RAPt

THE REHABILITATION FOR ADDICTED PRISONERS TRUST

stopping addiction. stopping crime.

Bridge Programme

Application Manual - A Clear Model of Change

RAPt
THE REHABILITATION FOR ADDICTED PRISONERS TRUST
stopping addiction. stopping crime.

BRIDGE PROGRAMME: APPLICATION

TABLE OF CONTENTS

1. INTRODUCTION

1.1 FACTORS TARGETED BY THE PROGRAMME

The Bridge Programme is an offending behaviour programme aimed at medium-high risk substance dependent male offenders and is intended to be run in prison settings, ideally on dedicated residential units.

The main dynamic risk factors targeted by the programme are:

- Substance dependence and abuse.
- Drug-related offending

The other general dynamic risk factors for re-offending targeted by the programme are:

- Weak ties to, and lack of identification with, pro-social/anti-criminal models
- Strong ties to, and identification with, anti-social/criminal models
- Weak social support systems for tackling drug use
- Strong social pressure to use drugs and/or drink alcohol
- High impulsivity
- Deficits in decision making
- Lack of assertiveness
- Poor pro-social interpersonal skills
- Deficits in emotion management, particularly anger management
- Weak commitment to avoiding re-offending and/or remaining abstinent
- Low self-efficacy
- Dysfunctional or anti-social attitudes, cognitions and beliefs related to re-offending and/or substance use
- Difficulty recognising personally relevant risk factors for re-offending and/or relapse
- Difficulty generating appropriate strategies for coping with personally relevant risk factors for re-offending and/or relapse
- Difficulty in coping with cravings

Both offending behaviour and substance dependence frequently arise in the context of multiple circumstantial and adaptive difficulties which underlie, trigger and exacerbate those already listed above. Some of these which have been identified as being particularly relevant for this population include:

- Mental health difficulties and dual diagnosis issues
- Current symptoms related to histories of trauma and/or abuse
- Lack of housing

The Bridge Programme is a full-time six week programme. Because of its limited duration, it is designed to take into account these additional factors and needs only with regard to their immediate impact on participants' capacity for treatment engagement. Where appropriate, participants are linked to further treatment and throughcare providers in order to continue work on these risk factors. Evidence demonstrating the importance of addressing each targeted factor in this way has been provided in Section Three of the *Bridge Programme Theory Manual*.

1.2 Programme overview

The Bridge Programme is an intensive six-week abstinence-based twelve-step programme, incorporating elements of Motivational Enhancement Therapy (MET) and Seeking Safety (SS). Its primary aims are to strengthen motivation for recovery, encourage Narcotics Anonymous (NA) affiliation, link participants with secondary care and address cognitive and behavioural patterns which undermine participants' ability to successfully maintain abstinence, affiliate with NA or engage in further treatment.

1.2.1 Continuous elements

Several elements are present daily, every week or fortnightly and provide continuity throughout treatment. These include a weekly speaker meeting with a volunteer NA speaker from the local community, ongoing attendance at a minimum of two NA meetings per week (outside of treatment time), fortnightly individual counselling sessions and the completion of daily Significant Events Sheets and assignments. Discussion groups based on reading the personal recovery stories of prisoners in recovery are held every Friday afternoon. From Week Two to Five, two one-hour group therapy sessions are held per week. Emphasis on throughcare services and linking participants to appropriate secondary care/treatment is also a continuous theme of the programme. The Throughcare Manager conducts two group sessions in Weeks Two and Five) and two one-to-one

sessions in Weeks Five and Six to identify and discuss participants' individual throughcare needs and preferences.

Node-link mapping and Motivational Interviewing are "continuous methods" rather than "continuous elements" used in individual counselling sessions, Seeking Safety (SS) sessions and Living Clean (LC) sessions. Motivational Interviewing is used a style of group facilitation and counselling through treatment. Node-link mapping is a visual tool used to represent certain thoughts, feelings or concepts and how they are linked to one another. This learning approach is inspired by the usefulness of flow diagrams and organisational charts for aiding memory and has been shown to enhance treatment outcomes in similar settings to the Bridge Programme (Pitre et al., 1998). Node-link maps can be used to plan recovery and how to implement new skills, for example, to identify feelings and triggers that cause participants to use drugs and plan individual coping strategies to deal with these triggers. Evidence of the effectiveness of the continuous elements and methods used in the Bridge Programme are outlined in Section Four of this manual and in further detail in Section Six of the *Bridge Programme Theory Manual*.

1.2.2 Week One

The first week provides an overview of treatment and an introduction to group work. It comprises two Intake and Orientation sessions; two MET sessions; three assignment group sessions introducing group members to one another and building group cohesion; four LC skills sessions focused on introducing the programme's approach and basic skills needed for engaging in treatment; one session on diversity; and a two-hour SS session introducing the concept of 'safety' and its importance to recovery, including learning how to say 'no' to offers of drugs or alcohol.

1.2.3 Week Two

This week is focused on the development of cognitive and behavioural coping strategies through four LC skills workshops and five SS skills workshops. Basic relapse prevention strategies, grounding skills for managing trauma symptoms and extreme emotions, anger management and one session providing education on addiction are among the key themes explored in the skills sessions. One LC session introduces participants to their Throughcare Manager who delivers a LC session on Coping with Triggers "First Things First."

1.2.4 Week Three

This week introduces participants to the fundamental twelve-step concept of powerlessness through the completion of Step One (Part One) assignments and assignment groups. Powerlessness is used as a means of helping participants recognise that they have a problem and accept their need for help, motivating them to focus attention and energy on recovery. The assignments build on work done in the MET sessions of Week One. Week Three also includes step lectures, readings and workshops and a two-hour SS session on 'Asking for Help'.

1.2.5 Week Four

This week participants explore the concept of unmanageability in their Step One (Part Two) assignments and assignment groups. This assignment helps participants to recognise the consequences of drug dependence, extending the cost-benefit evaluation method used in the MET sessions of Week One. A LC skills workshop on the NA slogan 'H.A.L.T.' (Hungry, Angry, Lonely, Tired) provides participants with a mnemonic for remembering to address basic self-care needs in order to minimise relapse risk.

1.2.6 Week Five

This week returns the focus of treatment from dealing with denial and motivation to developing coping skills. Peer evaluations provide participants with confidence, guidance and encouragement. An educational session, conducted by the Throughcare Manager, regarding available support within the prison and throughcare post-release is provided. The Throughcare Manager covers support services available to participants and family members/significant others supporting their recovery. Two SS sessions focus on actively encouraging participants to access aftercare support and services and rehearsing grounding skills while a LC session develops participants' skills for coping with relapse triggers. Step lectures provide participants with summary introductions to Steps Two and Three in order to increase familiarity with key twelve-step concepts and facilitate the development of participants' sense of membership and belonging in the twelve step recovery community.

1.2.7 Week Six

The last week consolidates previously developed skills through extended relapse prevention planning. In most of the sessions, participants complete an element of their personal relapse prevention plans; these are reviewed in individual counselling sessions and in the penultimate group session of the week. Five LC skills sessions focus on planning the development of recovery environments, accessing sponsorship and peer support within NA, recovery prioritisation and time

management. Six SS sessions develop participants' ability to identify and cope with personal risk factors; rehearsing skills needed to access support/ask for help and use anger constructively/address unhealthy beliefs, reviewing self-care and identifying areas to work on, cognitive behavioural strategies for rethinking negative cognitive patterns and factors to consider in developing healthy support networks. Treatment is concluded with a LC session reviewing participants' relapse prevention plans and other plans for the future, followed by a final session reviewing the treatment experience and providing a chance for participants to share and reflect what they have learned.

1.3 How targeted risk factors are addressed by the programme

Social support

- *Weak ties to, and lack of identification with, pro-social/anti-criminal models*
- *Strong ties to, and identification with, anti-social/criminal models*
- *Weak social support systems for tackling substance use*
- *Strong social pressure to use drugs and/or drink alcohol*
- *Poor pro-social interpersonal skills*

This risk factor is addressed in Seeking Safety sessions 3.3 and 6.5 'Asking for Help,' 5.2 'Assessing Aftercare' and 6.8 'Getting Others to Support your Recovery'. Living Clean sessions 6.6 'Sponsorship in NA' and 6.7 'Getting Active in NA' focus on building a new social network of others in recovery. Introductions assignments, peer evaluations and NA speaker meetings also encourage identification with fellow peers in recovery and contribute to establishing a support network.

The single-cohort structure of the Bridge Programme results in significant emphasis being placed on the development of trust and peer support. The small group size (ideally ten persons) encourages engagement. Assignments require self-revelation while skills workshops and group therapy require active participation. The therapeutic group process provides participants with direct experience of what it means to belong to a social group which supports growth and recovery. This encourages participants to question past identifications with anti-social and anti-recovery social groups and increases participants' comfort with the group format of community twelve-step support. Peer supporters provide ongoing support on the Bridge Programme and reinforce the pro-social emphasis of the programme, where addicts help each other. Peer supporters are graduates selected by treatment staff and are required to receive training by RAPt in order to fulfil this role effectively and must be retained on the programme for up to six months post-graduation. See Section 5.1 of the

Bridge Theory Programme Manual for further information on the selection and supervision of peer supporters.

Required attendance at NA and speaker meetings also supports the development of positive identification with a readily accessible network of pro-recovery social support. Direct and repeated experiences of NA meetings and encounters with NA members from the community are expected to counter pre-existing misconceptions and fears regarding twelve-step groups. The use of NA literature, relapse prevention and coping strategies in LC sessions further strengthens participants' sense of belonging and affiliation with NA. A significant advantage of using a twelve-step approach is that the social support network of NA can provide continuous support during treatment, for the remainder of participants' sentences and upon release. The affiliation process initiated in treatment fosters the creation of ties to the NA community. The Throughcare Manager provides a familiar source of support in prison and develops a care plan with the participant to support them for the remainder of their sentence. The care plan will also indicate post-release needs for participants who are nearing the end of their sentence.

Pro-social interpersonal skills are also explicitly introduced and rehearsed throughout treatment. Anti-social attitudes and cognitions are challenged in several LC and SS skills sessions and in group therapy sessions.

Emotion management

- *Deficits in decision making*
- *Deficits in emotion management, particularly anger management*

Deficits in emotion management are addressed through Living Clean and Seeking Safety sessions which introduce practical ways to manage drug cravings, trauma symptoms, anger and anxiety. Deficits in decision making are addressed by challenging dysfunctional cognitive patterns and introducing cognitive tools for engaging in a more productive decision making process.

In Seeking Safety sessions 2.7, 2.8 and 6.4 on 'Healing from Anger' and 'Using Anger Constructively', participants identify and rehearse constructive ways to cope with anger and develop their own personalised anger management plans. The Seeking Safety sessions 2.1 and 5.8 on 'Grounding and Relaxation' involve participants actually practicing techniques for detaching from intense emotions and trauma symptoms. The grounding exercises practiced in the session can be applied to a range of

emotions, including anger and drug cravings. Participants are encouraged to experiment and continue to practice these throughout treatment.

In LC sessions traditional NA methods of emotion management and decision making are discussed and practiced. Slogans are frequently used within NA and other twelve-step fellowships as mnemonics for remembering new, recently learned cognitive strategies to problems. For example session 2.3 'Just for Today' encourages breaking down long-term goals into manageable short-term ones, while session 2.9 'First Things First' helps participants to remember their priorities and ensure that decisions reflect these. Node-link mapping is used in several sessions to encourage participants to focus on one goal at a time and plan how to cope with potential obstacles to achieving these goals.

Step work on powerlessness and unmanageability leads participants to reflect on past decision making patterns and motivate them to address personal deficits identified. Decisions to use drugs or not to seek help are given particular attention, but exploration of all underlying attitudes and perspectives which need to change form a fundamental part of both LC and SS sessions.

Impulsivity and cravings

- *High impulsivity*
- *Difficulty in coping with cravings*

Throughout the Bridge Programme, participants are encouraged not to rely on will power or logical reasoning alone in order to deal with cravings and impulses—instead, they are encouraged to practice taking immediate actions such as asking for help from those around them. This is based on the recognition that sheer determination is not itself a sufficient solution to high impulsivity and cravings. New habitual reaction patterns need to be acquired and then established through repetition and practice.

Difficulty in coping with cravings is addressed in Seeking Safety session 2.6 'Coping with Triggers' and Living Clean sessions 2.9 and 5.3 'Coping with Triggers' and sessions 6.3 'Creating a Recovery Environment' and 6.11 'Relapse Prevention Planning' revise these skills and direct them towards post-treatment planning.

Further to this Session 1.9 on Safety allows participants to learn and practice how to say 'no' to offers of drugs and alcohol. This part of the session focuses on setting boundaries in relationships and interactions with others and introduces participants to different methods of saying 'no.' A behavioural assignment requires participants to practice saying 'no' in real-life or role-play situations in order to establish safety as the first priority and to develop self-respect.

Step assignments help participants explore and identify the need to develop new coping strategies rather than relying on will power. The repeated rehearsal of active behavioural coping responses through discussions, role play and node-link mapping in and out of group facilitates the creation of new coping habits. The use of grounding strategies is also encouraged as a means of coping with accompanying emotions and to manage situations in which they are isolated from sources of help. These are introduced in Week Two. Participants are then encouraged to practice them alone, with encouragement and review in individual counselling sessions. Their progress is then reviewed and further practice provided in Week Five.

Low motivation

- *Weak commitment to avoiding re-offending*
- *Weak commitment to recovery*
- *Low self-efficacy*

The delivery style used throughout the Bridge Programme is designed precisely to address this risk factor: Motivational Interviewing techniques are use to strengthen participants' commitment to effecting change, avoiding re-offending and relapse, and continuing treatment and/or NA affiliation.

In addition, the MET sessions 1.3 and 1.4 in Week One provide intensive interventions to address these factors. Exercises are used in which participants examine the pros and cons of drug use and the costs and benefits of change. Such exercises and ensuing discussions encourage the natural development of motivation and commitments based on self-interest and are therefore more effective than attempts to directly convince or coerce individuals of the benefits of change (see Section Six of the *Bridge Programme Theory Manual*).

Node-link mapping is used to plan recovery and how to implement new skills. This learning approach has been shown to enhance motivation in drug treatment programmes in similar contexts to the Bridge (Pitre et al., 1998) (see Section Six of the *Bridge Programme Theory Manual*).

Low self-efficacy is addressed through exposure to a large number of stories of addicts from a range of backgrounds through speaker meetings, NA meetings and NA literature. Discovering that individuals from all backgrounds, with many different life experiences, talents, type of addiction can and have achieved recovery provides many participants with inspiration and self-belief. This is strengthened by peer support and exploration of self-doubt in group therapy and individual counselling. NA members' stories, shared in meetings and in literature, also strengthen commitment to recovery by repeatedly reminding participants of the benefits recovery can offer. NA speakers will also encourage participants to engage their own NA sponsor and they may volunteer to act as temporary sponsors. Participants who are not going to be living locally post-release will be encouraged to engage a temporary sponsor locally who will then help them to locate one in their own area. Arrangements will be made for participants remaining in custody to meet with NA volunteers on a regular basis to sustain motivation and progress made in treatment.

Dysfunctional cognitions and attitudes

- *Dysfunctional or anti-social attitudes, cognitions and beliefs related to re-offending and relapse*
- *Difficulty recognising personally relevant risk factors for re-offending and relapse*
- *Difficulty generating appropriate strategies for coping with personally relevant risk factors for re-offending and relapse*

Dysfunctional cognitions and attitudes are addressed and challenged in Seeking Safety sessions 2.4 'Taking Back Your Power', 2.6 'Coping with Triggers', 6.9 'Recovery Thinking' and in Living Clean sessions 2.5 'Taking Back Your Power', 2.9 and 5.3 'Coping with Triggers'. Step lectures and assignments also encourage participants to consider their addiction from a different perspective and adopt new patterns of thinking.

Self-awareness is developed through various skills sessions exercises and through written assignments. Sessions on self-care and on identifying and coping with triggers all explore the role of personally relevant risk factors (PRF's). Participants are encouraged to examine their own experiences in order to learn about their own PRF's and are then provided with skills and strategies for coping with them. Sessions focusing on particularly common PRF's (e.g. difficult emotions, trauma symptoms, anger, anxiety, insomnia) increase participants' familiarity with these new skills and encourage them to practice them further. This process is then built into a solid foundation for post-

treatment recovery through the personal relapse prevention planning process in Week Six, where participants are supported in finalising post-treatment plans and goals tailored to their particular needs.

1.4 Adapting treatment methods to meet individual needs and respond to diversity

The Bridge Programme has been developed specifically to meet the needs of drug dependent male offenders serving shorter sentences. A search of the literature, including the review published by Home Office's Research Development and Statistics Directorate in 2003 (*The substance misuse treatment needs of minority prisoner groups: women, young offenders and ethnic minorities - Development and Practice Report 8*) did not identify any particular systematic differences in the treatment needs of ethnic minority groups from those of the majority ethnic community. However, careful attention has been paid to ensure that the programme does not use any materials or exercises likely to be perceived as offensive. Discriminatory language and behaviour of any sort is expressly prohibited by the Bridge Programme's rules and expectations (see Section 11.1 of the *Bridge Programme Manual One, 'Introduction and Overview'*).

1.4.1 Meeting individual needs

Individual counselling sessions and individually developed relapse prevention plans, as well as the setting of personal assignments, are all shaped by the particular needs and characteristics of individual participants. Additional help and support is provided as required. Continuous assessment and exploration of participants' Significant Events Sheets and daily assignments allow individual needs or issues to be monitored throughout treatment and discussed both in group settings and in individual counselling sessions with focal counsellors.

Each participant has a focal counsellor who is assigned to him during Week One. The focal counsellor acts as the participants' primary staff contact point and conducts all of their individual counselling sessions throughout treatment. The participant actively works with his focal counsellor to develop a treatment plan suited to his specific personal needs. The focal counsellor also works closely with the participant in the final two weeks of treatment to ensure that personal goals and plans developed during the relapse prevention planning process are suitable, realistic and address the participants' primary therapeutic needs. The focal counsellor feeds back any relevant information or concerns about each participant's throughcare needs to the Throughcare Manager. The Throughcare Manager holds two one-to-one sessions with each participant to discuss throughcare/resettlements needs, including any concerns arising in the sessions with their focal counsellor.

The ongoing treatment plan used throughout treatment is used to meet current needs and may add very simple tasks to the overall programme. For example, a participant who tends to isolate may like to have a "buddy" assigned with whom he agrees to share one feeling each day and record his success on his Significant Event Sheet. Treatment plans are subject to continuous evaluation, predominantly in individual counselling sessions between the participant and his focal counsellor. Case reviews are conducted regularly by the treatment team to monitor each individual's progress.

The *Bridge Programme Manual Three. 'Participants' Guide'* is tailored to address literacy difficulties and differing learning styles, including two versions of most of the handouts; one less wordy with use of visual tools/diagrams to convey messages. This also gives participants the freedom to choose which handout version to use. Session materials that explain important concepts and skills will include another version using node-link maps, flow diagrams or pictures. Facilitators may also use these second versions of handouts to 'test' and ensure that all participants have fully understood the concepts covered or to explore how the topic relates to participants' beliefs and experiences. For example facilitators may use Handout 1 from session 3.1 'Understanding Step One' to explore participants pre-conceptions and experiences of the terms used in Step One to help them engage with topic.

Additional support is always made available for those with literacy difficulties. Participants with literacy difficulties should be matched to a peer supporter or a peer 'buddy' who would help provide him with appropriate support. Prison security requirements allowing, audio versions of NA literature and NA members speaking at conventions would be provided for the participant to listen to. Where participants have difficulties reading and writing their peer supporter or 'buddy' will be given scheduled time to read to the participant from NA literature or treatment materials and/or write down dictated assignments. See Section 5.1 of the *Bridge Theory Manual* for further information on the selection and supervision of peer supporters.

See the 'Meeting Individual Needs' section in each session of the *Bridge Programme Manual Facilitators' Guide* for a more detailed explanation of how individual literacy needs are met.

The participants' focal counsellor is also responsible for assimilating all assessment material, including the CARAT Comprehensive Substance Misuse Assessment (CSMA), the RAPt Assessment and Mental Health Screen, staff observations, treatment plans and information from staff conducting programme sessions. Information provided by the participant in the process of preparing

and reading his introductory assignment in Week One can also be used to inform case management and ensure that individual needs are met.

Further issues that need to be dealt with post-treatment are identified in the relapse prevention planning process and then incorporated into comprehensive throughcare plans during Week Six of the programme. These are then dealt with in detail in each participant's Post-Programme Report and may include sustained support for addressing mental or physical health problems, childhood abuse history, housing, education and employment needs. Participants work with their facilitators, focal counsellors, Throughcare Manager and where appropriate CARAT worker, DIP workers and probation officers to agree a suitable plan for secondary care and support based on their needs. Any need for secondary care following release would be detailed at this stage, included in the report and addressed by the Throughcare Manager or where appropriate, their assigned CARAT worker.

Finally, following completion of the programme, participants complete feedback forms which allow their views from actual participation in the different elements of the programme to be fed back to facilitators. This process is designed to ensure that the Bridge Programme is informed by the views of participants.

1.4.2 Responding to diversity, and participants' life experiences

The programme is carefully tailored in its delivery to the needs and backgrounds of the participants—taking full account of any problems with literacy and of issues associated with diverse backgrounds (including in relation to ethnicity, culture and belief, as well as histories of sexual and/or physical abuse).

A workshop on the importance of tolerance and diversity is conducted in Week One. It is based on the twelve-step slogan 'Live and Let Live' and on the NA membership policy, which explicitly states that all individuals are welcome in NA, regardless of gender, race, culture, sexual orientation or belief, so long as they are interested in achieving recovery. The diversity workshop encourages participants to identify and question their beliefs about difference and relate these to their own experiences with prejudice and stereotyping, for example as prisoners and addicts. The session provides a chance for self-reflection, focusing on the importance of inclusion and acceptance for successfully working with others.

RAPt is an equal opportunities employer and aims to ensure that the ethnic mix of facilitators mirrors the ethnic mix of participants. Many of our facilitators are themselves in recovery from addiction and a significant number have histories of offending behaviour.

Since gaining a professional qualification in counselling can be prohibitively expensive, RAPt began its own counsellor training course in 1997. Graduates from our training programme come from a wide range of ethnic backgrounds and have a broad range of life experiences. Such diversity among our facilitators means that we are well placed to respond to participants with diverse needs and life experiences.

RAPt has an equal opportunities policy. All counselling staff are trained to work with diversity. RAPt recognises the problems experienced by those who because of race, age, belief, mental illness, offending history or other life experience find themselves in a minority both within the treatment group and the establishment.

1.4.3 Meeting additional needs

Details of how the Bridge Programme meets additional needs are provided in Section 3.6 of this manual.

1.5 Evidence of likely effectiveness

There is strong evidence, discussed in Section 4.3 of this manual and presented in greater detail in Section Six of the *Bridge Programme Theory Manual,* to show that twelve-step treatment in general, and the Bridge Programme in particular, is likely to be effective in addressing the underlying factors it seeks to target and, in so doing, reduce drug use and re-offending after release.

1.6 Treatment methods used to address risk factors

A more detailed account of the methods used to address risk factors are detailed in Section Five of the *Bridge Programme Theory manual*. The following information provides a summary of the approaches incorporated into the Bridge Programme.

1.6.1 Motivational Enhancement Therapy (MET)

Two MET sessions are conducted on the second day of treatment. MET is based on the principles of motivational psychology and is well grounded in both theory and research (see Section Six of this manual).The aim of providing MET sessions early on is to pro-actively encourage dynamic

engagement with treatment. Since the approach assumes that the responsibility and capacity for change lie with the participant, the facilitators' task in these sessions is to create a set of conditions that will enhance the participants' own motivation and commitment to change. This is done through the use of various established motivational enhancement techniques and exercises.

1.6.2 Motivational Interviewing approach

A Motivational Interviewing approach to working with participants is used by facilitators throughout the programme. Many offenders are likely to have complex negative reactions to attempted coercion, due to the disempowerment inherent in being a prisoner (Wild et al., 2006). These factors make Motivational Interviewing a far more suitable intervention for this population than confrontational approaches.

Motivational Interviewing's emphasis on encouraging participants to take control of their own treatment process and commit to change for themselves also fits well with the Bridge Programme's goal of linking participants to secondary care and ongoing NA affiliation. Such post-treatment changes may be strongly encouraged but cannot be mandated by treatment: the implementation of such plans therefore depend on the participants' desires for change.

1.6.3 Node-link mapping

Node-link mapping (NLM) is used throughout the programme within sessions, individual counselling sessions and as homework assignments. NLM is used to identify goals and obstacles on the road to recovery and link these to coping strategies and new skills learned. NLM has been particularly shown to be effective for individuals who struggle to sustain attention (a common challenge for those in early abstinence) and/or with limited literacy (a common challenge among offenders) (Czuchry & Dansereau, 2003). Although a set number of node-link mapping exercises are provided in the *Bridge Programme Manual Three, 'Participants' Guide'* facilitators can choose to use this method as often as they deem appropriate in individual counselling and group skills sessions, according to their knowledge of the group or individuals. For further detail of the effectiveness of node-link mapping see Section 4.3 of this manual.

1.6.4 Twelve-step motivational strategies

In order to successfully link participants to secondary care and NA, behaviours and cognitive distortions which undermine treatment engagement and weaken motivation need to be addressed. Practical skills training and education are therefore provided. The development of positive coping

strategies in these sessions is also likely to benefit those participants who, for whatever reasons, choose not to continue in treatment or attend NA.

In order to strengthen the sense of connection and belonging with NA, and retain the benefits of twelve-step treatment while introducing practical skills, the Bridge Programme skills training and cognitive interventions are based on the NA book *Just for Today* (1991). These sessions are interchanged with highly complementary Seeking Safety sessions which focus on coping skills found to be relevant to this client group but not adequately addressed in NA literature. Education workshops are used to educate participants about substance dependence and resources available to them within the criminal justice system and in the community. The Throughcare Manager provides participants with information about the services they or the CARAT team can provide which includes linking participants to NA sponsors or volunteers in their local area or temporary sponsors in the prison's local area.

The NA book *Just for Today* concerns practical matters and relapse prevention strategies. Unlike other NA texts, such as NA's Basic Text *Narcotics Anonymous* (1983) and *It Works: How and Why* (1990), *Just for Today* does not discuss details of NA philosophy, the twelve-step programme nor the twelve steps themselves. Instead, the focus remains firmly on the practical application of twelve-step methods for coping with different situations, cravings, and difficult emotions. The division of the book into short topic-specific passages also makes it more readily accessible to those in early recovery and easily adaptable to topic-focused skills sessions.

Because of their emphasis on the development of immediate relapse prevention and safe coping skills, LC skills sessions provide an appropriate first-stage brief intervention while retaining many of the strengths of a traditional twelve-step approach, such as linking participants to the support of fellowship meetings and introducing them to NA principles, general recovery strategies and language. The latter is intended to increase their sense of belonging and membership within NA. *Just for Today*'s colloquial, straightforward language combined with its incorporation of relevant excerpts from other NA literature provides an accessible but wide-ranging overview of other NA literature.

Behavioural change is emphasised in skills sessions through the direct implementation and practice of new skills. At each session, participants commit to taking one recovery-based action, however small. Each participant agrees to concrete steps they will practice between sessions, and post-

session assignments require action to complete. Attendance at twelve-step meetings is also required throughout.

Cognitive changes in attitudes, beliefs and perceptions are also encouraged in a variety of other ways. As discussed above, action is often used as a means to test the validity of deeply held beliefs (e.g. in the example of sharing step assignments, the belief that others will judge a participant for actions he has taken in the past followed by the realisation that peers in recovery are, in fact, more likely to identify with and accept him). Slogans are repeated in meetings, in group sessions and hung on the walls in order to reinforce alternative and more constructive perspectives through repetition (e.g. “Just for Today,” “First Things First”). The steps also elicit cognitive changes through action.

The first step asks the new participant to develop an understanding of himself as an addict who has an incurable disease and who is powerless over his drug use and its effects on his life. This process is triggered by self-reflection and an examination of past experiences. Once such a cognitive change has occurred, participants are freed to focus on those behaviours over which they *do* in fact have control and through which they can remain abstinent. Instead of doomed efforts to moderate drug consumption or fighting cravings while remaining in drug-associated environments, they can successfully focus energy on recovery strategies that enable them access support while avoiding triggers and relapse. This can be an empowering shift in perspective for those who have become accustomed to viewing themselves as “weak” or “failures” because of their inability to abstain from drug use.

1.6.4 Seeking Safety skills training

Substance dependent male offenders generally have relatively severe psychological profiles characterised by multiple areas of clinical need. In particular, insomnia, anxiety, impulsivity/anger and trauma symptoms have all been shown to adversely affect treatment retention and motivation if not effectively addressed (see Section Three of the *Bridge Programme Theory Manual* for more details). Since practical approaches to dealing with these particular problems are not contained in NA literature, Seeking Safety sessions were incorporated into the Bridge Programme. SS is highly compatible with the LC approach and has a strong evidence base.

SS is a recently developed approach based primarily on cognitive-behavioural principles and designed to address substance dependence and trauma symptoms concurrently. Similar cognitive, behavioural and educational methods are used in SS as in LC sessions. In order to provide continuity

for participants, SS and LC sessions are delivered following much the same formats—the only difference is that SS sessions are opened with a quotation while LC sessions are not. The formats of SS check-in and check-out processes are used in LC sessions, providing the safety of a consistent daily framework. A check-in is used to open treatment each morning and a check-out to close treatment in the afternoon. The brief timing of the check-ins and check-outs has a strong evidence base with the SS treatment model and is intended as a 'snap shot' of how participants are feeling and coping with the treatment rather than to provoke in-depth exploration of these topics. Deeper discussions of treatment progress is addresses in individual counselling sessions and group therapy sessions, while rehearsal of new skills is saved for skills review sessions.

Like LC sessions, SS sessions do not attempt in-depth therapeutic work nor do they explore trauma histories. Rather, the focus remains restricted to developing practical skills which will be of immediate use to participants who struggle to engage effectively with treatment due to coping skills deficits and debilitating symptoms. By focusing on the present, SS sessions successfully complement LC skills workshops.

1.7 THE TWELVE-STEPS

Based on their own experiences of achieving recovery from alcoholism, the originators of Alcoholic Anonymous, Bill Wilson and Bob Smith, identified twelve steps to recovery. These steps were set out in the book *Alcoholics Anonymous*, published in 1939 and after which the fellowship of AA was named. The twelve steps of Narcotics Anonymous (NA) were adapted from these and published in *Narcotics Anonymous*, NA's Basic Text, in 1983. The twelve steps below are those used in NA and on the Bridge Programme:

1. *We admitted we were powerless over our addiction, that our lives had become unmanageable.*
2. *We came to believe that a Power greater than ourselves could restore us to sanity.*
3. *We made a decision to turn our will and our lives over to the care of God as we understood Him.*
4. *We made a searching and fearless moral inventory of ourselves.*
5. *We admitted to God, to ourselves, and to another human being the exact nature of our wrongs.*
6. *We were entirely ready to have God remove all these defects of character.*
7. *We humbly asked Him to remove our shortcomings.*
8. *We made a list of all persons we had harmed, and became willing to make amends to them all.*
9. *We made direct amends to such people wherever possible, except when to do so would injure them or others.*

10. *We continued to take personal inventory and when we were wrong promptly admitted it.*
11. *We sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.*
12. *Having had a spiritual awakening as the result of these Steps, we tried to carry this message to others, and to practice these principles in all our affairs.*

2. SELECTION OF OFFENDERS

The *Bridge Programme Management Manual* details the procedures and protocols used for selection of offenders onto the Bridge Programme. The following information summarises the key elements.

To maximise the programme's impact on re-offending, priority is given to those in the medium-high range of re-offending (as defined by the sentence planning risk predictor and/or the Offender Assessment System). However, offenders with a lower risk score are accepted where places are available.

There are three key areas which determine participants' suitability:

- Risk of re-offending (including drug dependence as a risk factor)
- Their individual needs
- Whether the Bridge Programme can meet those needs

2.1 SELECTION CRITERIA

The selection criteria for admission to the Bridge Programme are as follows:

A. Medium-high risk of re-offending (as defined by the sentence planning risk predictor)
B. A history of drug dependence (as defined by DSM-IV(TR)[1])
C. Drug dependence as a significant risk factor for re-offending
D. Aged 21 years or older
E. Sufficient time left to serve in custody to complete programme

The Bridge Programme is an abstinence-based programme aimed at offenders with a history of substance dependence, as defined by the DSM-IV-TR. It is not intended for those who are alcohol but not drug dependent or for those with a history of only problematic drug use rather than dependence.

Where someone has been assessed as meeting the DSM-IV-TR criteria for substance dependence, their dependence will be assumed to be a significant risk factor for re-offending even if it was not a

[1] *Diagnostic and Statistical Manual of Mental Disorders*, 4th Edition, Text Revision; published by the American Psychiatric Association

factor in any of the offenders' previous crimes. However, those with a clear history of drug-related offending will be given priority where there is pressure for places on the programme (again, in order to maximise the programme's likely effectiveness)**.**

[Note - this programme addresses a broad range of factors recognised by the Correctional Services Accreditation Panel as 'general offender dynamic risk factors'. As such it would be expected to be of value for someone even where substance dependence was not a primary factor in their previous offending histories.]

2.2 EXCLUSION CRITERIA

Offenders who meet the selection criteria set out above are excluded from the programme if any of the following apply:

- Level of cognitive ability insufficient to cope with programme
- Mental health condition likely to interfere with response to the programme
- Use of substitution medication
- Objection to participation from the security department
- Outstanding application for transfer/insufficient time to serve

An offender would not be excluded from the programme on the grounds of apparently low levels of motivation. Any offender who applies for the programme will be assumed to have sufficient levels of motivation to participate and Week One of the programme contains a motivational enhancement component. However, a participant may be de-selected from the programme after admission for a variety of reasons, some of which may be related to his level of motivation.

The *Bridge Programme Management Manual* and the *Bridge Programme Assessment and Evaluation Manual* provide further details of the rationale for the selection and exclusion criteria used by the programme and explain how these are applied in practice (including a list of, and references for, assessment instruments employed in selection, together with a justification for their use and an account of their psychometric properties, i.e. reliability and validity).

Care is taken to ensure that potential participants are not inappropriately excluded in the selection process on the basis of their background, and admission data are analysed to monitor the programme's success in this (the *Bridge Programme Assessment and Evaluation Manual* and *the Bridge Programme Management Manual* provide more details).

2.3 Monitoring diversity

All RAPt facilitators are trained in issues of diversity. The Bridge Programme is monitored to ensure that potential participants are not discriminated against on the ground of the type of offences they have committed, ethnicity, belief, disability, gender identity, sexuality or age.

All assessment documents of participants accepted and of those deemed not to have met selection criterion are regularly reviewed by the Treatment Manager. The reasons for exclusion are checked for compliance with the programme's exclusion criterion. If the reasons for exclusion are unclear or poorly documented, the Treatment Manager will arrange to meet with the potential participant to review the documentation and ensure that no discriminatory practices have taken place.

RAPt's participant database will hold information on the chief demographic characteristics of all referrals onto the Bridge Programme. Selection and retention of participants is regularly reviewed to ensure that participants' characteristics reflect the general prison population. Additionally, the standard Participant Feedback Form (see Section 9.8 of this manual. A copy will also be provided in the Appendices section of the *Bridge Programme Assessment and Evaluation Manual*) monitors participants' subjective perceptions of the quality and helpfulness of the programme, with particular attention paid to the perspectives of those in various minority groups.

2.4 De-selection criteria

Breaches of the Bridge Programme's rules and expectations may result in de-selection. The progression to de-selection would normally occur after the following procedures had been initiated:

- Verbal warning
- Official verbal warning
- Written warning
- De-selection

Verbal and official verbal warnings may be administered by a facilitator without seeking the authorisation of the Treatment Manager. However, any disciplinary measure that may lead to de-selection must be discussed within the treatment team and approved by the Treatment Manager. Breaches of the Bridge Programme's rules and expectations are to be managed constructively. The facilitator should attempt to help the participant understand that the rules and expectations are not designed to be punitive, but to aid the therapeutic process. During the early stages of the programme, non-compliance will be dealt with more leniently than in the later stages of the

programme. Non-compliance is seen as a clinical issue which needs to be balanced against the impact on the wider treatment community.

2.4.1 Verbal warning

A verbal warning would normally be given to a participant for a minor breach of the Bridge Programme's rules and expectations. This may include failure to submit Significant Events Sheets on time, or failure to complete a written assignment by the agreed submission date. A verbal warning is to be followed up in the next individual counselling session and used as a tool to address underlying obstacles to engagement.

2.4.2 Official verbal warning

An official verbal warning would normally be given to a participant for a second breach of a minor rule or expectation. It may however be given in the first instance, for a more significant breach, e.g. an unauthorised absence from a treatment session. Issues stemming from a lack of engagement will be incorporated into the offenders' treatment plan.

2.4.3 Written warning

A written warning would normally be administered for repeated or more serious breaches of the Bridge Programme's rules and expectations. A written warning must be given in the presence of either the Programme Manager or another facilitator. The written warning must detail the reasons for the warning and expected changes in behaviour.

A written warning must be discussed in the group session following its implementation. The participant should be made aware that continued non-compliance with the Bridge Programme's rules and expectations may result in de-selection. The facilitator should encourage the participant's peers to support him in bringing about the desired behavioural changes and an action-plan should be agreed outlining ways in which the participant can address the underlying causes of his disruptive behaviour.

2.4.4. De-selection

Immediate de-selection can only be considered in the following circumstances:

- A request from security that the participant be de-selected
- Dealing
- Bullying

- Violence
- Threats of violence

De-selection for reasons other than the ones highlighted above will only be considered when the participant has repeatedly breached the Bridge Programme's rules and expectations and has progressed through the programme's warnings procedures. De-selection is a last resort which is used when all efforts to engage and motivate a participant have proved unsuccessful and his continued presence in treatment undermines the therapeutic safety of his peers. In these cases an exit session must be held between the participant, his focal counsellor and the Throughcare Manager or assigned CARAT worker. De-selected participants will be referred back to the CARAT team for follow-on work, where appropriate. Gains made whilst on the programme should be discussed, unmet needs identified, and in particular, more suitable treatment options explored.

2.4.5 Relapse while in treatment

Where a participant relapses in treatment, it will be treated as a serious breach of rules and expectations. The standard response will be to issue a written warning and hold an additional individual counselling session with the participant to reflect upon the factors which led to his relapse. Further assignments and counselling sessions may also be arranged. The response to relapse is not intended to be punitive. The emphasis is on learning to identify causes and personal risk factors and to develop renewed motivation by learning from the experience. However, where the participant put other group members at risk through his relapse (e.g. by encouraging them to join him and/or planning the relapse in advance), has relapsed repeatedly, has lied about relapsing, has already received written warning(s) for other breaches of rules and expectations or other contextual factors warrant concern, de-selection may be considered.

2.5 Re-admission

If a participant is de-selected, they may be able to restart the programme at a later date if, following an interview, the AIMs are satisfied that the reasons for de-selection have been addressed. It is recommended that a period of at least three months have passed since de-selection from the programme before re-applying.

In all cases a care plan aimed at addressing the behaviours and attitudes that led to de-selection must be drawn up with the participant prior to re-entry.

3. TARGETING A RANGE OF DYNAMIC RISK FACTORS

3.1 DYNAMIC RISK FACTORS FOR RE-OFFENDING TARGETED BY THE PROGRAMME

The two main dynamic risk factors targeted by the programme are:

- Substance dependence and abuse; and
- Drug-related offending behaviour

The other general dynamic risk factors for re-offending targeted by the programme are:

- Weak ties to, and lack of identification with, pro-social/anti-criminal models
- Strong ties to, and identification with, anti-social/criminal models
- High impulsivity
- Deficits in decision making
- Lack of assertiveness
- Poor pro-social interpersonal skills
- Deficits in emotion management, particularly anger management
- Weak commitment to avoiding re-offending
- Low self-efficacy
- Dysfunctional or anti-social attitudes, cognitions and beliefs related to re-offending
- Difficulty recognising personally relevant risk factors for re-offending
- Difficulty generating appropriate strategies for coping with personally relevant risk factors for re-offending

3.2 FACTORS TARGETED IN RELATION TO DRUG ABUSE AND DEPENDENCE

In seeking to address drug problems, the Bridge Programme targets a range of underlying factors relevant to drug misuse, a number of which overlap with the other dynamic risk factors for re-offending targeted by the programme:

- Weak social support systems for tackling substance use
- Strong social pressure to use drugs and/or drink alcohol
- High impulsivity
- Deficits in decision making
- Lack of assertiveness

- Poor pro-social interpersonal skills
- Deficits in emotion management, particularly anger management
- Weak commitment to recovery/treatment
- Low self-efficacy
- Dysfunctional or anti-social attitudes, cognitions and beliefs related to substance use
- Difficulty recognising personally relevant risk factors for relapse
- Difficulty generating appropriate strategies for coping with personally relevant risk factors for relapse
- Difficulty in coping with cravings

3.3 Evidence concerning appropriateness of factors targeted by the programme

The dynamic risk factors for re-offending and underlying risk factors associated with relapse which are targeted by the programme have been recognised as appropriate targets for interventions by the Correctional Services Accreditation Panel (CSAP). Evidence to show that these risk factors are likely to be present in those taking part in the programme is discussed in detail in Section Three of the *Bridge Programme Theory Manual.*

3.4 How these risk factors and changes in them are assessed and measured

The factors targeted by the programme and changes in them are assessed and measured using a battery of psychometric measures administered on referral and completion. Details of these assessments are provided in the *Bridge Programme Assessment and Evaluation Manual* and further information about methods of measuring treatment effects is provided in Section Ten of this manual.

3.5 How targeted risk factors are addressed by the programme

Details of how each of the targeted risk factors is addressed by the Bridge Programme are provided in Section 1.3 of this manual.

3.6 Meeting additional needs

Alternative intervention strategies are developed for participants who fail to engage in the programme, either for reasons of poor motivation or extreme vulnerability. In almost all such instances, the introduction of additional counselling sessions is initially employed as a means of exploring difficulties. Where the participant presents with a history of mental health problems, close attention is paid to his mental health status throughout his time on the Bridge Programme and the

level of support provided closely mirrors his level of vulnerability. In all such cases, a shared care approach is adopted with the Prison's Health Department.

It is the goal of the programme to treat participants in six weeks. Sometimes, due to external events (e.g. bereavement or illness), a participant may miss a significant number of sessions. Treatment may be suspended until such time as the participant is emotionally able to resume treatment, at which point he may wish to join a subsequent cohort after at least three months.

Issues that need to be dealt with post-treatment are identified and incorporated into individualised throughcare plans developed by each participant, his focal counsellor and the Throughcare Manager during the last two weeks of the programme. These plans incorporate goals identified by the participant and his focal counsellor over the first five weeks of treatment, issues indentified in follow-up one-to-one sessions with the Throughcare Manager and those identified by the participant himself in his personal relapse prevention plan developed in Week Six group sessions. The throughcare plans are detailed in each participant's Post-Programme Report and may include sustained support for addressing anger management, mental or physical health, childhood abuse history, educational, housing or employment needs. Participants' level of need for secondary care for substance dependence following release would be detailed at this stage and included in the report. These comprehensive throughcare arrangements help to ensure that additional needs not targeted by the Bridge Programme are addressed following treatment. If a participant is due for release within three months of completing the programme the Throughcare Manager will provide onward referrals (e.g. to community Drug Intervention Teams, Job Centres, training, secondary treatment), offer direct support and advice prior to release, regarding employment, housing options or locating NA meetings and sponsors. Participants with longer than three months still to serve are referred to an assigned CARAT worker who will continue to provide support in prison, arranging contact with NA volunteers/sponsors and ensuring that appropriate referrals for secondary care are made prior to release.

4. EFFECTIVE METHODS

4.1 TREATMENT METHODS USED TO ADDRESS FACTORS TARGETED BY THE PROGRAMME

The programme uses twelve-step, Seeking Safety (SS) and Motivational Enhancement Therapy (MET) methods to address the factors it targets.

MET sessions are held in the first week of treatment to strengthen participants' commitment to treatment and to develop motivation and self-efficacy. Motivational Interviewing techniques are then used throughout the remainder of the programme to help sustain participant motivation.

Twelve-step methods are used throughout treatment, with regular required attendance at twelve-step meetings, use of NA literature, work on Step One assignments, lectures on twelve-step concepts, NA literature reading groups and a series of skills workshops which introduce practical twelve-step relapse prevention strategies, based on the NA text *Just for Today.*

SS sessions are also conducted throughout treatment but with greater intensity in Weeks Two and Six. These sessions introduce further concrete coping skills addressing deficits which might otherwise undermine participants' engagement with treatment or subsequent access to further support.

Further details of the methods employed on the programme and how they are integrated with one another are provided in the *Bridge Programme Manual Two, 'Facilitators' Guide'*, while the *Bridge Programme Theory Manual* provides theoretical justification for these treatment methods in respect of the dynamic risk factors identified in Section One of this manual.

4.2 ADAPTING TREATMENT METHODS TO MEET INDIVIDUAL NEEDS AND RESPOND TO DIVERSITY

Details of how the Bridge Programme meets individual needs and responds to diversity and participants' life experiences are provided in Section 1.4 of this manual.

4.3 EVIDENCE OF EFFECTIVENESS

Please see Section Six of the *Bridge Programme Theory Manual* for a more detailed review of evidence demonstrating the efficacy of the chosen treatment methods in relation to the type of offender targeted by the Bridge Programme.

4.3.1 Time-Limited intensive interventions

While studies have repeatedly found that longer treatment retention is associated with more positive outcomes (Simpson, 2004), the most important factors appear to be ongoing access to support and extended low-level treatment contact rather than simply the length of time spent in residential treatment (McKay, 2005). All Bridge participants are encouraged to affiliate with the fellowship of NA, which provides a free and indefinitely accessible support and a pro-abstinence social network, the effectiveness of which was recognised in NICE guidelines on psychosocial interventions for drug misuse (NICE, 2007). Where more structured and intensive ongoing interventions are indicated, an appropriate onward referral will be made to engage participants with secondary treatment on release.

The recent NICE guidelines noted that delays in accessing treatment lead to loss of motivation, relapse and criminal behaviour (NICE, 2007). Most significantly, some service users reported that delays negatively impact seeking further treatment and that accessing treatment in prison was problematic. Speed of entry to treatment has been found to significantly affect treatment effectiveness (Bien et al., 1993; Babor 1994; Moyer et al, 2002), with delays known to decrease motivation and engagement (Bacchus et al., 1999).

The Bridge Programme ensures that substance dependent offenders are able to rapidly access intensive treatment during their sentence—when they are unable to obtain drugs as readily as in the community, are actively experiencing the costs of their using and are therefore more likely to consider treatment (Inciardi, 1994; Lawenthal et al., 1996; Peters and Murrin, 1998). The programme then provides pro-active case management linking participants to further sources of support in prison and in the community, playing an important role in the treatment pathway for all substance dependent participants, whatever their level of need.

4.3.2 Individual counselling sessions

The individual counselling sessions provided fortnightly throughout the programme allow the development and maintenance of an effective working alliance between each participant and his

focal counsellor. This “therapeutic alliance” has been found to be an effective and powerful tool in successful drug treatment (Haaga et al., 2006).

Focal counsellors delivering individual sessions provide participants with empathy and respect; focus on collaboration rather than confrontation; offer direction; help participants to elucidate and then achieve their own goals; and maintain structure through treatment plans and regular individual counselling sessions. Finally, focal counsellors work with participants on relapse prevention plans and final throughcare plans addressing post-treatment needs. All of these therapeutic processes have been recognised as defining elements of effective treatment interventions (Haaga et al., 2006; McCrady and Nathan, 2006; Lebow et al., 2006).

4.3.3 Style of treatment delivery

Evidence supporting the use of a Motivational Interviewing style of session delivery is reviewed below (Section 4.3.4). Node-link mapping is listed on the US government’s Substance Abuse and Mental Health Administration (SAMSHA) website as an evidence-based method of drug treatment. Extensive research has been conducted examining node-link mapping’s effectiveness in facilitating communication and information transfer. Several evaluations have concluded that node-link mapping graphic representations are more easily recalled and understood than traditional spoken or written language explanations (Dansereau, Dees, & Simpson, 1994; Larkin & Simon, 1987; Mattaini, 1993). There is further evidence suggesting that this method is particularly effective for individuals who struggle to sustain attention (a common challenge for those in early abstinence) and/or with limited literacy (a common challenge among offenders) (Czuchry & Dansereau, 2003).

Pitre et al. (1998) conducted a randomised study which specifically evaluated the effectiveness of node-link mapping in a residential drug treatment programme for convicted offenders on probation. The programme in the study was similar to the Bridge Programme in length, setting and intensity. Participants who were given node-link mapping were more involved and retained more effectively than those in treatment as usual. They also reported better personal progress toward treatment goals, more positive affective responses to treatment, and greater treatment engagement.

4.3.4 Motivational Enhancement Therapy

Loss of motivation and hope for change are strongly associated with treatment attrition and are the most frequently reported subjective reasons for dropping out of or not engaging with treatment (Ball et al., 2006a; Anderson and Berg, 2001; Broome et al., 2002). MET is one of the most carefully

developed and rigorously studied of brief therapeutic interventions (Miller and Rollnick, 1991; Hettema et al., 2005; Ball et al., 2006b). Even in brief treatment doses, it has been shown to significantly lower the detrimental impact of low motivation and self-efficacy (Claus and Kindleberger, 2002).

MET interventions have also been shown to work well as "primers" before engagement in more intensive twelve-step treatment. An increase in motivation for recovery is often a pre-requisite to participants agreeing to further, long-term treatment and to their active engagement, during treatment. It is therefore addressed on the second day of the programme and then built upon through the use of Motivational Interviewing techniques and other motivational exercises (see Section Five of this manual). The strengths of MET are thus exploited by including MET sessions early on, followed by skills training and further intensive treatment which revisits motivational themes. The efficacy of integrating MET with other approaches has been empirically supported in a recent study of male offenders (Lincourt et al., 2000) and in community populations (Baer et al., 1999; Vasilaki et al., 2006).

4.3.5 Seeking Safety skills training

The role of trauma in the aetiology and maintenance of drug dependence and the importance of integrated treatment was noted in the recently issued NICE guidelines on psychosocial interventions for drug misuse, reflecting increasing awareness of the trauma-addiction relationship in research literature (NICE, 2007). However, traditional substance dependence programmes do not address trauma symptoms. As a result, individuals who experience them have significantly poorer outcomes, with trauma symptoms identified as strong predictors of substance use relapse (Mills et al., 2007; Brown and Wolfe, 1994; Najavits et al., 1997; Najavits et al., 2007).

SS was developed in the early 1990s to rectify this situation and provide concurrent and integrated intervention for trauma and addiction concurrently (Najavits, 2002). Various studies have demonstrated that such an integrated approach is more effective than treatments addressing just one or both sequentially (Najavits et al., 1997; Read et al., 2004; Mangrum et al., 2006). SS was the first empirically studied intervention for those with this dual diagnosis and remains the most studied model to date (Najavits, 2007). It is based largely upon cognitive behavioural therapy (CBT), which is itself recognised as a highly effective treatment for substance dependence and for offender rehabilitation and skills training (Wilson, 2005; Miller et al., 1995; Finney and Monahan, 1996; Morgenstern and Longabaugh, 2000).

There have now been eleven completed outcome studies of SS, conducted across a range of populations, using several designs, and reporting consistently positive results. Multi-site controlled trials of clients with co-occurring disorders (Morrissey et al., 2005) and veterans (Desai & Rosenheck, 2006) found that follow-up substance use outcomes were equivalent to those of substance dependence treatment alone but trauma, mental health symptoms and overall functioning were significantly better in the SS condition. Four controlled trials have been conducted (Desai and Rosenheck, 2006; Hien et al., 2004; Morrissey et al., 2005; Najavits et al., 2006). All reported positive results for SS on its own and in combination with other treatments. A pilot study with women offenders recorded positive outcomes for SS in a group modality combined with twelve-step treatment (Zlotnick et al., 2003).

4.3.6 Twelve-step treatment

Despite its origin as a self-help movement and the non-professional stance of NA, the twelve-step approach has increasingly been the subject of systematic empirical examination in the last two decades. Integration of twelve-step philosophy and methods into professional treatment has also been widespread. Its effectiveness in the UK context received support from the National Treatment Outcome Research Study (NTROS), in which twelve-step residential treatment centres made up approximately half of the residential units included in the study. Residential centres, including those using twelve-step facilitation, were found to be effective in reducing most forms of drug use at five year follow up: frequency of heroin use was halved one year after intake to treatment and remained so throughout the 4-5 year follow-up period (Gossop et al., 2003).

A large-scale prospective cohort study by Moos et al. (1999) found that substance dependent participants who completed twelve-step treatment had superior abstinence outcomes with regard to both illicit drugs and alcohol than those in CBT treatment. Fiorentine and Hillhouse (2000) found twelve-step facilitation to be more effective in linking participants to twelve-step fellowships such as NA. Timko et al. (2006) found that intensive referral methods encouraging affiliation with twelve-step fellowships, such as those used on the Bridge Programme, resulted in increased levels of twelve-step meeting attendance and fellowship involvement at six-month follow-up. Participants in the intensive referral group were also more likely to be abstinent and showed lower levels of drug and alcohol use than those in the standard referral group.

4.3.7 Twelve-step fellowship affiliation

The recent NICE guidelines reviewed evidence for the effectiveness of twelve-step fellowships as interventions for drug dependence and concluded that they were effective (NICE, 2007). The guidelines therefore issued a recommendation that information on twelve-step self-help groups, in particular NA and CA, should be routinely provided to substance misusers. Much of the evidence described below is a summary of that considered in the guidelines.

Seven studies met the NICE criteria for inclusion: two randomised controlled trials (McAuliff, 1990, Timko et al., 2006), two cohort studies (Moss et al., 1999; Ethridge et al., 1999), a prospective longitudinal study (Fiorentine and Hillhouse, 2000), a case series (Tombourou et al., 2002) and an analysis of self-help participation in all groups of a randomised controlled trial (Weiss et al., 2005). These studies provided consistent evidence that twelve-step affiliation combined with treatment results in significantly improved drug use outcomes (NICE, 2007, p. 181).

4.3.8 The RAPt treatment programme

The effectiveness of RAPt's own standard twelve-step treatment programme among UK male offenders has also been evaluated. An outcome study by Martin and Player (2000) found that in a sample of 200 men who were followed up, RAPt graduates were significantly less likely to have been re-convicted or report re-offending within a year. Graduates were also significantly more likely to be entirely abstinent or abstaining from their drugs of choice.

A subsequent reconviction analysis of RAPt graduates (Liriano, 2002) used data from the Offender's Index. RAPt graduates were found to have significantly lower rates of re-offending than the comparison group (offenders released from the same prisons, at the same time, with similar ages, number of convictions, and risk assessment scores). Only 20-32 % of those stating heroin, opiates, or crack/cocaine as their drug of choice had been reconvicted. The two-year reconviction analysis (Martin et al., 2003) used a smaller sample (n=137) but also showed significantly lower levels of re-conviction and relapse among RAPt graduates compared to expected rates based on risk assessments.

A recent analysis of RAPt clients' pre- and post-treatment psychometric measures in a six-week residential Alcohol Dependence Treatment Programme (ADTP) showed that programme completion was associated with improvements on measures of a range of dynamic risk factors for re-offending and underlying factors shown to be associated with relapse (RAPt, 2008a, 2009).

5. SKILLS ORIENTATED

5.1 SKILLS DEFICITS ADDRESSED BY THE PROGRAMME

The programme seeks to address a range of skills deficits including:

- Poor pro-social interpersonal skills (including assertiveness);
- Skills deficits associated with high impulsivity and decision making deficits;
- Skills deficits associated with the management of anger and intense emotions;
- Skills deficits associated with poor self-care
- Skills deficits associated with difficulties coping with cravings
- Skills deficits in relation to coping with anxiety, insomnia and/or symptoms of past trauma.

5.2 WHY ACQUISITION OF THESE SKILLS WOULD BE EXPECTED TO HELP REDUCE RE-OFFENDING

Each of these skills deficits is clearly linked to one or more of the factors targeted by the programme. The reasons for supposing that these deficits are relevant to those participating in the programme and that addressing the factors to which they relate will contribute to reducing re-offending are summarised in Sections One, Three and Four in this manual.

5.3 HOW THESE SKILLS DEFICITS ARE ADDRESSED

These skills deficits are addressed in Living Clean and Seeking Safety skills training sessions and reinforced by engagement with twelve-step recovery through attendance at NA meetings and active affiliation with the NA fellowship. A heavy emphasis on use of peer support and the use of group therapy, in particular, encourage participants to actively practice new interpersonal skills, and develop support for recovery. For detail of how these skills deficits are addressed by treatment methods of the Bridge Programme are in outlined in Section One and Six of this manual and in further detail in Sections Four and Five of the *Bridge Programme Theory Manual*.

5.4 ADDRESSING ADDITIONAL SKILLS DEFICITS

Comprehensive throughcare arrangements help to ensure that additional skills deficits not addressed by the Bridge Programme are addressed outside and/or after treatment. It is anticipated that many Bridge Programme graduates will continue to secondary care on release in order to address their substance dependence in greater depth. Those who remain in prison are supported

through continuing access to NA meetings, weekly speaker meetings organised by RAPt treatment staff, ongoing meetings with their assigned CARAT worker, where possible regular meetings or contact with their NA sponsor or temporary sponsor and the recovery community provided by the Bridge Programme treatment unit.

6. SEQUENCING, INTENSITY AND DURATION

6.1 STANDARD SEQUENCING, INTENSITY AND DURATION

The Bridge Programme is a full-time, high-intensity six week programme. Participants are expected to undertake a considerable amount of assignment work out of core programme hours. The nature of this cell work is documented in the *Bridge Programme Manual Two*, '*Facilitators' Guide'* and *Bridge Programme Manual Three, 'Participants' Guide'*. In addition, participants are expected to participate in NA fellowship meetings throughout treatment and afterwards.

The views expressed by participants have informed the development of the programme both in content (for example, the emphasis on anger management skills), sequence and structure.

6.1.1 Continuous elements

Details of the continuous elements and a summary of weekly topics are detailed in Section One of this manual.

6.1.2 Secondary care and ongoing NA participation

Participants are expected to attend regular NA meetings during the programme and for the rest of their sentence. Most participants will be strongly encouraged to access secondary care in order to address their substance dependence more fully upon release. Those who are unwilling or unable to do so will be encouraged to engage with NA for the remainder of their sentences and after release, attending meetings daily if possible for at least the first 90 days post-release, and having regular contact with an NA sponsor. Where participants have less than three months remaining to serve the Throughcare Manager will make every effort to link them to a temporary NA sponsor, via an initial telephone exchange or meeting, who will help them locate a sponsor in their local area. Where participants have longer to serve and if appropriate their assigned CARAT worker should make every effort to link them to a NA sponsor in their local area and/or arrange regular meetings in the prison between a NA volunteer local to the prison and the participant.

Contact with NA members while on the programme and in prison is aimed to facilitate the transition from pre-release to post-release affiliation. The Throughcare Manager or assigned CARAT worker

will ease this transition by making onwards referrals and arrangements to address individuals' secondary treatment, mental health and housing needs.

6.2 Adapting to the individual

Fortnightly individual counselling sessions, individualised treatment plans, one-to-one throughcare sessions and daily Significant Events Sheets and assignments enable consistent monitoring of participants' well-being and progress, providing scope in each case for facilitators and the Throughcare Manager to address each participant's unique needs and problems. Where a participant is particularly struggling—for example, with treatment issues, life problems, insomnia or trauma symptoms—additional individual counselling sessions are provided. Additional support is also provided where someone is experiencing difficulties understanding the material presented on the programme or where they are responding less quickly to the programme than might normally be expected. One-to-one sessions with the Throughcare Manager provide additional support focussed on addressing individual needs in throughcare plans. The case review process provides a mechanism to ensure that treatment is effectively individualised.

6.3 Homework/assignments

As part of the Bridge Programme it is required that participants have an assignment to work on at the end of each day. For some assignments such as node-link mapping exercises or behavioural exercises that involve practicing a skill, participants are given several days to complete them and may have other smaller daily assignments within this period. On days where there is no assignment already in progress participants are set an assignment to complete on their Significant Events Sheet (SES) to include responses about a specific topic they covered that day. On these days participants would answer the questions on the SES about general challenges they faced that day/how they coped then they would also specifically answer this about challenges they faced within a chosen topic.

Participants are usually given some choice over which topics to focus on for their daily assignments or what examples to use to complete their node-link map diagrams. It has been recommended that providing participants in this client group with an opportunity to use their own imagination and have some control over activities and topics may enhance their engagement in treatment (Najavits, 2002).

6.4 EVIDENCE THAT INTENSITY AND DURATION ARE SUFFICIENT TO ACHIEVE SUSTAINED CHANGE

The Bridge Programme has been developed specifically to meet the needs of substance dependent offenders who are likely to be serving short sentences. Its length is therefore based on practical necessity, with the aim of making it available to those prisoners most likely to need it. Each intervention incorporated into the programme and each session's focus has been included based on research demonstrating its ability to effect significant and sustained change in the target population within the relevant time frame and its compatibility with the rest of the programme. More detailed evidence supporting the effectiveness of intense short treatment interventions in facilitating long-term changes is detailed in Section Six of the *Bridge Programme Theory Manual*.

7. ENGAGEMENT AND MOTIVATION

Motivation is assessed pre-treatment via the use of the URICA (University of Rhode Island Change Assessment) (DiClemente et al., 1998). This measure is used to gauge motivation by identifying participants' position within the transtheoretical conception of the "cycle of change" (pre-contemplation, contemplation, action or maintenance). Scores are not used to assess suitability, but simply as a guide to the level of work the offender will need to undertake in the first few weeks of treatment in order to enhance his motivation and engagement.

Since attrition rates and relapse among offenders can be linked to low motivation and self-efficacy, the MET sessions in Week One have been included to address ambivalence, strengthen self-belief and minimise attrition. These are built upon with twelve-step methods of enhancing motivation (e.g. listening to outside speakers, peer support systems, NA literature) and the use of Motivational Interviewing as a delivery style throughout. The rationale for combining these approaches is based on research suggesting that an MET session conducted prior to engagement in a full-time twelve-step treatment programme can significantly increase retention rates (Miller et al., 1997).

Motivation is further developed by the assignment of a focal counsellor who is responsible for ensuring that needs associated with a participant's age, life experiences (including any past trauma), ethnic background, learning style and relationship or family problems are adequately addressed. All participants will be offered a family conference, to be held during the two weeks following programme completion. These meetings will be open to family, partners or any other close supporters. For any men who have no family members, partners or close friends to invite to a meeting, additional individual counselling sessions are provided so that they can explore and express their sense of loss and lack of support. Counselling sessions are provided fortnightly throughout the programme and use Motivational Interviewing techniques to continue strengthening and sustaining motivation and engagement.

Attendance at twelve-step NA meetings provides an opportunity for participants to engage with offenders who have successfully completed the Bridge Programme. Additionally, they will have access through such meetings to people who have been in recovery from substance dependence for significant periods of time. Attendance at NA meetings aids retention and motivation by providing

positive peer modelling and support. Twelve-step fellowships also offer participants a ready-made social network supportive of the changes they are making. This is important for substance dependent offenders, who typically lack positive social networks. Motivation following treatment is further encouraged through the support of the Throughcare Manager or assigned CARAT worker and their role in contacting other services and making arrangements on the participants' behalf.

8. CONTINUITY OF PROGRAMME AND SERVICES

The Bridge Programme is integrated into the overall management of the offender via the sentence planning process.

All participants undertake a CARAT comprehensive assessment prior to treatment entry. Regular reviews of progress throughout their time in treatment are facilitated through individual counselling sessions, treatment planning, one-to-one throughcare sessions, case review processes, and staff team meetings.

The Throughcare Manager will be appointed full-time to the Bridge Programme and will be jointly recruited and supervised by RAPt and the CARAT Manager/Team Leader. The Throughcare Manager is viewed as an integral part of the treatment team, regularly attends team meetings and organises and chairs each participant's Post-Programme Review. S/he is thereby kept aware of educational, housing, health, family, trauma counselling or any other potential post-programme needs identified by the treatment team. Such needs are assessed and identified in the Post-Programme Report before being further discussed with the participant, treatment staff and other key staff involved in throughcare (e.g. probation, CARAT team, DIP worker) at the Post-Programme Review.

Responsibility for meeting the throughcare needs of participants will be met by the Throughcare Manager for all participants whose release date is within three months of completing the programme. CARAT will be responsible for ensuring continuity of care for participants remaining in custody for at least three months by overseeing arrangements for secondary treatment and resettlement and making referrals to community DIP workers to implement these plans prior to the participant's release from prison.

The integration of key throughcare personnel in the treatment process ensures continuity with the programme's post-completion aims, facilitating referrals to relevant services able to support and maintain the gains participants make while in treatment. Demographic and personal risk factors that may impact on long-term prognosis are addressed in case conference discussions.

The Throughcare Manager, Bridge treatment staff and CARATs will be particularly sensitive to the graduates' response to treatment completion and the potential difficulties associated with this change to their routine. The final individual counselling sessions and one-to-one throughcare sessions will focus on their feelings about this transition and devising personalised plans to help them cope with this, including additional support that may be needed on the days immediately following treatment completion. For programme graduates remaining in custody the Throughcare Manager or CARAT Team will make every effort to retain them on the 'treatment wing' (where this is available in the establishment) and to ease this transition by maintaining some of the structure inherent on the Bridge Programme, such as weekly NA speaker meetings and meetings or contact with a sponsor.

All key personnel involved in ensuring the continuity of post-programme goals are invited to the Post-Programme Review within four weeks of graduation. The invitations are sent by the Throughcare Manager, who is responsible for ensuring optimum attendance. Any key personnel who are unable to attend the review are asked if they can take part in a telephone conference session.

Invitations to the final course review are sent to the following parties (where appropriate):

- Participant
- CARAT workers
- Participant's focal counsellor
- Probation internal/external
- Sentence Planning
- Personal Officers
- Local Drug Intervention Programme (DIP) Team

Prior to the review meeting, the participant's Post-Programme Report is circulated to the individuals listed above. The report details the participant's engagement with the programme and highlights risk factors that have been addressed. Personal risk factors that should continue to be addressed and significant needs not met by the programme are also identified. These may include, for example, issues of anger management, violent outbursts, or trauma-related symptoms that require more specialised counselling and mental or physical health treatment needs.

The individualised nature of the Post-Programme Report and Review ensure that the unique needs and concerns of each individual are attended to. The overall aim of the final review is to ensure that

the participant's post-programme needs are addressed both for the remainder of his sentence and post-release and to ensure that the Throughcare Manager or assigned CARAT worker liaises with the participant and fully understands their needs in order to take on this responsibility. Participants will generally be encouraged to consider secondary care and, in all cases, to continue to engage with NA for the remainder of their sentences and upon release. The Throughcare Manager or assigned CARAT worker can put participants in contact with NA sponsors or temporary sponsors and provide them with details of NA meetings in their local area.

The Post-Programme Review will consider a range of risk factors implicated in long-term prognosis. These include, but are not restricted to, the following:

- Secondary care
- Additional treatment needs and links to other service providers
- Additional clinical needs (e.g. for depression or trauma counselling)
- Family network and social support network
- Accommodation post-release
- Personal relapse prevention plan

The Throughcare Manager or assigned CARAT worker will monitor the implementation of the post-programme action plan and will make onward referrals and enquiries on their behalf to ensure their needs are met in terms of secondary treatment, housing and other services. This process will involve regular consultation with the parties involved in the final review session.

A more detailed account of these processes is provided in Section Seven of the *Bridge Programme Manual Two, 'Facilitators' Guide'* and in Section Five of the *Bridge Programme Management Manual*.

Participants who fail to complete all elements of treatment (i.e. who are de-selected or leave before completion) receive both an exit interview with an assigned CARAT worker and a detailed report on gains made whilst on the programme. All de-selected participants will be referred back to the CARAT team for follow-on work and are encouraged to access alternative sources of support to address any issues which prevented their engagement with treatment.

9. MAINTAINING INTEGRITY

Fundamental to the delivery of an effective treatment programme is the maintenance of programme integrity. The Bridge Programme is independently audited annually and is regularly monitored by RAPt in the following key areas:

- Selection and treatment completion of participants
- Selection and supervision of facilitators and AIMs
- Integrity of programme delivery
- Case management
- Monitoring throughcare arrangements

9.1 PARTICIPANTS SELECTION AND EXCLUSION CRITERIA

The selection and exclusion processes are detailed in the *Bridge Programme Management Manual* and are summarised in Section Two of this manual. Monitoring compliance with selection and exclusion procedures is the responsibility of the Bridge Programme's Treatment Manager. This is undertaken through regular examination of all programme documentation.

The selection and monitoring of peer supporters is jointly managed by programme facilitators and the Treatment Manager. See Section 5.1 of the *Bridge Programme Theory Manual* and Section 3.4 of the *Bridge Programme Management Manual.*

9.2 MONITORING DIVERSITY

The demographic characteristics of programme participants are monitored and reviewed quarterly. The ethnic mix of referrals and entrants onto the programme is compared with the establishment's ethnic population. If a particular ethnic group is found to be under-represented on the Bridge Programme, measures would be implemented to encourage referrals from the under-represented ethnic group. Further information is provided in the *Bridge Programme Assessment and Evaluation Manual.*

9.3 FACILITATORS' MAINTENANCE OF PROGRAMME INTEGRITY

The process of selecting facilitators and Throughcare Managers are detailed in Section Four of the *Bridge Programme Management Manual*. Each facilitator's ability to maintain programme integrity is monitored and records of all supervision sessions are kept through:

- The Probationary Period Review
- Supervision sessions notes

The Throughcare Manager receives joint supervision from the Treatment Manager and CARAT Manager/Team Leader. Supervision of the Throughcare Manager on the programme is undertaken by the Treatment Manager as they are directly involved with delivery of two group sessions and two one-to-one sessions. However the Throughcare Manager is part of the CARAT Team therefore the Treatment Manager will attend quarterly meetings with the CARAT Manager/Team Leader and should report back any concerns regarding the Throughcare Manager's performance.

See the *Bridge Programme Management Manual* for further details of selection, management, supervision and training of all Bridge treatment staff.

9.4 TREATMENT MANAGER'S MAINTENANCE OF PROGRAMME INTEGRITY

RAPt's Area Manager undertakes a unit visit at least monthly. The purpose of the unit visit is to provide supervisory support and to monitor the performance of the Treatment Manager. The Operations Director will make a report of all unit visits. The report should detail the following information:

- Frequency of facilitator supervision sessions
- Quality of supervision session notes
- Frequency of observations of programme sessions
- Quality of observation notes
- Results of documentation and participant files check
- Frequency of local management team meetings
- Minutes of local management team meetings
- Action points

The Area Manager is required to undertake a yearly internal quality assessment of the programme using the standard document. Details of this documentation are provided in the *Bridge Programme Management Manual.*

9.5 Programme delivery

Whilst many elements of the Bridge Programme are didactic and therefore easily represented in the *Programme Manuals*, others (such as group therapy sessions) do not easily lend themselves to a prescribed format. However, whilst group dynamics and individual needs may influence these sessions, the relevant processes and goals remain constant. All elements of the programme can therefore be effectively monitored.

Compliance with *Bridge Programme Manual Two, 'Facilitators' Guide'* is monitored to ensure that all sessions are delivered in a sequential order and that the programme content reflects what is specified. Furthermore, monitoring systems ensure that the ethos of the twelve-step approach is being maintained throughout the Bridge Programme. Such monitoring is implemented in the following ways:

- Observation of programme sessions
- Process review record
- Monitoring attendance at all phases of the programme

9.6 Case management

Monitoring of the case management process in undertaken via:

- Treatment plans
- Case notes
- Individual counselling session schedule and record
- One-to-one throughcare session schedule and record

9.7 Throughcare/aftercare

All offenders attending the Bridge Programme will have been assigned focal counsellors who, alongside the Bridge Throughcare Manager, will ensure consistency and continuity of post-programme plans. The setting and achievement of post-programme goals is ensured through the following processes:

- Two one-to-one sessions with the Througcare Manager in Weeks Five and Six to discuss and plan secondary care/treatment needs and preferences.
- Post-Programme Reports
- Monitoring process to map a participants' progress through treatment
- De-selection interviews to ensure unmet needs are identified, and other treatment options explored.

- Post-Programme Review with: the Throughcare Manager, CARAT, Supervising Probation Officers and other personnel.
- The Throughcare Manager will be responsible for making arrangements and referrals for secondary care/treatment agreed in the Post-Programme Review for any participants who have less than three months still to serve. For participant with at least three months remaining in custody they will be assigned a CARAT worker who will attend their Post-Programme Review, arrange for ongoing support and meetings with NA volunteers in prison and arrange for referrals to secondary care/treatment prior to release.

9.8 PARTICIPANT FEEDBACK

Significant Events Sheets (SES) are completed daily and require each participant to self-report his evaluation of changes in his behaviours and attitudes. SES and daily assignments are submitted to the treatment team each morning and are reviewed at the staff process meeting. Monitoring compliance with this procedure is the responsibility of the Treatment Manager, who will maintain a daily record of the receipt of SES. Copies of SES are provided in the *Bridge Programme Manual Three, 'Participants' Guide'* (Session 1.1, Handout 2) and in the *Bridge Programme Manual Two, 'Facilitators' Guide'* (under 'Continuous Elements').

All participants are asked to evaluate their experiences of the Bridge Programme on completion. Standard Participant Feedback Forms relating to experiences of treatment are provided to all participants for this purpose. More detailed feedback, using open questions, is obtained through the administration of Extended Participant Feedback Forms to a random sub-sample of participants on completion or de-selection. Monitoring responses and ensuring that the programme continues to meet the diverse needs of its participants is the responsibility of the Treatment Manager and RAPt's Service Director. Copies of both participant feedback forms are provided in the Appendices section of the *Bridge Programme Assessment and Evaluation Manual*.

10. ONGOING EVALUATION

10.1 MONITORING REFERRALS

The ethnic mix of all referrals to the Bridge Programme is routinely monitored and the information forwarded to RAPt's Head Office. Additionally, participants' demographic and clinical characteristics are also recorded and reasons for non-acceptance onto the programme detailed. The referral process is subject to a quarterly review by a member of RAPt's Senior Management Team. The review checks that referrals deemed unsuitable for the programme were excluded on the basis of set criteria (identified in Section Two of this *Application* and in further detail in the *Bridge Programme Assessment and Evaluation Manual*) and that no discriminatory practices have been used in the selection process.

10.2 MONITORING COMPLETION RATES

While the programme might be expected to bring real benefits in relation to motivating participants and giving them the skills to affiliate with NA and/or engage with more in-depth treatment, no such assumptions can be made for those who start the programme but, for whatever reason, do not finish it. Completion rates must therefore be taken into consideration when interpreting the clinical significance of post-treatment outcomes for programme completers.

For these reasons, completion rates for the programme as a whole, together with data on reasons for non-completion (drop-out, discharged at staff request, transferred out, other) are routinely collected by the Treatment Manager and forwarded to RAPt's Research Department in Head Office to be monitored.

10.3 MEASURING IMPACT ON UNDERLYING FACTORS TARGETED BY THE PROGRAMME

The programme seeks to address a range of factors likely to impede successful affiliation with NA, to motivate and support participants in engaging in further treatment and providing them with basic skills for maintaining abstinence (see Section Three of the *Bridge Programme Theory Manual* for details of the full range of factors targeted by the programme and for an explanation of their relationship to drug use and offending in this population.)

As noted above, several psychometric measures (URICA, SPSI-R, DTCQ's and Crime-Pics II) will be administered prior to treatment and then re-administered on completion or de-selection. This will provide a measure of within-treatment change in relation to a range of factors targeted by the programme.

Participants' pre- and post-treatment scores on these measures will be collected locally and passed to RAPt's Research Department at Head Office, where they will be analysed and written-up on an annual basis. More details about the psychometrics, their administration and their use are provided in the *Bridge Programme Assessment and Evaluation Manual*.

10.3.1 RAPt Assessment and Mental Health Screen

The RAPt Assessment and Mental Health Screen was developed by RAPt in order to provide a reliable but relatively quick, straight-forward and cost-effective means of assessing potential participants against the standard selection criteria and screening potential participants for mental health symptoms which might require attention in treatment. Part One of the assessment collects standard demographic information. Part Two of the assessment uses detailed questions based on DSM-IV-TR diagnostic criteria for substance dependence, alcohol dependence, and alcohol abuse to assess offenders' drinking and level of drug dependence. Part Three consists of a Mental Health Screen, with questions based on DSM-IV-TR criteria for those Axis I and II disorders known to be most prevalent in UK prisons followed by a set of questions designed to highlight relevant mental health histories, possible suicide risk and any current mental health treatment.

10.3.2 URICA (University of Rhode Island Change Assessment)

The URICA is administered to participants on the first day of treatment and then re-administered on the last day. It is used to measure the programme's impact on 'weak or fragile commitment to remaining abstinent.' If the programme does affect this factor, participants' scores will reflect a move through the 'cycle of change' during the treatment process—and shown by lower in post-treatment scores on 'pre-contemplation' and 'contemplation' sub-scales and increased post-treatment scores on 'action' and 'maintenance' sub-scales.

10.3.3 Alcohol-Taking Confidence Questionnaire (ATCQ) and Drug-Taking Confidence Questionnaire (DTCQ)

The ATCQ and DTCQ are confidence measures designed to evaluate participants' coping self-efficacy across a range of high-risk relapse situations. Research indicates that self-efficacy is a predictor of

outcome with particular significance; increased self-efficacy is strongly associated with lower relapse and better use of positive coping strategies. Thus, increased post-treatment scores (i.e. higher confidence levels) on the DTCQ would indicate that the Bridge Programme effectively impacts the following risk factors: 'low self-efficacy,' 'deficits in decision making,' 'difficulty recognising appropriate strategies for coping with personally relevant risk factors for relapse,' 'difficulty in coping with cravings,' 'deficits in emotion management' and 'high impulsivity.' However, it must be noted that the DTCQ measures self-efficacy and confidence, but does not directly assess participants' real-life coping skills; it is therefore an indirect measure. The ATCQ uses the same questions as the DTCQ but measures attitudes in relation to alcohol, rather than drug use.

10.3.4 SPSI-R

The SPSI-R is designed to measure problem-solving deficits. It is administered before treatment and re-administered on completion to help evaluate the programme's impact on each graduate's problem solving orientation, since a positive impact on this factor would be expected to be reflected in positive changes in graduate's scores on this measure.

10.3.5 Crime-Pics II

Crime-Pics II is designed to measure changes in offenders' attitudes to offending. It is administered before and after treatment in order to evaluate the extent of the programme's impact on 'dysfunctional or anti-social attitudes, cognitions and beliefs related to re-offending,' 'strong ties to and identification with, anti-social/criminal models,' 'weak ties to, and lack of identification with, pro-social/anti-criminal models' and 'weak commitment to avoiding re-offending.' Positive changes in these factors are expected to be reflected in participants' scores on this psychometric measure.

10.3.6 Assessment considerations

Data from the RAPt Assessment and Mental Health Screen and the psychometric measures listed above are collected locally and passed to RAPt's Research Department based at RAPt's Head Office, where they are analysed and reported on an annual basis.

As noted above in relation to the DTCQ, changes in psychometric scores can indicate changes in participants' attitudes and skills but cannot prove their occurrence nor show that treatment is a causal factor. Such instruments rely on self-report and measure attitudes associated with relevant risk factors; they are not direct assessments of participants' actual skills or progress. In addition, the psychometric battery detailed above does not measure all of the factors targeted by the programme

(for example, a measure of 'social support systems in relation to tackling drug/alcohol use' is currently absent). However, in spite of these caveats, positive changes in participants' psychometric scores would suggest that the Bridge Programme has a positive impact on several of the key factors it targets.

10.4 Measuring change in drug taking and institutional behaviour post-treatment

A key measure of success for the Bridge Programme will be the number of graduates who proceed into secondary care. Ongoing engagement with NA while in prison, much less in the community upon release, is difficult to monitor. Rates of engagement with long-term treatment, whether in residential or outpatient secondary care, will provide a ready measure of programme impact on motivation. A further of indication could be provided through comparison of pre- and post-treatment drug tests results; this data will be collected where possible. However, as programme participants are likely to be serving short sentences, post-treatment prison drug tests data may be lacking.

10.5 Measuring change in offending behaviour

The ultimate aim of this, and all offending behaviour programmes, is to reduce re-offending. RAPt collects informed consent for the use of personal data in research and reconviction analysis from programme participants and collates all relevant participant data. These procedures are intended to enable future evaluation using reconviction rates of those offenders who complete treatment. Although lower than expected rates of reconviction would not necessarily establish the programme's efficacy in reducing offending behaviours, this would strongly support such an interpretation.

10.6 Participant feedback

RAPt recognises that participants can provide valuable management information on a programme and its delivery. As such, at the end of each phase, all participants are asked to complete Standard Participant Feedback Forms and randomly selected participants are asked to complete the more in-depth Extended Participant Feedback Forms (copies of both are provided in the Appendices section of the *Bridge Programme Assessment and Evaluation Manual*).

Participant feedback forms are intended to collect information on participants' perceptions of the quality and helpfulness of individual programme elements, as well on checking that participants have received all the services with which they should have been provided.

10.7 EVALUATING RESPONSIVENESS TO ISSUES OF DIVERSITY

The *Bridge Programme Manual One, 'Introduction and Overview'* and *Two, 'Facilitators' Guide'* detail the steps taken to try to ensure that the programme itself is fully responsive to issues of diversity.

In order to evaluate the success of these measures, the completion and outcome data detailed above will be broken down by ethnic status and analysed to assess the impact of other demographic characteristics. Likewise, to measure the success of steps taken to ensure that offenders are not disadvantaged on the grounds of ethnic status in either referral or admission to the programme, rates of referral and admission will also be broken down by ethnic status and compared with the ethnic mix of the prison itself.

As with other data sets, these figures will be collected locally and then analysed and reported annually by the Research Department at RAPt's Head Office.

11. REFERENCES

Anonymous (1939) *Alcoholics Anonymous.* New York City, NY: Alcoholics Anonymous World Services, Inc.

Anonymous (1975) *Living Sober*. New York City, NY: Alcoholics Anonymous World Services, Inc.

Anonymous. (1988) *Narcotics Anonymous (5th Edition)*. Chatsworth, CA: Narcotics Anonymous World Services, Inc.

Anonymous. (1990) *Behind the Walls*. Chatsworth, CA: Narcotics Anonymous World Services, Inc.

Anonymous. (1991) *Just for Today*. Chatsworth, CA: Narcotics Anonymous World Services, Inc.

Anonymous. (1993) *It Works: How and Why*. Chatsworth, CA: Narcotics Anonymous World Services, Inc

Anderson, S. and Berg, J.E. (2001) The use of a sense of coherence test to predict drop-out and mortality after residential treatment of substance abuse. *Addiction Theory and Research*, **9***,* 239-251.

Babor, T.F. (1994) Avoiding the horrid and beastly sin of drunkenness: does discussion make a difference? *Journal of Consulting and Clinical Psychology*, **62**, 1127-1140.

Bacchus, L., Marsden, J., Griffiths, P., *et al*. (1999) Client perceptions of inpatient treatment: a qualitative account with implications for service delivery. *Drugs: Education, Prevention and Policy,* **6***,* 87–97.

Baer, J.S., Kivlahan, D.R., and Donovan, D.M. (1999) Integrating skills training and motivational therapies: Implications for the treatment of substance dependence. *Journal of Substance Abuse Treatment,* **17**, 15-23

Ball, S.A., Todd, M., Tennen, H., Armeli,S., Mohr, C., Affleck, G. and Kranzler, H.R. (2006a) Brief motivational enhancement and coping skills interventions for heavy drinking. *Addictive Behaviors,* **31***,* 320-330.

Ball, S.A. Carroll, K.M., Canning-Ball, M., and Rounsaville, B.J. (2006b) Reasons for drop-out from drug abuse treatment: Symptoms, personality and motivation. *Addictive Behaviors,* **31***,* 320-330.

Bien, T.H., Miller, W.R., and Tonigan, J.M. (1993) Brief interventions for alcohol problems (Review). *Addiction*, **88**, 315-316

Broome, K.M., Simpson, D.D., and Joe, G.W. (2002) The role of social-support following short-term inpatient treatment. *American Journal on Addictions,* **11***,* 57-65.

Brown, P.J. and Wolfe, J. (1994). Substance abuse and posttraumatic stress disorder comorbidity. *Drug and Alcohol Dependence,* **35***,* 51-59

Burke, B.L., Arkowitz, H., and Menchola, M. (2003) The efficacy of motivational interviewing: a meta-analysis of controlled clinical trials. *Journal of Consulting and Clinical Psychology,* **71***,* 843-861

Carroll, K.M., Ball, S.A., Nich, C., Martino, S., Frankforter, T.L., Farentinos, C., Kunkel, L.E., Mikulich-Gilbertson, S.K., Morgenstern, J., Obert, J.L., Polcin, D., Snead, N. and Woody, G.E. (2005) Motivational interviewing to improve treatment engagement and outcome in individuals seeking treatment for substance abuse: A multi-site effectiveness study. *Drug and Alcohol Dependence,* **81***,* 301-312

Claus, R.E. and Kindleberger, L.R. (2002) Engaging substance abusers after centralised assessment: Predictors of treatment entry and dropout. *Journal of Psychoactive Drugs,* **34***,* 25-31.

Cox, W.M. and Klinger, E., Eds. (2004) *Handbook of Motivational Counseling: Concepts, Approaches and Assessment.* Chichester, UK: Wiley.

Desai, R.A. and Rosenheck, R.A. (under review). Effectiveness of Treatment for Homeless Veterans with Psychiatric and Substance Abuse Disorders: Impact of Seeking Safety and Residential Treatment on One-Year Clinical Outcomes.

DiClemente, C.C. & Prochaska, J.O. (1998). Toward a comprehensive, transtheoretical model of change: Stages of change and addictive behaviours. In Miller, W.R. &Heather, N. (Eds.), *Treating Addictive Behaviours, 2nd Edition.* New York: Plenum.

Dunn, C., Deroo, I. and Rivara, F.P. (2001) The use of brief interventions adapted from motivational interviewing across behavioural domains: A systematic review. *Addiction,* **96***,* 1725-1742

Ferri M, Amato L, Davoli M. Alcoholics Anonymous and other 12-step programmes for alcohol dependence. *Cochrane Database of Systematic Reviews* 2006, Issue 3. Art. No.: CD005032.

Finney, J.W. and Monahan, S.C. (1996) The cost-effectiveness of treatment for alcoholism: a second approximation. *Journal of Studies on Alcohol,* **5***,* 229-243.

Fiorentine, R. and Hillhouse, M.P. (2000) Drug treatment and 12-step program participation: The additive effects of integrated recovery activites. *Journal of Substance Abuse Treatment,* **18***,* 65-74

Gossop, M., Marsden, J., Stewart, D. and Kidd, T. (2003) The National Treatment Outcome Research Study (NTORS): 4-5 year follow-up results. Addiction, **98**(3), 291-303.

Gossop, M., Stewart, D. and Marsden, J. (2008) Attendance at Narcotics Anonymous and Alcoholics Anonymous meetings, frequency of attendance and substance use outcomes after residential treatment for drug dependence: a 5-year follow-up study. Addiction, **103**(1), 119–125

Gossop, M., Harris, J., Best, D., Lan-Ho, M., Manning, V., Marshall, J. and Strang, J. (2003) Is attendance at Alcoholics Anonymous meetings after inpatient treatment related to improved outcomes? A 6-month follow up study. Alcohol and Alcoholism, **38**(5), 421-426.

Haaga, D.A.F., McCrady, B. and Lebow, J. (2006) Integrative principles for treating substance use disorders. *Journal of Clinical Psychology*, **62**, 675-684.

Hettema, J., Steele, J. and Miller, W.R. (2005) Motivational Interviewing. *Annual Reviews of Clinical Psychology,* **1***,* 91-111.

Hien, D.A., Cohen, L.R., Litt, L.C., Miele, G.M. and Capstick, C. (2004) Promising empirically supported treatments for women with comorbid PTSD and substance use disorders. *American Journal of Psychiatry,* **161**, 1426-1432.

Humphreys, K. (1997) Clinicians' referral and matching of substance abuse patients to self-help groups after treatment. *Psychiatric Services*, **48**, 1445-1449.

Humphreys, K. (1999) Professional interventions that facilitate 12-step self-help group involvement. *Alcohol Research and Health*, **23**, 93-98.

Humphreys, K. (2004) *Circles of Recovery: Self-Help Organisations for Addictions*. Cambridge, UK: Cambridge University Press.

Inciardi, J.A. (1994). *Screening and Assessment for Alcohol and Other Drug Abuse Among Adults in the Criminal Justice System*. Rockville, MD: Centre for Substance Abuse Treatment (TIP #7).

Kelly, J.F. (2003) Self-help for substance-use disorders: History, effectiveness, knowledge gaps, and research opportunities. *Clinical Psychology Review,* **23***,* 639-663.

Lawenthal, E., McLellan, A., Grissom, G., Brill, P. O'Brient, C. (1996). Coerced treatment for substance abuse problems detected through workplace urine surveillance. Is it effective? *Journal of Substance Abuse,* **8**, 115–128.

Lebow, J., Kelly, J., Knobloch-Fedders, L.M., and Moos, R. (2006) Relationship factors in treating substance use disorders. In L.G. Castonguay and L.E. Beutler (Eds.) *Principles of therapeutic change that work*. New York City, NY: Oxford University Press.

Lincourt, P., Kuettel, T.J., and Bombardier, C.H. (2000) Motivational interviewing in a group setting with mandated clients. *Addictive Behaviors,* **27**, 381-391.

Liriano, S. (2002). *Reconviction Analysis of the RAPt Drug Treatment Programme*. Home Office RDS Internal Report, 01/02.

Mangrum, L.F., Spence, R.T. and Lopez, M. (2006) Integrated versus parallel treatment of co-occurring psychiatric and substance use disorders. *Journal of Substance Abuse Treatment,* **30***,* 79-84.

Martin, C. and Player, E. (2000) *Drug Treatment in Prison: an evaluation of the RAPt treatment programme*. Winchester, UK: Waterside Press.

Martin, C., Player, E. and Liriano, S. (2003) Results of evaluations of the RAPt drug treatment programme. In Ramsay, M. (Ed.), *Prisoners' Drug Use and Treatment: Seven Research Studies: Home Office Research Study 267*. London, UK: Home Office.

McAuliffe, W. E. (1990) A randomized controlled trial of recovery training and self-help for opioid addicts in New England and Hong Kong. *Journal of Psychoactive Drugs*, **22**, 197–209.

McCrady, B.S. and Nathan, P.E. (2006) Treatment factors in treating substance use disorders. In L.G. Castonguay and L.E. Beutler (Eds.) *Principles of therapeutic change that work*. New York City, NY: Oxford University Press.

McKay, J.R. (2005) Is there a case for extended interventions for alcohol and drug use disorders? *Addiction,* **100***,* 1594-1610.

McLellan, A.T., Lewis, D.C., O'Brien, C.P. and Kleber, H.D. (2000) Drug dependence, a chronic mental illness: implications for treatment, insurance, and outcomes evaluation. *JAMA*, **284**, 1689-1695.

Miller, W.R., Brown, J.M., Simpson, T.L., Handmaker, N.S., Bien, T.H., Luckie, L.F., Montgomery, H.A., Hester, R.K. and Tonigan, J.S. (1995) What works? A methodological analysis of the alcohol treatment outcome literature, in: Hester, R.K. and Miller, W.R. (Eds.) *Handbook of Alcoholism Treatment Approaches: effective alternatives.* Boston: Allyn and Bacon. 12-44.

Miller, W. R. and Rollnick, S. (1991) *Motivational Interviewing: Preparing People to Change Addictive Behaviors.* New York City, NY: Guilford Press.

Mills, K.L., Teesson, M., Ross, J. and Darke, S. (2007) The impact of post-traumatic stress disorder on treatment outcomes for heroin dependence. *Addiction*, **102**, 447–454

Moos, R. H., Finney, J. W., Ouimette, P. C., *et al*. (1999) A comparative evaluation of substance abuse treatment: I. Treatment orientation, amount of care, and 1-year outcomes. *Alcoholism: Clinical and Experimental Research*, **23**, 529–536.

Moos, R.H. and Moos, B.S. (2003) Long-term influence of duration and intensity of treatment on previously untreated individuals with alcohol use disorders. *Addiction*, **98**, 325-337.

Morgenstern, J. and Longabaugh, R. (2000) Cognitive-behavioural treatment for alcohol dependence: A review of evidence for its hypothesized mechanisms of action. *Addiction,* **95***,* 1475-1490.

Morrissey, JP, Jackson, EW, Ellis, AR, Amaro, H, Brown, VB, Najavits, LM. (2005) Twelve-month outcomes of trauma-informed interventions for women with co-occurring disorders. *Psychiatric Services*, **56**, 1213-1222.

Moyer, A., Finney, J.W., Swearingen, C.E. and Vergun, P. (2002) Brief interventions for alcohol problems: a meta-analytic review of controlled investigations in treatment-seeking and non-treatment-seeking populations. *Addiction*, **97**, 279-292.

Najavits, L.M., Weiss, R.D. and Shaw, S.R. (1997) The link between substance abuse and posttraumatic stress disorder in women: A research review. *American Journal on Addictions,* **6***,* 273-283.

Najavits, L.M. (2002) *Seeking Safety: A Treatment Manual for PTSD and Substance Abuse.* New York City, NY: The Guilford Press.

Najavits, L., Schmitz, M., Gotthardt, S., and Weiss, R.D. (2005) Seeking Safety plus Exposure Therapy for Dual Diagnosis Men. *Journal of Psychoactive Drugs*, **27**, 425-435.

Najavits, L.M. (2007). Seeking Safety: An evidence-based model for substance abuse and trauma/PTSD. In: KA Witkiewitz & GA Marlatt (Eds.), *Therapists' Guide to Evidence-Based Relapse Prevention: Practical Resources for the Mental Health Professional*, pages 141-167. San Diego: Elsevier Press.

Najavits LM, Harned MS, Gallop RJ, Butler SF, Barber JP, Thase ME, Crits-Christoph P (2007). Six-month treatment outcomes of cocaine-dependent patients with and without PTSD in a multisite national trial. *Journal of Studies on Alcohol and Drugs*, **68**, 353-361.

National Institute for Health and Clinical Excellence (2007) *Drug misuse : Psychosocial interventions*. National Clinical Practice Guideline Number 51

Offender Assessment System (OASys) *Data Evaluation and Analysis Team's analysis of over 120,000 OASys assessments between 2004 and 2005 FROM NOMS BOOKLET*

Ouimette,P.C., Ahrens, C., Moss, R.H., and Finney, J.W. (1998). During treatment changes in substance abuse patients with posttraumatic stress disorder: The influence of specific interventions and program environments. *Journal of Substance Abuse Treatment,* **15***,* 555-564.

Ouimette, P.C., Moos, R.H. and Finney, J.W. (1998) Influence of outpatient treatment and 12-step group involvement on one-year substance abuse treatment outcomes. *Journal of Studies on Alcohol,* **59***,* 513-522.

Ouimette, P.C., Brown, P.J., and Najavits, L.M. (1998) Course and treatment of patients with both substance use and post-traumatic stress disorders. *Addictive Behaviors,* **23***,* 785-795.

Project MATCH Research Group (1997) Matching alcoholism treatments to client heterogeneity: Project MATCH post-treatment outcomes. *Journal of Studies on Alcohol*, **58**, 7-29.

RAPt - Rehabilitation of Addicted Prisoner's Trust (2008a) *Participant Data Summary and Analysis: April 2007 to April 2008*. Unpublished Report.

RAPt - Rehabilitation of Addicted Prisoner's Trust (2008b) *Participant Survey Data*. Unpublished Report.

Read, J.P., Brown, P.J. and Kahler, C.W. (2004) Substance use and posttraumatic stress disorders: Symptom interplay and effects on outcome. *Addictive Behaviors,* **29,** 1665-1672.

Simpson, D.D. (2004) A conceptual framework for drug treatment process and outcomes. *Journal of Substance Abuse Treatment*, **27**, 99-121.

Timko, C., Debenedetti, A. and Billow R. (2006) Intensive referral to 12-Step self-help groups and 6-month substance use disorder outcomes. *Addiction*, **101**, 678–688.

Toumbourou, J.W., Hamilton, M., U'Ren, A., *et al.* (2002) Narcotics Anonymous participation and changes in substances use and social support. *Journal of Substance Abuse Treatment,* **23,** 61–66.

Vasilaki, E.I., Hosier, S.G. and Miles Cox, W. (2006) The efficacy of motivational interviewing as a brief intervention for excessive drinking: A meta-analytic review. *Alcohol and Alcoholism,* **41***,* 328-335.

Weaver CM, Trafton JA, Walser RD, Kimerling RE (2007) Pilot test of Seeking Safety with male veterans. *Psychiatric Services*, **58**, 1012.

Weiss, R. D., Griffin, M. L. & Gallop, R. J. (2005) The effect of 12-step self-help group attendance and participation on drug use outcomes among cocaine-dependent patients. *Drug and Alcohol Dependence,* **77,** 177–184.

Wild, T.C., Cinningham, J.A., and Ryan, R.M. (2006) Social pressure, coercion and client engagement at treatment entry: A self-determination theory perspective. *Addictive Behaviours,* **31***,* 1858-1872.

Wilson, R.J. (2005) Are Cognitive Problem-Solving Skills Programmes Really Not Working? A Response to 'Evaluating Evidence for the Effectiveness of the Reasoning and Rehabilitation Programme.' *The Howard Journal*, **44**, 319–321

Zlotnick, C., Najavits, L.M., Rohsenow, D.J., and Johnson, D.M. (2003) A cognitive-behavioural treatment for incarcerated women with substance abuse disorder and post-traumatic stress disorder: findings from a pilot study. *Journal of Substance Abuse Treatment,* **25***,* 99-105.

CORRECTIONAL SERVICES ACCREDITATION PANEL

From (Chair)
Please address replies c/o Carole Wham, the Panel Secretariat, 1st floor,, Abell House
John Islip Street, London SW1P 4LH
Telephone 020 7 217 5714
e-mail Carole.Wham@justice.gsi.gov.uk

Gail Jones
Deputy CEO
RAPt (Rehabilitation for Addicted Prisoners Trust)
Riverside House
27-29 Vauxhall Grove
London SW8 1SY

cc Lucy Dean

24 August 2010

Dear Gail,

RAPt Women's Substance Dependency Treatment Programme (WSDTP) – application for accreditation

1. At its meeting of 30th July 2010 the Correctional Services Accreditation Panel (CSAP) considered your application for accreditation of the Women's Substance Dependency Treatment Programme.

2. The Panel asked for some changes to be made to the manuals, regarding interpersonal and behavioural skills acquisition and door-to-door management of offenders on their release. It was agreed by the Panel that if these changes were submitted to the Sub-Panel Chair, Mike Gossop, he would take Chair's Action to assess them rather than reconvene another full meeting. The changes have been submitted and the Chair has approved the revised manuals. Consequently, the Panel is now able to score the programme.

3. The Panel marks applications against each of the accreditation criteria, awarding scores of 2 (fully met), 1 (partially met) or 0 (not met) to each. The maximum possible score is 20 for the ten criteria. To be fully accredited an application must score at least 18 points. Where a Programme scores 16 points, the Panel will award provisional accreditation.

4. **The Panel awarded the programme a score of 19 points and I am pleased to inform you that the Women's Substance Dependency Treatment Programme has been awarded full accreditation.**

5. The Panel would like to review this accreditation in three years time and looks forward to receiving further monitoring and evaluation information at that point.

General Comments

6. The Panel felt the developers had done well to integrate background philosophies and theories from a number of diverse sources and to provide a comprehensive framework within which treatment methods from these diverse sources have been brought together in a coherent way.

7. The Panel was impressed by the comprehensive and clear presentation of the programme, but felt the manuals could have been shorter and more focused.

8. Overall the Panel felt the programme to be well structured and well thought-out, with good supportive training, management and supervision, and would like to congratulate the developers on devising and running this intervention.

Criterion 1 - A Clear Model of Change **Score 2**

9. This criterion was fully met.

Criterion 2 - Selection of Offenders **Score 2**

10. This criterion was fully met.

11. The Panel was aware of the complex needs of this offender population and felt the developers had come up with an appropriate set of selection and exclusion criteria.

Criterion 3 – Targeting a Range of Dynamic Risk Factors **Score 2**

12. The Panel understands that whilst participants are all likely to have serious trauma issues, the intention of the programme is to contain trauma and not to treat it and that where necessary participants will be referred on for specialist trauma treatment. Given the range of complexity and severity of the problems of the women who will attend this programme the Panel considers it is important to set clear limits to the issues that can be dealt with on the programme, and that containment of trauma is the right approach. However, it would prefer that this is emphasised much more strongly and consistently in the manuals so as to avoid any possibility that facilitators will stray into the treatment of trauma issues. At present, the issue is rather hidden away in the text (e.g. p.89 of the Facilitators' Manual for Phase 2) and in other places it is not clear that the intention is to contain rather than treat (e.g. in the list of exacerbating factors on p.4 of the Introduction and overview). Clear statements about containment need to be made and to be given a higher profile in the manuals.

13. During the discussion with the developers the Panel learned that at Send Prison a greater number of violent offenders have been admitted to the programme, and that this has led to a change in thinking from 'women as victims' to 'women as perpetrators'. The Panel felt this would impact on work on anger, as the manuals currently emphasise problems of anger against the self, rather than anger against others. The Panel was reassured to learn that there is flexibility in the programme to redirect treatment to

externalised anger where necessary, and suggested the developers keep track of this shift in emphasis with a view to adapting the 'problems with anger' part of programme if this becomes appropriate.

Criterion 4 - Effective Methods **Score 2**

14. This criterion was fully met.

15. The Panel was impressed that the programme brings in so many different approaches from a range of different sources and has integrated these with the approaches generally taken by AA/NA. The Panel felt that in doing this the developers have produced a coherent and balanced package.

16. The Panel was impressed by the steps taken to include participants with lower levels of literacy such as buddying systems and the availability of more visual versions of participants' handouts.

Criterion 5 - Skills Orientated **Score 2**

17. The Panel was pleased with the emphasis on social relationships, and was impressed that throughout the programme the focus is on sorting out negative relationships and developing positive ones.

18. The Panel was also pleased to see the inclusion of the work on grounding.

19. The Panel regarded the Significant Events Sheet and Significant Events Diaries as useful means of bringing real incidents into the structured course, and felt that these would allow valuable opportunities to consider and practice alternative responses.

20. The Panel felt that an emphasis on practice – on doing rather than talking about – should be consistently maintained to prevent a slide away from practice and towards talking. It was noted in the Panel discussion that such a slide is a common form of Programme Drift and needs to be guarded against.

21. In addition the Panel noted a number of errors in the materials and asked that the manuals be properly proof-read, particularly as some of the errors reverse the intended meaning. In particular the Panel noted the following:

- Introduction and Overview, p. 6, para. 1.3.1 – 'Strong ties to and lack of identification with anti-social/criminal models. This is also on p.6 of the Application
- Theory Manual p.6: 'If left undressed'
- Theory Manual p.58: 'comparison of positive and benefits'
- Application Manual p.26: 'Our controlled trails have been conducted'. Apart from the word 'trails' it is not clear what is meant by 'our'.

22. Since there are many other small mistakes, it is important that all the manuals are fully proof-read. In addition, it will be necessary to check that the page numbers set out in the contents pages of the manual tally with the manuals themselves (eg: this is not currently the case for the Facilitators' Manual for Phase 2).

Criterion 6 – Sequencing, Intensity and Duration **Score 2**

23. This criterion was fully met. The Panel noted that this is an intensive programme which takes place on a residential wing to provide immersion in the treatment. It was satisfied that the overall length and intensity of the programme would be sufficient to produce positive change, and that the sequencing of components was appropriate.

Criterion 7 – Engagement and Motivation **Score 2**

24. This criterion was fully met. The Panel noted that Phase 1 of the programme explicitly adopts Motivational Enhancement Therapy and that these are reinforced in Phase 2. It also noted that there are elements of the Facilitators' Training Course which deal with MET and with the motivational opportunities afforded by the Focal Counsellor.

25. It was impressed by the variety of means available to re-motivate participants who become demotivated, for example in the approach to participants given verbal and written warnings.

Criterion 8 – Continuity of Programme and Services **Score 2**

26. The Panel was impressed by the care planning which develops the work already done by CARATs (p.24, para. 2.7 of the Management Manual). It felt this was good example of continuity of treatment.

27. The Panel was also very impressed by the use of secondary residential treatment. Since there is evidence that post-prison residential treatment greatly reduces the likelihood of relapse, this should be made much more prominent in the materials so that it continues to be emphasised in practice.

28. The Panel was pleased to see the 'door-to-door' system of meeting released prisoners at the gate and escorting them to further safe care, as this is clearly a very dangerous time when a recovering drug user can quickly relapse.

Criterion 9 – Maintaining Integrity **Score 2**

39. This criterion was fully met.

30. The Panel felt it would be challenging for the management team to keep this essentially 12-step programme running in line with the diversity of approaches described in the manuals, and considered there are good mechanisms in place to ensure this challenge is met.

Criterion 10 - Ongoing Evaluation **Score 1**

31. The Panel greatly appreciated receiving the well-written and well-thought out account of the changes in psychometric scores for participants. This was informative and represents a commendable effort to evaluate outcome.

32. However, there is as yet no information on longer term relapse and/or reconviction rates. To remedy this, the Panel recommended that an outcome evaluation be carried out to test the effectiveness of the programme. Whilst acknowledging the difficulties that evaluation involves, the Panel believes that a proper evaluation of the programme should assess post-intervention changes.

33. If you would find further clarification of the Panel's discussion helpful, you are welcome to contact the Chair of the Sub-Panel, Mike Gossop on m.gossop@iop.kcl.ac.uk

Thank you for bringing this application to the Panel. I trust that you will find this advice helpful.

Yours sincerely,

David Griffiths

CSAP Chair

Members of the sub-panel who considered this application are listed below:
Mike Gossop (chair)
Ray Hodgson
Barbara Rawlings
Stan Renwick