Ministry of JUSTICE

The Correctional Services Accreditation Panel Report

2010–2011

Annex E:
Applications for accreditation by programme developers and feedback letters produced by the Panel

CSAP feedback letter – the COVAID-GC Programme

COVAID-GC – Application manual

CSAP feedback letter –Women's Substance Dependency Treatment Programme

Women's Substance Dependency Treatment Programme – Application manual

CORRECTIONAL SERVICES
ACCREDITATION PANEL
From: Nicola Hewer (Chair)

Please address replies c/o the Panel Secretariat,
9th Floor, 102 Petty France,
London SW1H 9AJ
Telephone 0203 334 2475
e-mail Maureen.Nwafor@justice.gsi.gov.uk

Steve Delight
Delight Training Services Ltd
Hillside Croft
Congleton Edge
Congleton
Cheshire
CW12 3NA

cc: Mary McMurran

29th November 2010

Dear Steve,

1. At its meeting on 28th October 2010, the Correctional Services Accreditation Panel (CSAP) considered your submission for accreditation for the COVAID-GC Programme.

2. 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.

3. The Panel awarded the programme a score of 18 points and I am pleased to inform you that the **COVAID-GC Programme has been awarded full accreditation**.

General Comments

4. The Panel appreciated the resubmission of this programme, especially as no other programme of this type is presently available in the community setting.

5. The Panel was of the opinion that a programme that was being provided in the community is able to make use of the day to day life experiences and circumstances encountered by participants. This is a real source of strength for a community programme. However it also represents a potential difficulty if participants were not to fully engage with the programme because they are too embedded in the criminogenic aspects of their day to day environment.

6. The Panel recognised that many of the changes that were recommended in our letter of 12th March 2008 have been made.

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

7. This Criterion was fully met

Criterion 2: Selection of Offenders **Score 1**

8. With regards to alcohol dependence and severity of alcohol problems, we noted the justification provided in your letter. The Panel was willing to accept that the OGRS score may be used for the selection of offenders. The Panel also wished to avoid the too rigid application of a selection cut-off. However the phrase "professional discretion may be exercised" is unsatisfactory. It is vague and gives no indication of the circumstances in which exceptions might be made nor of what criteria might be used for making such exceptions. The Panel would like to see a clear record kept of those cases for which exceptions were made, and of the reasons for making such exceptions.

9. The Panel accepted that the selection criteria are now more clearly defined than in the original submission. Nonetheless, the Panel felt that there remained some uncertainty about what types of offenders would respond well to this programme. It would be helpful if such information could be included in the recommended evaluation.

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

10. This criterion was fully met. The Panel was satisfied that the range of risk factors was appropriate. The Panel was of the view that the programme might be less effective in meeting the needs of participants with antisocial personality disorders and therefore further thought should be given to the manner in which such offenders would be admitted (or not) to the programme, and if admitted, how they would be managed within the programme

Criterion 4: Effective Methods **Score 2**

11. This criterion was fully met. Running this programme in the community provides many important opportunities to make use of problem identification and skills practice in the real life setting. Developers might wish to consider strengthening the methods as the programme evolves. The experience of relapse by an offender should be mentioned and discussed in the group session but the Panel was of the view that due to lack of time this might not be fully addressed.

Criterion 5: Skills Orientated **Score 2**

12. This criterion was fully met. The list of skills on page 14 of the application for accreditation seemed satisfactory.

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

13. This criterion was fully met. With regards to intensity, the Panel recommended that where it becomes apparent that an offender has a severe alcohol dependence problem, this should be seen as an opportunity for referral to a more appropriate alcohol dependence treatment programme.

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

14. This criterion was fully met. The Panel accepted that the most recent submission represents an improved programme compared to the earlier submissions. The issue of engagement and motivation is a key component in delivery of COVAID in the community setting. Consistent effort will be required to maintain these at high levels if the programme is to be effective.

Criterion 8: Continuity of Programme **Score 2**

15. This criterion was fully met. The Panel felt that as with all other programmes the issue of continuity is important and should be linked to the National Communities Programme Management manual.

16. The Panel accepted that the providers may not be in a position to develop links with other programmes, However, they asked that the providers should nevertheless raise the issue of sequencing COVAID with other programmes and interventions with management and delivery teams.

Criterion 9: Maintaining Integrity **Score 2**

17. This criterion was fully met. The Panel appreciated the greater detail and specificity that was added to the management manual. This enhances the opportunity for systematic audits. The issue of maintaining integrity will require careful attention if the programme is to be rolled out on a larger scale.

Criterion 10: Ongoing Evaluation **Score 1**

18. The Panel wishes to thank the developers for submitting the research document on the COVAID programmes. 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 reoffending data and a suitable comparison group.

19. This evaluation should be in place within three years and the results of the evaluation (with at least preliminary outcome data) should be provided to the Panel within this time frame. The evaluation should also include data on characteristics of the offenders, dropout rates and other relevant process information.

If you would like further clarification of the Panel's discussion, you are welcome to contact Michael Gossop the sub-panel Chair at: michael.gossop@kcl.ac.uk

Yours sincerely,

Nicola Hewer
CSAP Chair

Members of the Sub-Panel which considered this application are listed below:

Michael Gossop (Chair)
Friedrich Lösel
Barbara Rawlings
Daryl Harris (Co-opted member)

COVAID-GC

(Control Of Violence for Angry Impulsive Drinkers – Group Community version)

Application for Accreditation
Correctional Services Accreditation Panel
England and Wales
October 2010

Application made by:

Professor Mary McMurran
Institute of Mental Health
University of Nottingham
Sir Colin Campbell Building
Triumph Road
Nottingham
NG7 2TU
M: 07777 687966
Mary.McMurran@nottingham.ac.uk

Steve Delight BSc BA DipPsych
Delight Training Services Ltd
19 Chestergate
Macclesfield
Cheshire
SK11 6BX
T: 01625 421045
M: 07768 405409
steve@delight.co.uk

1. A Clear Model of Change

Who is COVAID-GC for?

COVAID-GC is specifically designed for male offenders who are violent when intoxicated, particularly in social circumstances. In the face of provocation or frustration, an intoxicated person may become angry and impulsive, leading to aggression and violence. This is particularly true if the person is of an aggressive disposition, expects alcohol to fuel aggression and is drinking in a trouble „hot-spot'. COVAID-GC targets the features that increase the likelihood of intoxicated violence. COVAID-GC is based on evidence that intoxicated violence in social settings is primarily a problem for young, white men.

COVAID-GC does not cover issues specifically relating to domestic violence. COVAID-GC may form part of the treatment of a domestic violence offender whose offences are primarily alcohol-related, but COVAID-GC is not a substitute for a domestic violence programme.

What dynamic risk factors are addressed?

A developmental risk factor model is outlined. Through reciprocal interactions between the individual and his or her social environment, we trace the development of maladaptive behaviours, attitudes and beliefs, and the failure to develop adaptive skills. These form the dynamic risk factors that are addressed in COVAID-GC.

The five COVAID-GC targets

1. Improve thinking and problem solving skills
2. Reduce the level and frequency of intoxication
3. Control and manage anger
4. Identify and alter risks for alcohol-related violence
5. Address alcohol outcome expectancies, i.e., drinking to give confidence and associating drinking with aggression

The model of change

In their review of intoxicated aggression, Graham et al. (1998) concluded that there was a need for interventions aimed at reducing violent behaviour, especially interventions that "not only employ standard treatment techniques (e.g., anger management), but also use knowledge of the effects of alcohol and the process of aggression in treating violent individuals" (p. 670). COVAID-GC aims to meet this need.

COVAID-GC organises the treatment targets in the COVAID-GC system (see Figure 1), an augmented version of Novaco's angry aggression system. This heuristic helps people understand the therapy tasks. Participants are invited to make changes to all aspects of this system in order to reduce the risk of alcohol-related violence.

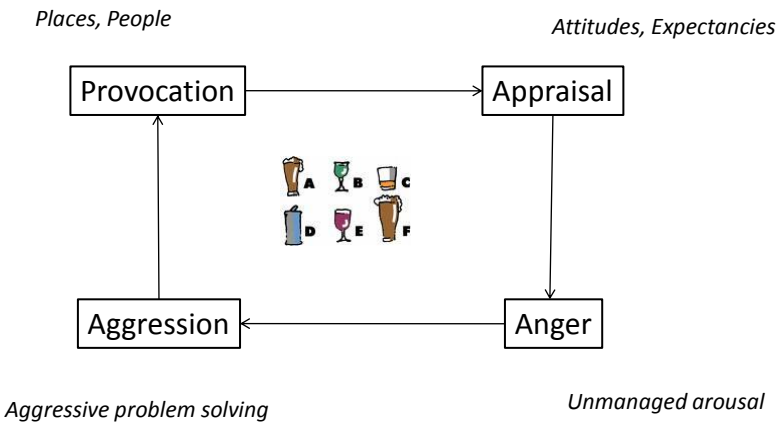


Figure 1. The COVAID-GC system

Empirically supported interventions are used in tackling each part of the COVAID-GC system. These include:

- Tackling drinking though behavioural self-control training (Miller et al., 1992)

- Anger management (Beck & Fernandez, 1998; Edmondson & Conger, 1996)
- Challenging alcohol outcome expectancies ((Beck, Wright, Newman, & Liese, 1993),
- Social problem solving skills training (Hayward, McMurran, & Sellen, in press; Huband, McMurran, Evans, & Duggan, 2007; McMurran, Fyffe, McCarthy, Duggan, & Latham, 2001; McMurran, Richardson, Egan, & Ahmadi, 1999).
- Relapse prevention (Carroll, 1996).

Evaluation in the form of multiple single case outcome studies indicates that, overall, COVAID-GC positively impacts upon the treatment targets of anger control, impulsiveness, alcohol-related aggression expectancies, controlled drinking self-efficacy and alcohol consumption (McCulloch & McMurran, 2008; McMurran & Cusens, 2003). Further offences were not observed during COVAID-GC and in the 3 months after COVAID-GC, although caution must be exercised in attributing this effect to COVAID-GC.

Information with regards to the acceptability of COVAID-GC to staff and participants is available. Community participants report finding COVAID-GC useful, particularly in helping with aggression/ violence, enjoyable and interesting. More recently, Francis (2008) reported upon the implementation of COVAID-GC in a prison, finding that referrals were made to COVAID-GC, the majority of those who started completed COVAID-GC, and both staff and prisoners were positive in their views of COVAID-GC.

A feasibility study for a randomised controlled trial of COVAID-GC has been conducted in prisons in South Wales. Reports have been made available to the Panel, in confidence. Significant improvements were noted for the COVAID-GC group compared with a treatment-as-usual group on measures of alcohol-aggression outcome expectancy and confidence in controlling drinking. Reconviction data will be collected in future. Overall, participants' comments about COVAID-GC were positive.

2. Selection of Offenders

The selection criteria are specified below. These criteria are assessed via official record checks, screening, participant interviews, psychometric tests, and gathering information from key workers.

1. *Medium risk of reoffending*

Participants should pose a „medium' risk of reoffending on a structured clinical assessment scale such as the Offender Group Reconviction Scale-2 (Taylor, 1999) or the HCR-20 (Webster et al., 1997).

Professional discretion may be exercised to include a) high risk individuals, but procedures need to be put in place to support completion, and b) low risk individuals, where the assessment team have additional information regarding risk.

Risk assessment is a specialised area requiring separate training that is not part of COVAID-GC. Its importance is, however, crucial in that offender treatments are most effective and, indeed, are less likely to have an adverse effect, when there is appropriate allocation in terms of risk (Andrews et al., 2006; Palmer et al., in press).

2. *Has a record of alcohol-related violence*

Participants will have a recent record (i.e., in the 2 years prior to detention) of at least three alcohol-related violent incidents. These incidents may be violent crimes (e.g., assault, affray, robbery) or violent incidents admitted by the participant which are not recorded as crimes (e.g., fights, assaults). Most of the participant's violence will be alcohol-related – violence when sober will not be a common occurrence. Most offenders drink and so a history of drinking is not in itself sufficient evidence of alcohol-related violence for selection into COVAID-GC. There should be evidence that the incidents of violence occur whilst intoxicated, that is the individual had been drinking in the hours prior to the incident of violence. Evidence of this may be contained in official accounts

of the incidents, or may be that the offender admits that the events were alcohol-related.

3. *Literacy and comprehension*

The COVAID-GC programme includes essential written work, therefore a moderate standard of literacy and comprehension is required for participation in COVAID-GC. An ability to read a tabloid newspaper is an adequate guide. This criterion may be modified for those on the individual programme and for those in groups where a mentor is available.

4. *Not severely dependent on alcohol*

COVAID-GC is unsuitable for those who are severely dependent on alcohol and who wish to aim for lifelong abstinence. This is assessed using information from the AUDIT (a total score of 20 or more, with scores of 3 or 4 on items 4, 5 and 6); plus self-identification as an „alcoholic' or being dependent on alcohol; plus a goal of permanent abstinence from alcohol.

5. *Motivation*

After being informed about the aims, content, frequency, and duration of COVAID-GC, the offender agrees to participate.

Exclusion criteria

Referrals will be rejected if:

- they are high risk of reoffending,
- they are low risk of reoffending,
- they are violent only when not intoxicated,
- they frequently get intoxicated but show no violence under these conditions,
- there is only one incident of intoxicated violence, regardless of the seriousness of that incident,
- there is evidence of severe alcohol dependence,

- their language and comprehension abilities are insufficient for COVAID-GC.

Special groups

Although most of the evidence on which COVAID-GC is based relates to young, white, male „binge' drinkers, the COVAID-GC programme may be used with other male groups. COVAID-GC is not designed for women offenders. Guidelines are presented below, and further information is contained in the Theory Manual.

- *Ethnicity, Religion, and Culture*. In probation services, compared with white participants, more black and minority ethnic (BME) group offenders actually complete substance use programmes (NOMS, 2008). Since completion is related to reduced recidivism (McMurran & Theodosi, 2007), it is likely that BME participants are reasonably well served by substance misuse interventions. Department of Health/National Treatment Agency for Substance Misuse (2006) guidelines for working with alcohol misusers, advise „sensitivity' to ethnic and religious issues. In providing a responsive service for black and minority ethnic group members, it must be remembered that there are differences within groups as well as between them (Raistrick et al., 2006). All services should aspire to be ethno-culturally competent and diversity guidelines should be adhered to (National Probation Service, 2003). COVAID-GC allows considerable latitude for taking the individual's circumstances into account from his/her own perspective. COVAID-GC may, therefore, be administered in a way suited to people from a range of ethnic, religious, and cultural backgrounds. Where possible, singleton placements on groups should be avoided, since some people find this uncomfortable.

- *Multiple drug users*. Many alcohol abusers are also illicit drug users. Research has, however, consistently shown alcohol to be the

substance most strongly associated with violence. COVAID-GC may reduce violence in drinkers, even if they use other substances. Other interventions may be appropriate for such participants' drug use.

- *Personality disordered offenders*. Although treatment gains may be less with personality disordered compared to non-personality disordered substance misusers, treatment does lead to reduced substance misuse and symptomatology over time.

- *Domestic violence perpetrators.* COVAID-GC does not cover issues specifically relating to domestic violence. COVAID-GC may form part of the treatment of a domestic violence offender whose offences are primarily alcohol-related, but COVAID-GC is not a substitute for a domestic violence programme. COVAID-GC is appropriate for impulsive and undercontrolled men, whose violence occurs in a relationship where there are frequent drunken conflicts. Such a person typically has acceptable attitudes to his partner and wishes to remedy the problem. COVAID-GC is probably not appropriate in cases where the person appears to use violence in a controlled manner and drink is not always involved or is used to legitimise violence. Such a person typically has unacceptable attitudes to his partner and believes that his behaviour is justified.

Deselection

Participants will be deselected if:

- they miss more than two sessions (catch up sessions provided for a maximum of two absences)
- their behaviour deviates from that agreed in the COVAID-GC participants consent form and they fail to respond to feedback as outlined in the COVAID-GC management manual

3. Targeting a range of dynamic risk factors

Specific dynamic risk factors have been identified from a developmental risk factor approach to understanding intoxicated aggression and violence. The developmental risk factor approach explains a person's behaviour in terms of a reciprocal interaction between the person and other people in his or her life.

Target 1: Improving thinking and problem solving skills

Early impulsivity, hyperactivity, and aggression are associated both with later aggressive offending and problem drinking. These characteristics may be directly associated with deficits in problem-solving, planning, and self-regulation. Additionally, early impulsivity may be indirectly associated with poor problem solving, planning and self-regulation in that difficult characteristics impact upon the child's carers, leading to family management practices which are not conducive to the child's learning to behave appropriately develop those cognitive skills relevant to behavioural self-control.

Target 2: Reducing the level and frequency of intoxication

Once drinking begins, it affects behaviour to increase the likelihood of violence by increasing psychomotor activity, reducing anxiety, dampening pain sensitivity, and disrupting problem solving.

Target 3: Controlling and managing anger

Most incidents of drunken aggression and violence are heated with the flames of anger.

Target 4: Altering drinking venues and drinking companions

When they are of a legal age to drink in bars, people then begin to drink more in social settings – pubs, clubs, and parties. Violence is more likely to happen where people are grouped together, particularly if others are also drunk and of an aggressive disposition.

Target 5: Addressing alcohol outcome expectancies

One of the main predictors of alcohol-related violence in young men is drinking to give them confidence in social situations. The increased likelihood of violence may be explained by intoxicated, confident (perhaps overconfident), young men meeting others who are drinking for the same reasons in noisy, crowded drinking venues, which may well lead to clashes where aggression and violence result. The co-occurrence of drinking and violence is an important consideration. Repeated experiences of an association between drinking and violence leads to the formation of the expectancy that where there is alcohol there is also aggression or violence.

These risk factors are not individually assessed for selection and change is not measured on each of these risk factors over the course of COVAID-GC. Instead, we measure the broader outcomes we wish to achieve in COVAID-GC, namely:

- A reduction in alcohol-related aggression outcome expectancies, as measured by the Alcohol-Related Aggression Questionnaire (McMurran et al., 2006),
- An internalisation of motivation for therapy using the Treatment Motivation Questionnaire (Ryan et al. 1995), and
- Greater self-efficacy in controlling drinking or abstaining from drinking using the Controlled Drinking Self-Efficacy Scale (Sitharthan et al., 2003) or the Alcohol Abstinence Self-Efficacy Scale (DiClemente at al., 1994) as appropriate.

What does COVAID-GC not cover?

A chaotic lifestyle of unemployment, unstable accommodation, and unstable relationships and having criminal associates are broad issues that need to be tackled if crime reduction is to be sustained. While COVAID-GC may have a positive impact on some of these areas, they are not the specified focus of the programme. However, session evaluation forms completed at the end of each session for each participant require that facilitators log such areas of outstanding need and communicate these to the participants' offender managers or key workers. This is designed to ensure that the intervention does not exist in isolation but rather contributes to the wider sentence or care plan for individual participants.

4. Effective Methods

COVAID-GC is based upon evidence what works in offender treatment and its components draw on what is known to be effective in interventions aimed at reducing drinking and/or aggression and violence.

A structured cognitive-behavioural programme

Meta-analyses have firmly established that programmes effective in reducing criminal behaviours in the criminal justice field are those which address criminogenic need through structured cognitive-behavioural or multi-modal programmes. In line with this evidence, COVAID-GC targets alcohol-related violence, which is a well-established criminogenic need, and is a structured, cognitive-behavioural treatment programme.

Anger management

COVAID-GC is based on Novaco's model of anger management (Robins & Novaco, 1999). This encompasses recognising triggers for anger, arousal reduction techniques, cognitive restructuring aimed at changing the way events are appraised, teaching non-aggressive coping skills, and stress inoculation for preparing to deal with difficult situations. Meta-analyses of the effectiveness of treatments for anger problems using methodologically sound treatment evaluation studies show medium to large effect sizes for cognitive-behavioural treatments, and there is evidence that Novaco's approach is effective with juvenile delinquents, adult offenders, and mentally disordered offenders.

Changing drinking

Since it is intoxication rather than overall heavy drinking that is implicated in aggression and violence, the main aim of COVAID-GC is to reduce the level and frequency of intoxication. This is an appropriate goal for most young male drinkers. However, COVAID-GC allows participants to choose their own goals – to reduce their quantity and frequency of drinking or to abstain from drinking. Changing drinking is done through behavioural self-control training, in which drinker learns to become a personal scientist by collecting and

analysing information about drinking, setting goals for change, altering triggers to drinking, changing the drinking behaviour *per se*, and changing the consequences of drinking. This intervention is successful for non-dependent drinkers who choose either to abstain from alcohol or to moderate their consumption. Dependent drinkers are not eligible for COVAID-GC.

Challenging attitudes

In COVAID-GC, attention is paid to antisocial attitudes. Antisocial attitudes are addressed throughout by non-confrontational challenge, gradually moving people from a position of unqualified self-interest to one of qualified self-interest, where the person is persuaded to take other people's feelings into account because there is something to be gained in so doing.

Challenging alcohol outcome expectancies

Alcohol outcome expectancies are the effects one expects to experience as a result of drinking. The two most important expectancies for young men who are prone to be violent are social confidence (If I drink, then I will be confident) and aggression (If I drink, then I will become aggressive). These are important because of their relationship with levels of alcohol consumption and alcohol-related behaviour. The approach used in COVAID-GC to change expectancies is Socratic challenge, whereby the therapist aims to elicit evidence, or lack of it, for a participant's belief through questioning the participant about his or her observations and experiences.

Relapse prevention

Relapse prevention aims to help people maintain change over time by recognising and coping with situations which present a high risk of relapse to problem drinking, for example unpleasant emotions, experiencing cravings, or social pressure. An individual profile of high-risk situations is drawn up and coping strategies are taught, including coping with temptation, dealing with cue reactivity (i.e., the desire to drink that is elicited by exposure to drink-related cues, a reaction that is built up over time through repeated association of cues and drinking), and coping with lapses. Relapse prevention is a promising intervention for reducing the intensity of relapses, particularly for

those who show deficits in coping skills. In COVAID-GC, relapse prevention is focused on preventing relapse to alcohol-related aggression and violence.

Problem solving skills training

Social problem solving is the ability to recognise, define, and solve problems in the interpersonal domain. The version used here teaches participants to use bad feelings as a cue to start problem solving, then to define the problem accurately, set goals for change, generate a range of options, think through the consequences of each option, produce a means-end action plan, and evaluate the effectiveness of the plan. Studies with offenders have indicated that problem-solving skills training leads to improvements in social problem solving, although changes in behaviour have yet to be demonstrated.

As mentioned earlier, the content of these components should be sensitive to all diversity issues.

5. Skills Orientated

The COVAID-GC programme requires people to practise skills throughout.

~ *Self-monitoring* of aggression and drinking (throughout) and identifying associations between the two

~ *Behavioural analysis* to elucidate connections between triggers and behaviour and perceived impact of drinking

~ *Analysis of benefits of change* to enhance motivation to change

~ *Identification of current methods of behaviour control* (throughout)

~ *Skills practice* within sessions

- practising sober responses (sessions 2 and 3)
- thinking calming thoughts (session 4)
- acting relaxed (session 5)
- leaving a risky situation (session 6)

~ *Conducting behavioural experiments*

- harm reduction (sessions 3/4)
- stress reduction (sessions 4/5)
- controlling triggers (sessions 5/6)
- people watching (sessions 6/7)

~ *Relaxation* (sessions 3 and 4)

~ *Decision review* to remind about reasons for change (session 7)

~ *Problem solving* (sessions 8 & 9)

~ *Action planning* to prepare for the future (session 10)

~ *Learning reinforcement* – review of skills application (booster session)

Any skills deficits are identified during sessions and noted to offender supervisors for appropriate action. Specified support sessions are provided by offender supervisors or directly by COVAID-GC facilitators on a one to one basis during the programme to support learning and engagement.

6. Sequencing, Intensity and Duration

COVAID-GC consists of ten 2 - 2½ hour sessions, two 1hour pre-intervention sessions, a minimum of two 1hour support sessions, and one 1hour booster session, totalling 24 to 29 hours minimum of face-to-face work, plus assignments. (Support sessions are provided at a ratio of 20 sessions per group of ten participants thus providing a framework for additional responsivity to need as required). In meta-analyses of offender treatment studies, Lipsey (1992; 1995) identified higher „dosage' treatments as most effective in reducing recidivism. These intensive treatments were at least 26 weeks duration, with two or more contacts per week, and amounting to more than 100 hours of treatment. However, the offender treatment literature and the clinical treatment literature, particularly alcohol treatment, are somewhat at odds with regard to treatment intensity. In alcohol treatments, brief interventions, including advice, self-help manuals, and brief motivational enhancement therapy, have a good record of effectiveness, particularly with people with less severe drinking problems who request help (see review by Heather, 2004). In clinical settings, cognisance of limited resources and the need for cost-effectiveness has led to a stepped care model of treatment, where a minimal intervention is given first, and, if that does not work, successively more intensive interventions are given until the client shows signs of benefit. Economising in this way means that scarce resources can be shared among more people. COVAID-GC best suits medium-risk, non-dependent drinkers, however, high-risk offenders and dependent drinkers may benefit as long as other needs are met and responsivity issues are attended to.

The content of the programme is sequenced as follows:

Pre-programme introduction
1. Introduction
2. Explaining drunken aggression
3. Harm reduction
4. Managing stress and tension
5. Altering triggers
6. Exploring beliefs about the effects of alcohol
7. High risk situations
8. Problem Solving
9. Problem solving 2
10. Review, evaluation, and moving on

Crime harm reduction.

Because violence is so damaging, a repertoire of ways of reducing the likelihood of aggression or violence is built early on as a harm reduction strategy. In this, harm reduction strategies in all areas are identified. This serves to give the participant an overview of the value of COVAID-GC.

Changing drinking.

The next aim is to reduce intoxication and heavy consumption and thus reduce the likelihood of aggression and violence.

Managing anger.

The participant is taught to recognise anger arousal and act to avoid trouble. This may be to escape the situation and reduce arousal. Calming alternatives to inflammatory, hostile thoughts are addressed

Managing stress.

This is based upon the principle that the more generally stressed and angry a person is, the more likely is a provocation to trigger aggression and violence. Within this component, stress management in broader terms is addressed. Relaxation techniques are also taught.

Altering triggers.

Triggers for anger and aggression identified via self-monitoring are reviewed. These are interpreted within the COVAID-GC system framework. Coping skills are then introduced.

Weakening beliefs about alcohol.

The expectancies that alcohol facilitates social interaction and leads to aggression are attenuated through Socratic challenge.

Identifying high risk situations.

High risk situations are identified. Avoiding risk by taking evasive action early in a behaviour chain is advocated. Methods of coping with risk are generated.

Problem solving skills training.

There are two aims in problem solving skills training. The first is to counter impulsive aggression in the face of provocation by teaching people to generate non-aggressive solutions, consider the consequences of their actions, and formulate non-aggressive action plans. The second is to identify and address problems that may arise when drinking behaviour is changed, e.g., the need to find other things to do and other ways to cope with emotions.

Relapse prevention

In the final sessions, plans are made for acquiring additional support and therapy after the conclusion of COVAID-GC. The COVAID-GC booster session ensures that learning is followed up – where sentencing allows this is conducted in the community setting so maximising potential for real-life application of COVAID-GC learning.

7. Engagement and Motivation

Understanding the rationale

The COVAID-GC model (see Figure 1) is presented to the participant to help him understand the relevance of the targets of intervention. This understanding is important to client engagement.

Motivational style

The COVAID-GC intervention is conducted in a motivational style. Brief motivational enhancement therapy alone has been shown to have positive outcomes in reducing drinking comparable with more intensive broad-based therapies (UKATT Research Team, 2005), and is particularly effective with participants who are high in anger (Project MATCH Research Group, 1997). Within the motivational framework, assessment of the problem behaviour and feedback of results has been shown effective in reducing drinking. COVAID-GC includes self-monitoring of drinking and aggression, plus a range of assessments. COVAID-GC incorporates these techniques in the early sessions, to promote a decision to change, with goal-setting confirming this decision.

Themes

Throughout COVAID-GC, there are three key themes.

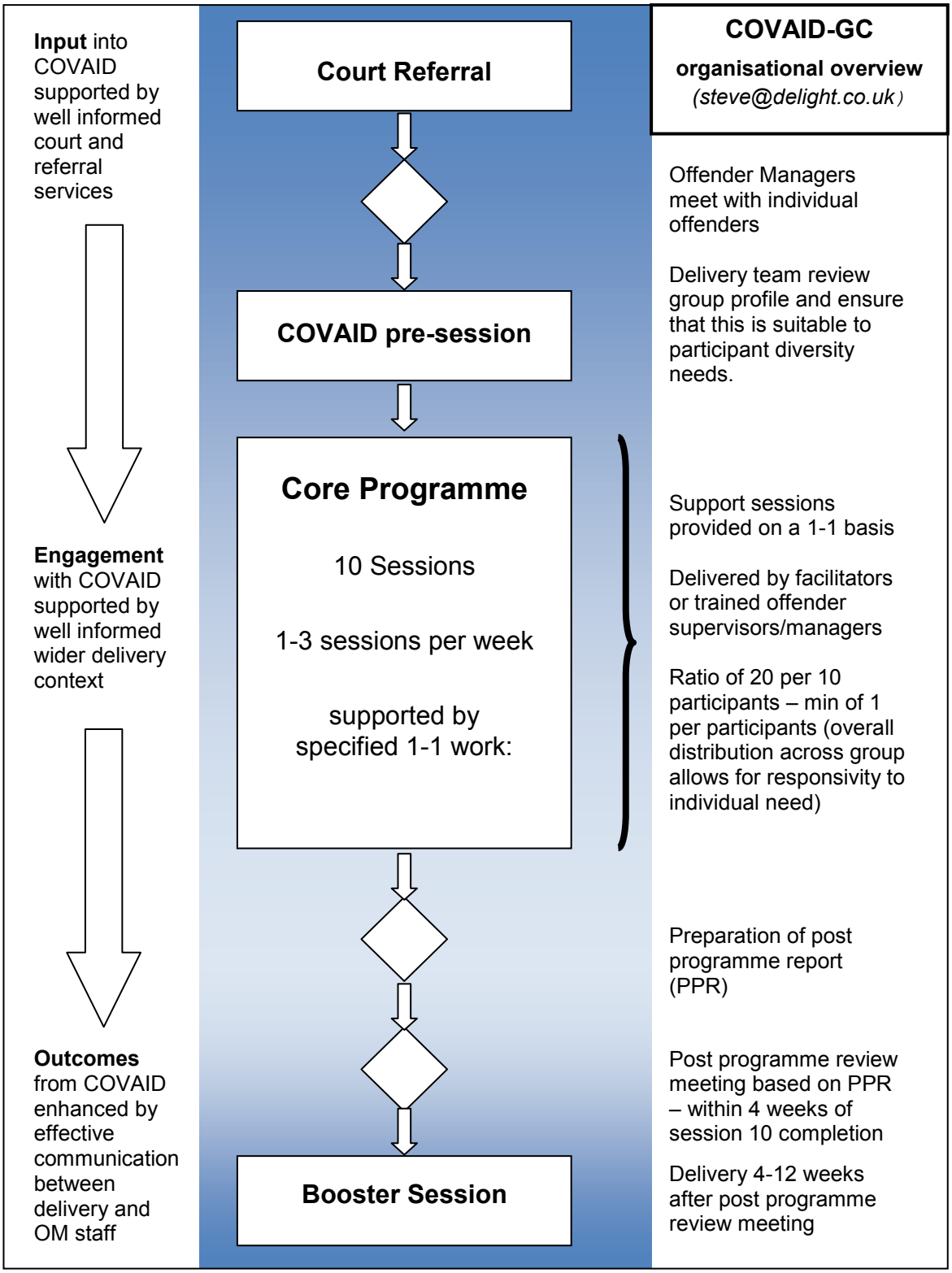
~ *Control not cure.* The participant is taught that s/he is being helped to discover methods of self-control.

~ *A 'personal scientist' approach:* The „personal scientist' bases behaviour change on „studies' of triggers to his behaviour, „experiments' involving change, and „evaluation' of progress.

~ *Self-efficacy.* The participant is also acknowledged as already having skills of behaviour control („My Methods') and is encouraged in identifying what these are. Extra control strategies are added to his own methods of control. The participant's self-esteem is thus protected and he is given control of the intervention.

8. Continuity of Programmes and Services

The COVAID-GC programme is designed to be a complete intervention in its own right with integrated support and booster sessions as outline in the diagram below:



As indicated previously, COVAID-GC has a clear screening process, specified structure, built in closing sessions which include end of programme feedback to the participants, and finally provision of a booster session linked via the COVAID-GC post-programme report to participants' end of programme action plan for application of learning. In order to further enhance the integration of the COVAID-GC intervention into the wider NOMS offender management framework, training can be provided so that booster sessions are conducted by offender managers directly thus enhancing application of learning from programme delivery to participants community context. It has been acknowledged in the documentation that delivery of the booster session may fall to COVAID-GC facilitators and training on its delivery is included in the facilitator training.

Whilst the COVAID-GC intervention is complete in its own right, it is not an expectation that it will sit in isolation. As for other interventions, COVAID-GC should be offered in response to participant need and at the most appropriate time in the participant's sentence or order. Furthermore, links should be made with other provision both during and after COVAID-GC as relevant to the agency context. It is beyond the remit of the COVAID-GC documentation as to how other interventions should be used, but advice has been provided in the Management Manual as to the issues that need to be considered in sequencing alongside anger management programmes such as CALM, generic offending behaviour programmes such as TSP, and alcohol-specific interventions.

The development of NOMS and the overall approach of Offender Management have done much to provide a platform upon which improved integration of interventions such as COVAID-GC can be placed. Direction has been provided in the Management Manual as to how the Offender Management model should operate within the context of COVAID-GC. This direction has taken into account the sometimes differing ways that Offender Management is implemented.

Continuity of services clearly needs to be supported both internally and externally to the COVAID-GC delivery format. The Management Manual therefore also describes in detail the key management roles of programme and treatment manager and how these should operate alongside Offender Management teams.

9. Maintaining Integrity

In providing a high quality of COVAID-GC provision we have agreed with RSG that national audit be provided by them directly. We have liaised extensively with their staff and have reviewed the updated management manual for this submission against the allocated lead audit manager from RSG to ensure that the direction contained within is fit for purpose in allowing a full compliance and quality audit to be conducted against the COVAID-GC programme. We have also provided direct support for RSG in developing audit staff such that they can conduct meaningful quality audit of videoed COVAID-GC delivery so that a quality assurance system can be properly put in place against local treatment manager supervision.

A significant development involved in the above has been the direct specification of the management roles involved in supporting COVAID-GC implementation locally. These are detailed further in the management manual but core roles outlined in this document are as follows:

A programme manager – this person's overall role will be the practical management and resourcing of COVAID-GC provision.

Specific responsibilities will include:

- To organise and attend monthly meetings with COVAID-GC treatment managers in their area to attend to ongoing issues of programme implementation. Minutes of these meetings should be recorded to ensure continuity of management processes and evidence for audit where required.
- Ensuring that appropriate facilities are provided to deliver the programme including group room, individual interview rooms as required, equipment for delivery and appropriate storage facilities for programme materials.

- Ensuring that appropriate staffing is provided in order to properly resource programme delivery – this includes availability to deliver but also to prepare and debrief as indicated later in this manual.
- Ensuring that there are sufficient numbers of offenders organised to attend the programme and that ongoing communication with offender managers is maintained to maximise engagement and attendance on the programme.
- Ensuring in collaboration with the treatment manager that new facilitators are selected and trained when needed and that existing facilitators maintain their delivery experience as outlined later in this manual.
- To action in collaboration with the treatment manager any necessary de-selection of facilitators as they arise
- Ensuring that briefing for court referral staff takes place to ensure ongoing effective referral to the programme.
- Ensuring that staff awareness training is provided in the wider organisational setting as outlined later in this manual.
- Ensuring that the ongoing implementation of the programme is planned and budgeted for in annual reviews in line with regional DOM requirements.
- To attend national and regional management meetings as provided by RSG or as directed by regional DOM
- To attend relevant Programme Manager training as provided by RSG or as directed by regional DOM

A treatment manager – this person's overall role will be the ensuring of quality delivery of the COVAID-GC programme to offenders.

Specific responsibilities will include:

- To attend monthly meetings with the COVAID-GC programme manager in their area to attend to ongoing issues of programme implementation. Minutes of these meetings should be recorded to

ensure continuity of management processes and evidence for audit where required.

- Ensuring in collaboration with the programme manager, that delivery of COVAID-GC is done so in line with programme documentation and in order that agreed KPT is achieved.
- Ensuring in collaboration with the programme manager that local court services are sufficiently well informed to ensure appropriate selection of offenders, or, to supervise the provision of selection interviews by COVAID-GC facilitators.
- Ensuring that the make-up of each COVAID-GC group is sensitive to the diversity needs of offenders.
- Ensuring that appropriate combinations of facilitators are assigned to COVAID-GC groups such that continuity of delivery is achieved as outlined later in this manual and also that less experienced facilitators can learn from and thus be supported by those more experienced in their role.
- Ensuring that potential new facilitators are recruited and go through the appropriate selection centre before attending facilitator training
- Ensuring that where the shorter 7 day facilitator training event is selected by training commissioners, all trainee facilitators have either successfully attended the national core skills training or have equivalent skills and experience.
- Ensuring in collaboration with the programme manager that facilitators are provided with enough time to plan for, deliver, and debrief COVAID-GC sessions as outlined later in this manual.
- Ensuring that facilitators maintain their skills of COVAID-GC delivery through regular programme delivery or attendance on COVAID-GC facilitator refresher training as outlined later in this manual.
- Ensuring that they maintain their skills of COVAID-GC delivery through direct programme delivery / attendance on refresher training as outlined later in this manual.

- Ensuring that where facilitators rather than offender managers deliver one to one support sessions, these facilitators are provided with sufficient resources and support to meet this demand.
- Ensuring that facilitators receive supervision in their roles as outlined later in this manual. This supervision should be logged for continuity of management and audit purposes.
- To provide support for and appropriate gate-keeping for facilitators work in writing post programme reports and communicating with individual offender managers in order to convene post programme reviews
- To ensure that catch up sessions are provided by facilitators to offenders as outlined later in this manual.
- To maximise the implementation of COVAID-GC booster sessions in line with local resources and offender needs.
- To ensure that anonymised data is recorded and made available to COVAID-GC programme developers in order that an ongoing data base of COVAID-GC implementation can be maintained.
- To support facilitators in any de-selection of offender as outlined later in this manual.
- To support programme manager in any arising de-selection of facilitators
- To attend national and regional management meetings as provided by RSG or as directed by regional DOM
- To attend relevant Treatment Manager training as provided by RSG or as directed by regional DOM

Offender Manager Teams – their overall role in the implementation of COVAID-GC will be to support offenders during attendance and to ensure that learning is effectively summarised and integrated into ongoing supervision as appropriate.

Specific responsibilities will include:

- Communicate with the individual offender after referral to COVAID-GC to ensure that they are clear on the requirements of any order with regard to COVAID-GC attendance.
- Dependent on local arrangements, ensure that the participants consent form is completed by the offender (it can be agreed locally that this is completed in the COVAID-GC pre-session)
- Notify the programme delivery team of any arising issues that might undermine the offender's attendance and engagement with the programme.
- Maintaining ongoing communication with programme delivery teams such that individual offender attendance and engagement with COVAID-GC is maximised.
- Where offender managers have been trained in delivery of the COVAID-GC one-to-one support session, ensuring delivery of these as set out in the programme materials.
- Where offender managers have been trained in the delivery of the COVAID-GC booster session, ensuring delivery of these as set out in the programme materials.

10. Ongoing evaluation

COVAID-GC includes information collection and psychometric assessments which could form the basis of an evaluation by services. A feasibility study for a randomised controlled trial of COVAID-GC has been conducted in South Wales, funded by NOMS Cymru.

COVAID-GC also has measures within the programme. The measures used in COVAID-GC are:

Interview

All referrals who pass the screening will be thoroughly assessed to collect general demographic information, plus information about their drinking, offending, and violence.

Psychometrics

Alcohol Use Disorders Identification Test (AUDIT; Babor, Higgins-Biddle, Saunders, & Monteiro, 2001) is a 10-item screening test developed to identify alcohol misuse and early drinking problems. Total scores range from 0 to 41. Guidelines for interpreting scores are as follows:

- Scores of between 8 and 15 indicate hazardous drinking.
- Scores of between 16 and 19 suggest the need for brief counselling and monitoring drinking.
- Scores of 20 or over warrant further investigation for alcohol dependence.

The purpose of using the AUDIT is to screen out people who are severely dependent upon alcohol. Surveys indicate that between 30% and 50% of male prisoners score over 16 on the AUDIT (McMurran, 2005; Singleton et al., 1999), therefore excluding male prisoners on their total AUDIT score may exclude many who might benefit from COVAID-GC. It is recommended that a score of 4 on any of items 4, 5 and 6 should be interpreted as indicative of dependence. In these cases, a specialist assessment is warranted.

Alcohol-Related Aggression Questionnaire (ARAQ). The ARAQ is a 28-item questionnaire designed to measure the relationship between alcohol and aggression (McMurran, et al., 2006). In COVAID-GC-GS, the ARAQ is used only once to examine aspects of the alcohol-aggression relationship, namely alcohol-aggression outcome expectancies, trait aggression, drinking contexts, sensitivity to pain and anxiety, and drinking high alcohol/low cost beverages. The ARAQ is systematically associated with drinking and aggression, being younger, and of lower socioeconomic status. It discriminates offenders whose violent offences are alcohol-related from those whose violent offences are not alcohol-related or who are not violent.

Treatment Motivation Questionnaire (TMQ). The TMQ is a 26-item questionnaire measuring motivation to change in treatment (Ryan et al., 1995). It has three factors – external motivation, internal motivation, and confidence in treatment. Internal motivation correlates with successful engagement in treatment, and external motivation correlates with dropping out of treatment. The TMQ is administered at the start and end of COVAID-GC to assess change.

Either

Controlled Drinking Self-Efficacy Scale (CDSES). The CDSES (Sitharthan et al., 2003) is a 20-item scale measuring a person's confidence in moderating consumption in the face of high-risk situations, and reducing consumption and frequency of drinking. It has four subscales for men: negative affect, frequency of drinking, positive mood/social context, and quantity of consumption.

Or

Alcohol Abstinence Self-Efficacy Scale (AASE). The AASE (DiClemente et al., 1994) aims to measure self-efficacy regarding abstinence from alcohol in high-risk situations. There are 20 items to be rated twice: first, according to how strongly tempted the respondent would be to drink in the particular situation, and second, according to how confident the respondent would be that s/he could resist drinking. The AASE has four factors: (1)

negative affect (NA); (2) social/positive (SP); (3) physical and other concerns (PO); and (4) withdrawal and urges (WU).

The CDSES or the AASE are administered at the start and again at the end of COVAID-GC to assess change.

Anger and aggression diaries

Anger and aggression diaries are used throughout. Diaries help the participant to identify the frequency, intensity and duration of the anger, the triggers to the anger, the behavioural outcomes, and the consequences of the incident.

Alcohol diaries

Alcohol consumption is measured retrospectively between sessions and related to aggression as recorded in the diaries.

Long-term follow-up

In the long-term, official measures of crime and information about resettlement may be collected in order to examine the ultimate outcome criterion at which the programme was aimed -- intoxicated violence.

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

RAPt

THE REHABILITATION FOR ADDICTED PRISONERS TRUST

stopping addiction. stopping crime.

Women's Substance Dependency Treatment Programme

Application Manual

CONTENTS

1.1 Factors targeted by the programme

The Women's Substance Dependency Treatment Programme (WSDTP) is 18-22 week offending behaviour programme aimed at medium-high risk female offenders with a history of drug dependence and is intended to be run in prison settings, ideally on dedicated residential units.

The WSDTP has been developed by the Rehabilitation of Addicted Prisoners Trust (RAPt) to meet the specific needs of substance dependent female prisoners. The current programme is an updated and modified version of the one originally developed for men, which was evaluated in three separate studies and found to contribute to significant reductions in drug use and re-offending (Martin, Player and Liriano, 2003).

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

- Substance dependence
- Offending behaviour linked to substance dependence

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 substance use
- Strong social pressure to misuse substances or drink alcohol
- High impulsivity
- Poor problem solving
- Deficits in decision making
- Lack of assertiveness
- Poor pro-social interpersonal skills
- Deficits in emotion 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
- Relationships with physically or emotionally abusive partners
- Relationships with partners who encourage drug/alcohol use and/or offending
- Difficulty in coping with cravings

Both offending behaviour and drug dependence frequently arise in the context of multiple circumstantial and adaptive difficulties, particularly in the case of female offenders. This programme is thus designed to take account of a range of factors and needs which underlie, trigger and exacerbate those listed above. These factors include:

- Mental health difficulties and dual diagnosis issues
- Physical health difficulties and concerns
- Past experiences of trauma and/or abuse
- Continuing domestic violence issues
- Parenting difficulties

Evidence regarding the importance of taking account of the above listed risk factors is discussed in the *WSDTP Theory Manual.*

1.2 Programme overview

The WSDTP is a three phase abstinence-based 12-step programme, designed to be run over approximately 18-22 weeks (the exact length depends on the time between phases and the needs/progress of the individual).

Where the programme is run on a dedicated treatment wing, it is recommended that participants are able to move onto the wing before they are formally admitted onto the programme (such as at HMP Send where the programme is being piloted). In such cases it is necessary for participants to be introduced to the Rules and Expectations and structure of the ‗RAPt treatment unit' to ensure the smooth running of the treatment community. Also this offers benefits for integrating pre-treatment participants with programme participants and motivating them to engage in treatment at an early stage (see Section Six of this manual). Where possible, pre-treatment participants should be encouraged to attend NA/AA meetings and will meet regularly with Peer Supporters and their assigned ‗buddy' (a participant in the Primary Phase of treatment) to provide support and guidance. Pre-treatment participants should also be able to attend Seeking Safety Workshops with Phase One participants where there are spaces to do so.

Phase One comprises ongoing attendance at Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) meetings, an Intake and Orientation session, a MET session, eight Seeking Safety Skills (SS) Workshops, two to three Step Lectures and two to three Workshops attended with the Primary Group and two individual counselling sessions. The entire phase lasts for 2 ½-3 weeks. The focus in this phase is on the development and implementation of basic safe coping skills. Attention is also paid to enhancing participant motivation and self-efficacy. Self-care, management of anger and other emotions, interpersonal skills and boundary setting are explored and rehearsed. Women in Phase One are also invited to attend all daily meditations, Step Lectures and Workshops and Community and Speaker Meetings where possible with the Primary group to ease their transition into Primary/Phase Two. In addition the women in this phase spend 45 minutes every morning with peer supporters to share their commitments from the previous day, read chapters from the NA ‗Blue Book' or other NA/AA texts and to discuss any particular challenges or concerns and receive support and encouragement.

Phase Two is in essence a 12-14 week 'Primary Programme' focused on taking participants through the first five of the 12 Steps of AA/NA recovery[1]. It comprises: Group Therapy; Step Reading Groups; Community Meetings; Speaker Meetings;,Video Sessions; Step Assignment sessions; Educational sessions and Lectures; Peer Evaluations; Goals Groups; Seeking Safety and other Workshops; Graduations; Significant Events Sheets; Meditation and Wind Downs; and individual counselling sessions held forthnightly..The weekly Workshop in this phase would usually focus on SS topics that are either introduced or revisited from Phase One in response to issues within the group, for example a session on ‗Managing Anger' to address behavioural problems or ‗Honesty' to address dishonest behaviour. Some of the weekly Workshops may be held in response to other issues identified in the treatment community or may be used as Creative Workshops.

Phase Three consists of two individual counselling sessions and six Seeking Safety (SS) Skills Training Workshops of group work focusing on developing individualised Relapse Prevention Plans based on the following SS topics: ‗Red and Green Flags,' ‗Recovery Thinking,' ‗Commitment,' ‗Setting Boundaries in Relationships,' ‗Getting Others to Support Your Recovery,' and ‗Respecting Your Time.'. Phase Three is run over a period of three to four weeks. To maintain continuity of care participants are still required to attend NA/AA meetings and may also attend daily meditations, Speaker Meetings and Community Meetings where possible (for example at HMP Send participants are usually engaged in part-time employment by Phase Three).

1.3 How target factors are addressed by the programme

1.3.1 Social support and destructive relationships

- *Weak social support systems for tackling substance use*
- *Strong social pressure to misuse substances or drink alcohol*
- *Weak ties to, and lack of identification with, pro-social/anti-criminal models*
- *Strong ties to, and lack of identification with, anti-social/criminal models*
- *Relationships with physically or emotionally abusive partners*
- *Relationships with partners who encourage drug/alcohol use and/or offending*

Engagement with peers in the three main treatment phases, as well as on-going involvement with AA/NA, provides strong ties to pro-social and pro-recovery social networks. The importance of avoiding old social networks associated with drug/alcohol use and offending is highlighted throughout the programme, particularly in the Relapse Prevention Planning process during Phase Three. Attendance at NA/AA meetings is a continuous element of the programme and is permitted and encouraged during interim periods (before beginning Phase One and in between phases) when possible. Participants who are not going on to secondary residential treatment within 6 months of programme completion are strongly encouraged to engage a NA/AA sponsor after graduating from treatment. Programme graduates who remain in the prison are welcome to attend AA/NA meetings in the evenings and Graduate Extended Care Groups and are strongly encouraged to do so upon release.

Destructive relationships are especially dangerous for female offenders in treatment and are linked to relapse and re-offending (see the *WSDTP Theory Manual* for discussion). Relationship skills, particularly in relation to setting boundaries, self-protection and avoiding re-victimisation and strategies for ending abusive relationships are explicitly addressed in dedicated Phase One and Phase Three skills sessions and are reviewed in group or individual counselling sessions when appropriate. Many of the cognitions which underlie repeatedly seeking out self-destructive companions are also addressed in other Phase One Workshops (e.g. Safety and Self-Care). In the SS Workshop in Phase One on ‗Healthy Relationships' the group explore the difference between healthy and unhealthy relationships and beliefs about relationships and will practise setting boundaries by specifically rehearsing how to say no to offers of drugs and alcohol or detach from people who do not respect their goal of abstinence. Associated cognitions and beliefs are also addressed through Step Assignments (in particular the Cross-Addiction Assignment) and in Group Therapy sessions throughout Phase Two and additional SS workshops are held in response to issues raised by individuals and the group. In Phase Two participants discuss with their counsellor and in group sessions which of their relationships are supportive of their recovery and, where the programme permits, counsellors arrange family/friends conferences with close supporters.

Where necessary, Relapse Prevention Plans in Phase Three may include planning about how to effect domestic changes and two SS sessions in this phase focuses on relationships: ‗Setting Boundaries in Relationships,' and ‗Getting Others to Support Your Recovery'. The Cross-Addiction Assignment is reviewed in Phase Three, as participants at HMP Send (where this programme is being piloted) have expressed the poignancy of cross-addiction issues, particularly in relationships, for their continued recovery. In certain cases (e.g. where a participant is concerned about domestic violence upon release) thoughcare arrangements would involve helping the participant to access support from relevant agencies.

1.3.2 Impulsivity and emotion management

- *High impulsivity*
- *Poor problem solving*
- *Deficits in decision making*
- *Lack of assertiveness*
- *Poor pro-social interpersonal skills*
- *Deficits in emotion management*

A range of interpersonal and emotion management skills, such as grounding, are taught and rehearsed during Phase One and participants are expected to continue implementing and practising these skills throughout Phases Two and Three. As Seeking Safety is a continuous approach across all phases of treatment, there are many opportunities to practise and review emotion management, problem solving and interpersonal skills throughout. Deficits in each of these areas, and in wider interpersonal behaviour, are monitored so that individually focused interventions can be made. Reversions to problematic coping strategies are challenged in Group Therapy, Peer Evaluations and individual counselling. Goals Groups also provide an opportunity for participants to be guided by their peers to identify deficits in emotion management, decision making, problem solving and interpersonal skills to address in the coming week

Participants are thereby regularly reminded to apply recently learned skills and thus become more familiar with using these new coping strategies over the course of their treatment. In addition, facilitators model pro-social interpersonal skills throughout, and reinforce the implementation of SS skills in individual counselling sessions as required.

The strategies participants are introduced to for managing intense emotions and extreme symptoms during Phase One also provide a starting point for tackling deficits of impulse control. Participants are urged to practise such calming techniques when they feel tempted to act rashly out of difficult emotions. Participants' feedback indicates that the SS ‗Grounding'

session is particularly effective in helping them detach from emotional pain and lightening their mood. The importance of thinking carefully before taking action is underlined in Phase Two by the Life Story and personal inventory Assignments (associated with Steps One, Four and Five) where patterns of impulsive action and negative consequences are recognised. Daily Meditation and Wind Downs provide scheduled opportunities to continue practising self-soothing skills throughout treatment. When impulsive behaviours manifest or are noted in Significant Events Sheets or Diaries, participants are encouraged to recognise the behaviours and their costs during individual counselling and/or in Peer Evaluations.

Debilitating levels of shame, guilt and low self-esteem are particularly problematic for substance dependent female offenders. These are frequently associated with childhood abuse histories and compounded by negative self-judgments about addiction and drug related behaviour. Correcting damaging self-perceptions reduces susceptibility to negative emotions. Enhancing self-esteem and overcoming shame and guilt are therefore key treatment aims. A core message of 12-step recovery is that people are responsible for change but are not responsible for having the condition underlying addiction. This empowering message, repeatedly reinforced through the steps, in treatment and in AA/NA meetings, can gradually replace self-defeating beliefs about personal weakness and failure which only exacerbate low self-esteem and undermine self-efficacy. Many WSDTP participants at HMP Send have reported that the exploration of this so-called ‗Disease Concept' was a crucial turning point in their recovery, where they no longer felt it necessary to ―beat themselves up" about their past predicaments. This message is reinforced in SS Workshops on ‗Safety,' ‗Powerlessness and Empowerment,' and ‗Healing from Anger' where participants are guided to view their addiction as their way of coping and to focus on new ways of coping. These SS Workshops and Step One work encourage participants to understand that they cannot control their using/drinking through willpower alone and to direct their energies towards things they can control such as ‗Asking for Help' from others as an essential part of recovery.

In Phase Two, Step One and Steps Four and Five involve the mutual sharing of Life Stories and explicitly revealing personal shortcomings with supportive and non-judgmental peers and their counsellor. These steps act as catalytic processes through which participants' experiences of deep acceptance powerfully contradict their previous negatively distorted self-beliefs.

1.3.3 Low motivation

- *Weak commitment to avoiding re-offending*
- *Weak commitment to remaining abstinent*
- *Low self-efficacy*

Weak or fragile commitment to tackle drug/alcohol use is addressed throughout the programme in numerous ways. Women's commitment to treatment has been found to be particularly affected by low self-efficacy and distrust stemming from trauma histories. Facilitators therefore use a motivational interviewing, rather than confrontational, style of delivery which allows participants to naturally develop their own commitment to change without triggering resistance. Details of delivery style are provided in Section Nine of the *WSDTP Introduction and Overview Manual.* Seeking Safety Workshops throughout Phase One use cognitive and behavioural techniques to explicitly address the cognitive distortions and damaging trauma-related beliefs which exacerbate participants' low self-efficacy.

A Motivational Enhancement Therapy (MET) session is completed before participants begin the Seeking Safety Workshops in Phase One in which the 'Drug History Graph' exercise is used to enhance participant commitment to recovery by visually exploring the extent of their past substance abuse allowing them to see long-term patterns and recognise larger patterns in their lives. This theme is then revisited through assignments and group work in Phase Two, particularly those relating to Steps One and Three, and is further reinforced through on-going engagement with AA/NA. An additional MET Workshop may be held in Phase Two to explore the costs and benefits of substance dependence and of change through a MET exercise in order to help maintain motivation while half way through treatment and remind participants of the need for strong, enduring commitment to their recovery. This is also fits in well in Phase Two after participants have completed their Step One Assignment and explored and shared the costs of their addiction on their relationships, health, education, employment and housing.

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

As with motivation to change, low self efficacy is also addressed throughout treatment, in individual counselling sessions, SS Workshops and step work. The potential for change is also a consistent theme in Phase Two and in AA/NA, particularly in those elements relating

to Step Two, and is reinforced by the fact that most of the facilitators on the programme, as well as AA/NA sponsors, are themselves in recovery.

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 after treatment and to continue to attend meetings. 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.

The Peer Supporter systems and the ~~“b~~buddy scheme” whereby Phase Two participants are paired with newer participants to provide help and support, act to reinforce participants‘ belief that they can help others as well as working on their own recovery and that their peers will be willing to provide support to them.

1.3.4 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*

The 12-step elements of the programme and AA/NA focus on: encouraging people to take responsibility for change and not to blame others for their predicament (especially in elements relating to Steps Four and Five, and Six to Ten); accepting the help and support of others (emphasised particularly in Steps Two and Three and Five to Seven) and accepting the need for abstinence (a consistent theme throughout and particular focus of Step One). These messages are further reinforced in individual counselling throughout the programme. The common belief that cravings and urges are irresistible is addressed directly in Phase One and throughout Phase Two.

Any unhelpful attitudes and beliefs relating to drug and alcohol use manifested during the programme are challenged in individual counselling, Group Therapy and Peer Evaluations,

while more functional attitudes and beliefs are explored in SS sessions such as ‗Powerless and Empowerment,' and ‗Asking for Help' in Phase One and ‗Recovery Thinking' and ‗Commitment' in the Seeking Safety in Relapse Prevention Planning Phase and modelled by facilitators throughout.

The SS Workshop ‗Safety' in Phase One encourages participants to identify situations in which they feel unsafe or that may trigger cravings to use or impulses to harm oneself or others and helps them to plan specific safe coping strategies to practise and draw upon throughout treatment. The Relapse Prevention Planning process in Phase Three of the programme, especially the session on ‗Red and Green Flags,' focuses in more depth on identifying personal risk factors for drug/alcohol use and re-offending post-treatment, and on developing strategies for dealing with them. The preceding Life Story and personal inventory work during Phase Two (associated with Steps One, Four and Five) also helps in the initial identification of personal risk factors both for substance misuse and offending, while many of the skills taught elsewhere on the programme assist in the development of appropriate strategies for dealing with these.

1.3.5 Difficulty in coping with cravings

Management of cravings and urges to use is addressed during Phase One. The common belief that cravings are irresistible is challenged, with participants encouraged to examine its function and validity. Such beliefs are further undermined by facilitators in recovery and visiting AA/NA members providing direct testimony of their experiences of successfully overcoming cravings. Participants' are encouraged to evaluate their current methods of coping with cravings and identify ineffective responses. Various alternative behavioural strategies are introduced and rehearsed within sessions. Key actions for successfully maintaining abstinence in the face of temptation are detailed. Chief among these is the expectation that participants will share with peers and bring to their group any cravings/urges to use that they experience. The need for each participant to access support available to them is repeatedly emphasised. Where participants succeed in sharing about cravings, they are supported and possible ways of coping are discussed. Facilitators monitor participants' experiences of cravings or urges during individual counselling and through Significant Events Sheets. Even where a participant resists cravings, a tendency to rely on will power rather than actively implementing effective coping behaviours (in particular, asking others for help) would be challenged and form the basis for ongoing intervention in individual counselling and group sessions.

1.4 Meeting individual needs and responding to diversity

The WSDTP targets a range of issues which are central to women's recovery but typically overlooked by traditional male-oriented programmes (see the *WSDTP Theory Manual*). Chief among these are interventions focused on coping with childhood abuse, domestic violence, or sexual assault, identifying and ceasing destructive relationships, managing feelings around the loss of children/poor relationships with children, interrupting patterns of disordered eating and self-harm/self-mutilation. The programme delivery style, which incorporates motivational interviewing techniques and emphasises individuals' choices, has been tailored to assuage the low self-efficacy identified as characteristic of female participants.

A search of the literature, including the review published by Home Office, RDS 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 in the WSDTP 'Rules & Expectations'. The programme uses a version of the 12-step language for assignment work that has been adapted specifically for women. 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 numeracy and of issues associated with diverse backgrounds. For further detail of how the programme addresses literacy difficulties see Section Seven of the *WSDTP Introduction and Overview Manual.*

Individual counselling and Relapse Prevention Planning, as well as the setting of assignments and tasks in Phase Two, are shaped by the particular needs and characteristics of each participant. Additional help and support is provided as required, and, where necessary, provision is made for participants to 're-take' elements of Phase One and/or to remain on Phase Two longer than the standard 12 weeks.

Each participant has a Focal Counsellor. The participant's Focal Counsellor is responsible for assimilating all assessment material, including the CARATs Comprehensive Substance Misuse Assessment (CSMA), the RAPt assessment, observations and information from staff conducting Phase One of the programme. Information provided by the participant in the process of preparing and reading their Life Story can also be used to inform case management and ensure that individual needs are met. Participants themselves are actively involved in the formulation of their individualised treatment plans.

The use of comprehensive psychometric tools in the assessment process and post-treatment ensures that treatment planning can be tailored to the needs of the individual (see the *WSDTP Assessment and Evaluation Manual*). The results of the psychometric assessments are discussed with the participants and personal risk factors form the basis of goal setting and ongoing evaluation. Focal counselling sessions provide an opportunity for the facilitator and participant to explore individual needs and diversity issues.

1.5 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 presented with a history of mental health problems, close attention would be paid to their mental health status throughout their time on the WSDTP and the level of support provided would closely mirror their level of vulnerability. In all such cases a shared care approach would be adopted with the Prison‘s Health Department.

Issues that need to be dealt with post-treatment are identified and incorporated into individualised throughcare plans during Phase Three of the programme. These are detailed in each participant‘s Post Programme Report and may include sustained support for addressing domestic violence, parenting, mental or physical health, childhood abuse history, educational, or employment needs. Any need for secondary care for substance dependence following release would be detailed at this stage and included in the report. Comprehensive throughcare arrangements help to ensure that additional needs not targeted by the Women‘s Substance Dependency Programme are addressed outside the programme.

1.6 Evidence of likely effectiveness

There is strong evidence, discussed in section 4.3 of this application and presented in greater detail in Section Six of the *WSDTP Theory Manual*, to show that 12-step treatment and the Seeking Safety approach in general, and the combination of approaches used in the WSDTP in particular, are likely to be effective in addressing the underlying factors the programme seeks to target and, in so doing, reduce drug and alcohol use and re-offending after release.

1.7 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 *WSDTP Theory Manual.* The following information outlines the explanation given.

1.7.1 Phase One – Seeking Safety

The methods employed in Phase One of the programme are designed to provide both the motivation and skills needed to engage fully in an intensive treatment programme. The methods are grounded in the research literature and have been shown to be highly effective in addressing both the motivational and skills deficits in women presenting for drug treatment services.

Motivational Enhancement Therapy (MET)

MET focuses on tackling ~~-w~~eak or fragile commitment to tackle drug/alcohol use," ~~-d~~ysfunctional attitudes and beliefs related to drug/alcohol use" and ~~-l~~ow self-efficacy." MET has been widely researched and shown to be effective in increasing self-efficacy and developing participants' motivation and commitment to change. It therefore provides an effective intervention by tackling important risk factors and by preparing participants for engagement in intensive therapeutic work. A MET session in Phase One has been dedicated to completing and discussing a 'Drug History Graph' exercise which illustrates the extent to which drugs and alcohol have monopolised various stages of participants' lives and how this has impacted upon or interacted with other significant life events. It has been found that, at HMP Send where this programme is being piloted, this MET exercise is the most effective in motivating participants to engage in treatment. Participants themselves have reported that this exercise reflected a crucial turning point in their awareness of their drug/alcohol dependence in conjunction with other aspects of the programme. There are opportunities to attend further MET sessions in Phase Two of the programme, particularly if staff observe a decrease in participants' motivation.

Seeking Safety (SS) Workshops

The introduction of Seeking Safety Skills Workshops in Phase One of the programme is designed to tackle a number of significant risk factors and to enhance engagement and retention in treatment. As detailed in Section Three of the *WSDTP Theory Manual*, female offenders typically enter treatment with multiple trauma-related needs and behaviours, such as disordered eating, self-harm, involvement in dangerous relationships, and extreme symptoms (e.g. flashbacks, dissociation and nightmares). These endanger participants' well-being and prevent effective therapeutic engagement. Seeking Safety is a CBT-based treatment developed specifically as a first-stage intervention for substance dependent individuals with these types of trauma-related symptoms. As such, it is highly structured with a focus on developing immediate practical skills for managing distressing symptoms and replacing self-destructive behaviours. Written exercises, role-plays, skill rehearsals and cognitive experiments are all methods used to challenge cognitive distortions and enhance

participants' development of new coping skills. The Seeking Safety approach is supported by a strong evidence base for its ability to improve outcomes in terms of relapse and overall functioning (physical and mental health, relationships, employment etc.) in similar settings to the WSDTP. See Section Six of the *WSDTP Theory Manual* for further detail. Given the acute clinical profile of female drug dependent offenders Seeking Safety has been employed as a continuous approach throughout all phases of the WSDTP, particularly to prepare for and support the in-depth therapeutic work undertaken through step work.

Risk factors addressed through the development of new coping skills and strategies include poor emotion management, difficulty in coping with cravings, difficulty in recognising and generating appropriate strategies for personally relevant risk factors, deficits in decision making, lack of assertiveness, poor pro-social interpersonal skills, weak social support systems and involvement in dangerous relationships.

1.7.2 Phase Two (Primary)- 12-step treatment

Phase Two of the WSDTP is routed in the philosophy of the 12 steps of Narcotics and Alcoholics Anonymous. The 12-step programme provides participants with a strong sense of support and identification with other women who have become addicted to drugs and/or alcohol. The focus on a common predicament or problem that is shared amongst group members is a powerful precipitant of change. The methods used to bring about the sense of identification are attendance at NA/AA fellowship meeting, the use of a peer support network, community and therapeutic group processes.

Through identification with peers who have made a commitment to remain drug and alcohol free and address dysfunctional attitudes and beliefs, the participant is provided with a strong social support network that helps in the maintenance of abstinence whilst providing appropriate challenges to anti-social attitudes and beliefs.

The 12-step assignments, daily significant events sheets, and group participation throughout this phase of the programme enable both facilitators and peers to gauge whether the attitudinal and cognitive changes that need to take place as part of the treatment process have occurred. Seeking Safety Workshops continue to be held at least fortnightly throughout this phase to revise safe coping skills from Phase One and to introduce new SS topics to complement the learnings from the Step Assignment work (for example the Seeking Safety topic on Creating Meaning). Seeking Safety topics may be held in response to issues or concerns that arise during this phase of treatment, for example staff may hold a Seeking Safety Workshop on Honesty if they are observing dishonest behaviour within the group or a

Workshop practising Grounding skills if participants are struggling to cope with intense emotions while completing and sharing their Step Assignments.

1.7.3 Phase 3 – Seeking Safety in Relapse Prevention Planning (SS in RPP)

This phase of the programme employs a Seeking Safety approach to aid participants in identifying and managing personal risk factors associated with a return to drug use and re-offending on release. This is facilitated via the following:

- A thorough review of skills learned in Phase One and Two of the programme (including Seeking Safety skills and Cross-Addiction Assignment which the participants at HMP Send report to be particularly crucial in their RPPs)
- The development of an individualised Relapse Prevention Plan that takes into account a range of demographic and personal risk factors associated with long term prognosis. This plan is developed via a set of Seeking Safety Workshops that are of particular relevance to Relapse Prevention Planning (e.g. Red and Green Flags, Recovery Thinking, Commitment, Setting Boundaries in Relationships, Getting Others to Support Your Recovery and Respecting Your Time) and are reviewed in individual counselling sessions.
- Emphasis on the importance of continued attendance at NA/AA meetings throughout the remainder of participants' sentences and post-release.

1.8 The 12 steps of NA and AA

Based on their own experiences of achieving recovery from alcoholism, the originators of Alcoholic Anonymous, Bill Wilson and Bob Smith, identified 12 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 12 steps below are those used in NA, which are the same as the 12 steps used in AA save for the substitution of the words ~~o~~ur addiction" for ~~a~~lcohol" in the first step.

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 practisethese principles in all our affairs.***

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

2.1 Selection

The programme is aimed at adult females who meet the following criteria:

- medium-high risk of re-offending (as defined by the sentence planning risk predictor);
- a history of drug dependence (as defined by DSM-IV-(R));
- drug dependence as a significant risk factor for re-offending;

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 OASys). However, offenders with a lower risk score are accepted where places are available.

The WSDTP is an abstinence-based programme aimed at offenders with a history of drug dependence, as defined by DSM-IV(R). It is not intended for those with a history of problematic drug use only, nor for those whose history of dependence relates to alcohol only. Priority is given to those with a history of dependence on more than one substance (including alcohol).

Where someone has been assessed as meeting the DSM-IV(R) criteria for drug dependence, their dependence will be assumed to be a significant risk factor for re-offending even if it was not a factor in any of the offender‘s previous crimes (if, for example, drug use escalated since imprisonment). 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 CSAP as ‘general offender dynamic risk factors’. As such it would be expected to be of value for someone even where dependence on drugs was not a primary factor in their previous offending histories.]

2.2 Exclusion

Female 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
- Would be using methadone as an opiate substitute if admitted to the programme
- 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 woman who applies for the programme will be assumed to have sufficient levels of motivation to participate, and as detailed in the *WSDTP Phase One Facilitators' Guide*, Phase One of the programme contains a motivational enhancement component and a motivational interviewing style is adopted throughout treatment (see Section Nine of the *WSDTP Introduction and Overview Manual*).

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The *WSDTP Management Manual* and *Assessment and Evaluation Manual* between them provide further details of and the rationale for the selection and exclusion criteria used by the programme and explains how these are applied in practise (including detailing the psychometric measures used).

Care is taken to ensure that people are not unfairly disadvantaged in this regard on the basis of their background, and admission data are analysed to monitor the programme's success in this (the *WSDTP Assessment and Evaluation Manual* and *Management Manual* provide further detail).

2.3 Monitoring diversity

All WSDTP facilitators are trained in issues of diversity. The programme is monitored to ensure that potential participants are not discriminated against on the ground of the type of offences they have committed, race, ethnicity, religion, gender, disability, sexuality or age.

All assessment documents of participants accepted and those deemed to have not met the selection criterion are regularly reviewed by the Treatment Manager. The reasons for exclusion are checked for compliance with the programmes 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.

The WSDTP database holds information on the ethnic origins of all referrals onto the WSDTP. Selection and retention of participants from different ethnic groups is regularly reviewed. Additionally, the Participant's Feedback Forms (see section 9.8 of this application) seek information on the ethnic origins of participants to allow monitoring of the perceptions of the quality and helpfulness of the programme amongst different ethnic groups.

2.4 De-selection

Breaches of the WSDTP'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
- Final Written Warning
- Lay-down
- 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 should only be considered when the participant has repeatedly breached the programmes Rules and Expectations, and has progressed through the programme's warnings and lay-down procedures.

De-selection should always be considered a last resort when all efforts to engage and motivate the participant to meet the WSDTP's Rules and Expectations have proved unsuccessful.

An exit session must be held between the participant, her Focal Counsellor and the Throughcare Manager. Gains made whilst on the programme should be discussed, unmet needs identified, and treatment options explored. See the *WSDTP Introduction and Overview Manual* and *Management Manual* for further detail on the de-selection procedures.

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
- Offending behaviour linked to substance dependence

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
- Poor problem solving
- Deficits in decision making
- Lack of assertiveness
- Poor pro-social interpersonal skills
- Deficits in emotion 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
- Relationships with physically or emotionally abusive partners
- Relationships with partners who encourage offending

3.2 Factors targeted in relation to drug/alcohol abuse and dependence

In seeking to address drug and alcohol problems the WSDTP targets a range of underlying factors relevant to substance misuse (according to evidence presented in the *WSDTP Theory Manual*), a number of which overlap with the dynamic risk factors (identified by CSAP) for re-offending targeted by the programme:

- Weak social support systems for tackling substance use
- Strong social pressure to misuse substances or drink alcohol
- High impulsivity
- Poor problem solving
- Deficits in decision making

- Lack of assertiveness
- Poor pro-social interpersonal skills
- Deficits in emotion management
- Weak commitment to remaining abstinent
- 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
- Relationships with physically or emotionally abusive partners
- Relationships with partners who encourage drug/alcohol use
- Difficulty in coping with cravings

3.3 Evidence concerning appropriateness of factors targeted by the programme

The majority of the dynamic risk factors for re-offending which are targeted by the programme have been recognised as appropriate targets for interventions by the CSAP. ~~"~~Relationships with physically or emotionally abusive partners" and/or ~~"~~relationships with partners who encourage offending or drug/alcohol use" are the only targeted risk factors for re-offending not specifically identified by the CSAP. They were included due to strong empirical evidence of their relevance and significance for female offenders. In addition to the dynamic risk factors for re-offending addressed in the programme, further factors associated with an increased risk of relapse have been identified in the literature. These additional 'risk factors' for relapse have also been addressed in the programme on the basis that an increased risk of relapse can in turn lead to an increased risk of re-offending, as recognised by CSAP. Evidence demonstrating the appropriateness of these and all the other factors targeted by the WSDTP is presented in the *WSDTP 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 admission and completion. Details of these assessments are provided in the *WSDTP Assessment and Evaluation Manual* and further information about methods of measuring treatment effects is provided in Section 10.3 of this Application.

3.5 How the target factors are addressed by the programme

Details of how each of the targeted risk factors is addressed by the Women‘s Substance Dependency Treatment Programme are provided in Section 1.3 of this manual.

3.6 Meeting additional needs

Details of how the Women‘s Substance Dependency Treatment Programme addresses participants‘ additional needs are provided in Section 1.5 of this manual.

4.1 Methods used to address factors targeted by the programme

The programme uses 12-Step, Seeking Safety, Motivational Enhancement and Motivational Interviewing methods to address the factors it targets.

Phase One comprises ongoing attendance at AA/NA meetings, one Intake and Orientation session, one MET session, two sessions of individual counselling, and eight Seeking Safety Skills Workshops. It focuses on motivational enhancement, and on teaching self-care, emotion management, trauma-symptom management, assertiveness, and interpersonal skills. This phase is run over a period of two and a half to three weeks.

Phase Two is in essence a 12-week 'Primary Phase' focusing on taking participants through the first five of the 12 steps of AA/NA recovery. It comprises: Group Therapy; Step Reading Groups; Community Meetings; Speaker Meetings; Video Sessions; Assignment Sessions; Educational Sessions and Step Lectures; Peer Evaluations; Goals Groups; Seeking Safety and other Workshops; Graduations; Significant Events Sheets; Meditation and Wind Downs; and individual counselling (held fortnightly).

Phase Three comprises two individual counselling sessions and six Seeking Safety in Relapse Prevention Planning Workshops of group work focused on developing individualised Relapse Prevention Plans. It is run over a period of three to four weeks.

Further details of the methods employed on the programme and how they are integrated with one another are provided in the *WSDTP Facilitators Guides* for each phase while the *WSDTP Theory Manual* details how these methods are believed to contribute to addressing the factors targeted by the programme.

4.2 Meeting individual needs and responding to diversity

Details of how the Women‘s Substance Dependency Treatment Programme addresses individual needs and diversity is provided in Section 1.4 of this manual.

4.3 Evidence of effectiveness

There is a growing evidence base which suggests that 12-step treatment in general and the WSDTP in particular is likely to be successful in addressing many of the underlying factors

targeted by the programme and lead to significant reductions in both substance misuse and re-offending after release.

[Note: Empirical evidence regarding the effectiveness of the treatment models, methods and interventions used by the WSDTP to address risk factors is presented and discussed in detail in Section Six of the *WSDTP Theory Manual*, entitled ‗Evidence Relating to Effectiveness.']

4.3.1 MET

Motivational Enhancement (MET) is one the most carefully developed and rigorously studied brief therapeutic interventions for substance use (Miller and Rollnick, 1991; Ball et al., 2006; Carroll et al., 2004; Hettema et al., 2005). There is a substantial body of research demonstrating that MET sessions like the one conducted in the WSDTP lead to significant improvements in the underlying factors of participant motivation and self-efficacy. The magnitude of this effect has been found at levels comparable to those resulting from several times as many cognitive behavioural (CBT) sessions (Project MATCH; Burke et al. 2003; Dunn et al. 2001). 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. 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. MET is also rare in that it is an intervention whose efficacy among women participants and among offenders when used as a ―primer" preceding intensive 12-step treatment has been studied and empirically supported.

4.3.2 Style of treatment delivery

Evidence supporting the use of a Motivational Interviewing style of session delivery is reviewed above (section 4.3.1). 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. 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). Research reviews examining disparate primary studies have concluded that the evidence consistently and reliably shows that this methods is effective for enhancing understanding, memory and treatment engagement (Dansereau, 2005, & Simpson, 2004). 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). A study by Pitre et al. (1998) supports the effectiveness of NLM in prison drug treatment settings in terms of treatment retention, engagement and self-reported progress towards recovery-based goals.

4.3.3 Seeking Safety

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). Substance abuse is often viewed as a form of self-medicating to alleviate or control overwhelming emotional pain. It is important to treat substance abuse and trauma symptoms simultaneously because treating one does not reduce the other, rather some trauma symptoms become worse with abstinence (Brady, Killeen, Saladin, Dansky and Becker 1994; Kofoed et al. 1993, Root 1989). Integrated treatment is therefore more likely to maintain engagement and motivation for abstinence.

SS was developed in the early 1990‘s 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). Seeking Safety is grounded in CBT, which has been extensively researched and is generally accepted as an effective approach for addressing skills deficits. Seeking Safety is more specifically tailored for female offenders, with interventions designed specially to target underlying factors which significantly impact this population.

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.our controlled trails 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.

Hien et al. (2004) compared urban low-income women participating in Seeking Safety with those in traditional CBT treatment. All subjects were substance dependent and had trauma histories (88% met DSM-IV criteria for current PTSD), with the groups matched for symptom and substance use severity. This sample‘s clinical profile was markedly similar to that of female offenders (in particular in the analysis of the WSDTP pilot programme at HMP Send 89% of women reported having experienced trauma pre-treatment). With regard to substance use, Seeking Safety was found to be slightly, but not significantly, more effective than CBT at six- and nine-month follow ups. With regard to trauma symptoms, psychiatric symptoms and coping skills, the Seeking Safety group showed significantly more improvement at both six and nine months post-treatment follow-ups. Zlotnick et al. (2003) studied female prisoners engaged in 12-step treatment with supplemental Seeking Safety sessions; they found that Seeking Safety led to significant improvements in prisoners‘ coping skills and functioning with accompanying reductions in trauma symptoms.

4.3.4 12-Step/Primary Phase

Despite its origin as a self-help movement and the non-professional stance of NA, the 12-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. The effectiveness of 12-step facilitation in the UK context received support from the National Treatment Outcome Research Study (NTORS), in which twelve-step residential treatment centres made up approximately half of the residential units included in the study. Residential centres, including those using 12-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 four to five year follow-up period (Gossop et al., 2008).

Finney et al. (1998) carried out a study of the clinical impacts of a variety of therapeutic approaches to tackling both drugs and alcohol misuse, including twelve-step treatment. They did not look at the impacts of treatment on all of the substance misuse-related factors targeted by the WSDTP, but their findings were consistent with twelve-step treatment leading to improved motivation to change and more realistic appraisals of the costs and benefits of substance misuse, increased self-efficacy in relation to change, improved general coping skills (including in relation to social problem solving and managing 'negative emotions'), and improved and more extensive relapse prevention strategies. They also found that clients were more likely to attend AA/NA after treatment and had developed more extensive social support for their commitment to tackle their substance misuse. In addition, the researchers found that the clinical impacts of twelve-step treatment were at least as marked in all of these areas as those of CBT. A large-scale prospective cohort study by Moos et al. (1999) found

that substance dependent participants who completed 12-step treatment had superior abstinence outcomes with regard to both illicit drugs and alcohol than those in CBT treatment. Humphreys et al. (1999) obtained similar results and highlighted that those in twelve-step treatment were more highly involved in 12-step groups.

Morojeje and Stephenson (1992) examined the impact of twelve-step treatment on clients' beliefs and attributions and found that treatment was associated with, among other things, increased commitment to change, enhanced self-efficacy in relation to change and more positive beliefs about the benefits of change, as well as reduced self blame and guilt.

Steigerwald and Stone (1999) found that twelve-step treatment led to significant improvements in pro-social attitudes and beliefs, one of the WSDTP's targeted dynamic risk factors. In analysing the data from Project MATCH, which compared treatment outcomes among alcoholics for twelve-step treatment with those for CBT and Motivational Enhancement Therapy (see below for more details), Longabaugh et al. (1998) found that twelve-step treatment, with its emphasis on links with the abstinence-supportive network of AA, was particularly effective (and more effective than CBT and MET) at helping to tackle strong social support and/or pressure for continued drinking (for a review, see Kelly, 2003). This makes it a particularly appropriate intervention for female prisoners, who suffer from especially low levels of social support and often enter treatment enmeshed in anti-social, drug-based social networks and relationships (Del Boca and Mattson, 2001; see Section Three of the Theory Manual). Women in Project MATCH attended more meetings and reported higher levels of integration, benefit and involvement in AA than men, supporting the view that the twelve-step approach and twelve-step fellowship are likely to prove even more suitable for addressing risk factors associated with social identification and support among female than among male offenders (Del Boca and Mattson, 2001).

The *WSDTP Theory Manual* provides a strong theoretical justification for supposing that incorporating MET and Seeking Safety's CBT-based elements would be expected to strengthen these (and other) impacts, a claim which is given at least some indirect empirical support from research showing improved substance misuse outcomes for 12-step programmes which include elements drawn from other approaches (Fiorentine and Hillhouse, 2000).

4.3.5 12-step affiliation

The recent NICE guidelines reviewed evidence for the effectiveness of 12-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.

Seven studies met the NICE criteria for inclusion: two randomised controlled trials (McAuliff, 1990, Timko et al., 2006), two cohort studies (Moos 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).

Results from NTORS support the conclusions reached in the NICE guidelines. Clients who attended 12-step meetings after treatment were more likely to be abstinent at all follow-up points when compared with non-attendees or those who attended infrequently (Gossop et al., 2008).

Impact on substance misuse and offending behaviour

Through its effect on participants‘ motivation, self-efficacy and treatment engagement, the MET session in Phase One enhances treatment retention and participants‘ commitment to abstinence and avoiding re-offending. Its effects on substance use and offending behaviour may thus be significant but indirect.

CBT programmes have been shown to be effective at tackling drug dependence (*cf* Carroll, 1996). Seeking Safety in particular has been found to reduce substance use in female offenders. This reduction, combined with the effects of Seeking Safety treatment on trauma/psychiatric symptoms and coping skills (detailed above), is likely to have a significant impact on participants‘ offending behaviour both directly (reducing drug-related crime and pro-criminal social/relationship pressure) and indirectly (through changes in attitude, management of personal risk factors and generally improved functioning). Seeking Safety sessions also provide participants with skills which enable them to engage more deeply and effectively in the WSDTP‘s Primary Phase of the programme, thereby deriving correspondingly greater benefit from treatment.

In the last decade, empirical investigations have consistently shown 12-step treatment to be one of the most effective interventions for substance use. In a review of fifteen separate studies, Ouimette et al. (1997) compared outcomes for twelve-step treatment with CBT and 'eclectic treatment' (drawing on both twelve-step and CBT principles) for a subject group made up of people with drug and/or alcohol problems. They found that subjects undergoing

twelve-step treatment, either on its own or in conjunction with CBT, had more positive substance misuse outcomes overall than those receiving CBT only.

Project MATCH (1997) was one of the largest clinical trials ever conducted which investigated the efficacy of different treatments for alcohol dependence. One-year outcomes showed that twelve-step treatment was more effective than CBT or Motivational Enhancement Therapy. At three-year follow-up, subjects who had received twelve-step treatment were significantly more likely to be abstinent and had significantly lower levels of alchol use and related problems than those in the two other treatment groups (Project Match, 1998). While Project MATCH focused only on alcohol dependence, other research (including the Ouimette study above and another large multi-site controlled trial, the Collaborative Cocaine Treatment Study, by the National Institute of Drug Abuse and presented in Crits-Christoph et al., 1999) supports the conclusion that twelve-step treatment leads to significantly reduced levels of dependence and is equally or more effective in this regard than CBT.

These findings are further corroborated by the more recent NTORS study which found that UK residential centres, including those using 12-step facilitation, were found to be effective in reducing most forms of drug use at five year follow up (Gossop et al., 2008).

There is considerable evidence that successful treatment of drug dependence can lead to dramatic reductions in offending, both in community settings (*cf* Gossop et al., 1998) and in prisons (Lipton, 1998), while Turnbull and Webster (1998) found a two year reconviction rate for prisoners on a residential drug free unit run on twelve-step principles of 40%, significantly lower than for a matched control group.

In addition to this, three studies of RAPt‘s twelve-step primary programme (Player and Martin, 1996; Martin & Player, 2002; Liriano, 2002) found significant overall reductions in drug use and infringements of prison rules while in custody among those who were admitted to the programme, as well as significant reductions in post-release drug use and offending behaviour among programme graduates. One-year post-release reconviction rates were 25% for programme graduates, significantly lower that the 38% found in the matched comparison group (Martin, Player and Liriano, 2003). Although these studies only examined the efficacy of RAPt‘s programme for male offenders, there is evidence to suggest that interventions which are effective in men, such as the core primary programme model, are likely to be effective for women as well—so long as women‘s particular needs are also addressed, as they have been by the WSDTP.

An analysis of the pre and post psychometric measures on the WSDTP pilot reveal promising early results that support the programme‘s effect on the main dynamic risk factors it aims to address. The analysis focussed on the programme‘s impact on a range of psychometric measures which have been reliably shown to predict long-term post-treatment outcomes (including lower relapse rates and rates of recidivism). Programme completers were found to improve significantly more than programme non-completers on measures of self-efficacy, social problem solving, general attitude to crime, victim awareness and anticipation of re-offending. Importantly it was found that non-completers‘ motivation dropped significantly and, although the finding fell short of significance, completers‘ motivation was sustained. As the study is not a random comparison the results are not conclusive but are a strong preliminary indication that the programme effectively targets the range of criminogenic risk factors recognised by the Correctional Services Accreditation Panel (CSAP).

In addition Section Six of the *WSDTP Theory Manual* presents recent evidence that women are just as likely to benefit from 12-step treatment as men, particularly from extended NA/AA affiliation give their chronic lack of social support.

Taken together, all of these studies between them suggest that a well run twelve-step treatment programme for prisoners with a history of drug dependence is likely to lead to significant reductions in both drug use and offending behaviour after release. As already noted, there is also good reason to suppose that the tailoring of the WSDTP to the particular needs and risk factors most relevant to female offenders will enhance the programme's impact on substance misuse and re-offending. This position is supported, at least in relation to substance misuse outcomes, by research into the additive effect on substance misuse of combining other treatment approaches both within a twelve-step framework (Fiorentine and Hillhouse, 2001) and with regards to addressing multiple areas of need (reviewed in Najavits, 2002).

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 poor self-care
- 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 difficulties coping with cravings and trauma symptoms.

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, while 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 detailed in the *WSDTP Theory Manual* and summarised in this manual in Sections One, Three and Four (sub-section three).

5.3 How these skills deficits are addressed

These skills deficits are addressed in Seeking Safety Skills Workshops throughout treatment,,(most predominantly in Phase One and Three) which is complemented and reinforced through on-going engagement with AA/NA as detailed in the *WSDTP Theory Manual* and summarised in this manual in Sections One and Three.

5.4 Addressing additional skills deficits

Where possible (for example at HMP Send where the programme is being piloted) education sessions will be provided within the prison to complement the skills learned on the programme. Comprehensive throughcare arrangements, linked to the Relapse Prevention Planning process in Phase Three of the programme, help to ensure that additional skills deficits not addressed by the WSDTP are addressed outside the programme (such as through education and vocational training).

6.1 Standard sequencing, intensity and duration

The Women's Substance Dependency Programme comprises three distinct phases—Phase One (Seeking Safety), Phase Two (Primary Phase), and Phase Three (Seeking Safety in Relapse Prevention Planning). Participants are expected to undertake a considerable amount of assignment work out of core programme hours. The nature of the cell work is documented in the *WSDTP Facilitators'* and *Participants' Guides* for each phase. In addition, participants are expected to participate in AA/NA fellowship meetings throughout treatment and afterwards.

6.1.1 Phase One

Phase One comprises on-going attendance at AA/NA meetings, an Intake and Orientaton session, one MET session, eight Seeking Safety skills Workshops, two to three Step Lectures and two to three Workshops with the Primary Group and two sessions of individual counselling. The first individual counselling session is held in the first week of Phase One and the second is held in the last week. During this phase, participants complete the Intake and Orientation and MET sessions, followed first by the Seeking Safety Workshops. Participants also begin to complete daily Significant Events Sheets (SES) in this phase.

Phase One would be expected to typically take around two and a half to three weeks in total to complete.

6.1.2 Phase Two

Phase Two has at its core a 12-step 'Primary Programme' comprising: Group Therapy; Step Reading Groups; Community Meetings; Speaker Meetings; video sessions; Step Assignment sessions; educational sessions and Step Lectures; Peer Evaluations; Goals Groups; Seeking Safety and other Workshops; Graduations; Significant Events Sheets (SES); Meditation and Wind downs and individual counselling sessions.

Phase Two typically lasts 12-14 weeks overall, though this may be extended for some participants where their counsellors feel this would be appropriate. This is a rolling programme which participants can join at any time (subject to their being a space available).

6.1.3 Phase Three

Phase Three comprises six two-hour Seeking Safety in Relapse Prevention Planning (SS in RPP) Workshops of group work and two 60-minute sessions of individual counselling focused on Relapse Prevention Planning and reviewing key skills from the previous two phases of the programme. Phase Three begins with the first session of individual counselling. Participants then undertake the six SS in RPP Workshops, followed by the final individual counselling session.

Phase Three would typically be expected to take around three to four weeks in total to complete.

6.1.4 Ongoing NA/AA attendance

Participants are expected to attend regular AA/NA meetings during the programme and for the rest of their sentence, if possible at least once a week. They are also expected and encouraged to engage with AA/NA after release, attending meetings daily if possible for at least the first 90 days post release, and having regular contact with an AA/NA sponsor.

6.2 Adapting to the individual

Fortnightly individual counselling, individualised treatment plans and daily Significant Events Sheets and Diaries enable consistent monitoring of participants‘ well-being and progress, providing scope in each case for counsellors to address each participant‘s unique needs and problems. Where a participant is particularly struggling—for example, with treatment issues, life problems, self-destructive behaviours 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. Where necessary, provision is made for participants to 're-take' elements of Phase One and/or to remain on Phase Two longer than the standard twelve weeks. See Section Seven of the *WSDTP Introduction and Overview Manual* for details of how the programme addresses literacy difficulties.

6.3 Evidence that intensity and duration are sufficient to achieve sustained change

The WSDTP has been developed specifically to meet the needs of female offenders. Each intervention incorporated into the programme 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, as detailed in Section Six of the *WSDTP Theory Manual.*

Motivation is assessed pre-treatment via the use of the University of Rhode Island Change Assessment (URICA). This measure is used to gauge motivation by identifying participant's position within the transtheoretical conception of the ~~-~~cycle of change" (pre-contemplation, contemplation, action or maintenance). The results of this assessment are not used to assess suitability, but simply as a guide to the level of work the offender will need to undertake in Phase One in order to enhance her motivation and engagement.

The Intake and Orientation session in Phase One employs a Motivational Interviewing style and aims to enhance motivation, self-efficacy and engagement in treatment. Since attrition rates and relapse among female offenders can be linked to motivation and self-efficacy, the MET session in Phase One has been included to address ambivalence, strengthen self-belief and minimise attrition. The rationale for this approach is based on research suggesting that an MET session conducted pre-engagement in an intensive twelve-step treatment programme can significantly increase retention rates (Miller et al., 1997). Additional MET sessions may be held in Phase Two (at least once in a weekly Workshops slot) if staff observe a decline in participants' motivation for treatment, particularly if they are finding the step work challenging.

The rolling nature of Phase Two ensures that new entrants are exposed to peers who have progressed within the programme. Such peers are able to provide positive role modelling to new participants, thereby enhancing motivation. Of particular importance to female offenders, peers who have been able to successfully engage with the treatment programme provide new entrants with hope that change is possible for them too, thereby enhancing self-efficacy.

Motivation is further developed by the assignment of a focal counsellor who is responsible for ensuring that needs associated with the participant's age, life experiences (including any past trauma), ethnic background, learning style and relationship or family problems are adequately addressed. Individual counselling sessions are provided weekly throughout Phase Two of the programme and use Motivational Interviewing techniques to continue strengthening and sustaining motivation and engagement.

Attendance at 12-step NA/AA meetings provides an opportunity for participants to engage with women who have successfully completed the WSDTP. Additionally, they will have access through such meetings to women who have been abstinent from drugs and alcohol for significant periods of time. Attendance at 12-step meetings aids retention and motivation

by providing positive peer modelling and support. 12-step fellowships also offer participants a ready-made social support network supportive of the changes they are making. This is important for female offenders, who typically lack positive social networks.

The weekly Community Meeting is open to all facilitation and prison staff with whom participants are in contact. By providing a forum within which all staff involved in the welfare of the participants can air concerns and gain information on the progress of participants, pro-treatment attitudes are encouraged amongst all grades of staff. Additionally, training courses designed to provide insights into the aims and philosophy of the WSDTP assist in the development of pro-treatment attitudes amongst discipline staff.

Retention rates in the WSDTP have ranged from 60—85%. There is research evidence suggesting that addressing self-destructive behaviours and trauma symptoms early in treatment through Seeking Safety skills training has a significant positive impact on women's ability to engage and remain in treatment (see Section Six of the Theory Manual). The current programme manual has introduced a number of significant improvements that RAPt believes will enhance retention rates. On the basis of the evidence presented in Section Four of this manual and Section Six of the *WSDTP Theory Manual,* incorporating the Seeking Safety treatment methodology across all phases of the programme is likely to decrease the risk of destructive behaviours and relapse. Node-link mapping, in some cases used in similar contexts to the WSDTP, has been shown to be associated with higher retention rates and treatment engagement (Dansereau, 2005, & Simpson, 2004; Pitre et al., 1998)

Participants who fail to complete all elements of the WSDTP receive both an exit interview and a detailed report on gains made whilst on the programme. The views expressed by participants have informed the proposed increases in counselling sessions whilst undertaking the twelve-step treatment programme and have informed the development of the MET and Seeking Safety elements of Phase One, the continuous use of the Seeking Safety approach throughout all phases of treatment, as well as the provision of ongoing Group Therapy sessions during Phase Three.

The Women's Substance Dependency Treatment Programme is integrated into the overall management of the offender via the sentence planning process.

All participants undertake a CARATs comprehensive assessment prior to entry into the WSDTP. Regular reviews of progress throughout their time in treatment are facilitated through individual focal counselling sessions and staff team meetings.

The Throughcare Manager is viewed as an integral part of the offender's case managemet and attends monthtly AIM meetings as detailed in the *WSDTP Management Manual*. They are thereby kept aware of educational, trauma counselling, housing, health, family or any other post-programme needs identified by the treatment team. 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 the WSDTP. Demographic and personal risk factors that may impact on long-term prognosis form the basis of case conference discussions.

Key personnel involved in ensuring the continuity of post-programme goals are invited to a Post Programme Review meeting within four weeks of participants' completion of Phase Two. 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 programme review are sent to:

- CARATs
- Participant's focal counsellor
- Probation internal/external
- Personal Officers
- Participant
- Other relevant personnel

Prior to the review meeting, a 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 abuse or trauma-related symptoms that require more specialised counselling, unresolved domestic violence situations at the end of a participant's sentence, parenting concerns 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 her sentence and post-release.

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

- Additional treatment needs and links to other service providers (e.g. for trauma symptoms and/or mental health issues)
- Family network and social support network
- Relationship and/or domestic violence risks
- Accommodation post-release
- Relapse Prevention Plan
- Risk of a return to dependency and offending

The Throughcare Manager will monitor the implementation of the post-programme action plan and will continue to check the progress of the offender for a period of at least twelve weeks post-completion. 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 the *WSDTP Management Manual.*

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

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

9.1 Participants selection and exclusion criteria

The selection/exclusion process is detailed in the *WSDTP Management Manual*. Further information is already provided in Section Two of this manual. Monitoring compliance with WSDTP selection and exclusion processes and procedures is the responsibility of the Treatment Manager. This is undertaken through regular examination of all programme documentation.

9.2 Monitoring diversity

The ethnic mix of programme participants is 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 WSDTP, measures would be implemented to encourage referrals from the under-represented ethnic group.

9.3 Facilitators maintenance of programme integrity

The process of selecting facilitators is detailed in the *WSDTP 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 record

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 RAPt Area Manager 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 assessment of the WSDTP using the standard document (details of this documentation will be provided in the *WSDTP Management Manual).*

9.5 Programme delivery

Whilst many elements of the WSDTP are didactic and therefore easily represented in the *WSDTP 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 WSDTP can therefore be effectively monitored.

Compliance with the *WSDTP Programme Manuals* is monitored to ensure that all sessions are delivered in a sequential order and that the programme content reflects that which is specified in the *WSDTP Facilitators' Guides* for each phase. Furthermore, monitoring systems ensure that the ethos of the 12-step approach is being maintained throughout all phases of the WSDTP. 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:

- Care Plans
- Case notes
- Individual counselling schedule and record

9.7 Throughcare/aftercare

All offenders attending the WSDTP will have been assessed by CARATs and will have an assigned CARAT worker in order to ensure consistency and continuity of post-programme plans. The setting and achievement of post-programme goals is ensured through the following processes:

- Post-programme review with: Focal counsellor, Throughcare Manager, CARATs, Supervising Probation Officers and other personnel.
- Post-programme reports
- Monitoring process to map a participant‘s progress through the WSDTP
- De-selection interviews to ensure unmet needs are identified, and other treatment options explored

9.8 Participant feedback

Significant Events Sheets (SES) are completed daily and require each participant to self-report her evaluation of changes in her behaviours and attitudes. SES 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 forms are provided in the *WSDTP Facilitators' and Participants' Guides* and in the *WSDTP Assessment and Evaluation Manual.*

Participants are asked to evaluate their experiences of the WSDTP on completion of each phase of the programme. Participant Feedback Forms relating to each phase are provided to participants for this purpose. 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. A copy of the participants‘ feedback forms are provided in the *WSDTP Assessment and Evaluation Manual.*

Three separate studies of RAPt's twelve-step primary progamme's effectiveness among male offenders have already been conducted, which between them have provided strong evidence that the core Primary Phase of the programme does lead to reductions in drug use and offending behaviour both in custody and after release. For more details of the studies and their findings see Martin and Player (2000); Liriano (2002); and Martin, C., Player, E. & Liriano, S. (2003). Results of evaluations of the RAPt drug treatment programme can also be found in Ramsey (2003) and online at www.homeoffice.gov.uk/rds/pdfs2/hors267.pdf.

However, these evaluations related to an earlier version of the programme designed for male prisoners. The WDSTP was developed for women prisoners and incorporates several new and distinct elements. While each element has been empirically evaluated and found to be effective for women prisoners (see the WSDTP Theory Manual), the WSDTP as a whole has only recently been developed. The importance of monitoring its effectiveness is recognised, and ongoing evaluation will provide more detailed information about its effectiveness.

10.1 Monitoring referrals

The ethnic mix of all referrals onto the WSDTP are 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 (which are identified in the *WSDTP Management 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 substance use and offending after release for those who complete it, 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, and for each phase separately, together with data on reasons for non-completion (drop-out, discharged at staff request, transferred out, other) are routinely collected by treatment managers and forwarded to RAPt Central Office.

10.3 Measuring impact on underlying factors targeted by the programme

The programme seeks to address a range of underlying factors related to drug use and offending behaviour among female offenders (see the *WSDTP 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) are administered prior to treatment and then re-administered on completion of the programme. This provides a measure of within-treatment change in relation to a range of factors targeted by the programme.

The outcomes of the recent analysis of pre and post-psychometric scores for the WSDTP provide an early indication that the programme is capable of impacting upon its target risk factors (see the *WSDTP Theory Manual* for further detail). Participants' pre- and post-treatment scores on these measures will continue to be collected locally and passed to RAPt Central Office, where they will be analysed and written-up on an annual basis.

The *WSDTP Assessment and Evaluation Manual* provides details of all the psychometric scores measured before and after programme completion or drop-out. This includes justification for the use of each measure and its ability to predict the impact of the programme upon outcomes for relapse and re-offending.

As noted in the WSDTP Assessment and Evaluation Manual 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 battery of psychometric measures 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).

In spite of these caveats, positive changes in participants' psychometric scores would suggest that the WSDTP has a positive impact on several of the key factors it targets.

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

Should the WSDTP impact drug-consumption and offending behaviour to the extent expected, programme graduates will have fewer positive drug tests and Governor‘s reports following treatment than before. The average monthly rate of positive drug tests and guilty adjudications on Governor‘s reports for WSDTP graduates will therefore be compared with their average monthly rates in the six to twelve months before they entered treatment.

Drug test and adjudication data will be collected locally and passed to RAPt Central Office where they will be analysed and written up on an annual basis.

Fewer in positive drug tests and guilty adjudications cannot prove commensurate reductions in actual drug use and institutional offending nor demonstrate causal links between any real reductions and treatment participation. However, strong associations between treatment completion and apparent reductions would at least suggest the existence of such a link and support the view that participation in the WSDTP reduces offenders‘ substance use and offending behaviour.

10.5 Measuring change in offending behaviour

The ultimate aim of this, and all offending behaviour programmes, is to reduce re-offending. As such, as part of an on-going evaluation of all CSAP accredited programme, reconviction rates of those women who complete the WSDTP are monitored by the Research, Development and Statistics Directorate in the Home Office and compared with those of an untreated control group.

Although lower than expected rates of reconviction would not necessarily establish the programme‘s efficacy in reducing offending behaviours they 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, participants are asked to complete Participant Feedback Forms.

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 responsivity to issues of diversity

The *WSDTP Introduction and Overview Manual* details 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.

Likewise, to measure the success of steps taken to ensure that offenders are not disadvantaged on 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 written up annually by RAPt Central Office.

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