

**University of Bradford**

**Alcohol misuse and coercive treatment: exploring  
offenders' experiences within a dialogical framework**

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## Abstract

In the UK there has been growing concern about the relationship between levels of alcohol consumption and offending behaviour. The Alcohol Treatment Requirement (ATR) was introduced to the UK in 2007 and was piloted in a District in the north of England in July 2007. The ATR is a coercive form of treatment delivered jointly by the probation service and the National Health Service (NHS) and was funded by the NHS. The ATR centres on supporting offenders to cease their offending behaviour and reduce or end their alcohol misuse. Two female alcohol treatment workers have been appointed to specifically deliver the ATR. Therefore this study aimed to investigate the delivery of the ATR, and more specifically, aimed to explore what impact the ATR might have in relation to positive behaviour change and rehabilitation for offenders with alcohol problems.

In order to meet the expectations of producing 'outcome' data for the NHS funders, and in-depth theoretical data worthy of an academic PhD, this research took a pragmatic methodological approach which enabled different social realities of the ATR to be explored. To this end, a mixed methods design was employed involving quantitative and qualitative data collection methods. The data for this research was generated in three phases with Phase One aiming to explore quantitatively the characteristics, impacts and outcomes of those sentenced to the ATR. This phase revealed that the ATR is being delivered to predominantly young, male, alcohol dependent, violent, persistent offenders. This analysis further revealed that the ATR was effective in bringing about positive treatment outcomes and in reducing reoffending. In order to explore further *how* this positive change was occurring, Phase Two consisted of qualitative participant observations of the treatment interaction involving the female alcohol treatment workers and the male offenders. By drawing on positioning theory, the analysis considered the complexity of the gendered interactions that occurred during these encounters. It was found that the two female alcohol treatment workers resisted positions of 'feminine carer' offered up by these young men in order to occupy positions of control. Indeed this analysis provided great insight into the constant flow of negotiations and manoeuvring of positions that occurred between the alcohol treatment worker and the offender, argued to be vitally important in working towards positive behaviour change. During Phase Three ten offenders were interviewed in order to explore through a dialogical lens (Bakhtin, 1982) how they constructed and experienced treatment on the ATR. In exploring the offenders' stories dialogically, the analysis highlighted how the ATR was enabling, in that it offered a 'space' for these offenders to engage and internalise a dialogue that draws on the authoritative voice of therapy. Therefore it was revealed that through dialogue with the 'other', offenders were able to re-author a more 'moral' and 'worthy' self. Moreover, the ATR has been found to be successful in enabling the offenders' hegemonic masculine identities to be both challenged and protected as a result of the multilayered interactions that occurred during these treatment encounters. This research therefore concludes that coercive treatment, rather than being a concern, should be embraced as a way of enabling change for offenders with alcohol problems. Furthermore, this research has highlighted the value of the relational aspect of treatment in bringing about positive behaviour changes. Finally this research has shown that community sentences offer a more constructive way of engaging with offenders than those who receive a custodial sentence.

## Table of contents

|  |             |
|--|-------------|
| <b>ABSTRACT .....</b>  | <b>I</b>    |
| <b>LIST OF TABLES AND FIGURES .....</b>  | <b>VII</b>  |
| <b>ACKNOWLEDGEMENTS .....</b>  | <b>VIII</b> |
| <b>CHAPTER 1: ALCOHOL CONSUMPTION: CONTEXT AND CONSEQUENCES IN THE UK.....</b>             | <b>1</b>    |
| <i>Introduction .....</i>  | <i>1</i>    |
| <i>Alcohol ‘use’ and ‘abuse’ .....</i>   | <i>2</i>    |
| <i>Levels of alcohol consumption in the UK .....</i>                                       | <i>3</i>    |
| <i>Drinking ‘patterns’ .....</i>   | <i>6</i>    |
| <i>Tackling terminology .....</i>  | <i>9</i>    |
| <i>Level of alcohol ‘misuse’ in the UK.....</i>  | <i>12</i>   |
| <i>The role of culture in alcohol use and ‘misuse’ .....</i>                               | <i>14</i>   |
| <i>The ‘new alcohol order’ .....</i>   | <i>15</i>   |
| <i>Men, masculinity and alcohol.....</i>   | <i>18</i>   |
| <i>Alcohol-related harm .....</i>  | <i>19</i>   |
| Alcohol and health .....   | 19          |
| Social impact and costs .....  | 20          |
| <i>Alcohol-related crime.....</i>  | <i>22</i>   |
| <i>Tackling alcohol-related crime: the ‘intervention paradigm’ .....</i>                   | <i>24</i>   |
| <i>A health care response .....</i>  | <i>26</i>   |
| <i>Criminal justice response .....</i>   | <i>27</i>   |
| <i>Introduction of the Alcohol Treatment Requirement: A ‘whole systems approach’ .....</i> | <i>28</i>   |
| <i>Treatment and the criminal justice system – the concept of coercion .....</i>           | <i>29</i>   |
| <i>Summary.....</i>  | <i>30</i>   |
| <i>Research aims.....</i>  | <i>31</i>   |
| <b>CHAPTER 2: ALCOHOL MISUSE: AN OVERVIEW OF TREATMENT APPROACHES AND IMPLICATIONS FOR</b> |             |
| <b>BEHAVIOUR CHANGE .....</b>  | <b>33</b>   |
| <i>Introduction .....</i>  | <i>33</i>   |
| <i>Alcohol misuse: a brief historical context .....</i>                                    | <i>33</i>   |
| <i>The disease concept.....</i>  | <i>34</i>   |
| <i>A new alcohol perspective .....</i>   | <i>37</i>   |

|  |    |
|--|----|
| Broadening the base of alcohol treatment .....                                   | 38 |
| <i>Treatment approaches</i> .....  | 41 |
| The breaking of a habit: cognitive behavioural therapy .....                     | 42 |
| Brief interventions .....  | 44 |
| Motivational Interviewing.....   | 46 |
| Transtheoretical model.....  | 49 |
| The Twelve Step Facilitation programme (TSF) .....                               | 51 |
| <i>The ‘recovery paradigm’ shift</i> .....                                       | 53 |
| <i>Treatment and the criminal justice system – the concept of coercion</i> ..... | 55 |
| <i>Summary</i> .....   | 60 |

### **CHAPTER 3: DEVELOPING THE METHODOLOGY: BRIDGING THE VOID BETWEEN THE ‘ACADEMIC’ AND**

#### **‘REAL WORLD RESEARCH’ .....62**

|   |    |
|---|----|
| <i>Introduction</i> .....                                 | 62 |
| <i>Contextualising the research methodology</i> .....     | 63 |
| <i>Negotiating ‘expectations’</i> .....                   | 65 |
| <i>Epistemology and bodies of evidence</i> .....          | 68 |
| <i>Tensions of designing funded research</i> .....        | 70 |
| <i>Developing a mixed methods way of thinking</i> .....   | 72 |
| <i>Mixed methods research: the ‘third paradigm’</i> ..... | 73 |
| <i>The paradigm ‘wars’</i> .....                          | 74 |
| <i>Taking a pragmatist approach</i> .....                 | 76 |
| <i>Doing mixed methods</i> .....                          | 78 |
| <i>Overview of the research design</i> .....              | 81 |
| <i>Summary</i> .....                                      | 82 |

### **CHAPTER 4: DATA COLLECTION ON THE ATR .....83**

|   |    |
|---|----|
| <i>Introduction</i> .....   | 83 |
| <i>Delivering the ATR in the District</i> .....                       | 84 |
| <i>Understanding the ATR treatment pathway</i> .....                  | 84 |
| <i>Designing the research: taking a phased approach</i> .....         | 88 |
| <i>Phase One: impacts and outcomes of the ATR</i> .....               | 89 |
| Collating the data.....   | 90 |
| <i>Phase Two: observing and exploring the treatment setting</i> ..... | 91 |
| Analysing the setting.....  | 94 |
| <i>Recording the experienced and observed setting</i> .....           | 96 |
| Capturing dialogue.....   | 98 |

|   |            |
|---|------------|
| <i>Beginning an analytical approach: ‘the evolving social episode’</i> .....                | 101        |
| <i>Phase Three: exploring offenders’ subjective experiences of the ATR</i> .....            | 101        |
| <i>Gaining access to subjective experiences</i> .....                                       | 102        |
| The narrative approach.....   | 104        |
| Developing the narrative interview .....  | 105        |
| Recruitment .....   | 108        |
| <i>Ethical considerations</i> .....   | 109        |
| <i>Summary</i> .....  | 113        |
| <b>CHAPTER 5: OFFENDER CHARACTERISTICS, IMPACTS AND OUTCOMES OF THE ATR .....</b>           | <b>114</b> |
| <i>Introduction</i> .....   | 114        |
| <i>Offenders on the ATR</i> .....   | 115        |
| <i>Interagency working</i> .....  | 117        |
| <i>Offender characteristics</i> .....   | 118        |
| Gender, age and ethnicity .....   | 119        |
| Employment.....   | 119        |
| <i>Identifying drinking ‘patterns’</i> .....  | 120        |
| <i>Data sources of drinking patterns</i> .....  | 121        |
| <i>Offending behaviour</i> .....  | 125        |
| <i>Offence category</i> .....   | 128        |
| <i>Analysing ‘outcomes’ on the ATR</i> .....  | 129        |
| <i>Completion of orders</i> .....   | 130        |
| <i>Outcomes in relation to changes in alcohol consumption and drinking ‘patterns’</i> ..... | 132        |
| <i>Previous treatment involvement</i> .....   | 133        |
| <i>Outcomes in relation to completion rates</i> .....                                       | 137        |
| <i>The main findings</i> .....  | 138        |
| <i>Summary</i> .....  | 141        |
| <b>CHAPTER 6: ANALYSING THE FIELD DATA: INTRODUCING THE OBSERVED/EXPERIENCED .....</b>      | <b>142</b> |
| <i>Introduction</i> .....   | 142        |
| <i>Using field notes: interpreting the social world</i> .....                               | 143        |
| <i>Actively creating realities through field notes</i> .....                                | 146        |
| <i>Developing an analytical approach</i> .....  | 147        |
| <i>Introducing the setting</i> .....  | 149        |
| <i>The alcohol treatment workers</i> .....  | 150        |
| <i>Gaining ‘entry’ to the field: ‘inside –outside’ status</i> .....                         | 151        |
| Initial reception.....  | 151        |

|   |            |
|---|------------|
| <i>Negotiating the insider –outsider status .....</i>   | <i>154</i> |
| <i>Orientation to the fieldwork role .....</i>  | <i>155</i> |
| <i>Developing relationships .....</i>   | <i>156</i> |
| <i>Becoming a trusted ‘insider’ .....</i>   | <i>158</i> |
| <i>Introducing the observations: the treatment setting .....</i>  | <i>160</i> |
| <i>Analysing the observed/experienced.....</i>  | <i>163</i> |
| <i>Finding a focus.....</i>   | <i>163</i> |
| <i>Delivering the ATR: a gendered practice?.....</i>  | <i>165</i> |
| <i>Positions of power and control .....</i>   | <i>170</i> |
| <i>Malignant positioning of domestic violence perpetrators.....</i>   | <i>176</i> |
| <i>Managing masculinity .....</i>   | <i>178</i> |
| <i>Summary – is this a gendered practice? .....</i>   | <i>181</i> |
| <b>CHAPTER 7: EXPLORING THE SUBJECTIVE EXPERIENCES OF THE ATR.....</b>                                      | <b>183</b> |
| <i>Introduction .....</i>   | <i>183</i> |
| <i>Exploring subjective experiences pragmatically .....</i>   | <i>184</i> |
| <i>Analysing interview data: towards a subjective reality of the ATR .....</i>                              | <i>185</i> |
| <i>Turning to language .....</i>  | <i>185</i> |
| <i>Beginning the analytical approach .....</i>  | <i>186</i> |
| <i>Taking the analysis further: narrative and the joint construction of meaning .....</i>                   | <i>192</i> |
| <i>The dialogical self .....</i>  | <i>195</i> |
| <i>Summarising the analytical approach .....</i>  | <i>198</i> |
| <b>CHAPTER 8: LISTENING TO VOICES: CULTURAL NORMS AND THE STRUGGLE TO RESIST.....</b>                       | <b>200</b> |
| <i>Introduction .....</i>   | <i>200</i> |
| <i>Bringing the analysis together.....</i>  | <i>201</i> |
| <i>Narrative tone.....</i>  | <i>202</i> |
| <i>Imagery .....</i>  | <i>202</i> |
| <i>Themes .....</i>   | <i>203</i> |
| <i>Taking the analysis further: a dialogical approach.....</i>  | <i>204</i> |
| <i>Contextualising the interviews .....</i>   | <i>206</i> |
| <i>Introducing the offenders .....</i>  | <i>208</i> |
| <i>Presenting the analysis .....</i>  | <i>212</i> |
| <i>Drinking as performance: cultural voices of alcohol, masculinity and the quest for drunkenness .....</i> | <i>213</i> |
| <i>Locating the voices .....</i>  | <i>213</i> |
| <i>Drunken performance: the battleground of the past .....</i>  | <i>215</i> |
| <i>Contagious consumption: sober performance and being outside .....</i>                                    | <i>221</i> |

|  |            |
|--|------------|
| <i>'I'm a lover not a fighter': alcohol, violence and bad faith narratives</i> .....                           | 227        |
| <i>Summary</i> .....   | 236        |
| <b>CHAPTER 9: (RE)CONCEPTUALISING THE TREATMENT SETTING</b> .....  | <b>238</b> |
| <i>Introduction</i> .....  | 238        |
| <i>The story so far</i> ... ..   | 239        |
| <i>Gendered voices</i> .....   | 240        |
| <i>The road to recovery: being treated differently</i> .....   | 251        |
| <i>'I were hoping for a happy pill': moving beyond the medical</i> .....                                       | 254        |
| <i>Summary</i> .....   | 259        |
| <b>CHAPTER 10: (RE) CONSTRUCTING AN ALTERNATIVE DIALOGUE: ADDING ANOTHER VOICE TO THE<br/>REPertoire</b> ..... | <b>261</b> |
| <i>Introduction</i> .....  | 261        |
| <i>Stories of change within the dialogical landscape of coercive treatment</i> .....                           | 262        |
| <i>Locating stories of change</i> .....  | 265        |
| <i>Reaching rock bottom: normative narratives of change?</i> .....   | 267        |
| <i>'Just being there': listening to active agents</i> .....  | 275        |
| <i>Coercive treatment, paradox or productive?</i> .....  | 276        |
| <i>Flexibility and openness on the ATR</i> .....   | 277        |
| <i>Moving on to the dialogical relationship</i> .....  | 279        |
| <i>Trusting in treatment: therapeutic conversations of alcohol 'use' not 'abuse'</i> .....                     | 282        |
| <i>Managing the tension between care and control</i> .....   | 286        |
| <i>(Re) authoring the dialogical self: narrating progress</i> .....  | 287        |
| <i>Summary</i> .....   | 291        |
| <b>CHAPTER 11: BRINGING IT ALL TOGETHER: THEORISING TREATMENT ON THE ATR</b> .....                             | <b>292</b> |
| <i>Contextualising the ATR</i> .....   | 293        |
| <i>Negotiations and manoeuvrings in treatment</i> .....  | 294        |
| <i>Understanding treatment on the ATR as a dialogical encounter</i> .....                                      | 297        |
| <i>Coercive treatment: should we be asking good or bad?</i> .....  | 300        |
| <i>ATR: working towards recovery?</i> .....  | 301        |
| <i>Doing mixed methods research: what worked?</i> .....  | 303        |
| <i>Implications and further research</i> .....   | 304        |
| <b>REFERENCES</b> .....  | <b>308</b> |

|   |            |
|---|------------|
| <b>APPENDICES .....</b>   | <b>342</b> |
| <i>APPENDIX 1: INTERVIEW SCHEDULE.....</i>                                    | <i>343</i> |
| <i>APPENDIX 2: CONSENT FORM - Alcohol Worker Observation .....</i>            | <i>344</i> |
| <i>APPENDIX 3: PARTICIPANT INFORMATION SHEET - Alcohol Worker.....</i>        | <i>345</i> |
| <i>APPENDIX 4: CONSENT FORM - Offender treatment observation.....</i>         | <i>347</i> |
| <i>APPENDIX 5 : PARTICIPANT INFORMATION SHEET - Offender observation.....</i> | <i>348</i> |
| <i>APPENDIX 6: CONSENT FORM – Offender interview.....</i>                     | <i>350</i> |
| <i>APPENDIX 7: PARTICIPANT INFORMATION SHEET – Offender interview.....</i>    | <i>351</i> |
| <i>APPENDIX 8: EXAMPLE OF DRINK DIARY .....</i>                               | <i>353</i> |
| <i>APPENDIX 9: OFFENDING RELATED FACTORS.....</i>                             | <i>354</i> |

## List of tables and Figures

|  |    |
|--|----|
| FIGURE 1: FLOWCHART OF THE ATR PATHWAY. ....                                     | 85 |
| FIGURE 2: THE FUNNEL STRATEGY. ADAPTED FROM HAMMERSLEY AND ATKINSON (1995) ..... | 96 |

|   |     |
|---|-----|
| TABLE 1 :SHOWING ATR FIGURES FOR BOTH PROBATION SITES’ OFFENDER CASE LOADS. JULY 2007 TO MARCH 2009 ..... | 115 |
| TABLE 2: OFFENDER CHARACTERISTICS .....   | 119 |
| TABLE 3: BRIEF DEFINITION OF DRINKING CATEGORIES .....  | 121 |
| TABLE 4: DRINKING PATTERNS AND AGE RANGE OF OFFENDERS .....   | 124 |
| TABLE 5: PREVIOUS OFFENCES .....  | 126 |
| TABLE 6: RISK OF RECONVICTION IN RELATION TO AGE CATEGORY .....   | 127 |
| TABLE 7: OFFENCE CATEGORY.....  | 129 |
| TABLE 8: NUMBER OF ATR ORDERS COMPLETED .....   | 131 |
| TABLE 9: SUMMARY OF OFFENDERS’ TREATMENT OUTCOME .....  | 132 |
| TABLE 10: NUMBER OF OFFENDERS PREVIOUSLY KNOWN TO OTHER VOLUNTARY ALCOHOL SERVICES .....                  | 134 |
| TABLE 11: FINAL ASSESSMENT OF OFFENDERS UPON COMPLETING TREATMENT .....                                   | 135 |
| TABLE 12: NUMBER OF OFFENDERS WHO HAD REOFFENDED .....  | 137 |
| TABLE 13: PROCESS OF THEMATIC ANALYSIS – ADAPTED FROM BRAUN AND CLARKE (2006) .....                       | 189 |
| TABLE 14: INTERVIEW MATRIX.....   | 206 |



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## **Chapter 1: Alcohol consumption: context and consequences in the UK**

### **Introduction**

The level of alcohol-related harm including crime, and morbidity is considered to be unacceptably high in the UK (British Medical Association [BMA], 2008). Alcohol consumption therefore, has become a central concern for policy makers in their approach to addressing and providing solutions to the problem. This chapter aims to explore a range of diverse factors that are deemed to have impacted upon the levels of alcohol-related harm in the UK. In order to do this, it will be necessary to consider the level of alcohol consumption in the UK before going on to examine levels of alcohol 'misuse' and attributed problems. It is here that the chapter will deal with culturally accepted, and even encouraged, forms of alcohol consumption as they are found in British culture. This chapter will then go on to explore how alcohol-related harm, and in particular crime, is being dealt with through the 'intervention paradigm' which involves interagency working between health and criminal justice in order to minimise alcohol-related criminal behaviour and health.

## **Alcohol 'use' and 'abuse'**

Drinking alcohol is a widespread source of individual and social pleasure in most countries around the world (Wilson, 2005). Drinking beverage alcohol is generally associated with many positive aspects of life, for example for many people, drinking alcohol is a means of achieving relaxation and reducing stress (Peele and Brodsky, 2000). Indeed consuming alcohol for pleasure constitutes an integral part of social life in many cultures including the UK (Stimson *et al.* 2007). Furthermore, research by Brodsky and Peele, (1999) has been conducted on the positive health benefits of consuming alcohol which include; psychosocial benefits (such as subjective health and mood enhancement; Grant and Peele, 1999), social benefits (such as sociability and social cohesion; Brodsky and Peele, 1999), and cognitive and performance benefits (such as long term cognitive functioning and creativity; Brust, 2002). Therefore it can be argued that people drink in part, due to the anticipation of some of these immediate positive outcomes of drinking. Alcoholic beverages also have distinct cultural and symbolic meanings (Edwards, 2002; Babor *et al.* 2003; Stimson, 2007) that are shaped by culturally specific habits and rituals which are neither legally restricted or medicalised. For example, consuming wine in France is considered to be an essential part of what it means to be French (Demossier, 2005), while drinking beer in the Czech culture has specific rules which must be followed in order to command 'respect' for both the beer and one's companion (Hall, 2005).

Nevertheless, the behaviours and beliefs surrounding the consumption of alcohol are complex and indeed its consumption across cultures can be recognised as having both

positive and negative consequences. Alcohol, therefore, can be considered simultaneously as socially problematic and socially acceptable in a variety of ways. For example alcohol may be considered as a potential source of 'addiction', yet consuming alcohol can also be viewed as a 'right of passage' into manhood (Hunt, Mackenzie and Joe-Laidler, 2005). It is increasingly recognised that alcohol can be dangerous if 'abused' and that alcohol abuse can take many different forms and occur in many different contexts. For example Hopkins and Sparrow (2006) highlight that there is now a greater recognition that alcohol 'abuse' not only refers to the concept of 'alcoholics' or habitual daily drinkers but increasingly attention is becoming focussed on drinking 'behaviour' and the *ways* in which people drink alcohol. It is evident that while there may be positive benefits associated with alcohol consumption, the vast majority of research on the consequences of consuming alcohol is in direct relation to alcohol 'misuse' and problem behaviour. Therefore, prevalence of both alcohol use and misuse needs to be addressed before attempting to understand the link between alcohol consumption and its negative consequences.

### **Levels of alcohol consumption in the UK**

The level of alcohol consumption is said to be changing globally in direct relation to the changing social conditions in both developing and developed countries (Stimson *et al.* 2007). For example, the UK total recorded consumption is said to have doubled between 1960 and 2002, explained by an increase in household disposable income, where alcohol was 62% more affordable in 2005 than in 1980 (Mistral, Velleman, Mastache and Templeton, 2007). Furthermore, traditionally, North American and

European countries were divided into groups with either high or low alcohol consumption, or so called 'wet' and 'dry' cultures. In wet cultures, alcohol is integrated into daily life activities (e.g. consumed with meals) and is widely available and accessible, often associated with European countries. In dry cultures, alcohol consumption is not as common during everyday activities, and access to alcohol is more restricted and found to be associated with the Scandinavian countries, the US and Canada (Peele, 1997). However subsequent research has found that, especially in Europe, the previous wet/dry division seems to be disappearing and a homogenization of consumption rates and beverage preferences is increasingly evident (Bloomfield, Stockwell, Gmel and Rehm, 2003). In the UK, there has been a growing concern about the increasing levels of alcohol consumed and the impact this may have on individuals, family, community, and public order (Gmel and Rehm, 2003). Thus, an examination of levels of consumption enables appropriate information about patterns of drinking and specific target groups to be considered when making decisions around alcohol policies.

Information concerning the amount of alcohol consumed by adults in the UK is derived from a variety of alcohol surveys conducted by government and health organisations, such as the Prime Minister's Strategy Unit [PMSU] and the BMA. The data on consumption is typically based on government guidelines for weekly and daily drinking limits translated into 'units' (Government guidelines recommend 14 units per week or less for women and 21 units per week or less for men). A unit is approximately equivalent to half a pint of ordinary strength beer, a small glass of wine or one measure of spirits. However, as Dingwall (2006) points out, this is far from exact as the alcoholic strength of some drinks, for example, beer or wine, varies considerably.

Indeed 'unrecorded alcohol consumption' including home production, travellers' imports, smuggling and tourist consumption is estimated to be approximately 2 litres per person per year above actual recordings (Leifman, 2001). It is therefore, acknowledged that reported 'estimates' around alcohol consumption cannot, by their very nature, provide a definitive picture of consumption patterns, however they can offer an indication of the levels of alcohol consumption in the UK.

Historically, the trend in alcohol consumption in the UK over the last century has varied considerably (Dingwall, 2006). According to the PMSU (2003), British people are drinking less than they were 100 years ago, but considerably more than they were 50 years ago. At the beginning of the 20<sup>th</sup> century, national per capita alcohol consumption (amount of pure alcohol per person per year) was higher than at any point in the subsequent years. The inter-war years showed a significant reduction in alcohol consumption, however since 1950, consumption had risen from 3.9 litres per capita per year to 9.4 in 2004. By 2006, this figure had declined to 8.9 litres, nevertheless per capita consumption in Britain has remained consistently above 7 litres per capita per year since 1980 (BMA, 2008), while consumption in other European countries, for example, France, Italy, and Spain has fallen steadily over the same period (WHO, 2004). Indeed, the BMA's (2008) report on alcohol misuse in the UK, shows the UK to be among the heaviest alcohol consuming countries in Europe.

It has been estimated that the proportion of adults who consume alcohol is around 90 per cent in England (PMSU, 2004). According to the Office of National Statistics (2006) only 9 per cent of the white British population are 'non-drinkers', however the



proportion is higher among all ethnic minority groups, increasing to 90 per cent or more among those of Pakistani and Bangladeshi origin. It is estimated that overall, adults in the UK consume alcohol in 'moderation' which is defined by the BMA (2008) as drinking less than the UK recommended daily limits for alcohol. Nevertheless, the UK has been characterised (in comparison to other Northern European countries) as having a high per capita consumption (Heath, 2000) largely due to the number of 'heavy drinkers' and 'heavy episodic drinkers' defined by WHO (2004) as those adults who consume six or more alcoholic drinks per occasion at least once weekly. Findings such as these have become increasingly common in both survey reports and the literature on alcohol consumption. Furthermore, research on alcohol consumption has begun to distinguish between different 'patterns' of use, indicating that alcohol consumption is a more complex and diverse activity than previously acknowledged.

### **Drinking 'patterns'**

The need to explore and assess drinking 'behaviour' has become pivotal to the increasing demand for evidence based policies, which aim to better understand and tackle alcohol-related harm. A considerable amount of data on *how* people consume alcohol in the UK has been published over recent times due to the Labour Government's commitment to provide an alcohol harm reduction strategy (Prime Minister's Strategy Unit, 2004). Drinking patterns that describe how people consume alcohol, and are said to describe features of drinking that have been demonstrated to be important in determining outcomes, (for example, chronic health problems) often in relation to epidemiological research (Russell, Light and Gruenewald, 2004).

Stimson *et al.* (2007) maintain that drinking beverage alcohol is a widespread source of individual and social pleasure in most countries around the world, nevertheless they remind us that some drinking 'patterns' can lead to serious physical, mental and social harms. Stimson *et al.* (2007) note that over the past two decades, research into drinking patterns has provided a wealth of information about drinkers, their behaviours, and the likely consequences of consumption. For example, drinking patterns can comprise of *quantity* of alcohol consumed, *duration* and *frequency* of drinking, the *settings* in which drinking takes place and the *cultural role* and significance of alcohol. Thus, patterns of drinking will be deeply embedded in localised cultural contexts, and subsequently, interventions required to change such practices are likely to vary.

Historically, research in relation to drinking patterns has relied on population total volume consumption data (BMA, 2008), however this approach has been criticised on the grounds that populations are not homogenous in terms of drinking patterns (Filmore *et al.* 1991). Indeed it has been more recently acknowledged that different cultures and their respective drinking patterns are multifaceted as they may be shaped by a variety of social, economic, biological and psychological factors, therefore 'sub-populations' (such as, gender, ethnicity, and age) have been found to differ with regard to their drinking behaviours and resulting effects of consumption (van Oers *et al.* 1999; General Household Survey, 2006).

Nevertheless, it is seemingly apparent that the relationship between drinking patterns and outcomes is complex (Stimson *et al.* 2007). With the growing body of literature

exploring the impact of how people consume alcohol, many studies are beginning to find that negative consequences of alcohol consumption incorporates a much broader spectrum than chronic health problems. Klingemann (2001) argues that research into the impacts and consequences of alcohol consumption has until recently, been concerned mainly with those that affect health or are more readily quantifiable or measurable. He acknowledged that many consequences, harmful as well as beneficial, can be characterised as 'social' and in no way medical, or at least indirectly related to health. For example, domestic violence, unemployment, deviant behaviour, and public safety are described by Klingemann (2001) as some of the 'forgotten' social consequences of alcohol consumption.

A growing body of research has begun to explore social consequences of specific drinking patterns which are associated with criminal behaviour (see for example Klingemann, 2001; Richardson and Budd, 2003; Dingwall, 2006). For example, 'heavy episodic' drinking has been found to contribute to the risk of interpersonal violence and aggression for some people (Wells and Graham, 2003). The UK has been found to have high rates of 'explosive' drinking patterns, in which alcohol is consumed less frequently but then drunk to intoxication, leading to an increased risk of an alcohol-related crime being committed. Indeed Richardson and Budd (2003) found that 'binge' drinkers were five times more likely to admit to committing an offence involving fighting than those defined as 'regular drinkers'. By gaining insight into the complexity of how people consume alcohol, a way of reducing alcohol-related harm can begin to be approached. Indeed as Stimson *et al.* (2007) point out, a generalised 'one size fits all' approach to reducing alcohol-related harm cannot necessarily suit the diversity of

drinking patterns and problems within a community, and may not be relevant to a particular target population, and thus should be a major consideration for the policy makers attempting to minimise harm in relation to alcohol consumption.

## **Tackling terminology**

Drinking patterns and the way in which people consume alcohol provides valuable insight into how alcohol-related harm can be understood. However, before exploring some of the main consequences of alcohol consumption in relation to drinking patterns, a note on terminology is required in order to make sense of how alcohol-related behaviour and associated harm is defined.

Changes in the way that alcohol problems are conceptualised have brought about new ways of identifying and classifying how people drink in order to better understand related risks and harm (Russell *et al.* 2004). In 2001 the World Health Organisation made recommendations for the prevention and treatment of alcohol dependence. These recommendations were premised on viewing alcohol problems on a continuum with the notion that 'one size does not fit all' and that a more flexible approach was needed to tackle drinking behaviour and alcohol-related problems. Indeed the policy drive from the Alcohol Harm Reduction Strategy for England (PMSU, 2004) illustrates the more recent need to broaden the base of treatment and interventions for alcohol misuse. The widening of responses to alcohol-related harm is aimed at capturing a large group of drinkers whose problems are deemed 'less serious than those with severe dependence on alcohol' (Raistrick, Heather and Godfrey, 2006, p.26).

Research, therefore suggests that there has been a move in the way that alcohol-related harm has been conceptualised, particularly the identification of social outcomes and the recognition of the consequences that different drinking behaviours can have on individual's lives. Nevertheless, the most widely used definitions for alcohol-related harm are still conceptualised within a medical framework (as 'disorders') and are found in two major classification systems of 'disease': the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV; American Psychiatric Association, 1994), and the International Classification of Diseases (ICD-10; WHO, 1993). Both the DSM-IV and ICD-10 define two alcohol use disorders – '*dependence*' and '*abuse*'. Classification systems published prior to 1980 included only one disorder, *alcoholism*. Both classification systems are utilised as a tool for psychiatric diagnosis and educational research and as such the concepts and definitions of DSM and ICD alcohol diagnoses form a unifying framework that underlies research and discussion of alcohol use in the UK and other countries. Indeed, Hasin (2003) maintains that clear, accurate definitions of medical conditions and disorders are important for research and clinical practice.

Both the DSM-IV and the ICD-10 have similar diagnostic criteria for alcohol dependence. For both systems, alcohol dependence is characterised by a maladaptive pattern of drinking that leads to significant distress in the individual's life, characterised by cognitive (persistent desire for alcohol), behavioural (important activities are given up because of desire to drink), and physical symptoms (increased tolerance and withdrawal). It has been found that the modern definitions of alcohol dependence stated in the DSM –IV and the ICD-10 show high reliability and validity

indicating favourable agreement when diagnosing this category using either system (Hasin, 2003; Hasin, Schuckit and Martin, 2003). However, the evidence in support of reliability and validity for the alcohol *abuse* category has produced far weaker results (Hasin, 2003) illustrating the complex nature which surrounds the notion of alcohol 'abuse', its definition and its diagnosis.

More recently, it appears that there is no generally agreed terminology for the notion of 'alcohol abuse'. What is offered consists of a number of terms that are used inconsistently in the literature to describe different drinking 'patterns' (Stimson *et al.* 2007). For example, terms used to describe lower volumes of alcohol consumption include; *sensible drinking*, *light drinking* and *moderate drinking*. Terms used to describe high volume of consumption include; *heavy drinking*, *excessive drinking*, *problem drinking*, *harmful drinking*, *hazardous drinking*, *heavy episodic drinking* and *binge drinking*. Indeed the classification of binge drinking was recognised as a somewhat problematic concept by the PMSU (2003):

'[Binge] drinking is a debated term. Since alcohol will affect different people in different ways, there is no fixed relationship between the amount drunk and its consequences. So although many people understand 'bingeing' to mean deliberately drinking to excess, or drinking to get drunk, not everyone drinking over 6/8 units [of alcohol] in a single day will fit this category. Similarly, many people who *are* drinking to get drunk, will drink far in excess of the 6/8 units in the unit-based definition.' (PMSU, 2003, p.11).

Furthermore, the PMSU's 2004 strategy for alcohol reduction incorporates three categories of alcohol misuse, based on the ICD-10, namely *hazardous*, *harmful* and *dependent* drinking behaviours. However sub-categories of '*moderately dependent drinking*' and '*severely dependent drinking*' are included in this spectrum. In addition, there is a further category which involves '*drinkers with complicated needs*' which may include co-morbid psychiatric disorders or polysubstance misusers.

Although numerous terms have been used in the literature to describe the types of drinking behaviour that may result in harmful consequences to the drinker (or indeed other parties involved), this research will use the terms that are specified in the Models of Care for Alcohol Misusers [MOCAM] (National Treatment Agency, NTA, 2006) which identifies *hazardous* and *harmful* drinkers as *alcohol misusers*. According to NHS Choices (2009) *hazardous* drinkers are described as a person who drinks over the recommended weekly limit (currently 21 units for men and 14 units for women) and *harmful* drinkers are described as a person who drinks over the recommended weekly limit and has experienced health problems directly related to alcohol. The terms 'alcohol abuse' and 'alcohol dependence' will be used as defined by the WHO ICD-10 system in line with UK policy on all alcohol related harm.

### **Level of alcohol 'misuse' in the UK**

While the alcohol market is said to be worth over £30 billion a year in the UK (Strategy Unit, 2003), alcohol misuse costs the country around £20 billion a year (PMSU, 2004). Data concerning the level of alcohol misuse in the UK can provide important information about drinking behaviours and patterns on both a national and community

level. This information can, in turn, inform and enhance appropriate interventions that are argued to be more likely to be effective in minimising alcohol-related harm (International Centre for Alcohol Policies, 2002). Alcohol is said to be the most abused chemical substance in the world (Royce, 1981) and research from the Department of Health (2001) highlights that approx 8.2 million people in England are drinking either at hazardous, harmful or dependent levels, and that 1.1 million people are dependent on alcohol.

It has been found that people in the UK have one of the highest levels of alcohol use and 'binge drinking' in Europe which is believed to have reached 'epidemic proportions' (British Medical Association, 2003). According to the British Medical Association's (2008) report on alcohol misuse in the UK, comparison of per capita consumption among adults aged 15 and over finds the UK in eighth position in the 'hard drinking' nations of Europe. On a regional level, the highest levels of binge drinking and drinking above recommended guidelines was found to be in the northern regions of England in particular Yorkshire and Humberside.

In the UK, men are more likely to exceed the recommended UK guidelines and to drink heavily compared to women (BMA, 2008). According to the 2004 Alcohol Needs Assessment Research Project (ANARP) approximately 8.2 million people consume alcohol at hazardous or harmful levels of which 32 per cent are men and 15 per cent are women. A report by the Parliamentary Office for Science and Technology (2005) estimated that 5.9 million adults in the UK engage in binge drinking and that 23 percent were men and 9 per cent were women. Although the levels of alcohol misuse



remains lower for women than men, it is highlighted by Bloomfield *et al.* (1999) that this 'gender disparity' is shrinking in many established economies including the UK. This, according to Stimson *et al.* (2007, p.15) could be explained by the fact that 'drinking patterns, especially among women, are gradually changing in many societies as gender roles evolve'. Traditionally, consuming alcohol was considered to be a 'male activity' as a way of bonding, for example studies on miners (Dennis *et al.* 1969) and shipbuilders (Winlow, 2001) emphasised the extent to which group solidarity at work and masculine identities was further established by drinking together on and off the job. For Winlow (2001), the cultural surroundings of the time were crucial in understanding the behaviour of the men he was studying. His study portrays a time before the leisure industry and 'consumer culture' had arrived, which impacted differently on how individuals behaved.

### **The role of culture in alcohol use and 'misuse'**

It is widely acknowledged that consuming alcohol is related in some way to many aspects of culture (Heath, 1987; Stimson *et al.* 2007; Martinic and Measham, 2008). Stimson *et al.* (2007) propose that most cultures where alcohol is consumed can be divided into three broad categories: *wine cultures* as in the Mediterranean region; *beer cultures*, as throughout most of Europe and Africa; and *spirits cultures*, including Eastern Europe, the Scandinavian countries, and regions of Asia. According to Bloomfield *et al.* (2002) drinking is a complex, dynamic, culturally and socio-demographically bounded phenomenon. Indeed, Wilson, (2005) points out that while many social scientists have concentrated on alcohol consumption in relation to

‘drunkenness’ and outright problems (i.e psychological or health concerns), there is still a need to consider alcohol consumption in its cultural and historical contexts as part of often acceptable, predictable, encouraged, mainstream and normative behaviour:

‘drinking [alcohol] practices are active elements in individual and group identifications, and the sites where drinking takes place, the locales of regular and celebrated drinking, are places where meanings are made, shared, disputed and reproduced, where identities take shape, flourish and change’ (p.10)

Here Wilson (2005) considers consuming alcohol to be a culturally dependent phenomenon, where identities are formed. Moreover, he takes the view that consuming alcohol is an expression of culture because it is socially learned and patterned, and varies in structure and function from society to society.

### **The ‘new alcohol order’**

Consuming alcohol is a widespread, culturally accepted behaviour that has long been established in the UK. Indeed it is said that its entrenchment is so great that the word ‘drink’ is often assumed to imply an alcoholic beverage (Plant, 1995). According to Measham and Brain (2005) the consumption of alcohol has become central to the development of night-time economies in British towns and cities with the creation of a ‘new alcohol order’ which caters for the young culturally diverse consumers who are far more ‘drug wise’ in comparison to the ‘traditional male industrial working-class

beer consumers of the community pub' (p.267). Measham (2004) identifies several key components which are considered to have transformed the UK from an industrial to a post-industrial alcoholic 'order'. These include the recommodification of alcoholic beverages in the 1990s to include high strength bottled beers, ciders and lagers, fortified wines, alcopops, ready to drink spirit mixers, 'buzz' drinks containing legal stimulants such as caffeine and guarana, and shots and shooters introduced in the early 2000s. Measham (2004) further highlights that alcohol products have been increasingly advertised as lifestyle markers in sophisticated campaigns to appeal to a more niche market. There has, in addition, been a major overhaul in the design and promotion of drinking establishments through the creation of café bars, dance bars and themed pubs. This saw the retail trade 'move from 'spit and sawdust' working class back street pubs to modern 'chrome and cocktails' city centre café bars' (Measham and Brain, 2005, p.268) aimed at attracting a new customer base to licensed leisure. The consumer economies that have now developed in western capitalist societies such as the UK and are argued to rely on hedonism (Brain, 2000). Thus, it is viewed that traditional norms and values which might have served to limit excessive consumption are disappearing. Also attitudes and behaviour towards alcohol have changed in the last 10 years where 'determined drunkenness' and 'binge drinking' have become the norm for many British towns and cities (Measham, 2004; Measham and Brain, 2005; Dingwall, 2006).

Marlatt and Witiewitz, (2002) suggest that many people still believe that the only problems caused by alcohol are alcohol dependence and its sequels, specifically liver cirrhosis and other chronic conditions. In many cultures including the UK the risks of

acute intoxication are dismissed and viewed as a matter for little concern (Martinic and Measham, 2008). Indeed intoxication is seen as an incentive for further drinking, as a demonstration of bravery (especially young men) and as a way of having fun and gaining prestige (Winlow, 2001) . For many people, alcohol consumption is largely a planned activity (Brain, Parker and Carnwath, 2000). Richardson and Budd, (2003) argue that for many the main goal is to get drunk and that consumption is tailored to this goal. Martinic and Measham, (2008) have termed this new order of drinking 'extreme drinking' where excessive alcohol consumption is recognised as part of the overall drinking experience, considered more typical in countries like the UK as opposed to countries like Italy where this would be rare and not thought of as normative behaviour.

With the development of the new 'alcohol order' and the 'new culture of intoxication' that is emerging in the UK (Measham, 2004; Measham and Brain, 2005; Hopkins and Sparrow, 2006) there is a distinct focus on young people as the target cohort within the existing literature. However, there is also a large body of literature that explores the relationship between gender and consumption of alcohol (see for example, Winlow, 2001; Alcohol Concern, 2005; Hunt, Mackenzie and Joe-Laidler, 2005). Therefore, although it is important to consider the rise in alcohol consumption for both men and women, this should not disguise the fact that alcohol misuse by men still remains a significant issue and needs to be explored.

## **Men, masculinity and alcohol**

Gender is said to play an important role in shaping drinking behaviour. In general, men are more likely to drink and drink more than women (Stimson *et al.* 2007). Graham and Wells (2003) postulate that the cultural values and expectations of young men who frequent bars appears to be very important in terms of explaining the association between violence and the social processes of drinking in bars. They found that the 'romance' of bar room brawls and the general tolerance for aggression in bars, combined with the 'macho' values of many young men and expectations about the effects of alcohol have created a social context in which male-to-male aggression is normal and accepted. Men's aggressive behaviour in pubs was found to be motivated in the proximal sense by 'male honour, face saving, group loyalty and fun' (Graham and Wells, 2003, p.548).

However, Graham and Wells (2003) noted that alcohol-related aggression varies enormously across cultures with some cultures demonstrating little or no aggressive behaviour in drinking settings, suggesting that drinking behaviour is highly malleable and highly responsive to societal norms and controls. Indeed Hunt, MacKenzie and Joe-Laidler's (2005) research on youth gangs in America found that there is no one pattern of masculinity. They found that although all gang members shared some common social characteristics, they nevertheless 'did gender' in their own culturally determined way, including the way they drank. For example African-American gang members viewed being drunk as 'not cool' whereas Latino gang members exhibited their machoism by being 'wild and reckless'. In UK cultures, heavy drinking is strongly

associated with masculinity (Stimson *et al.* 2007). This type of drinking behaviour, coupled with the rise of 'determined drunkenness' has led to a major concern in relation to the consequences of alcohol consumption, both within a health and social context.

### **Alcohol-related harm**

Over recent years the level of alcohol misuse in the UK has been increasing and in particular the pattern of 'binge drinking' and 'heavy drinking'. Alcohol misuse has become a significant problem in the UK, described as an 'epidemic' by the BMA (2008), and it has been highlighted that measures need to be taken to reduce the mean level of consumption (British Medical Association, 2006). Despite many scientific advances, alcohol problems continue to present a major challenge to medicine and public health (Room *et al.* 2005).

### ***Alcohol and health***

It has long been noted that alcohol consumption is responsible for increased illness and death (Pearl, 1926; Anderson *et al.* 1993; Pincock, 2003) and in England and Wales alcohol is implicated in up to 40,000 deaths per year and is directly responsible for 5,000 deaths (DOH 2001). Consumption of alcohol above recommended limits is said to pose a major threat to the health of individuals including physical health problems like liver damage, mouth and throat cancers and raised blood pressure (BMA, 2006). Such chronic harm to somatic or physical health is more typically associated with long term heavy drinking patterns. However the harms caused by hazardous, harmful and

dependent drinking are also said to be associated with chronic health problems such as cancer, stroke and coronary heart disease and inequalities in life expectancy (Alcohol Concern, 2006). Nevertheless, in light of the reported findings on the relationship between chronic health conditions and alcohol consumption, it is important to take into consideration other dimensions of an individual's lifestyle which may have an impact on health outcomes. Additional influences such as age, general health, diet and exercise can contribute to an individual's problems. For example, it has been found that the relationship between excessive alcohol consumption and oral cancers is strongly influenced by smoking (Stimson *et al.* 2007). Acute outcomes, including unintended injuries, are said to correlate with heavy episodic drinking or 'binge drinking' (Gmel and Rehm, 2003). Rodriguez-Martos *et al.* (2007) have found that patients attending emergency services because of injury are more likely to have positive blood alcohol concentration (BAC) than non-injured patients.

### ***Social impact and costs***

Excessive drinking can result in many social factors such as; breakdown in relationships, trauma, hospitalisation and prolonged disability (Klingeman, 2001). Moreover, alcohol misuse is a major factor in violent crime including domestic violence (Quigley and Leonard, 1999) and also child abuse (Rossow, 2000). Subsequently, it is now widely recognised that individuals who misuse alcohol are not the only ones who can be affected by the consequences. For example Klingemann (2001) states that partners of alcohol abusers are at serious risk of violence, divorce or break-ups. Furthermore, higher rates of depression and anxiety disorders among women who have concerns

about their partner's alcohol consumption have been found (Patel *et al.* 2004) along with stress and other mental health problems (Gaunekar *et al.* 2005). Children can also be severely affected for example, abuse, neglect, isolation and insecurity are said to be much more common in the families of alcohol abusers (Kingemann, 2001).

Alcohol misuse is said to place huge burdens on the cost of public sector institutions such as the health services; social services; the Police and criminal justice system, and schools and educational institutions (Alcohol Harm Reduction Strategy for England, 2004). Statistics show that up to 70 percent of all admissions to accident and emergency units are related to alcohol consumption. The total cost of alcohol misuse to the NHS is estimated to be approximately £3 billion a year (Alcohol Concern, 2006). It was found that one in four acute male admissions is alcohol-related and that over 28,000 hospital admissions are due to alcohol dependence or the toxic effects of alcohol (Luke, 1998). It is therefore anticipated that treatment for alcohol problems would be cost effective as major savings could be made in health and social care settings. Indeed Raistrick, Heather and Godfrey (2006) estimate that for every £1 spent on treatment £5 is saved elsewhere. In addition, and even more alarming, is that the annual cost of crime and antisocial behaviour linked to alcohol misuse is said to be £7.3 billion in the UK (£3 billion of which is directly related to health) (British Medical Association, 2006). Therefore it appears that the cost of alcohol misuse in relation to crime and disorder, and health are placing a huge burden on today's society in the UK.



## **Alcohol-related crime**

‘Alcohol-related crime’ according to the Institute of Alcohol Studies (2007) is used to refer to two main categories of offences:

- a) Alcohol-defined offences such as drunkenness offences or driving with excess alcohol.
- b) Offences in which the consumption of alcohol is thought to have played a role of some kind in the committing of the offence, usually in the sense that the offender was under the influence of alcohol at the time. Examples of offences which are often committed by people under the influence are assault, breach of the peace, criminal damage and other public order offences.

(Institute of Alcohol Studies, 2007, p.1)

Research has consistently shown that alcohol use is present in a high proportion of offences (Budd, 2003; Richardson and Budd, 2003). This relates both to drinking by the offender and to drinking by the victim if the offence in question is one of violence. It has been found that approximately half of all violent crimes and 360,000 incidents of domestic abuse are linked to alcohol misuse (Strategy Unit, 2004). A study by Felson, Burchfield and Teasdale, (2007) explored the impact of alcohol on different types of violent incidences and they found that in violence involving strangers, offenders are more likely to be consuming alcohol, whereas victims are more likely to be sober. Man *et al.* (2002) found that detainees arrested for alcohol-related offences tended to be more disruptive and violent than other detainees and as a result spent nearly 2 hours

more in custody compared to other detainees. Indeed Deehan (2002) found that from approximately 10.30pm to 3.00am the majority of arrests are for alcohol-related offences and place a huge burden on the police (and other public services). Furthermore, Deehan found that intoxicated prisoners can be disruptive, uncooperative and may present severe hygiene problems, urinating in their clothing during or after arrest. Results from the British Crime Survey (Budd, 2003) show that the majority of alcohol-related assaults are highest among inner-city areas and that being a 'young male; single; unemployed; frequently visiting nightclubs or pubs; and high levels of alcohol consumption' (p.11) were characteristics strongly associated with high rates of alcohol-related assault.

There is a wealth of statistical evidence also linking alcohol to many issues around crime and disorder (Babor *et al.* 2003). Social problems such as antisocial aggressive and violent behaviour (Parliamentary Office of Science and Technology, 2005) have been found to be related to the consumption of alcohol. For example it has been found that people who had visited a pub or a wine bar more than three times a week within a one month period had a higher risk of victimisation for violent crime (Nicholas, Povey, Walker and Kershaw, 2005). Furthermore, the British Crime Survey 2004/2005 showed that victims believed the offender or offenders to be under the influence of alcohol in nearly half (48%) of all violent incidents (Home Office, 2006).

The prevalence of 'binge drinking', particularly among young people (Measham, 2004) has meant that the acute effects of alcohol have become more noticeable within the

community, and as a result awareness of such problems is beginning to increase, (Alcohol Concern, 2006; Dingwall, 2006).

It has therefore been shown that a high proportion of violent crime offenders have consumed alcohol before committing the offence. A large amount of alcohol-related crime consists of violent offences including assault often carried out in inner-city areas. These findings cannot be ignored and should be used to inform policy makers when considering ways to reduce alcohol-related crime and disorder.

### **Tackling alcohol-related crime: the ‘intervention paradigm**

White and Kurtz (2006) argue that with the development of problem conceptualisation to treatment strategies, cultures across the world have embraced widely divergent views regarding the origin of alcohol problems, they go on to state that:

‘[alcohol] problems and their resolution have been defined in religious terms (sin and redemption), spiritual terms (hunger for meaning and personal transformation), criminal terms (amorality/immorality and reformation), medical/disease terms (sickness and recovery), psychological terms (flawed thinking/coping and maturation) and socio-cultural terms (historical trauma/oppression and liberation/cultural renewal) ... The question of which model is ‘true’ or ‘works’ is not a trivial one. The model choice dictates cultural/professional ownership of AOD [alcohol and drugs] problems – whether these problems belong to priests, judges, physicians, psychologists, addiction counsellors or community activists. The chosen model dictates

particular intervention philosophies and settings (whether the alcoholic is punished in a jail cell or counselled in a treatment center).’ (White and Kurtz, 2006, p.5).

It appears that the way in which alcohol misuse and related problems are conceptualised, has direct consequences in relation to how the intervention is applied. It is therefore argued by White and Kurtz (2006) that it is the underlying assumptions about the ‘problem’ which dictates what may happen in, for example, treatment for alcohol addiction. Therefore understanding alcohol abuse could be just as crucial as the delivery of intervention itself. White and Kurtz (2006) point out that the ‘intervention paradigm’ is currently being utilised in the UK. This paradigm aims to prevent drug and alcohol problems by intervening; punishing offenders and providing treatment. According to Stimson *et al.* (2007) interventions aimed at reducing the potential harm associated with drinking can be divided into two overall categories. The *population-level approach* to prevention relies heavily on controlling the volume of drinking across entire populations. However for Stimson *et al.* (2007) population-level measures rely on a ‘top-down’ approach that casts a wide net across the population as a whole, which considered alone are inadequate as they are unable to respond to the needs of different cultures and contexts. The *targeted interventions* approach involves interventions that are applied in a targeted way, focusing on particular groups, behaviours, drinking patterns or settings, where the potential for harm is increased. In this approach, initiatives can be developed which reflect the specific needs of the community, the culture and the role of alcohol within it. For example a targeted intervention will aim to explore the association between drinking and violence in areas

where this has become a growing concern. Indeed at a population-level, the high numbers of adults found to be drinking at harmful, hazardous and dependent levels in the UK resulted in two major policy documents, the Alcohol Harm Reduction Strategy for England (PMSU, 2004) and the Choosing Health White Paper (DOH, 2005), which both identified a need for better identification and treatment of alcohol problems. The main focus of both these publications is to reflect current UK policy in the substance misuse field, to facilitate the development of effective alcohol treatment services and reduce and control alcohol-related harm . However, in light of the increasing evidence concerning alcohol-related crime in some of the towns and cities across the UK, more localised responses have begun to be encouraged through both the health care system and the criminal justice system.

### **A health care response**

With a need to address the issues associated with alcohol misuse, public health policy has a major part to play in preventing alcohol related problems by for example, giving advice on the safe limits of alcohol consumption. Indeed the Models of Care for Alcohol Misusers (MoCAM) (NTA, 2006) has developed a three tiered conceptual framework, adapted from the Models of Care for the Treatment of Adult Drug Misusers (NTA, 2002) which gives guidance regarding the level of intervention required for individual alcohol misusers (*harmful, hazardous and dependent*), ranging from brief intervention to a more structured and intensive treatment programme. This approach to intervention has been used as a commissioning framework to deliver alcohol treatment services. Although alcohol misuse and violence can be considered as two

separate problems, in practice, and as this review has identified, they commonly coexist (Asare and West, 2008). Hence it is now recognised that health providers can in turn, have a central role in preventing alcohol-related violence, as they are ideally placed to inform, implement and monitor effective interventions (WHO, 2005). The National Treatment Agency (2006) published an extensive and comprehensive review of the effectiveness of treatment for alcohol problems, designed to provide clear guidance on the development of 'local' systems and to further inform local partnerships in the community of how best to respond to alcohol problems and alcohol-related crime.

### **Criminal justice response**

The link between alcohol and crime has also been recognised at the level of the policy maker (Dingwall, 2006). Hopkins and Sparrow (2006) identified that over a decade ago, the link between alcohol and crime was being acknowledged by the Home Office and one of the first working parties was set up in relation to alcohol misuse (Home Office, 1995). It was suggested that health agencies and local authorities should be giving alcohol at least as much attention as drugs. The report also remarked on the tension in the criminal justice system between a policy that punishes offenders for alcohol-related crime and one that prevents re-offending through treating alcohol misuse. Traditionally, Hopkins and Sparrow, (2006) note that alcohol and crime was often treated as two separate issues where serious problem drinkers were dealt with by specific health providers both statutory and voluntary. Nevertheless, the 1998 Crime and Disorder Act and the Crime Reduction Programme made it a statutory duty for

local authorities to conduct crime audits and develop a 'crime reduction strategy' for their local area. As a result of this legislation, a number of local audits recognised that alcohol was a contributory factor in a high proportion of crime in their area and the Crime Reduction Programme therefore, provided funding for a number of initiatives to tackle alcohol-related offences on a local, community basis.

### **Introduction of the Alcohol Treatment Requirement: A 'whole systems approach'**

The Alcohol Harm Reduction Strategy for England (2004) proposes a 'whole system approach' which encompasses not only health but social services and the criminal justice system as it is recognised that alcohol misuse cuts across all these areas and demands an integrated response. Indeed MoCAM (NTA, 2006) reflects this approach highlighting how alcohol misuse should be tackled from a local perspective:

'Commissioners need to ensure that all tiers of intervention are commissioned to form a local alcohol treatment system to meet population needs. Local systems should allow for some flexibility in how interventions are provided, with the crucial factors being the pattern of local need and whether a service provider is competent to provide a particular treatment intervention' (p.19)

Indeed within the Alcohol Reduction Strategy Interim Analytical Report (Strategy Unit, 2003), there was a 'cross government' approach to tackling the harms and costs of alcohol misuse. This triggered work to be undertaken in four areas; better education

and communication; improving health and treatment services; combating alcohol related crime and disorder; and working with the alcohol industry. At the same time, Alcohol Treatment Requirements (ATR) were introduced through the legislation of the Criminal Justice Act 2003, making available to the courts an ATR as one of the possible requirements of a community order for offenders who have committed an alcohol-related offence. The ATR is said to provide an opportunity to introduce legal supervision and coercion into evidence based models of alcohol treatment for problem drinking.

### **Treatment and the criminal justice system – the concept of coercion**

The shift towards crime prevention and coercion has been growing in popularity since innovations such as the Drug Treatment and Testing Orders (DTTO) were introduced in Britain nearly a decade ago (Turnbull *et al.* 2000). Indeed Hunt and Stevens (2004) highlight that a model of coerced treatment has become a key part of British drug policy and practice since the first drug court in the UK was set up in West Yorkshire by the District Drugs Action Team in 1998 (Olson and Barker, 1999). Within this model, the offender receives treatment for abstaining or stabilising their drug habit with the goal being to reduce their drug use and re-offending, thus reducing the number of offenders in prison (Longshore *et al.* 2001).

This new form of treatment strategy has been referred to as ‘coercive treatment’ whereby at sentence, offenders may be faced with an ‘offer they cannot refuse’ (Hough 1996) in that refusal to agree to treatment as part of a community sentence may well trigger a prison sentence. For an ATR to be granted by the courts there are



several criteria that have to be fulfilled before such a requirement can be offered to the offender. Section 212(2) of the Criminal Justice Act 2003, states that the court must be satisfied that the offender is dependent on alcohol; that they may be susceptible to treatment and that the offender has to be 'willing to comply' with the requirements of the order. The latter requirement raises a somewhat interesting perspective when considered alongside the coercive element of a treatment programme such as the ATR. Motivation is widely viewed as a critical factor in treatment participation, retention and success, (Hiller, Knight, Leukefeld and Simpson, 2002; Miller and Rollnick, 2002; Longshore and Teruya, 2006). Consequently the concept of pressuring individuals into treatment for substance abuse and other forms of treatment has been the subject of heated debate (Lidz and Hoge, 1993; Lawental, McLellan, Grissom, Brill and O'Brien, 1996; Marlowe *et al.* 2001; Norland, Sowell and Dichiara, 2003). Some of the main questions arising from the debate include, does the coercive strategy of 'forcing' individuals into treatment work? Would individuals accept treatment? Would they engage in treatment to the same extent as those who participate on a voluntary basis? And finally, would coerced individuals show any improvements following treatment?

## **Summary**

This chapter has provided an overview of the levels and patterns of alcohol consumption in the UK. It has been established that the estimated increases in per capita consumption has the potential to lead to an increase in a variety of harms including health, and social factors. An exploration of the way alcohol 'misuse' is

conceptualised has illustrated that alcohol misuse now incorporates a much broader spectrum, including categories such as *harmful*, *hazardous* and *dependent* drinking behaviours. The way people consume alcohol appears to be culturally dependent, and the patterns of alcohol consumption have been shown to influence related problems. In addition to positive aspects of consuming alcohol, this review has focussed on how alcohol misuse can negatively impact on both individuals and communities across the UK. This has been particularly apparent in the literature surrounding alcohol-related crime which is a growing concern for many towns and cities in British society. The government's response to the 'rising epidemic' of alcohol consumption and its consequences on both crime and health have been documented, which illustrates the ever increasing need for organisations to work together in order to bring about positive changes to communities and individuals in relation to alcohol misuse and its consequences. Finally, approaches located within the current intervention paradigm have included the introduction of the ATR in certain parts of the UK which suggests that there is a clear governmental belief that rehabilitative work can be beneficial. Nevertheless, the concept of providing coercive treatment along with the possible tensions that may arise from attempting to both treat and punish alcohol-related offenders warrants further consideration.

## **Research aims**

This research has the over-arching aim to investigate the delivery of the Alcohol Treatment Requirement (ATR) in Northern England; specifically aiming to explore what impact the ATR might have in relation to behaviour change and rehabilitation.

More specifically the research aims to:

1. explore and understand the process of assessment and eligibility for the ATR;
2. explore in depth, the subjective experiences of offenders, in relation to engagement, progress and completion of the ATR;
3. explore offending behaviour and offender characteristics in relation to alcohol related crime and disorder in Northern England on the ATR;
4. develop a comprehensive theoretical framework for assessment and delivery of alcohol treatment, and
5. disseminate findings to reflect on current practice and to assist in the ongoing development of the ATR.

## **Chapter 2: Alcohol misuse: an overview of treatment approaches and implications for behaviour change**

### **Introduction**

This chapter opens with a brief historical context of alcohol treatment which aims to highlight that the way alcohol 'misuse' is characterised and understood is largely influential in determining how treatment is developed and delivered. It is identified that the concept of alcohol-related problems appears to have undergone a considerable transformation (Miller, 1999). Alcohol-related problems have gradually become conceptualized as a much broader phenomenon not just limited to the concept of 'addiction', as therapists now recognise that clients are a heterogeneous group of individuals who enter treatment with different problems and experience treatment differently (Washton and Zweben, 2006). To this end, what follows is a review of the main treatment approaches on offer in the UK for alcohol related problems which incorporates both traditional and more contemporary approaches in the alcohol and addiction field. Finally, treatment and the criminal justice system will be explored in relation to coercive treatment and its implications for individual behaviour change.

### **Alcohol misuse: a brief historical context**

Addiction treatment and alcohol treatment have been shaped by history with fundamental shifts in the design of treatment both in the US and the UK (White, 2000). Historically, the treatment of alcohol misuse has employed a variety of approaches

which appear to have been largely depended upon how alcohol abuse has been understood (Babor *et al.* 2003). Thus it seems that underlying assumptions about the 'problem' appears to dictate what may happen in treatment. Therefore, understanding and conceptualising alcohol abuse is arguably just as crucial as the delivery of treatment itself. For example, previous to the nineteenth century, excessive drinking was deemed a sin in the eyes of the Christian Church therefore the framework with which to understand and respond to drinking problems was located within the province of moralism and the clergy (Edwards, Marshall and Cook 2003). Drunkenness was preached against and it was the responsibility of the sinner to repent and stop sinning with no medical intervention. This understanding of alcohol abuse was in stark contrast to later nineteenth and twentieth century ideas where alcohol was no longer constructed as a sin but as a disease of the mind which opened the way to developments of scientifically based treatment approaches.

### **The disease concept**

This view point was regarded as revolutionary, (Edwards, Marshall and Cook, 2003) in that drunkenness was no longer considered a sin but a habit that could be unlearned. Thus, people previously labelled as 'drunkards' and 'inebriates' were positioned as a minority suffering the disease of 'alcoholism' (Heron, 2003). Thus, treatment of 'alcoholism' involved medical interventions that arose from explanations of causes of the disease. This disease concept of alcoholism is argued to be the product of a professional movement strongly associated with the Centre of Alcohol Studies established at Yale University in 1941 (Wilton and DeVerteuil, 2006). The term

'alcoholic' began to be used by medical professionals (largely consisting of doctors and psychiatrists) and this was substantiated with the publication of E.M. Jellineck's *The Disease Concept of Alcoholism* (Jellineck, 1960). Jellineck's (1960) work elaborated the disease concept, defining it in general terms as 'any use of an alcoholic beverage that causes any damage to the individual or society or both' (p.35). According to Jellineck, alcoholism could have various sub-types which could be classified as disease or not disease. He argued that only instances where individuals lost control over their drinking were to be considered addiction. Therefore this 'scientific' concept of alcoholism (Levin, 1995) claimed to distinguish those who were in need of medicine and 'worthy' of treatment, from those who were from 'common' backgrounds and thus considered to display 'unworthy' states of drunkenness. For Jellineck, (1952) alcoholism was a disease which was progressive and therefore needed life-long abstinence to cease its progression.

Levin (1995) highlighted that the disease concept had considerable influence as it legitimised alcoholism as a medical problem providing the optimistic message that, as with other diseases, help and cure were possible. However, the disease model of substance abuse seems to suggest that a substance-dependent person cannot recover from dependency, and thus it is argued that this can be problematic when defining the client group (Levin, 1995). It suggests a 'once dependent, always dependent' label (Blume and Ziberman, 2004). Furthermore, Wilton and DeVerteuil (2006) note that the disease concept encountered serious problems as it was unable to offer a workable clinical definition of alcoholism. While a focus on 'loss of control' enabled alcohol studies to offer some distinction between seemingly 'real' alcoholism and other forms

of problem drinking, it could not clearly define the line between problem drinking and 'normal drinking' both of which may also be further influenced by culturally defined boundaries (Bancroft, 2009). Therefore the term 'alcoholism' became problematic. As it was located within the disease model, it became apparent that only those who were presenting with extreme consequences such as loss of control and severe withdrawal symptoms would be considered for medical treatment (Jellinek, 1960). Notably, in the 1950s the World Health Organisation (WHO) stressed the importance of alcoholism as a disease and emphasised the role of the medical profession and the medical 'ownership' of the alcohol field (Thom, 1999) which was largely lead by psychiatrists at that time. Such 'tunnel vision' created boundaries within the treatment domain as service provision and public health responses were 'dictated' by the word 'alcoholism' (Edwards, Marshall, and Cook, 2003). As a result, Thom (1999) pointed out that the person who was drinking in excess and perhaps suffering health and social consequences, but who did not conform to the stereotype, of the 'down and out drunk' was left with no offer of help.

Indeed Emmelkamp and Vedel (2006) argue that the *severity* of the dependence is an important factor in evaluating the disorder, which in turn is important in determining the appropriate level of care. For example, they made the distinction between a heavy 'binge' drinker who would benefit from 'outpatient counselling' from a heavy daily alcohol drinker with high levels of tolerance and withdrawal symptoms, needing more specialised treatment including medically supervised 'detoxification'. Thus definitions of alcohol misuse appear to have the potential to be prescriptive, rather than simply descriptive in relation to treatment interventions.

## **A new alcohol perspective**

It was later acknowledged that alcohol problems were much more widely apparent and that large numbers of the population did not conform to the stereotype of the disease state (Room, 1977, cited in Edwards *et al.* 2003). Indeed Thom (1999) writing on the disease concept of alcohol reflects that:

‘What emerges from the literature is that the ‘career’ of the disease concept since the nineteenth century has reflected the symbolic use of the concept as a marker of change in perceptions of the alcohol problem and its value as an organising concept around which to rally support for action in the alcohol field ... The conclusion that the statement ‘alcoholism is a disease’ indicated a recommendation for public policy rather than a scientific discovery ... aptly conveys the primary importance of the disease concept as a vehicle for the dissemination of a new wisdom. This was as important in the UK as in the US.’ (Thom, 1999 p.32).

As Thom (1999) highlights, there began to be a shift in the way in which alcohol misuse was being conceptualised which appears to have policy related implications in terms of how alcohol problems are dealt with. Indeed Room (2005) suggests that the ‘political world’ has a strong interest in the governing images by which alcohol consumption and its problems are thought about and subsequently acted upon.



### ***Broadening the base of alcohol treatment***

An alcohol movement was beginning to emerge where alcohol problems were being redefined within a competing paradigm of a 'drinking problems' perspective. As a result treatment services in some countries began to broaden their focus with a new emphasis on early or brief intervention in primary care and hospital settings (Levin, 1995). The World Health Organisation's 1977 framework (Edwards, *et al.* 1977) incorporated a two dimensional framework for understanding problem drinking, with alcohol dependence being distinguished as conceptually different from alcohol-related problems such as levels of consumption and other health issues. Within this framework, those who could be suitable for treatment ranged from anyone who wanted help with their drinking, whether or not they were dependent on alcohol. This arguably marked the beginning of the 'broadening out' of treatment for alcohol (Wilbourne and Miller, 2002)

Thus the policy focus during the 1970s also began to shift away from the provision of alcoholism treatment towards a concern with alcohol consumption and 'problem drinking'. This, according to Thom (1999) resulted in a much broader, more diverse alcohol treatment field encompassing a wider range of clients, professionals and intervention approaches. The move away from the disease concept brought about issues of 'ownership'. If alcoholism was not a disease, it could not be claimed by doctors and thus becomes a social problem to be undertaken by the social scientists (Room, 1983). The concept of alcohol 'problems' was borne out of the growing critique of the disease concept and as a result the term 'alcoholism' was replaced with the

phrase 'alcohol dependence syndrome' (Skinner and Allen, 1982). Alcohol dependence syndrome represented a dimensional definition rather than a categorical definition of the condition and therefore widened the scope and importance of social and health problems associated with alcohol. To this end, there became a need to respond to alcohol related disabilities whether an individual was regarded as 'dependent' or not (Thom, 1999). This reframing of the concept of 'alcoholism' was seen to have important implications for policy and practice responses. As part of this paradigm shift, alcohol debates focussed on levels of consumption and alcohol related harm in the society (including public drunkenness and offending behaviour), and thus the control of alcohol availability became a public health issue (Greenaway, 2003).

As Wilbourne and Miller (2002) note that within the space of two decades since the 1980s, professional opinion changed dramatically, from constructing alcoholism as a unitary disease, to a full spectrum of problems related to excessive drinking. Indeed it is now widely acknowledged that there can be a major spectrum of alcohol use/misuse (Miller, 1999; Room, 2005; Washton and Zweben, 2006). One individual may 'misuse' alcohol on a regular basis with little or no social consequences, whereas a second individual may consume similar amounts and suffer both health and social consequences on a much more detrimental scale (Bancroft, 2009). Moreover, many individuals who have sustained serious problems as a result of their drinking do not become dependent on alcohol therefore will not experience any physiological disturbance on withdrawal (Levin, 1995). For individuals who show dependence to a slight or moderate degree, only slight withdrawal symptoms may be experienced but to no large detriment. On the other hand, there may be individuals who will suffer a

great deal upon withdrawal which for some will precipitate life-threatening disturbances (Edwards, 1982; Levin, 1995). Thus, given that there appears to be such a broad spectrum of individual experience, at a practice level it would seem inappropriate to tackle the treatment of alcohol misuse with a 'one size fits all' approach. Such variance in alcohol use/misuse and its consequences calls for a spectrum of treatment which endeavours to incorporate such individual/idiosyncratic cases. For example, different treatment modalities may need to be considered in relation to the goals set for the individual. Indeed it has become increasingly the case that the individual's life situation in conjunction with the person's alcohol consumption should be considered when assessing treatment and evaluating treatment options (Thom, 1999).

Indeed past studies have found that the concept of alcohol related problems is much broader than dependency and covers a wide array of problem drinking (Grant and Ritson, 1990). Therefore services and policies have begun to provide programmes and treatment which include early recognition, low cost interventions and more effective ways to match patients' needs with appropriate programmes (Babor *et al.* 2003). Since the late 1970s, the paradigmatic shift in perceptions of alcohol problems, the broadening of the base of professionals, target groups and intervention activities within the alcohol arena has resulted in a change from 'treatment' towards prevention, public health, and the management of health 'risk' in the population (Greenaway, 2003; Room, 2005). This incorporated a transformation from a largely clinical treatment response to alcoholism, to a social, community-based response to problem drinking. Consequently as Thom (1999) notes, policy discourse on treatment

began to be located within a more comprehensive framework which included consideration of the prevention of harmful drinking. The concept of 'harm minimisation' was introduced in direct response for the need to attempt to minimize the harm caused by alcohol consumption (Pates, 2002). Thus by the 1990s, policy was concerned with the management of 'risk' and the reduction of harm from alcohol consumption (Rassool, 2009) rather than the treatment of 'alcoholism'.

What follows is a brief overview of some of the main treatment modalities on offer which incorporate different levels of interventions ranging from brief intervention and early detection through to more specialized treatments for alcohol related problems.

### **Treatment approaches**

Adopting a 'problem-drinking' perspective along with a concern to address health risks has resulted in services and service approaches becoming more diversified and 'fragmented' (Thom, 1999). Treatment agencies began to broaden their role to include, for example, early interventions and increasingly, the concept of alcohol abuse has begun to include drinking behaviours which do not directly relate to the concept of addiction or 'psychological dependence' (Wilbourne and Miller, 2002). There is a considerable amount of literature showing that treatment for alcohol problems is both effective and cost-effective (Raistrick *et al.* 2006; Rapley *et al.* 2006; Miller and Wilbourne, 2002). Treatment for alcohol problems often involves a set of services, ranging from diagnostic assessment to therapeutic interventions and continuing care (Babor *et al.* 2003). There is a wide range of treatment approaches available, indeed past research has identified over 40 differing approaches to the treatment of alcohol

problems, more generally known as ‘treatment modalities’ (Babor *et al.* 2003). Examples of the treatment modalities commonly used include, motivational counselling, marital and family therapy, cognitive behavioural therapy, relapse prevention training, aversion therapy, pharmacotherapy and interventions based on the Twelve Steps of Alcoholics Anonymous. These modalities are delivered in a variety of settings, including residential facilities, psychiatric and hospital settings, outpatient programs, primary care and in the community.

### ***The breaking of a habit: cognitive behavioural therapy***

Historically, as explored above, the notion of habit was proposed in the late 1700s (Rush 1790, and Trotter 1804). This idea first became ‘re-awakened’ in the early 1900s where aversion therapy employed painful shock as the unconditioned stimulus. Voegtlin and Lemere’s (1950) approach was based on the theory of Pavlov whereby the conditioned stimulus, (alcohol) was to be associated with an unconditional stimulus, (nausea induced by injection of emetine) with the objective of developing an unconditioned response to alcohol.

With increasing interest in psychological principles being applied to treatment, the extension to apply behavioural, then cognitive methods to the treatment of drinking problems was argued to be ‘natural progression’ (Edwards *et al.* 2003). The idea of bad drinking as a habit which could in turn be ‘unlearned’ with appropriate psychological methods was becoming more and more popular and is still currently well established with the application of cognitive-behavioural therapy (CBT) used as a common

treatment approach within the health care setting (Callaghan and Gregg, 2005; O'Donahue *et al.* 2005; Rosenblum *et al.* 2005). CBT is a widely used therapeutic approach that has been applied to the treatment of conditions as varied as depression, anxiety, schizophrenia and substance misuse (Bennett, 2002). The central tenet of CBT is that it is not simply what happens to individuals that effects their mood or behaviour, but how events are interpreted through beliefs about the world. For example beliefs that may encourage alcohol abuse may include not being able to get through a dull party without it or a belief that alcohol makes people more sociable. Also implicit in this approach is the belief that problem drinking is a learned behaviour and that treatment involves replacing the maladaptive pattern of drinking behaviour with more appropriate drinking or abstinence.

Thus CBT constructs individuals as 'cognitively impaired' and the aim of treatment is to work with individuals (or groups) to identify 'dysfunctional thinking' in order to generate alternatives to ineffective thought processes (Soravia and Barth, 2008). Individuals are encouraged to document their thoughts in order that they might, at some point, be able to 'alter' their negative cognitions. A large part of CBT treatment typically focuses on behavioural elements of the intervention, aimed at improving the individual's social skills such as identifying behaviours that are more likely to reduce their addiction, and increase opportunities to receive social 'reinforcers' (Conroy, Brower and Crawford, 2008). Thus CBT relies heavily on individuals completing assignments and task oriented work outside the treatment setting (Baker, 2008). CBT places emphasis on teaching concrete coping skills and relapse avoidance (Baker, 2008). In this approach therefore, less attention is given to other aspects of the

individual's addiction, such as talking through how they might feel about their addiction, etc. Indeed it has been highlighted that little emphasis is placed on the 'therapeutic relationship' (Coren, 2001) rather CBT is viewed as a directive 'tools oriented' approach to behaviour change (Hofmann and Reinecke, 2010). Treatment takes on a 'training' approach and sessions can include activities such as *functional analysis, managing thoughts, problem solving, planning and practice* (Baker, 2008).

It has been argued that with the CBT approach, there is a relative lack of motivational emphasis compared to other client centred approaches to behaviour change. therefore, CBT has been found to be more suitable to individuals who may struggle to express or identify their feelings such as individuals with anti social personality disorders (Chaney, 1989). Nevertheless more recent developments of CBT now incorporate motivational elements.

### ***Brief interventions***

Gilliver (2009) notes that the majority of people who enter treatment do so at the late stages of the problem's severity and complexity, however both the US and the UK have begun to address issues of treatment access by introducing early screening and brief intervention programs. According to Babor *et al.* (2003) considerable progress has been made in public health practice to develop more cost-effective treatments, including brief interventions amongst others which aim to manage persons whose alcohol consumption puts them at risk. Attention has shifted away from the most severely affected, dependent drinkers, towards hazardous drinkers whose

consumption level or drinking pattern increases the risk of harm and, according to Rapley, May and Kaner (2006) may be more 'amenable to clinical intervention aimed at modifying behaviour' (p.2419). Rapley, May and Kaner (2006) go on to suggest that those who can be alerted to risk at an earlier stage are most likely to act upon themselves. This new population of 'risky' drinkers exhibit *latent vulnerabilities* (May, 2001) upon which it is said to be legitimate for the doctor to act. Brief interventions are characterized by their low intensity and short duration (Babor *et al.* 2003). They have been designed to motivate high risk drinkers to moderate their alcohol intake rather than promote total abstinence (Room, Babor and Rehm, 2005). Brief interventions offered by professionals such as general practitioners, typically involve personalised, structured advice for non-treatment seeking patients with early stage problems (Rapley, May and Kaner, 2006.) They are typically made up of around one to three sessions involving information, brief advice and support for behaviour change and, if targeted appropriately, Raistrick, Heather and Godfrey (2006) propose that it can help to encourage more 'responsible' drinking and reduce risks to health. Such intervention is intended to be provided at the early stages or soon after the onset of alcohol related problems and to this end are designed to motivate high-risk drinkers to moderate their alcohol consumption rather than encouraging total abstinence which would require further specialized treatments (Babor *et al.* 2003).

There is now a wide range of research available which consistently finds that brief interventions are effective in reducing heavy or problematic drinking (Bien, Miller and Tonigan, 1993; Babor, 1994; Dunn, Deroo, and Rivara, 2001; Ball *et al.* 2007). However



it has been argued that this approach is only minimally utilised in the primary care sector (Rapley, May and Kaner, 2006).

### ***Motivational Interviewing***

Motivational interviewing is classed as a less-intensive treatment, (Raistrick *et al.* 2006) often used as part of a brief intervention programme for individuals who may be at risk regarding their alcohol consumption. Brief interventions often adopt the techniques of theoretical approaches to counselling for example motivational ones. Miller and Rollnick (2002) propose that one or two sessions of counselling can often bring about greater behaviour change than no counselling at all. It has been argued that strong motives can change specific behaviours and level of motivation has been often identified as an important factor in the treatment of alcohol problems and other addictive behaviours (Prochask and DiClemente, 1982; Miller and Rollnick, 2002). Miller and Rollnick define motivational interviewing as '*a client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence*' (p.25). MI draws on the earlier work of Carl Rogers' client centered counselling and has emerged as a practical and acceptable treatment approach for individuals who are reluctant to change and who are ambivalent about changing. It is in stark contrast to the more traditional 'confrontational' approach to counselling where heavy emphasis was put on labeling (i.e. 'alcoholic') and resistance was seen as 'denial'.

During MI, the interviewer (counsellor) '*seeks to create a positive interpersonal atmosphere that is conducive but not coercive to change*' (Miller and Rollnick, 2002, p.34). The interview session is characterised as collaborative, whereby the counsellor adopts a partner – like relationship. The collaborative process is designed to set the scene for eliciting and drawing out motivation from the client, rather than simply imparting knowledge to the client about his/her treatment programme. A further key component of this approach is to ensure that responsibility for change is left with the client, with the overall goal being that the client becomes more intrinsically motivated. Thus allowing motivation to come from within rather than being imposed upon, results in changes serving the client's own goals and values. Notably, this particular approach suggests that motivation is something that individuals somehow 'possess within them' and as a result possible externally motivating factors are seemingly ignored. Indeed Miller and Rollnick (2002) maintain that MI can only work when focus is on the client's intrinsic motivation for change, that is, unless change involves the person's own values and beliefs, it will not happen. An interesting point to note here is that MI is largely used as a brief intervention strategy in settings such as the criminal justice system where offenders are 'coerced' into treatment for substance misuse. Thus in this sense, relying on 'intrinsic motivation' as an approach to behaviour change may prove to be problematic, an area that will be returned to at the end of this chapter.

What is also of importance to note in this therapeutic approach is that in comparison to alternative therapies on offer, MI relies heavily on the therapists' interpersonal and therapeutic style (Miller and Rollnick, 2002). Motivational interview therapists need to be reflective and empathic amongst other interpersonal skills, and imbue the 'spirit' of

motivational interviewing. This according to Miller and Rollnick is fundamental in the therapeutic process:

‘If motivational interviewing is a way of being with people, then its underlying spirit lies in understanding and experiencing the human nature that gives rise to that way of being. How one thinks about and understands the interviewing process is vitally important in shaping the interview’ (2002, p.34)

As is clearly evident from the above quote, this approach takes the view that motivation to change is enhanced by the practitioner, therefore will not be successful without the therapist having received adequate training and practice. Motivational interviewing involves the integration of a complex set of clinical skills which, according to Miller and Rollnick, cannot be acquired by simply reading or listening to lectures. Indeed as Miller and Rollnick state, for some counsellors or clinicians this may take months or even years to perfect. The training and learning process for MI appears to be just as crucial as the interview process itself. Therapists can enhance or interfere with the client’s process of behavioural change and there is always the danger that the client may refuse to engage in the behavioural change process and can sabotage the treatment (DiClemente, 2003). In contrast the client may comply with the treatment but remain ambivalent throughout and therefore refuse to change. Thus treatment outcomes can be affected by many variables including implementation of the treatment, engagement in treatment, and client satisfaction with treatment (DiClemente, 2003).

MI has been shown to be effective in reducing alcohol intake in problem or heavy drinkers in a variety of settings including primary care and general hospitals (Bien *et al.* 1993). A recent influential trial (Project MATCH Research Group, 1998) found no differences in outcomes between Motivational Enhancement Therapy (MET), Cognitive Behavioural Therapy (CBT) and the Twelve Step Facilitation (TSF) after a twelve treatment week period. The improvements that occurred during the treatment phase were still evident in a 1 year and 3 year follow up study (Babor *et al.* 2003). A recent meta analytical review revealed that MI is an effective intervention for reducing alcohol consumption particularly for young adults who are heavy or low-dependent drinkers than for older drinkers or those with a more severe drinking problem (Vasilaki, Hosier and Cox, 2006). One of the main advantages of Motivational Interviewing is that it can be used in conjunction with other treatment approaches which aim to facilitate change. Miller and Rollnick (2002) acknowledge that for some, Motivational Interviewing may be sufficient in moving them from ambivalence to commitment without any additional help. For others MI would serve as a preparation for further assistance (which was its original intentions) which may be needed in order to bring about the required change, for example cognitive behavioural therapy.

### ***Transtheoretical model***

This model, developed by Prochaska and DiClemente (1982) brings together a range of theoretical constructs in order to attempt to describe the process of change in human behaviour. Individual motivation and 'will to change' are stated as the underlying constructs which influence whether an individual is able to make and sustain change to

prevent post-treatment relapse. Similar to the MI approach, this model of change is directly related to the motivations of the individual and therefore relies heavily on individual factors and their own willingness to initiate life change rather than the clinicians' ability to diagnose and prescribe a treatment plan (Schulz and Floyd, 2002). According to this model, an individual's 'state of readiness' for change can be conceptualised as the motivation for change (Sussman and Ames, 2001). This model includes five stages. The first is *precontemplation* which is identified by a lack of interest in change. In this stage the client may remain ambivalent for any length of time (from minutes to years) until there is a realization of a problem which has real consequences. Once a problem is recognised, the client moves into stage two which is *contemplation* here consideration of behaviour change is beginning to emerge. The third stage is *preparation*, this occurs when the individual becomes motivated to make behavioural changes. The fourth stage is *action*, where changes such as cutting down or abstinence happen. And finally stage five is the *maintenance* of the changes made which will involve efforts to avoid relapse and establishing ways to keep committed long term

This model clearly identifies that readiness to change can sometimes be strong, sometimes weak but more typically it can fluctuate between the five stages outlined by Prochaska and DiClemente (1982) identifying the process as cyclical rather than linear. People can move backwards and forwards through the stages, for example, thinking about changing, getting ready for change then choosing not to follow this through and returning to the contemplation stage is a common occurrence (Edwards *et al.* 2003).

The transtheoretical model (TTM) has played a large role in the development of motivational interviewing and brief interventions using a motivational approach. DiClemente and Velasquez (2002) argue that motivational interviewing is an excellent counselling style to use with clients who are in the early stages of precontemplation. These individuals do not want to be pushed into change by having techniques forced upon them but need to be in a non-threatening and supportive environment which encourages the client to take responsibility for their own situation. Indeed DiClemente and Velasquez go on to demonstrate how motivational interviewing approaches can be linked to each of the five stages of change from the transtheoretical model. Nevertheless, as with motivational interviewing approaches, this model is based upon the argument that we as individuals seemingly possess 'intrinsic motivation'. Thus motivation to change, in this sense, considers 'intrinsic' or 'self' motivation as key to positive change. Therefore less emphasis seems to be paid to external motivating factors such as family or indeed courts who potentially play a crucial role in bringing the individual into treatment. Therefore motivational interviewing approaches may have a tendency to focus on intrinsic client centered approaches without considering the situated lives of the person in treatment and how this might influence their progress.

### ***The Twelve Step Facilitation programme (TSF)***

The 12 Step Programme is an approach to treatment which was borne out of the Alcoholics Anonymous (AA) self help organisation founded in the 1930s by Bill Wilson and Bob Smith. The underlying principles of the Twelve Steps was developed from

Wilson and Smith's own experiences of maintaining sobriety through sharing with others in a group/community setting. Although, as Elliot (1993) points out, the founders were cautious to state that the Twelve Steps were only suggestive ways for living and not requirements for membership in A.A., for over fifty years, these steps have guided millions, helping them 'live lives of hope rather than lives of quiet desperation' (Elliot, 1993, p.vii). These programmes are available in communities throughout the world. Many rehabilitation programmes include AA meetings on site and encourage their clients to become involved.

There have been some attempts to evaluate the efficacy of the Twelve Step Programme however research is generally lacking due to methodological problems that are inherent in the study of a voluntary programme of self help (Edwards *et al.* 2003). The evidence of efficacy has largely been suggestive, being based upon popularity, personal testimony and perceived benefit rather than more empirical findings (Edwards *et al.* 2003). Nonetheless project MATCH, a large multi centre study has shown that the TSF programme is as equally effective as Cognitive Behavioural Therapy (CBT) and Motivational Enhancement Therapy (MET). The study further showed that after 12 months TSF was indeed superior to the other two treatments, and after 3 years was superior to MET. It was found that this finding was due to the ongoing support networks associated with AA meetings and attendance, and attendance was associated with better outcomes.

## **The 'recovery paradigm' shift**

The emergence of recovery as an organising paradigm for the addiction treatment field has been conceptualised as the new 'recovery movement' (Kelly and White 2010). White (2000) proposes that recovery oriented systems of care should involve networks of formal and informal services developed to sustain long-term recovery, and designed to avoid people being released back into communities that then 'devoured' them. Therefore, White (2000) argues that it is not just about treatment, there is a need to start talking about 'treatment communities', building communities that people can recover in. White (2000) argues that people know how to get sober, however they don't know how to stay sober in the community. White (2000) maintains that recovery management should be based in the home, neighbourhood and community, underpinned by the philosophy that long-term recovery has to be anchored to the individual's natural environment. White further argues that recovery must be a voluntary process, which therefore views coerced recovery as an oxymoron where an individual cannot be 'forced' to be free. Within this paradigm shift, portraying the 'newly sober' individual as a paragon of recovery, according to White (2000), is a gross misrepresentation of reality:

'it is also a fact that thrusting individuals in the earliest stages of recovery into the limelight is to invite disaster for them ... the focus needs to shift from the addiction, the addicted and the barely sober, to those in sustained recovery (p.18)



In this sense, White (2000) argues that within the current cultural and professional context there is a pressure to extend the design of addiction treatment from a model of 'acute biopsychosocial stabilization' (p.3) towards a model of sustained recovery. White (2008) thus argues that,

'Recovery is a philosophy of organizing addiction treatment and recovery support services to enhance early prerecovery engagement, recovery initiation, long term recovery maintenance, and the quality of personal/family life in long term recovery' (p.3)

White's (2008) argument here is that in order to promote a long-term stable recovery, addiction should be conceptualised as a chronic and recurring illness. In this sense, addiction, according to White (2010) should be approached as a complex dynamic process which has considerable variations across individuals. Therefore treatment services within this approach need to shift and broaden out from short term treatment to support long term recovery within a life course conceptual framework. In this sense, Kelly and White (2010) argue that often the individual/family/community is under the impression at discharge that 'cure has occurred' (p.2). Thus, in order to promote long term recovery where an individual is personally sustainable without further professional assistance, Kelly and White (2010) suggest that aftercare programs should be available that extend beyond the formal treatment episode.

It seems that the recovery paradigm has been largely developed as a backlash for the increasing way in which many treatment providers have become involved in the criminal justice system where coercion has become a major tool for getting people into

treatment (in the USA and also in the UK). The recovery paradigm appears to shift the emphasis of treatment success upon the situated lives of the individual where families and communities are the providers of long term support rather than treatment institutions. Thus White (2000) maintains strongly that recovery is a voluntary process, arguing that coercion may work in getting people into treatment but it cannot sustain people into recovery.

### **Treatment and the criminal justice system – the concept of coercion**

In the UK, management of the 'substance misuser' has historically been located within the medical domain (Summers, 2002). As a result, funding for treatment came from the Department of Health with the focus being to treat the individual in order to improve their health and welfare. Nevertheless, as Hunt and Stevens (2004) point out, since 1997 and the new Labour government, there has been a shift in the drugs policy discourse which largely focuses on 'drugs as an engine of crime' (p.334). This shift in emphasis in UK drug policy has re-conceptualised the notion of 'drug related harm' and how this is prioritized within the service industry. Harm reduction has been widely acknowledged as an 'effective public health approach' (Tsui, 2000) which involves effective harm reduction strategies for example, needle exchange and methadone maintenance in reducing transmission of infectious diseases such as HIV (Strang, 1998, cited in, Hunt and Stevens, 2004) and other forms of voluntary drug treatments such as residential rehabilitation services based on abstinence (Gossop, Marsden, Stewart and Treacy, 2002). Hunt and Stevens (2004) argue that these successful services were developed with an ethos that prioritises the health and well-being of the client by

helping them to make changes voluntarily. However, as drug-related harm has become more understood to be the harm 'by' people who use drugs, rather than the harm done 'to' them, so, Hunt and Stevens (2004) argue, there has been a shift to the increasing use of coercion into treatment through the criminal justice system. Indeed the Home Affairs select Committee (2002: paragraph 270) stated that 'harm reduction rather than retribution should be the primary focus of policy towards users of illegal drugs'.

In contrast to the moral and disease models of alcoholism which works within a framework of 'zero-tolerance', harm reduction, according to Marlatt and Witkiewitz (2002) offers a more pragmatic approach to alcohol consumption and alcohol related problems based on three core objectives:

*1) to reduce harmful consequences associated with alcohol; 2) to provide an alternative to zero-tolerance approaches by incorporating drinking goals (abstinence or moderation) that are compatible with the needs of the individual; and 3) to promote access to services by offering low-threshold alternatives to traditional alcohol prevention and treatment (p.868).*

This framework, according to Marlatt and Witkiewitz (2002), sets out to work towards a more 'compassionate' approach to the prevention and treatment of problem drinking which shifts the focus away from the behaviour itself to the consequences of harmful drinking. However, Hunt and Stevens (2004) point out that there is no consensus about what harm reduction is and what it has achieved, which consequently is of little help in selecting programmes which benefit either individual health, increase

community safety or reduce overall costs to society. They raise concern over the fact that policy decisions made in this way may move away from the priority of the health needs of the individual towards the needs of more 'populist politics'.

Nevertheless, it is argued that individuals who are in contact with the criminal justice system (for example, arrestees, inmates, probationers) are far more likely to suffer from addiction or other substance use disorders than the general population (Miller, Miller, Tillyer and Lopez, 2010). As a result treatment for alcohol and drug addiction within criminal justice settings has become common place within the United States and the UK (Miller, 1999; Ginsburg *et al.* 2002). Indeed the shift towards crime prevention and coercion has been growing in popularity since innovations such as the Drug Treatment and Testing Orders (DTTO) were introduced in Britain nearly a decade ago (Turnbull *et al.* 2000). Indeed Hunt and Stevens (2004) highlight the notion that coerced treatment has become a key part of British drug policy and practice. In addition, the aim of rehabilitating offenders whose offending behaviour was believed to be linked to drinking has been one of the aims of the probation service in the UK. Their emphasis was becoming more fixed on a treatment model rather than a penal model as a more appropriate response to deal with the problem of alcohol related crime (Dingwall, 2006). More recently there has been a strong governmental belief that rehabilitative work is beneficial and the Criminal Justice Act 2003 introduced the ATR as a new measure specifically aimed to help those with alcohol problems (s.177(1)(j)). This new form of treatment strategy has been specifically referred to as 'coercive treatment' whereby at sentence, offenders may be faced with an 'offer they

cannot refuse' (Hough 1996) in that refusal to agree to treatment as part of a community sentence may well trigger a prison sentence.

There are several criteria that have to be fulfilled before such a requirement can be made. Section 212(2) of the Criminal Justice Act 2003, states that the court must be satisfied that the offender is dependent on alcohol; that they may be susceptible to treatment and that the offender has to be willing to comply with the requirements of the order. The latter requirement raises a somewhat interesting perspective when considered alongside the coercive element of a treatment programme such as the ATR. Motivation is widely viewed as a critical factor in treatment participation, retention and success (Hiller, Knight, Leukefeld and Simpson (2002). Seddon (2007) points out that increasingly, it is argued that coerced treatment is doomed to failure precisely because individuals do not have the motivation to change. Norland, Sowell and DiChiara (2003) considered the role of coercion in therapy finding the two concepts to be an 'ill-suited combination in that different social conditions are associated with therapeutic and punitive efforts. Nevertheless it has been noted that pressures to enter into treatment are not always simply a result of the courts, as other external factors such as family members or friends can often have a strong influence over an offenders' decision to receive treatment (Cosden *et al.* 2006). The term 'perceived coercion' has been used to reflect the client's perception of the pressures they experience to enter a treatment programme. Nevertheless, other evidence suggests that coercion by the criminal justice system brings addicts into their first encounter with treatment earlier in their addiction career than might otherwise have been the case (Anglin, Brecht, and Maddahian, 1989)

Klag *et al.* (2005) indicate that the criminal justice system is naturally interested in social control and public protection; in contrast treatment providers are traditionally concerned with rehabilitation and have previously viewed the criminal justice system as at odds with the therapeutic process. Therefore it would appear that it is important to establish a balance between the two competing agendas and to determine what could be termed 'effective' treatment i.e. less or no drug use or reduced offending. Moreover, there is also the argument that the fundamental nature of the addictions treatment world is that an addict cannot recover until he or she possesses the internal motivation to do so (Prendergast *et al.* 2002). Therefore coercive treatment would be deemed unsuitable for offenders and it is argued that it would indeed only serve to create an environment where resistance to treatment is fostered.

Evidence is limited in terms of the effectiveness of coercive treatment in the UK however there are some studies which have explored this. The National Treatment Outcome Research Study has highlighted that treatment can contribute towards substantial reductions in offending for some individuals (Gossop *et al.* 2005). Norland, Sowell and Dichiara (2003) in their review of coercive treatment found that clients in treatment programmes do improve on their drug use and that legally coerced individuals tend to remain in treatment longer than voluntary admissions. However, Norland *et al.* (2003) raise concern about what specifically is responsible for such changes, as they point out that positive changes tend to occur regardless of programme type, 'maintenance and drug free programmes, short and long terms efforts, residential and outpatient regimens all appear to help and to about the same extent' (p.517). This may be the case, however what is not known is whether the

person entering into a coercive treatment programme would have voluntarily entered into treatment at that point, if indeed at all. Indeed Dingwall (2006) argues that this new approach to treatment (including ATRs) may have the benefit of raising awareness amongst sentencers who would benefit from better training about the availability of alcohol programmes for offenders which may not have been previously identified. Subsequently there may be more people who could benefit from a treatment programme than previously known.

According to Sorenson, Hettema and Larios, (2009) the substance abuse field is experiencing a transition from reliance on personal evidence and subjective testimony to a more objective, evidence-based approach. In recent years, there has been a growing emphasis on substance abuse treatments that have a strong scientific base. Indeed in America there has been increasing pressure for programs to justify their actions against competing approaches so that they can collect insurance reimbursement and this way of needing 'hard scientific' evidence to maintain programs' existence has become just as important for the likes of commissioners and policy makers in the UK (Sorenson, Hettema and Larios, 2009).

## **Summary**

This chapter has explored some of the main treatment modalities on offer in the UK in relation to alcohol related problems. It has been identified that with the reconceptualisation of alcohol misuse has come the development of new techniques which aim to treat alcohol problems on a much broader scale. The move away from a disease/addiction model of alcohol abuse has paved the way for more individualistic

goal-oriented treatment programmes to be developed. The introduction of coercive treatment within the criminal justice system has raised questions in relation to its effect on treatment retention and behaviour change. Thus it appears evident that the efficacy of one treatment over another is complex and will to some extent depend on how outcomes are to be evaluated. Some for example may argue that treatment should be evaluated solely on the criterion of complete abstinence, whilst others may argue that outcome status such as employment, social functioning and psychological status is a measurable and desirable outcome (Babor *et al.* 2003). Therefore this review of addiction treatment approaches raises some particularly interesting questions. In particular, to what extent does the ATR as a coercive approach to treatment enable behaviour change? How do offenders sentenced to the ATR experience the treatment process? Furthermore to what extent is the treatment modality offered by the ATR a crucial component in bringing about a desired change?



## **Chapter 3: Developing the methodology: bridging the void between the 'academic' and 'real world research'**

### **Introduction**

The aim of this chapter is to explore the methodological approach that underpins the research process and to provide a rationale for the methods and techniques utilised for data collection. Firstly, an account of how the research project was developed will be presented, providing insight into the complex nature of publicly funded health research and how this has influenced, in part, the development of the research framework. What follows is a detailed exploration of how a 'pragmatist' perspective of social research can enable the utilisation of a mixed methods approach to data collection. By rejecting the traditional, mono-methodological approach to social research, this chapter will explore the recent growing recognition of utilising a mixed methods approach to social enquiry, and in turn, how this approach has been adopted for the current research. Finally, this chapter will outline the chosen methods and techniques that were employed for data collection.

## Contextualising the research methodology

The initial idea for this research project was primarily driven by the specific need of a large metropolitan district in the North of England<sup>1</sup> to engage and respond to the rising statistics of alcohol-related crime and disorder. The District's Primary Care Trust (PCT) saw the need to 'act' on this problem, whereby, as a proactive Public Health Team, the PCT began to collaborate with both the criminal justice service in order to begin to address the current problem. Collaborative working in the NHS is described as:

'Being committed to working and engaging constructively with internal and external stakeholders ... Effective partnership promotes the sharing of information and appropriate prioritisation of limited resources. It also supports 'joined up' provision of integrated care. The quality of dialogue in collaborative work is critical so that problems can be identified and common solutions agreed' (NHS, Institute for Innovation and Improvement, 2006, p.1).

By adopting a collaborative approach the PCT and the Criminal Justice Service were able to actively work together to begin developing and ATR service. Guidelines drawn from the Criminal Justice Act 2003 and National Treatment Agency (NTA, 2006; NOMS, 2006) enabled an ATR to be implemented and piloted with the aim to address the District's needs at a local level. . Rather than the ATR being solely implemented

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<sup>1</sup> This area will be termed the 'District' throughout the remainder of the thesis.

through the imposition of a 'top down' policy-led approach, this program also involved initiation from a 'bottom up' perspective where local services and agencies became involved in the development and implementation of the ATR. Initially, local representatives from the police, probation and alcohol services were invited to join the ATR stakeholder meetings, where collaboration enabled the services to effectively plan and develop the ATR. Further consultation with the local alcohol treatment workers and offender managers from across the District provided additional insight in relation to how the ATR would be operated at 'grass roots' level. It was therefore hoped that that having flexibility to implement the program from these perspectives would be advantageous for its success both locally and organisationally. As this was to be a 3 year pilot project, a research grant was included in the funding allocated to the project which would provide key stakeholders with the opportunity to monitor and evaluate service provision within the ATR. The University of Bradford was invited to consult with key stakeholders in relation to the research project, and as a result, a 3 year postgraduate studentship was advertised. I attended an interview at the University of Bradford, and was offered the studentship in April 2007, three months prior to the launch of the ATR in the District. The research project at that time was entitled *'Investigating the delivery of the ATR in the District'*.

My initial goal for the project was to become involved with the services at an early stage, which felt crucial both in terms of forging relationships with service professionals and also beginning to develop a framework for the research project. Throughout the research project, ongoing collaboration with both the Health Service and the Probation Service served to be invaluable during the research design phase.

Nevertheless, it was soon apparent that the tensions between undertaking NHS funded research, which fundamentally concerns the need for ‘outcomes’ and ‘results’ (Brannen, 2008) compared to my academic desire to meet the demands and requirements for a sound theoretical piece of work, would both bear an influence on how the research project developed methodologically.

### **Negotiating ‘expectations’**

Conducting (and developing) research within a ‘policy-informed research environment’ (Brannen, 2008) particularly within a health care setting, can often be influenced by the organisation’s need for useable results/outcomes that may inform decisions and policies. Indeed, the original documentation for this research project largely reflected the interests of the funders, concentrating on service delivery and potential outcomes of the ATR delivery. Thus there was a level of *expectation* about what the research would aim to provide. This *expectation* was specifically linked to the funder’s assumptions about what they perceived to be relevant and useful knowledge that would best make sense of the ATR and its potential future. To this end, the first two research aims for this project were to ‘*explore and understand the process of assessment and eligibility for the ATR*’ and to ‘*explore offending behaviour and offender characteristics in relation to alcohol-related crime and disorder in the District*’. Understandably, an evaluative piece of research would serve to provide useful insights into the implementation of the ATR program. Documenting the ATR ‘treatment pathway’ and detailing characteristics about offenders who enter the program was one of the desired objectives/expectations of the research made explicit by the Health

Services. Furthermore, exploring a way to document outcomes was a further requirement for the research, as, ultimately, ‘outcome information’ could influence commissioning bodies who have the power to sustain and provide a future for the ATR program and its employees. To this end, it was mutually agreed during this early planning stage that I would provide the services with a final report which would enable them to gain knowledge about the delivery and process of the ATR. This report would be an overall evaluation of the intervention (ATR) that would document the ATR process, including how the program is delivered across the District, treatment pathways, involving the ‘offender’s journey’ from assessment to completion of the order, and finally, analysis of probation data-base records providing information on offender characteristics. This part of the research was directly related to research aim ‘4’ where I proposed to *‘develop a comprehensive theoretical framework for assessment and delivery of alcohol treatment’* and research aim ‘5’ which aimed to *‘disseminate findings to reflect on current practice and to assist in the ongoing development of the ATR’*. These particular aims of the research represented the specific *expectations* of the funders to produce *evidence based research* (Mertens, 2004) that can be used to inform service delivery and practice. Indeed there has been a distinct shift towards the promotion of ‘evidence based practice’ specifically within the health care setting which relies on ‘controlled scientific methodology’ (Hayes, 2005). Thus it became clear that this approach to developing the research methodology represented a distinctive research tradition where ‘objective social science’ methods are employed.

However, Hammersley (2002) argues that doing research in this way results in raising *false expectations*, the notion that somehow, evidence-based solutions can be found for all social problems. The promotion of scientific models of research by funding bodies, for Hammersley (2002), peddles *false expectations* where commonsense and reflective experiences are often downplayed. He does however, acknowledge that scientific research is important to the extent that it provides practitioners with some, (but not all) relevant knowledge, nevertheless he maintains that practice cannot be *founded* on what research produces (Hammersley, 2002, p.52) since practice must draw upon knowledge and experiences of individuals within their field. Indeed for this research, documenting the 'treatment pathway' can provide some, but not all, of the components of the offenders' 'journey' whilst undergoing an ATR. It could be further argued that the scientific method of research enquiry can become constraining and problematic as it can reduce the human element of research down to mere numbers and units which says little about the individual's experience whilst participating on the ATR. To this end, research aim '3' specifically aimed to '*explore in-depth, the subjective experiences of offenders in relation to engagement, progress and completion of the ATR*'. Thus by broadening out the research aims, the importance of the experience of the individual is not 'downplayed', rather it serves to provide a more holistic picture of the ATR adding a further valuable dimension to the research design. Therefore to acknowledge individual subjective experience as 'valuable' together with the more traditional scientific enquiry within the research design, is to accept that there is ultimately a social world that is multi-faceted, multi-layered and multi-perspectival (Pawson, 2008). The process and pathways of the ATR becomes the offender's

‘journey’, the nature of enquiry and explanation becomes ‘deepened’ , and the inner workings of intervention and change can be more deeply understood.

The framework for this research design, was partly a result of a negotiated settlement between stakeholders. It was important that the research design had ‘policy relevance’ that would be able to ‘speak’ to policy makers and inform practice, and their ‘reality’ largely constitutes facts and figures that can be counted and measured objectively, and therefore called for a quantitative methodological approach. In addition to this approach it is argued that there is also a subjective reality that can be analysed and interpreted which calls for a qualitative methodology. Both these approaches needed to be understood philosophically and practically in relation to how to successfully ‘combine’ them within the research design.

### **Epistemology and bodies of evidence**

Research in the social sciences encompasses a range of different methods, different forms of knowledge, and different criteria by which that knowledge is judged (Benton and Craib, 2001). The social world is viewed as complex and is studied by different people from different perspectives with different ends in view, producing their own knowledge of the social world. Different assumptions about the very nature of the social world (ontology) and how it can be understood (epistemology) inevitably produce different ‘realities’. Indeed Moses and Knutsen (2007) point out that as long as can be recalled, people have argued over the nature of reality. There are different ways of ‘knowing’ which inevitably affect the methods chosen to study social phenomena. Within any given research project, the choice of research design and

methods is said to be largely influenced by the researcher's understanding of the nature of the world and how it should be studied (Moses and Knutsen, 2007). Therefore how methodologies and methods relate to one another becomes an important part of the research process. Different methodological perspectives draw on different understandings of the nature of social reality. Furthermore, Flick (2006) argues that different methods do not simply provide varying kinds of information about the same object, but constitute the world in different ways. To this end, it would seem 'automatic' that research should operate strictly within the confines of a single epistemological paradigm and indeed many researchers would advocate this approach (Guba, 1990; Crotty, 1998; Benton and Craib, 2001; Willig, 2008). According to Brew (2001) the 'rules' of research, which include the way research is conducted, reported and peer reviewed, are fundamental to any understanding of the nature of research. The 'conventional' approach to research relies on consistency and coherence, largely based on a singular epistemological and ontological perspective depending upon how reality is conceptualised. For example, positivism relies on rigorous consistency which strives for objectivity and neutrality. However, Hammersley (2008) argues that

'While people may have different perspectives on the world, and we do of course need to take this into account, in practice they will rarely act on fundamentally discrepant assumptions about the nature of what exists in the relevant domain, or about how we can gain knowledge of it. Rather, what we generally find are sets of accounting practices that involve overlapping as well as discrepant assumptions, the degree of overlap and discrepancy varying considerably across cases.' (p.29)



What is argued by Hammersley is that the relationship between philosophy and method are much more complex. To be 'restricted' to one way of viewing the world is to provide only part of the picture. Hammersley (2008) rejects the idea that doing research automatically leads to the assumption that there is only one single reality that can be known. Similarly Brew (2001) also recognises that in social research, a change is needed that moves away from 'closed' and 'coherent' systems of general rules that govern research behaviour to a more 'pluralistic' system of rules. For Brew (2001) emphasis on the exploration of how to operate in a complex and uncertain world is the future of social research. Furthermore, Moses and Knutsen (2007) advocate strongly 'methodological pluralism' in the social sciences and therefore accept the possibility of embracing more than one ontological (hence methodological) perspective. They argue that considering different perspectives can bring something 'unique to our understanding of complex social phenomena' (p.290). However, if methodologies, including data sources, are to be combined then issues emerge around conflicting epistemological assumptions. To combine different epistemologies, would seemingly reject the idea that there is a single reality and accept the belief that there are multiple realities or forms of life.

### **Tensions of designing funded research**

Lee (1993) posits the argument that in social research, policy makers and implementers can possess their own agenda which carries their own assumptions about reality, which can often differ from that of the researcher. Where the researcher may be concerned with thoroughness and depth, officials can be deeply concerned

about their organisation's image when it comes under independent scrutiny. Cowen and Goulbourne (1998) suggest that researchers need to be explicit about the research process and that collaboration can be a crucial feature of funded social research, especially where policy development is concerned. Furthermore Brannen (2008) considers this process to be a direct result of the way that research, and in particular health research, has developed:

‘In today's world, researchers are required to address the needs of research stakeholders and users, with funders often framing our research questions for us and sometimes even our methods’ (p.56)

Historically, evaluation research and ‘systematic reviews’ have been the major perspective of choice for evidence-based policy, specifically within the clinical health setting where quantitative explorations of a given intervention were defined in terms of ‘solid outcome measures’ and rigorous experimental procedures termed the ‘*meta analysis*’ (Pawson, 2008, p.121). In contrast, Pawson draws on the distinction between the rigours of clinical research with the idiosyncrasies of social intervention programs:

‘The meta-analytic approach, so goes the prevailing critique, is fine for drawing together evidence on clinical research in which the interventions are singular and discrete and the intended effects are simple and agreed. Social programs, by contrast, are made in long and contested implementation chains; they depend for their efficacy on the vagaries of human volition; their effects are enormously sensitive to context; they throw up a range of intended and unintended consequences; and, if all that was not enough, they even tend to

change the conditions that make them work in the first place.’ (Pawson, 2008, p.121).

By highlighting the difficulties inherent in researching social programs Pawson (2008) recognises that social enquiry is in need of more adequate strategies for ‘combining idiosyncratic methods and synthesizing ideographic data’ (p.122). The need to ‘investigate’ outcomes and characteristics of the ATR became evident from the service providers’ viewpoint, who, understandably, wanted information and research that would inform decisions on a policy level. This coupled with my own interest for in-depth subjective experiences, lead to the emergence of a more practical approach to laying the foundations for the research project. As an experienced qualitative interviewer, I was interested in exploring, in depth, the subjective experiences of the offenders who would be serving on the ATR program. This would enable me to explore the offender’s individual concepts of the treatment program and any impact this may have had on their lives and consequent drinking behaviour. Thus my initial thoughts in relation to the research methodology, were based around questions such as how could it be possible to meet both demands without compromising on integrity and soundness of the research? It became clear that in order to develop a rationale for the research, a combination of elements would need to be considered in order to enable an appropriate route to the required knowledge.

### **Developing a mixed methods way of thinking**

Conducting research within a ‘policy-informed research environment’ (Brannen, 2008), often invites a more practical way of thinking about knowledge production (O’Cathain,

Murphy and Nicholl, 2007). The need for comprehensiveness, in addressing the impact of the delivery of the service, with a focus on process as well as outcomes, can often result in the researcher having to speak two 'languages'. Indeed Brannen (2008) argues that strategic and practically oriented research must entail the technical language of research and a language which makes research results accessible to a wide variety of audiences, thus words become as important as numbers. Moreover, Bryman (1984) suggests that, in practice much research is driven by what is termed as 'pragmatic' assumptions as much as it is driven by philosophical assumptions. Nevertheless for this research, the philosophical challenges inherent in designing the research needed to be explored and worked through in order to avoid providing only a vague justification for utilising a pragmatic stance to inform the methods and techniques utilised in this research. Thus having acknowledged the possible tensions of developing the research design, and considered the need for a research strategy that would apply to both the policy field and the academic field, it was ultimately inevitable that a mixed methods research strategy which would enable a range of research questions to be addressed.

### **Mixed methods research: the 'third paradigm'**

The emergence of the idea of mixing methods in the social sciences has spanned over the past three decades (Greene, 2007) which has begun to change the way of thinking about the approach to social enquiry. Indeed Greene (2007) states that the contemporary interest in mixed methods approaches to social enquiry is a 'natural and logical development, given the recent history of social scientific thought and practice' (p.32). Therefore understanding the main outlines of this history is essential in

beginning to appreciate fully, how mixed methods has grown in popularity and can be successfully utilised within the social research community (Brannen, 2005).

### **The paradigm ‘wars’**

Research paradigms are said to be important in shaping the choice of methods for data collection (Brannen, 2005). In this chapter, the term *research paradigm* is taken from Burke-Johnson and onwuegbuzie (2004) to mean a set of beliefs, values and assumptions that a community of researchers have in common in relation to the nature and conduct of research, including ontological and epistemological standpoints. It is widely acknowledged within the social research methods literature that advocates of quantitative and qualitative research paradigms have engaged in fervent dispute over the last century (Howe, 1988; Henwood, 2004; Todd, Nerlich and McKeown, 2004; Brannen, 2005; Parker, 2005; Greene, 2007;). In the methodology of social science, the either-or perspective has been held for a long time (Danermark, Ekstrom, Jakobsen and Karlsson, 2002) where the researcher’s choice of methods is crucially driven by specific philosophical assumptions, both ontological and epistemological, which inform the research process. Brannen (2005) points out that the perception that qualitative and quantitative research is distinct is that they are said to be based on different philosophical principles. These competing principles are said to belong to different ‘paradigms’, therefore, according to the paradigmatic position, qualitative and quantitative research are seen to be intrinsically different entities underpinned by different philosophical assumptions (Brannen, 2005).

Burke-Johnson and Onwuegbuzie (2004) draw upon the *incompatibility thesis* (Howe 1988) in order to explain the ‘paradigm wars’ of quantitative and qualitative research. The thesis posits that qualitative and quantitative research paradigms, including their respective methods, cannot and should not be mixed. Indeed, the ‘great qualitative-quantitative debate’ (Greene, 2007) led to the emergence of ‘purists’ on both sides (Burke-Johnson and Onwuegbuzie, 2004).

Since the inception of psychology as a ‘science’ in the nineteenth century, quantitative methods were seen to be the favoured choice (Nerlich, 2004) often referred to as the ‘mainstream’ approach in psychological research (Parker, 2005). Quantitative ‘purists’ (Popper, 1959; Maxwell and Delaney, 2004) take the epistemological stance commonly referred to as positivism. A positivist philosophy is argued to have originated from the natural sciences (Flick, 2006; Greene, 2007), for example quantitative purists believe that social observations should be treated as entities in much the same way that physical scientists treat physical phenomena. Bryman (2004) summarises some of the main assumptions of positivism as; only phenomenal knowledge confirmed by the sense can be warranted as knowledge (phenomenalism); theories are used to generate hypotheses that can be tested to which explanations follow (deductivism); knowledge can be produced by collecting facts that provide the basis for explanation (inductivism); and science can only be conducted in a way that is value free and thus objective. Therefore, quantitative research should be objective, and context-free which can be determined reliably and validly (Burke-Johnson and Onwuegbuzie, 2004). Furthermore, quantitative researchers have traditionally called for ‘rhetorical neutrality’ involving a formal writing style, using the impersonal passive voice and technical terminology

(Tashakkori and Teddlie, 1998), and is widely known as the 'scientific' approach to social enquiry.

In contrast, it is widely affirmed that qualitative purists reject what they call positivism and argue for the superiority of constructivism, idealism, relativism, humanism, and hermeneutics (Guba and Lincoln, 1989; Parker, 2005; Flick, 2006; Bergman, 2008). It is therefore often claimed that qualitative research is based on the assumption that reality is either constructed or does not exist (Bergman, 2008) and that time and context-free generalisations are neither desirable nor indeed possible. Qualitative research is said to be value-bound, in that it is seen as impossible to differentiate fully causes and effects and that 'knower' and 'known' cannot be separated because the subjective knower is the only source of reality. The qualitative paradigm is further characterised by a move away from detached and passive styles of writing, utilising instead a more detailed, rich and in-depth description written on a more informal level (Burke-Johnson and Onwuegbuzie, 2004). This approach is often characterised as 'constructivist' where it is argued that reality is a social construction.

### **Taking a pragmatist approach**

Burke-Johnson and Onwuegbuzie, (2004) take the view that mixed methods research should use a method and philosophy that attempts to fit together the insights provided by qualitative and quantitative research into a workable solution. To this end they advocate the consideration of the pragmatic method of the classical pragmatists premised on the works of Pierce (1934), James (1907) and Dewey (1930) who believed that the truth of a statement can be defined in terms of the utility, that is, the practical

usefulness of accepting it (Greetham, 2006). The pragmatist position is becoming increasingly popular where it is acknowledged that some research questions are better answered by a variety of methodological approaches. This has been particularly evident in health services research where data collection can be seen to be more complex (Barbour, 1999).

According to Pring (2000) a '*false dualism*' has been created between the scientists and the constructivists where an 'epistemological and ontological apartheid' all too often divides qualitative and quantitative researchers. Furthermore, Brew (2001) argues that the positivist paradigm has come to dominate research, and suggests that this '*false primacy*' has been achieved by research being driven by performative and economic agendas, usually funded by governments who favour a more 'objectivist, outcomes-approach' (Brew, 2001, p.7). What Brew (2001) argues for is a move away from a closed positivist system of research towards a more open and pluralistic approach. This concern is one of the fundamental aspects that is shared amongst most pragmatic philosophers. It is a distrust of what Dewey (1930, cited in Baert, 2005) called the 'spectator theory of knowledge' which sees knowledge as predominantly, if not exclusively, a way of representing the inner nature of an outer world as accurately as possible (Baert, 2005).

In endeavouring to achieve such 'accuracy' pragmatists see no point in making one form of enquiry any more important or valuable than any other, since they are all ways of helping people to cope with the world. The pragmatic stance, often termed the 'balanced' or 'pluralist' position is argued to enable improved communication among



researchers from different paradigms in an attempt to advance knowledge (Maxcy, 2003).

Indeed from a pragmatic perspective, knowledge acquisition is seen as active in that it is a way of coping with life's demands. Burkitt, (2008) points out that this coping involves not simply coming to terms with the world as given, but in actively transforming it to suit human purposes and to better meet their needs. Therefore, in contrast to rationalists who would see reality as 'ready made' waiting to be discovered, for pragmatists knowledge is always in the making (Baert, 2005). Rorty (1999) also takes this viewpoint and in doing so challenges the scientific view which suggests that there is an actual reality out there waiting to be discovered, where scientific truth seemingly responds to reality. Therefore Rorty (1999) argues that pragmatists, unlike positivist scientists, do not go about 'finding truth' as a distinct human project, nor does he believe that there is one single way of looking at the world. Therefore what Rorty argues for is in contrast to a scientific approach, whereby inquiry leads to descriptions that meet our particular needs. In this way, descriptions about the world can only be 'tentative', possible and suggested and can only last as long as they are overtaken by even more useful descriptions. In this way, such descriptions are not discovered but are *constructed* (Badley, 2003).

### **Doing mixed methods**

According to Greene, (2007) the primary purpose of using mixed methods in a research project is to better understand the complexity of the social phenomena being studied. It is here, therefore that a mixed methods epistemology is argued to respect multiple

ways of knowing, reject a one sided approach to knowing and consequently move to gaining a more deeper and enriched piece of research (Greene, 2007, p.27). Burke-Johnson and Onwuegbuzie (2004) define mixed methods research as:

‘The class of research where the researcher mixes or combines quantitative and qualitative research techniques, methods, approaches, concepts or language into a single study.’(p.17).

Thus Mixed methods research attempts to avoid restricting or constraining the researcher’s choices by legitimating the use of multiple approaches in answering research questions. Philosophically, mixed methods research has been branded as the ‘third wave’ or the ‘third paradigm’ that moves beyond the paradigm wars by offering a more practical and logical alternative (Tashakkori and Teddlie, 2003). The major characteristics of mixed methods research draws on the pragmatist principle that the specific research question(s) are more important than the method of data collection or the philosophy underlying the method.

However, as Bergman (2008, p.13) points out, the fundamental differences between qualitative and quantitative research methodologies have produced a wide array of literature which takes a ‘there-are-two-kinds-of-research-methods’ perspective (Lincoln and Guba, 1985; Denzin and Lincoln, 1994;1998; Silverman, 1997; Flick, 1998;) which tends to hinder the development of a theoretically grounded application of mixed methods design. Bergman (2008) argues that the ‘incompatibility theory’ or ‘paradigm wars’ are utilised in an over-simplistic way which does not successfully allow for a good justification of mixed methods to be applied. For Bergman, the post-

positivist/constructivist dichotomy which divides the two paradigms both ontologically and epistemologically show too quickly the stark differences whilst ignoring how the two approaches cover a wide array of heterogeneous methods which can in many instances be complimentary rather than conflicting. While it is beyond the scope of this chapter to discuss in detail Bergman's argument (see Bergman, 2008 for a more detailed discussion) it is however worth noting that he concludes by stating that

'From a methodological perspective, it does not make sense to declare one approach more or less valid or valuable, scientific etc. Instead, how to understand and analyze data must be based to a large extent on the consistency formed between how to understand data in conjunction with the specific research question, rationale, aims etc.' (Bergman, 2008, p.15)

Within this argument it was clear that for this research project it was important to move beyond producing simply a 'fuller picture' of the ATR under study using mixed methods, towards developing a more complimentary analysis of how the different approaches can be successfully combined and integrated. Nevertheless, Bryman (2008) considers the extent to which both quantitative and qualitative research data can be genuinely integrated. Bryman (2008) argues that the popularity of adopting a mixed methods way of thinking often results in providing little or no explanation of what it actually *means* to mix/combine different methodologies. Bryman has expressed concern about the way that mixed methods research is often insufficiently justified resulting in researchers overemphasising outcomes rather than rationales, and suggests partly that there is no unified 'language' for expressing mixed methods

research. Thus how one type of information has the potential to go on and make sense of another was considered, and a three phased approach was employed in line with the research aims and drew upon a combination of quantitative and qualitative data collection methods.

### **Overview of the research design**

Having considered methodologically that a pragmatist approach would enable a mixed methods approach to exploring the ATR, the next step was to begin to plan and design the three phased approach to data collection. Below is a summary of the three research phases employed for this project.

*Phase One:* Systematic review of treatment files and probation records.

*Phase Two:* Qualitative participant observations of the treatment setting.

*Phase Three:* Narrative interviews conducted with offenders sentenced to the ATR.

In designing the research phases, it was argued that each phase would enable a 'thickening of the story' (Denzin, 1989) of the ATR in relation to process, delivery and individual treatment journeys. Each of the three phases will be outlined in more detail in the following chapter.

## Summary

It was apparent from the outset of this PhD that, as a funded research project, expectations both from the academic supervisory team and the funders would have to be negotiated. Thus bridging the gap between the academic, steeped in complex levels of theory and detail, and the funders, embedded in policy and evidence based practice, was inevitably anticipated in relation to developing the theoretical framework for the project. The challenge of moving away from traditional ways of doing social research however, has the potential to enable researchers to stay open to new ways of addressing research questions. Thus although funded research may at times arguably constrain research integrity, it is argued that in this instance, developing the research pragmatically arguably enabled a more in-depth, multidimensional and multilayered investigation of the delivery of the ATR to be conducted. Therefore, finally, in Bryman's sense (Bryman, 1988), this research was initially influenced by situated pragmatic reasons and yet over time the approach became a justified and accepted methodological way of thinking and doing real world research.

## **Chapter 4: Data collection on the ATR**

### **Introduction**

In the previous chapter, it was established that seeing research through a 'pragmatic lens' enables the researcher to embrace diverse forms of evidence/data and acknowledge that there can be different opinions about the nature of social reality. Moreover, it was recognised that by drawing on the philosophy of pragmatism, which encourages methodological pluralism, a compromise can be sought by allowing the researcher to reflect on the various objectives that underlie social research examining how each objective can be achieved by being sensitive to the multitude of interests implicated in commissioned research projects. This research project, therefore, adopted a pragmatic mixed methods research design and was 'managed' in three phases. This chapter will begin by contextualising the ATR in relation to how it is delivered across the District. Each phase of the research project will then be outlined in detail paying particular attention to the methods utilised and the 'value' each can bring to understanding the ATR.

## **Delivering the ATR in the District**

The District is served by two probation offices. At the time of data collection the District was divided into two catchment areas<sup>2</sup>. The smaller of the two will be referred to as the 'East Site', and is located 12 miles to the east of the City Centre and covers 7 towns and villages, with the District's 'Centre Site' being the larger area covering 44 towns and villages including the city centre. The delivery of the ATR across the District is a joint initiative between West Yorkshire Probation and the NHS local Alcohol Team. Two alcohol treatment workers were appointed in July 2007 to case manage offenders based on National Probation guidance and the Alcohol Team's existing 'stepped care' approach to assessment, treatment and aftercare of patients/clients with alcohol problems. The probation services within the District have accommodated the alcohol treatment workers 'on site' at the two probation offices.

## **Understanding the ATR treatment pathway**

Working to identify the process of the ATR was a useful way of understanding the offender's 'journey' from sentencing to completion of the order. Figure 1 shows the process involved from an offence being committed through to a possible ATR being granted by the courts.

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<sup>2</sup> This District has since been re-organised into new catchment areas

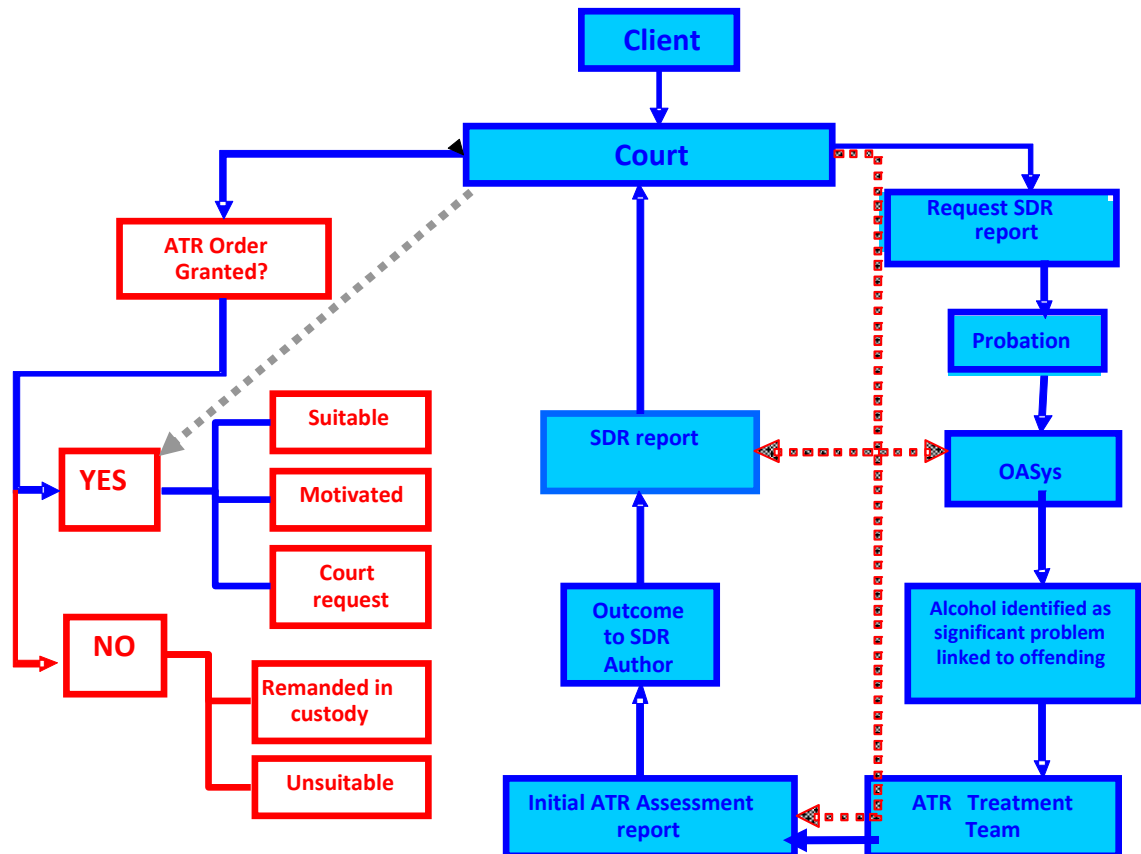


Figure 1: Flowchart of the ATR pathway.

The main and most common route is that indicated by the solid blue line in Figure 1 above. After having committed an offence and being charged and convicted, the offender is given a date to appear in court. During the court attendance it may be identified that there is an established link between the crime committed and alcohol misuse. A request is then made for a sentence delivery report (SDR, formerly known as a 'pre sentence report' – PSR) where offender managers at the probation site undertake a preliminary assessment of the offender using the Offender Assessment System (OASys) including alcohol and drug misuse and any other risk factors that may predict re-offending. The main risk prediction instrument used in the probation service



is the Offender Group Reconviction Scale 2 (OGRS 2) which is a predictor of re-offending based only on statistical risks (Howard, Francis, Soothill and Humphreys, 2009). The OGRS 2 system forms part of the OASys documentation and primarily uses previous offending histories and demographic variables in order to predict subsequent offending. During this assessment, if alcohol has been identified as a significant factor in their offending behaviour, offender managers then make a referral to an alcohol treatment worker. An alcohol treatment worker then conducts an initial assessment interview with the offender, using the AUDIT C alcohol assessment tool, and based on this interview, a treatment assessment report is then completed and included in the SDR information for the courts. The SDR report, which details summaries of the assessments carried out, is received in court where an ATR sentence can then be granted, either as part of a community sentence or as a 'stand alone order' (the latter being less likely to occur). Once the ATR order is made the offender must consent to alcohol treatment and subsequently the first alcohol treatment appointment is arranged. A summary of the different pathways is presented below:

- The broken red line in Figure 1 indicates a second possible route where the court refers directly to the alcohol team for an ATR assessment without alcohol misuse being identified from the OASys report.
- The solid red line indicates instances where the offender has been assessed but has not been granted an ATR due to a custodial sentence being served; a court decision not to grant the order, or the offender being assessed by an alcohol treatment worker as 'unsuitable' for treatment.

- The third route is indicated by the grey broken line. The offender in this case is granted an ATR direct from the courts without an ATR assessment being conducted. At the time of data collection there was only one such case where this route was identified therefore this may be an isolated incident and therefore not considered a usual route for offenders.

Policy guidance outlines that the ATR is targeted at dependent drinkers however the Health Survey for England (National Centre for Social Research, 2005) showed that within the District, the estimated proportion of adults that binge drink was just over 21 per cent and had increased to 22 per cent which is higher than the national average of 18 per cent (Association of Public Health Observatories, 2009). Therefore, in response to the reported severity of 'binge drinking' across the District offenders who had hazardous and harmful drinking patterns were also deemed 'suitable' for the ATR.

As part of the treatment all ATR offenders (who are assessed as 'dependent') have the opportunity to undergo an alcohol 'detoxification' with the support of the alcohol treatment workers and medical assistance from the District's Alcohol Team and local General Practitioners (GPs). However, this procedure accounts for only a small part of how treatment on the ATR is delivered. The majority of the alcohol treatment focuses on support and counselling. Offenders are bound by the same conditions as the probation services' National Standards, therefore, non-attendance would result in 'breaching' the order. Nevertheless, one of the main aspects of the treatment process is the promotion of open communication and 'flexibility'. For example offenders may experience 'relapse' several times before reaching their desired goals, encouragement

rather than punishment is offered, enabling individuals to positively reassess their situation. Taking this into consideration the alcohol treatment workers are trained in 'motivational interviewing' techniques (Miller and Rollnick, 2002). As part of the ATR offenders are asked to monitor their levels of drinking using a 'drink diary' and work with offenders involves education around safe levels of alcohol consumption; individual goal setting; lifestyle changes and relapse prevention strategies.

### **Designing the research: taking a phased approach**

As I have already indicated in the previous chapter (Chapter Three), this research has been funded by the NHS. Hence the research aims outlined in Chapter One reflect in part the requirements of the funders for outcome information in relation to the delivery of the ATR and in particular, how treatment can be 'measured' and evaluated. On the other hand, there was also an expectation that this research would need to meet the needs of an academic audience that is more exploratory and theoretically driven. To this end, and perhaps inevitably, a mixed methods design was employed for the research. Nevertheless, conducting mixed methods research, particularly in the health care setting can prove to be valuable. Indeed Sale, Lohfeld and Brazil (2002) acknowledge that not only is combining qualitative and quantitative methods in health care research now widely accepted, it is also useful because the complexity of the phenomena often requires data from a large number of perspectives. Therefore, with the growing acceptance of mixed methods in health care research and the acceptance of methodological pluralism within the pragmatic approach, there is some potential for compromise that can embrace diverse forms of evidence/data without straying too far

from the original ideology of the research. Therefore, what follows is a detailed outline of the phased approach to data collection which specifically details the methodology, methods of data collection and data analysis employed for each phase of the research.

### **Phase One: impacts and outcomes of the ATR**

Phase one of the research involved a quantitative analysis of existing records and files kept by the probation service and the health service. As established in Chapter Three, different methods of data collection are indeed based on a particular paradigm with a specific set of assumptions about the ontological and epistemological way of viewing reality and what can be known about the phenomena under study. This quantitative phase of the research relies on traditional 'rules' (Brew, 2001) inherent in the positivistic approach to research enquiry. The positivist/objectivist rules of detachment have been argued to be characteristic of Western thought and the predominant approach to research in the natural, physical and social sciences up until the 1960s and 1970s (Coben and Crabtree, 2008). Such traditional approaches in the social sciences can be argued to be pervasive in the norms and values of the funders' community. They hold the belief that social reality can be established and made sense of through logic supported by empirical evidence (Brew, 2001) and is the only reality considered to be useful or acceptable. Therefore this approach relies on a realist ontology where only facts can be gained independent of an individual's opinions, beliefs or cultural background. Notably, the importance of evidence based practice in the NHS is argued to be based around an ideology and method that enables clients to 'be provided with the most effective intervention possible' (Bloom, fischer and Orme, 2009, p.43). This

largely entails evidence from systematic research and randomised controlled trials (Ferguson and Russel, 2000). Indeed by collecting data and ‘facts’ about those who have participated in the ATR, it may be possible to present a certain objective reality about the ATR which can provide contextual information about the characteristics of the offenders, the number who remained in treatment and treatment outcomes of those who completed their treatment. This kind of evidence was anticipated to be useful to the health care community and policy makers who have a stake in the ATRs future.

### ***Collating the data***

Permission was granted by the District’s probation Service to access both the OASsy and the Case Record and Management System (CRAMS) where details of individual offenders are stored and updated. Access to these details enabled the extraction of offender information that provided insight into the characteristics of individuals who were deemed ‘suitable’ for an ATR. In addition, permission to access offenders’ treatment files held by the District’s alcohol team, was granted by the NHS Committee for Research Ethics (COREC), now known as the National Research Ethics Service (NRES). Access to these treatment files provided further information about the offenders’ treatment, participation and progress on the ATR.

With the introduction of the ATR in July 2007, data was collected between the months of July 2007 to March 2009 for offenders who were granted an ATR by the court. During that time, 81 offenders’ details and characteristics were explored through a

systematic analysis of all case records available. During the data collection phase all offenders were identified by using a code number in order to ensure anonymity. The data collected from this phase of the research was analysed and presented statistically. These analyses included; characteristics of the offenders; identification of drinking patterns; offending behaviour patterns; outcomes and impacts of the ATR. It must be noted that this particular phase of the research took considerably longer than originally anticipated. Treatment files and probation files are complex, thus extracting data from these files and attempting to make the data meaningful in relation to the research aims was extremely time consuming. The data that was collected was analysed and had to be organised and made sense of in order to be presented in a report for the funders. These quantitative findings based on an overview of the impacts and outcomes of the ATR were presented in a full interim report for the funders and key stakeholders involved in the project which will be presented in Chapter Five (also see Ashby, Horrocks and Kelly, 2009; 2011).

## **Phase Two: observing and exploring the treatment setting**

The traditional approach to data collection outlined in Phase One, although valuable in presenting 'outcome' data would not have provided further specific insight into the complexity and culture of the ATR. Indeed it is argued that research can no longer be evaluated simply in terms of additions to the general store of objective knowledge (Brew, 2001). Brew acknowledges that there has been a move towards an emphasis on the exploration of how to operate in a complex uncertain world. In order to understand the social world in its complexity, and as far as possible in its 'natural state',

a naturalistic research method is required. Phase two of the research project therefore, acknowledged that looking at the process of the ATR from records and files in isolation would provide a limited perspective on the ATR. Thus having the opportunity to observe the treatment setting enabled further contextualisation of how the ATR was delivered in the District.

The majority of treatment is delivered at the probation sites (there were occasional home visits conducted and clinical assessments made by GPs at local surgeries) and entails the offender visiting the probation site in order to meet with their alcohol treatment worker. Assessment for the ATR and alcohol treatment takes place in an interview room between the offender and the alcohol treatment worker. I was granted access to sit in and observe these sessions thus there was an opportunity to explore in more detail how offenders 'talked' about their offending behaviour and their alcohol problems, to describe the nature of the setting and the people involved. Having the opportunity to observe how the interviews/sessions were conducted provided an understanding of how; decisions were being made to either offer or reject alcohol treatment to the offender; how treatment was delivered to offenders; and to explore the social interaction between the alcohol treatment worker and the offender.

Initially, the ethnographic method of overt, non-participant observations was decided upon as a useful tool with which to conduct this phase of the research. However, it is argued that in contrast to conducting interviews and participant observations this method refrains from interventions in the field (Flick, 2006). At the very early stages of the research phase this was employed as a desirable research strategy, as it was

considered to be obtrusive to impose upon the alcohol treatment workers or offenders during what could be described as a sensitive and often stressful (specifically in terms of an initial assessment) situation. However it became clear in the very early stages of this Phase that trying to remain 'impartial' during these observations was perhaps a little ambitious and with hindsight unrealistic.

The expectations inherent in carrying out this particular observational method was that the researcher would simply observe the 'flow of events' with no interruption or intrusion so that the natural setting can be observed as it would be if the researcher was not present (Hammersley and Atkinson, 1995). The main limitation with this approach is that there is inevitably some doubt as to what extent the events observed remain 'natural' as the act of observation itself may influence those being observed (Emerson, Fretz and Shaw, 1995). Indeed during the early pilot observations this problem emerged. For example, it became apparent that my presence of not only observing but also taking notes, may have been having an impact on the treatment session and consequently the interaction between the offender and treatment worker. Although informed consent was gained at the beginning of each observed session, offenders could have been reluctant to talk openly about their drinking or their offence during the times that I was observing. Furthermore, as I would be in the field one or two days a week for the duration of at least one year, it was realised that participation in the everyday culture of the service would be inevitable and could not be separated from non-participating observations. For example, on one occasion, after observing an offender's treatment session, I was invited to engage in a detailed discussion about the offender with the alcohol treatment workers, and my field notes

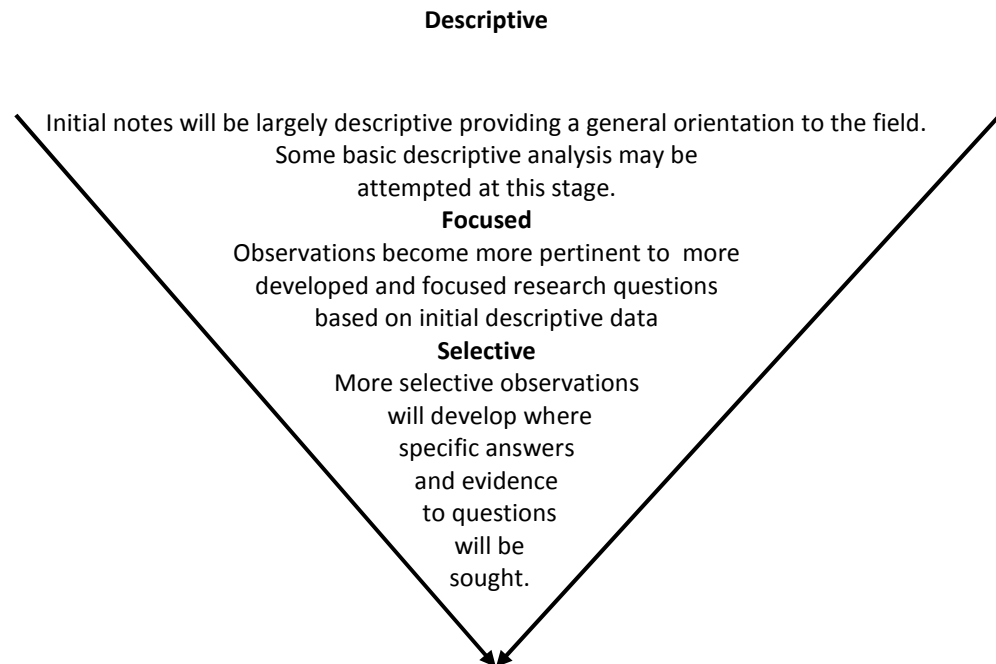


were referred to in order to clarify details of the interview. Thus it became apparent that however one endeavours to avoid 'getting involved' there becomes a point where resisting participation could jeopardise the rapport that is being built between service professionals who are essentially the 'gatekeepers' of desirable information. Indeed I was aware of the potential power of the alcohol treatment workers in relation to accessing information regardless of my approved access. Furthermore, in agreement with Hammersley and Atkinson (1995) it is argued that *all* social research is a form of participant observation, because one cannot study the social world without being a part of it. Thus due to the extensive level of involvement required for this field study, it was argued that an ethnographic method using participant observations was the most appropriate way to describe the method utilised in this phase of the research.

### ***Analysing the setting***

As part of ethnographic participant observations, it is the job of the researcher to write down regularly what has been observed. Thus the researcher creates an accumulating written record of these observations and experiences (Emerson, Fretz and Shaw, 1995). Field notes were gathered and transcribed which were analysed qualitatively. For the early stage of the analysis the work of Hammersley and Atkinson (1995) and Emerson, Fretz and Shaw (1995) was drawn on. Both texts provided useful and informative details of how to go about writing and analyzing ethnographic field data. Hammersley and Atkinson (1995) in particular, provided a comprehensive theoretical overview of ethnographic methods. Their work gives useful advice on how to go about writing in the field, and more importantly, how the process of field note writing and analysis has

a progressive focus rather than a distinct stage. Their work also considers some of the difficulties inherent in working with this kind of data and how best to address these concerns. Indeed in ethnographic work, it is acknowledged that the analysis of the data cannot be separated out as a distinct stage of the research process. Thus, Hammersley and Atkinson (1995) maintain that the analysis begins in the pre-fieldwork phase where research questions are being formulised and continues through to the process of writing the finalised reports or articles. Hammersley and Atkinson identify both formal and informal processes; formally, analysis can begin to develop through initial notes made in the field; informally, they suggest that some part of the analysis is 'embodied' in the ethnographer's initial ideas (1995, p.205). This early phase of analysis cannot take place without being involved in some process of 'reflexivity' where the field data is being constantly developed and reviewed in order to ensure that merely describing the scene is avoided and a move to a more analytical interpretation is gained. To this end, Hammersley and Atkinson suggest that a 'funnel structure' should be employed where the data is progressively focused over time. This approach to fieldwork is in direct relation to how the design of the study was developed, where a move from mere description to more developed and selected field notes can be captured. This design and approach to analysis, although time-consuming, can facilitate the discovery of what the research is *really* about.



**Figure 2: The funnel strategy. Adapted from Hammersley and Atkinson (1995)**

Figure 2 above provides a diagram of the ‘funnel strategy’ that was employed during the data collection stage, which at the same time, was used to begin the initial analysis of the field note data. This technique, according to Hammersley and Atkinson (1995) is particularly useful in finding a focus for the research which can be developed on an ongoing basis.

### **Recording the experienced and observed setting**

Emerson, Fretz and Shaw (1995) note that fieldnotes are written accounts that describe experiences and observations that the researcher has made while participating in an intense and involved manner. Thus, it could be assumed that writing and describing an observation is perhaps a straightforward and transparent process. However Emerson *et al.* (1999) argue that to make the assumption that reality is simply out there to be observed, that there can be an accurate account of what has

been observed, is to claim that there is only one 'best' description of a particular event. According to Emerson *et al.* (1999) fieldnote taking cannot claim to be objective in this way. Indeed they maintain that rather than fieldnote writing being a matter of passively copying down facts about what happened, writing in the field involves,

'active processes of interpretation and sense-making: noting and writing down some things as "significant", noting but ignoring others as "not significant", and even missing other possibly significant things altogether. As a result, similar (even the "same") events can be described for different purposes, with different sensitivities and concerns.' (p.8)

Therefore it is clear that writers in the field do more than describe the social world. It is also evident that the observer participates with members and in doing so constructs that social reality. Coffey (1999) takes a similar viewpoint as she proposes that,

'Like any other text, fieldnotes are themselves literary creations, authored and crafted. And like other literary forms there are conventions about what we write and how we do so. In taking and making fieldnotes we are involved in the construction and production of textual representations of a social reality of which we are a part. At the same time as 'producing' a field, we use fieldnotes as a way of documenting our personal progress. Fieldnotes serve as private records, documents of a personal journey and diaries of our experiences' (p. 120).

Coffey (2000) goes on to explore the notion of fieldnotes as personal diaries, often perceived as 'personal and sacred objects' (p.121). There were indeed times at the beginning of this research phase where note taking was an uncomfortable experience. Knowing when and where to write fieldnotes can be determined by the environment and relationships that are formed in the field (Lofland and Lofland, 1995). In this research, the decision was made to avoid perceiving my fieldnotes as 'secret' and confidential to others. I wanted to ensure that I captured as much detail as possible thus as I wrote my fieldnotes (including recording verbatim conversations as my technique improved) I was happy to talk about and share what I had recorded with the alcohol treatment workers. My aim was to create a relationship that was built on trust, therefore I was happy to re-read my notes to them if they asked. Yet I found that soon enough my fieldnote taking became a part of 'what Jo does' and often they would laugh and joke about the contents 'I dread to think what she is writing about me now!' or after a controversial conversation they would remark 'stick that in your book!'. Therefore, where there may have been a degree of 'strained performance' and suspicion by the two alcohol workers at the beginning of my observations, it appeared that over time, our relationship was such that these barriers appeared to reduce significantly.

### ***Capturing dialogue***

In order to capture as much detail as possible about the ATR, during field observations it was attempted wherever possible, to reproduce dialogue as accurately as possible. This could involve conversations that occurred during the observations, or indeed,

conversations that participants reported having had with others. Lofland and Lofland (1995) state that field notes are mainly 'a running description of events, people, things heard and overheard, conversations among people, conversations with people' (p.93). Lofland and Lofland (1995) go on to state that the writing of the 'running description' should involve distinguishing where possible, verbatim accounts from paraphrased or generally recalled events. Emerson *et al.* (1999) note that most dialogue reproduced by observers can be through, *direct*, and *indirect* quotation, through *reported speech*, and by *paraphrasing*. Drawing on Emerson *et al.*'s (1999) guidance, during data collection of this kind, it was noted that only those phrases identified as quoted verbatim were placed between quotation marks. All other dialogue reproduced were recorded as either indirect quotations or paraphrases. The following example illustrates how dialogue has been reproduced in this way to convey back-and-forth conversation:

I talked to Susan today about a difficult offender she has been working with called Craig. Susan and his offender manager, Zoe, have been working together with him for the last 6 months and it seems that they are becoming more and more frustrated with this case. 'How is Craig doing' I asked, to which she replied 'oh don't ask' I reply with a small laugh 'Oh right ok!'. Susan tells me that he had fallen out with his neighbour again and he had said to her 'I can't get on with him, he drives me to drink, I just want to punch him''. I reply by saying 'oh dear' to which Susan replies 'oh he would argue with himself if he could'. Susan then went on to say that he was a funny character who often made her laugh with his stories.

In this excerpt the flow of the conversation has been captured by including indirect quotation as well as direct and paraphrased conversation. Below is the same excerpt but this time the dialogue has been clearly marked in order to illustrate how they work together:

**Direct:** 'oh don't ask'

**Direct:** 'oh right ok!'

**Indirect:** Susan tells me that he had fallen out with his neighbour again ...

***Reported speech***

**Direct:** and he had said to her 'I can't get on with him ...

**Direct:** 'oh he would argue with himself if he could'

**Indirect:** Susan then went on to say...

It has been suggested by Emerson *et al.* (1999) that by avoiding simply paraphrasing this conversation, the 'flavour of chatting and offering confidences' (p.75) is highlighted rather than obscured by only relying on the author's own paraphrased account. Moreover the voices and character traits of the participants can be conveyed to the reader. Although it can be complex and often difficult to capture every spoken word, reproducing dialogue in this way persuasively convinces the reader that one 'was there' thus wherever possible, this method of data collection was used.

### **Beginning an analytical approach: 'the evolving social episode'**

What was of further interest during the field observations was how the offenders talked about their drinking and their offending behaviour during their treatment sessions. The early pilot observations enabled a focus to develop that centred around the offender and the alcohol treatment workers' social interactions. Harre and Moghaddam (2003) talk about the dynamics of the 'evolving social episode' and how their theory of social positioning is largely concerned with how speakers construct their identities and their relationships through talk. Therefore positioning theory was used as an analytical tool with which to analyse the field observations, as it offered a useful way of understanding the ATR in relation to what occurs during 'treatment' and what positions are made available during this interaction. As such this approach to analysis will be elaborated on further in Chapter Six where the field note analysis will be presented.

### **Phase Three: exploring offenders' subjective experiences of the ATR**

There were several considerations taken into account during the development of the research which led to incorporating an exploration of the offenders' subjective experiences of the ATR into the design of the study. The rationale for this additional phase of the research was to add a further dimension to understanding the ATR from the perspective of the offenders. Thus it was argued that by incorporating subjective experiences of the ATR into the research design, a more contextual understanding was enabled. Finally by combining these different perspectives, it is argued that there was potential for a more 'complete picture' of the ATR to be presented rather than a one



dimensional view. To this end, research aim 'two' was developed which aimed to *'explore in depth, the subjective experiences of offenders, in relation to engagement, progress and completion of the ATR'*.

### **Gaining access to subjective experiences**

Willig (2001) highlights that qualitative researchers are largely concerned with meaning. In this way, qualitative research considers the view of the individual and how they make sense of the world and how they experience events. Thus qualitative research aims to understand what it is like to experience certain phenomena and how situations that arise through experiences are managed. In relation to the research aim highlighted above, this phase of the research aimed to explore further, the meanings that the offenders attributed to their situations and experiences of being on the ATR.

In thinking about how best to access the subjective experiences of a relatively small number of offenders (approximately 10), I initially drew upon the idea of utilising semi-structured interviews. Parker (2005) argues that an interview in qualitative research is always semi structured and suggests that interview research 'provides an opportunity to question the separation between individuals and contexts, to ground accounts of experience in social relations' (p.53). I also drew on the work of Hollway and Jefferson (2000) who argue that all participants are meaning-making, and go on to describe participants as 'defended subjects' (p.26) who:

- May not hear the question through the same meaning-frame as that of the interviewer or other interviewees;

- are invested in particular positions in discourses to protect vulnerable aspects of self;
- may not know why they experience or feel things in the way that they do;
- are motivated, largely unconsciously, to disguise the meaning of at least some of their feelings and actions.

The notion of 'defended subject' seemed fitting with offenders on the ATR as their situated lives and experiences were located within a 'meaning frame' that I had no knowledge or experience of. They would be, at the time of the interview, in treatment for alcohol problems which could position them as vulnerable and they may at that time be experiencing new alternatives to the way they previously constructed alcohol consumption which may not be easy to express. In this sense, it was considered that the way in which the offenders were interviewed would need to be carefully considered in order to ensure that they were enabled to speak from their own meaning frames rather than being 'controlled' by my questioning. Nevertheless although fitting, it must be acknowledged that Hollway and Jefferson's (2000) work is explicitly based on a psychoanalytical understanding of the defended subject. Therefore it must be made clear that that in drawing upon the notion of defended subject I do not intend to adopt a psychoanalytical approach for this research, for reasons that will become clear in the preceding chapters.

### ***The narrative approach***

After identifying many shortfalls with more conventional semi structured interviewing approaches, Hollway and Jefferson (2000) arrived at the narrative approach to interviewing maintaining that this particular approach enabled participants to tell stories about their life experiences. They found this approach enabled participants to talk about their experiences using their own words and phrases which respected and retained their situated meaning frames. Mishler (1986) argues that rather than suppress the interviewees' tendencies to 'tell stories' (often inherent in more traditional interview formats) the narrative approach allows for richness and complexities of experiences to be explored within the subjects' narrative accounts.

Hollway and Jefferson (2000) claim that in order to approach data collection from a narrative approach, the roles within the interview setting need to be reconceptualised as the researcher becomes the 'listener' and 'the interviewee is a story-teller rather than a respondent' (p.31). Thus if the notion that people make sense of their lives through stories is maintained, Chase (1995) argues that instead of 'answering' questions, interviewing should become an opportunity for researchers to ask for life stories. Indeed Clandinin and Connelly (2000) argue that 'the way an interviewer acts, questions and responds in an interview shapes the relationship and therefore the ways participants respond and give accounts of their experience' (p.110). They go on to state that often research interviews have an inequality about them in that the focus of the interview and the questions posed are governed by the interviewer. However they acknowledge that often structured interviews are extremely difficult to conduct as

even when the interview begins with a specific focus, it almost always turns into a form of conversation. Thus in an approach that embraces a more semi structured approach, the agenda of the interview, rather than being prescriptive, is open to continuous development and change depending upon the subjective experience of the narrator. Arguably, the stories that may unfold during an interview are to some extent dependent upon a researcher who is skilled at developing ways in which to invite the 'story-teller' to tell 'their' stories and 'to encourage them to take responsibility for the meaning of their talk' (Chase, 1995, p.3). Nevertheless it must be acknowledged that the aim of interviewing offenders was to gain access to their experiences of being in treatment on the ATR. To this end, the interview phase did have an agenda in that the storying needed to be about their time on the ATR.

### ***Developing the narrative interview***

As an experienced qualitative interviewer I was reasonably confident about interviewing and felt that I had gained good skills in enabling participants to share their personal stories with me. However I also acknowledged that as an interviewer I have to be ready and prepared for the unexpected to happen during an interview situation. Indeed the challenge of aiming to interview offenders about their experiences of alcohol, offending and being in treatment required considerable thought. I needed to find a way of being able to engage with my participants successfully without compromising the richness of data I wanted to collect. In doing so I turned to several authors in the narrative field in order to find a narrative interview that would best

serve the purpose of my research aims, and more importantly, the specific cohort of participants I would be working with.

Dodge and Geis (2006) cite the work of Rosoff (2004) who highlight the challenges that arise when interviewing offenders;

‘Interviewing offenders of any hue or collar is a tricky proposition. It’s a textbook case of social exchange. The interviewer wants something of value, but so too does the interviewee – validation, a sympathetic ear, a soap box, whatever. The difference between higher-status offenders and underclass street criminals, I believe, is that the latter are trying to achieve a respect they’ve never enjoyed’ (Rosoff, 2004, cited in Dodge and Geis 2006, p.88).

Thus in order to establish some level of mutual respect within the brief time I would have with these offenders I firstly considered the structure of the interview process. The strategy of using a structured set of questions where the researcher’s intentions are uppermost was rejected in favour of an approach that would enable the participants to tell their stories in their own way. In this case the participants’ intentions become uppermost.

In exploring the narrative interview further, it was evident that there were several ways to design and conduct the interview. According to Wengraf (2001, p.1) narrative or more specifically ‘biographic-narrative interviews’ rely on ‘minimal interviewer interaction’ and structuring, whereas semi-structured interviews involve ‘partially prepared questions that are fully structured by the researcher’. The approach to

generating stories is evidently varied. McAdams (1993) and later Crossley (2000) propose the use of semi-structured interviews where some degree of control is maintained by the researcher, yet still enabling stories to be told. Nevertheless this approach takes the narrative metaphor literally and in doing so asks interviewees to think of their life as if it were a book. This approach then goes on to ask participants to divide their 'book' into 'life chapters' and explore 'key events', 'significant people' negative life events, and finally sum up their narrative into a 'coherent theme'. This particular narrative approach, although appealing, was considered unsuitable for this research. It was important that the offenders were able to convey meaning through their own frame of reference, yet asking them to divide their lives into chapters may have taken the interview too broad and away from their subjective experiences of entering treatment on the ATR. Thus in order for the research objectives to be met, I needed to have some broad areas of enquiry that would enable the interview to flow.

I arrived at an approach that was considered to be based on a 'generative narrative approach' (Flick, 2006) rather than a biographical approach (Parker, 2005). A biographical approach to interviewing aims to elicit a 'complete life story' (Parker, 2005, p.75), often with one single question asked at the beginning of the interview, such as 'tell me your life story'. The aim of the interview in this way is for the interviewee to take centre stage with very little contribution made by the researcher (Wengraf, 2001). Although this approach would enable what is meaningful to the participant to be narrated, I was also aware of how such an approach may impact upon the offender's accounts during the interviews as it may direct attention away from talking about their experience on the ATR and thus it would have the potential to lose

sight of the original aims of the research. Therefore I designed the interview based around a semi-structured schedule (see Appendix 1 for interview schedule) and endeavoured to place the research in context and provide each participant with a clear picture of the focus of the study.

### ***Recruitment***

Designing and conducting the research in three phases inevitably meant that a considerable amount of time would be spent 'out in the field'. The data collection in Phase One took over a year of once or twice weekly visits to the sites, and further time was taken to be available to sit in and observe treatment sessions. Indeed for some researchers this may seem like a disadvantage, however for this research, the initial time spent in the field was hugely advantageous for gaining access to talk with offenders. It was also valuable as it enabled relations to be built with the alcohol treatment workers who came to understand my research with a good degree of interest and support. Both alcohol treatment workers were subsequently able to talk to offenders about my research and help with recruiting potential interviewees. I had no set criteria for recruitment selection, but did however impress on the alcohol treatment workers that being able to speak to offenders who were nearing the end of their treatment would be preferable. Recruitment therefore, was largely dependent on the support of the alcohol treatment workers who were, thankfully, at this point in the research, willing to 'help out'.

Although this particular strategy was successful, I was acutely aware that the alcohol treatment workers may possibly 'cherry pick' offenders who they deemed to be appropriate for interview. Indeed it was often suggested that those who were described as 'difficult' by the alcohol treatment workers would perhaps not be suitable for my interviews. Whilst it was not my intention to insist that all offenders be interviewed, I was however keen to ensure that the offenders had as much opportunity to be involved as possible. To this end I attempted to impress upon the alcohol treatment workers that I was happy to talk to any offender who was willing to be interviewed regardless of their treatment outcomes or progress. However I also acknowledged the need to respect the alcohol treatment workers' judgement in relation to 'offenders' situation and was particularly cautious that the interviews should not contribute to an offender's existing psychological distress. Nevertheless throughout the recruitment process I became aware that some of the offenders who were approached for an interview were selected by the alcohol treatment workers on the basis that they 'did really well' or had an interesting story to tell. Therefore in analysing their stories I was aware that some of the narratives elicited from the interviews may be influenced in part by the alcohol treatment workers' aim to present the ATR in a positive way.

### **Ethical considerations**

Permission to access treatment sessions and treatment files held by the District's Alcohol Team was granted by the NHS Committee for Research Ethics (COREC) now known as the National Research Ethics Service (NRES). Further access to probation



records and probation sites was granted by the District's Probation Head Office and Research department. Thus what follows is a detailed account of the ethical issues I needed to consider in applying for access and also in considering my own role within the research process.

Prior to the beginning of the data collection for each phase of the research I had to consider and identify the ethical implications inherent in such a research design. Indeed it is now widely accepted that in most social research there is a need for ethical issues to be considered which aim to protect the interests of those who are willing to take part in a study (Flick, 2006). The growing sensitivity for ethical issues in the past has led to the formulation of codes of ethics, for example the British Psychological Society's (BPS) Code of Conduct (2007) which are designed to regulate the relations of researchers to the people and fields they intend to study. Thus considering ethics becomes more than simply 'jumping through hoops' as it enables research to be considered from the participants perspective and enables thoughtful steps to be taken in order to establish positive and respectful relationships whilst in the 'field'.

In the first instance, gaining informed consent from the two alcohol treatment workers was of key importance to the progression of the research project. I developed a consent form and a participant information sheet (see Appendix 2 and 3) that outlined the aims of the research, why they had been invited to participate, what the research involved, and what would happen to the information after their participation and upon finishing the project. I contacted the two alcohol treatment workers and arranged to meet with them to go through the information and the consent forms. I chose to do

this so that I could elaborate on any of the points on the sheets and could also reassure them verbally of my role as the researcher.

In considering the participant observations of the treatment setting involving the offender and the alcohol treatment worker, a further participant information sheet and consent form was devised (see Appendix 4 and 5). The information consisted of the aims of the research, the nature of the research, the nature of participation in the research and what would happen to the information once the project ended. However, how and when consent should be sought from the offenders was given considerable attention. Further considerations were given to the recruitment of offenders, in relation to how they would be selected. It was agreed that the alcohol treatment worker would initially approach the offender and if they agreed to participate, then informed consent would be sought. It must be acknowledged that recruitment in this way raised some ethical dilemmas as those who were selected for an ATR may feel 'coerced' into participating as part of their court order. Thus, offenders were told that their participation was not mandatory and would not impact upon their engagement with the ATR in any way. This was also stressed in the participant observation sheet.

For the interviewing stage of the research, an additional consent form and participant information sheet was developed (see Appendix 6 and 7). This again indicated the aims of the research, the nature of the research, the nature of participation in the interviews and what would happen to the data collected. Offenders were recruited through liaising with their alcohol treatment worker who would initially talk to them about the research and administer the participant information sheet. It was further

acknowledged that consent is an ongoing process that may require re-negotiation (de Laine, 2000). Therefore once their participation was confirmed, prior to the interview commencing I would go through the consent form and the participant information sheet once again in order to impress on them their rights as participants to stop the interview at any time and their right withdraw their accounts without any further consequential effects after the interview was conducted. It was further acknowledged that individuals sentenced to the ATR have been identified as requiring treatment for their alcohol problem. It was therefore anticipated that these individuals may have additional and sometimes complex needs (other than alcohol problems) which may deem them as vulnerable at some stage or all stages of their treatment. This was taken into consideration during the interview phase and while it is not the purpose of the research to provoke any upsetting conversations it may be that in the development of the interview such conversations occur. Therefore it was considered that should the participant become distressed they would be asked if they would like to take a short break or if they would like the interview to end. It was also acknowledged that due to the nature of the research, disclosure of any unlawful activity that participants may discuss would be passed to the appropriate authorities. This underlying responsibility was outlined in the participant information sheet and was also stated at the beginning of the interviews.

In addition to gaining informed consent from all participants, steps were also taken to protect the identity of the participants and to inform the participants of these issues prior to participation. Firstly, in order to address issues of anonymity, each participant was allocated a pseudonym. Whilst reviewing the probation files and treatment files,

no identifying information was extracted from the records and access to records was conducted on the probation premises only and at no point were data base records removed from the building or copied. In addition, where possible, at the transcribing stage, identifying information was removed from the transcript. Any further identifying information such as health groups, other service professionals or other organisations were also removed. Finally participants were informed that their accounts along with field notes, voice files and transcripts would be confidentially kept. To this end participants were told that any hard copies of their transcripts were kept in a locked filing cabinet in the University's research office and any electronic voice files or transcripts would be stored on a password protected PC at the University.

## **Summary**

The aim of this chapter was to provide a detailed outline of the research design and the methods employed for data collection. Adopting a pragmatic methodological approach to the research enabled the ATR to be explored from various positions, each representing a unique social reality different from the other. The phased approach to the research design enabled structure, but also enabled a 'thickening of the story' (Denzin 1989) from factual information of the offenders to their subjective experiences of the ATR. It was noted that the data collection phases resulted in spending considerable amounts of time 'in the field', nevertheless this was viewed as valuable in gaining trust, respect and access to information and participants. This chapter has finally explored some of the important ethical issues that needed to be considered during the research phases and how these issues have been addressed.

## **Chapter 5: Offender characteristics, impacts and outcomes of the ATR**

### **Introduction**

This chapter specifically focuses on quantitative data that was collected from probation records and treatment files that aimed to provide insight into the characteristics and progress of offenders who were granted an ATR order from the 'East Site' or the 'Centre Site' within the District. The data collected was based on information extracted from the Offender Assessment System (OASyS) and the Case Record and Management System (CRAMS) where details of individual offenders are stored and regularly updated. In addition data was also collected from treatment files held by the alcohol treatment workers which provided further information about the offenders' treatment, participation and progress. Thus what follows is a detailed quantitative analysis of 81 offenders who were granted an ATR between the months of July 2007 to March 2009. This analysis was also made available in a report format to the funders (Ashby, Horrocks and Kelly, 2009) and was subsequently adapted and accepted for publication in 2011 (Ashby, Horrocks and Kelly, 2011).

## Offenders on the ATR

Table 1 below provides a breakdown of the figures for the Centre Site and the East Site's offender base. Since the beginning of the ATR in July 2007 to March 2009 a total of 181 ATR assessments had been conducted across the District. Out of these assessments, a total of 120 (66 per cent) offenders were granted an ATR order by the courts.

**Table 1: Showing ATR figures for both probation sites' offender case loads. July 2007 to March 2009**

|   | Centre Site  | East Site    | Total for the District |
|---|--------------|--------------|------------------------|
| <b>Total No. of ATR assessments attended</b>  | <b>107</b>   | <b>74</b>    | <b>181</b>             |
| <b>No. of ATR orders proposed</b>             | <b>81</b>    | <b>64</b>    | <b>145</b>             |
| <i>(% of total no. of assessments)</i>        | <i>(75%)</i> | <i>(86%)</i> | <i>(80%)</i>           |
| <b>No. of orders granted</b>                  | <b>79</b>    | <b>41</b>    | <b>120</b>             |
| <i>(% of total no. of assessed)</i>           | <i>(73%)</i> | <i>(55%)</i> | <i>(66%)</i>           |
| <i>(% of total no. of orders proposed)</i>    | <i>(97%)</i> | <i>(64%)</i> | <i>(82%)</i>           |
| <b>No. of orders proposed but not granted</b> | <b>7</b>     | <b>14</b>    | <b>21</b>              |
| <i>(% of total no. of orders proposed)</i>    | <i>(8%)</i>  | <i>(21%)</i> | <i>(14%)</i>           |
| <b>No. of orders completed</b>                | <b>43</b>    | <b>20</b>    | <b>63</b>              |
| <i>(% of total no. of orders granted)</i>     | <i>(54%)</i> | <i>(48%)</i> | <i>(52%)</i>           |
| <b>No. of orders revoked</b>                  | <b>16*</b>   | <b>3</b>     | <b>19</b>              |
| <i>(% of total no. of orders granted)</i>     | <i>(20%)</i> | <i>(7%)</i>  | <i>(15%)</i>           |
| <b>No. of orders currently ongoing</b>        | <b>27</b>    | <b>18</b>    | <b>45</b>              |
| <i>(% of total no. of orders granted)</i>     | <i>(34%)</i> | <i>(43%)</i> | <i>(37%)</i>           |

\*Including breach of order, custody and 2 offender transfers

Table 1 above shows that out of the 181 offenders assessed for an ATR order, a large proportion, (80 per cent) were deemed suitable for the program. Out of those who were assessed as suitable, a large majority (82 per cent) were granted an ATR order by the courts. At the time of data collection there had been a total of 63 completed orders (52 per cent) with only a small amount of orders either revoked or transferred

(15 per cent). There were, in addition, 45 offenders (up to March 2009) at the time of the data collection, undergoing treatment on the ATR program across the District.

Only a small proportion (14 per cent), of offenders, assessed as suitable for treatment, were not granted an ATR. Upon further examination of the data, it was evident that the small amount of offenders who were not granted an ATR were more likely to have received a custodial sentence due to the severity of their crime. As these offenders were assessed as suitable for alcohol treatment, it could be suggested that there is a cohort of offenders who may benefit from alcohol treatment whilst in custody and upon being released from prison. Indeed, Senior (2003) found that up to 70 per cent of those entering prison have a mental health or substance misuse problem. Furthermore Stewart (2008) found that between November 2005 and November 2006, out of 1,457 newly sentenced prisoners in England and Wales, 36 per cent reported that they were 'heavy' alcohol consumers.

Since the launch of the Alcohol Strategy (HM Prison Service, 2004) alcohol treatment has been available for offenders who are serving a prison sentence. However it seems important to consider if effective 'through care' and timely follow up care is made available on release. The Offender Management Model (National Offender Management Service, 2006) highlights the need for offender managers to plan and manage interventions for offenders throughout their sentence whether or not they are in custody or the community. Furthermore, the Resettlement Strategy (Senior, 2003) also highlights the need to address substance misuse post-release in order to tackle reoffending rates. Under existing legislation, in 2005 offenders could receive extended

drug testing as part of a 'post conditional licence' (Home Office, 2004) upon early release from prison. This process aims to reduced reoffending and increase up-take of treatment for drug misuse. Considering the ATR program as a conditional licence requirement could have a beneficial impact upon offenders who have had the opportunity to abstain from alcohol use during their prison sentence. Prison 'In-reach' work, largely based on relapse prevention strategies conducted within the ATR program could provide a continuum of care for offenders with alcohol problems as they move through different components of the criminal justice system, from custody to community.

### **Interagency working**

The figures presented in Table 2 show that overall a large proportion of offenders who were referred for an ATR assessment by the Probation Service (i.e. offender managers) were indeed considered suitable for treatment by the alcohol treatment workers. This suggests that the referral process between the offender managers and the alcohol treatment workers in was an effective process. Programs like the ATR rely on interagency working which involves the merging of two different cultures; public health that aims to treat substance misuse and addictions and public safety that aims to protect the community. The success of such inter-agency working relies largely on the ability to communicate effectively (Lacey, 2003). Notably, effective communication is said to lead to trust which in turn makes it more likely that professionals will work together in the same premises with the same aims (Lacey, 2003). The reported effectiveness of the referral process suggests that communication was working well



and this may have related to proximity. Both the Centre Site and The East Site probation services have accommodated the alcohol treatment workers 'on site'. Tilstone and Rose (2003) found that effective interagency working depends on factors such as having specific locations and opportunities within which to develop, for example working in close proximity or having a shared project. Furthermore, they suggest that having shared aims between agencies, powerful enough to counter their very different core purposes is further testament to an effective way of interagency working. Therefore, the shared aims of the ATR and the physical proximity of working in the same building appeared to be enabling effective communication and positive working relationships between the alcohol treatment workers and the offender managers.

### **Offender characteristics**

Some of the characteristic features of offenders that emerge consistently in the research literature can often be useful in determining risk factors of, for example, alcohol related violence (Budd, 2003). Characteristics such as age, gender, ethnicity, and employment are considered to be important risk factors for criminal behaviour. Indeed it has been reported that in the UK young men are more likely than other people to engage in excessive alcohol consumption (de Vissor and Smith, 2007) and as a result there is widespread concern about the health and social consequences of young male drinkers, for example alcohol related crime. Table 2 presents data collected regarding 81 ATR offenders and shows some of the main characteristics of the offenders, taken from probation and treatment records.

**Table 2: Offender characteristics**

| ATR client characteristics | n  | %     |
|----------------------------|----|-------|
| <b>Gender</b>              |    |       |
| Male                       | 74 | 91.4% |
| Female                     | 7  | 8.6%  |
| <b>Ethnicity</b>           |    |       |
| White British              | 80 | 98.8% |
| Black Caribbean            | 1  | 1.2%  |
| <b>Age Group</b>           |    |       |
| 18-35                      | 48 | 59.3% |
| 36-50                      | 30 | 37%   |
| 51-65                      | 3  | 3.7%  |
| <b>Employment</b>          |    |       |
| Unemployed                 | 63 | 77.8% |
| In work                    | 13 | 16%   |
| Unknown                    | 5  | 6.2%  |

***Gender, age and ethnicity***

Table 2 shows that the majority of the ATR offenders within this sample, are male, with a larger proportion of younger (aged between 18-35) males who describe themselves as 'white British'. Across the UK, alcohol-related aggression and violence is most typically associated with young white males who consume alcohol to intoxication (McMurran, 2007).

***Employment***

A large proportion (77 per cent) of the 81 ATR offenders were recorded as unemployed at the time of data collection (Table 2). This category included any individual who was

recorded as 'unable to work' due to ill health or disability. Indeed across the District, unemployment levels are slightly higher than the national average, with the District's Community Strategy (WDP, 2006) showing that unemployment across the District has remained high since 2003. The unemployment rate in May 2006 was 2.8% with around 5,500 people claiming jobseekers allowance. There are around 30,000 people in the District claiming incapacity benefit and severe disability allowance. During the ATR program, offenders are given the opportunity to consider employment and can be 'signposted' to other agencies who offer support for those who wish to take up employment. This has benefitted some of the offenders on the order and will be explored in more detail later in the analysis.

### **Identifying drinking 'patterns'**

Stimson, Grant, Choquet and Garrison, (2007) note that over the past two decades, research into drinking 'patterns' has provided a wealth of information about individuals who consume alcohol, their behaviours, and the likely consequences of consumption. For example, drinking patterns can comprise of *quantity* of alcohol consumed, *duration* and *frequency* of drinking, the *settings* in which drinking takes place and the *cultural role* and significance of alcohol.

The Models of Care for Alcohol Misusers (MoCAM) (National Treatment Agency, 2006) specify four main categories of alcohol misusers who may benefit from some kind of intervention or treatment; *hazardous drinkers*; *harmful drinkers*; *moderately dependent drinkers* and *severely dependent drinkers* (p.12). Drawing on MoCAM, the alcohol treatment workers operate within an approved framework that identifies three

main categories of alcohol consumption namely, ‘*dependent*’ ‘*binge*’ and ‘*hazardous*’.

These are utilised in order to identify offenders’ patterns of alcohol consumption.

Table 3 below provides a brief overview of each category.

**Table 3: Brief definition of drinking categories**

| <b>Drinking pattern</b> | <b>Description</b>   |
|-------------------------|--|
| <b>Dependent</b>        | <i>Where offenders were found to be consuming alcohol heavily on a daily basis and reported having withdrawal symptoms upon waking or going long periods without alcohol</i> |
| <b>Binge</b>            | <i>Where excessive amounts of alcohol were consumed over a short period of time, often with the intention to become intoxicated</i>  |
| <b>Hazardous</b>        | <i>Where offenders are consuming alcohol over the sensible drinking limits and may increase the risk of harmful consequences for the user.</i>                               |

### **Data sources of drinking patterns**

In order to examine ATR offender’s drinking patterns, three main data sources were examined:

- **Comprehensive assessments:** Upon being granted an ATR, each offender undergoes an initial comprehensive alcohol treatment assessment which provides the alcohol treatment worker with an opportunity to gain a more in-depth understanding of the offender’s background, lifestyle, health and current alcohol consumption. This information enables the alcohol treatment worker to decide and develop an individual treatment plan for each offender.
- **Drink diaries:** From the offender’s initial assessment, the alcohol treatment worker gains insight into the client’s alcohol consumption, and drinking ‘pattern’. However, it is often the case that at this early stage in the treatment, offenders are not fully aware of the amounts they have been, or are currently consuming, and

understandably in many cases, often find it difficult to 'quantify'. One of the most common methods used to identify drinking patterns on the ATR program is the use of 'drink diaries'. The offender is asked to record daily, the amount of alcohol consumed (often converted into units either by the client or during treatment sessions by the alcohol treatment worker) on a weekly chart which can be discussed in more detail during treatment sessions. For the majority of offenders this method appears to be to be an effective way of recording and reporting their alcohol consumption. Moreover, there appears to be an educational aspect to the diaries as offenders have the opportunity to learn about alcohol units and in turn, how to safely reduce their alcohol consumption (see Appendix 8 for a drink diary example). Offenders' drink diaries (where available<sup>3</sup>) provided a further source of information in relation to the identification of drinking patterns.

- **CRAMS data base:** All ATR offenders have the same supervision conditions to attend treatment as the probation service's National Standards (Ministry of Justice, 2007), therefore alcohol treatment workers are also required to document all ATR activity (including treatment progress, non attendance; telephone calls etc.) with their offenders on the CRAMS data base via an electronic 'contact log'. Information about the offenders' treatment has been explored via contact logs written by the alcohol treatment workers.

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<sup>3</sup> Some offenders choose not to utilise drink diaries during their treatment program.

The data has been collected, collated and analysed using comprehensive assessments, drink diaries and CRAMS. It must be acknowledged that the data sources above were not specifically designed for research purposes and it was often found that there were variations in the content and detail of the records that were held. In addition, and more importantly, it is essential to acknowledge that a large part of the information gathered in relation to drinking patterns is based on offenders' 'self-reporting'. This method has raised controversy in the research literature in relation to its validity when assessing levels of alcohol consumption and drinking behaviour patterns (Connors and Volk, 2004). However it has also been argued that self-reports can be relied upon when there is assurance of confidentiality and where the setting encourages honest reporting (Allen, 1997).

Table 4 presents a breakdown of the offenders' drinking patterns in relation to age categories, showing that a large proportion of the offenders were assessed as 'dependent drinkers' (75 per cent) and out of those, just under half (44 per cent) were aged between 18 - 35. A smaller proportion was classified as 'binge' drinkers' (14 per cent). Only 5 per cent of the sample was classified as 'unknown'. This was due to either the complexity of the offenders' alcohol consumption and other lifestyle factors or the low level of engagement during treatment sessions. Both of these factors resulted in difficulty with regard to accurately identifying any specific patterns of alcohol consumption by the alcohol treatment worker. Only one offender was recorded as 'abstinent' at the beginning of the treatment program. This was due to an 'offender transfer' thus the offender had received alcohol treatment in a different geographical area prior to being transferred to the ATR program in the District.

**Table 4: Drinking patterns and age range of offenders**

| Drinking pattern | Age Categories |         |       | Total |
|------------------|----------------|---------|-------|-------|
|                  | 18 – 35        | 36 – 50 | 51-65 |       |
| Dependent        | 36             | 22      | 3     | 61    |
| % of total       | 44.4%          | 27.2%   | 3.7%  | 75.3% |
| Binge            | 7              | 5       | 0     | 12    |
| % of total       | 8.6%           | 6.2%    | 0%    | 14.8% |
| Hazardous        | 1              | 1       | 0     | 2     |
| % of total       | 1.2%           | 1.2%    | 0%    | 2.5%  |
| Unknown          | 4              | 1       | 0     | 5     |
| % of total       | 4.9%           | 1.2%    | 0%    | 6.2%  |
| Abstinent *      | 0              | 1       | 0     | 1     |
| % of total       | 0%             | 1.2%    | 0%    | 1.2%  |

\* Female client reported as 'abstinent' prior to sentencing.

With the apparent rise of binge drinking over the past few years (British Medical Association, 2008) seemingly prevalent among young men (Lader, 2009), there was a tendency to expect a higher proportion of young male binge drinkers being sentenced to the ATR program. Indeed research shows that the prevalence of binge drinking among adult men and women to be much higher than the prevalence of alcohol dependent adults. For example the Alcohol Needs Assessment Research Project 2004 (Department of Health, 2005) found that 21 per cent of men and 9 per cent of women were 'binge drinkers' compared to only 3.6 per cent of adults (6 per cent men, 2 per cent women) who were found to be alcohol dependent. On a local level, data from the Health Survey for England (National Centre for Social Research, 2005) revealed that

within the District, the estimated proportion of adults that binge drink is just over 21 per cent, and in 2009 the proportion of adults who binge drink had increased to 22 per cent, higher than the national average of 18 per cent (Association of Public Health Observatories 2009). During the development phase of the ATR program, the ATR Stakeholder Group acknowledged that dependent drinkers would be assessed as priority cases, however the group discussed at length and agreed that the program would also allow 'hazardous' and 'harmful' drinkers due to the severity of the binge drinking problem across the District. The higher proportion of young men assessed as dependent drinkers found in this data has uncovered an unexpected characteristic. Thus the ATR program has identified problematic drinkers and is predominantly providing much needed alcohol treatment to a large number of alcohol dependent young men within the District.

### **Offending behaviour**

Historical information about offenders' previous convictions is used as a predictor for identifying offending behaviour and levels of reoffending by the probation service. Based on data extracted from probation records, information regarding the offender's current and previous offence history was explored. A large majority of the offenders had up to 5 previous offences with only 7.4 per cent of the entire sample having no previous offences upon being granted an ATR order (Table 5).



**Table 5: Previous offences**

| No. of previous offences | No. Of offenders | %     |
|--------------------------|------------------|-------|
| None                     | 6                | 7.4%  |
| 1- 5                     | 44               | 54.3% |
| 6- 10                    | 12               | 14.8% |
| 11-15                    | 3                | 3.7%  |
| 16-20                    | 2                | 2.5%  |
| 21-25                    | 1                | 1.2%  |
| 26-30                    | 1                | 1.2%  |
| 30 and above             | 6                | 7.4%  |

The main risk prediction instrument used in the Probation Service is the Offender Group Reconviction Scale 2 (OGRS 2) which is a predictor of re-offending based only on statistical risks (Howard, Francis, Soothill and Humphreys, 2009). The OGRS 2 system forms part of the OASys documentation and primarily uses previous offending histories and demographic variables in order to predict subsequent offending. Offender managers enter information about the offender, based on 13 offending related factors (see Appendix 9) and the OGRS calculates a percentage probability of reconviction. The percentage score is then categorized into 'high', 'medium' or 'low' risk of reconviction. The age that the offender first came into contact with the police and the age that the offender first appeared in court was taken from the OASys records. This was then explored in relation to their risk of reconviction (OGRS score). It was found in this research that the younger the offenders were when they first came into contact with the police and the courts, the more likely they were to have a 'higher risk' of reconviction. This is shown in Table 6. Indeed Home Office Statistics (2008) from the 2006 cohort show that just over 50 per cent of offenders given a community sentence

reoffend within two years with younger offenders aged below 35 years having the highest frequency rates of reoffending.

**Table 6: Risk of reconviction in relation to age category**

| Age first in contact with police/courts |              | Risk of reconviction |        |       | Total |
|---|--------------|----------------------|--------|-------|-------|
|   |              | High                 | Medium | Low   |       |
| Age category                            | 11-19        | 21                   | 19     | 2     | 42    |
|   | 20-25        | 3                    | 16     | 0     | 19    |
|   | 26-30        | 0                    | 4      | 3     | 7     |
|   | 31-35        | 0                    | 3      | 0     | 3     |
|   | 36 and above | 0                    | 2      | 5     | 7     |
|   | Total        | 24                   | 44     | 10    | 78*   |
| %                                       |              | 30.7%                | 56.5%  | 12.8% | 100%  |

\*missing value = 3

Over half of the sample was assessed as having a medium risk of reconviction with over 30 per cent assessed as high risk. Only a small proportion of the sample was assessed as having a low reconviction rate. The ATR program is aimed at reducing the levels of alcohol related crime therefore, offering offenders alcohol treatment as part of a community sentence may enable offenders to reconsider their criminal careers and help to break the 'cycle' of reoffending.

## Offence category

Identifying and recording crime data is argued to be an important measure of activity locally and a source of operational information to help identify and address local crime problems (Hoare and Povey, 2008). At a local level, violent crime in the District accounts for 35% of all recorded crime in the District and in town centres, the influence of alcohol is estimated to be considerably higher than elsewhere (The Yorkshire and Humber Public Health Observatory, 2005). Thus the ATR program was developed to directly address alcohol related crime across the District. Indeed all of the 81 ATR offenders in this sample had committed crimes that were assessed as 'alcohol related' by their offender manager. That is, offender managers found alcohol to be a significant factor when committing the convicted offence. Table 7 provides a summary of offenders' main offences in relation to the three main drinking patterns recorded by the alcohol treatment workers. 'Violence against the person' was the most common offence category which included common assault; aggravated bodily harm; actual bodily harm and sexual assault (1 incident of sexual assault was recorded out of the entire sample). Out of the 32 offenders who were convicted of an assault, nearly half (46.8 per cent) of these offenders were perpetrators of domestic violence, the assault involved partners, ex-partners, other relatives or household members. All of the domestic violence offences were committed by males to female victims with the exception of one offender who was a female perpetrator to a female victim.

**Table 7: Offence category**

| Offence category   | Drinking pattern  |                         |                   |                 |                 |
|--|-------------------|-------------------------|-------------------|-----------------|-----------------|
|  | n                 | %                       | Dependent         | Binge           | Hazardous       |
| <b>Violence against the person</b><br>(Proportion involving domestic violence) | <b>32</b><br>(15) | <b>39.5%</b><br>(46.8%) | <b>20</b><br>(11) | <b>8</b><br>(2) | <b>1</b><br>(1) |
| <b>Driving offences</b>  | <b>10</b>         | <b>12.3%</b>            | <b>8</b>          | <b>1</b>        | <b>1</b>        |
| <b>Public order</b>  | <b>9</b>          | <b>11.1%</b>            | <b>9</b>          | <b>0</b>        | <b>0</b>        |
| <b>Theft &amp; handling stolen goods</b>                                       | <b>7</b>          | <b>8.6%</b>             | <b>7</b>          | <b>0</b>        | <b>0</b>        |
| <b>Burglary</b>  | <b>6</b>          | <b>7.4%</b>             | <b>6</b>          | <b>0</b>        | <b>0</b>        |
| <b>Harassment</b>  | <b>4</b>          | <b>4.9%</b>             | <b>3</b>          | <b>1</b>        | <b>0</b>        |
| <b>Criminal damage</b>   | <b>3</b>          | <b>3.7%</b>             | <b>2</b>          | <b>0</b>        | <b>0</b>        |
| <b>Possession of weapon</b>  | <b>3</b>          | <b>3.7%</b>             | <b>3</b>          | <b>3</b>        | <b>0</b>        |
| <b>Drug offences</b>   | <b>2</b>          | <b>2.5%</b>             | <b>1</b>          | <b>1</b>        | <b>0</b>        |
| <b>Other</b>   | <b>5</b>          | <b>6.2%</b>             | <b>1</b>          | <b>0</b>        | <b>0</b>        |

The high level of alcohol related assaults, reflect the findings of the British Crime Survey 2007/08 (Kershaw, Nicholas and Walker, 2008) which found that in nearly half (45%) of all violent incidents, victims believed offenders to be under the influence of alcohol; 37% of domestic violence cases involved alcohol; and in nearly a million violent attacks in 2007/08 the aggressors were believed to be drunk. Moreover, a large majority of the assaults including domestic violence were carried out by offenders who were subsequently assessed as alcohol ‘dependent’.

### **Analysing ‘outcomes’ on the ATR**

All ATR offenders (who are assessed as ‘dependent’) have the opportunity to undergo an alcohol ‘detoxification’ with the support of the alcohol treatment workers and medical assistance from the District’s Alcohol Team and local General Practitioners. However this procedure accounts for only part of how the treatment on the ATR

program is delivered. The majority of the program focuses on support and counselling which is offered throughout the duration of the treatment. As already explained, both alcohol treatment workers are trained in 'motivational interviewing' techniques (Miller and Rollnick, 2002) and work with offenders involves education around safe levels of alcohol consumption; individual goal setting; lifestyle changes and relapse prevention strategies.

The data presented in the following sections is largely based on a systematic review of each ATR offender in relation to their alcohol treatment records and CRAMS contact logs kept by the alcohol treatment workers. These consist of a record of every treatment episode throughout the duration of the offender's treatment program.

### **Completion of orders**

Table 8 below shows the number of offenders who completed their ATR order. Out of the 81 ATR offender data that were analysed it was recorded that a high proportion, 57 (70 per cent), completed their ATR order. A smaller proportion (14 per cent) failed to complete their order due to 'breach' or committing a further offence (reoffending and consequently receiving a custodial sentence). A small number of offenders (11 per cent) were currently still serving on the order during data collection.

**Table 8: Number of ATR orders completed**

|                      | ATR order completed? |       |
|----------------------|----------------------|-------|
|                      | No.                  | %     |
| Completed            | 57                   | 70.4% |
| Transferred          | 3                    | 3.7%  |
| Order revoked/breach | 12                   | 14.8% |
| ongoing              | 9                    | 11.1% |

The ATR program requires the offender to undergo treatment for a set period of between 6 months and 2 years. In the time that this data sample was collected, more than half of the orders were ongoing for 6 months (61 per cent) and just over 30 per cent were 12 months and above. Notably, completion rate for the ATR program is relatively high compared to other treatment requirements such as the Drug Treatment and Testing Orders (DTTO) now known as the Drug Rehabilitation Requirement (DRR) where offenders receive treatment for drug misuse. In 2003 it was reported that retention rates for the DTTO were relatively low with only 30 per cent completing their order and 67 per cent having their orders revoked (Home Office, 2003). Therefore the ATR program appears to be successful in retaining clients throughout the set duration of the treatment. Nevertheless, it must be acknowledged that alcohol, as a socially accepted drug, cannot in many ways be compared to illegal drug misuse and is not subject to the same method of testing. Offenders who relapse with a positive drug test on a DRR program can be subjected to further punitive measures whereas testing for

alcohol use during an ATR order is mainly used as a motivational tool for measuring reduced consumption levels and therefore has no punitive consequences.

### **Outcomes in relation to changes in alcohol consumption and drinking 'patterns'**

By accessing treatment files and consulting alcohol treatment workers, it was possible to quantify how offenders were assessed upon completion (or near to completion) of their order. Both alcohol treatment workers were asked to make a brief assessment of each offender and describe, where possible, their drinking behaviour upon completion of their treatment. Alcohol treatment workers made their assessment based on what progress was made during the treatment and the offenders' self reports about their alcohol consumption and other lifestyle changes.

**Table 9: Summary of offenders' treatment outcome**

| Description of outcome                       | No. of clients | % of total |                          |
|--|----------------|------------|--------------------------|
| Abstinent                                    | 26             | 32.1       |                          |
| Reduced alcohol consumption                  | 9              | 11.1       | Positive outcome = 54.4% |
| Controlled alcohol consumption               | 9              | 11.1       |                          |
| Same – no engagement                         | 13             | 16.1       |                          |
| Too complex/unknown                          | 12             | 14.8       | Negative outcome = 45.6% |
| Binge  | 1              | 1.2        |                          |
| Deterioration of alcohol consumption/relapse | 10             | 12.3       |                          |
| 'Heavy' alcohol consumption                  | 1              | 1.2        |                          |
| Total  | 81             | 100%       |                          |

The results are shown in Table 9 above. It was found that a larger proportion of the offenders (32 per cent) were described as 'abstinent' upon completion of their treatment. 11 per cent were described as achieving a state of 'controlled' alcohol consumption and a further 11 per cent were described as having 'reduced' their alcohol consumption. Each of these categories were described as 'positive outcomes' by the alcohol treatment workers and in total it was found that over half of the entire sample was recorded as having made positive changes to their levels of alcohol consumption and drinking behaviour patterns.

Table 9 also shows that just under half of the offender sample (45 per cent) had either no change in their alcohol consumption or indeed their alcohol consumption had 'deteriorated' whilst serving on the order (i.e. alcohol consumption had increased). A large proportion of the negative outcome offenders were described as 'too complex' or 'unknown'. This according to the alcohol treatment workers, was due to offenders presenting with many additional complex issues during treatment (for example drug addiction; mental health issues etc.) that could not be 'oversimplified' into one single category.

### **Previous treatment involvement**

During examination of the offender's treatment files, it became evident that some offenders had previously attended voluntary alcohol services in their local area. Table 10 shows the number of offenders who were known to have accessed voluntary alcohol services previous to their ATR treatment (based on self reporting). Only 16 per cent of the sample had reported that they had received alcohol treatment on a



voluntary basis prior to receiving an ATR order. For a large majority of the offenders however, this was either not reported or not recorded. This information could be explored in more depth and further research involving offender interviews may provide more detail. Nevertheless for many offenders, the ATR may be the first time they have received any support or treatment for their alcohol consumption.

**Table 10: Number of offenders previously known to other voluntary alcohol services**

| Previously accessed voluntary services? | Number of clients | % of total |
|---|-------------------|------------|
| Yes                                     | 13                | 16         |
| No                                      | 22                | 27.2       |
| Unknown                                 | 46                | 56.8       |
| Total                                   | 81                | 100%       |

Table 11 shows a summary of the ATR offender data in relation to outcomes other than their alcohol consumption. Just over 37 per cent of the sample completed their ATR order 'successfully' without needing any further support (this information is based on their alcohol treatment worker's reports). It was also evident that, out of the large majority of offenders who completed their ATR order, there were some offenders who, again according to their alcohol treatment worker, did not 'engage' successfully during treatment (14.8 per cent) or relapsed towards the end of their treatment (9.8 per cent).

**Table 11: Final assessment of offenders upon completing treatment**

| <b>Final overall assessment by alcohol treatment worker</b>          | <b>No. of clients</b> | <b>% of total</b> |                  |
|--|-----------------------|-------------------|------------------|
| <b>Completed order successfully</b>                                  | 30                    | 37.1              |                  |
| No. and % of completed clients actively looking, training or in work | 9                     | 30                |                  |
| % of total sample  |                       | 11.1              | 27% of clients   |
| <b>Poor outcome – never engaged/attended</b>                         | 12                    | 14.8              | accessed further |
| <b>Relapsed</b>  | 8                     | 9.8               | services         |
| <b>Referred to local Alcohol Team</b>                                | 7                     | 8.6               |                  |
| <b>Order revoked /unknown</b>  | 7                     | 8.6               |                  |
| <b>Referred to Mental Health Services</b>                            | 6                     | 7.4               |                  |
| <b>Unknown</b>   | 6                     | 7.4               |                  |
| <b>Currently ‘doing well’</b>  | 4                     | 4.9               |                  |
| <b>Currently ‘not engaging’</b>                                      | 1                     | 1.2               |                  |
|  | 81                    | 100%              |                  |

Social factors such as accommodation, education and employment are said to be significantly associated with reoffending (Social Exclusion Unit, 2002). The ATR program offers offenders the opportunity to engage in additional support services during their treatment. These additional services are often ‘signposted’ by their alcohol treatment worker or offender manager. For example, due to the high number of alcohol ‘dependent’ offenders within this data sample, it would understandably be expected that a large majority would find it difficult to remain in employment. However during treatment, the offender may feel more able to begin to look for employment opportunities. This social element of rehabilitation is concerned with helping offenders re-construct their social positioning to allow them a realistic way of

living without alcohol and offending. Through their alcohol treatment worker, offenders can be referred to agencies such as 'Progress to Work' where help and support in finding employment can be provided. Table 11 shows that, out of the 81 ATR offenders, 11 percent are currently either in employment, or are currently looking for employment. On further analysis it was found that 7 out of the 9 ATR offenders in this category who were abstinent upon completing the order were classified as 'alcohol dependent' at the beginning of their treatment program. This suggests that for some, the ATR program can positively change a person's overall lifestyle as well as their alcohol consumption.

It was further acknowledged that many alcohol misusers have multiple needs and that alcohol misuse and mental health are frequently interlinked (Stimson *et al.* 2007). Table 11 indicates the number of offenders who were referred to the mental health services after completion of their order (7.4 per cent) and the number who were referred on to the local Alcohol Services in order to continue with their treatment (8.6 per cent). All ATR offenders have the opportunity to be introduced to these services whilst participating on the program. A psychiatric mental health nurse visits the treatment program regularly (usually every 3 to 4 weeks) and clinics are held at the local alcohol services for those who are preparing for an alcohol 'detox'. Although these figures are relatively small, the 27 per cent of offenders who are now accessing other services are being provided with ongoing support that they may not have accessed if they were not participating in the program.

## Outcomes in relation to completion rates

The ATR program was developed through a need to locally address and reduce the level of alcohol related offences across the District. The Ministry of Justice (2009) reported that nationally, reoffending rates for offenders who are released from custody or receive a community sentence in 2007 has reduced from 43 per cent to 39 per cent since 2000. Table 12 presents a summary of offending behaviour for those who had completed their ATR order. Out of the 81 ATR offenders who were examined, 72 had completed their order. At the time of data collection it was recorded that a large majority of the offenders had not reoffended (81 per cent). Only 6 per cent had reoffended and 11 per cent had gone on to receive a prison sentence. This appears surprising and unexpected in relation to reoffending rates and the high proportion of offenders in this sample who were classified as high/medium risk offenders.

**Table 12: Number of offenders who had reoffended**

| Has the client reoffended?  | No. of clients | % of total who completed ATR order |
|-----------------------------|----------------|------------------------------------|
| No further offence recorded | 59             | 81.9                               |
| Prison                      | 8              | 11.2                               |
| reoffended                  | 5              | 6.9                                |
| Total                       | 72             | 100%                               |

These figures show a relatively low percentage of reoffending rates. However, the Ministry of Justice (2009) report reoffending rates by measuring the actual number of

offences the cohort committed during the one year follow-up period which resulted in a conviction at court. It must be noted therefore, that this data set was collated over a period of approximately 1 year 6 months, therefore the time lapse from completion of an order, for each offender, varied considerably. For example, some of the offenders in the data set had only recently completed their orders, whilst others completed their orders as long as 6 to 12 months previously. In order to allow for a substantial time lapse with which to measure reoffending rates within a one year follow-up, this data set would need to be revisited.

### **The main findings**

The aim of this analysis has been to explore and understand in detail the characteristics of 81 offenders who were granted an ATR order by the courts as part of a community sentence. Moreover, this analysis has aimed to provide a quantitative evaluation of 'outcomes' in relation to the treatment program.

This analysis has revealed several major findings. Firstly, it was identified that the large proportion of offenders who were assessed as 'suitable' for an ATR by the alcohol treatment workers were subsequently recommended for an ATR by their offender managers and granted an ATR by the courts. This would seem to demonstrate the success of inter-agency working between the criminal justice system and the health service. It seems that for both agencies, having shared goals and working in close proximity was perhaps pivotal to the ATR's operational success. In terms of the profile of offenders being sentenced to the ATR, it was found that from this particular sample, a large majority were male, aged between 18-35 years, predominantly 'white British',

unemployed, dependent on alcohol, with predominantly assault related offences. Thus the ATR has made available alcohol treatment to predominantly alcohol dependent young men within the District.

In terms of evaluating treatment 'outcomes' there is now a more contemporary view to how this is approached within the drug and alcohol field (McLellan *et al.* 2005). There has been a move away from the traditional reliance on abstinence as the sole criterion of treatment success. Treatment outcomes have recently extended to a focus that attempts to answer questions such as are patients/clients engaging in treatment; reducing their alcohol intake; improving their health and social function; and reducing threats to society? Thus, in this sense, it was found that there were more 'positive outcomes overall than 'negative outcomes'. A large majority of the offenders had completed their order, and on closer inspection it was found that just over half had made positive changes to their alcohol consumption levels. Indeed just over 32 per cent were recorded as abstinent and a further 22 per cent had achieved levels of 'controlled drinking' or had made attempts to reduce their level of consumption. In relation to offending 'outcomes' it was found that a large majority (over 80 per cent) had completed their ATR with no further offences committed.

Finally, the coercive element of the ATR was considered within this analysis. Indeed it was noted that all offenders had the same conditions to attend treatment as the probation services' National Standards, therefore non-attendance would result in 'breaching' the order which may result in the offender returning to court for further sentencing. According to the alcohol treatment workers, the 'coercive' element of the

treatment program (offenders can refuse to receive treatment but may face further undesirable options such as custody) enforces the offenders to attend regularly, and for many of the offenders, this appeared to have resulted in them remaining longer in treatment and consequently moving closer to their therapeutic objectives.

Nevertheless, a smaller proportion of offenders were found to have made no changes to their alcohol consumption during treatment, and according to their alcohol treatment worker this was due to offenders failing to engage during treatment sessions. This would suggest that 'coercive' treatment may be successful in getting the offender to attend treatment sessions, but, for some offenders, is not necessarily effective in bringing about the desired changes. There were a small number of offenders who were recorded as having 'relapsed' where controlled or abstinent drinking had been achieved at some point during treatment, but not sustained. Although these offenders had been recorded as a 'negative' outcome, it could be argued that they have at the very least had the opportunity to experience sobriety and consequently, have been made aware that there is support in the community should they decide to voluntarily access services in the future. Indeed 27 per cent of offenders who had completed their order were referred on to other voluntary services (for example, mental health; alcohol treatment; employment agencies etc.) where ongoing support can be offered post treatment. Therefore in considering the coercive element of the ATR it is evident from this analysis that it has the tendency to enable positive changes to be made, or at the very least experienced.

## Summary

The quantitative data presented in this chapter has served to provide an 'objective' overview of the ATR program. However, the very nature of the data could, if viewed in isolation result in an oversimplification of the complexity of the ATR program, the offenders, the treatment workers and the everyday functioning of the service.

There can be a whole range of social, environmental, individual and cultural factors which exert an influence on the 'therapeutic relationship' and the ATR, making it more difficult to precisely establish the role of the ATR in behaviour change through statistical analysis alone. Therefore the second and third phase of this research aimed to build on this quantitative phase and provide a more 'holistic' view of the delivery of the ATR, the interactions that occurred during treatment on the ATR and how this might impact on individual lives. Therefore what follows in the next chapter is the presentation and analysis of the field note data recorded during the observations of the treatment setting.



## **Chapter 6: Analysing the field data: introducing the observed/experienced**

### **Introduction**

Phase Two of the data collection stage of the research involved conducting participant observations in the 'field' in order to gain insight into how the ATR was delivered at the two probation sites. Extensive field notes were written during my visits to the sites which spanned a period of approximately two years. This chapter aims therefore to present an analysis of the field notes collected. However firstly, issues surrounding field note data are explored in relation to approaching the data analysis. This chapter then moves on to set the scene of the treatment sites by drawing on and describing my own experiences as a researcher entering the field. It is here that I acknowledge my initial position of 'outsider' and how this was negotiated to 'insider' status during my field visits. Finally in this chapter, a qualitative analysis of my field observations of the treatment settings is presented drawing on positioning theory (Harrè and Moghaddam, 2003) in order to explore the social interactions that took place between the alcohol treatment workers and the offenders.

## Using field notes: interpreting the social world

It was established in the previous chapter that the method of writing fieldnotes moves beyond simply describing what happens in the field. Rather, fieldnote taking is an interpretative process that 'textualises the world on the page' (Emerson *et al.* 1999, p.8). It involves an immersion into the social worlds of others and therefore rules out the notion of the researcher conducting field research as a detached passive observer. There is therefore a 'consequential presence' (Clarke, 1975) often linked to how people may talk and behave in the presence of the researcher. The researcher's presence in a setting inevitably has implications and consequences for what may occur. However, Emerson *et al.* (1995) suggest that this should not be seen as 'contaminating' the research, rather these effects are said to be the very source of what is observed and learned.

There is nonetheless a concern about using field data which can result in researchers becoming over cautious about producing field notes in order to capture field experiences (Hammersley and Atkinson, 1995). There is often a fear that the field experience will be lost, and as a result an overuse of tape recorders and video cameras is often favoured as researchers can analyse the transcripts taken as verbatim evidence of the setting, perhaps free from interpretation of the researcher. However, Emerson *et al.* (1999) point out that even the use of recorded transcripts that seemingly catch and preserve almost everything occurring within an interaction, can only capture a small section of ongoing social life. Transcribed recordings have similar limitations where reduction of data occurs at the interviewing, transcribing and

analysis stage of the research. Indeed DeWalt and DeWalt (2002) argue that field notes are simultaneously sets of data *and* analysis. They also agree that field notes are a product constructed by the researcher. The researcher decides what to write and what not to write, how much detail to include and which parts of the conversation are to be recorded.

According to Hammersley and Atkinson (1995) fieldnotes are traditional means in ethnographic methods for recording observational data. However, Atkinson (1990) argues that largely field notes remain private documents, unavailable for analysis. Emerson *et al.* (1995) note that field notes can often be seen by researchers as too personal, idiosyncratic or too messy to be shown to an audience. Nevertheless, Emerson *et al.* (1995) take the position that field note taking involves skills that can be learned and developed over time. However, there has been some criticism in the past concerning the credibility of using findings from ethnographic methods, in particular field notes. Such findings have been argued to be unreliable and lacking in validity (LeCompte and Goetz, 1982). Subsequently there have been attempts to address validity issues in constructing and presenting fieldnotes, such as respondent validation or triangulation. Respondent validation attempts to establish a 'correspondence' (Lincoln and Guba, 1985) between the researcher's and the participant's social world by exploring the extent to which participants recognise and agree with the researcher's findings. Triangulation (Denzin, 1989) broadly involves the comparison of data relating to the same phenomenon, but takes advantage of using more than one data set to produce a more accurate or 'valid' representation of the field.

The idea that combining methods leads to greater validity of the findings has been criticised by Bryman (1988) as naïve and is clearly not compatible with a social constructionist view that there is no one 'true' version of reality, only different competing versions. Indeed Denzin (1996) states that ethnographers have:

'Historically assumed that their methods probe and reveal lived experience. They have also assumed that the subject's world is always final, and that talk directly reflects subjective or lived experience. The literal translation of talk thus equals lived experience and its representation.' (p.132).

Denzin goes on to challenge these assumptions. He states that language and speech do not mirror experience, they create it and in that process 'constantly transform and defer that which is being described' (p.132). He therefore argues that the meanings of an individual's statement is constantly in motion, 'there can never be a final, accurate representation of what was meant or said, only different textual representations of different experiences' (p.132). Similarly, it is argued that there is no such thing as 'pure description' in ethnographic methods (Hammersley and Atkinson, 1995, p.221). Data therefore can never be taken at face value. Indeed attempts to address 'respondent validity' can create its own problems. The practice of 'testing' ethnographic accounts by requesting the participants involved to validate the researchers' analysis, relies on meanings being reconstructed on the basis of memory. However, as Hammersley and Atkinson (1995) state, much of the observed social action operates at a subconscious level, thus leaving no memory traces, therefore leaving the practice open to further critique and analysis.

## Actively creating realities through field notes

Denzin (1996) suggests that attempts to 'validate' qualitative findings in this way is an attempt to 'reauthorize' a text's authority in the post-positivist moment (p.133). He argues that such attempts to validate are based on the presumption of a 'world out there' that can be truthfully and accurately captured by the researcher's methods and written text. Indeed Emerson *et al.* (1995) point out that even with developed skills in writing and recording field observations the researcher must realise and acknowledge that they are not just simply recording witnessed events, rather through writing they are actively creating realities and meanings. This level of awareness is said to generate an appreciation of the *reflexivity* of ethnographic research. Thus, Atkinson (1990) states that:

'The notion of reflexivity recognises that texts do not simply and transparently report an independent order of reality. Rather, the texts themselves are implicated in the work of reality-construction' (p.7).

In this research the work of Emerson *et al.* (1995) was drawn on heavily to inform the production of the field notes. Their approach to field note taking was driven by the 'assumptions of an interactionist, interpretative understanding of ethnography, derived from the traditions of symbolic interaction' (p.xii). In adopting this approach, this research aimed to include the researcher's voice since it was acknowledged that the researcher's interactions in the field shape the writing.

## Developing an analytical approach

The aim of the following analysis was to attempt to produce a coherent, focussed analysis of the observed social life of the ATR, those who have participated in it, and its day to day running. To this end the initial stage of the fieldnote analysis was based on Hammersley and Atkinson's (1995) approach to data collection and analysis. In addition, due to the large volume of field notes and personal reflections collated, Emerson *et al's* (1999) guidelines on how to process and code fieldnote data was drawn upon. This provided a structural stage by stage account of how to begin to make sense of the 'data corpus'. These guidelines suggest that there are seven stages to organising and analysing field data:

- Stage one: *re-reading* through all recorded fieldnotes, subjecting the broad collection of notes to close, intensive reflection and analysis.
- Stage two: *analytically coding* fieldnotes. This involves categorising the notes line-by-line and examining and exploring the data in order to create 'codes' that aim to capture more general categories into a meaningful and theoretical data set that relates to the researcher's questions.
- Stage three: *open coding*. This involves the work of stage two above, however the type of coding at this stage should be free from any pre-established notions in relation to the fieldnotes. Rather this stage should seek to generate as many codes as possible regardless as to whether they fit with the researcher's initial focus, as it is suggested that at this stage, the focus may change as the researcher moves through the notes.
- Stage four: *writing initial memos*. Here the researcher begins to create a range of ideas and insights about what is going on in the data. At this stage in the analysis the ideas

should become more analytical than descriptive in nature, and further theoretical implications can be explored around the ideas generated. At this stage the analysis should remain flexible and open in order to avoid restriction of new ideas, linkages and connections. Eventually however the analysis should begin to move beyond the open and inclusive procedures to enable a more focussed and intense generation of 'themes'.

- Stage five: *selecting themes*. At this stage in the analysis the researcher begins to identify and select 'core' themes for further analysis. To this end, the large data set is now broken down into more manageable chunks of data. The data is then rearranged to fit into the selected themes for further analysis.
- Stage six: *focused coding*. Having decided on core themes, a further line-by-line analysis of the data is carried out. At this stage the data is re-examined to either fit into the core themes, or made into sub-themes that relate to one another in some way. At this stage, with the focussed coding, the researcher may be at a stage where an argument or story can be developed.
- Stage seven: *integrative memos*. This involves presenting and linking the codes together by providing integrative memos in the write up that aim to integrate theoretical connections between the fieldnote excerpts.

Within this analysis, it was evident that rather than proceeding deductively with the data, a more open-ended approach is used that seeks to identify issues and ideas through paying close attention to the data and remaining open to a range of possibilities. There should however, be some caution applied to this approach as with most research, it does not, and cannot claim to be completely free of existing theory. Although this approach to analysis resists operating on a deductive level, where theory

simply waits to be supported, it should also be acknowledged that data of this kind can never claim to be value free and is always a product of prior interpretation (Hammersley and Atkinson, 1995). Indeed as previously argued, the process of analysis begins as soon as the field notes are recorded where selection and interpretation is inevitably involved. Indeed, for this research, data analysis was ongoing, with field notes and personal reflections being transcribed after each visit. Therefore this analysis does not claim to have taken a grounded approach.

### **Introducing the setting**

In this section I aim to present an overview of the setting where the field observations took place. As mentioned in the previous chapter, the District is located in the north of England and there are two probation sites that serve the District. There are two alcohol treatment workers who were employed to work on the ATR project, Amy and Susan (pseudonyms). The ATR began as a 'pilot' project which was to 'go live' in August 2007. Both Amy and Susan began their new posts in July 2007, by which time the research project had received ethical approval and permission was granted to conduct the research at the two probation sites.

At the time of the research Amy was based at the 'Centre' site and Susan was based at the 'East' site. The majority of the alcohol treatment was conducted by the alcohol treatment workers at the probation sites. As highlighted in Chapter Five, one of the main reasons for this particular arrangement was to facilitate 'joined up working' (Tilstone and Rose, 2003) with the probation staff. The majority of offenders were granted an ATR as part of a requirement of a community order and had an offender



manager assigned to them. It was therefore not unusual to observe offender managers discussing individual offender cases with Amy and Susan on a regular basis. Amy and Susan's main role was to conduct alcohol treatment assessments and produce reports for court and to conduct alcohol treatment sessions with offenders. The majority of the treatment sessions were conducted 'on site' in interview rooms that were also shared with all probation staff. Therefore much of the everyday happenings of the ATR involved Amy and Susan going 'in and out' of their offices, seeing clients and writing up reports.

### **The alcohol treatment workers**

At the time of the research Susan was approximately in her mid forties. Before her alcohol treatment position, Susan had worked in a woman's prison as a prison officer for over two years. Previous to working in the prison Susan and her husband managed a local pub. She said that she has had no alcohol treatment experience but that she had to 'deal with' drug dependent and alcoholic offenders on the prison wing and saw the effects of alcohol during her time working at the pub and claimed that she had 'seen it all'.

Amy was in her early twenties. Before her alcohol treatment position, Amy had completed a degree in psychology and after graduating had worked as a volunteer in a homeless shelter. Amy also had no experience in alcohol treatment but she had experienced and worked with 'alcoholics' who visited the shelter. Upon being appointed Amy and Susan both completed a 4 day training course in motivational interviewing skills. In addition they both received training at the local alcohol services

where they had the opportunity to 'shadow' alcohol treatment workers and observe their work.

## **Gaining 'entry' to the field: 'inside –outside' status**

### ***Initial reception***

As mentioned, my fieldwork was carried out at the two probation sites. Since the introduction of the ATR in July 2007 to March 2009, I visited the sites once or twice a week, both to collect data from documents and records and to observe the setting. I knew very little about the probation service and had never visited a probation office before, yet I did have experience in undertaking health related research. My only prior contact with the alcohol treatment workers was at an ATR stakeholder meeting where I was briefly introduced as 'the PhD student'. Therefore I entered the field setting with some experience as a researcher, however I had little knowledge of what to expect early on. Indeed in my initial field notes it was clear that my early role in the field was one of an 'outsider' entering into an 'insider's' world (Coffey, 1999). This was evident in the early days of the research project when I first arrived at the sites to begin my fieldwork:

Field notes: *The East site:*

Today I carried out my first 'field observation'. I was due to meet Susan the alcohol treatment worker at 2pm at the East probation site where she is stationed. I entered the building through the blue doorway and was immediately standing in the waiting room area. The smell of the room hit me immediately, which was unpleasant. Through a window I gave the receptionist my name and asked for Susan to which she immediately replied 'have you got any ID?' I fumbled around in my bag trying to find my University ID badge, and as I did she looked me up and down and said 'oh you're ok, you look ok'. She then 'buzzed' me in. Susan came to greet me, I was pleased to eventually see Susan as I was frustrated that I was late, she put me at ease immediately saying that she had the same problem when she first arrived. I then followed Susan we went through a security locked door where she turned and said 'welcome to the madhouse'. She is seated in a large open plan office in amongst the offender managers. I was introduced to some of the offender managers as 'Jo, a student from the University of Bradford, she's doing a PhD study on the ATR'. We sat down and immediately Susan said slapping her hands on her knees 'right then what do you want to know?' This felt rather abrupt, it seemed as though Susan was a little nervous of me and I suspect also suspicious of my possible agenda. Sensing this, I began by trying to explain my role and that I wasn't there to 'check up' on her. We then chatted about the research and Susan cleared a drawer out for me to use.

Here, my status as an 'outsider' was evident immediately as I did not know where I was going and ultimately got lost trying to find the building. Indeed Susan reaffirms my 'outsider' position by recalling and comparing her own experience of being an outsider when 'she first arrived' with my own experience. The receptionist's request for my 'ID' badge indicates my status as a 'visitor' and therefore an 'outsider' attempting to gain

access to their world, however my appearance, seemingly allows me the brief privilege of being accepted as a possible 'insider', 'oh you're ok, you look ok'. As I enter the office, Susan demonstrates her position as an 'insider' by claiming familiarity over her working environment. As a member of her group she is able to make an acceptable joke about the office, calling it a 'madhouse'. Furthermore, as we walk to her desk, the need for an introduction defines me as somebody who is a stranger to the office staff. Finally, Susan's abrupt question indicates an orientation to my assumed academic role, as somebody who wants information and needs to 'know'.

Similarly my first visit to the Centre site was further evidence of my early 'outsider status':

Field notes: ***The Centre site:***

Today I visited Amy at the Centre site. This building is slightly bigger than the East building and has a small car park attached to it. I walked through the door, into the waiting room area, and was hit by that familiar stench of unwashed clothes and stale smoke that I had experienced at the East site. The waiting room was empty and I walked over to the reception window to my left. A young blond girl greeted me and after I had presented my ID to her she 'buzzed' me through to the other side and asked me to sign in. Amy appeared and I followed her to her desk. She also shared an open plan office with offender managers. We got straight into the matters of my research. I asked Amy if there was any chance of gaining access to her files to which she replied 'what do you mean, what it is you're wanting?' I explained that I needed to collect data from the systems but could also possibly find the information in her files. She then showed me where her files were kept and said 'I'm not sure you'll find everything in there, hopefully its all there and nothing's missing'.

She then instructed that I could take one file at a time so long as she didn't need it. I was then left to get on with my work. I sat the remainder of the morning reading files and made a note to bring my laptop next time.

Here, my 'outsider' status was exemplified by my need to ask for information and Amy's responses 'what you mean, what is it you're wanting? , she appears suspicious and unsure of my research, perhaps concerned that I would be making judgements about the quality of her files. My 'outsider' role was further illustrated in what was not said. Indeed often it can be said that researchers in the field can come to experience not only what can be seen and talked about directly, but also the things that are not said and done which shape the 'narrative structure' of their observations (Clandinin and Connelly, 2000, p.68). I recall very little conversation between myself and Amy during my early visits. Indeed our conversations were brief and centred around my queries in relation to information in the files. I often sat a few desks away from Amy and I was therefore left to get on with my data collection, a powerful reminder of the fact that however important the research may have been to me, it did not appear to figure very highly in Amy's overall scale of priorities.

### **Negotiating the insider –outsider status**

These initial visits to the field were conceptualised as the 'orientation' (Coffey, 1999) phase of my work, not only to the culture of the probation field, but to the relations between myself, Amy and Susan. Moreover, in this initial phase of the research I was constantly aware of the positions both Amy and Susan occupied. They were relatively new both professionally and organisationally to the probation service, and as such

would perhaps, understandably, prefer not to be 'studied'. This was evident in their reaction towards my initial visits. In addition to this was the acknowledgement that their 'choice' to participate in the research may have been constrained by the realisation that their employers had indeed funded the research project. Such detail, if not considered during the orientation phase of the project, could potentially create further negative barriers which could have serious implications for the amount and nature of the data collected.

### **Orientation to the fieldwork role**

The above excerpts from my fieldnotes illustrate the beginning of the journey. The role of participant observer was challenging. Coffey (1999) makes explicit that the primary task of the fieldworker is 'to analyse and understand a peopled field' (p.39). She argues that this can only be achieved through social interaction and shared experiences, therefore fieldwork is largely dependent upon and guided by the relationships that are built and maintained over time. Indeed in all aspects of the research project, social relations remain key. Thus it is always desirable that positive relationships are sought with those who are being studied. Coffey (1999) goes on to state that 'however artificially, and perhaps cynically construed in the first place, fieldwork relationships are real in their consequences, both in terms of the quality of the data and the lived experience of the research' (p.40). Indeed, Hammersley and Atkinson (1995), highlight that knowing who has the 'power' to open or restrict access is clearly an important aspect of field research. I had permission to conduct the research both from the relevant NHS ethics committees and the health and criminal justice authorities, yet it

was soon realised that Amy and Susan would be the prominent 'gatekeepers' who could close off certain avenues of enquiry such as observations of the treatment setting, or particular 'difficult' ATR clients. Indeed at the beginning of the research, the client observations were very few and far between. I found myself being overly polite and cautious about asking to 'sit in' with offenders for fear of putting them under pressure early on in their own professional development. Therefore, I was keen to build relationships with Amy and Susan, in order to seek out genuine experiences of the ATR, but realised that this would take some time to develop.

### **Developing relationships**

Field relations are a crucial aspect of ethnographic methods. As I have previously stated, my aim for this phase of the research was to observe the process through which the ATR was delivered in its daily practice and to understand how alcohol treatment was delivered by the alcohol treatment workers. It was therefore necessary to take measures to overcome the perceived social distance between myself and the alcohol treatment workers, which entailed a conscious management of my field work position (Coffey, 1999).

As the ATR and the research project began simultaneously, there were often times at the beginning when it felt like we were all leaping into the 'unknown' together. However it appeared that initially I was perceived as the 'expert academic from the University' by Amy and Susan which often created tensions between us and appeared to put a strain on how they performed. For example, after an early observation with Susan and her offender, Susan said that she had felt nervous of my presence and she

was further surprised and suspicious to see the amount of notes I had written, commenting 'oh my god what have you been writing about me, look at all those notes!' Therefore, during conversations I specifically tried to convey my position as a 'learner' and a 'beginner' in relation to the ATR and the research project. For example I talked openly about myself as a research student learning to fit into the academic field. This was a strategy that I often relied on in my early days in the field where a conscious effort was taken to manage my own 'self-disclosure' (Allen, 2004) in order to develop trust and acceptance.

Field notes: ***Talking with Susan:***

Susan was typing up a treatment report for court and she asked me for another word for 'fed up'. I sat and thought and said 'I don't know' and queried if she had a thesaurus check on her computer. 'Oh do you use that as well?' she replied sounding surprised. I said 'absolutely, all the time'. We chatted about writing essays and reports and I commented that I always found it difficult. I told her that I would often get my written work back with comments 'all over it' to improve and openly shared with her my anxieties about writing and producing work that is 'good enough' for a PhD.

My self-disclosure exemplified above appeared to be successful in encouraging a rapport to develop between us and I was gradually included in general conversations with increased intimacy and openness. Furthermore, our relationship became more collaborative, for example during team meetings we would arrange to go together and I would discuss the data that I had collected from the files which often presented both Amy and Susan in a favourable light in relation to statistics based on their performance.



They, in turn, became less cautious and more relaxed about my presence both in the office and during treatment observations. Therefore, the degree to which I was accepted and granted 'insider' status by Amy and Susan was negotiated through ongoing open interaction and was evident in the establishment of reciprocity in our developing collaborative relationship.

### **Becoming a trusted 'insider'**

As the ATR case load increased, Susan began to share the offender case load with Amy at the Centre site which resulted in Susan working two or three days a week at the Centre site. As a result of this arrangement, Amy and Susan were re-located to a small office of their own at the Centre site. This for me marked a further significant development in our relationship. Both Amy and Susan now had their own desks in a small office that they shared. When Susan was working at the East site, I was able to use her desk and as a result it became easier for me to spend longer hours there. The new office space seemed to create a sense of belonging for Amy and Susan and surprisingly for me also. Their growing acceptance of me even extended to making room for me to store my things such as files, stationary, coffee cup etc. Indeed Schneekloth and Shibley, (1995) argue that people are hugely affected by particular places and propose that places are constructed both symbolically as well as materially as a way of making communities and connecting with other people. Thus this new sense of 'place' for Amy, Susan (and for myself) appeared to consolidate our relationship further. Rather than being perceived as an 'outsider', both Amy and Susan began to talk openly about their work telling it 'like it is' rather than being constrained

to telling public accounts of their practice (Emerson *et al.* 1995) as is evident in the following field note excerpt:

Field notes: **Mark Smith:**

I talked to Susan today about a difficult client she has been working with called Mark Smith (pseudonym). Susan and his offender manager, Zoe, have been working together with him for the last 6 months and it seems that they are becoming more and more frustrated with this case. 'How is Mark Smith doing' I asked, to which she replied 'oh you mean *that* Mark Smith!' I reply with a small laugh 'yes that's the one'. Susan updates me on his latest episode telling me that just before I arrived he had called her on the phone two hours late for his appointment and she tells me that he said to her 'I can't get in to see you today because I've had me ear bitten off'. I am shocked at this horrific attack and my reaction was clear to Susan who then replied angrily 'oh it'll be summat and nowt knowing him'. Susan then warned me that if he did show up then she thought it was best if I didn't come down with her as she was 'hopping mad' this time, 'enough's enough!'

Susan's conversation with me about her assigned offender Mark Smith shows a genuine openness about her feelings in relation to his behaviour. Her performance was not strained by having to put on a public 'front' for me as the observer, and her frustration and anger in relation to the situation provided contextual insight into the difficulties of working with complex offenders. Nevertheless, Susan still appears to exert some degree of control by steering me away from what could be perceived as a further disruptive and possibly damaging confrontation with her offender if he were to 'show up'. This serves as a strong reminder of the extent to which I was accepted as an insider and that as an observer I was not always guaranteed access to all data available

within the setting. Understandably, Susan may be concerned as to the image of the ATR that could be created, and may wish to be presented in a favourable light. Nevertheless, her openness about her feelings towards her offender with me conveyed a level of acceptance and trust in our relationship which afforded such insider accounts.

It was apparent that a key factor in my insight into the context of the ATR within both the health service and the criminal justice service across the District has been the development of these relationships. Both Amy and Susan have enabled crucial opportunities to observe and access offenders during alcohol treatment, providing a more situated understanding of the ATR, which, it is argued, could not have been achieved through the exploration of documentary evidence alone.

### **Introducing the observations: the treatment setting**

The observations that were conducted during the treatment sessions were not and could not always be directly planned. In some instances, I would aim to plan my visits when I knew that Amy and Susan were seeing offenders, thus opening up more opportunities for me to observe offenders in the treatment setting. There were many occasions during my visits when the possibility of conducting a treatment observation would not happen. During my early visits, it was a slow process as Amy and Susan seemed reluctant to let me observe them, a reluctance that was perhaps in part due to their inexperience of delivering the ATR. However other instances included; offenders own refusal to be observed; offenders not keeping their appointments; offenders re-arranging their appointments; or offenders too sick to attend. Nevertheless, if I did

not get the chance to carry out a treatment observation, my visits were never a wasted journey as I always had the document analysis to be getting on with.

On days when I was able to observe the treatment sessions Amy or Susan would allow me to read the offender's files before we 'went down' to meet them as I this been ethically approved. Both sites operated the same in relation to seeing offenders. Both sites had a number of interview rooms (approximately 6 or 7 at each site) on the ground floor of their buildings which were utilised for offender interviews. The rooms were of different sizes, some were very small, fitting only a desk and a few chairs, and some were larger containing a desk, 3 or 4 chairs and a small round coffee table. The procedure was always the same with both Amy and Susan, they would walk along the corridor peering in to each room to see if there was anyone occupying it. I would wait in the room until the offender had been collected from the waiting area. It was at this point that the offender would be asked if they minded being observed before entering the room. If the offender agreed then I would introduce myself and go through the information form and ask them to sign a consent form.

Field notes: ***Going into battle:***

Amy answered the phone 'right thanks' she turned to me and said '[offender's name] is here. Do you want to read his file?' she chuckled me his file over which contained a record of police notes and a copy of a police statement which detailed the incident from the police officer's point of view, and a photocopy of a handwritten statement from the victim. I quickly read through the statements realising that this was a young man who had violently attacked a young girl, described as his 'girlfriend'. 'Are you ready?' asked Amy

‘sorry yes I’m coming’ I replied. I often experience a ‘shift’ from inactivity in the office to ‘hyper’ activity when going down to see an offender. I find myself rushing along the corridors following Amy with my notes under my arm trying to keep up, it feels like we are going down to the ‘front line’, getting ready for action. We are in the corridor where all the interview rooms are and it smells dirty. Amy rushes along the corridor turns to me as she is walking, ‘see if you can get a room’ and she rushes into the reception area. I walk along, peering in through the windows. The big room is free so I go inside, quickly arrange the chairs and as I do I can hear Amy saying ‘Is it ok if a student sits in and observes today? She’s studying the ATR and wants to sit in’ I hear a deep voice answer ‘yeah yeah that’s ok’ and they enter the room. I stand up and say ‘hi, thanks’ to which the man replies ‘yeah its fine’. I go through the forms then sit back to observe, trying to be as quiet as I can.

Each observation began like this. The shift from ‘inactivity’ to ‘activity’ was observed on many occasions and was a common reoccurrence in my field notes. Both Amy and Susan often performed this way prior to seeing offenders. On each observation my notes did not describe a casual walk down to the interview rooms, rather there was always a sense of anticipation, of ‘going into battle’ often described in my notes as preparing to ‘meet the enemy’.

At the beginning of these observations, I recall feeling that I had entered a different world. My notes reflected this, I remember early on reflecting and writing about my responses to the situations, the strangeness of writing about these young men who I had never met before, and in many cases, would not meet again. I recall being unsure about what to focus on in my initial note taking, when to write, when to stay still, when to look and observe. Often the room size made my presence more obvious,

which limited the amount of data I could capture. At other times my physical positioning made it possible for me to 'hide' and thus I was able to capture much more detail. Nevertheless, as I began to develop my field note writing skills and develop my thoughts about the treatment setting, I was then able to develop a more focussed observation of what was occurring during these sessions.

### **Analysing the observed/experienced**

All of the field notes collated for this research were written and recorded during Phase Two of the research which aimed to observe and understand how the ATR was delivered by the alcohol treatment workers. Over a hundred and fifty typed and hand written pages of fieldnotes were collated which included observations from approximately 23 specific individual treatment sessions, gathered over a period of approximately two years. What follows is an analysis of field observations of the ATR.

### **Finding a focus**

In accordance with Hammersley and Atkinson (1995), the process of writing my field notes (highlighted in Chapter Four) took on a 'funnel strategy' where more focussed observations were developed as the research developed. What became evident during these observations was how my focus 'shifted' from gathering factual data (how many units offenders were drinking, previous offence history, mental health history etc.) to observations which became more concerned with the social interaction between the female alcohol worker and the male offender. As I observed the treatment sessions, I was always immediately struck by the stark contrast between the

male offender and the female treatment worker. For example, there was the immediate physical sense of 'maleness' and 'femaleness' as the two entered the room and consequently occupied their space. Thus my research questions became more gender focussed as each subsequent observation began to reinforce my initial thoughts about the male and female 'performance' being 'acted out' and how certain 'positions' were occupied during these interactions. What was of further interest was how offenders 'talked' about themselves, their drinking and their offending behaviour during these sessions. Was this talk a 'masculine performance' intended for a female audience? How might a feminine discourse impact upon the interaction taking place? What was *not* talked about during these sessions? How do they present themselves to each other? Therefore, in order to begin to understand these social interactions, positioning theory (Davis and Harrè, 1990) was considered as a useful way of making sense of how individuals appear to co-construct their 'selves' through discursive action. Indeed beginning to use positioning theory as a dynamic, analytical tool enabled further insight into how individuals understand their roles as they interact. According to this approach, as individuals interact with each other, they co-construct a storyline wherein each person plays a part and these storylines are made explicit through a discursive process. Therefore the positions people take will be linked to specific storylines. Drawing on this approach enabled my observations to become more focused. It became apparent that positioning theory could provide a useful way to observe and make further sense of how treatment was delivered and consequently how offenders were managed on the ATR.

## **Delivering the ATR: a gendered practice?**

It is perhaps fair to say that early on in this research I was initially very sceptical about how effective the ATR would be in successfully treating offenders for their alcohol problems. As my observations became more 'gender focussed' I fell into a trap of operating within a stereotypically gendered framework, which for some time had consequences for the way in which I focussed my attentions. I drew heavily on the knowledge that Amy and Susan were appointed with no 'formal' qualifications in the alcohol treatment or addiction field. Indeed I turned to the literature which supported my ideas that the way in which the role and work of the alcohol treatment workers was conceptualised was within the feminised role of 'care and support' (Abbott *et al.* 2004; Armstrong and Armstrong, 2004; Hakim, 2006). It was evident that their 'treatment' role was not afforded the same status or resources that perhaps a medical intervention would have (Chiarella, 2002). Treatment carried out by a doctor or a clinician, within the dominant medical model, is able to claim more scientific authority and expertise over their practice (Chiarella, 2002). Indeed women's roles in the healthcare setting have been traditionally compatible with the view of woman as 'caregiver' drawing on their 'natural' skills. Thus 'care' and 'support' is often viewed as 'women's work' and as such is accorded 'low status'. Therefore the alcohol treatment workers on the ATR appeared to be marginalised in terms of funding/resource allocation and professional status. Consequently, my early thoughts were based on the assumptions that gender would inevitably be 'acted out' in a way that would reinforce my initial scepticism of the delivery of the ATR. My scepticism was formed amongst the backdrop of a stereotypically gendered analysis of the interactions I



observed which concluded that due to the nature of the caring and supportive environment provided by Amy and Susan, the ATR could be potentially conceptualized as an 'easy' option for these young, complex, aggressive, 'masculine' men. As I was operating within this gendered framework, it appeared that from a professional and operational perspective, the ATR would have only a minimal influence over the behaviour and lives of these young men. In addition, I also began to question how the program may have been conceptualized if it was managed by male alcohol treatment workers. Would an approach toward behaviour change that is viewed as more 'masculine' and 'controlling' influence the delivery of the program and its outcomes differently? Therefore in order to explore these ideas further it was important to 'be in the field' as much as possible. Indeed one of the positive aspects of having the time to develop good rapport with Amy and Susan was having the opportunity to talk more openly about their practice and to gain further insight into their thoughts and feelings in relation to the ATR. Having the time to develop a focus and taking time to understand the complexity of what Amy and Susan were 'doing' was crucial in gaining a more informed understanding of the ATR. Therefore during my ongoing observations of the treatment sessions I found that my analytical focus began to shift as there were subtle clues which began to change my awareness of what was occurring. This was evident in an early observation with Amy and an offender named Lee:

Field notes: **Lee**

Amy delves into his situation a bit more to check he is doing ok, she praises Lee (pseudonym) for doing well and reducing his alcohol units but he doesn't seem convinced. He says 'its fucking shit, I want rid of it, it's that bad, I can't even get on a bus without having a can'. Amy goes on to talk about his detox. She is talking him through what will happen once he begins the detox program and looks on his notes to see what his doctor has written. Lee is worried and says 'what about me liver test, were it bad?' Amy carries on talking whilst reading the notes and says 'well it's not the best result I've seen, there is a lot of damage here, that's quite high (pointing to a figure on the notes). Lee appears to show concern and seems ashamed of this. Amy looks up and says 'but don't worry you're not on death's door just yet!' to which he replied 'I wish I was'. Amy then goes on to talk about directions to the clinic 'Right, so do you know where you are going next week?'

I recall in my notes that I am 'shocked' at Amy's lack of sympathy for Lee. He was clearly unwell and depressed about his health therefore I found Amy's flippant remark cold and uncaring rather than supportive and caring. Indeed what was evident during these observations was that the more I began to look for my anticipated (stereotypical?) gendered interactions, the more I found the opposite occurring. Amy's response here (and in many other interactions) did not appear to reflect characteristics of 'care and support' indeed it appeared that she was performing something quite different. Amy in the above interaction appeared to avoid discussing Lee's depression which was evident in her inattention to his remark about wishing he was on 'death's door'. I recall observing a young, clearly depressed, alcohol dependent man who I felt might benefit from a sympathetic caring approach to his situation, therefore I was

surprised when this was seemingly ignored. Indeed there were many instances where I would observe similar performances by Amy and Susan. Thus what became of further interest was the positions that were occupied during these interactions, and how these positions were made available through what was said (or indeed not said). Thus I began to turn to positioning theory in order to understand these interactions further.

Within positioning theory (Harrè and Langenhove, 1999), discourse and discursive practises are viewed as the main component parts in relation to subjectivity. However positioning theory also ascribes agency to the individual in relation to such discursive acts. Therefore conversation within positioning theory is theorised as co-constructed. Positioning theory is viewed as a 'possible conceptual apparatus that allows for social constructionist theorizing based on a dynamic analysis of conversations and discourses.' (Harrè and Langenhove, 1999, p.2). Positioning theory engenders the possibility for choice and agency due to the wide range of potential positions with the discourses available at any one point in time and often there is said to be an assignment of fluid 'parts' or 'roles' to the speakers involved in the joint construction of the storyline. What was evident in the previous excerpt was that Amy is positioned through her talk as occupying the role of 'organiser', she is positioned as someone who needs to get things done, someone who is 'on task'. Amy therefore appears to resist taking on the role of feminine carer and this is further illustrated by her remarks about Lee's liver test. Amy's resistance of the feminine caring position seems to enable her to stay 'on task' as she moves swiftly on to talk about the arrangements of his detox and the logistics of how he will be getting to the clinic. Indeed Lee's remark 'I wish I was', framed within a discourse of depression could be interpreted as a 'cry for help' often

located with discourses of suicide (Chambers 1991). Yet Amy, rather than offering sympathy, remains focussed and effectively avoids entering into a 'therapeutic' conversation about his depression. Indeed there were many instances where my field notes clearly demonstrated Amy and Susan resisting the feminine nurturing role that was being made available by these young men:

Field notes: ***Susan meeting Wayne***

I followed Susan down to the interview rooms to sit in and observe her session with an offender called Wayne. As I looked for a room, she went to collect Wayne, as she opened the door to the waiting room area I heard him say 'hello sweetheart' to which Susan replied, 'I am not your sweetheart, from now on you call me Susan'. Wayne replied by saying 'oh sorry, Susan'

In this excerpt, Susan immediately rejects Wayne's attempts to position her as a feminine 'sweetheart' and in doing so takes up the position of 'being in control' by making it clear how she would like to be addressed from the beginning. Susan's position of 'control' is further established as Wayne apologises and addresses Susan accordingly. Here Susan has taken charge and through her initial interaction with Wayne, has enabled professional boundaries to be set in place. In this example, and there were many others, Wayne seems to be operating within a dominant cultural voice of gender where more traditional roles of 'masculine' and 'feminine' are constructed and performed. However it was clear from this excerpt that the feminine 'sweetheart' was rejected in order for Susan to occupy a more professional position which perhaps served to enable Susan to fulfil her role more effectively.

The above excerpts were examples of many of my observations that exemplified how talk during these social interactions enabled positions to be made available, or indeed resisted and rejected in favour of other alternate positions. It was clear through exploring these positions, that both Amy and Susan were not 'doing women's work' in the way that I had originally anticipated. Indeed gender identity and the notion of male dominance appeared to embed the 'everyday' work of Amy and Susan as I observed more and more, which raised interesting and challenging questions about 'women's work' and their role within that. It seemed that Amy and Susan's resistance to the stereotypical female caring role with these (predominantly) male offenders, was crucial in creating the appropriate setting within which treatment could effectively be delivered.

### **Positions of power and control**

As the observations gathered momentum it became more apparent that there were further contextual layers of meaning to consider during the exploration of subject positions during the treatment sessions. Harrè and Moghaddam (2003) propose that positioning is largely concerned with how speakers construct their identities and their relationships through talk, however their analytical framework also takes into account the dynamics of the 'social episode' under analysis:

“The upshot of the new paradigm research was a catalogue of situation-specific meanings and sets of context-sensitive rules that explained the pattern of the

evolving social episode, as an actual sequence of meaningful social actions (Harré and Moghaddam, 2003, p. 3.).

Such 'evolving social episodes' are governed by what Davis and Harré (1990) refer to as the local moral order which involves local systems of rights, duties and obligations within which both public and private intentional acts are done. Within this framework, positions are conceptualised as a loose set of rights and duties that limit the possibility of action. Indeed the situational context of these social interactions became more complex than a simple storyline between the female alcohol treatment worker and the male offender. There were other dynamics also at stake which informed the construction of the storyline. Treatment was delivered on the probation premises and as such was governed by probation's national standards, rules and regulations. Therefore there was an underlying context of 'control' and 'punishment' to be considered within my analysis. In addition, there was the reoccurring theme of the gendered interaction and the notion that there were two women delivering treatment who had been placed in a position of authority and power over these male offenders. Indeed Harré and Langenhove (1999) state that the assumptions people make as to the character of the social episode that they encounter can have a profound influence on what people say and do. Therefore this contextual analysis of the evolving social episode began to develop further. Thus how Amy and Susan and the offenders discursively negotiated positions of power and control during their interactions became a further focal point of the study.

The following extract is taken from one of my later observation of an initial assessment conducted by Amy involving an offender interview with a young male (Ricky) of 28 who had subjected his 19 year old girlfriend to a 'sustained prolonged attack throughout the night leaving the victim badly bruised and cut' (police report). Amy was conducting an assessment to see if Ricky would be suitable for an ATR. It is at this stage in the pathway that – after being charged with an alcohol related offence - the offender can be referred to an alcohol worker for an ATR assessment by their offender manager or the courts (see Chapter Four for a detailed outline of the ATR pathways). These assessments are conducted in an 'interview' room at the probation site. The assessment process is a key area as it represents the initial stage where decisions are made regarding the match between intervention and sentence. The interview serves to assess the offender's 'suitability' for alcohol treatment upon which a report is produced and considered in court as part of the sentencing procedure.

Field notes: ***Ricky's assessment***

After filling in various forms Amy states that she wants to get to the bottom of Ricky's (pseudonym) drinking. She asks Ricky about his drinking and when it became a problem for him. He said that he drunk out of boredom after leaving his job. He then became depressed and now uses alcohol as a way of dealing with it, 'I just turn to drink, some people comfort eat, I turn to drink'. Ricky continued to talk about his bad behaviour saying its 'alcohol fuelled' and that when he is sober he is a very 'quiet person' who 'wouldn't say anything to anyone'. Ricky says he is now 'back' with his girlfriend who drinks a lot 'well like most 19 year olds drink a lot don't they?' I notice that throughout the interview Amy's facial expressions show no response either way (agreeing or disagreeing) to what Ricky is

telling her. Further on in the interview Ricky says that he doesn't want to give up drinking 'no I'll never stop drinking, I just want to control it', Ricky can't see himself 'not drinking, I'm being honest about this' Amy asks about the positive aspects of his drinking which he mentions a long list including using alcohol as a 'pain killer to forget'. Amy suggested that if he did enter treatment, he would need to have a period of abstinence to allow his body to recover and to begin to find new strategies to deal with his 'bad thoughts'. Ricky replied by saying that he didn't need alcohol every day. They then talked about the negative aspects of his drinking and he could see the 'mess its got me into now'. Ricky goes on to reflect on the offence saying 'what happened – the violence, I'd drunk a lot of vodka that night, it brings out the worse side of me. It's the first time its ever happened to me, I know I can get verbally aggressive'. Ricky stated that he really wants to address his drinking and wants a 'normal life'. He also added 'I don't need to address my anger problems, it's the drink that makes me aggressive, I don't need anger management I need to deal with my drinking and get it under control'. After the interview, Amy turned and asked 'what did you think?' I said I wasn't sure to which she replied 'I hope I don't get him, he's trying to pull the wool over my eyes. When I get a chance to look at Ricky's records, it was stated that he has a three year history of violent incidences with women (17 police callouts to domestic violence incidents).

Within positioning theory, it is theorised that positions can be taken up, constructed and resisted, therefore people are said to constantly adopt and defend their positions and accept or confront the positions of others. For example, the strong adopt positions of power, those who achieve power are said to be able to influence outcomes and define the relationships of others. A person can assume a certain position or a position can be imposed on that person. Likewise a person can challenge a position assumed by another or challenge a position imposed on themselves. The above excerpt illustrates



this dynamic interplay of subject positions and I begin my analysis with Amy who as an alcohol treatment worker, has been placed in a position of authority and is thus able to question Ricky and try to 'get to the bottom of his drinking'. Within this position Amy resists, the position of 'feminine, emotional carer', this is evident where Amy remains indifferent throughout the interview. She doesn't respond to any of Ricky's talk in an emotional or sympathetic way. However Ricky also appears to take up a position of authority as he states outright to Amy that he will 'never stop drinking', thus discursively adopting the role of the 'knowledgeable expert', someone who knows what's good for him 'I just want to control it'. Ricky's 'honest' telling to Amy about his drinking suggests that he is defiantly 'telling it like it is' and by doing so perhaps downplays Amy's role as the 'expert' and enables him to take control.

Nevertheless, Amy appears to challenge and reject Ricky's attempts to control the interview, Amy thus positions herself as the 'knowledgeable expert' which sees the shift from Ricky's perceived position of power back to Amy, not only in the way she remains indifferent, but also by Amy clearly stating what would be expected of him if he were to enter treatment for his alcohol misuse. Ricky's construction of the treatment is contested as rather than aiming for 'controlled drinking' Amy makes it clear that she would expect him to give up drinking for a period of time. Ricky would have certain duties to carry out and through the positions made available here it was evident that Ricky would not be accorded authority to direct his own course of action over his drinking by Amy.

Ricky subsequently appears to accept Amy's position of being in control as he then discursively frames himself as a 'person in need of help' with his drinking and also his depression. However, this does not gain any sympathy from Amy as she remains unmoved by his 'telling' claiming her position of control and refusing to take the position of sympathetic helper. Furthermore throughout the interview Ricky constructs his subject position as 'blameless' in relation to his offending behavior using vodka as a way of positioning himself outside the crime. He constructs the reality that for him, his offending behavior is the result of the drinking. He thus rejects the position of a 'bad offender' by placing himself as blameless for the offence and attempts to reinforce this as he talks about the offence as a 'one-off' situation. Finally, Ricky rejects the position of 'domestic abuser' by constructing the offence as minimal, referring to it as 'the violence' and stating that he can get 'verbally aggressive'. Indeed he does not tell Amy the full extent of his offence (for example, there is no mention of the physical violence towards his girlfriend), instead he positions himself as a good person who is usually quiet and in need of some help to control his drinking.

It appears that from this interaction, Ricky was careful not to explicitly 'tell' or divulge too much information about the attack, positioning himself as having committed a minimal crime. What seems evident from Amy and Ricky's interaction is how discourses can function in the construction and negotiation of subject positions. Ricky's attempts to exert control over his treatment (and Amy) appear to reflect the typical social constructions of masculinity, therefore is Amy being positioned as a naive young woman here? Within this framework, the consequence of telling, especially in relation to the physical attack on another woman may be something he cannot afford

to risk. Nevertheless Amy is skillful in resisting the position of naïve young woman and is suspicious of his motivation positioning him as a deceptive character which will ultimately influence what goes in the report and how Ricky is sentenced. Therefore a person who is positioned either by others or themselves as the powerful authority, can seemingly enable or obstruct change. Indeed during the analysis of my field notes, there were many examples of this kind of negotiation and maneuvering of positions occurring between the alcohol treatment workers and the male offenders. Thus it provided interesting insight into the dialogical and relational nature of treatment on the ATR, which lead to providing further important insights into the treatment approach adopted.

### **Malignant positioning of domestic violence perpetrators**

Sabat (2006, p.290) suggests that 'often in everyday social interaction, it is quite simple for a person to reject being positioned in a negative or undesirable way'. Indeed as recently explored, through the process of positioning, individuals are able to explain their own behaviour as well as that of others. In this sense, Langenhove and Harré (1999) argue that to explain someone's action in ways that emphasise the person's negative attribution, is to position that person in a potentially 'malignant' way. During my conversations with both Amy and Susan, it was interesting to hear their views about the offenders they were treating. It was evident (and understandable) that they 'got on' with some offenders more than others. There were times when they would express frustration about offenders who were not progressing or engaging effectively. However on numerous occasions I noticed that domestic violence perpetrators, in

particular, seemed to be malignantly positioned as somewhat different to other offenders by Amy and Susan. Below is an excerpt of my field notes taken during a conversation with Amy and Susan about how they felt about treating domestic violence perpetrators:

Field notes: ***Amy and Susan talking about domestic violence***

I asked Amy if she is always consciously aware of this when she sees him or indeed any other client who abuses women to which she replied 'well no not really, I mean you tend to forget what they've done once you get to know them but there is just something about these men (violent abusers), they're all horrible, really horrible'. I asked what she meant by this to which she replied 'there is just something about them, you can just tell they're not nice people, can't you Susan?' Amy now brings Susan in to the conversation – perhaps for support for her argument.

Susan: 'oh yeah, she's right, there is just something about them, you just get a sense that they are not nice men, and you know, they think that they're invincible, there they are sat opposite you trying to manipulate you and you just know what they are doing, but they have no clue that we know what's going on with them, they just think they're in charge, they're just horrible' Susan goes on to recall a client she had who had got drunk in town when he had his baby with him: 'do you remember him Amy? Drunk in charge of baby. I just thought ooh, who could do that to a kid! But then once you get to know em, you forget, you forget what they've done and I quite liked him, he were a real nice guy, obviously when he were sober, and he did really well. But when it comes to domestic violence, I don't know what it is, there's just something about them, they're just horrid'.

What both Amy and Susan revealed in their discussion by saying that domestic violence perpetrators are 'horrible' and 'horrid' was arguably based on their beliefs and ideologies about the act of domestic violence and the way in which this potentially positions women. Domestic violence is predominantly discursively framed as men attempting to establish their power and masculinity over less powerful women (Segal, 2007). Thus it is argued that men are socially and culturally positioned as having a 'right' to control women. Indeed Susan in the above excerpt constructs domestic violence perpetrators as 'manipulative' and seems to be suspicious of their character. Nevertheless, Susan is quick to point out that she is very aware of 'what they are doing' and as a result positions herself as 'knowing' and 'in control' as she is able to see through their attempts to be 'in charge'. Such malignant positioning therefore, seems to have initiated their attempts to be 'one step ahead' of these offenders in order to remain in positions of control during their treatment. However to what extent Amy and Susan's malignant positioning of these offenders impacted upon their treatment progress remained to be explored.

### **Managing masculinity**

It has been established that the world of crime and offending activity is one of male dominance (Winfrey and Abadinsky, 2010) and one in which masculinity is exaggerated and expressed as hegemonic masculinity (Connell, 2003). The everyday life experiences and activities for many of these men are occupied with displays that reflect the need to prove masculinity or protect their fear of losing their identity.

Field notes: *Amy and Dave*

Dave (pseudonym) goes on to talk about his father. Dave: 'I can go see him whenever I want, but when it comes to being a father figure he were never there. I've got nine brothers and sisters, same father, all to same dad, four different mums ... he's a knob head'. At this point in the interview Amy glances over at me and rolls her eyes with a slight grin on her face. She appears not to be 'phased' by his manner and indeed seems to be relaxed and in control of the interview. As part of the assessment Amy asks Dave if he is taking any other medication for any mental health issues. Dave: 'just depression'. Amy: 'medication?'. Dave: 'I was but I sacked it off [why?] cause I can't be arsed, I just want to get off beer'. Amy goes on to ask Dave about his drinking and uses Likert scales for most of the questions which Dave seems to understand and respond well to. Amy: 'how much are you drinking? How much did you drink yesterday?' Dave tells Amy that he had drunk 6 litres of cider yesterday but this is probably a rough guess. Dave: I always fall asleep, wake up and drink so I don't know'. Amy: 'what do you want to do about your drinking'. Dave: 'stop!'. Amy: 'why?'. Dave: 'cause I'm addicted to it and its just making me feel ..... well how am I supposed to explain it? (Dave has now raised his voice and appears to be angry with Amy but Amy remains silent) like I can't do what I want to do and I can't get a job ... my granddad's an alcoholic so it must run in family, my brother in law died of it ..... I wanna get off it before I kill me self .. either me liver or me kidneys are gonna go'

Again in this extract Amy appears to resist, immediately the position of 'feminine, emotional carer', this is evident in this extract where Amy remains indifferent during the interview. She does not respond to Dave's talk in an emotional or sympathetic way. Amy appears in control of the interview. Dave begins to talk about his family and immediately positions himself as a neglected child with a poor father figure, a victim of

his family situation. However, at no point during their exchange is Amy seduced by Dave's position of victim. When Dave mentions his depression, Amy's response is somewhat clinical and unemotional, '*medication?*' ticking boxes. Amy moves swiftly on to the Likert scale questionnaire, going on to tick more boxes and fill out numerous forms, again positioning herself as the 'professional', she is the one in control Amy is not drawn into talking about Dave's depression and resists the position of supportive counsellor by avoiding further exploration of Dave's emotional state. It appears that Amy is focused and controlled in completing the task in hand. Dave, perhaps sensing this, relinquishes his position of victim and begins to ultimately engage more effectively with the task in hand.

Again further on in the extract, Dave attempts to emphasize his position as 'victim' as he tries to relay to Amy how much he is drinking '*I always fall asleep, wake up and drink so I don't know*' however with Amy's response comes a degree of tension as rather than a sympathetic response, Amy moves on to ask him what he wants to do about his drinking. Dave's response '*stop!*' indicates a rising level of frustration with Amy and her questioning. Dave's conceptualization of alcohol treatment is possibly naïve, seeing abstinence as the only option available. However Amy challenges his response, again reinforcing her position of control '*why?*'. Dave's frustration becomes aggression, acted out towards Amy, he appears to find it difficult to express himself and as a result is angry with Amy for challenging his masculine position and exposing him as vulnerable '*well how am I supposed to explain it?*' again Dave positions Amy as the 'professional' 'you're the professional – you tell me!' . Dave's aggression could be a direct result of, again, Amy's resistance to position herself within the feminine caring

role. Dave, realizing that Amy is not going to react to his aggression attempts to regain his composure by positioning himself as a victim and someone in need of help. He constructs a stark and bleak picture of his life and his future with the ultimate realization that he could die from his alcohol abuse. Perhaps, for Dave this will influence Amy to engage on a level that he anticipates – the sympathetic carer. However Amy again, avoids being seduced by this and goes on to talk frankly about what an alcohol detox entails. Amy is the knowledgeable expert and through her positioning is able to keep control of the interview and minimize his own attempts to regain control.

### **Summary – is this a gendered practice?**

This chapter firstly aimed to introduce the ATR setting by drawing on my early experiences of 'entering the field'. I have aimed to document my research journey and in doing so I hope to have successfully highlighted the importance of forging positive relationships in the field which enabled me to progress from 'outsider' to 'insider' status. In the latter part of this chapter I set out to explore how my field note data could be effectively analysed in order to make further sense of how the ATR was being delivered by Amy and Susan. It was found that positioning theory was a useful analytical approach to exploring the data collected. In particular, positioning theory enabled close examination of the social interactions that were occurring within the treatment setting between the female alcohol treatment workers and the male offenders. Thus by exploring social positions made available through talk, I was able to see that, in contrast to my earlier (sceptical and somewhat stereotyped) perspectives



of the delivery of the ATR, there was evidence of Amy and Susan effectively 'managing masculinity' in relation to the predominantly young, male, aggressive and alcohol dependent offenders who were sentenced to the ATR at that time. Therefore during this particular phase of the research I was constantly asking the question, to what extent is the delivery of the ATR a gendered interaction? Indeed what was revealed in the analysis of the many fieldnotes produced, was the way in which both Amy and Susan appeared to have resisted the position of the female nurturing role in order to effectively manage these young men and bring about a positive behaviour change.

## **Chapter 7: Exploring the subjective experiences of the ATR**

### **Introduction**

In this chapter I aim to explore in further detail, the way in which interviews enable further valuable insights into the offenders' situated experiences of the ATR. I will briefly recap on how pragmatism can enable a range of social realities to be explored including the subjective views of the offenders, providing a further valuable dimension towards a more holistic understanding of the ATR. This chapter will then begin to explore the theoretical considerations of how best to begin to interpret the offenders' accounts of their experiences on the ATR. This entails an exploration of the way in which subjectivity is conceptualised and subsequently interpreted through rigorous analysis of interview transcripts. The process of analysis is outlined which deployed a staged approach. This enabled the analysis to develop from a foundational thematic analysis in stage one to a deeper and contextualised interpretation of the interview data in stage two. The second stage of the analytical approach is then discussed by firstly drawing on narrative theory which explores the way in which individuals actively make sense of their experiences through telling stories. These ideas were then developed further by drawing on Bakhtin's dialogical theory which locates these narratives within a relational model of the self and argues that identity is always active and ongoing through relations with the 'other'. It is concluded that both approaches, when combined provide a valuable framework for the analysis of the offender interviews.

## Exploring subjective experiences pragmatically

Conducting research within a pragmatic theoretical framework has enabled differing ways of social reality to be explored and interpreted. Collating quantitative data and qualitatively observing the treatment setting provided valuable insights into the delivery of the ATR. Yet this cannot be argued to provide and reflect the ATR in its entirety. Therefore, rather than viewing the ATR from one unitary position/perspective which would limit the capacity to understand fully the ATR, pragmatism offers a more holistic way of approaching how best to understand research phenomena. Indeed pragmatic theorising takes the view that there is a complex interplay between selves and societies (Martin, 2009). Martin (2009) goes on to argue that the pragmatic perspective takes the view that ‘throughout our lives, we act toward, and in relation to, objects and other persons based on our cumulative history of direct, practical experience with them’ (p.3). In this sense it can be seen how pragmatism views individuals as dynamically interacting with their communities and societies. Thus as argued by Archer (2000) ‘social reality enters objectively into our making, but one of the greatest of human powers is that we can subjectively conceive of re-making society and ourselves’ (p.315). It is therefore, within this epistemological position, accepted that object and subject are intertwined and can be explored accordingly. Furthermore Sale *et al.* (2002) point out that combining quantitative and qualitative methods is useful in the health care setting because the complexity of the phenomena often requires data from a large number of perspectives.

## **Analysing interview data: towards a subjective reality of the ATR**

### ***Turning to language***

The main objective of conducting interviews with offenders who had participated on the ATR was to gain a deeper understanding of the ATR through focusing on the individual's points of view and on the meaning they attribute to experiences and events during their time on the ATR. Engaging with offenders in this way aimed to add a further valuable dimension, both to the objective document analysis conducted in Phase One and the qualitative observations conducted in Phase Two of this research.

As highlighted in Chapter Three the 'shift' in emphasis of social theory has moved from assumptions that there can be an external world that can be objectively known, to one which acknowledges that the world can never be known directly. Indeed Mishler (1986) argues that interviewing as a line of enquiry should pay close attention to the 'intertwined problems of language, meaning and context – problems that are critical to understanding how interviews work' (p.233). Hollway and Jefferson (2000) argue that this 'shift' occurred because of the recognition of language and how

'...everything we know ... is mediated by language, and the meanings which are available through language never represent the world neutrally. This shift is variously referred to as the shift from 'world' to 'word', the 'turn to language' or the 'hermeneutic turn' (that is, a move to emphasise meanings and their interpretation).' (p.14).

In this sense, language is seen as 'productive' and thus can potentially create and construct particular versions of reality (Willig, 2001; King and Horrocks, 2010). Therefore, according to Harrè and Langenhove (1999) social constructionists argue that 'personhood is created primarily in the process of engaging in certain types of spoken discourse. The subjective sense of self emerges in the mastery of *sotto voce* discourse' (p.8). Therefore, the turn to language provides further and alternative ways to analyse qualitative data that has the potential to uncover understandings about the discursive construction of social reality (Willig, 2001).

Furthermore, within the pragmatic sense, experience is viewed as both personal and social. Clandinin and Connelly (2000), drawing on the work of Dewey, argue that,

'both the personal and the social are always present. People are individuals and need to be understood as such, but they cannot be understood only as individuals. They are always in relation, always in a social context' (p.2)

Therefore, in order to understand offenders' accounts of their experiences of the ATR it was also important to consider further, how subjectivity is developed and constructed through both language and society, before beginning to analyse and interpret their accounts.

### **Beginning the analytical approach**

Having already undertaken a thorough analysis of my field notes I was aware of the process involved in analysing qualitative data. Indeed through the application of Emerson *et al's* (1995) analytical framework and Davis and Harrè's (1999) positioning

theory I was able to gain an understanding of how the offenders and the alcohol treatment workers are shaped by the position(s) that are made available during the observed social interactions. However, for this phase of the research, it was acknowledged that through the, semi-structured approach I had adopted towards interviewing the offenders, I had produced rich, lengthier data which entailed their own subjective accounts of their experiences. These accounts covered the offenders' diverse experiences with their families, friends, criminal justice agencies, such as the police, courts, offender managers and also health care professionals. With such a vast array of data, not unlike Emerson *et al.* (1995), there was a need to begin to organise the data corpus and work through the data systematically in order to identify possible themes and patterns about the offenders' experiences. However there was also a need to extend the analytical focus into a richer, deeper analysis of how these accounts were formed and constructed and to understand what purpose they might serve in relation to their audience, enabling a fuller interpretation of the subjective meaning offenders ascribe to their experience of the ATR.

To this end, the analytical approach for the interviews involved a two staged approach. The first stage of the analysis adopted a thematic approach (Braun and Clarke, 2006; King and Horrocks, 2010). Braun and Clarke (2006) argue that thematic analysis can serve as a 'foundational method for qualitative analysis' (p.78). In this way, thematic analysis is viewed as a 'flexible' research tool which has the potential to be compatible with a range of theoretical and epistemological perspectives. On a 'basic level' thematic analysis enables the researcher to look for patterns of 'themes' across a full data set illuminating commonalities and differences across interviewees' accounts.

King and Horrocks (2010) provide the following definition of a theme in thematic analysis,

‘Themes are recurrent and distinctive features of participants’ accounts, characterising particular perceptions and/ or experiences, which the researcher sees as relevant to the research question’ (p.150).

As the analysis was aimed at gaining participants’ subjective experiences of the ATR, each individual interview was analysed in depth. Thus the emphasis of the analysis was towards a ‘within case’ analysis focusing on individual accounts, rather than a ‘cross case’ analysis which would have limited the findings to mere variables (King and Horrocks, 2010). As suggested by Braun and Clarke (2006) themes from the interviews were identified by adopting an ‘inductive’ approach to the analysis. Within this approach, themes are generated from the data itself rather than being driven by the researcher’s particular interests or research questions. Data analysis in this way is said to be ‘data driven’ however as Braun and Clarke (2006) point out, researchers can never fully detach themselves from their theoretical and epistemological approaches to their research, thus data can never be analysed in an ‘epistemological vacuum’ (p. 84). Therefore it was acknowledged that during the analysis there was a balance to be negotiated between the inductive process and my own research aims and interests. Indeed I had begun to develop some ideas during my observations of the ATR in Phase One and Two of the research and could not rule out the possibility of these ideas forming my analytical approach to the interviews. Nevertheless during the analysis I

had no specific research question in mind and themes were identified through the coding process outlined by Braun and Clarke (2006).

In my searches of the qualitative research literature, it was evident that there were many versions written about how to begin analysing interview data, however Braun and Clarke (2006) were identified as offering the most comprehensive step-by-step guide to conducting qualitative thematic analysis. Therefore this first part of the analysis focused exclusively on their approach to qualitative analysis and is briefly outlined in table 13 overleaf.

**Table 13: Process of thematic analysis – adapted from Braun and Clarke (2006)**

| Phase of analysis |  | Description of the process   |
|-------------------|--|--|
| 1                 | Familiarising yourself with your data: | Transcribing data, reading and re-reading the data, noting down initial ideas.   |
| 2                 | Generating initial codes               | Coding interesting features of the data in a systematic fashion across the entire data set, collecting data relevant to each code.   |
| 3                 | Searching for themes                   | Collating codes into potential themes, gathering all data relevant to each potential theme.  |
| 4                 | Reviewing themes                       | Checking if the themes work in relation to the coded extracts (level 1) and the entire data set (level 2), generating a thematic 'map' of the analysis.  |
| 5                 | Defining and naming themes             | Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.   |
| 6                 | Producing the report                   | The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis. |

The above table briefly outlines the six steps of thematic analysis. The first stage of the analysis was undertaken utilising this process. In addition, the *level* of analysis was also



considered as outlined by Braun and Clarke (2006). They make the distinction between codes and themes that are identified at a *semantic* or *explicit* level with an analysis that identifies codes and themes on a *latent/interpretative* level. They argue that coding on a semantic level concerns itself with surface meanings of the data without looking beyond what a respondent has said. Conversely a thematic analysis at the latent level enables the researcher to move beyond surface meanings and begin to explore underlying ideas, assumptions and conceptualisations that theoretically inform the descriptive level of the data. Indeed Braun and Clarke (2006) identify that this level of data analysis can be located within a constructionist paradigm and as such can provide a useful foundation for beginning to understand more about how offenders construct their own realities in relation to their offending, alcohol misuse and treatment.

With this approach in mind, the first step of this analysis involved reading and re-reading each transcript, making notes in the margins at a descriptive level of the interviewees' responses. Once I had familiarised myself with the transcripts on a descriptive level, I was able to move on to step two where codes were developed around the descriptive notes, for example, at this early stage codes identified from the first few pages of Sam's interview included:

*'Young age; family turmoil; family problems; nearly going into care; bad stuff; parents in violent relationship; cared by grandparents; arguments; happy times when in band practice'*

These descriptive codes were collated and developed for each individual transcript which could then be developed into themes/codes that were more interpretative. In Sam's account for example, there were themes that related to *good/bad offending; treatment as structure; alcohol and masculinity*. These were refined and developed as more transcripts were included and enabled overarching themes to be identified that could then be drawn upon in order to convey a more coherent, focused analysis. Therefore one of the early overarching themes that emerged from this analysis including its sub-themes is presented in a hierarchical 'tree diagram' in Figure 3 below.

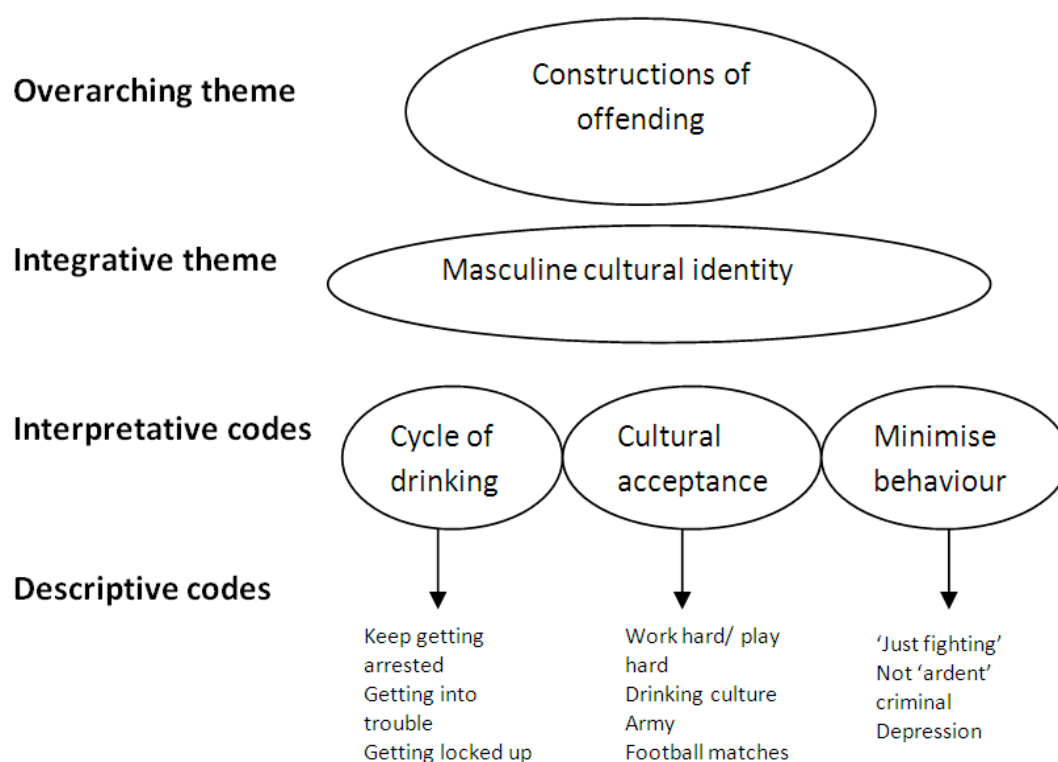


Figure 3: Example of early thematic analysis

The diagram above illustrates one example of how the thematic analysis began to take shape in relation to each offender interview. It was evident, however that as the analysis developed, there were various themes that re-occurred in many places

throughout each individual transcript, for example issues relating to *gender* and *culture* featured predominantly across the interviews. To this end, a further *integrated theme* (King *et al.* 2002), was incorporated (as shown in Figure 3 above) which illustrated common themes that cut across the hierarchical nature of the thematic analysis outlined by Braun and Clarke (2006). This represented the first phase of the analytical approach to the interviews and enabled many themes to be generated from the data corpus that was to then inform the basis of phase two of the analytical process.

### **Taking the analysis further: narrative and the joint construction of meaning**

A thematic analysis of the interview transcripts enabled the identification of themes and codes that could be drawn on in order to highlight common experiences of the ATR. However what was also of valuable concern during the focus of the analysis was the way in which each individual ‘story’ was told. Exploring how these offenders ‘storied’ their lived experience enabled the analysis to move beyond a thematic analysis and begin to reveal more about how identities are constructed and how this can be important in beginning to offer an interpretation of the offenders’ interviews .

Widdershoven (1993) considers narrative identity from a hermeneutic point of view where human life is said to be interpreted in stories.

‘We live our lives according to a script, which secures that our actions are part of a meaningful totality. Our actions are organised in such a way that we can

give an account of them, justify them by telling an intelligible story about them.’ (Widdershoven, 1993, p.7).

Widdershoven (1993) takes the position that experience is reconstructed in stories, thus stories help to relay past experiences and events and therefore concludes that life and story are intertwined.

Alasuutari (1997) points out that there has been a shift away from the assumption that every person possesses an authentic self that could be captured in a text where a person tells his or her story in an honest way. Rather, it is now acknowledged that life-story narrating is always situational and like discourse, serves a function. Alasuutari (1997) goes on to note that life stories consist of ‘retrospective accounts of the past, accounts that are given for particular reasons and in particular situations’ (p.7). There is therefore an acknowledgement of an individual’s inner speech (required to create continuity of self) coupled with the recognition that such narrative accounts are not private, rather they are created by drawing upon interpretative resources that are made available at that particular time, that also contributes to creating a sense of self. The concepts and discourses, or ‘interpretative repertoires’ (Potter and Wetherell, 1987) refer to the discourses or systems of meanings people draw upon through others and society in their talk. Therefore when constructing stories, it is argued that people have certain linguistic resources or repertoires available to them. Thus how individuals construct their individuality and sense of self is said to be ‘discursively accomplished’ (Alasuutari, 1997) through the use of life-story narration. McAdams (1993) also argues that narratives should be viewed as a psychosocial construction of a

person's identity and accordingly an individual is able to define themselves within society through the creation of an internalised and dynamic life story (or myth) where life meaning and purpose is achieved. Therefore in summarising this approach Maruna (1997) concludes that;

‘The construction and reconstruction of this internal narrative integrating one's perceived past, present, and anticipated future is itself the process of identity development in adulthood.’ (p.62)

Therefore within this approach a person's identity is not to be found in how they behave or react to situations, but within their narrative storytelling. However such storytelling is considered as part of the social interaction that is occurring, for example within the interview setting, the interviewee enters an interaction and thus presents a particular ‘face’, that is to ‘successfully and consistently play the role we chose to take when entering the situation.’ (Alasuutari, 1997, p.8). Indeed Hollway and Jefferson (2000) argue that the interviewer does not simply elicit narratives from the interviewee, rather they have an active role in co-constructing the storyline. Thus, narratives are said to be always a product of the dialogical relationship between the interviewer and interviewee. This ‘dialogical relationship’ can be explored further from a Bakhtinian perspective (Saul and Emerson, 1990) and an understanding of the ‘dialogical self theory’.

## The dialogical self

According to Bakhtin (1981) the self and dialogue are seen as interconnected and are synonymous with the self and society. The self is representative of an internal process whilst dialogue is associated with the external environment. For Bakhtin, existence is the event of co-being, and dialogism is rooted in social experience therefore Bakhtin's ontological position argues that within dialogism, the very capacity to have consciousness is based on 'otherness' (Holquist, 2002). Self is created through the 'other', therefore subjectivity is created always from experience and the resources available for that creation that is shared by others. Bakhtin draws on the notion of 'utterances' which he proposes are active and alive and are infused with meaning and social intention, therefore utterances are dialogical.

The self according to Bakhtin is conceived as a triad between three elements: a *center*, a *not-center*, and the relation between them (Holquist, 2002). The 'center' is the *I-for-myself* which refers to how my self looks and feels to my own consciousness. The 'not center' is the *I-for-others* and refers to how my self appears to those outside it and the *other-for-me* refers to how outsiders appear to my self (Saul and Emerson, 1990). Within this triad, there exists no stable self or a stable 'given' world, rather the concept of the dialogical self eliminates a self-other dichotomy and fuses the external with the internal creating a 'society of mind'. Dialogism further argues that existence or self is defined by a person's place within it thus the self is always relative and dependent for its existence on the other, therefore self and position are relative in creating meaning in dialogue with an other;

‘Conceiving being dialogically means that reality is always experienced, not just perceived, and further that it is experienced from a particular position. Bakhtin conceives that position in kinetic terms as a situation, an event, the event of being a self.’ (Holquist, 2002, p.21).

For Bakhtin therefore, a dialogue does not function as a mere back and fourth interplay of words. Rather a dialogue refers to an active exchange in which we are addressed by others or have the ability to manipulate others, thus conflict and power can exist on the level of words. This interplay was often evident during the interviews with the offenders and in the treatment sessions, for example there were times when I perceived their voice to be more powerful and responded accordingly (by not probing further around a particular issue) and yet there were other times when they were positioned as oppressed and less powerful where my responses would be more optimistic. Bakhtin sees existence as akin to a novel where selves are ‘authored’ through dialogue. He approaches the self as an entity that performs ‘acts’ but not through a determined ‘whole’ self identity, but rather through a series of goals and values and through the consciousness asking ‘what for?’ ‘to what end?’ or ‘is this right?’. Indeed within this perspective Saul and Emerson (1990) reflect on Bakhtin’s notion of the ‘novelistic self’ as someone with no ‘plotted story’ but rather;

‘When we tell the story of our own lives autobiographically, what speaks in us most often is not direct experience or memory but a narrator with an imagined other’s values and intonations.’ (p.217).

Bakhtin acknowledges that the self like the novel is a highly complex combination and dialogue of various voices and ways of speaking, each incorporating a distinct sense of the world. The self is viewed as a conversation which can consist of often differing voices with each other; 'voices speaking from different positions and invested with different degrees and kinds of authority' (Saul and Emerson, 1990, p.218). Indeed every utterance is addressed from a particular voice to a particular voice, and perhaps more importantly for this analysis, every voice reflects previous voices, therefore much of how these offenders talk about their experiences may reflect larger social discourses that are available to them.

This 'public language' – what Bakhtin would call the 'authoritative voice' – is said to be drawn upon and the different voices of societies are 'ventriloquized', such as gender, race, class, and so on. Nevertheless Bakhtin also acknowledged that there exists a 'private voice' – what Bakhtin would call 'internally persuasive language' - where authoritative words are internalised, learned and combined with the voices of others which reflect selfhood, however these internally persuasive voices or discourse are constantly changing and developing in response to other inner persuasive voices. Bakhtin proposed that there are many voices or relations in society that can be drawn upon at any one time, and that each voice, will contain the voices of others. Therefore language is seen as active and developing and meaning is essentially 'unfinalizable'. Indeed it was anticipated that the offenders would narrate their past lived experiences of alcohol consumption and offending by drawing on the voices of their communities and would thus 'ventriloquise' (Holquist, 1981) dominant cultural voices. Therefore the analysis aimed to begin by exploring to what extent ventriloquism was evident in



their stories. Of further interest was the extent to which these offenders were able to draw on alternative dominant voices located within the treatment setting in order that they become internally persuasive thus changing the meanings and significance of their past lived experiences.

### **Summarising the analytical approach**

In considering further the way in which subjectivity is both socially constructed through narrative accounts and co-constructed through relations with 'others' it is therefore argued that dialogism and narrativity share a common foundation of relationalism that is appropriate for this extended analysis. This relationship oriented perspective (de Peuter, 1998) enables the analysis to consider the offenders' narratives as 'active dialogues' which embraces multiple plots, time, place and culture. Therefore, this extended analysis involved moving beyond what was said and what could be known by the offenders thematically (Braun and Clarke, 2006), to an exploration of their storied accounts (Sarbin, 1986). However, the shift to this level of analysis was made possible through the process of the thematic analysis which enabled familiarisation of the data. Thus the thematic stage of the analysis is argued to be a vitally important part of the process of this analysis. Moreover, this analysis also deployed an exploration of the dynamics of the interview relationship and its importance for the production of data (Hollway and Jefferson, 2000; King and Horrocks, 2010). Conversations are seen as having some constraints and regularities. That is although the interviewer's meaning may not be the same as the respondent's, nevertheless, within this approach the respondent will take into account some

understanding, however flawed, of the interviewer's meaning and thus formulate a response accordingly. Therefore, this stage of the analysis entailed the identification and acknowledgement of the ways in which the offenders' storied accounts are co-constructed and thus how each response and subject position was negotiated through the different positions made available through the social heteroglossia of the treatment setting and the criminal justice setting. Therefore how voices of the ATR and the probation service have been ventriloquised was of further value to this analysis.

Finally through these situated joint narratives, the way in which the self is constructed through situated dialogical contexts (Holquist, 2002; Saul and Emerson, 1990) was explored in order to identify how the offenders were able to actively (re)author themselves by drawing on multiple voices and discourses available to them. These multi voices identified were then considered to enable the identification of the wider cultural narratives (authoritative voices) in which they might be located.

## **Chapter 8: Listening to voices: cultural norms and the struggle to resist**

### **Introduction**

In the previous chapter it was acknowledged and accepted that a way of coming to understand offenders' experiences of the ATR would be to consider the way in which the offenders 'storied' their experiences during the interviews. Moreover, the way in which these stories were told was argued to be co-constructed through a relational dialogue with the 'other'. Thus how their stories were situated socially and culturally was considered during the analysis. This chapter therefore begins with by outlining in further detail, the analytical approach used in order to begin to explore the offenders' accounts within a narrative dialogical framework. This chapter then moves on to present the first part of the analysis, focusing specifically on how the offenders resisted or complied with 'normalising' views of alcohol consumption and offending. In the first section of this analysis I aim to explore how identities are indeed multiple and fragmented in nature. This analysis therefore considers the way in which identities are discursively constructed. In this sense there is an understanding that identity is multi-voiced, where reflexive constructions unfold over time and are embedded in broader discursive (cultural) practices. To this end, the first section deals specifically with the cultural construction of alcohol and how 'drinking as a performance' has the potential to create collective identities, and thus consequent struggles to resist. The second part of the analysis takes the notion of resistance further in relation to alcohol, violence

and offending and considers the way in which bad faith narratives (Craib, 2001) may serve as a strategy for easing anxieties and guilt around the offenders' past behaviour.

### **Bringing the analysis together**

The process of analysis carried out began as the interviews were transcribed and continued in a more explicit way as the transcripts were read and re-read in accordance with Braun and Clarke's (2006) approach to thematic analysis (as detailed in Chapter Seven). This first stage of the analysis enabled themes to be developed across the 10 interviews and thus provided a foundation for further theoretical analysis to be developed. The use of 'generative narrative questioning' (Flick, 2006) during the interviews enabled individual narrative accounts to develop from each of the offenders, and therefore the meaning of each offender's story was given considerable attention, in accordance with an idiographic approach to the analysis.

It became apparent during the analysis stage that each respondent expressed somewhat similar notions about their experiences throughout their storied accounts. Here caution was applied, as simply generating themes in relation to where stories overlap was not the intention of the analysis. Rather it was the aim of the analysis to present, where possible, an analysis that enabled the offenders' stories of their own individual experiences and understandings to be heard. To this end, the way in which McAdams (1993) talks about the importance of storytelling was a useful tool in understanding and making sense of the offenders' stories. His theory of human identity, which proposes that each of us comes to know who he or she is by creating a 'heroic' story of the self, includes exploring each personal 'myth', created to perform

healing functions (Craib, 2000). McAdams (1993) identifies three elements of a personal narrative which can be identified as important concepts and thus can be looked for within an analysis of this kind, namely narrative tone; imagery; and themes.

### ***Narrative tone***

Narrative tone can be present in both the manner and the concept in which the story is told (King and Horrocks, 2010). For example, the tone can be predominantly optimistic or pessimistic. Accordingly, an optimistic story can be viewed as positive, for example even when bad things happen in the story, it is told in a way which is constructed as hopeful that things will get better. Conversely if a story is pessimistic, then the way in which the story is told will be largely negative, especially when bad things happen. Therefore, in order to identify this element within a story, it is not just *what* has been told, but the *way* the story has been told which is important.

### ***Imagery***

According to McAdams (1993) this pays particular attention to how people employ imagery in order to make sense of who they are in their stories. This involves focusing on the kinds of language used to describe and characterise certain life chapters or key events. McAdams argues that we make our own images through symbols and metaphors, but this is strongly dependent upon raw materials (i.e. language) made available in our culture, for example dominant discourses and interpretative repertoires. This analysis therefore moves beyond a thematic approach through

acknowledging language as 'active' and thus having the potential to actively shape who people 'believe themselves to be' (King and Horrocks, 2010, p. 231).

### ***Themes***

Here dominant themes are identified within the narrative accounts, which draws upon the notion of motivation. McAdams (1993) argues that power (the desire for agency and independence) and love (the desire for connection and dependence) constitute two of the most important themes of stories because they correspond to two of the central, often conflicting motivations in human life.

During the reading and re-reading of the transcripts each of the above concepts were explored and highlighted where appropriate. Each time, the stories were read differently, in order to identify new meanings in relation to one of the above themes. Once this was established further reading explored the use of language in relation to dominant discourses surrounding the offenders' experiences of the ATR. Indeed as King and Horrocks (2010) point out, narrative interviewing enables an appreciation of the social world from which narrations are drawn. Fairclough (1989) explores the relationship between language and power by pointing out that language is a vehicle through which power is imposed on people through the creation of ideologies that make people accept what is said is true. Therefore 'statements' about life in general, which seemed to reflect a particular view of the world were noted. Placing the offenders' accounts within a broader social, political and structural context, emphasised where the offenders were speaking from in terms of cultural norms and

societal values. Therefore cultural norms and societal values placed upon alcohol and offending behaviour were explored to enable further contextual layers of meaning to the overall analysis.

### **Taking the analysis further: a dialogical approach**

As established in Chapter Seven, according to de Peuter (1998) traditionally, narrative identity has been defined as a continuous, coherent ordering of events from the perspective of a single author. However, for this analysis, although it is accepted that narrative storytelling plays an important role in the formation of identity, the ‘monological’ approach to narrative identity is challenged in favour of a combination of multiple plots, themes and voices. During the analysis it was important to be mindful of what the narrators ‘do’ with their talk and the discursive resources they drew on. In taking this further, a return to positioning theory (Davis and Harrè, 1990) enabled the role of discourse to be located in the construction of their stories and also in the way that the offenders ‘positioned’ themselves and thus positioned the ‘other’ during the interview. This approach to the analysis therefore, considers discourses in the performance of identities as ‘interactionally meaningful’ (Tate, 2005). Indeed there were various ways in which I myself was positioned by different participants in the interviews and there were ways in which I tried to position myself, i.e. as a research student, as an interviewer, as a friendly, trustworthy person.

Finally, in order to explore fully how these offenders storied their experience of the ATR during the interview, this analysis draws upon Bakhtin’s (1981) dialogical theory

which enables the interview to be conceptualised as relational and thus treated as a 'joint action' between myself as the interviewer and the offender as the interviewee. Therefore within this analysis specific attention was applied to the way in which my interview 'talk' and the offenders' dialogue came together during the interview and how this may have diversely affected each other. Indeed Frank (2005) argues that in actual social science practice the dialogical approach 'emphasises research participants' engagement in their own struggles of becoming; its focus is stories of struggle, not static themes or list of characteristics that fix participants in identities that fit typologies' (p.968). This notion of 'struggling' is a process that Bakhtin (1981) refers to as the process of 'ideological becoming' where others' words that come from the voices of community and society are either internalised or resisted in order to re-voice a subjective reality. This 'struggle' is therefore, for Bakhtin, important in understanding how a person will ultimately come to his or her own sense of 'ideological consciousness'. The offenders' subjective experiences were therefore examined and analysed in the context of their social surroundings, which involved identifying how the offenders constructed their dialogical stories through a layering of voices and subject positions. This layering of voices is argued to be a form of ventriloquism (Holquist, 1981) as the narrator is positioned as a ventriloquist who draws on the dominant voices of others in order to express their own dialogical self. Indeed Holquist (1981) argues that for Bakhtin 'all utterance is ventriloquism' (p.181). Therefore during the course of this analysis it has been acknowledged that the voice of these offenders includes the voices of many others, and also reflects other voices that have been experienced previously in life, in history and in culture. This 'heteroglossia'



of culturally situated voices are thus ventriloquated through the singular voice that is claimed by that individual.

### ***Contextualising the interviews***

A total of 10 interviews were conducted with offenders who were sentenced to the ATR. As mentioned above the alcohol treatment workers assisted in the recruitment of the participants by asking offenders if they would agree to be interviewed, and explaining the research project to them. Upon agreement a date and time was arranged for the interview which took place at the probation sites. An interview matrix was developed recording each interview and some information about the participants (each given a pseudonym) which is presented in table (1) below:

**Table 14: Interview matrix**

| <i>Name</i>   | <i>Age</i> | <i>Ethnicity</i> | <i>Offence</i>     | <i>Drink pattern</i> | <i>Previous offending?</i> | <i>Previous treatment?</i> | <i>ATR Worker</i> |
|---------------|------------|------------------|--------------------|----------------------|----------------------------|----------------------------|-------------------|
| <b>Cherry</b> | 39         | White British    | Assault            | Dependent            | yes                        | Yes- alcohol               | Susan             |
| <b>Sam</b>    | 37         | White British    | Burglary           | Dependent            | Yes                        | No                         | Amy               |
| <b>Shane</b>  | 28         | White British    | Assault            | Dependent            | No                         | Yes- alcohol               | Susan             |
| <b>Barry</b>  | 34         | White British    | Drunk disorderly   | Dependent            | Yes                        | No                         | Amy               |
| <b>Brenda</b> | 40         | White British    | Assault            | Dependent            | Yes                        | Yes- alcohol               | Amy               |
| <b>Garry</b>  | 42         | White British    | Assault            | Dependent            | Yes                        | No                         | Amy               |
| <b>Daniel</b> | 20         | White British    | Malicious wounding | Dependent            | Yes                        | Yes- alcohol               | Susan             |
| <b>Nigel</b>  | 34         | White British    | Theft              | Dependent            | Yes                        | Yes - heroin               | Amy               |
| <b>David</b>  | 35         | White British    | Theft              | Dependent            | No                         | No                         | Susan             |
| <b>Dara</b>   | 32         | Black Caribbean  | Drink driving      | Binge                | No                         | No                         | Amy               |

Table 14 above shows that there were 2 female and 8 male interviewees who participated in the research. Only one of the interviewees described themselves as 'Black Caribbean' with the remainder describing themselves as 'White British'. Out of the 10 interviewees, 5 were charged with assault related offences. Only one interviewee was described as a binge drinker by their alcohol worker, with the remaining 9 interviewees assessed as 'dependent' on alcohol at the beginning of their order. Over half of the interviewees had committed offences prior to their most recent offence which resulted in being sentenced to the ATR. Therefore 7 out of the 10 interviewees had some previous experience with the police, the probation service or the courts. Half of the interviewees had accessed alcohol treatment prior to attending the ATR, for example both Shane and Brenda had voluntarily accessed their local alcohol treatment services prior to appearing in court for their current offence. Nigel reported having previous experience with drug treatment programs, Cherry had accessed her local alcohol services approximately a year previous to her ATR, and for Daniel, this was his second ATR sentence.

Upon arriving at the probation site, the interviewee would be met by their alcohol treatment worker and shown to an interview room where I would be waiting to be introduced. I would be introduced to the interviewee and then, if there was nothing further to be discussed between the alcohol treatment worker and their offender (in relation to their treatment sessions, future appointments, etc.) we would be left to begin the interview. All interviews were recorded on a digital voice recorder and varied in length between 10 minutes up to 1 hour.

## Introducing the offenders

The participants for the interview phase of this research were offenders who had been sentenced to a community order and as a requirement of their order, were, at the time of the interviews, undergoing alcohol treatment on the ATR. In total 10 offenders were interviewed at the probation site where they visited regularly to attend alcohol treatment appointments and offender manager appointments.

**Cherry:** I had met Cherry twice before interviewing her. Both times previously she had agreed to let me sit in and observe her alcohol treatment sessions with Susan her alcohol treatment worker. Cherry was 39 and at the time of her interview she was coming to the end of her 6 months of alcohol treatment and was described by Susan as one of her 'success stories'. Susan recalled that when she first met Cherry she was very quiet and reserved. Cherry was convicted of an assault-related offence and had a past history of drinking and fighting.

**Sam:** When I met him Sam he had completed both his ATR and his community order and therefore the interview was to be his last visit to the probation service. Sam was 37 at that time and had been convicted of burglary and assault which involved him entering a woman's property under the influence of alcohol which he states was due to mistaking it for a friend's house. I recall Sam being very articulate and open during the interview. Sam had enjoyed a career in the Army where excessive drinking was the 'norm'. He was dismissed from the Army due to his escalating alcohol problems and after a brief time working as a trainee police officer, he began to drink daily and was asked to leave the force. He has had numerous encounters with the police and after

trying to keep his factory work going, eventually became unemployed with both alcohol and mental health problems. After completing the ATR Sam expressed a desire to find himself a job perhaps in a supermarket.

**Shane:** Shane was 28 years when I interviewed him. Shane had served 6 months in prison before being released on to a community order, and at the time of the interview he was just coming to the end of 6 months alcohol treatment on the ATR. He was described by Susan (his alcohol treatment worker) as ‘alcohol dependent’ and had been charged with assault and attempting to intimidate a witness. Reflecting on Shane’s interview I can recall quite vividly how he was particularly memorable because of his relaxed and seemingly humorous disposition throughout our exchange. There was often ‘light banter’ between us and we quickly developed a rapport that was to last throughout the duration of the interview. He had a job working night shifts at the time of the interview which he managed to keep during his prison stay.

**Barry:** Barry was 36 years old when I interviewed him. He was described as alcohol free by Amy his alcohol treatment worker and his interview was conducted on the last day of his ATR. I recall Barry being a large stockily built man with shaved hair and tattoos on his face and arms. He was convicted of an assault related offence which involved fighting in the town centre and had served approximately 6 months of his 12 months ATR.

**Brenda:** I first met Brenda during one of my observations at the Centre site. I recall that she was a very ‘chatty’ and ‘lively’ woman who was at the time of the interview, trying to enrol on a food hygiene course so that she could get a job working in a

kitchen. Brenda was 40 years old and had been convicted of an assault related offence involving an altercation with her neighbour. She was alcohol free at the time of the interview and was described as 'doing well' by Amy.

**Garry:** Garry was 42 when I met him at the Centre site. Garry had been convicted of an assault related offence that had involved being in the town centre, drunk, and had subsequently hit a police officer. He was nearing the end of his treatment on the ATR and was also alcohol free at the time of his interview. I recall that Garry was a keen football fan and enjoyed his trips away to watch the matches.

**Daniel:** At the time of interviewing Daniel he had just turned 20 and when I met him he was very shy but polite and had a cheery disposition. This was Daniel's second time on the ATR. When asked why he was sentenced to the ATR Daniel talked about two significant and shocking events that had happened to him in the past year. His Grandfather died and later his mother was murdered. Daniel was convicted of malicious wounding and claimed that he was a dependent drinker,. I recall Daniel's interview being one of the shortest in time, he gave very short answers and I sensed that he was a little uncomfortable or perhaps nervous. Nevertheless he was a pleasant young man and he talked about his new baby girl and how becoming a father was a good thing for him. During his time on the ATR Susan, his alcohol treatment worker had sent him on a health and safety course so that he could work on construction sites as he was aiming to find a job within the next 6 months.

**Nigel:** Nigel was 34 years old at the time of his interview. When I interviewed Nigel he was approximately half way through his alcohol treatment and he was sentenced to a

12 months community order and a 12 month ATR. He was charged with theft for stealing alcohol. Nigel was unemployed at the time of the interview. He had previously undergone treatment programs for heroin dependency and said he had replaced his heroin addiction with alcohol. He described himself as an 'alcoholic' with a long history of offending and has been on probation orders for the past 18 years. Nigel now suffers from ill health and has had several stays in hospital. He did however express aspirations to join a local voluntary organisation on completion of his community order.

**David:** David was 35 years old at the time of his interview. Susan described him as having done well on the ATR as he had gone from drinking heavily on a daily basis to being alcohol free. David was a postman prior to his conviction of theft. He said that he was lucky not to be prison as he had been throwing mail into a skip rather than delivering it. This was David's first offence and he seemed keen to change his past behaviour in order to get back to work and provide for his wife and his children again.

**Dara:** Dara was 32 at the time of the interview and had been convicted of drink driving. Dara was described by Amy as alcohol free and had made good progression with his treatment. Dara talked a lot about the offence saying that he had regretted what he had done.

## **Presenting the analysis**

In presenting the analysis, overarching themes will be introduced that enable the offenders' stories to be situated. However the themes that I introduce are not aiming to represent a finalised interpretation of these offenders, rather they serve as a backdrop where individual stories can then be presented. The first two themes presented in this chapter specifically draw on how the offenders narrated their 'past selves' (Ricoeur, 1991) in the context of their current lived experiences. In exploring notions of the 'self' Bruner (2003) suggests that one primary aspect of the understanding of the self is that it relies on selective remembering to 'adjust the past to the demands of the present and anticipated future' (p.213). Thus Ricoeur's (1991) notion of 'past selves' seemed pertinent in analysing how my interviewees constructed alcohol consumption and offending behaviour as an offender sentenced to treatment on the ATR.

## **Drinking as performance: cultural voices of alcohol, masculinity and the quest for drunkenness**

### ***Locating the voices***

Within all of the narrative accounts, each offender at some point in their interview, told stories about their experiences of consuming alcohol. These stories were understood and located within the broader economic and social class context, which for these offenders reflected a working class social structure. Burkitt (2008) argues that self-identity cannot be considered as separate from social class, and moreover that social class has a profound influence on the self both in terms of who a person is, but also in what they can become. For Bakhtin (1981), this creation of a 'social self' is a product of constant mutual authorship, to be understood within the social and cultural landscape of the individual. This analysis therefore begins by addressing the social significance of alcohol consumption in working class cultures within the north of England. Therefore throughout this first part of the analysis the notion of 'performance' is explored in two contexts: firstly in relation to cultural constructions of everyday alcohol consumption as a social performance; and secondly the performance of alcohol in the creation of masculine subjectivities.

Alcohol consumption in the UK has changed over the last 10 years and 'determined drunkenness' and 'binge drinking' have become the norm for many British towns and cities (Measham, 2004; Measham and Brain, 2005; Dingwall, 2006). According to Garvey (2005) drunkenness, although characterised by individualised choice, is also often found to be constrained by group pressures and can be 'indicative of high levels



of integration into collective cultures' (Wade, 1994, p.884). Garvey (2005) goes on to make the point that alcohol can be significantly important in creating and maintaining cohesion within a community and argues that individual 'performances of alcohol consumption are inspired and driven by collective action' (p.93). It appears that social and cultural patterns can determine drinking rituals (Mitchell and Armstrong, 2005). Indeed Douglas (1987) talks about 'constructive drinking' and by doing so emphasises the extent to which alcohol consumption produces social identities.

Measham (2008) has pointed out that in England, there has been the development of alcohol consumption as a recreational activity specifically conducted by men outside the home. Indeed alcohol appears to reinforce socially constructed masculine behaviours (Gaunekar *et al.*). Studies have explored how social expectations seem to influence the way in which men and women consume alcohol (Brown *et al.* 1980; Pyne, Claeson and Correia, 2002; Obot and Room, 2005; Measham, 2008; schachtebeck, 2010). In a Bakhtinian sense, such studies highlight how dominant cultural voices inherent within socialisation appears to discursively position men and women (masculine and feminine) differently. Thus particular drinking performances, values and meanings, reflect the dominant voices inherent both at the individual and the societal level surrounding men, women and their communities. Indeed Measham, (2008) points out that, for women, (since the middle of the 16<sup>th</sup> century) temperance has been surrounded by discourses of virtue, modesty and femininity (Measham, 2008) whereas female 'drunkenness' was surrounded with discourses of moral and sexual depravity. Nevertheless Measham (2008) goes on to highlight that as women's educational and employment aspirations and opportunities have changed there has

been a re-emergence of concern around women's public drinking and drunkenness. The changing drinking patterns of the 'modern woman' has also raised discourse around the 'new female criminal' with the argument that as women's lives 'increasingly emulate men's in the workplace, we might also expect their behaviour to emulate men in terms of a range of deviant or criminal behaviours, such as heavy drinking, drug use, violence, or acquisitive crime' (p.23).

### **Drunken performance: the battleground of the past**

Many of the offenders at some point in their interview recalled how alcohol had influenced their 'past' behaviour and to some extent, had played a significant role in how their lives were acted out and performed. As expected many of the themes of these stories were located in the past, since they were undergoing treatment at the time of their interview, and one of the themes that was identified during the analysis was 'the battleground' where a large majority of past performances were constructed as aggressive and violent. This was particularly evident in Cherry's story as a large part of her violent past was attributed to her alcohol abuse.

Since Cherry had been on the ATR she had managed to get her job back working part-time at a local taxi rank. In the following excerpt Cherry recalls an incident that happened recently on one of her shifts where trouble had broken out with some men fighting outside the office;

**Cherry:** *it was terrible, you do get fighting there but most of the time it's night clubs, but they don't actually come in the office, we were just scared for the young girls, they were stood outside*

**Jo:** *so they were fighting?*

**Cherry:** *loads of men fighting and we were scared for young girls we tried getting them in and then everybody just piled into everybody and it was just horrible and I kept my cool there and that's a good thing*

**Jo:** *really? so what would you have normally done there then?*

**Cherry:** *well most time I would have been in drink anyway, but I've learnt to control my anger a lot as well and walk away from situations what's going on*

**Jo:** *what's going to get you going?*

**Cherry:** *yeah we just got girls into office, we shut bottom door and phoned for the police*

**Jo:** *then it's done then*

**Cherry:** *whereas before I would have gone in with em! (both laugh) I would though! I wouldn't have gone fighting but I would have tried to*

What was immediately evident in Cherry's account of the taxi rank incident was the way in which she constructed the violence as 'terrible' and 'horrible' through a sober lens, which was in stark contrast to the way in which she constructed similar events through her 'in drink' lens. Cherry's narrative exemplifies how alcohol would have significantly affected the way that she would have performed in that particular situation. In Cherry's account, alcohol was constructed as a catalyst for her past aggressive behaviour. As she begins to recall the event, the tone of her narrative signifies a sense of peril and fear, as the men, unusually, enter into the taxi rank office. As Cherry reflects on her recent performance, there is a sense of achievement. Her self is re-constructed as she takes up the position of 'protector' in her attempts to shield the girls from the fighting men. However the tone in her narrative shifts and becomes more humorous and self deprecating as she considers how she would have performed in this situation 'in drink' – her 'past self'. The notion of Cherry attempting to single

handedly take on the men in the office and go 'in with em' was constructed as 'laughable' and perhaps served to conceal her anxiety or guilt about her past aggressive performances. Segal (2007) argues that women are often 'sensitised to greater social condemnation of female aggressiveness – shouting fighting and so on.' (p. 223). Indeed Cherry has had to learn to 'control' her 'anger' and can now keep her 'cool' which was constructed as a 'good thing'. Perhaps here Cherry is ventriloquising cultural voices of gender in relation to her constructions of her past drunken performance. Cherry's story of the 'protector' in this instance, perhaps locates her with a culturally acceptable position. Therefore Cherry's story is arguably told – as Bruner, (2003) would argue - in order to highlight her re-constructed self in order to meet the demands of her present and anticipated future

When I interviewed Sam, it was clear that he had been exposed to the performance of alcohol from a very young age. Sam's story began at the age of around 5 and recalled vivid memories of his parents and in particular his father;

***Sam:** that's how the arguments used to start because my dad was a heavy drinker ... he used to like a drink, yeah I witnessed him sort of being violent towards my mother as well through drink, erm yeah I saw a lot of things that went off really*

***Jo:** so you saw alcohol from an early age as probably being*

***Sam:** yeah it was always around even just being there sitting outside a pub, I had to wait outside until they had finished*

Sam recalled that from an early age he was aware of alcohol 'always around' him. He described his father as a 'heavy drinker' and attributed his father's drinking to the 'arguments' and the violence that he witnessed towards his mother. Thus from a young age Sam was exposed to his father's 'violent performance' towards his mother

as a result of his alcohol consumption. Therefore it was evident that Sam constructed alcohol as disruptive, violent and consistently 'always around'. Thus Sam's 'battleground' was the home he grew up in. Sam is positioned as an observer in his story, witnessing events from outside and indeed was physically positioned as an outsider as he recalls waiting for his parents 'outside until they had finished' at the pub. Nevertheless during these unhappy times, Sam talked about activities away from his parents that he enjoyed such as his band practice and going to stay with his grandparents, all of which were constructed as positive experiences.

At the age of sixteen Sam had the opportunity to pursue his 'interest in flying' and joined the air cadets 'so we used to go away doing shooting and flying and doing constructive things, things that I enjoy'. He went on to join the RAF at 19 and constructed this time as a way to 'get away and start my own sort of life'. Unfortunately for Sam, although the RAF was constructed as a 'good opportunity' he also began to get 'into trouble';

***Sam:** well this is where I get into a drinking culture ... well on military bases, couple of times I got drunk and disorderly and what have you*

***Jo:** looking back on it, you talk of this drinking culture, would that have been accepted?*

***Sam:** oh it was accepted yeah, well it was part of that life*

***Jo:** part of that life?*

***Sam:** part of that kind of life, you get up early on a morning and you do physical things all day, after you've passed through basic training you get more time on your hands and you get more money obviously so you've got more disposable income to go out and do it*

It was evident that Sam, in his attempts to 'get away' and begin his own life, moved from the drinking culture of his family, to the drinking culture of military life. Sam's

narrative above illustrates how alcohol once again featured heavily in his life. Sam constructs his drinking as an accepted way of life in the Army, therefore dominant voices of alcohol consumption were evident and were ventriloquised in his attempt to justify getting drunk and being arrested in the RAF.

In relation to Sam's upbringing it is interesting to explore how psychological theorists would perhaps make much of his family experiences. His account of his father's alcohol consumption could be argued to reflect the notion of family culture and 'alcoholism transmission' (Bennet and Wolin, 1990) where certain family processes are identified as precipitating or protecting factors in the continuity of alcoholism. It has been argued that young men whose fathers are alcohol dependent are more at risk of developing their own alcohol problems (Collins, Leonard, and Searles, 1990). Indeed according to Maisto, Carey and Bradizza, (1999), Bandura (1969) applied social learning theory to drinking behaviour and argued that cultural and subcultural norms define alcohol use and behaviour patterns. Bandura argued that the development of alcohol abuse was most likely to occur in families with one or more alcoholic parent because in such a context children are more likely to observe heavy drinking as a dominant response to stress reduction. However this does not appear to have been the case for Sam. Rather it is later in his military career that he appears to make the connection between his own drinking and the culture he is immersed in 'this is where I get into a drinking culture'. Thus for Sam, in his attempt to 'get away' and begin his own life, he moves from one drinking culture of his family home, to the drinking culture of the RAF. Therefore what is evident in Sam's story is that the battleground of his home now

becomes the 'battleground' of the military where fighting and drunkenness became a regular performance and a culturally 'accepted ... part of that life'.

Sam's storying of his father being a 'heavy drinker' and his own drunken performances in the RAF are indicative of what has been recently termed 'extreme drinking' (Martinic and Measham, 2008). The narrative of the 'extreme' is often characteristic of contemporary youth (Nahoum-Grappe, 2008) and has more recently been explored in relation to alcohol. Indeed Nahoum-Grappe (2008) argues that 'the "heroes" of the extreme "thirst for drunkenness" are typically young men' (p.44). In Sam's story it could be argued that the social structure of the military situates young men in relation to similar others and in this way, Hunt *et al.* (2005) suggest that collectively they experience the world from a specific position and construct cultural ideas of masculinity that reflect ideas of hegemonic masculinity such as dominance, control and independence. Indeed much of the literature that surrounds masculinities and crime has focussed on aggression and violence as a way for men to individually and collectively express hegemonic masculinity. Moreover studies have shown that the form of male bonding through drinking acts as an important resource in the production of masculinity. Indeed Graham and Wells (2003) found that young men perform more aggressively when drinking in pubs due to 'male honour, face saving, group loyalty and fun' (p.548). What was particularly evident from the stories of Sam and indeed all of the male offenders interviewed was the notion of masculine collective performance and 'contagious consumption' constructed as one of the main struggles of performing sober in a drunken world.

### **Contagious consumption: sober performance and being outside**

As noted in the previous section, there were many incidences in the stories that were told where alcohol appeared to be related to performance, indeed this theme was evident in the majority of the stories told. This performance was a consequence of how their lives were culturally situated, and where dominant voices of 'extreme drinking as acceptable' were ventriloquised. Not surprisingly the 'drunk performance' was largely associated with negative consequences for all of the offenders and often resulted in aggressive and violent behaviour. What was of further interest was the way in which alcohol consumption and being drunk was constructed as a collective cultural performance therefore drunkenness was not only a way of *being* but a way of *interacting*. As a result, the drunk performance would perhaps have no meaning if not conducted in a group. Indeed Garvey (2005) notes that as individualised action, being drunk is a prime example of sticking out and the collective interaction of drunkenness serves as a way to become obscure for fear of acting in an embarrassing way in public. Therefore a person is defined socially with how one 'fits in with others' (Garvey, 2005, p.103). The previous section also highlighted that many of the offenders (as highlighted by Cherry's story) seemed motivated to narrate their 'past selves' (Ricoeur, 1991) as located within a culture of violence and alcohol, in order to convince their audience of their re-constructed selves since being on the ATR. In this sense, many of the offenders were 'motivated tellers' (Hermans, 2002) in that they were keen to reconstruct a more morally acceptable self.



Nevertheless, having highlighted the extent to which alcohol can be constructed as a cultural and collective performance, it was thus interesting to explore the impact of a sober performance for these offenders. Therefore, to what extent can a sober person 'fit into' a drunken world which is argued to represent 'a form of social interaction and performance through which disorder is routinized, controlled and structured' (Garvey, 2005, p. 104).

The theme of 'being outside' was evident for most offenders as they re-entered their social circles as sober individuals. Nigel's story particularly exemplified the way in which the struggle to remain sober becomes progressively harder in certain social situations where alcohol and drunkenness is, normal, accepted and performed regularly;

**Nigel:** *but like drinks everywhere int it? ... this is where I want to be where I'm drinking what the government says the limits are, two cans, two or three cans a day at night not, at night not during the day*

**Jo:** *Yeah and have you tried that? Is that where you're struggling at the moment?*

**Nigel:** *you see ... what I should have done, is I need to get this in place because, I turn into a really boring person because all my mates drink, and like if I'm not drinking and I go see my mates and they're drunk obviously what they find funny I don't find funny, do you know, if you're out with your mates and you've all had a drink, you're all wahaay! [mimics laughing and waving his hands in the air]. If you've all had a drink it's funny int it, if you've not had a drink its 'what you laughing at? There's nowt funny here about that' so I'd be sat there like a bore.*

Nigel begins by stressing that 'drinks everywhere int it?' which seems to reflect today's society but perhaps more importantly this is a construction of his cultural background, his friends and his family. His utterance frames his situation as helpless perhaps serving to justify his ongoing struggle to remain sober. There was a sense of frustration

in his narrative tone. His goal was to be able to drink within the 'acceptable' limits of 'what the government says' which might suggest that he has been internally persuaded by the authoritative voice of the government to 'drink sensibly'. However this also indicates Nigel's frustration of having to perform sober. Nigel's construction of the sober performance was to be 'boring' and is located 'outside' of the collective interaction of his 'mates' laughter. His sober position appears to restrict his interaction with the group as he can no longer join in on the jokes and indeed challenges the interactions as 'nowt funny about that'. Thus dialogically, Nigel is drawing on the dominant cultural voices of his community. Drinking in his community is framed as 'enabling fun and laughter' therefore by not drinking, Nigel is constructed as the opposite. Therefore by being positioned 'outside' of the group, he is discursively located as 'not able to join in the fun'.

Throughout Nigel's narrative there was a sense of despair and frustration in relation to his struggle to resist drinking. His social world was constructed as being 'surrounded' by drugs and alcohol which heightened his sense of 'outsider' when trying to remain sober. Thus a reminder of how powerful voices of culture and society can be. Indeed in a Bakhtinian sense we use the words of society in order to construct and describe reality and thus are sensitive to the reactions of others. According to Bakhtin (1981) we see ourselves always through the eyes of others whether in moments of being judged or recognised (Belova, 2010). Indeed it seems that Nigel senses he is being judged for his sober performance. Yet perhaps more importantly, Nigel's story provides insight into his cultural frame of reference in relation to what it means to be a young man sober in a culture surrounded with alcohol. Similarly Garry's experience of

being sober among his friends discursively positions him as the 'outsider', yet for Garry the sober performance unlike Nigel's was constructed in a much more positive light;

**Garry:** *and I found going to football easy an all cos, excuse my French, but I thought lads would have taken piss out of me for not drinking, do you know what I mean, so I was really worried about that cos I watch Leeds United (Jo laughs). Don't laugh! Erm and I go to most of away games and normally, if we're playing in London, we'll either go Friday night so they can have a night round Camden Town ... then Saturday night it'll be Soho Leicester Square and Sunday Paddington and back home*

**Jo:** *a full weekend?*

**Garry:** *three days on beer and I'm three days on Britvic Orange. I even asked Amy [alcohol treatment worker] if I could drink shandy, she said 'I wouldn't bother' cos its, it's got alcohol in it ant it?*

**Jo:** *yeah it has*

**Garry:** *first couple of weeks I had rib taken out of me but they were alright after that*

**Jo:** *what do you mean rib taken out of you?*

**Garry:** *just taking piss out of me, trying to wind me up but I think a lot of them now wish they could do it*

There were two distinct themes to note from Garry's narrative above, namely the social normalisation of the drinking performance that surrounds the football match and the male 'bravado' that was signified within the collective performance of alcohol consumption. Football, for Garry was constructed as predominantly an occasion for drinking and he later reflects that 'its all centred around beer!'. In Garry's narrative there was a strong sense of alcohol consumption as a male dominated activity centred around 90 minutes of a football match. Indeed during Garry's entire narrative of the rituals of going to watch football, the only female mentioned was his mother who he would often 'have to borrow some money' from in order to pay for the often expensive 'price of beer in London'. It is argued that alcohol can be used as a way of

encouraging male 'togetherness' and therefore as a convenient tool for separating men from women (Hunt, MacKenzie and Joe-Laider, 2005). Football is constructed as a male dominated sport in relation to the players and the spectators (Schachtebeck, 2010). Similarly from Garry's narrative, going to watch football was constructed as a 'lad's weekend away'.

The apparent maleness that surrounds Garry's drinking was evident in the tone and imagery that he conveyed. There was evidence of male banter and perhaps by drawing on his own dominant cultural voices of maleness and drinking, he seems to accept that to remain sober positions him 'outside' the 'pack' particularly during football matches. We see this imagery clearly in his utterance 'and I'm three days on Britvic Orange'. Although Garry was not explicit about what the others were drinking, one gets little impression that they would have abstained from alcohol and their own quest for drunkenness in order to be sensitive to Garry's situation. Indeed what was clear from Garry's account was that he has had to endure his friends 'taking piss out of me, trying to wind me up'. Nevertheless, although Garry appears to position himself as outsider, rather than taking up the position of victim as his friend's taunt him, he manages to construct his position of outsider as empowering as he reflects 'I think a lot of them now wish they could do it'.

Consuming alcohol collectively has been identified as a way of male bonding and a way in which male identities are formed (Garvey, 2005). Therefore drinking in company can legitimate such behaviours with 'contagious consumption' perhaps being viewed as a way of fitting in with others and avoiding being positioned as an 'outsider'. When I

spoke to David, it was evident that he was aware of the influence his friends had over his alcohol consumption. As a result David is also positioned as an outsider in his struggles to remain sober:

*Jo: so do you socialise with other people who drink?*

*David: obviously I did do, I've err first cut my friend base down by a good 95 per cent*

*Jo: and has that been sort of on purpose?*

*David: yes I had to, when phones going 'come on get yoursen out' 'oh you're alright just have one, just have one then have a coke' you'd just have fifteen pints and get arseholed!*

David sees the sacrifices of having to avoid his friends as an obvious choice, given the amount of influence he sees them having over his drinking. Thus he appears to construct his 'friend base' as part of his transgressive alcohol abuse, and as 'not being able to understand' his need to remain sober. The theme of contagious consumption appears to be something that David, without articulating it, is aware of and through this is positioned as powerless to resist and thus narrates his recovery as 'staying away'. Once again, as with many of the offenders I spoke to, the cultural voice of alcohol and drunkenness as acceptable forms of socialising was dominant here. Indeed Dara's fears about becoming alcohol free echoed many of the offenders' stories about being 'outside' as a sober performer:

*Dara: there was always that fear of what will I do if I stop drinking, my friends what will happen to them, how will I cope with life*

So far my analysis has revealed how these offender's stories are located within a culture that accepts drunkenness as a social performance and a way of 'fitting in' with

communities and families alike. It seems that these offenders have a sense of being defined socially with how one 'fits in' with others. Therefore in struggling to resist cultural norms of drinking behaviour, it seems almost inevitable that this means 'becoming an outsider' This analysis has also considered how offender's 'past selves' (Recoeur, 1991) have been narrated in context to their current selves and is something that will be explored further in the next section of this analysis.

### **'I'm a lover not a fighter': alcohol, violence and bad faith narratives**

In the previous section, themes were identified that illustrated how male performance and cultural acceptance of alcohol consumption located offenders' past behaviour arguably within the cultural expected 'norm' of the quest for drunkenness. Their cultural background largely underpinned and informed how they constructed alcohol consumption and dominant voices of their communities were ventriloquised which seemed to reinforce constructions of the sober performance as 'being detached and outside' In this next section I want to explore these dominant cultural voices further in relation to alcohol, violence and offending by drawing on their past narratives and the notion of bad faith narratives.

All of the interviews conducted in Phase Three of this research aimed to explore in further detail how offenders experienced alcohol treatment on the ATR. However the narrative accounts that were elicited from the interviews revealed much about the complexity of how these stories were told, and, in accordance with Craib (2000) it was acknowledged that some stories can indeed be referred to as '*bad faith narratives*'

because the way in which they are told can serve to deny agency. Therefore stories can reflect ‘not what a person does, rather what is done to that person, and thus what that person becomes because of what has been done to them’ (Craib, 2000, p.45). Bad faith narratives according to Craib (2000) serve as a function to make things normal, unproblematic, and enable avoidance of acknowledgement or feelings of guilt. Thus stories can be told to ease anxieties or to avoid appearing in an unfavourable position in front of an ‘other’.

The ATR was an initiative that was developed through a need to address locally the level of alcohol related violence that was occurring in the local communities. Moreover, having explored the records of 81 offenders who participated on the ATR, it was difficult to ignore the high levels of alcohol consumption and the high numbers of violent crimes that had been committed by these persistent offenders (Ashby, Horrocks and Kelly, 2009; 2011) . Indeed out of the 10 offenders interviewed, 6 had committed serious assaults, and 9 were described as alcohol dependent at the beginning of their ATR (see Table 1, p.125). Nevertheless, during each individual interview with the offenders, there were many discursive attempts to resist being positioned as a violent, alcohol dependent, persistent offender. In order to illustrate this further, I will begin the analysis with Shane. During my interview with Shane I invited him to tell me more about his drinking since he began treatment on the ATR;

*Jo: but, how would you describe where you are now being happy with it [alcohol], what's that about? Is it just having a few drinks with your mates or*

*Shane: I don't know, yeah I'm not drinking on me own no more its*

*Jo: and what about fighting and things like that, you said you were fighting*

**Shane:** *like I say I'm with a good set of lads when I'm drinking, when I'm not drinking I'm not a fighter I'm a quiet placid lad me [smiles]*

**Jo:** *yeah? [small laugh]*

**Shane:** *I'm a lover not a fighter know what I mean, but when I'm bevvied up like its*

**Jo:** *does that change you then?*

**Shane:** *the red mist descends! [spoken in a slow deep voice]*

The above dialogical exchange between myself and Shane exemplified the way in which Shane was able to position himself as a 'good person' thus resisting the position of 'bad offender' throughout his interview. Shane's change in his drinking was constructed as 'in good hands'. Here contagious consumption is seen only to occur if in bad company. Thus 'being in good hands' suggests a collective supporting environment as Shane is drinking with 'a good set of lads' rather than drinking on his own. Garvey (2005) points out that the 'alcoholic is frequently portrayed as the lone drinker' (p.87) and perhaps for Shane, drinking alone is constructed as the negative potential for excessive drinking rather than with his peers. Thus drinking in 'good' company is legitimisation of his positive social drinking and resistance to the position of 'lone alcoholic'.

Nevertheless what was most evident in Shane's narrative was the 'light hearted' tone conveyed throughout his storytelling. Shane's narrative about his drinking and his fighting takes a diversion as he states that 'when I'm not drinking, I'm not a fighter, I'm a quiet placid lad me' he then smiles at me indicating a 'tongue-in-cheek' tone to his utterance, and my response is to challenge him with a laugh 'yeah?'. Shane's tongue-in-cheek approach enables him to caution his audience against taking him too seriously. Indeed according to Palmer (1994) the use of humour in relationships is argued to be a



way of preventing ‘unnecessary dysfunctional stress and tension’ (p.63). Our conversation has become ‘banter’ and by aligning myself with his resistance I am perhaps helping to co-construct his identity. Shane has achieved his position as a good person whose dialogical self identifies with the voice of the male ‘charmer’ to his female audience. His construction of self is reinforced by referring to the ‘I’m a lover not a fighter’ cliché repeatedly, perhaps, as Craib (2000) would suggest, to make his story believable to his audience and yet more importantly to himself. He finally draws on strong imagery in order to convey the effects of alcohol when he is ‘bevviied up’ by claiming that ‘the red mist descends’. His use of imagery depicts a scene from *Dr Jekyll and Mr Hyde* (Stephenson) where the alcohol becomes a chemical that has the ability to ‘unleash the monster’. The use of tone and imagery throughout Shane’s story is indicative of his persuasive positioning during the interview that he is a morally good person. By returning to Craib (2000) it can be argued that Shane’s account serves to close down meaning and deny agency over his behaviour. The imagery that Shane draws on in this excerpt exemplifies the way in which alcohol may be drawn upon as an excuse or a strategy to deflect criticism. Fekjær (1994) highlights that this approach is based on the assumption that when intoxicated, a person is not fully aware of their actions and can become out of control and thus is not entirely responsible. Therefore Garvey (2005) points out that within numerous studies based on deviant behaviour, guilt is frequently attributed to inebriation and often ‘the more stigmatised the behaviour the more guilt is attributed to the influence of alcohol’ (p.92). Thus alcohol is often constructed as an ‘alibi’ (Fekjær, 1994, p.2) for action. The theme intonated here in Shane’s account permeated throughout all of the interviews I conducted, and

suggests that there is a strong sense of struggle for these offenders to resist authoritative voices of the bad offender.

Similarly, Garry, when asked about his drinking and his offending, managed to resist offering any detail of his past heavy drinking and his persistent offending;

*Jo: have you got a long history of drinking?*

*Garry: Yeah*

*Jo: so I imagine that's quite a big thing to take on [an alcohol detox] right at the beginning, but there must have been something which made you feel okay about doing it?*

*Garry: sick of getting arrested*

*Jo: right so you've been arrested quite a lot at that point?*

*Garry: I was more of a binge drinker do you know what I mean cos I'm on incapacity benefit cos I've got sciatica down this side [points to his back] I'm osteo arthritic in this hip so I don't sleep, I'm on antidepressants 99 per cent of the time, I'm totally medicated out of my eyes! But I've got to go see erm an osteo arthritic consultant at [place] on Thursday because when I was complaining, because I've got two allotments'*

*Jo: oh two?*

What was worth noting about Garry's interview was that he became more open and offered more detailed as we moved away from the subject of both his drinking and his offending behaviour. The above excerpt illustrates how Garry managed to avoid talking about his offending and instead goes on to offer his somewhat subjective version of his alcohol consumption. Garry states that he was 'sick of getting arrested' and in response to this I begin to probe further about his involvement with the police, however Garry, rather than follow my line of questioning, begins to persuade me that he 'was more of a binge drinker' before narrating himself as a victim of illness yet an active man who keeps two allotments. Thus his narrative has enabled him to resist discursively positioning himself as either an offender or an alcohol dependent person

(he was assessed by Amy as 'alcohol dependent'). Indeed he appears to reject the notion of being alcohol dependent and does not refer to any professional assessment of his drinking, rather he positions himself as the expert and claims that in his opinion he was 'more of a binge drinker'.

Similarly in Sam's account, although he talked in more depth about his offending behaviour than Garry, what was pertinent here was the way in which he constructed his identity as an offender;

***Jo:** so what was it like being arrested?*

***Sam:** it was a shock, came as a shock to me, but then I got arrested again and again and again and again [by same police force]*

***Jo:** really, for the same sort of thing?*

***Sam:** yeah same sort of things yeah ... well I've never been, I wouldn't say I'm an ardent criminal but what, I'm not a burglar I'm not a thief I've never been arrested for anything like that but things like assault, drunk and disorderly, breach of the peace, you know all them type of things*

Sam constructs his early experiences of being arrested as a 'shock' however there is an immediate sense that this soon becomes normalised as he is consequently arrested 'again and again and again and again'. Thus it seems that the 'shock' of being arrested was not enough for him to cease offending. Sam's self characterisation interestingly positions himself as a criminal, yet he appears to downplay and resist any notion that he is a bad or 'ardent' criminal. His narrative appears to function as a way to attempt to persuade me that there are indeed different categories of criminals, some which appear to be less serious than others, his being less serious. The narrative tone during this account becomes factual and informative, which seems to reflect the way in which Sam has normalised his discourse of the 'good/bad criminal'. Sam constructs burglary

and theft as more serious crimes in comparison to ‘two guys scrapping’ indicative of his own criminal behaviour. The voices of the criminal justice system and society appear to be evident in his dialogical self identity where certain punitive measures are based on the level and severity of the criminal act (Budd, 2003). By drawing on these voices, Sam is able to resist the position of ‘ardent’ criminal and thus minimise his own criminal behaviour, by constructing, ‘assault, drunk and disorderly’ and ‘breach of the peace’ as less severe.

In relation to Sam’s narrative, Bakhtinian theory would perhaps suggest that Sam is ‘struggling’ to transform public language into private consciousness by accepting that the construct of ‘criminal’ can be challenged and multilayered;

‘A conversation with [another’s] word that one has begun to resist may continue, but it takes on another character: it is questioned, it is put in a new situation in order to expose its weak sides, to get a feel for its boundaries’ (Bakhtin, 1981, p.348).

Sam, by his own admission is characterised as a criminal in the eyes of the Criminal Justice System, yet his ‘process of becoming’, his struggle to resist being positioned as a bad criminal results in him favouring the authoritative systematic voice of the legal system which functions as a social barometer in enabling a position of ‘better than most criminals’ to be taken up and internalised.

According to Craib (2000), attention should be paid to the way in which stories are told and to what purpose they might serve. It appears that Sam’s self construction of ‘good

criminal', Garry's resistance to telling and Shane's 'lover not fighter' images in the previous excerpts serve as a way to overcome their anxieties and guilt about their offending behaviour. Indeed Sam's bad faith narrative becomes more evident when later on in his story there is a shift to a more serious tone and he talks about a turning point in his offending career where things began to get more 'serious'. Indeed his latest offence involved him walking into 'some ladies house through drink' mistaking it for a friend's house when he was 'out of it'.

***Sam:** but I actually got charged for assault because she pushed me and then I pushed her, so it's actually assault, it's not burglary ... and I knew that things were serious then*

***Jo:** right, so had you been to court at this point?*

***Sam:** I'd been to court several times and never received probation*

***Jo:** so what happened then?*

***Sam:** fines, I just got fines*

***Jo:** you just got fines, so what's different about this time?*

***Sam:** well I think it's because it happened in someone's home which I understand fully, I'd walked into somebody's home so er ... and I was violent*

***Jo:** so you frightened someone to death?*

***Sam:** so I frightened some poor woman to death which I'm not proud of ....was violent*

This turning point in Sam's narrative reveals an important insight into the struggles that Sam was faced with in terms of his offending behaviour and self identity. His latest offence was constructed as 'serious' and 'violent' acknowledging that he had moved beyond the boundaries of public space and had entered the private space of someone's 'home'. Finally, through my own construction of the offence as frightening 'someone to death' Sam was positioned as a bad criminal. Sam appears to take up this position without resistance and reveals a sense of guilt for his offence claiming that it

is something 'which I am not proud of'. Perhaps this particular admission of guilt reflects the gender of the victim. Sam has not only moved beyond public space into private space, he has also moved beyond the normalisation of 'men scrapping' by acting out his physical aggression towards a woman. Furthermore perhaps Sam's expression of guilt and shame was told in a particular way because I was his audience.

The above extracts appear to draw on cultural constructions of the aggressive drunk male and clearly like most of the offenders I interviewed this is reason to resist being positioned as such. It must be noted that both Shane and Garry were convicted of serious assaults and perhaps understandably they attempt to position themselves in a favourable light and in doing so minimise both their offence and their alcohol consumption.

Interestingly David's narrative is based on what he constructs himself *not* to be, reiterating in another mode, the voices present within society. The cultural voice of the stereotypical bad offender is drawn on and then resisted in favour of a counter narrative that enables him to portray characteristics of a good person;

***David:** I mean going back before I was drinking I was always, been quite level headed so it makes it a bit easier, don't want to butter myself up but I've never been too much of an idiot, I've never been hot headed, not out fighting every weekend, so there's none of that rubbish. I've always gone to work, gone out and earned my keep as such, and its just trying to get back to that cos that's normality for me.*

David presents his past self as living a life of 'normality' which was constructed as going out to work and earning his 'keep' and by doing so constructs his offence as not normal rather an exception. He doesn't do any of the 'rubbish' that others do and thus

positions himself as an exception to the rule in relation to offender characteristics. He is perhaps drawing on voices of both community and society that through dialogue construct offending within a particular dominant narrative that portrays offenders as 'idiot', 'hot headed', often in fights, and not someone who goes to work and earns a living. His expression of 'I don't want to butter myself up' suggests that he is in a morally preferable position, he displays some modesty about this however continues to position himself as a good man.

## Summary

Listening to the offenders' stories and exploring their constructed and situated experiences has raised important questions about how the voices of others can be a powerful influence over normative behaviour. In this analysis I have begun to illustrate how the offenders' stories were situated within a culture that appears to embed collective cultural performances of drinking and drunkenness as accepted and the 'norm' of their communities. It was evident that these offenders were to some extent ventriloquising dominant voices of gender and alcohol consumption that accept such performances as a backdrop in which group identity and masculine identities are formed. The storying of their 'past selves' appeared to be entrenched with authoritative discourse that suggest immorality and for some, despair. Thus within their sober performances, it was evident that their struggles to resist the collective and normative performance had consequences of 'not fitting in'. Moreover it was revealed how the bad faith narrative has the potential to represent denial in relation to their past behaviours. Indeed to talk about their crimes would be to accept blame, thus bad

faith narratives ,evident in these stories, arguably served to ease anxieties about being positioned as a bad, violent, alcohol dependent offender in favour of a more 'morally acceptable' person.



## **Chapter 9: (re)conceptualising the treatment setting**

### **Introduction**

In the previous chapter, analysis of the offender interviews provided insight into the ways in which the offenders' narrative accounts appeared to draw on dominant cultural voices of offending and alcohol abuse. The analysis drew upon Bakhtin's dialogical theory, and it was considered how utterances, as a relational construction, frame a person's identity as a way of being in relation to others. The analysis revealed how cultural voices of offending and alcohol abuse were resisted during their talk which enabled them to take up positions of a more worthy and moral self. Moreover it was found that the way in which the offenders drew on their past narratives in order to construct new identities, was largely located within a gendered discourse of masculinity and male performance. Indeed in the analysis of the interviews gender was identified as a major integrated theme (King and Horrocks, 2010) that permeated each of the thematic codes generated. In this chapter therefore, I return to question and explore further, the gendered social interactions of the treatment sessions that were observed in phase two of the research (see Chapter Six). It was here that my own observations left me to question the possible gendered nature of the ATR, as it is delivered by Amy and Susan, largely to young men. However the observations provided only one viewpoint of the ATR, therefore, analysis of the offenders' individual accounts of the treatment setting enabled a further exploration of how offenders

might interpret their individual experiences of engaging in 'coercive' treatment within the probation setting.

### **The story so far ...**

In chapter five an in-depth analysis of the field observations of the treatment settings were presented. This analysis provided an interpretation of the social interactions that occurred between the female alcohol workers and the male offenders during alcohol treatment sessions. The analysis of these ethnographic fieldnotes (Emerson *et al.* 1995) revealed interesting insights into the ways in which both Amy and Susan appeared to effectively manage offenders during their treatment. They appeared to resist positions of 'feminine carer' by taking up positions of power and control within their professional roles. My overall interpretation of these sessions subsequently lead to further thoughts about how the ATR was delivered by Amy and Susan and thus left me questioning, to what extent was the delivery of the ATR a gendered practice? In this section therefore, I return to consider the delivery of alcohol treatment, however this time, through the narrative accounts of offenders who had experienced treatment on the ATR. Thus in keeping with a pragmatic epistemology, multiple views and experiences have been able to be explored, which in turn has enabled a more holistic account of the ATR to be developed and understood. Inviting the offenders to talk about their treatment experience was considered to be a way in which subjective understandings of self and identity could be revealed through their stories (McAdams, 1993; Gergen and Gergen, 1986). Moreover, it is argued that these stories need to be understood in the offenders' social and cultural contexts. Thus it was anticipated that

how these offenders interpret their treatment experience and their requirement to 'self-change' (Horrocks, 2002) would be, in part, in relation to the social and cultural context of their lived experiences.

For Bakhtin, 'self-change' is conceived as a struggle between 'one's own words and point of view about one's self, and the words and points of view of others' (Burkitt, 2008, p.53). This 'mutual authorship' is viewed as a significant catalyst for self-change as, through life, the attitudes, voices, and emotions of others can influence self-identity. Nevertheless through dialogic exchange, it is evident that there is optimism, as the world is open to being partially reconstructed (Burkitt, 2008). Dialogism recognises both passivity and activity in the construction of the self, whereby voices of others, although influential, can be part of an interaction where voices of the self can become active during social interactions. Thus an active 'authoring' of the self through others is achievable. In this sense, the offenders interviewed were conceived as 'active agents' (Horrocks, 2002) in the treatment process. Nevertheless it is perhaps worth being reminded that often, dominant voices of society can be difficult to resist and there is often a struggle against a single 'monoglossia' of meaning (Dentith, 1995) for example the often 'embedded interaction' of the dominant discourse of gender.

### **Gendered voices**

Alcohol treatment on the ATR is provided by the NHS and it has been argued that healthcare organisations across the UK and Europe are usually conceptualised as hierarchical with a 'top-down' structure (Sebrant, 1999). Gender and social discourse in healthcare organisations has been explored from healthcare worker's viewpoints

where a social discourse of 'females as carers' seemingly prevails. Sebrant (1999) claims that the majority of healthcare personnel are women and thus organisations are known for being strongly gendered with male dominance and female subordination. Indeed Bullock and Waugh (2004) argue that dominant cultural norms dictate that women 'nurture others' and despite some 'loosening of traditional gender role expectations, women continue to be seen as caregivers' (p.767). Therefore, to what extent do gendered hierarchies of health care shape the interaction between clients and professionals? More importantly for this research, how would these interactions impact and influence the individual experiences of the offenders undergoing treatment on the ATR?

Holmes (2006) argues that gender 'talk' is a pervasive part of social interaction and thus provides the backdrop of every communicative encounter that 'creeps' into dialogue in subtle or not so subtle ways. Indeed Weatherall (2000) points out that;

'The identification of a person as belonging to one of two gender groups is a fundamental guide to how they are perceived, how their behaviour is interpreted and how they are responded to in every interaction and throughout the course of their life' (p.290)

It appears that there is no arena that gender cannot enter and ultimately influence. However for Bakhtin, language is the dominant source of how gender identities are relationally developed. Bakhtin suggests that language holds many 'voices' and that these voices construct selves and others accordingly. The main premise of Bakhtin's dialogical model of discourse is the notion that we engage simultaneously in cultural

and personal dialogues, with the dominating powers of a society attempting to impose one discourse on all others. This 'monoglossia', it is argued, can turn dominating discourses and its corresponding meaning into what is constructed as truth in society (Dentith, 1995). Thus authoritative voices such as gender are often difficult to resist, and as such become internalised and performed. For example, Uchida (1998) found in her study of speech patterns acquired by girls and boys, that 'typical female' characteristics such as 'nurturing; supportive; expressive; emotive; friendly' (p.287), are associated with 'weakness' and 'powerlessness' whereas boys' patterns, on the other hand are associated with 'assertiveness, challenging and arguing' (p.287) which serves to control 'the floor' and take up powerful masculine traits.

During the individual interviews, each offender was invited to talk about their experience of receiving treatment as part of their community sentence. Interestingly, when asked specifically about their experiences of engaging in treatment with either Amy or Susan, their responses appeared to draw on authoritative voices of gendered discourse consisting of the masculine/feminine, tough/soft dualism (Segal, 2007). This theme was especially exemplified during Garry's interview as he narrated his account of his first impression of Amy, his alcohol treatment worker;

***Jo:** so when you first started coming here on the ATR, when you first met Amy how did that go, what was that like?*

***Garry:** excellent, very kind, very nice to talk to, down to earth and I found that she was very erm what's the word I'm looking for, accommodating, erm she wasn't oppressive do you know what I mean? She was very helpful, friendly and kind and, which I think made me feel better to start with*

Garry's narrative account resonates with many of the stories that the offenders told when invited to talk about their experiences of their alcohol treatment. It is worth being reminded at this point that alcohol treatment delivered within the context of the ATR is conceptualised as 'coercive' and the offender is governed by the attendance rules of the National Probation Service, which if not met, could result in further court appearances. Therefore Garry may have initially expected his alcohol treatment to be an 'oppressive' experience. Nevertheless, Garry's narrative account of Amy tells a contrasting story as Amy is characterised as 'kind' 'nice to talk to' helpful' and 'friendly' which appears to construct Amy as an expressive and caring practitioner, perhaps drawing on the 'female as carer' discourse. She was indeed constructed as 'accommodating' rather than 'oppressive' which seemingly influenced how Garry felt. It could be argued that Garry identified with hegemonic masculine character traits (Connell, 2003) which positions men as superior to women, thus his first encounter with a female professional could be constructed as less of a threat to his masculinity. I do not suggest that men cannot be described as 'kind' 'friendly' and 'nice', or that all men see themselves as superior to women, however a gender related pattern of discourse was evident in many of the offenders' accounts which appeared to draw on the discourse of 'female as carer'.

This particular construction of Amy could be influenced by Garry's cultural view of women and the dominant voices of his community, thus there was perhaps more of a tendency for Garry to draw upon this discourse when describing Amy. Indeed the way in which Garry describes Amy could be viewed as typical of women within his culture, thus his utterances reflect what he might perceive as normative forms of gender

behaviour (Edley, 2001) and characteristics that are conventionally associated with women, such as caring and nurturing. This conventional view of women, however, is perhaps socially and historically located within the culture of the working class community. Indeed as Connell (2003) points out, masculinity and femininity are not natural or innate, rather they are socially constructed and as such, vary between cultures, ethnicities, social class and contexts. Therefore the 'female as carer' discourse may be the dominant voice of the working classes of which Garry and the majority of the offenders belong to. Indeed Skeggs (1997) found that femininity for many working class women is strongly identified with 'caring' as a positive value that was central to their self identity. Skeggs (1997) explains this in terms of limited capital whereby these women have limited resources that limits their competition in the job markets therefore their feminine cultural capital is made up of unpaid labour, often in the guise of carers within families. In contrast the working class model of masculinity consists of physical strength and power (Connell, 2003) where the notion of hegemonic masculinity allows men to dominate women. However Bakhtin would question such gender identities within the relational dialogical context of culture and society. Within this framework, a speaker always involves a social language in producing an utterance and this social language shapes what the speaker's individual voice can say. As highlighted in Chapter Eight this process is termed 'ventriloquation' whereby one voice speaks through another. Therefore, in Bakhtinian terms, it could be argued that the characterisation of Amy offered by Garry reflects ventriloquized voices of traditional femininity. Indeed would Garry draw upon the same kind of discourse if his treatment worker was a man?

Harrè and Moghaddam (2003) point out that 'by positioning someone in a certain way someone else is thereby positioned relative to that person' (p.7). Indeed, in Chapter Six my analysis of the observations of the treatment setting highlighted the stark positions of the female alcohol workers in relation to the male offenders. However, although this male/female positioning was observed during my field observations of the treatment sessions, it seemed that Garry's subjective positioning was in contrast to the way in which I interpreted Amy's performance. Indeed, upon analysing their performances in Chapter Six, it was found that both Amy and Susan resisted positions of the feminine caring role during their interactions with the offenders, rather they took up positions of control in order to successfully manage both the offenders and thus arguably the treatment process. However, this interpretation contrasted with the way in which Garry, and indeed all of the offenders interviewed, appeared to characterise and construct Amy and Susan. Indeed Nigel described Amy as 'like having a social worker'; Shane described Susan as 'a nice lass' who would 'support' him so he was able 'to discuss things and talk about things'; and Dara described Amy as 'lovely and kind'. Therefore, these conflicting interpretations of the way in which Amy and Susan were constructed by these offenders warrants further analysis.

Bakhtin's concept of dialogism maintains that people are immersed in ideology and that their beliefs and values are fundamentally bound up with their daily activities even, according to Holquist (2002) when what they do might not reflect what they believe they are doing. It was indeed interesting to note that none of the offenders interviewed constructed Amy or Susan as being in control or having power over their treatment and possible outcomes (when indeed they both had the power to refer back



to court and consult with probation staff and the health service about their progress). Therefore, what appeared to be distinctive positions of 'power and control' taken up by Amy and Susan in my observations of their roles in the treatment setting, were conversely interpreted as 'care and support' by the offenders. In Bakhtinian terms, an understanding of the opposing conceptualisations of the treatment setting may be in some way related to how the male offenders in this research resisted being positioned as subordinate to women. This may be in part due to the fear of real or imagined judgement from others in relation to their perceived social position. As Burkitt (2008) highlights in his work on social relations and social class;

'bound into this network of moral evaluation are evaluations about one's own self that are, as Bakhtin showed, always dialogically related to the way we imagine that others see us. The way we value ourselves depends on the dialogical relations we have to others and the level of recognition and respect we get from them' (p.150)

Indeed Lundgren (1995) argues that gender is created through social interactions with others throughout the lifespan. According to Lundgren (1995) social factors can act differently for men and women in the same context. Thus, in a patriarchal context, a man socially subordinated to a woman, can still construct himself as superior to her due to cultural gender norms. Therefore, in this argument, the power and hierarchy of gender in some cases outweighs the power and hierarchy of social position. Höglund and Holmström's (2008) study found that men speaking to female telenurses expressed characteristics of hegemonic masculinity (Connell, 2003) where gender

power was used against the nurse's social power. This notion of social versus gender power may indeed reflect how the male offenders in this research perceived their own position of power within the treatment setting. It is therefore, perhaps likely that for these offenders, the social voices available to them in relation to gender discourse have been internalised and have become part of their inner dialogue which has the potential to shape their social reality and interactions with others.

Lorber and Moore (2002) point out that most physicians, both men and women acknowledge the importance of understanding their patients' daily lives, family roles and emotional needs to adequately treat them for physical illness. Nevertheless it has been found that patients still claim to find women physicians more 'humane' and more responsive to their social and emotional problems than men physicians. They further suggest that women physicians tend to encourage participation and interaction and take time to listen to their responses, and in turn patients feel that women doctors are less intimidating and thus can be challenged and interacted with easier. Within a dialogical framework therefore, it could be suggested that Garry has internalised gendered discourse from the public authoritative voices of his cultural background in order to construct Amy within the nurturing professional role. This internalisation has thus resulted in the way in which Garry possibly takes up his position of the 'accommodated' which for Garry, seemingly creates a non-threatening environment and appears to make him 'feel better' about any hopes and fears he may have had about his treatment.

The construction of Amy and Susan as the ‘feminine carer’ resonated throughout many of the offenders stories of their treatment. In Sam’s story, for example, his experience of treatment on the ATR involved interaction with various professionals as he was also assigned to a mental health nurse and had the opportunity on the ATR to visit Steve the Psychiatric nurse once a month;

**Sam:** *I’ve seen Steve (psychiatric nurse) I found it very useful to see Steve erm up at the alcohol unit, obviously Amy’s been there with me, been very understanding towards me and I found it very helpful that both of them have actually sort of turned me around how I feel now*

In Sam’s account, Steve, the psychiatric nurse is constructed as being ‘useful’ in contrast to Amy who is constructed as ‘understanding’. Therefore, although subtle, Sam’s perceptions of Steve and Amy appear to signify the culturally and socially located voices of gender hierarchy in the health care setting (Sebrant, 1999). Steve is positioned as the male ‘useful’ practitioner and in relation to this, Amy is ultimately positioned as the caring ‘understanding’ female who ‘obviously’ goes with him. Thus Amy’s professional role appears to be conceptualised as ‘moral support’. Indeed his narrative conveys an image of Amy as a nurturing, mother figure who would accompany him to see the psychiatric nurse much as a doting mother might do for her child. This was in stark contrast to the practical usefulness that was ascribed to the male nurse’s role.

What was particularly interesting about David’s storying of the activities that he and Susan did together during treatment sessions was the distinctive tone of his narrative

which appeared to downplay any sense of importance in relation to his treatment program;

***Jo:** so did you do goal setting and things like that with Susan?*

***David:** yeah, we went through a little program of aims and objectives and what for ... well when we first started like we did a little drinks plan so Susan could see what I actually was drinking ... everything's been helpful, beneficial, she couldn't have been nicer.*

The application of setting goals in treatment is argued to be important as it enables the practitioner and the 'client' to initiate an action oriented structure for treatment and subsequently increases motivation and positive performance (Miller and Rollnick, 2002). However in David's account there appears to be less importance placed on the value of these exercises. Indeed his utterance conveys a patronising narrative tone which is signified in his deployment of the word 'little' to describe his initial care plan and his drinks diary. His patronising tone and his characterisation of Susan as 'helpful' and nice has the potential to maintain the dominant voices of society which portray women as 'caregivers', rather than seeing Susan as a professional practitioner. David's narrative account of his treatment may also be influenced by the dominant medical discourse that surrounds social practices within the health sector (Allwood, 1996). This may explain why, for David, less importance appeared to be paid to practices such as goal setting and drinks diaries. For David, these activities may not be constructed as trusted measures of treatment compared to perhaps the more 'worthy' and accepted forms of medical treatment such as medical drugs administered by doctors. Indeed alternative approaches to treatment such as a psychotherapeutic model is argued to be viewed by some traditional medical realms as undermining the power and control

of medical discourse (Ray, 2006). Therefore, it could be argued that David's cultural constructions of gender and the health care setting has largely been influenced by dominant cultural voices of femininity and medicalisation, which may in turn, have impacted on how he initially interacted and engaged with his alcohol treatment.

The ways in which all of the offenders appeared to ventriloquise and appropriate conventional feminine voices in their constructions of the ATR was largely identified through their characterisations of Amy and Susan, as in the stories of Garry, Sam and David. Their stories of entering alcohol treatment, and their interactions with Amy and Susan reflected a narrative theme that was arguably a persuasive attempt to resist positions of oppression or subordination by these young women. It appeared that in order to maintain a masculine social identity of power and control, there was possibly a tendency to resist positioning Amy and Susan as having control, and in doing so, they drew upon dominant cultural voices of femininity accordingly. Nevertheless, in Barry's narrative, there is perhaps a subtle indicator that indeed the women were perceived as 'in control', however the reluctance to express this is perhaps a telling reminder of the struggles against monoglossia to resist dominant voices;

*Jo: So nothing bad about it at all?*

*Barry: it was a doddle actually ... no no, Amy's delightful! (both laugh)  
did that [voice recorder] pick it up?*

*Jo: I'm sure it did!*

*Barry: yeah she were very nice! I'll miss her*

As I ask Barry to reflect on his alcohol treatment, I invite him to talk about negative aspects or bad experiences he may have encountered on the ATR. In his response he perhaps senses that I may report his comments back to Amy, his alcohol treatment

worker, and thus constructs her as 'delightful!' However his utterance, framed in a humorous tone suggests that he is perhaps masking his real feelings for Amy. He checks to make sure that his response has been recorded and proceeds to claim, again in a tongue-in-cheek tone, that she was 'very nice!' and finally states that he will 'miss her'. Bakhtin takes all utterances that an individual speaks, as an attempt to convey his or her meaning to the listener, termed the 'addressee'. Barry's tongue-in-cheek approach was therefore perhaps an attempt to convey his reluctance to 'tell on' Amy by disclosing bad or negative experiences for fear of possible repercussions. Interestingly, Barry's construction of Amy as 'delightful' and 'nice' is possibly drawing on cultural voices of appropriate ways in which Barry could comfortably talk about Amy as a woman, especially as his 'addressee' is indeed another woman. However what was evident here was the way in which Barry used humour, seemingly as a way to avoid constructing his treatment experience as anything other than a 'doddle' and perhaps in doing so, senses Amy's position of power and chooses not to jeopardise this, taking on a narrative of 'I don't want to get into trouble'. Therefore, it seems that Barry in his utterances was perhaps mindful of the potential consequence of 'telling it like it is' in relation to his treatment experience with Amy, and as a result positions Amy as indeed powerful and in control.

### **The road to recovery: being treated differently**

Having explored how the offenders appear to conceptualise 'being in treatment on the ATR, it became evident that their relationship with their alcohol treatment workers seemingly contributed to the way in which treatment was experienced. Amy and Susan

appeared to be constructed through a cultural gendered ideology which appeared to normalise hegemonic masculinity (Connell, 2003) and in turn, the positions of power and control taken up by Amy and Susan were resisted by these offenders in their utterances. Moreover, the seemingly positive ways in which both their treatment experiences and Amy and Susan were constructed, could possibly suggest that indeed the ATR was perceived as an easy option for these offenders. Indeed my early scepticism about the success of the ATR began to emerge as I listened to the offenders' positive accounts of their treatment experiences. The majority of offenders deemed suitable for treatment on the ATR were described as 'dependent' (Ashby, Horrocks and Kelly, 2009;2011) rather than 'binge', with some offenders reporting drinking between 6 and 9 litres of strong cider daily. In addition, many of the offenders had other health and social problems and thus were often described as 'entrenched' in relation to their alcohol misuse. Therefore, it would possibly be expected that their treatment experience would, understandably, be constructed as difficult, challenging and fraught with new and often negative experiences. Indeed in many of the offenders' stories, their drinking was constructed as a 'heavy burden' rather than a 'choice'. Utterances such as 'being a slave to alcohol' (Dara); 'getting pissed every day' (Barry); 'its drink, the demon drink ... it was just killing me and clouding my brain' (Sam); and, 'I was drinking more cause I couldn't get off it' (Dave), were illuminating of the characteristic patterns of their alcohol problems, and the realisation of the forceful grip alcohol had over them. Therefore, fears and expectations of going through the potential agony of alcohol withdrawal, and facing stressful life situations without relief was expected to underpin the offenders' stories of their treatment journey. However,

such 'challenges to sobriety' (Burman, 1997) were not evident in their narrative accounts of the ATR.

All of the offenders interviewed had either completed or had almost completed their treatment sentence; however they were still assigned to an offender manager in relation to their community order which can last up to two years. Therefore it was possible that in their attempt to present themselves in the best possible light, they may have drawn upon narratives of 'hero'. Thus caution was applied in accepting their claims of self recovery as a 'doddle'(Garry) or being independent of external voices of the criminal justice system with its potential to punish if expectancies are not met; indeed if they fail to engage or attend treatment, they may be sent back to court for further sentencing. Thus it could be argued that these offenders were simply 'ventriloquising' a culture that expects rehabilitation to encompass discourses of positive self-change. Nevertheless, it would be inappropriate to suggest that the offenders' stories of their treatment were not valid. Yes, it appeared that there was resistance to accept that Amy and Susan were in positions of power, however, the offenders' feminisation of them did not appear to take away the importance of the support structure of the ATR that Amy and Susan offered and effectively managed. Thus although the offenders may have perceived their relationship in ways that served to conserve their masculine identity, they did nevertheless appear to find the ATR enabling.



### **‘I were hoping for a happy pill’: moving beyond the medical**

As part of treatment on the ATR, all offenders who are classed as ‘dependent’ have the opportunity to undergo an alcohol detoxification with the support of the alcohol treatment workers and medical assistance from the District’s Alcohol Team and local general practitioners. However, this procedure accounts for only a small part of how treatment is delivered on the ATR. The majority of alcohol treatment focuses on support and counselling which is offered throughout the duration of the ATR (Ashby *et al.* 2011). Openness and flexibility is embedded within the approach in order to support offenders in achieving their personal goals. More importantly, if offenders experience relapse, rather than obsessing on potential failures (which can often be the case in drug treatment programs where positive drug tests have the potential to lead to further punitive measures) they are encouraged to re-examine their current situation and select new and appropriate goals accordingly. Thus, rather than locating alcohol treatment within the medicalised model of medicine, the ATR frames its practice largely within a therapeutic model of ‘self-change’ (Horrocks, 2002).

In returning to David’s story, my earlier analysis of his possible medicalised perception of the ATR becomes evident as he narrates the beginning of his treatment journey. David’s account of what he and Susan did together when he first attended the ATR was particularly noteworthy as his construction of treatment appeared to be firmly located within the authoritative voices of medicine as a treatment strategy;

***David:** I was actually drinking too much to start on medication so I had to cut down, so that were, that's only point I felt let, disappointed erm when Susan said 'you can't stop', I were hoping for a happy pill to stop like that [clicks fingers] but you have to cut down gradually which I did, but I were just so determined and hell bent on stopping*

David narrates his early experience of the treatment as a disappointment. His expectations appeared to echo the medical model of treatment where 'happy pills' are handed out and the patient is treated in order to 'cure' the illness. Thus his disappointment was perhaps partly due to the realisation that his goal to stop drinking may take longer than he initially anticipated. His narrative theme of the 'happy pill' therefore resonates with the metaphorical image of applying a sticking plaster to a much more complex problem. What is also particularly important to note here is that Susan, his alcohol treatment worker, would not have been able to make such a professional judgement without an accurate account of David's daily alcohol consumption. It was more than likely that Susan's decision to advise David to reduce his alcohol intake was due to the high levels of dependency he was experiencing. Indeed severe alcohol withdrawal can be potentially life-threatening (Curtis, 2009). Therefore this highlights the importance of the drinks diaries in enabling Susan to treat David safely and appropriately. Moreover, David's construction of the ATR as a medical model of treatment was noteworthy as his previous attempts to get help for his alcohol dependency from his doctor was not successful. On the occasion that he visited his doctor, he says he got a 'fob off' from his doctor and 'a blunt fob off as well'. Perhaps for David, specialised alcohol treatment on the ATR was a way of obtaining the medication he possibly expected to receive from his doctor. However he is quickly

told that he would have to reduce his alcohol intake to a safer level without pills, and was quick to convey his compliance in relation to Susan's prognosis, by uttering 'which I did', thus positioning him as a 'good patient'. Therefore it seems that David's 'determined' attitude to stop drinking and the trust that he appeared to invest in Susan's approach to his treatment perhaps enabled him to actively embrace alternative ways of re-constructing and experiencing his treatment journey.

The dominant voice of medicine and the discourse and practices that medicine makes available in relation to treatment were echoed throughout the offenders' stories. Cherry narrated her experience of past attempts to seek help for her alcohol consumption as a voluntary client before being sentenced to the ATR;

**Cherry:** *I did cut down, I went to see somebody in [voluntary] drink team, I didn't take any tablets then or anything then, I just stopped on my own and cut down gradually and gradually but then just started again, but I don't know why, there were no reason for starting again.*

Cherry appears to construct treatment within the medical model, however she resists the authoritative voice of the medical profession by refusing to take the 'tablets' and managing to stop drinking on her 'own'. Her resistance to conventional medical treatment therefore positions her as a 'martyr' in relation to those who would embrace medical interventions in order to ease the suffering of withdrawal symptoms. Nevertheless although Cherry's narrative signifies agency in relation to her choices to access treatment and resist medication, she is conversely positioned as passive when her attempt to remain sober fails. Indeed this shift from 'heroine' to 'victim' resonated throughout Cherry's narrative in relation to her alcohol problems. What was

interesting to note in the above excerpt was the way in which Cherry appears to be constrained within her own narrative in relation to searching for a reason as to why she began drinking again. Her narrative conveys imagery of being alone, and the tone conveyed in the content of her experience suggests that she was restricted both in help and dialogue to make sense of her return to alcohol. Indeed her story of her earlier treatment experience is in stark contrast to the way in which she constructed treatment on the ATR;

***Jo:** How have you experienced the ATR with Susan?*

***Cherry:** I've thought a lot, because Susan sits talks to you about, and its not just about your drinking, its how your feeling how this will affect that and how ... like when I went before, nobody explains all different things to you ... its like Susan said 'well buy a smaller bottle, use a smaller glass, water it down'. All different techniques and different stuff which is totally different to what I was getting before ... it's like the difference with talking to [partner] about it cos before I would just go down to shop and get a bottle of wine, but then after I'd come here for a few times I'd say to [partner] 'I'm really craving a drink its you know its really getting to me' whereas before I wouldn't*

For Cherry, her experience of the ATR has enabled her to open up into dialogue with herself, Susan and her partner. It appears that through the ATR, Cherry has begun to realise that self-change can be a complex process which cannot be reduced down to 'just about your drinking'. Her narrative conveys an image of social support and openness rather than the closed off 'being alone' image of her earlier experiences of entering voluntary treatment and therefore she narrates herself as able to manage tough situations without alcohol. It is perhaps worth being reminded at this stage that having been charged with an offence and subsequently sentenced to treatment, there is perhaps the opportunity to enter into a dialogue that reflects the aims of the

treatment program, the courts and the probation service. Therefore as Horrocks *et al.* (2004) suggest, coercive treatment anticipates change and for those who enter into treatment, they have the opportunity to enter into dialogue that may lead to particular narratives. This is not to suggest that offenders' narratives are simply a consequence of alcohol-related offending, as clearly these offenders were in need of assistance due to their 'entrenched' and complex lives as a result of alcohol misuse. Rather it appears that the ATR is enabling in that it offers offenders the opportunity to develop and extend their narrative identities. Indeed Horrocks *et al.* (2004) suggest in their research on coercive treatment for drugs misuse that;

'it may be that entering coercive treatment provided access to a different storying of the self. Participants are able to tell a different story about themselves and are also able to tell a different story to themselves' (p.350).

Cherry's narrative appears to have adopted the authoritative voices of others and has appropriated them as her internally persuasive voice. Cherry's story signifies how she is able to 'enact a story of linear progress' (Horrocks *et al.* 2004, p.350). A re-framing of her experiences of alcohol dependency was elaborated in order to promote a redefinition of her, now, active role in her recovery. Being able to talk openly about her feelings to both Susan and her partner signifies the way in which Cherry has progressed in her treatment journey. Thus these enacted 'tellings' of progress, like Horrocks *et al.*'s (2004) research, depict much more than ventriloquation of authoritative voices. Rather they have become internalised and personalised through a

treatment setting that appears to understand the socially situated complex nature of individuals with alcohol misuse problems.

## Summary

In summarising, this analysis has revealed interesting insights into how the offenders appeared to construct and conceptualise treatment on the ATR. It seems that throughout the offenders' accounts there were links between how the offenders' dialogical self was constructed in relation to the female treatment workers, and how this in turn has possibly influenced their treatment experience. In considering the delivery of the ATR as a 'gendered practice' it appears that through their constructions of Amy and Susan as the 'feminine carer' they are able to engage and respond to treatment without possibly feeling that their masculine identity is under threat. Therefore it would seem that engagement in treatment becomes a dialogical exchange in relation to gendered identities. Nevertheless, It seems that in order to understand their subject positioning, there is a need to consider the way that these offenders are already positioned at the outset of their interactions (Taylor, 2005). The context in which I met the offenders can place 'prior positions' on them which may constrain or influence certain ways of telling. Indeed before meeting them, they were positioned as offenders bound by rules and regulations of the probation service and thus perhaps saw themselves through others as 'powerless'. Therefore drawing on dominant voices of gender in their stories may have enabled these offenders to regain a sense of power and control considered to be a dominant acceptable position within their socially located lives.

Moreover, the way in which the treatment was delivered enabled the offenders to resist the 'monoglossia' of the medical model of treatment. Indeed through Bakhtin's notion of 'heteroglossia' the ATR has perhaps made available an alternative voice of treatment that the offenders are able to embrace and internalise. Thus how the offenders engaged with this particular treatment model is what the next chapter will aim to address.

## **Chapter 10: (Re) constructing an alternative dialogue: adding another voice to the repertoire**

### **Introduction**

In this final section of the interview analysis, the treatment model employed by the ATR will be explored in relation to the offenders' subjective experiences of undergoing coercive treatment within the probation setting. The previous chapter explored how the treatment setting was constructed and experienced by the offenders as they talked about the beginning of their treatment journey. This chapter moves on to focus on 'motivation to change' and thus how the offenders narrated their dialogical selves towards the end of that journey. All of the offenders interviewed had either completed or were near to completing their treatment at the time of the interview. Therefore each offender had the opportunity to talk about and reflect on their current life experiences after having undergone a considerable amount of alcohol treatment (consisting of approximately 6-12 months) on the ATR. The apparently flexible and open approach to treatment on the ATR is explored, and this chapter ends by considering how coercive treatment has the potential to enable individual identities to be reinterpreted and reconstructed through the dialogical exchange that occurs within the treatment setting.



## **Stories of change within the dialogical landscape of coercive treatment**

Stories of change featured heavily in many of the offenders' accounts of their treatment experiences on the ATR. In analysing these stories, it was again useful to return to Bakhtin's (1981) notion of social heteroglossia as, Thibault (2006) suggests that in doing so, it encourages and invites the analyst to understand the wider field of intertextual relations within which individual narratives are constituted and negotiated. Indeed Thibault acknowledges that:

'In selectively engaging or negotiating with diverse social voices and their values and in reenvoicing or adaptively modifying these in their own internal dynamics, agents construe intentions and then enact them as a flow of goal-seeking activity. Action is thus seen to be a function of the agents' affective identification and alignment with and ideological positioning in relation to some voices rather than others in the overall system of heteroglossia' (p.42)

Thus according to Thibault (2006) the offenders' intentions, moral judgements and decisions are made in and through the voices afforded by the system of social heteroglossia. Therefore, it could be suggested that for these offenders, stories of change are located within the 'ideology' of the criminal justice system where punitive discourses predominantly guide criminal justice processes (Whitehead, 2010). Indeed considering that these offenders were sentenced to treatment through the criminal justice system, where suitability is based on the individual's motivation and readiness to change, it was to some extent expected that stories of change would feature in their

narratives. Inherent in such a sanction as coercive treatment is the underlying assumption that the offender is in need of 'rehabilitation'. Dialogically, within the discursive landscape of the criminal justice system, the dominant discourse of 'the bad offender' and the authoritative voice of the criminal justice system as 'punitive' prevails. Thus the court plays a major legitimating role in framing offenders as the 'criminal other' (Garland 1996). Garland's (1996) understanding of the 'criminology of the other' as a construct takes the view that 'offenders are viewed as alien others which represent criminals as dangerous members of distinct racial and social groups which bear little resemblance to 'us'.' (p.461). Within this discursive framework of the 'morally superior' criminal justice system and the 'bad' offender, there emerges an authoritative discourse of *behaviour change*. Behaviour change is viewed as an important factor in sentencing outcomes (Ashworth, 2010). Indeed within the field of the criminal justice system, requirements such as the ATR are aimed at reducing recidivism by helping offenders change their criminal behaviour. Notably, Hugh, Jacobson and Millie (2003) found that a large part of decisions made by magistrates were based on the 'moral quality' of the offender, that is whether the offender was motivated to stop offending or not. The moral status of the offender is thus constructed as 'immoral' (i.e. in need of punishment) but the offender is also constructed as 'in need of help' to change their ways (i.e. needing treatment). Indeed Thibault (2006) suggests that individuals construct their identities according to the ways in which they align with, conflict with, or co-opt with particular voices in the overall system of heteroglossia.

As the authoritative voice of the criminal justice system discursively locates and frames offenders as 'bad people' who must be seen to be punished. It could be argued that this authoritative voice may carry more weight than that of the offenders' at the point of sentence, as indeed offenders who are seen to align with the voice of the criminal justice system would be seen in a more favourable light than those who resist it. Thus it could be suggested that offenders at this point ventriloquise voices of the criminal justice system. Thus, stories of change in relation to the offenders' experiences on the ATR need to be considered within the discursive landscape of the criminal justice system and the coercive treatment setting. Indeed how can behaviour change be understood when the idea of 'change' or treatment is constructed as 'forced' in that they are faced with 'an offer they cannot refuse' and therefore must be seen to align themselves with discourses of 'change' and 'rehabilitation'? Moreover, are offenders on the ATR able to construct their own concept of behaviour change or is behaviour change constructed within the authoritative voice of the criminal justice system where offenders are simply told what they 'should' do in order to bring about change? Finally, to what extent are offenders able to re-author their self identity within the dialogue of the treatment setting, and to what extent are they constrained within the power dynamics of the criminal justice system and the coercive nature of the ATR?

Returning to Bakhtin (1981) and the dialogical self, it is argued that individual voices draw upon a wide range of complex discursive resources, or different languages that are enacted and occur in everyday life. This heteroglossia has the potential to manage

the meaning of an utterance and thus as a result Holquist (1990) suggests that dialogism:

‘... assumes that at any given time, in any given place there is a set of powerful but highly unstable conditions at work that will give a word uttered then and there a meaning that is different from what it would be at other times and in other places’ (p.69)

Moreover, in a Bakhtinian approach to interpreting psychological understandings the notion of ‘authorship’ is important (Horrocks *et al.* 2004) as the narratives told about one’s life are seen as a dialogical relationship involving both self and other. Thus, as explored in Chapter Seven, self is no longer seen as a product of a single monotonic voice, but rather is the result of the emergence of the interaction that occurs among *authoritative* and *internally persuasive* voices. This final analysis therefore aims to explore how authoritative voices of both the criminal justice system and the coercive treatment setting impact upon the way in which behaviour change was constructed and experienced by the offenders on the ATR.

### **Locating stories of change**

It was considered in Chapter Seven how the offenders’ storying of their past lives previous to the ATR was dominated by the cultural voices of their communities which seemed to ‘normalise’ alcohol consumption and the ‘quest for drunkenness’. Such ‘normative narratives’ that surrounded male performance and alcohol consumption

was not challenged by their own culture. Indeed alcohol, masculinity and drunkenness appeared to be an accepted element of community life. Thus it was evident that the dominant voices of their community were ventriloquized in their stories of alcohol use/abuse. However, as the offenders began to narrate their experiences on the ATR there was a distinct shift in the way in which their alcohol use was constructed. Substance abuse such as alcohol is arguably the product of interconnections between the multiple heteroglossic discourses within which alcohol abuse is situated. Indeed alcohol use/abuse is constructed everyday as either acceptable, normative or in other less accepting ways which can often be dependable upon where and when the constructions are made (Gergen, 1994).

Stories of change in this instance were narrated at a time when the punitive gaze of the criminal justice system would be upon the offenders. The punitive discourse of the criminal justice system therefore positions the offenders as less eligible subjects, in need of control and restraint. Therefore, in analysing the offenders' stories of change, the overall system of social heteroglossia was considered. In other words, was there a shift evident in relation to whose voice the offenders align themselves with as a result of being sentenced to the ATR? Moreover, does this shift influence Thibault's (2006) notion of 'reenvoicing' (p.42) in order that new, alternative stories become normative narratives?

### **Reaching rock bottom: normative narratives of change?**

It is well documented that often the motivation to engage positively in addiction treatment is a direct result of an experience or 'turning point' in a person's substance misuse career. Studies have highlighted that drug and alcohol abusers often report a 'rock bottom' experience and there becomes a point where the decision to give up drugs is made/consolidated (Taïeb *et al.* 2008). These turning points are often found to accompany, or precede, some experience or event that stimulates or triggers the decision to change (Blomqvist, 2002; McIntosh and McKeganey, 2002). Indeed, in Burman's (1997) study on 'natural recoverers from alcoholism and problem drinking' (p.41) her respondents narrated a significant crisis, or an accumulation of distressing events leading up to their transition to sobriety. Further studies such as Shinebourne and Smith (2010) and McIntosh and McKeganey (2000) have also highlighted how significant negative events or 'existential crises' (p.1507) are a common feature of recovering addicts' narrative emplotments. Thus it seems that turning points represent normative narratives in relation to behaviour change, located within the heteroglossia of addiction treatment.

Moreover, in relation to recovering 'addicts' it is argued that individuals draw on past performances as discursive resources (Menard-Warwick, 2007) where an attempt is made to re-interpret how things were in the past which enables the coherence and significance of those experiences to be explored. It appears that through their narrations, these offenders were able to make explicit 'judgement evaluations' (McIntosh and McKeganey, 2000) about their past behaviour in relation to their

alcohol misuse. Indeed metaphors of hitting 'rock bottom' and reaching low points were echoed throughout the offenders' stories in this research, specifically during accounts of their behaviour prior to treatment on the ATR. However, although the offenders' narratives were considered to be their own unique stories, it should be noted, as argued by Frank (1995) that these stories are composed by adapting and combining narratives that cultures make available.

Cherry constructed her situation before being sentenced to the ATR as 'reaching rock bottom'. Towards the end of her interview she began to reflect on the events that lead up to her arrest and subsequent appearance in court;

***Cherry:** I ended up hitting three people but I can only remember hitting one ... I was very, I wasn't just in drink, as well I was suffering from severe depression which the drink didn't make it any better, in fact it made it worse ... I knew on that night, after going to court I knew I was in trouble ... I was so low that day I just didn't know what to do, well I was so low at that time... and I was scared.*

Cherry narrated her story of violence, alcohol and depression as spiralling out of control where she 'ended up hitting three people'. Although she attempted to lay blame for her behaviour as being in part, due to her 'severe depression' it was clear that ultimately she could not deny that her alcohol consumption 'made it worse'. The narrative tone (McAdams, 2003) Cherry used to convey her story suggests that she recognised the gravity of her situation and constructs this low point as confusing and frightening. Indeed her narrative exemplifies a vivid image of reaching 'rock bottom', where her behaviour had become uncontrollable. However what was evident in

Cherry's story was that her appearance in court seemed to be constructed as the defining moment where a low point was reached; 'after going to court I knew I was in trouble ... I was so low that day'. Thus it seems that Cherry was beginning to ventriloquise the authoritative voice of the criminal justice system which was signified through her narrative where, after visiting court she was positioned as 'as bad as it gets' and someone who is 'bad person'. Indeed the authoritative voice of the criminal justice system as punitive may have, to some extent, resulted in Cherry feeling 'scared' about the consequences of her behaviour particularly in anticipation of being sentenced in court. It seems therefore, that narrative accounts of reaching 'rock bottom' located within the dialogical landscape of the criminal justice system offer some useful insight into the way in which authoritative voices have the potential to construct individual experiences. Indeed in a Bakhtinian (1981) sense Cherry is able to make sense of her experience through an act of ventriloquation. Being sentenced appears to legitimise the position of 'bad person', thus going to court is experienced as 'this is as bad as it gets' as this is where punishment will be served. Cherry's co-constructed understanding of her behaviour, located within the discursive landscape of the criminal justice system, enables stories of 'reaching rock bottom' and 'change' to be mobilised. Thus Cherry's story is one example (and there were many others) of how social heteroglossia and the dominance of one voice over another, can enable experiences to be reconstructed, and thus re-enacted. Indeed would Cherry have constructed her behaviour as reaching rock bottom in the absence of the voice of the criminal justice system?



Similarly, the metaphorical equivalent of 'reaching rock bottom' was drawn on in David's narrative in order to convey his life situation before being sentenced to the ATR, narrated as 'being down in gutter'. In David's account the repossession of his house was constructed as a trigger for his increasing alcohol consumption, offending behaviour and subsequent ATR sentence;

**David:** *we had our house repossessed, which is probably what kick started all this ... I've been down in gutter seeing nothing. First time I met Susan I burst into tears, but that's how low mood, I used to break into tears everywhere, on buses, taking kids to school, walking dog, you name it.*

David's narrative not only conveys an image of reaching a low point, it also conveys his struggle to see things clearly during heavy drinking periods, constructed here as 'seeing nothing'. There was a sense of his alcohol consumption 'blurring his vision' perhaps both physically and metaphorically, positioning him as 'weak and vulnerable' at that point in his life. Indeed David recalled his early sessions with Susan as a 'blur' and emotionally challenging. However interestingly, further on in David's narrative, it was evident that the consequences of being sentenced by the courts was also constructed as an uncertain and worrying time which may have contributed to his low mood;

**David:** *well, I was a postman and I threw some mail in the council skip, that's what I did, his [solicitor] opening line was 'postmen always go down'. I was too dependent on alcohol and if they'd have sent me down I don't know what would have happened, what I would have done. I've no idea how they treat it in a prison. I wouldn't have thought they'd let you out in prison.*

In David's narrative above, his solicitor arguably represents the authoritative voice of the criminal justice system where punishment was constructed as 'inevitable' due to the nature and severity of his crime, 'postmen always go down'. David's narrative of his experience of the time leading up to his court appearance seems to be informed by the dominant discourses of the criminal justice system. Within this framework David's fate appeared to be sealed, it seemed that he had no options other than prison and no reference as to how he might have coped with prison life. As with Cherry's story, David's alignment with the voice of the criminal justice system is evident here, particularly in his 'self diagnosis' in relation to his alcohol consumption 'I was too dependent on alcohol'. As Thibault (2006) suggests, David has adopted and identified with the voice of the criminal justice system rather than perhaps the previous voice of his community and friends. Thus David's moral judgement about his alcohol consumption is re-formulated through the voice of the ATR, evident in his storying of reaching rock bottom.

When Sam was asked about his experience of alcohol treatment on the ATR, part of his response involved an evaluation of his past behaviour:

**Sam:** *I never realised, I'd sunk so low because I used to drink cider, nine litres a day ... it made me think what I was drinking, the amount I was drinking, who I was drinking with ... I had to pull myself away from that.*

Like Cherry and David, Sam's evaluation of his past alcohol consumption was narrated as a 'low' point. Sam's narrative of his alcohol consumption suggests a movement or a journeying towards the potential of reaching rock bottom, 'I'd sunk so low'. However

what is also evident in Sam's narrative is the way in which he draws upon the ATR as a way of mobilising a coherent narrative that positions him as 'taking responsibility'. Craib (2003) argues that there is a need to have a coherent narrative and that a coherent narrative 'has a sort of reflexive rhetorical dimension, in which the narrator justifies him or her self' (p.3). He further argues that when we interview people they will produce the stories we want to hear. Thus again in a Bakhtinian (1981) sense it could be argued that Sam has also entered into the act of ventriloquising the dominant voice of the coercive treatment setting where factors such as alcohol consumption levels and the offender's social lifestyle would have been challenged. Therefore through the discursive framework of the criminal justice system and coercive treatment, Sam seems to be able to mobilise stories of having reached 'rock bottom' and 'engaging in change' in order to make sense of his ATR experience. Indeed Sam's story does suggest that treatment on the ATR enabled him to reflect and construct his past behaviour as negative and in need of change, perhaps made possible by the joint production of new meanings available within the social heteroglossia of alcohol treatment.

It was indeed interesting to find that during the offender interviews many of the stories told, drew on metaphors such as 'reaching rock bottom' which seemed to signify a 'turning point' in the way they constructed their alcohol use. In exploring the uses of metaphors in narrative accounts of addiction, Shinebourne and Smith (2010) conclude that such metaphors are;

‘inevitably informed by and articulated through the discursive frameworks of the agencies and recovery groups they are involved with, as well as the wider cultural, political and popular discourses of addiction and recovery’ (p.68).

For Bakhtin, the metaphors and discursive resources become unique and individual as they are internalised and appropriated for that person. Thus it can be seen in the previous excerpts that in Bakhtinian terms, the voices of addiction and recovery were possibly appropriated and internalised by the offenders and to some extent seemed to become the individuals own semantic and expressive intention. Moreover, it seemed that an important part of the offenders’ attempts to ‘fashion a non-addict identity’ (McIntosh and McKeganey, 2000) involved reinterpreting various elements of alcohol use in for example, a negative light. Part of this seemed to involve re-interpreting their experienced effects of alcohol, from something that was perceived as enjoyable and exciting, to something that was constructed as damaging and harmful. Indeed it could be argued that these evaluative judgements narrated by the offenders were an important part of their narratives of change and recovery. Nevertheless as it is suggested above, words take on their meaning within the context of an ongoing relationship. Thus as highlighted here, the offenders’ stories are perhaps the result not of individual action and reaction, but of joint-action brought about through understandings that are ‘culturally sedimented’ (Gergen, 1994). In this sense *justice* and *morality* within the criminal justice system arguably play a key role in how these offenders have constructed and made sense of their treatment journeys on the ATR. Indeed stories of change and reaching rock bottom seemed to enable these offenders

to demonstrate that they were no longer the same person they perhaps were when they were misusing alcohol. Thus reenvoicing (Thibault,2006) in this way arguably makes available new positions of a morally acceptable person within the culture of the criminal justice system.

Horrocks (2002) suggests that when trying to understand the complex nature of drug misuse, it is vital to gain an understanding of the way in which individual lives are socially situated within an ongoing and developing story. It appears that in many of the offenders' narratives, there was a sense that their stories of reaching rock bottom were situated within the dialogical landscape of the criminal justice system. In this sense, rather than assuming that the offenders' alcohol consumption resulted in rock bottom experiences, it is argued that the authoritative voice of the criminal justice system as 'punitive' has been internalised by the offenders who ultimately construct and experience being sentenced to the ATR as reaching rock bottom.

Thus again as with the majority of the stories told by these offenders, their normative narratives previous to the ATR, located within a community and culture of acceptance to excessively consume alcohol, seemed to be no longer acceptable within the dialogical landscape of coercive treatment. Nevertheless enabling a space for offenders to re-evaluate can, argues McIntosh and McKeganey (2000) provide the potential for the individual to reflect upon some of the most painful aspects of their life as an addict or in this case an alcohol misuser. Therefore it is suggested that for many of these offenders, the ATR at the very least enables an alternative dialogue to

be entered into. Indeed it has been argued that the coercive element of the ATR enforces regular attendance consequently increasing the potential for behaviour change. Therefore offenders who stay on the ATR are in the position of 'attendance' and thus have an opportunity to 'story' differently.

### **'Just being there': listening to active agents**

In Chapter Nine it was argued that through dialogism, self change can occur as a result of 'mutual authorship' in that voices of others can be part of an interaction where voices of the self can become 'active' during social interaction. In addition, in this chapter so far, Bakhtin's (1981) notion that society is always linguistically diverse or heteroglossic has been explored. Moreover it has been considered that the offenders on the ATR have the opportunity to engage in an alternative dialogue within the treatment setting that gives voice to different social positions, interests, values and social practices associated with such voices. Indeed according to Gergen and Gergen (1983) the social constructionist model maintains that meanings and understandings are born out of a co-construction of events, negotiated through social interaction and achieved through social consensus. Thus meanings constantly evolve in relation to the social context of a given interaction in which they emerge (Gergen and Gergen, 1983). Yet as the treatment on offer is delivered within a coercive framework, it seems necessary to consider how the tension between treatment and control influence the dialogical process.

## **Coercive treatment, paradox or productive?**

Here I would like to briefly return the question posed earlier in this chapter and consider whether offenders are able to re-author their self identity within the dialogue of the treatment setting, or whether they are constrained within the authoritative voice of the criminal justice system and the coercive nature of the ATR. It may indeed seem problematic to consider how ‘treatment’ under coercive controls can maintain success. DiClemente *et al.* (2003) highlight the notion that psychosocial treatment for addictive behaviours is dynamic in nature. Fish (2006) writing on US drug policy takes the firm view that coercive treatment does not work. He argues that:

‘ ...coercive treatment should be ended because it undermines the institution of therapy and the honesty, trust and confidentiality upon which it is based. In coercive treatment clients must pretend to participate in therapy in order to avoid punishment; therapists must pretend to be working for their clients when they are really agents of the state ... such therapy is a sham.’ (p. 170).

Indeed in the previous section it was suggested that the authoritative voice of the criminal justice system has the potential to shape how the offenders construct and experience treatment on the ATR. As a dominant cultural voice largely seeped in punitive discourse, the question of how effective enforced treatment under the processes of the criminal justice system can be in relation to bringing about desired behaviour change must be considered. Fish (2006) clearly takes the view that attempting ‘therapy’ within this framework is unethical and ‘undermines’ the

fundamental elements inherent within the field of therapy. Thus there seems to be some tension between the current punitive emphasis of penal discourse within court practices, and the need for the probation service to promote more community based responses to offending and rehabilitation (Whitehead, 2010). Indeed Whitehead (2010) has noted how this tension often occurs within probation, yet he also highlights how modern probation seems to be contributing to changing the existing penal discourse of the criminal justice system. As the ATR is based on both treatment and control and is delivered within the probation setting, it was interesting to explore how the offenders constructed their treatment experiences. But before this is considered, a note on how the treatment was designed to be delivered on the ATR will be briefly explained.

### **Flexibility and openness on the ATR**

The ATR was designed to be flexible unlike coercive treatment for illegal drug use. For example unlike drug treatment and testing orders, treatment on the ATR does not rely on testing for alcohol and anticipates changes in the offenders' goals and drinking behaviour during the course of their treatment. Moreover on drug treatment programs the main objective is to become drug free with the view that more drug free days translates into more crime free days (Carver, 2004). This is in contrast to the ATR which also considers 'controlled drinking' as an appropriate treatment goal for some individuals. Indeed the flexible nature of the ATR has been found to be an important element relating to the success of the program (Ashby, Horrocks and Kelly, 2011). Moreover, it is argued that for individuals who may have previously avoided alcohol



services or were unsuccessful, the ATR may encourage them to engage more successfully once they are aware that they would not be coerced into abstinence.

It can thus be argued that by offering controlled drinking as an additional treatment option makes available more personal choice which enables more individuals to be open to addressing their alcohol problems. In this way, the delivery of the ATR has been described as 'flexible' in that the alcohol treatment workers are able to work on a more *individualised* basis where realistic treatment goals can be set. For example, an offender may initially want to undergo a detox to become alcohol free (this may be understandable given the dominant discourse of change within the criminal justice system) yet may initially relapse. In this instance the offenders' treatment goals can be re-addressed on the ATR and new more realistic goals can be subsequently agreed such as a reduction program. Indeed interestingly, it was found that out of 81 offenders explored on the ATR, 70 per cent completed their treatment (Ashby, Horrocks and Kelly, 2011). This is considered to be a relatively high retention rate in comparison with other treatment programs and probation orders (Home Office, 2003; Ministry of Justice, 2009). Therefore the coercive element of the ATR in this instance provides the potential for offenders to attend and thus engage over a longer period than perhaps would be evident in the voluntary sector. Nevertheless that is not to say that the alcohol treatment workers were not in control here. As was evident in Chapter Six, both Amy and Susan were observed as taking control of these offenders. Thus 'flexible' in this instance refers to the broadening out of the treatment (as discussed in

Chapter Two) and the positive approach to individualised goal setting that is embedded within their ‘treatment’ approach

### **Moving on to the dialogical relationship**

As the offenders narrated their treatment stories during their interview, it was interesting to find that within their therapeutic relationships (with either Amy or Susan) there was very little evidence to suggest that intensive coercive controls were exerted upon them. For example none of the offenders talked about feeling pressured to remain abstinent or felt that the ATR was too intensive and controlling, i.e. being *told* what do. Indeed the offenders’ narratives appeared to suggest that the opposite was occurring. When the offenders were invited to talk about the treatment sessions with Amy and Susan, it was evident that controls over treatment or having to comply to specific treatment regimes were not included in their stories. For example Shane was asked to think of any negative aspects of the ATR he may have experienced, he replied by claiming ‘it was all good’ nevertheless I probed him further:

***Jo:** So there’s nothing else you would have liked to change about the way she [Susan] went about it?*

***Shane:** No I don’t think there would have been a right lot she could have done for me anyway rather than just be there and like, be there to listen to, that’s about it really*

When I interviewed Shane he had just completed six months of treatment on the ATR. He received a six month prison sentence prior to starting his ATR and was therefore sober when he began his alcohol treatment. Shane had talked about the difficulties of

not receiving any help for his alcohol problem during his prison stay and therefore framed his prison experience within the dominant voice of the criminal justice system where punishment rather than support was experienced and narrated. However conversely in his narrative the way in which Shane constructed Susan's role as 'just being there' signifies an alternative voice located within the therapeutic discourse of 'care and support'. Indeed Shane's narrative enables him to be positioned as 'expert' as he claims that 'I don't think there would have been a right lot she could have done for me anyway'. His evaluation could be construed as rather arrogant and self assured 'I know what's best for me', however perhaps what Shane was actually conveying here is a recognition that he was responsible for his recovery, and that Susan cannot do it for him. Thus what appears evident is that Shane has re-interpreted his ATR as 'being in therapy'. Indeed within the social heteroglossia of therapy, client 'as expert', 'just being there' and 'accepting responsibility' are dominant discourses located within the therapeutic community (Anderson and Goolishian, 1992; Gehart, 2010). Thus it seems that Shane has indeed internalised these therapeutic voices through the dialogue of the treatment setting where a space is created for enabling other persuasive voices to be internalised and enacted. The therapeutic voice was echoed throughout the offenders' stories of treatment on the ATR where Amy and Susan were constructed as 'just being there';

**David:** *err ... Susan's helped me and talked me through it and motivated me and I actually listened, she's someone I've not really had and erm just being there really ... its not just about getting an order out of the way ... its all been helpful its all sort of a roll on effect, you stop drinking and you see things ... I couldn't have done it on my own, no way.*

David acknowledges that Susan was able to help him and motivate him to change his behaviour and indeed at the time of the interview he was alcohol free. He was able to acknowledge that treatment for him was not just about 'getting an order out of the way' it was about opening his eyes to perhaps new possibilities 'you stop drinking and you see things'. However *how* Susan helped him and *how* she motivated him is not specifically described here. Indeed like many of the offenders' accounts it seemed that attempts to describe what Amy and Susan 'did' during treatment was not easy to articulate. At the beginning of David's narrative above, he took some time to think about what it was that Susan *did*. And although he narrates Susan as 'just being there', he does recognise that he would not have been able to remain sober without her 'I couldn't have done it on my own, no way'. Therefore once again like Shane's narrative, David's narrative of 'just being there' seems to be a ventriloquation of the therapeutic discourse and the authoritative discourse of support viewed as important within the process of recovery.

It therefore appears that the ATR is providing a therapeutic (ex)change through dialogue and the 'therapeutic conversation', suggested by McNamee and Gergen (1992) to be a social construction. The process of therapy within this approach maintains that a therapeutic conversation entails a mutual search for understanding and exploration through dialogue of 'problems'. Thus it is said to be a mechanism through which the therapist and the client participate in the co-development of new meanings, new realities and new narratives. Anderson and Gooloshian (1992) argue that the therapist's role is to create an environment where free conversational space is

created to enable an emerging dialogical process in which this newness can occur. Therefore the emphasis is not to 'produce' change but to allow space for conversation as Gehart (2010) states 'as long as conversations are dialogical, change and transformation are inevitable (p.408). Therefore Amy and Susan constructed as 'just being there' symbolises much more than mere presence. Thus it can be argued that what they were offering was something much more complex during their social interactions with these offenders.

### **Trusting in treatment: therapeutic conversations of alcohol 'use' not 'abuse'**

McNamee and Gergen (1992) argue that the exchange in therapy is the dialogical creation of new narrative and therefore the opening of opportunities for new agency;

'The transformational power of narrative rests in its capacity to re-relate the events of our lives in the context of new and different meaning. *We live in and through the narrative identities that we develop in conversation with one another* [author emphasis]. The skill of the therapist is the expertise to participate in this process. Our 'self' is always changing' (p.28)

Thus change is centred on co-created meaning, however change can encompass a broad range of treatment goals (Miller, 1999). Thus it could be argued that offering only one treatment option i.e. abstinence could prove detrimental to engage with treatment services. In contrast to past conceptions of treatment success, rather than

success being focussed solely on a person becoming abstinent, treatment goals and recovery are said to be multifaceted (White, 2000). Thus there are different definitions of recovery and it is argued that these varied definitions can have, clearly, different implications for both practice and research (White, 2008). After talking to both alcohol treatment workers it was clear that treatment success on the ATR encompasses a range of 'successful' outcomes. Indeed Susan stated that treatment success is

*'different for different people, the ATR aims to reduce harm to themselves and others around them, if that means reducing from 9 litres of cider a day to three litres then that's what we will do. Alcohol detox is not for everybody, we take each as it comes'.*

When I asked Amy what she considered to be a successful outcome, she replied that

*'A reduction [of alcohol] of any kind is progress, even if they relapse they have at least experienced positive changes and know about where to go to get help in future'.*

Therefore, it seems that the alcohol treatment workers construct the ATR as 'individualised' treatment that goes beyond simply managing their alcohol problems. One of their main aims is to reduce offenders' harm both to themselves and the people around them. This approach encompasses both health implications in relation to their alcohol misuse, and criminal behaviour as they acknowledge that harm can be caused to others through alcohol related crime. Indeed Miller and Rollnick (2000) suggest that the use of motivational interviewing with offenders does not have to be solely directed towards reducing recidivism. They argue that motivational interviewing can help offenders consider change, commit to change, engage in treatment and

remain in treatment, all of which could potentially lead to recidivism. Therefore the ATR provides, at least, a space for individuals to *consider* the possibilities of change through the dialogical relationship that is on offer. Nevertheless for many of the offenders it was clear that being able to talk about their alcohol *use* without recrimination was important;

**Brenda:** *It's a bit like, I like to see Amy cos I can get stuff off my chest and I don't feel as though she's judging me, but I don't lie to her at the same time ... I don't feel like I'm being pushed into telling, she just sits back and lets me tell her the main thing that's, that's the main thing she does right with me cos if I feel as though somebody's pushing me I won't tell them.*

Interestingly, through her construction of the way in which Amy seemingly performs within the therapeutic relationship, Brenda is able to position herself as the 'expert' in that she knows what Amy 'does right'. She constructs Amy as non judgmental and a good listener rather than someone who would be pushy with her and this appears to encourage a sense of trust as she claims that she wouldn't 'lie to her'. Brenda's narrative demonstrates how the ATR provides a therapeutic space needed in order for the dialogue to emerge. Brenda is drawing on therapeutic discourses which enable her to be positioned as 'open' and 'listened to' within the relationship, a space which Amy has created through her seemingly flexible approach.

Brenda continued to talk about how she was happy with the arrangements she had with Amy as the flexibility of her ATR appointments suited her lifestyle. However

flexibility was constructed in other ways, for example in the excerpt below, Brenda narrates a time when she relapsed and ‘had a drink’;

**Brenda:** *I can tell her truth, cos no point in lying cos I’m not helping myself so it’s been good that like I call and she can ring me and I’m straight down cos I’m crap at, like I say things just come off wall, all sorts of crap, with owt like that, but erm I don’t mind cos I can get a lot off my chest with Amy.*

Here Brenda narrates her relationship with Amy as flexible and open. Within her narrative Brenda conveyed an image of a chaotic lifestyle where ‘things just come off wall, all sorts of crap’ again locating the ATR within a therapeutic discourse where Brenda is able to ‘get a lot off my chest with Amy’. However the authoritative voice of coercive treatment is evident as when Amy rings her she is ‘straight down’ which signifies her compliance of being on the order. It might be expected that Brenda (and other offenders) attempt to conceal behaviours during treatment sessions that are perhaps not considered as ‘progressive’ such as relapse or increased alcohol consumption. In this sense it could be argued that offenders on the ATR avoid presenting themselves ‘truthfully’. However it is argued that a narrative represents ‘what it means to the teller of the tale’ (Blumenfeld-Jones, 1995, p.26). Thus Paley and Eva (2005) note that narrative is not ‘how it was’ but ‘how it seems to me’ therefore the ‘truth’ of the matter is irrelevant. What counts is ‘meaning’, the person’s perception and not whether that perception corresponds with ‘reality’. Nevertheless, the ATR does appear to enable a space for offenders to talk about their alcohol *use* rather than alcohol *abuse*.



## **Managing the tension between care and control**

As Highlighted earlier, treatment on the ATR acknowledges that relapse may be experienced and appears to have incorporated flexibility in order to manage relapse positively rather than relying on punitive measures. It is argued that relapse is common when people attempt to break out of a habitual cycle (Lowinson, *et al.* 2005). Thus relapse prevention strategies constitute a large part of Amy and Susan's treatment role. Notably, it was evident that treatment on the ATR was not just about tackling offenders' alcohol consumption. A large proportion of Amy and Susan's work concerns rehabilitation and working with offenders to develop skills that enable behaviour change to be sustained (Ashby *et al.* 2009). Lowinson, Ruiz, Millman and Langrod, (2005) suggest that 'Recovering from a substance misuse disorder involves gaining information, increasing self awareness, developing skills for sober living and following a program of change' (Lowinson *et al.* 2005, p.773). Indeed Amy and Susan's work appeared to involve a considerable amount of relational work in order to build trust that enabled offenders to 'open up' and discuss potential relapse situations. Yet at the same time, too much flexibility could have the potential to be counter productive enabling offenders to be encouraged to think that relapse is an option, reinforcing potential excuses that it is 'ok to relapse'. Thus it appeared that there was a fine line to be negotiated, nevertheless, the flexible nature of Amy's approach towards Brenda's treatment progress seemed to facilitate an openness within the relationship where, rather than fearing punishment for her relapse, Brenda was able to tell the 'truth' about her drinking. Moreover, Brenda appears to have taken ownership of her problems as she realised that she had a responsibility to be honest with Amy,

acknowledging that there was ‘no point in lying cos I’m not helping myself’ and by doing so enabled Brenda to take up the position of being in control. Again for Brenda it seemed important that there was a perceived sense of flexibility within her treatment program. Perhaps the punitive discourse inherent within the authoritative voice of the criminal justice system and coercive treatment on the ATR brought Brenda and other offenders to the point of engaging in treatment. Whereas the flexibility of the treatment and the availability of the dialogical relationship enables Amy and Susan to positively work around their clients’ chaotic lifestyles and maintain the majority in treatment.

### **(Re) authoring the dialogical self: narrating progress**

In returning to Bakhtin in this final section of the interview analysis, the suggestion that motivation to change is an individualised *process* becomes questionable. Holquist (1990) argues that the self is ‘dialogic’ thus the idea that individual consciousness exists can only ever be found in *otherness*, in other words, in relation to others. Indeed this notion has been explored throughout this analysis, and in relation to this chapter, it seems that behaviour change cannot occur without being in a dialogical relationship. What is harder to distinguish however, is whether behaviour change is a result of ventriloquised authoritative discourses of the treatment setting or a result of persuasive voices becoming internalised and enacted. To what extent are stories of change freely developed and applied to become an internally persuasive discourse? The notion that stories ‘do’ things suggests that ‘re-told self stories becomes life’ (Payne, 2006). This concept of narrative function is perhaps helpful when determining

the extent to which an authoritative discourse becomes appropriated into an internal discourse. Indeed as Horrocks *et al.* (2004) point out, the importance of being able to 'enact' ones progress would appear to be important, especially within the treatment setting where behaviour change is part of that process. Cherry's story was an example of some of the many stories where a process of change appeared to be 'enacted';

**Cherry:** *yeah, they kept my job for me for quite a long time, they come and took me back on, I said well, when I actually went back for the interview cos I'd been off for a couple of years erm he said yeah we'll give you your job back erm I said well I'll need time off for probation, I even spoke to him about my drinking which I'd have never have done before neither, and he was fine.*

Cherry's enacted telling conveys the progress she has made since beginning her treatment on the ATR. Being able to work again appears to symbolise progress for Cherry, yet more importantly she is able to talk openly to her boss about her probation order and her 'drinking'. Her story becomes much more than being reinstated in her old job, as there is a strong sense of her moving forward in her life as she is able to confront situations that she would 'never have done before'. Thus she conveys an image of where she has come from, indeed Horrocks *et al.* (2004) suggest that 'Metaphors of moving forward and getting somewhere are linguistic exchanges that are marked by an acceptance that both teller and listener are aware of the place(s) they are travelling from' (p.350-351). Indeed similarly for Sam, being on the ATR had made him 'think' about his current situation:

**Sam:** *so I stopped mixing with certain people who were drinking, thought about my lifestyle, Amy sort of made me think about my lifestyle and things like that and so, yeah that's it really, that's where I am today.*

This may not seem like a significant step forward in relation to treatment progress, yet being able to 'face up' to the realities of an addictive lifestyle is perhaps the most painful and difficult stage of the treatment process. Nevertheless, it seems that Sam Like many of the offenders I interviewed, is now able to deploy linguistic resources made available through the dialogue of the treatment setting. Similarly, Nigel's account echoes this notion:

**Jo:** *So you've done a drinks diary, and how does that help you?*

**Nigel:** *I do as much for these as I do for myself cos it helps me see what I'm drinking, d'you know what I mean cos sometimes you don't realise when your out, you don't realise how much you've drunk do you, until you actually write it down and you can look and when you're doing it week in and week out you can see some kind of pattern when its worse or better do you know what I mean? ... its like I've done it myself in it, I haven't done it because somebody's told me to do it, I've done it cos I wanted to do it.*

Nigel's narrative signifies his ability to draw upon new meaning making resources as he narrates a story of self agency and self control. Nigel's construction of the ATR is not as 'coercive' rather it is constructed as 'enabling self exploration' perhaps encouraging of an alternative behaviour. This was evident in his appraisal of his current drinking 'pattern'. Indeed perhaps like most of us, these offenders will tell and re-tell their stories of experience both for themselves and others in a variety of social settings, at different times and for different addressees. Thus through Bakhtinian theory, it is argued that the perspective of their experiences constantly changes in form, as they

gain new experiences through dialogical exchange with other people (Moen, 2006). To this end, the social setting of the ATR and the flexible approach employed, is perhaps enabling reconstructed stories and voices to be drawn upon and enacted in relation to positive behaviour change. Indeed Brenda's story signifies how the ATR has possibly enabled her to perform an alternative and preferred story of her life:

***Brenda:*** *I've had my confidence lowered with all the beer and me husband up and down and took me confidence from me, whatever I do is not good enough ... but I've started standing up to him now!*

Brenda's narrative emplotment was largely based around her relationship with her 'controlling' husband. Yet towards the end of her story, as illustrated above, she is able to re-enact and re-position herself as 'fighting back'. Thus her personal 'past self', constructed as 'lacking in confidence' is able to be viewed from a different perspective, located within the dialogical landscape of treatment and therapy that frames individuals as capable of reconstructing a self that is more consistent with the present. Therefore Brenda's recreated self as 'fighting back' has perhaps been made possible through being able to enter into an alternative dialogue offered within the ATR treatment setting.

## Summary

In this chapter, the offender interviews have been explored through a narrative-dialogical lens in order to understand further how treatment on the ATR enables offenders to enter into an alternative dialogue of change and recovery. Burkitt and Sullivan (2009) suggest that the struggle to find an authentic self and the finding of one's own voice is a 'question of power relations and the successful negotiation of those relations, struggling to free oneself from certain authoritative voices and aligning oneself with other voices that are felt to be more internally persuasive' (p. 575). In this sense, the process of ventriloquation is not a straight forward or static concept. Indeed all of the offenders interviewed illustrated throughout their narratives a struggle and a resistance that enabled them to interrupt and disrupt the social constructions of criminality and alcohol abuse. Therefore, although ventriloquation can be seen as powerful in silencing voices through dominant discourses and normalisation, it can also be considered a strategy and process of creation. The story of their lives before the ATR seems to be a story entrenched with authoritative discourses that suggest immorality and despair. Nevertheless all of the offenders, through their resistance and struggles have been able to develop 'counter stories' (Horrocks *et al.* 2004). These counter stories as we have seen, resist the authoritative voices and are replaced with a more honourable and morally acceptable self. Therefore any changes evident in these offenders are argued to reflect a complex interplay between societal discourse; experiences and personal stories brought about through individual *and* collective negotiation of the social heteroglossia on offer.

## **Chapter 11: Bringing it all together: theorising treatment on the ATR**

This research set out to investigate the delivery of the ATR, and to explore specifically explore what impact the ATR might have in relation to positive behaviour change and rehabilitation for offenders with alcohol problems. This final chapter therefore aims to bring together the key findings from each phase of this research project in order to present different social realities of the ATR, each of which it is argued contributes to a more holistic understanding of the ATR and how it is delivered. In doing so, this chapter aims to highlight the complex nature of treatment on the ATR and considers the positions that are occupied by the alcohol treatment workers and the offenders during treatment, and the role of dialogue as key in bringing about positive behaviour change. In addition this chapter will review the pragmatic methodological approach undertaken in relation to the effectiveness of employing a mixed methods research design. Finally the implications of the findings of this research for both the health service and the probation service are considered and directions for future research are outlined.

## Contextualising the ATR

This research had the over-arching aim to investigate the delivery of the ATR. More specifically, this research aimed to understand how offenders on the ATR engaged and experienced receiving treatment that is constructed as coercive. The ATR was implemented with the aim to address locally the level of alcohol related offending that was occurring across the District. Indeed it has been highlighted that the number of adults who drink at hazardous or harmful levels within the District is higher than the national average. Hence as a new treatment initiative, the ATR was aimed at offenders who were assessed as hazardous, harmful and dependent drinkers. This research has shown that offenders who are being sentenced to alcohol treatment on the ATR are predominantly unemployed, alcohol dependent young men who persistently reoffend and have been convicted of committing serious violent crimes as a result of their alcohol problems (Ashby *et al.* 2011). This research therefore, reveals that alcohol treatment workers on the ATR are largely working with a specific cohort of young male offenders. Although they position themselves as 'not criminal' they have been found to be committing predominantly serious assault related offences including domestic violence. Phase One of this research further revealed that the majority of offenders sentenced to the ATR over a period of one and a half years, from July 2007 to March 2009, completed their treatment on the ATR. Moreover, just over half of these offenders experienced positive treatment outcomes in relation to their alcohol misuse. What was further evidenced from this initial analysis was that a large majority of offenders (81 per cent) had not reoffended when the data records were revisited almost a year later in January 2010. This finding is particularly striking since the



majority of these offenders were assessed as medium to high risk in terms of reoffending upon entering treatment. Moreover the number of offenders who completed their treatment was considerably high, when compared to other drug treatment programs such as the Drug Rehabilitation Requirements (DRR). Therefore Phase One of the research revealed vitally important information about the kind of offenders the ATR works with, and also that the ATR is effective in engaging offenders and bringing about positive behaviour change, in relation to offending and alcohol misuse. In addition the findings of this research showed clearly that 'joined up' working between the criminal justice system and the health service in relation to delivering the ATR has been successful. Indeed the ATR has been delivered based on this new form of practice where joined up working enables solutions that are better suited to meeting complex and diverse client needs. Thus, as highlighted in Ashby *et al.* (2011) having the opportunity to work in close proximity with the probation service, has enabled shared aims between the two agencies to be delivered effectively. In this sense, a 'whole systems approach' proposed by the Alcohol Harm Reduction Strategy for England (2004) and subsequently mobilised by MoCAM (NTA, 2006) has been successfully implemented into the delivery of the ATR in relation to tackling alcohol misuse from a local perspective.

### **Negotiations and manoeuvrings in treatment**

Phase One provided vitally important information regarding the impacts and outcomes of the ATR, and indeed met the expectations of the funders in relation to producing summative evaluative information. It was nevertheless also the case that this research

needed to meet the demands of a theoretical piece of research worthy of a PhD. Therefore the challenge of moving beyond an evaluation model drove the research on to further explore questions that were generated as a result of the findings from Phase One, such as why was the ATR effective? How did this behaviour change come about? And thus what was occurring during treatment? Therefore Phase Two aimed to present a different social reality of the ATR that explored the treatment process from *within* the treatment setting. This particular phase is argued to provide a specific perspective of treatment that is very rarely researched. Indeed research concerning treatment interventions often relies solely on the therapists' view or the individuals' view post treatment. Thus what occurs *during* treatment is rarely considered in this kind of research, yet it is argued that this perspective provides vitally important insight into how treatment is delivered by the alcohol treatment workers on the ATR. Indeed as a result of the contextual information revealed in Phase One, further questions arose such as how effective could two female alcohol treatment workers be in managing these ostensibly violent male offenders? It was clear that the majority of these men were not reoffending, and that many experienced positive treatment outcomes, therefore, how was this positive change occurring? To this end, participant observations of the treatment setting provided great insight into the social interaction and the 'dynamic social episode' (Harrè and Van Langenhove, 1999) that unfolded between the female alcohol treatment worker and the male offender. Initially, there was some scepticism in relation to questioning the effective delivery of the ATR by alcohol treatment workers with limited knowledge and experience of the treatment field. Nevertheless as the focus of the observations developed it became clear that

understanding the complex gendered nature of these treatment encounters was important in answering the above questions. Indeed this particular methodological approach revealed a new understanding of the social interactions that occurred during these sessions and how important they were in working towards treatment goals. Yet it was only by drawing on and utilising positioning theory that the complexity of these gendered interactions could be indeed valued and understood. Positioning theory was a useful analytical tool which enabled insight into how individuals appear to co-construct their 'selves' through discursive action. It further argues that people are continuously involved in a process of positioning and repositioning both in relation to other people and also to the 'self'. Therefore positioning theory (Harrè, 2004) enabled a more focussed observation of the positions that were occupied by the alcohol treatment workers and the offenders, and in turn, how these were negotiated and re-negotiated during treatment sessions.

It was evident that these young men were predominantly from working class cultures that value hegemonic masculine behaviours. Indeed during the treatment interactions observed it could be seen how these young men positioned themselves as 'masculine' as they entered the treatment setting and in doing so made available positions of feminine carers for the alcohol treatment workers to take up. Nevertheless, the application and understanding of positioning theory enabled this research to reveal how distinctly feminine positionings of 'sweetheart' and 'carer' were resisted by the alcohol treatment workers during these encounters. Indeed it was clearly evident that these women, in their resistance against adopting a feminine role with these offenders,

occupied positions of control over these young men in order to effectively bring about positive behaviour change. Therefore observing these evolving social episodes enabled an appreciation of the complexity of the negotiations that occurred and the consequent positions that were either taken up or resisted during these encounters. Hence it was clearly evident from the analysis of these observations that these negotiations and constant manoeuvrings of positions that occurred between the male offender and the female alcohol treatment worker were pivotal to understanding how treatment was effectively delivered. Indeed it is argued that positioning theory has much to offer when understanding treatment on the ATR. Moreover this analysis further highlighted the importance of the relational aspect of treatment on the ATR in getting these young men to comply and consequently engage positively with their alcohol treatment worker.

### **Understanding treatment on the ATR as a dialogical encounter**

The complex gendered nature of the social interactions observed during treatment provided evidence showing that the majority of the offenders were compliant with 'treatment'. This suggests that in contrast to current debates regarding coercive treatment as being problematic (Stevens *et al.* 2003; Seddon, 2007) and ineffective (Fish, 2006), the ATR is enabling offenders to constructively engage with their treatment. Thus the argument that being coerced into treatment somehow creates an 'alienated bond' between the alcohol treatment worker and the offender is rejected. In this sense, how treatment was storied and talked about by these offenders enabled

this research to further understand the offenders' subjective experiences of being on the ATR.

By drawing on Bakhtin (1981) in Phase Three, a further theoretical understanding was gained with regard to how various positions and roles occupied during treatment on the ATR are enabled through the 'other'. Indeed this research has shown, as argued by Burkitt (2008), that everyday interactions and dialogue are vitally important 'because it is in these interrelationships that we come to identify our self through the image of some of the selves around us, with some of what they represent, while setting our self against the images of others' (p.188). In this sense, the image of the self as having some kind of 'essence' or 'truth of self' is rejected. Therefore drawing on the application of a narrative-dialogical perspective was found to be initially useful in understanding the situated lives of these offenders. It was evident from their interviews that their narrated past lives ventriloquized authoritative voices of others within their cultural communities where drinking was not only performed but also valued as a masculine activity. Indeed up until the point of being 'caught' and arrested it was evident from their narratives that the majority of these offenders did not position themselves as a criminal or an immoral person in relation to their alcohol consumption and related behaviour. Nevertheless what was clearly revealed from this analysis, was that appearing in court for these offenders signified a position of 'this is as bad as it gets'. It is through a dialogical understanding that the authoritative voice of the criminal justice system could be seen as clearly evident in framing these offenders as bad, immoral people because of their alcohol consumption and (now) 'criminal'

behaviour. Indeed it was clear that stories of 'reaching rock bottom' were mobilised as a result of the criminal justice system becoming internally persuasive. Hence, and of crucial importance, this analysis reveals how, for these offenders, the ATR became the 'turning point', a sudden realisation, an epiphany, where stories of their 'need to receive treatment' are narrated. In this research it is therefore argued that to understand treatment on the ATR is to understand the layers of complexity that occur during sentencing and consequent treatment with offenders within this particular setting.

Indeed it must be highlighted that treatment on the ATR *is* coercive in that offenders are sentenced to receive treatment and must comply with probation regulations regarding attendance in order to avoid further punitive consequences. This could involve having to return to court to face the possibility of a custodial sentence. Therefore, interviewing offenders in Phase Three enabled a subjective reality of the ATR that added a further valuable dimension in providing a more holistic understanding of the ATR. The interviews revealed that the ATR was not experienced by these offenders as 'coercive'; indeed conversely, it was evident that these offenders narrated positions of being 'in control' of their treatment journeys. The ATR operates within a social context in which 'clients' are stigmatised and labelled as deviant. Yet the ATR was seen to be providing a therapeutic 'space' for these offenders where an opportunity to engage in a dialogue that draws on the authoritative voice of therapy could become internally persuasive. Indeed this 'space' enabled offenders to talk frankly about their alcohol use rather than 'misuse'. In this sense, an appreciation of

the relational aspect of treatment on the ATR has revealed how a more 'moral self' is able to be enacted as a result of the dialogue offered through the 'other' which in this instance is the role occupied by the alcohol treatment workers. Indeed their internalisation of the therapeutic voice of the treatment setting not only enabled them to engage with the alcohol treatment workers, it also enabled these offenders to protect their hegemonic masculine identities. Thus it is important to highlight that the ATR has been successful in enabling the offenders' hegemonic masculine identities to be both challenged *and* protected as a result of the complex relational encounters that have been identified from this particular analytical approach.

### **Coercive treatment: should we be asking good or bad?**

The debate surrounding the nature and application of coercive treatment is steadily growing in the literature. This debate largely centres on questioning the effectiveness of treatment that is forced upon the individual under the process of the criminal justice system. Indeed within the addictions treatment world, an individual must be seen to possess the internal motivation to change, and until such a point is reached, therapy is argued to be ineffective. Thus some would argue that coercive treatment undermines the very nature of the therapeutic relationship (for example Fish, 2006). However, such arguments are based on understanding and conceptualising motivation to change as an intrinsic process. Indeed the main treatment approaches employed in relation to substance misuse and addiction includes 'readiness to change' (Prochaska and DiClemente, 1982; DiClemente, 2003); 'motivational interviewing techniques' (Miller and Rollnick, 2002) and cognitive behavioural therapy (CBT) (Soravia and Barth,

2008). Each of these treatment approaches rely on an ideology of individual agency in order to bring about change. In this sense, these treatment approaches rely heavily on individual factors and thus the individuals' own willingness to initiate change. Therefore these major treatment approaches contrast starkly with a more dialogical approach that is evidently occurring on the ATR. Treatment on the ATR clearly situates interaction and engagement as more important features of behaviour change. Indeed this research has shown that it is the relational aspect of treatment on the ATR that is important both with regard to behaviour change and personal identity. Therefore it is argued that the ATR cannot be simplistically constructed as 'good/bad' or 'effective/ineffective' as such an argument only serves to ignore the rich complexity and multilayers of what was occurring at the point of sentencing and beyond for these offenders. Therefore this research has illustrated that the coercive role taken up by the probation service has been effective in keeping these offenders in treatment. Yet more importantly it is the appropriate and professional role occupied by the alcohol treatment workers that has been shown to be most effective in building and developing positive dialogical interactions that enable change to at the very least be considered.

### **ATR: working towards recovery?**

It has been highlighted that the main treatment approaches on offer in the substance misuse and addiction field do not consider the relational aspect of treatment as important in enabling change. However, there is an increasing shift towards broadening systems of care to promote long term recovery. Kelly and White (2010)



argue that there needs to be a shift in acknowledging the 'other' in sustaining recovery that continues beyond the treatment setting. Therefore the recovery paradigm takes into account the nature of addiction and its complex interplay with various social systems. Indeed this research has clearly shown that treatment on the ATR is a dialogical process not just between the alcohol treatment worker and the offender, but also with the criminal justice system, the health care system and the wider cultural community. Indeed Bakhtin (1981) highlights how authoritative voices are internalised, learned and combined with the voices of others which come to reflect 'selfhood'. Thus the authoritative voices that are encountered on the ATR become internally persuasive. Therefore the treatment approach offered on the ATR is argued to have embraced the ideology of the recovery movement (White, 2000). In this sense, the ATR moves beyond an individualised model of change in order to appreciate culturally where the offender has come from, and indeed where the offender will be returning to once treatment ends. The recovery movement argues that long term recovery must be anchored to the individual's natural environment. Indeed this research has demonstrated how alcohol treatment workers have embraced the broadening out of treatment approaches. This was evident during treatment as they worked with these offenders in setting realistic goals that were not situated within an ideological framework that suggests sobriety is the only option for these offenders. Thus in offering flexibility in terms of treatment goals, the ATR enables individuals to consider change realistically and from the perspective of their situated lives. It is also important to note that community sentencing offers a constructive alternative to a custodial

sentence as offenders have the opportunity to re-story their lives, and 'get back on track' which would not be possible in a prison environment.

### **Doing mixed methods research: what worked?**

In order to meet the research aims of this project, a pragmatic methodological approach to the research was undertaken which embraced the practicality of drawing on multiple points of view in order to further understand social phenomena. As discussed earlier the research design in Phase One was developed as a result of being funded by the NHS, however the challenge was to move beyond a simplistic accountability evaluation of the ATR in order to begin to theorise coercive treatment. Thus the point of employing a mixed methods design was to enable the research to develop theoretically. Indeed it has been shown in the previous sections that methodological pluralism has been effective in enabling a deeper understanding of the ATR. Thus by moving away from the traditional mono-methodological way of doing research a shift from taking a one-dimensional line of enquiry opens up a research design that has, in this instance, successfully provided further contextual layers to understanding more fully, the delivery of the ATR from process to individual and relational experience. Nevertheless although this research clearly provides legitimacy for employing mixed methods research, this should not be viewed as an approach for utilising qualitative or quantitative methods as simply a 'triangulation' of the data (Silverman, 2006). Indeed triangulation is a methodology that combines multiple methods with the purpose of being able to claim validity in research. Thus, in this sense, different methods are used to see whether they 'corroborate one another'

(Silverman, 2006, p.290). This research does not claim to have drawn on triangulation as a methodology, as it is argued that the pragmatic approach employed here provided a window into the different social realities of the ATR which, as highlighted in the above sections, has been important in enabling a greater understanding of the complexity of delivering coercive treatment on the ATR. Therefore this research methodology has enabled insights into not only '*what works*' but also '*why it works*' in relation to treatment delivery on the ATR.

### **Implications and further research**

It has been six years since the Alcohol Harm Reduction Strategy (2004) was published, and yet in the five years up to 2009/10 there has been a 25 per cent increase in alcohol related hospital admissions, and a growing concern over young people's alcohol misuse (Guardian 2011; REF). Therefore alcohol misuse is still a growing concern in the UK 2011. This research has highlighted important issues that have implications for both the health service and the probation service in relation to addressing alcohol related problems. Firstly, it is evident that the role of probation in ensuring that offenders attend treatment sessions has been effective in opening up and maintaining dialogue, argued in this research to be pivotal in bringing about positive behaviour change. More importantly, this research has shown that the coercive nature of the ATR has not 'undermined' the therapeutic relationship offered by the alcohol treatment workers. This was evident in the offenders' narrative accounts of their treatment experiences, where stories of 'being forced to comply' were clearly absent. Indeed this research has shown that the ATR for these offenders is the 'turning point' and as such is the crucial

point at which 'alternative selves' begin. Thus it is argued that without the coercive element, the probability of offenders entering into this relationship becomes greatly reduced. In this sense, coercive treatment should not be viewed as a concern, rather it should be embraced as an opportunity for young offenders to re-enact an alternative story.

In addition it was the aim of this project to disseminate the research findings and also to reflect on current practice and assist in ongoing developments of the ATR. To this end, a research paper was recently published (Ashby, *et al.* 2011) based on a research report produced for the funders (Ashby *et al.* 2011). In this report it was recommended that the ATR would benefit offenders with alcohol problems who are released on licence after serving a custodial sentence. This recommendation was based on the recognition that they would have experienced a period of abstinence during their sentence that could be supported beyond prison into the community. This reflects recent research conducted by Weaver and Armstrong (2011) who, in talking to offenders, found that serving a short prison sentence was viewed as *easier* yet less beneficial than serving a longer sentence in the community. They highlight how research on sanction severity largely measures punitiveness yet does not measure other experiential aspects and meanings that are attached to community sentencing. Indeed as revealed in this research, there is a complex interplay between alcohol treatment workers and offenders which does not occur in a prison setting. Moreover, Weaver and Armstrong (2011) found that community sentencing had more of a *constructive* impact on offenders' lives and thus offenders were more onerous in the

challenges of compliance in contrast to the forced and passive compliance characteristic of prison regimes. Therefore it is argued that offenders in a community setting have the liberty to build relationships, regain a 'moral' and 'respected' self and thus work towards a positive recovery experience.

Secondly and perhaps more importantly, this research has emphasised the importance of valuing the relational aspect of treatment in bringing about positive behaviour change. The ATR has been driven by public health policies (NTA, 2006) that rely on treatment approaches that emphasise individual agency in determining and enabling change. However to over-rely on these approaches is to critically ignore the vitally important role of the 'other' in enabling change to occur that has been illustrated in this research. Moreover it is argued that the delivery of the ATR, in comparison to other medical treatment approaches, is relatively cost effective, taking into consideration the limited amount of training the alcohol treatment workers received. Thus the cost implication, perhaps in comparison to other more intensive treatment programs may be something to consider in planning future health initiatives.

In ending with the future, it seems fitting that this section should finally consider further research. The effectiveness of the ATR has been clearly evidenced throughout this research, however some caution must be applied to the impacts and outcomes of the ATR that were reported in Phase One. Although the findings of treatment outcomes and reoffending rates were extremely encouraging, these were based on a follow up study of approximately one year after the initial data collection. Therefore it

is proposed that the data is currently revisited in order to present the reoffending data and the treatment outcome data on a more longitudinal scale. This may uncover more about the impact of the ATR and its longevity in reducing alcohol misuse and alcohol related offending.

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## **APPENDICES**

## APPENDIX 1: INTERVIEW SCHEDULE

Thank you for agreeing to take part in this interview. I will now be asking you about your thoughts and experiences of being on the ATR. Before we begin I would just like to check that you have understood the participant information sheet and that you are still willing to take part in the interview.

So in this interview I would like to know how you personally have experienced being on the ATR. I have some ideas about what I would like to talk about and some questions but if you don't want to answer any of the questions I ask than that is fine.

- I would like to start by asking you why you think you were selected to be on the ATR.
  - Any previous treatment?
  - Feelings about being sentenced to the ATR, positive/negative
- What initial goals did you have in mind when you first entered into the ATR?
  - In relation to alcohol consumption
  - Other lifestyle changes
- How suitable do you think the ATR has been for you personally?
  - Treatment regime
  - Keeping on the order
- What are your feelings about having this kind of treatment imposed on you as part of your community order?
  - Good/bad things
- Can you tell me about any difficult times you have encountered during your treatment?
  - Relapse
  - Detox
  - Relationships
- What effect do you think the ATR has had on you personally?
  - Socially
  - Family - relationships
- Can you tell me a little bit about what you and [alcohol worker] have been doing during your treatment sessions?
- How do you feel about the services involved?
  - Courts
  - Probation
  - treatment
- Is there anything else you would like to talk about that we have not covered in relation to your experience on the ATR?

**Thank you for your time. Please do not hesitate to contact me if you would like to ask any further questions about this interview**

## APPENDIX 2: CONSENT FORM - Alcohol Worker Observation



**Title of project: Investigating the delivery of the Alcohol Treatment Requirement**

**Name of Researcher: Jo Ashby**

**Please initial box**

1. I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, and without any consequences for me. ☐
3. I understand that all information I provide will be treated as confidential, and will be anonymised. ☐
4. I understand that the information I give will be treated in the strictest confidence and information will only be passed on by the researcher, Jo Ashby, to other professionals if serious concerns are raised about poor or unsafe practice and/or there is any risk to myself or others. ☐
5. I understand that the research forms part of the researchers (Jo Ashby) post-graduate studies and I agree to the use of anonymised field notes from the observations in publications and presentations arising from this study. ☐
6. I agree to take part in the above study. ☐

\_\_\_\_\_  
**Name of Participant**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Researcher**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

## APPENDIX 3: PARTICIPANT INFORMATION SHEET - Alcohol Worker



### Investigating the Delivery of the Alcohol Treatment Requirement

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others about the study if you wish.

Ask me (contact details overleaf) if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

#### Background and aims of the study

In this study we want to find out how the delivery of the Alcohol Treatment Requirement (ATR) in [District] may benefit individuals who have been selected for the programme. In particular, we are interested in how the ATR will be delivered to clients and we would like to get a more naturalistic idea of the 'interworkings' of the ATR programme. In order to do this we would like to observe and capture the 'life' of the programme over a sufficient period of time. This time period will be negotiated between yourself and the researcher Jo Ashby and will be arranged at times most suitable to you.

There are two main reasons why it is important that this research is carried out now:

- The ATR has been made available through the Criminal Justice Act (2005) and opens up a new pathway to identify and engage with individuals who are harmful drinkers to access treatment which may not have been previously offered.
- The ATR is a new development in [District], therefore, gaining further insight into the programme will help the District Alcohol Team make sure that the delivery of the programme is effective.

#### Why have I been chosen?

The researcher will be observing two alcohol workers in the District and you have been chosen because you have been appointed as one of the key alcohol workers in this area. You have been identified in the course of the research as someone who may be able to shed useful light on the evolving process of this new programme.

#### Do I have to take part?

No. There is absolutely no obligation upon you to take part. If you do agree to take part you will be asked to sign a written consent form. Even after this, though, you are free to withdraw from the study at any time, with no further consequences for you.

**What will happen to me if I take part?**

The researcher will contact you, and arrange to carry out observations at a time that is suitable to you. The observations will be conducted at varied times and days depending on your work schedule and this will be a flexible arrangement which can be re-negotiated at any stage of the research project. Only the researcher, Jo Ashby will record and write up field notes from the observation and your name other names and other information that might identify you will be kept anonymous. We may wish to use field notes from the observations in publications and presentations arising from this project. Again we will ensure that these are kept anonymous. The notes from the observations will be destroyed at the end of the project.

**What are the possible disadvantages of taking part?**

The observations will focus on gaining a 'holistic' insight of the treatment programme in relation to the delivery of the ATR. I would not expect this to present any difficulties or to cause you any distress. However in the unlikely event that you find an observation distressing, you will be able to cease participation by telling the researcher you wish the observation to stop at which point the researcher will leave.

**What are the possible benefits of taking part?**

We do not expect significant direct benefits for you personally, however we do expect that this research will contribute to the practice and delivery of the ATR.

**What will happen to the results of the study?**

The research will give us an in-depth insight into the delivery of the ATR. It is anticipated that information gained may assist both the health services and the criminal justice services in refining and expanding the services to provide further support for offenders who drink at harmful levels. The research forms part of the researcher's post-graduate studies and it is anticipated that the research may at some point be published.

If something is heard that raises serious concerns about poor or unsafe practice and /or there was a risk to you or others, including child protection concerns, the researcher will have to report the matter locally. In the unlikely situation of this happening, the interviewer will discuss this with you and will explain what will happen.

**Who is organising and funding the study?**

This research is funded jointly by [District] Criminal Justice and [District] Primary Care Trust. The research is organised in collaboration with Bradford University.

**Contact for further information.**

If you wish to discuss this further before making a decision you may speak to Jo Ashby, Ph.D. Student, on 01274 234805 or at [j.ashby@bradford.ac.uk](mailto:j.ashby@bradford.ac.uk).

Thank you for taking the time to read this.

## APPENDIX 4: CONSENT FORM - Offender treatment observation



**Title of project: Investigating the delivery of the Alcohol Treatment Requirement**

**Name of Researcher: Jo Ashby**

**Please initial box**

1. I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, and without any consequences for me.
3. I understand that all information I provide will be treated as confidential, and will be anonymised.
4. I understand that the information I give will be treated in the strictest confidence and information will only be passed on by the researcher, Jo Ashby, to other professionals if serious concerns are raised about poor or unsafe practice and/or there is any risk to myself or others.
5. I understand that the research forms part of the researchers (Jo Ashby) post-graduate studies and I agree to the use of anonymised field notes from the observations in publications and presentations arising from this study.
6. I agree to take part in the above study.

☐
☐
☐
☐
☐
☐

\_\_\_\_\_  
**Name of Participant**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Researcher**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

## APPENDIX 5 : PARTICIPANT INFORMATION SHEET - Offender observation



### Investigating the Delivery of the Alcohol Treatment Requirement

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others about the study if you wish.

Ask me (contact details overleaf) if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

#### Background and aims of the study

In this study we want to find out how the delivery of the Alcohol Treatment Requirement (ATR) in [District] may benefit individuals who have been selected for the programme. In particular, we are interested in how the ATR will be delivered to clients. In order to do this we would like to observe and capture the 'life' of the programme over a period of time. It might be that you may be present during one of these observations during your time on the programme.

There are two main reasons why it is important that this research is carried out now:

- The ATR has been made available through the Criminal Justice act (2005) and opens up a new pathway to identify and engage with individuals who are harmful drinkers to access treatment which may not have been offered before.
- The ATR is a new development in [District], and so, further insight into the programme will help the District Alcohol Team make sure that the delivery of the programme is effective.

#### Why might I be observed?

The researcher will be observing two alcohol workers in the District therefore you may be present during one of these observations as a client attending the ATR programme.

#### Do I have to take part?

No. There is absolutely no obligation upon you to take part. If you do agree to take part you will be asked to sign a written consent form. Even after this, though, you are free to withdraw from the study without giving a reason by asking the researcher to leave at any time, with no further consequences for you.

**What will happen to me if I take part?**

The observations will be conducted at varied times and days in arrangement with the alcohol workers. As a client on the ATR you may be observed during one of your planned sessions. Only the researcher, Jo Ashby will record and write up field notes from the observation and your name other names and other information that might identify you will be kept anonymous. We may wish to use field notes from the observations in publications and presentations arising from this project. Again we will ensure that these are kept anonymous. The notes from the observations will be destroyed at the end of the project.

**What are the possible disadvantages of taking part?**

I would not expect this to present any difficulties or to cause you any distress. However in the unlikely event that you find an observation distressing, you will be able to cease participation by telling the researcher you wish the observation to stop at which point the researcher will leave.

**What are the possible benefits of taking part?**

We do not expect any direct benefits for you personally, however we hope that the findings of this research may be helpful in informing the future development of the ATR programme in [the District].

**What will happen to the results of the study?**

The research will give us an in-depth insight into the delivery of the ATR. It is thought that information gained may assist both the Health Services and the Criminal Justice Services in refining and expanding the services to provide further support for offenders who drink at harmful levels. The research forms part of the researcher's post-graduate studies and it is anticipated that the research may at some point be published.

If something is heard that raises serious concerns about poor or unsafe practice and /or there was a risk to you or others, including child protection concerns, the researcher will have to report the matter locally. In the unlikely situation of this happening, the interviewer will discuss this with you and will explain what will happen.

**Who is organising and funding the study?**

This research is funded jointly by [District] Criminal Justice and [District] Primary Care Trust. The research is organised in collaboration with Bradford University.

**Contact for further information.**

If you wish to discuss this further before making a decision you may speak to Jo Ashby, Ph.D. Student, on 01274 234805 or at [j.l.ashby@bradford.ac.uk](mailto:j.l.ashby@bradford.ac.uk).

Thank you for taking the time to read this.



## APPENDIX 6: CONSENT FORM – Offender interview



**Title of project: Investigating the delivery of the Alcohol Treatment Requirement**

**Name of Researcher: Jo Ashby**

**Please initial box**

1. I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, and without any consequences for me.
3. I understand that all information I provide will be treated as confidential, and will be anonymised.
4. I understand that the information I give will be treated in the strictest confidence and information will only be passed on by the researcher, Jo Ashby, to other professionals if serious concerns are raised about poor or unsafe practice and/or there is any risk to myself or others.
5. I understand that the research forms part of the researchers (Jo Ashby) post-graduate studies and I agree to the use of anonymised direct quotes from my interview in publications and presentations arising from this study.
6. I agree to take part in the above study.

☐
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☐
☐
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☐

\_\_\_\_\_  
**Name of Participant**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Researcher**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

## APPENDIX 7: PARTICIPANT INFORMATION SHEET – Offender interview



### Investigating the Delivery of the Alcohol Treatment Requirement

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others about the study if you wish. Ask me (contact details overleaf) if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

### Background and aims of the study

In this study we want to find out how the delivery of the Alcohol Treatment Requirement (ATR) in [District] may benefit individuals who have been selected for the programme. In particular, we are interested in your personal experience of being on the programme and we would like to know your views and ideas about how the programme may have impacted upon you personally.

There are two main reasons why it is important that this research is carried out now:

- The ATR has been made available through the Criminal Justice Act (2005) and opens up a new pathway to identify and engage with individuals who are harmful drinkers to access treatment which may not have been previously offered.
- The ATR is a new development in [District], and so talking to people who attend the programme will help the District Alcohol Team make sure that the delivery of the programme is effective.
- 

### Why have I been chosen?

The researcher will be interviewing around ten people from the District who have been selected for the ATR. You have been chosen because you have been selected for the treatment programme. You have been identified in the course of the research as someone who may be able to shed useful light on your experience of being on the programme.

### Do I have to take part?

No. There is absolutely no obligation upon you to take part. If you do agree to take part you will be asked to sign a written consent form. Even after this, though, you are free to withdraw from the study at any time, without giving a reason and with no further consequences for you.

### What will happen to me if I take part?

The researcher will contact you, and arrange to carry out an interview with you at a time that is suitable for you to attend the treatment centre. To ensure accurate recording and so as

not to interrupt the interview with note-taking, we would like to tape-record it, with your permission. We expect the interview to last about an hour.

Your name other names and other information that might identify you will be kept anonymous. We may wish to use quotes from your interview in publications and presentations arising from this project, and any information used will not be identified as yours. The tapes from the interviews will be destroyed at the end of the project.

### **What are the possible disadvantages of taking part?**

The interviews will focus on your experience of being on the treatment programme. I would not expect this to present any difficulties or to cause you any distress. In the unlikely event that you find a question distressing, you will have the opportunity to disregard the question, take a break before continuing, or terminate the interview. The nature of the interview is such that you will have considerable freedom to lead the discussion towards issues of importance to you, within the broad area of the study.

### **What are the possible benefits of taking part?**

We do not expect any direct benefits for you personally, although past experience from similar studies suggests that participants may find the interview a useful opportunity to reflect on their personal experiences. We hope that the findings of this research may be helpful in informing the future development of the ATR programme in [District].

### **What will happen to the results of the study?**

The research will tell us about the individual experiences of people who are currently undergoing treatment through the ATR. It is anticipated that information gained may assist both the health services and the criminal justice services in refining and expanding the services to provide further support for offenders who drink at harmful levels. The research forms part of the researcher's post-graduate studies and it is anticipated that the research may at some point be published.

If something is heard that raises serious concerns about poor or unsafe practice and /or there was a risk to you or others, including child protection concerns, the researcher will have to report the matter locally. In the unlikely situation of this happening, the interviewer will discuss this with you and will explain what will happen.

### **Who is organising and funding the study?**

This research is funded jointly by [District] Criminal Justice and [District] Primary Care Trust. The research is organised in collaboration with Bradford University.

### **Contact for further information**

If you wish to discuss this further before making a decision you may speak to Jo Ashby, Ph.D. Student, on 01274 234805 or at [j.ashby@bradford.ac.uk](mailto:j.ashby@bradford.ac.uk).

Thank you for taking the time to read this.

APPENDIX 8: EXAMPLE OF DRINK DIARY

|           | Type of Drink/How Much?  | Time of day | Who with? | Why did you drink?<br>How did it make you feel? |
|-----------|--|-------------|-----------|---|
| MONDAY    | LAGER (cans) 1 1 1 1 1 1 1 1 1 1 1 1 1 1<br>CIDER (bottles) 1 1 1 1 1 1 1 1        |             |           |   |
| TUESDAY   | LAGER (cans) 1 1 1 1 1 1 1 1 1 1 1 1 1 1<br>1<br>CIDER (bottles) 1 1 1 1 1 1 1 1   |             |           |   |
| WEDNESDAY | LAGER (cans) 1 1 1 1 1 1 1 1 1 1 1 1 1 1<br>1<br>CIDER (bottles) 1 1 1 1 1 1 1 1   |             |           |   |
| THURSDAY  | LAGER (cans) 1 1 1 1 1 1 1 1 1 1 1 1 1 1<br>1<br>CIDER (bottles) 1 1 1 1 1 1 1 1   |             |           |   |
| FRIDAY    | LAGER (cans) 1 1 1 1 1 1 1 1 1 1 1 1 1 1<br>1<br>CIDER (bottles) 1 1 1 1 1 1 1 1   |             |           |   |
| SATURDAY  | LAGER (cans) 1 1 1 1 1 1 1 1 1 1 1 1 1 1<br>1 1<br>CIDER (bottles) 1 1 1 1 1 1 1 1 |             |           |   |
| SUNDAY    | LAGER (cans) 1 1 1 1 1 1 1 1 1 1 1 1 1 1<br>1 1<br>CIDER (bottles) 1 1 1 1 1 1 1 1 |             |           |   |

## APPENDIX 9: OFFENDING RELATED FACTORS

Offending information

Offence analysis

Accommodation

Education training and employment

Financial management and income

Relationships

Lifestyle and associates

Drug misuse

Alcohol misuse

Emotional well-being

Thinking and behavior

Attitudes

Health and other considerations