms the priority placed on issues associated with illicit drugs rather than alcohol-related services for post-release prisoners:

In society we’re accepting the fact that if we can work with somebody with a drug issue, we can actually start to reduce and see the change in that, but the alcohol consumption goes up but we don’t worry about that because we’re getting the drugs down. (Participant 23)

These quotes from several participants suggest that there is a general lack or inadequacy of post-release treatment services for releasees with alcohol problems. These deficiencies were increased by the failure of government to consider the varying needs of individuals who require treatment. This was compounded (at the time interviews were conducted) by the discontinuity and lack of certainty regarding ongoing funding arising from the then impending reforms.

**Conclusion**

This chapter mapped the landscape of the various post-release alcohol treatment models and strategies delivered by forensic counsellors. The treatment models and strategies employed
by forensic counsellors include MI, which is a collaborative, person-centred approach which draws on goal-setting techniques to strengthen individuals’ motivation in order to encourage behavioural change. As demonstrated by participant voices, MI is a key technique commonly employed to counteract clients’ ambivalence to embrace change, which is often a factor in the recovery process. Importantly, ambivalence is also addressed through negotiation with clients to assist them to develop their own treatment plans. Enabling clients to set their own treatment plans and goals is seen by participants as fostering a sense of hope and empowerment in their clients, which is considered an important factor in initiating desistance and recovery journeys.

Personal agency is strongly encouraged as a means of promoting client optimism, which in turn engenders a belief that change is possible. Moreover, personal agency is also encouraged by enabling clients to choose either harm minimisation or abstinence as a treatment goal. Harm minimisation was stated to be the overarching treatment philosophy in Victoria. This approach recognises that pursuing a goal of abstinence at the commencement of treatment may be too big a step for some clients.

The uncertainty surrounding assured funding was raised by several participants in both Metropolitan Melbourne and Regional Victoria. At the time the interviews were conducted, the Victorian AOD sector was undergoing a retendering and reform process. This led to difficulty in being able to assess the availability of treatment services.

Although, the episodes of care (typically six one-hour sessions) are short in duration, nonetheless, they facilitate initial contact between forensic counsellors and clients, therefore, provide the opportunity for the development of a professional relationship. As this chapter argued, it would be beneficial for the duration of such sessions to be extended, if any
development is to be made in assisting prisoners transitioning with an AUD and developing coping strategies to avoid further harm or offending.

The next chapter builds on this discussion by examining the ways in which support workers and forensic counsellors develop a strong therapeutic alliance with their clients and how this relationship is used to assist releasees develop essential social and human capital resources. It also highlights the important role of support workers and forensic counsellors in the transition process.
Chapter Eight

Building Capital Resources through Post-Release Service Provision

This chapter examines the extent to which capital resources are generated through a strong therapeutic alliance in the post-release support and treatment setting. As discussed in the theoretical framework in Chapter Two, the propensity for individuals to desist from crime and recover from alcohol misuse or abuse is largely dependent on their accumulation of capital resources. Desistance scholars suggest that individuals who build reserves of social and human capital increase the likelihood of initiating a desistance lifestyle (Farrall, 2004; Maguire & Raynor, 2006; McCulloch, 2005; McNeill, 2009; McNeill et al., 2012). Similarly, other scholars maintain that recovery from alcohol misuse is more likely to occur when recovery capital resources, namely social, human, physical and cultural capital are accrued (Advisory Council on the Misuse of Drugs, 2013; Best & Lubman, 2012; Best et al., 2010; 2008; Edinburgh Alcohol and Drug Partnership, 2012; Lanarkshire Alcohol and Drug Partnership, n.d.; Laudet et al., 2009; Lyons & Lurigio, 2010; McHugh, 2013; Mistral & Wilkinson, 2013; United Nations Office on Drugs and Crime, 2008; Welsh Government, 2013).

This chapter examines three factors deemed crucial in the processes of desistance and recovery, namely the development of social and human capital resources and a strong therapeutic alliance. This will be achieved by drawing on the extant literature and the findings discussed in Chapters Six and Seven, to critically analyse the extent to which these important factors are fostered in the delivery of post-release support and treatment services.
Social Capital

Social capital is a relational concept that refers to the pro-social ties a person has with family, close friends, acquaintances and members of the wider community who are likely to be supportive of an individual’s desire to change their behaviours. The importance of having strong social ties with family, friends and other people involved in supporting an ex-prisoner’s desire to embark on the process of behavioural change is grounded in the desistance and recovery literatures (Baldry et al., 2003; Hirschi, 1969; Hser et al., 2007; Laub & Sampson, 2001, 2003; Sampson & Laub, 1993, 2003, 2005; Visher et al., 2004). In addition, the literature distinguishes between two forms of social capital: “bonding social capital”, which refers to the pro-social relationships developed with family members and close friends; and “bridging social capital”, which denotes new pro-social relationships developed with acquaintances and members of the wider community (Lyons & Lurigio, 2010; McNeill, 2009; McNeill & Weaver, 2010; Weaver & McNeill, 2011). Both forms will be discussed in this chapter.

It is important to note that desistance and recovery literatures strongly suggest that behavioural change is more likely to occur when both social capital and human capital resources are developed and accumulated. The difference between the two concepts is explained by Coleman (1988, p. S100), who notes that human capital is “embodied in the skills and knowledge acquired by an individual” and is a more tangible construct than social capital, which develops as a result of pro-social relationships. Moreover, these two concepts are inextricably linked from the perspective that the more social capital (supportive pro-social relationships) individuals have, the greater the opportunities for the development of human capital (skills and knowledge) through the creation of new social connections, which may
lead to employment opportunities or the development of meaningful relationships with members of the wider community.

**Family**

Family members and close friends are widely regarded as valuable forms of social capital that releasees can draw upon for support in their efforts to desist from crime and recover from alcohol misuse. Participant 2 explains the concept of social capital in relation to families. She states that “families can be a help”, providing the newly released prisoner with “stable accommodation, food and material and emotional support”. However, these sources of post-release support were, in the main, not available to the clients of those interviewed in this study. This indicates that the interviewees’ clients have very low social capital stocks to draw on in the behavioural change process.

As discussed in Chapter Six, participants indicated that in general, their clients with Alcohol Use Disorders (AUDs) “very rarely” had the support of families and friends as “they had burnt all their bridges” after continual cycles of drinking, incarceration and release. One respondent spoke of the reasons why most of her clients have little or no post-release support from family and friends:

Most of my clients will have little to no contact with their families. Their families have got to a point where they no longer want to have contact because it’s too difficult, too hard. It’s the same thing. It’s repetitive. They’ve tried and failed numerous times. They’ve supported them emotionally, financially, through accommodation, all sorts of different things, and nothing has actually helped, so they just cut ties. (Participant 2)

Participant 4 similarly spoke of her AUD clients having no support from family or friendship networks because “most people in their lives have wiped them [due to] their past behaviours”. She went on to explain that:
A lot of [family members] don’t understand alcoholism and the nature of addictions. So I’ve done a bit of work around family reconnection and just educating some parents that were forever rescuing their children. [But] it’s a challenge. (Participant 4)

Another respondent explained that if a client wants to try and repair a fractured family relationship, she suggests inviting the family to attend a counselling session:

If the client identifies that they’ve lost contact with their family, and that they would like to regain contact with them I say, “If they want, they can come in ... Shall we contact them and see if they want to come in and sit with us for a session?” So there’s [sic] informal things like that. Or we can say, “Look, we can actually offer your family a single session, or one-on-one counselling session.” But it’s always got to be client driven. If they want to re-engage with their family, then I’ll ask them, “Well, how are we going to go about this? What’s the best way to do it? Should we call them? Do you want to maybe call them on your own? Do you want to write them a letter? Do you want help with writing the letter?” (Participant 24)

Offering to assist individuals with re-engaging with their families is an example of how support workers and forensic counsellors can act as a form of ‘bridging social capital’. Although bridging social capital usually refers to building new pro-social relationships with members of the wider community, helping individuals re-engage with families – where the relationship is strained or broken – arguably performs a bridging function to a potential renewed family relationship. In turn, this may evolve into a meaningful form of bonding social capital that individuals can draw on for support and encouragement in their attempt to initiate a desistance and recovery lifestyle.

This is demonstrated by the “person-centred” approach adopted by Participant 24, where the focus is not only on addressing the client’s alcohol misuse, but on enabling the client to exercise their personal agency in determining if, how or when to involve their families in the recovery process. Participant 24’s comments demonstrate how she draws on
elements of a desistance-focused and recovery-oriented approach by working collaboratively in a problem-solving exercise with her clients, yet at the same time, enabling the client to be the ultimate decision-maker. This approach resonates strongly with desistance and recovery literatures that emphasise the importance of assisting ex-prisoners to develop a sense of personal agency (Adams, 1997; Best, 2010; Bottoms et al., 2004; Healy, 2010, 2013; McNeill et al., 2005; McNeill & Weaver, 2010; Paternoster & Bushway, 2009; Vaughan, 2007; Weaver & McNeill, 2007). Furthermore, by offering to assist the client in taking the initial steps towards re-uniting with family members, the counsellor is providing the client with a sense of hope for a better future, which is a subjective concept featured prominently in desistance and recovery literatures (Best & Lubman, 2012; LeBel et al., 2008).

Continuing the theme of having a supportive environment to return to after exiting prison, Participant 28 spoke of the importance of releasees having “good people” around them:

You need good people around you. Without good people, everyone’s going to struggle. So that’s the first thing we do with clients who [come] out of prison … [We try to] put a good circle around them so that [even if] they continue with their offending behaviour … they’d be learning things they didn’t even know they were learning.

In this quote, Participant 28 recognises “good people” as being supportive and further acknowledges that even if re-offending occurs, the support and encouragement of NGO professionals can provide the releasee with the capacity to learn other “things” such as “being able to communicate adequately with people outside [prison]”. He explained, “communication [in wider society] is different from being in prison … so they have to learn a new [way of communicating]”. This is important, as effective communication skills are likely to be a pre-requisite for building capacities to develop meaningful pro-social relationships.
The same participant spoke of one client he was currently seeing who was originally reluctant to communicate with people in the community but was now “talking to people that he wouldn’t have done in the past” (Participant 28). The counsellor attributed his client’s previous inability to effectively communicate with others to the effects of institutionalisation. He said:

[In prison] you’ve had everything done for you. You’ve been fed, dressed, your routine has been dictated, and to come out and to be unsure about where you’re going to be sleeping or sleeping in hotels of some sort … must be just terrifying. (Participant 28)

Another participant expanded the discussion of the effects of institutionalisation and spoke of the ‘stigma’ associated with having been incarcerated that makes some individuals hesitant to engage with others in the community:

I sense this dreadful sense of isolation and disconnection from the rest of the community because of the stigma associated with prison. They think that people know they’ve been in prison, as soon as they look at them. People really wear that on their sleeve and … that’s that whole disconnection from the community. It is really worrying because it just means that it’s more likely they’re going to find themselves back in prison if they don’t feel a connection to their community. (Participant 17)

When support workers and forensic counsellors assist their clients to develop effective communication skills, they provide learning experiences and human capital resources that clients can draw on and utilise when communicating with members of wider society. For example, as discussed in Chapter Five, releasees frequently require assistance and information regarding how to obtain a “Myki card” or “what to buy at the supermarket”. In order to carry out these tasks, releasees will need adequate communication skills to clearly convey what they require in order elicit a positive response from those they are seeking assistance or services from.
Further to learning “things”, Participant 25 highlighted the importance of releasees with AUDs building pro-social relationships with members of the wider community who do not drink problematically. She stated:

One of the things is about building friends that are not part of their drinking circle, ‘cause a lot of them talk about the drinking schools that they have, and so forth. Programs like *Men in Sheds*,

and community hubs can be really great, but the guys have to be relatively recovered before they get involved in those.

The importance of developing personal relationships in non-drinking environments was noted by another participated who stated:

Look, I think that’s really important because it gives that person a sense of belonging and a sense of purpose. And with a sense of belonging, if they feel accepted, they’re more likely to move on from what the issues are. Having said that, is also a sense of belonging so it’s about do they go back to that same environment, that same social circle? And it’s often about making them realise it’s, probably, not that social circle that’s ideal for you as part of your recovery. How about you make new friends this way. So it might be talking about join[ing] a gym. (Participant 21)

Forming relationships with people who are not “part of their drinking circle” resonates with the work of McIntosh and McKeganey (2000), who maintain that those who move away from socialising in drug-using networks and develop pro-social activities are more likely to achieve behavioural change. Additionally, the importance of accruing social capital through the development of supportive pro-social relationships mirrors the work of desistance and recovery scholars (Best & Laudet, 2010), who argue that those who have strong social bonds

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28 The modern Men’s Shed is an updated version of the shed in the backyard that has long been a part of Australian culture. The Australian Men’s Shed Association (AMSA) recognises a Men’s Shed as any community-based, non-profit, non-commercial organization that is accessible to all men and whose primary activity is the provision of a safe and friendly environment where men are able to work on meaningful projects at their own pace in their own time in the company of other men. A major objective is to advance the well-being and health of their male members (AMSA, 2011).
and supportive networks that encourage the individual in the change process are more likely to achieve positive outcomes.

The preceding discussion emphasises the value of developing pro-social relationships in order to accrue social capital resources. However, as previously discussed, the data strongly suggests that most of the interviewees’ clients have little post-release support from conventional sources such as family members or close friends. The low level of post-release support from these sources amplifies the need, and importance of, the support and encouragement that can be provided by support workers and forensic counsellors.

Non-Government Organisation (NGO) Professionals

The data suggests that post-release support workers and forensic counsellors are the primary source of support and assistance available to their clients. One participant suggested that regular contact with a post-release support worker or counsellor can provide social supports similar to those usually derived from family members and close friends. She said:

It is extremely difficult for socially isolated clients who don’t have a lot of access to social capital to recover. That is not to say they can’t. But from my experience, clients who have a supportive family or even a close friend or a worker that they see regularly are more likely to recover or make some positive changes than people who don’t have that. (Participant 20)

The suggestion that a post-release “worker” can be a source of social capital mirrors the contention of McNeill et al. (2005), who point to the importance of ex-prisoners having someone who believes in them and who in turn will be a vital source of encouragement and support through the “lapses and relapses” that are common obstacles faced in desistance and recovery journeys. This convivial type of relationship between professional and client can be seen as a form of “bonding social capital” in which a sense of “obligation” and the
development of “reciprocal trust” is likely to establish a bond between individuals who share
the common goal of achieving behavioural change. Thus in line with the literature, and the
findings from this study, in cases where ex-prisoners do not have the support and
encouragement of family and friends after exiting prison, the development of a strong
therapeutic alliance with their support worker or forensic counsellor may provide the best
available foundation for the development and acquisition of both “bonding” and “bridging”
stocks of social capital.

**A Strong Therapeutic Alliance**

The manner in which counsellors interact with clients is considered fundamental in how
clients respond to treatment for alcohol misuse. Importantly, it is the ‘quality’ of the
relationship that is a key component in engaging and retaining clients in a treatment program
and a salient factor in initiating a desistance and recovery lifestyle (Burnett & McNeill, 2005;
Hser et al., 2007; Kirby et al., 2010). Furthermore, research suggests that a sound therapeutic
alliance is more valuable than the specific treatment strategies employed, in terms of how
successfully clients respond to treatment and support services (Asay & Lambert, 1999;
Burnett & McNeill, 2005; McNeill et al., 2005). This was reflected in the interview data,
where some participants spoke of the variety of factors they consider essential in fostering a
therapeutic relationship with clients, including building rapport and trust, being non-
judgemental, and being genuine. The importance of building “rapport” was specified by one
counsellor in the following terms:

Rapport is paramount. You’re not going to get anywhere with the client unless
there’s … rapport there. Anyone, like you or I, wants to feel understood, wants
to feel heard. If you’ve got trust … real trust comes from setting a plan and
achieving goals and [the clients] seeing that you’re proactive and wanting to
help them. If you don’t have that, forget about it. (Participant 9)
Another respondent also spoke of the importance of “trust” in building a rapport with his clients:

The therapeutic relationship encompasses a lot of things. The trust and the openness. And I suppose at the end of the day, that feeling that they can say whatever they want, and they know that they call up whenever they want to. That’s a big part of that relationship for me ... don’t just come here once a week, and talk to me for one hour, and then you go home. No, no, no, no, no. You need to call [if you have a problem]. (Participant 24)

One counsellor suggested that trust is built when you tell a client you will do something for them and then “follow through” on the intention:

These clients don’t trust many people. What works in this [field] is [that] you follow through what you say you’re going to do ... It’s the doing that really helps strengthen that relationship. And that’s trust, that’s ... instilling hope, encouraging, always reminding them to reflect. I do that a lot, [get clients to] reflect on past achievements. Where they are now, sometimes when they’re feeling low or feeling, why should I continue doing it? What’s it all for? I’ve lost everyone. Well, you know, try and reflect on the past and how much they’ve achieved. (Participant 5)

Counsellors spoke about the importance of making clients feel comfortable when meeting with them for the first time. One suggested, “the first thing is making someone feel comfortable, and making them feel like they can be open and communicate with you … being an active listener” (Participant 19). Another explained that during the “first appointment” with a client, it is crucial to convey to them that you are genuine. He said: “It’s about just being real and probing for something that [interests them] or just even asking the question … what is important to you?” (Participant 9). Another respondent spoke of the importance of providing releasees with a “comfortable”, “safe” and “non-judgemental” counselling and working environment. He explained:
Personally I feel … it’s very important for the client to feel comfortable, and more importantly, safe, and not judged. The stigma that comes with [being] an alcoholic … that the social media, family, friends convey is hard enough. So the moment they walk into this room, I hope I provide a safe, non-judgmental, comfortable area where they can say, ‘Actually, I really enjoy a drink,’ and be brutally honest. Only then can you fight against the addiction. Because if that person is continuously saying, to please other people, ‘I’m trying, I’m trying, I’m trying,’ when really they don’t want to stop yet, they are enjoying it or they are not enjoying it and it’s masking something else and it’s helping, until they recognise that, you’re fighting a false battle. So [the] first thing is to build that rapport so they can feel comfortable and say whatever they want. (Participant 13)

The importance of being non-judgemental was further explored by another interviewee who alluded to the differences in emphasis in approaches adopted by correctional personnel and NGO support workers and forensic counsellors:

It’s simply about [clients being able] … to talk … without feeling like they’re going to be judged and without feeling like there’s going to be consequences. I had one client who used to give me the same information he would tell his Corrections worker; he would just blurt out the same paragraph of information. [I said to him] ‘Hey, look, I’m actually not looking at how much you’ve offended or how little you’ve offended, ‘cause I’m not from Corrections. I want to talk about … other [issues]. How’s your alcohol use? How’s your family connections? How’s all of that?’ (Participant 2)

One interviewee, who had previously worked in Corrections, also noted the different approaches adopted by Corrections personnel and NGO professionals and highlighted the importance of being “flexible and available”, rather than adhering to a rigid and inflexible approach when dealing with releasees and addressing their needs:

Being available, being flexible. That was something that I found was really good about coming from a Corrections background … because it’s so rigid there. But here, you’ve got the ability to really listen to your clients. And when they say, ‘Look, I don’t feel like coming to see you. I drank all last night, and I feel like crap. Can I see you later?’ And instead of it being, ‘No, you’re going to see me, otherwise you’re going to jail’. You have the ability to say to them, ‘You know what? It’s really great you’ve come up to me, and said that you don’t feel like actually doing solid work with me today, because I’d rather you
do it on a day you feel like it. Does tomorrow work for you? Yeah, cool. We’ll meet tomorrow’. And even just that little bit of acknowledging their human need, it can go so far, rather than forcing them to [attend an appointment] – it’s how you’d want to be treated yourself. You wouldn’t treat a friend or a family member like that, so you shouldn’t treat a client like that either. So, that’s a big thing, and the flexibility is massive, and being available, within reason. But I will also say to my clients, ‘Look, here’s my work mobile number, if you don’t feel like [meeting today] … text me. You don’t even have to call me - just text me. Happy to know you’re okay’. (Participant 6)

This comment from Participant 6 clearly demonstrates the philosophical disconnect between correctional personnel, in their role as parole officers and NGO professionals in the post-release context. Correctional staff are clearly “offence-focused” which, as discussed in Chapter Two, is unlikely to encourage positive behaviour change, as it is primarily concerned with accentuating the negative behaviours and attitudes associated with a person’s offending. An overt focus on individuals’ offending behaviour is considered to be undesirable and counter-productive for fostering desistance and recovery, whereas adopting a holistic, non-judgemental and flexible approach, in which the person’s well-being and future goals are given primacy, provides an environment that is conducive for change to occur.

Unfortunately, releasees are often confronted by the contradiction between an “offence-focused” Correctional approach and a more “person-centred” and “holistic” approach adopted by NGO professionals. At best, this is confusing for releasees and at worst, it is directly counter-productive to the prospects of success in achieving positive behavioural change. The conflicting approaches are a potential structural barrier to the initiation of desistance and recovery lifestyles, which the literature reveals is more likely to occur when post-release support and treatment services are prospective and focus on positive outcomes rather than adhering to a negative and retrospective focus.

A strong therapeutic alliance is crucial in developing social capital resources for individuals who exit prison without the support of family members, close friends or members
of the wider community. In the absence of traditional forms of social capital, post-release support workers and forensic counsellors are ideally placed to be a substitute and much needed source of social capital for releasees. The data clearly demonstrates the importance the respondents place on developing a good working relationship with their clients as early as possible. Developing a sound working relationship from the outset is thus crucial to laying the foundation for the development of social capital and human capital resources. As noted, support workers and forensic counsellors highlight the importance of providing clients with a safe, non-judgemental and flexible environment, which in turn, is likely to provide a platform for the growth of a professional relationship built on trust and mutual respect. The data shows that NGO professionals are a significant source of “bonding” social capital for their clients, which the literature suggests is an important factor for those who seeking to pursue a desistance and recovery lifestyle.

As flagged in Chapter Two, the concepts of social and human capital are inextricably linked. Coleman (1988) argues that the amount of social capital resources a person accrues has a direct result on the amount of human capital they can access. Accordingly, following the establishment of a good working relationship with their clients, NGO professionals are ideally positioned to assist releasees in developing skills and obtaining knowledge that will contribute to their stock of human capital resources.

**Human Capital**

Desistance and recovery literatures strongly suggest that behavioural change is more likely to occur when releasees accumulate both social and human capital resources. According to Coleman (1988, p. S100), human capital is “embodied in the skills and knowledge acquired by an individual” and is a more tangible construct than social capital, which develops as a
result of prosocial relationships. Human capital includes the acquisition of knowledge and skills that enable people to access opportunities such as employment or gain entry into courses that will enhance their prospects of finding employment. Human capital resources are commonly aligned with the development of knowledge and skills obtained by having access to further education or training programs that will increase the likelihood of individuals gaining suitable and stable employment. However, as discussed in Chapter Six, enrolling in skills development courses or seeking employment is not a priority for the respondents’ clients, as their primary focus after release is on developing basic living and social skills required to live independently or developing the skills and knowledge required to address their alcohol misuse. There is, however, a lack of community-based programs to assist releasees develop basic living and social skills. One support worker explained that releasees frequently seek help and advice how to accomplish some basic tasks:

I get asked about tax and how often you have to do your tax and about connecting utilities – just basic life skills – or ID. They never seem to have copies of ID or birth certificates or a lot of them come out … with no computer skills or phone etiquette, in that they’ve haven’t had a phone for however long, they don’t know how mobiles work, don’t know how the Internet works, but they get told to lodge things or print forms off online and they just have absolutely no idea what that’s about, and that’s a life skills gap that I can show them if they ask questions. But there must be a lot of questions that they’re not asking that I’m not helping them with. We need some sort of life skills workshop or something that could help [develop these skills]. (Participant 7)

The need to equip releasees with basic skills was supported by another participant who argued that there is no community-based program that releasees can access to learn some basic skills:

There’s programs for drug and alcohol, no matter how good or bad they are. You can have counselling, you can speak to a legal service, all those sort of things, but those life gaps where who do I call for this, what do I do this, what
should I buy at the supermarket, how do I manage my money, there’s no one to talk to about that. That seems to be the big gap and there’s no program for that. Our client group in many ways their needs are quite unique, and so the responses need to match that and the community resources aren’t there. (Participant 3)

The importance of assisting releasees to develop basic life skills is supported in existing research (Indig et al., 2009; National Research Council, 2008; Social Exclusion Unit, 2002). It is widely acknowledged that many prisoners come from disadvantaged backgrounds, have a low level of educational attainment, a long history of unemployment and have not adequately developed the skills required to manage their finances, retain employment or sustain meaningful relationships with others (Borzycki, 2005; Social Exclusion Unit, 2002; Visher & Travis, 2003). Furthermore, research indicates that, “[t]o survive outside, ex-prisoners need to have well-developed life skills” to successfully confront “the barriers they will face in accessing employment, benefits, housing, and other services (Social Exclusion Unit, 2002, p. 84).

These quotes also highlight a significant gap in post-release service provision in Victoria. The lack of programs to help releasees develop basic living skills which they will require to successfully integrate into community life after exiting prison emphasises the importance and value of NGO professionals in providing one-on-one support and guidance. The substantial lack of post-release programs to assist released prisoners to develop basic skills such as mobile phone and internet capabilities arguably constitutes a structural barrier to the building of human capital resources which are accrued through learning and skill development. This gap in post-release service provision echoes the concerns of the Victorian Ombudsman (2014) who suggests that “most” Victorian prisoners receive little pre-release support, and on release, only a minority of releasees are able to secure a place in a transitional facility which leaves them ill-equipped to live independently in the wider community. In
recognition of the existing gap in post-release service provision in Victoria, Corrections Victoria advised the Ombudsman that a new Reintegration Program to commence in January 2015, was developed to address some of the shortcomings in post-release service provision, including assistance with life-skill development (cited in, Victorian Ombudsman, 2014, p. 23). 29

Despite the lack of community-based programs to learn and develop basic living skills, one NGO in Metropolitan Melbourne provides a social program incorporating the opportunity for basic life skills to be learned and developed. The support worker explained:

There is a program that people can go to during the day. [It includes] cooking groups, quit smoking groups, [and] a music group. There’s [sic] computers for people to use. Staff members [are also in attendance]. So they [the clients] will have all of these opportunities. A lot of the time, when people are coming out of prisons they’ve lost a lot of those social skills that they might want to work on. So it’s an easy environment for these people, because there’s no substances; you can’t turn up if you’re substance affected. There’s food provided every day. They [clients] can talk to people about everything other than substances, so it’s a great environment to talk about the football or I’ve got a daughter, or all this sort of great stuff. They do activities together. (Participant 2)

Unfortunately, attendance at this program is only available to individuals who receive post-release support and treatment from one particular NGO, and is not accessible by the broader population of releasees with alcohol problems. It would be highly beneficial if this type of program was developed and made available to all released prisoners with AUDs (and even to releasees in general), as this program format provides social and basic life-skill training, which many who exit prison will need to develop to successfully integrate into the wider community and to desist from crime and recover from alcohol misuse. However, for releasees who desire to address their alcohol misuse, NGO professionals can provide assistance and

29 To date, there is no evidence that the “Reintegration Program” has been implemented in Victoria.
valuable information at the one-on-one level to assist their clients in building human capital stocks through equipping them with the knowledge and skills required to avoid lapsing or relapsing into alcohol misuse. This is often achieved by encouraging their clients to attend a mutual-aid group such as Alcoholics Anonymous (AA) (as discussed in the previous chapter). On the other hand, developing harm minimisation skills and relapse prevention skills can also contribute to knowledge acquisition and the accumulation of human capital.

**Building Social and Human Capital through a Strong Therapeutic Alliance**

For releasees with an AUD who choose to pursue a goal of abstinence in their recovery from alcohol misuse, attending regular AA meetings and embracing the AA philosophy is a viable option. However, not all releasees seek abstinence as their goal and, therefore, AA is not suitable for those who choose to pursue a goal of harm minimisation while they continue drinking. It is important to note that, in the absence of conventional social supports, a strong therapeutic relationship between support workers and/or forensic counsellors and their clients provides a foundation of support for individuals who choose to engage in the AA program:

AA is total abstinence, or that’s the goal of it. You’ve got to acknowledge that people can’t get abstinence immediately and the way I work with that with clients is that’s – if that’s what they decide that they want to go for then I will support them in any way I can in achieving that. I’ll attend the meeting with them to initially breakdown the fear of going to one and if they want to continue with that, that’s fantastic but that’s up to the client to pick and choose. If they’re saying to me that every time they drink their life falls apart, they sleep in parks, they hurt other people, they hurt themselves, they don’t see their children, then maybe AA is a real option but they have to come up with that for them. You talk about it. You put it all on the table [and highlight] the benefits. (Participant 28)

By offering to attend an AA meeting with his clients, Participant 28 is performing an important “bridging” function. As discussed previously, the accrual of “bridging social
capital” is dependent on developing new relationships with other social networks that may provide access to new knowledge and new opportunities. Arguably, by attending an AA meeting with his client, the counsellor is creating an opportunity for his clients to meet, and possibly form prosocial relationships with others who share a common goal and who are not necessarily released prisoners.

One of the benefits of engaging with the AA fellowship is that it provides individuals with the opportunity to develop pro-social relationships with other AA members who can be valuable sources of support and encouragement in the recovery process. As one participant explains:

AA is a good program because it’s about social networks. So these people are around at 11 o’clock at night. [Support] workers who work the 9 ‘til 5, they’re a small snippet of support really, in reality. A drinker is a drinker who drinks every day, and every minute of every day if they can. They need support more than just a couple of hours here and there once a week. AA you can go to three meetings a day. AA you can have coffee after a meeting in the evening. There’s far more social opportunities, which is, let’s be honest, if you’re feeling isolated and lonely it’s a good place to connect with people. (Participant 5).

In this quote, Participant 5 clearly explains how affiliation with the AA fellowship can be a significant source of both social capital and human capital resources. From the social capital perspective, attending AA meetings provides individuals with the opportunity to build relationships with members of a new social network who share common goals. In terms of building human capital, having access to the knowledge, skills and experiences of others who attend the AA fellowship could prove vital in seeking and achieving a goal of abstinence.

Yet, despite the obvious benefits of attending AA meetings and embracing the AA philosophy, as noted in the previous chapter, very few of the participants’ clients showed interest in attending AA mainly due to their perception that the AA program is based on
religious principles. In fact, most of the client cohort who wanted to change their drinking behaviours chose a goal of harm minimisation instead of a goal of abstinence. Accordingly, policy makers and those in the recovery field should consider developing an alcohol recovery program that draws on some of the principles of AA but does not have an overt religious focus. The broader appeal of such a revised program could provide an alternative for those individuals who are averse to the religious connotations of the AA program.

The majority of the respondents’ clients preferred to set a goal of minimising the harms associated with their alcohol consumption. A harm minimisation approach is adopted when individuals choose to continue drinking, but at the same time seek to reduce the adverse consequences often associated with their drinking habits. Minimising the harms of alcohol misuse arguably requires individuals to learn a new set of skills to address their harmful or hazardous drinking habits. As discussed in the previous chapter, support workers and forensic counsellors are able to provide clients with information, and teach them effective strategies to draw on when faced with cravings and triggers that they struggle to resist. They work with clients to help them identify when cravings may occur and to recognise any specific triggers that may lead to problematic drinking. In order to cope with times when the urge to drink is strong, counsellors have the professional expertise to teach their clients various strategies to distract themselves and delay the first drink, or discuss other harm minimisation strategies such as adding water to their drink and drinking water between alcoholic drinks. These approaches build knowledge and skills thereby providing individuals with vital stocks of human capital.
Conclusion

This chapter has shown how NGO support workers and forensic counsellors assist their clients to develop essential social and human capital resources through the development of a strong therapeutic alliance. The development of social and capital resources are considered crucial factors if a desistance and recovery lifestyle is to be realised. It is clear that prior to assisting clients in developing stocks of capital resources, first, a strong therapeutic relationship needs to be developed based on a foundation of “reciprocal trust” and “mutual obligation”, which provides a space for support or counselling in which the individual feels “safe” and “comfortable” with a professional who is “non-judgemental” and “an active listener”. The data reveals that NGO professionals place a strong emphasis on building a “quality” professional relationship with their clients. They seek to build “rapport” and “trust” with their clients and, thereby, maximise the opportunity of working collaboratively together in the building of social and human capital resources.

The data shows that the respondents’ clients very rarely have access to conventional support mechanisms such as family and close friends. Importantly, the data also reveals that through the development of a strong therapeutic alliance NGO professionals can become a significant source of “bonding social capital” and provide the support and encouragement that is usually obtained through conventional sources. The development of a strong “bond” between NGO professional and the client enables the worker to act as a form of “bridging social capital” in assisting their client to re-establish fractured family relationships or they can act as a ‘bridge’ in connecting clients with members of the wider community, for example, by attending AA meetings with them. Importantly, the client is the ultimate “decision-maker” in determining whether or not to re-establish contact with family members or whether to attend AA. This in turn encourages the individual to develop a sense of
personal agency, which is an important subjective factor in fostering a desistance and recovery journey. This means that through the development of a strong client/worker relationship, support workers and forensic counsellors are well placed to assist releasees to build stocks of capital resources they will require if a desistance and recovery lifestyle is to be realised.

The data also supports the contention that social capital and human capital are “inextricably linked”. NGO professionals are aware of this link and use it to assist releasees develop skills that enable them to improve their stocks of human capital.

This chapter has argued that while AA is an invaluable program for assisting individuals with alcohol problems, its reliance on religious principles deters some clients from engaging with the program. Development of a refined program, based on AA principles without the religious terminology or faith-based language, could be highly beneficial in attracting clients – who are reluctant to engage with the AA fellowship in its current form – to an alternate mutual-aid support group. Furthermore, it is clear that there is a lack of post-release programs that assist individuals to develop basic life skills. This thesis argues that the basic skills program offered by one Melbourne-based NGO should be replicated by other NGOs, thereby providing opportunities for more releasees to develop life-skills, which they either never developed or which were lost in the highly restricted prison environment. However, this will require government agency support, including policy development and on-going funding to develop and implement the program widely.

The findings in this chapter are particularly salient, as this type of qualitative analysis has not previously been undertaken in Victoria. There has been no prior examination of how the building of a strong therapeutic relationship leads to the development of client’s social and capital resources, which are factors considered crucial in fostering a desistance and
recovery lifestyle. The following chapter presents an overview of the key findings of this thesis, including its contribution to the literature, limitations of the data and the need for future research in this field.
Conclusion

This thesis has examined the complex and multi-faceted problems and needs that releasees with Alcohol Use Disorders (AUDs) face when transitioning from prison to the community. In doing so, this dissertation identified the support and treatment services available to releasees with AUDs and examined how such services promote the building of social capital (building pro-social relationships) and human capital (building knowledge and skills), which are considered important factors in driving the process of behavioural change. The service delivery approach adopted by support workers and forensic counsellors was also examined as well as the extent to which the approach taken applied the core principles of a desistance and recovery-oriented theoretical framework.

The findings were informed by 36 semi-structured interviews conducted with post-release support workers and forensic counsellors working for Non-Government Organisations (NGOs) in Metropolitan and Regional Victoria. The qualitative methodology enabled the collection, coding and analysis of the data to reveal how post-release alcohol misuse negatively impacts on, and can thwart the efforts of individuals exiting prison. More specifically, it sheds light on how the legality and ready accessibility of alcohol, together with Australia’s cultural acceptance of drinking to excess as normalised behaviour, complicates and negatively impacts the transitional process for ex-prisoners with AUDs.

This research is the first study to qualitatively examine post-release alcohol misuse, independent of other drug types, in Victoria. It makes a significant contribution to criminological scholarship by positioning post-release alcohol misuse, its effects on transitioning prisoners and the availability of relevant post-release services, as a topic for discussion and debate among Victorian policy makers, academics, program developers and the wider Alcohol and Other Drugs (AOD) sector.
This chapter presents an overview of the key findings framed by three central questions set out in the Introduction, which sought to determine the extent of alcohol misuse as a problem; the kind of post-release support and treatment services available; and whether or not such support and services assist in initiating a desistance and recovery pathway for released prisoners with AUDs.

The chapter begins by revisiting the theoretical theories underpinning post-release service models for prisoners with an AUD in Victoria and highlights the importance of building a strong therapeutic alliance between worker and client. Importantly, it shows how the service delivery approach adopted by post-release support workers and forensic counsellors utilises key principles of a desistance-focused and recovery-oriented model of rehabilitation to encourage behavioural change in their clients. The chapter then considers the problems associated with post-release alcohol misuse and details challenges these pose for releasees with an AUD upon re-entering the community. Following this, the chapter discusses the post-release needs of releasees and re-emphasises problems surrounding the lack of availability of suitable post-release housing, which was a significant finding of this study. To conclude, this chapter presents recommendations for further research in this important criminology research field.

A Therapeutic Alliance – from Theory to Practice

The post-release services analysed in this thesis apply both a desistance and recovery theoretical framework, in that the programs seek to assist releasees in developing strong pro-social attachments to others, who are likely to be supportive of an individual’s desire to change their behaviours. In addition, the services emphasise the importance of structural (external) factors such as suitable housing and stable employment, along with subjective
(internal) factors such as personal agency, hope and motivation, in initiating behavioural change. As demonstrated in the analysis chapters, such approaches require support and treatment services that address ex-offenders’ needs holistically, by helping them to develop social and human capital resources in the context of their social and personal environments. They also require service providers to develop strong therapeutic alliances between themselves and their clients. As argued in Chapter Eight, this relationship is particularly important in the context of assisting ex-prisoners with AUDs because, as the findings of this research reveal, support from family and friends is more often unavailable than available and, therefore, support workers and forensic counsellors are often the only people that a large portion of ex-prisoners can turn to for post-release support and advice.

The findings of this thesis demonstrate that the alcohol treatment models and strategies employed by forensic counsellors include that of Motivational Interviewing (MI), which is a collaborative, person-centred approach that draws on goal-setting techniques to strengthen individuals’ motivation in order to encourage behavioural change. This research revealed that MI is commonly utilised by forensic counsellors to counteract clients’ ambivalence to embrace change, which is often a factor in the recovery process. Ambivalence is also addressed through negotiation with clients to assist them to develop their own treatment plans. Enabling clients to set their own treatment plans and goals is seen by NGO professionals as a means of fostering a sense of hope and personal agency in their clients which are considered important factors in initiating desistance and recovery journeys (Farrall, 2002; Hser et al., 2007). Furthermore, the findings reveal that NGO professionals encourage clients to develop a sense of personal agency as a means of promoting client optimism, which in turn engenders a belief that change is possible. This was evident in enabling clients to choose either harm minimisation or abstinence as a treatment goal, which recognises that
pursuing a goal of abstinence at the commencement of treatment may be too big a step for some clients.

At the time the research was undertaken, the Victorian AOD sector was undergoing a major retendering and reform process and there was uncertainty surrounding future funding for NGOs. This led to difficulty in being able to assess the continuing availability of post-release alcohol treatment services. Significantly, the research found that episodes of care delivered to clients are short in duration, and fall well short of the recommended minimum duration of three months. The research also revealed that forensic counsellors consider an episode of care (six one hour sessions) inadequate to address the multiple and highly complex issues associated with alcohol misuse. Nonetheless, the six-session model was found to facilitate initial contact between forensic counsellors and clients and, therefore, provided the opportunity for a therapeutic alliance to be formed and developed.

Another key finding relating to the support worker and forensic counsellor role is the individualised way in which they assist their clients to develop essential social and human capital resources through the use of a therapeutic alliance. The findings show that support workers and forensic counsellors develop a therapeutic relationship with their clients based on a foundation of “reciprocal trust” and “mutual obligation”. This in turn provides a space for support or counselling to take place in an environment in which the individual feels “safe” and “comfortable” with a professional who is “non-judgemental” and “an active listener”. NGO professionals place a strong emphasis on building “quality” professional relationships with their clients that build “rapport” and “trust” and thereby maximise opportunities for working collaboratively in the building of social and human capital resources. Scholars suggest that ex-prisoners who accrue reserves of social (Brown & Ross, 2010; Coleman, 1988; Farrall, 2002, 2004; McNeill, 2002, 2009; McNeill et al., 2005; McNeill & Weaver,
2010; McNeill & Whyte, 2007) and human capital (Farrall, 2002; McNeill, 2009; McNeill & Whyte, 2007) increase the likelihood of initiating a desistance and recovery lifestyle. Accordingly, it is important that the roles of support workers and forensic counsellors are considered in any reforms to the programs available to releasees with an AUD moving forward.

The data further demonstrates how NGO professionals become a significant source of “bonding social capital” through providing releasees with support and encouragement that is often not available to them from other sources such as family and friends. The development of a strong “bond” between support workers, forensic counsellors and their clients enables the professionals to become a form of “bridging social capital” by acting as a bridge in connecting clients with members of the wider community. This in turn provided individuals with the encouragement to foster a sense of personal agency, which is an important subjective factor in fostering a desistance and recovery journey. This means that, through the development of a strong client/worker relationship, support workers and forensic counsellors are well placed to assist releasees to build the stocks of capital resources they will require if a desistance and recovery lifestyle is to be realised.

The data revealed that there is a lack of post-release programs to assist individuals in developing basic life skills. However, I argue that the basic skills program offered by one Melbourne-based NGO, which among other basic life skills, includes offering cooking classes, should be further developed to incorporate other basic contemporary life skills such as how to apply for personal identification documents, how to use a mobile phone and download forms or access information online. The program should also be replicated by other NGOs, thereby providing opportunities for more releasees to develop life-skills that they had either never developed or which were lost in the highly restricted prison environment. Life
skills workshops are needed to fill the “gap” that currently exists in post-release services. This will require government agency support including policy development and on-going funding to develop and implement the program more widely. The ways in which support workers and forensic counsellors utilise a therapeutic relationships with their clients as a platform for assisting them to develop important social and human capital resources is a significant finding of this research, as there has been no prior examination of this issue undertaken in Victoria.

Post Release Alcohol Misuse – A “Real” Drug Problem

In assessing the extent to which alcohol misuse is a problem for transitioning prisoners, the interviewees considered post-release alcohol misuse to be a significant – “massive”, “huge” – problem for many of their clients. Significantly, while poly-drug use was identified as a problem, the participants observed that although for a large portion of their clients, alcohol was the sole drug of choice, sufficient attention in terms of funding, resources and program availability, was not devoted to this form of drug treatment. This finding supports earlier scholarly work in the international context which argued that alcohol misuse is often considered “less serious” than illicit drug use, resulting in CJSs prioritising and responding to illicit drug misuse over and above alcohol (Fitzpatrick & Thorne, 2010; Heseltine et al., 2009; HM Inspectorate of Prisons, 2010; Howells et al., 2004; G. Jones & Hoffman, 2006).

As argued in Chapter Five, alcohol misuse is problematic for many ex-prisoners for a variety of reasons. In particular, my research suggests the legality, affordability, availability and social acceptance of alcohol use – even at harmful or hazardous levels – create significant pressures on transitioning prisoners. These factors distinguish alcohol misuse from illicit drug use and are key reasons underpinning the prevalence of alcohol misuse in the
transitional period, thereby demonstrating the need for separate service options for releasees with an AUD.

The study identified several reasons why releasees can consume alcohol problematically in the transitional period. “Celebrating release from prison” was one of the main reasons why releasees returned to problematic drinking. This, in conjunction with, the omnipresence of alcohol in many social settings makes it extremely difficult, if not impossible, for individuals who have an AUD to avoid drinking in a harmful or hazardous manner. Some releasees drank alcohol problematically to self-medicate, in order to temper their emotional pain stemming from difficulty in coping with the loneliness and social isolation that some experience following release. The data revealed that a strong link exists between ease of availability, Australian drinking and celebratory culture, and post-release problematic/harmful alcohol use. Therefore, if the problematic drinking patterns that some releasees with AUDs engage in are to be adequately addressed, Victoria needs to adopt a more collaborative partnership between Corrections and NGOs to ensure that prior to release, individuals who are at risk of drinking in a hazardous or harmful manner are linked in with support services in the community to assist them in avoiding resuming harmful or hazardous drinking patterns when released.

My research suggests that such action is not common in Victoria, and instead, it is dependent upon individual workers to attempt to make these connections for releasees. As noted in Chapter Seven, this task usually falls to the individual counsellor or worker to develop individualised techniques such as the importance of drinking water in between alcohol beverages, or developing ways to control drinking patterns in social settings, but there is no evidence that prior to release, prisoners are given relevant information on alcohol harm minimisation strategies. This is a potential barrier to releasees who desire to embark on
a desistance and recovery lifestyle, because without the relevant knowledge or skills, the risk of resuming drinking problematically is amplified.

The research also revealed that post release support can be obtained through participation in the AA program. NGO professionals reported that while AA is an invaluable program for assisting individuals with alcohol problems, its reliance on religious principles deters some clients from engaging with the program. I argue that the development of a refined program, based on the AA principles, but without the religious terminology or faith-based language, would be highly beneficial in attracting those releasees with AUDs, who are reluctant to engage with the AA fellowship in its current form.

**Post-release Harms and Needs**

This research also demonstrated that alcohol is a contributing factor in many of the physical and social harms that releasees experience. Physical harms range from serious injuries resulting from falls, being hit by vehicles, or being involved in acts of violence while intoxicated, through too potentially life changing and life threatening conditions such as developing an ABI or suffering from liver damage. The research further identified social harms relating to offending behaviours such as being “drunk and disorderly”, engaging in acts of “alcohol fuelled violence”, “sexual assault”, “family violence”, “stalking” and “theft”. The findings further revealed that in some cases the commission of these offences resulted in re-imprisonment. This study reveals the detrimental impact that alcohol misuse has on some individuals post-release, which suggests that they may be exiting prison without having been rigorously assessed for their risk of resuming drinking at harmful or hazardous levels, or without the knowledge of how to access support or treatment services in the community. It is therefore vital that pre-release processes are implemented to ensure prisoners are accurately
screened for AUDs prior to release and, if necessary, individuals are linked in with primary healthcare avenues. This highlights the importance of releasees having timely access to post-release treatment programs and support services for alcohol misuse, if the personal, social, and societal harms associated with harmful or hazardous alcohol consumption are to be minimised.

As argued throughout Chapters Six and Seven, releasees with AUDs have a vast array of needs after exiting prison. These span from immediate and basic needs, such as requiring assistance with transportation from prison, and help sourcing some form of personal identification to enable them to apply for unemployment benefits or other forms of welfare assistance and sourcing accommodation. As a group, prisoners have been shown to have high levels of physical and mental health needs, communicable diseases, alcohol and illicit drug misuse and poor dental health (Borzycki, 2005) with a high level of co-occurring disorders. Many lack basic life skills such as organisational skills to get to appointments. These needs extend through to longer-term requirements such as assistance with family reunification, and assistance sourcing primary and urgently needed health care services.

While such findings support the existing scholarship, one particular area of need that emerged in this research is access to a “good” GP. A “good” GP is often essential to ensure timely access to appropriate specialist health-care providers to provide continuity of care. This is not always the case, with the research disclosing that some GPs are reluctant to accommodate ex-prisoners, for instance, by removing the option for bulk-billing. As noted in Chapter Six, this is problematic because any improvements in an individual’s physical or mental health that have been achieved while imprisoned could be lost if primary health care services are not readily accessible on release. It also important to have ready access post-
release medical services to minimise the risk of further health harms that could result from resumption of drinking alcohol problematically.

As demonstrated in other studies, my findings also suggest that releasees need assistance finding employment (Victorian Ombudsman, 2014; Visher et al., 2008), enrolling in skills training courses (Gideon & Hung-En, 2011; Visher et al., 2004), and finding accommodation (Baldry et al., 2006; Borzycki & Baldry, 2003; Ogilvie, 2001; Victorian Ombudsman, 2014; Willis, 2004). They are often not well-equipped or skilled enough to satisfy these basic needs on their own. This suggests, despite claims to the contrary, that the principles of Through-care – that is, effective pre-release planning – are not being applied across the Victorian prison system. Corrections make little or no attempt to prepare prisoners for release by providing basic training in social and life skills, effectively “setting them up to fail”. This finding further highlights the need for re-considering the current post-release support system offered in Victoria to ensure appropriate and substantial support is available to prisoners in the lead up to, and at the time of release.

One of the most significant contributions this thesis makes to criminological scholarship, and what was previously unknown, was if, and how, alcohol misuse limits ex-prisoners with AUDs from obtaining safe and stable post-release housing/accommodation. My data reveals that accessing safe, secure and stable housing is a significant problem for releasees with AUDs; in fact, releasees with AUDs have limited housing options and in the main, have no choice other than to accept highly unsuitable and, at times, unsafe forms of accommodation that include rooming houses, private hotels, caravans, tents or homelessness. The findings reveal that these unsatisfactory forms of post-release accommodation present significant challenges and are structural barriers to those releasees desiring to embark on a desistance and recovery lifestyle. Unsuitable forms of post-release housing present specific
difficulties for those who wish to abstain from, or limit, their drinking, as they may find themselves exposed to peer pressure from other residents who are consuming alcohol excessively and they may do likewise in order to fit in socially. As one participant, who had a client living in boarding house accommodation, noted:

When he is put in a situation where he’s living with others … he drinks with others, then gets into fights with others. When he’s on his own in his own unit he’s actually a lot better. (Participant 5)

The data further revealed for the first time in a Victorian context that some releasees were amenable to residing in boarding houses providing they are “dry houses” and while this form of accommodation has been discussed by members of the AOD sector, the provision of dry houses has not yet eventuated as a key policy and prevention option. My study also found that individuals who continue to drink in a harmful or hazardous manner and engage in anti-social behaviours are often evicted from their accommodation and, therefore, at risk of ending up in even more unsuitable forms of accommodation. Of significance, the research found that these issues are amplified in Regional Victoria where availability of suitable accommodation is significantly lower than in the Melbourne Metropolitan area. Individually and collectively, these issues represent significant barriers for ex-prisoners with AUDs who wish to adopt a pro-social lifestyle and are ongoing challenges for NGO support workers and forensic counsellors.

The Five Ultimate Findings

The overarching aim of this thesis is to stimulate discussion and debate among Victorian policy makers, correctional authorities and those in the Alcohol and Other Drug (AOD) treatment sector to address post-release alcohol misuse as a separate issue, considering the
significant and widespread social and personal harms associated with its use. Five important issues have thus emerged from the research:

1. Funding will be required to extend episodes of care to be more in line with best practice recommendations. This is important because the findings reveal that the ‘six-session’ episodes of care model operating at the time this research was conducted show that not only are six sessions largely inadequate to address the complex issues associated with releasees’ alcohol misuse, but they do not provide adequate time for the development of a sound therapeutic alliance, which this research has shown to be crucial in initiating a desistance and recovery lifestyle.

2. Providing more “dry houses” will minimise the risk of resumption of harmful alcohol consumption. This issue is important because this research demonstrates for the first time, the complex relationship between the various forms of post-release housing available to releasees in Victoria and alcohol misuse. This research has demonstrated that ex-prisoners who cannot return to live with family and friends after exiting prison are faced with extremely limited housing options that are in the main “unsuitable”, “unsafe” and “unstable” forms of accommodation. The provision of publicly funded “dry houses” would increase the post-release accommodation options available to releasees with AUDs and, therefore, provide more suitable environments in which they can take major steps towards addressing their alcohol misuse and other underlying social and personal issues.

3. Provision of adequate pre-release support by Corrections and/or NGOs would ensure that releasees have the best possible preparation for the challenges they will face on return to
the community. This is important because prisoners transition immediately from the highly controlled and structured prison environment into the less constrained wider Victorian community. This research has demonstrated that releasees are often ill-prepared for the immediate challenges they will face, such as requiring assistance with transportation at the “moment of release”.

4. Allocation of funding is required for basic life skills programs so that they are more widely available to ex-prisoners. This research identified that there is a lack of pre-release and post-release programs to assist ex-prisoners to develop basic life-skills. Many of the interviewees’ clients require assistance to accomplish basic skills, such as how to be organised in order to arrange medical appointments, undertake supermarket shopping and making arrangements to meet Corrections’ obligations. Although post-release support workers and forensic counsellors take a holistic approach to addressing their clients’ needs, their heavy case-loads often prevent them from assisting their clients to develop basic life skills.

5. Researchers and policy makers need to maintain a focus on alcohol misuse as a topic in its own right, rather than continuing to conflate alcohol with illicit drugs in research and policy documents. This is particularly important as this study reveals the problems associated with post-release alcohol misuse and the vast array of complex needs that ex-prisoners with AUDs require assistance with during the transition from prison to the wider Victorian community, and how they differ from those with other drug addictions. Only when researchers and policy makers acknowledge alcohol misuse and its associated social, personal and societal harms as a topic for discussion and debate in its own right,
will meaningful inroads be made into assisting releasees with AUDs to initiate a desistance and recovery lifestyle.

**Future Research**

This study has revealed for the first time in the Victorian context, the significant problem post-release alcohol misuse poses for some releasees. It is important that future research seek to address alcohol misuse as a topic in its own right, rather than conflating it with other drug types or including it under the generic term of substance misuse. This would provide policy makers with a deeper understanding of the specific issues and challenges that releasees with AUDs confront when transitioning from prison into the wider community. This will enable a more specific focus on designing and developing programs that specifically address post-release alcohol misuse, which in turn, may increase the likelihood of releasees initiating a desistance and recovery trajectory after release.

Future research would also benefit from replicating this study to include those on straight release, women and Indigenous releasees. This would provide a broader understanding of the problems associated with post-release alcohol misuse as arguably these groups would have alternate transitional experiences and therefore different motivations and barriers when undertaking desistance and recovery pathways.

It would also be of benefit to speak with releasees directly. This would offer another avenue to understand the challenges, needs and complexities experienced by those with an AUD upon release.
Significance of this Research

As flagged in the Introduction, and argued by Paul McDonald, Chief Executive Officer, Anglicare Victoria (2015): 

Only alcohol is the true epidemic. No other drug has come close to causing as much death, illness, violence and lost productivity as alcohol. Yet it remains to some extent behind the lace curtains, almost a taboo subject, a blind spot in the national conversation.

Alcohol misuse has also, to a large extent, been a “blind spot” in criminological discourses, as research that addresses any form of substance misuse, in the main, fails to produce findings that distinguish alcohol from other drugs. In scholarly literature and official documents, alcohol is frequently conflated with illicit drug use or subsumed under the generic term of substance misuse. This research has responded to this gap in the literature by examining alcohol misuse in the Victorian post-release environment and providing an in-depth qualitative analysis of this under-researched topic.

The findings of this study are significant as no previous Victorian studies have attempted to separate alcohol from other drugs and examine the extent to which alcohol misuse is a problem in the post-release environment. In addition, previous studies have largely neglected to examine the nature of, and relationship between, post-release alcohol-related re-offending and re-incarceration.

In responding to a significant gap in the literature, this research contributes to criminological scholarship by situating post-release alcohol misuse, independent of other drugs, as a contemporary and important issue for discussion and debate. It also has the potential to impact on future policy and reform.
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Appendix A
Letter of Interest

To Whom It May Concern,

My name is Christina Kirtley and I am conducting a research project on post-release alcohol misuse in Victoria as part of my PhD, under the supervision of Dr Asher Flynn and Professor Sharon Pickering from the School of Social and Political Inquiry at Monash University.

My research seeks an understanding of the needs and issues faced by individuals with an alcohol problem who are transitioning from prison to the wider Victorian community. I am interested in talking to a variety of post-release support workers and forensic counsellors who work for non-government organisations in Metropolitan Melbourne and Regional Victoria.

I am seeking to interview individuals within your organisation who provide post-release services to individuals on parole or straight release. All interview questions will be based on professionals' perceptions of the needs, challenges and difficulties that individuals with alcohol problems face when attempting to transition from prison to life in the wider Victorian community. As an organisation that works closely with released prisoners, any assistance you can provide in finding participants will be valuable and appreciated.

My project has received approval from the Monash University Human Research Ethics Committee.

If you require further information regarding my project, please feel free to contact either myself or my supervisors:

Dr Asher Flynn: [redacted]
Professor Sharon Pickering: [redacted]

Thank-you for taking the time to read this request and I look forward to hearing from you.

Yours sincerely,

Christina Kirtley
PhD Candidate, Monash University
Appendix B

Explanatory Statement

Project: Post-release Alcohol Misuse in Victoria

You are invited to take part in this study being conducted by Christina Kirtley as part of a doctoral thesis, under the supervision of Professor Sharon Pickering and Dr Asher Flynn of Monash University. Please read this Explanatory Statement in full before deciding whether or not to participate in this research. If you would like further information regarding any aspect of this project, you are encouraged to contact the researchers via the phone numbers or email addresses listed below.

This research was approved by the Monash University Human Research Ethics Committee on August 6, 2013 – Project Number: CF132209-2013001166.

What does the research involve?

By drawing on the professional perceptions of post-release support workers and/or clinicians, this research seeks to gain an understanding of the needs and issues faced by released prisoners who have an Alcohol Use Disorder (AUD). The study seeks to examine the extent to which alcohol misuse is a problem among transitioning prisoners and whether or not the availability of, and access to, post-release support services increases individuals’ prospects of desisting from crime and recovering from alcohol misuse.

The research involves a semi-structured, one-on-one interview that will be conducted at an agreed time/date at your business premises. The interviews will be audio recorded, if you consent, and then transcribed verbatim at a later date. It is anticipated that the interview duration will be approximately 1 hour.

Why were you chosen for this research?

I am interested in talking to professionals within your organisation who work closely with individuals transitioning from prison to the community and have the primary responsibility for the management and delivery of support services to released prisoners with Alcohol Use Disorders (AUDs). I am interested in hearing from a number of professionals in Metropolitan and Regional Victoria. As individuals with expertise in these areas, your involvement in this project would be invaluable.

Consenting to participate in the project and withdrawing from the research

Involvement in this research is voluntary. You can choose not to participate in part, or all of the project and you can withdraw from the interview process at any stage without being penalised or disadvantaged in any way. If you would like to participate in the interview process, please email me at [email protected] so I can forward a consent form to you for you to sign and return to me via email, or I will collect it from you prior to commencement of the interview.

You can withdraw your involvement in the project and all related data, at any time prior to 31 December, 2014.
Possible benefits and risks to participants

This research will contribute to the limited knowledge of the challenges and difficulties that released prisoners with alcohol problems face when transitioning from prison to the wider community. This lack of knowledge is largely the result of alcohol misuse being conflated in scholarly literature and official documents with illicit drug use under the term ‘Alcohol and Other Drugs’, or subsumed under the generic term of ‘substance misuse’. As a consequence, the principal benefit of this research is to situate alcohol problems in the post-release environment, independent of other drug types, as a significant and contemporary issue for discussion and debate. While there are no direct benefits for people who take part in this study, contributing to this project will help inform current debates around this very important topic.

Involvement in this research is highly unlikely to cause any stress, inconvenience or discomfort beyond the normal experience of everyday life, in either the short or long term. There is minimal possibility that you may experience some discomfort when reflecting on this topic. However, it is highly unlikely that this will occur, as the questions are not focused on any personal experiences, nor are you asked to discuss any personal or sensitive information about your clients’ circumstances or experiences. Instead, the questions focus only on your professional perceptions. In addition, you can choose not to answer a particular question if for any reason you feel uncomfortable, or the interview can be stopped at anytime.

Confidentiality

Involvement in this study is voluntary and you are under no obligation to participate. All participants will remain anonymous through the use of codes. No names will appear in any data, transcripts or file notes. Pseudonyms will be used in draft copies and in the final thesis submissions to protect your privacy. This means that your involvement in the study will remain confidential.

Storage of data

All data collected will be stored in accordance with Monash University regulations, and kept on University premises, in a locked filing cabinet for five years.

Use of data for other purposes

In addition to the doctoral thesis, a report of the study may be submitted for publication in a journal(s) or through conference paper(s), but individual participants will not be identifiable.

Results

If you would like to obtain a copy of the thesis please contact me via [redacted] and, on completion I will email you to arrange for you to collect a copy from the Monash University Clayton Campus. The findings will be accessible for five years from June 2015.
Complaints
Should you have any concerns or complaints about the conduct of the project, you are welcome to contact the Executive Officer, Monash University Human Research Ethics Committee (MUHREC) and quote the following project number: CF132209-2013001166.

Executive Officer
Monash University Human Research Ethics Committee (MUHREC)
Room 111, Building 3e
Research Office
Monash University VIC 3800

Contact
Lead Researcher:
Christina Kirtley

You can also contact the Chief Investigator, Dr Asher Flynn or the Co-Investigator, Professor Sharon Pickering for any additional queries.

Dr. Asher Flynn
Lecturer in Criminology

Co-Investigator’s name:
Professor Sharon Pickering
Department of Criminology

Thank you,

Christina Kirtley
PhD Candidate
Appendix C
Permission Letter

<LETTERHEAD of Organisation giving approval>

Post-release Alcohol Misuse in Victoria

Christina Kirtley
School of Political and Social Inquiry
Department of Criminology
Faculty of Arts
MONASH UNIVERSITY VIC 3800

Date:

Dear Christina,

Thank you for your request to recruit participants from <insert organisation> for the above-named research.

I have read and understood the Explanatory Statement regarding the research and hereby give permission for this research to be conducted and to assist in promoting the research within the organisation for potential participants to then contact you.

>Please include any stipulations / clauses the Company / Organisation / may have about recruitment of human participants>.

Yours Sincerely,

<insert name of the above signatory>
<insert above signatory’s position>
Appendix D

Recruitment Flyer

Do you provide support and/or treatment services to released prisoners with alcohol problems? Are you over the age of 18? Then I would like to hear from you!

My name is Christina Kirtley and I am currently undertaking my PhD at Monash University. My research seeks an understanding of the needs, challenges and difficulties faced by released prisoners with alcohol problems who are transitioning from prison to the wider Victorian community.

I wish to interview post-release support workers and forensic counsellors who provide post-release services to ex-prisoners with alcohol problems. The interview will take approximately 1 hour and will be held at your business premises on a day and time of your choosing. A $50 voucher will be provided as a token of appreciation for your participation.

This research has received ethical approval from the Monash University Human Research Ethics Committee.

If you would like to be involved or would like more information on the project please contact me at: [Contact Information].
Appendix E

Consent Form

Project: Post-release Alcohol Misuse in Victoria

Chief Investigator: Dr. Asher Flynn
Student Investigator: Christina Kirtley
Co-Investigator: Professor Sharon Pickering

I have been asked to take part in the Monash University research project specified above. I have read and understood the Explanatory Statement and I hereby consent to participate in this project.

<table>
<thead>
<tr>
<th>I consent to the following:</th>
<th>Yes</th>
<th>No</th>
</tr>
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<tbody>
<tr>
<td>I understand that I will be interviewed by the researcher</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>I understand that unless I otherwise inform the researcher before the interview, I agree to allow the interview to be audio-taped.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>I understand that my participation is voluntary and I can choose not to participate in part, or all, of the project, and I can withdraw at any stage of the project without being penalised or disadvantaged in any way.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>I understand that any data the researcher extracts from the interview for use in a thesis, conference presentation(s) or published findings will not, under any circumstances contain names or identifying characteristics.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>I understand that I may ask at any time prior to 31 December, 2014 for my data to be withdrawn from the project.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>I understand that no information I have provided that could lead to the identification of any other individual will be disclosed in any reports on the project, or to any other party.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>I understand that data from the interview will be kept in secure storage and only accessible to the research team. I also understand that the data will be destroyed after a 5 year period.</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Name of Participant

Participant Signature __________________________ Date ____________
Appendix F

Interview Schedule

**Introduction** – brief explanation of the aims of the research project. Answer any questions the participant has about the research and the interview process.

**Topic to open discussion**
Can you tell me about your role as a support worker/forensic counsellor and what it entails?

**Topic 1 – Post-release alcohol misuse**
– In your opinion is alcohol misuse a problem among your clients? If so, to what extent do you perceive it to be a problem?
– Has alcohol misuse posed a problem for any of your current or recent clients? If so, how?
– In your experience, has alcohol misuse played a role in the offending behaviours of any of your clients? Is the relationship between alcohol and offending becoming more prevalent?
– Have any of your clients been re-incarcerated as a direct result of their alcohol misuse?
  Can you provide me with an example/s of how/why this occurred?

**Get a snapshot of:**
– How people are referred to your agency
– Mainly on parole or straight release (short-term/remand)
– How long support is provided to individuals

**Topic 2: Needs of released prisoners with alcohol problems**
– What types of support and services does your agency provide to released prisoners?
– In your opinion, what are the immediate and long-term needs of ex-prisoners with alcohol problems?
– Which needs are the most difficult to fulfill? Can you explain why? How is the lack of accessibility to this support likely to impact on individuals’ transitional experience?
– Thinking about a client with alcohol problems you are currently working with, can you explain to me some of their needs you are currently addressing? Which of these is the most challenging to fulfill? Why?
– Are there differences in the needs of problem drinkers and those without an alcohol problem? What are they?
– Is alcohol misuse a barrier for individuals accessing support services? Which services? Can you explain the nature of this difficulty? How does this impact on their ability to integrate into the community?
– Thinking about ex-prisoners with alcohol problems, can you rate the importance of the following needs on release: Alcohol treatment, housing/accommodation, employment, family support, other. Why do you consider this need important?
– Are there sufficient services available to address these needs?
– Do the needs of releasees with AUDs change in the months after release? If so, can you explain the nature of this change?

**Topic 3: Client traits/characteristics**
– In the main are your clients optimistic or pessimistic about changing their drinking and offending behaviours? Can you give me an example of a personal story that indicates an individual was either optimistic or pessimistic?
– What factors do you think contribute to their sense of optimism or pessimism?
– Do many of your clients display a personal commitment to change their behaviours (offending and alcohol misuse)? What are some of the reasons given for wanting to change or not change?

**Topic 4: Focus of support/treatment service**
– Is the main focus of your work with ex-prisoners on reducing their risk of reoffending or do you employ a more holistic approach in your treatment approach? Why do you consider this approach important?
– Do you consider it important to develop a good professional relationship with your clients? If so, why?
– What factors are important in establishing a good working relationship with your clients? How do you develop a working relationship with your clients?

**Additional questions for forensic counsellors**

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– What is the treatment model/s you employ in the clinical setting? Can you explain to me the nature of this treatment model?
– How are treatment sessions delivered? One-on-one or in a group setting?
– How frequently do forensic clients attend an alcohol treatment session? How long is a session?
– Are there any restrictions on how many treatment sessions a forensic client can attend?
– Does the treatment model you employ accommodate both abstinence and a harm minimization approach?
– To what extent are families/significant others involved in the treatment process? Do you see this as being important? If so, why?
– Is there a waiting time for forensic clients to access treatment?

**Concluding questions**
– What do you find the most rewarding and frustrating aspects of working with ex-prisoners?
– Are there any issues you consider important that I have not addressed?