COERCIVE TREATMENT FOR ALCOHOL MISUSE: AN INTERACTIVE AND RELATIONAL ANALYSIS

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Abstract
Alcohol misuse has become central for policy makers with approaches to addressing and providing solutions a persistent challenge. Alcohol Treatment Requirements (ATRs) 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. This form of ‘coercive treatment’ is delivered collaboratively with the criminal justice system and the National Health Service (NHS) working in partnership. Those sentenced to the ATR are predominantly young male, persistent offenders presenting with severe alcohol problems. As part of a research project funded by the NHS, qualitative participant observations were undertaken during treatment delivery on the ATR. This paper presents an analysis of the interactions observed between male offenders and female alcohol workers. Explored is the nature of coercive treatment and how young men sentenced to treatment engage with the process. The analysis utilises positioning theory to show how control and compliance operate within a complex, relational and interactive encounter that while focussed on alcohol consumption and behaviour change are impacted upon by wider cultural and social issues.

Key words: alcohol misuse, offending, coercive treatment, behaviour change, relational
Background

Alcohol related crime and drinking patterns

There is mounting evidence highlighting the social and economic impact of alcohol misuse in the UK. Nutt, King and Lawrence (2010) recently reported that whilst heroin, crack cocaine, and metamfetamine were found to be the most damaging to individuals, alcohol was found to be one of the most harmful to others. Research has consistently shown that alcohol use is present in a high proportion of criminal offences (Budd, 2003; Richardson and Budd, 2003; Hall and Innes, 2010; Flately et al. 2010; Chaplin, Flately and Smith, 2011; Home Office 2012a; Home Office 2012b) with approximately half of all violent crimes, and 360,000 incidents of domestic abuse, linked to alcohol misuse (Strategy Unit, 2004; Home Office 2012b). Moreover, a study by Felson, Burchfield and Teasdale, (2007) found that for violence involving strangers, offenders were more likely to have consumed alcohol, whereas victims were more likely to be sober.

In order to understand better the impact of alcohol consumption there now exists a growing body of research exploring specific drinking patterns 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). Notably, 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’.

Bearing in mind the evidence on drinking patterns, Models of Care for Alcohol Misusers [MOCAM] (National Treatment Agency, NTA, 2006) 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. MOCAM states that these hazardous and harmful drinkers do not have significant evidence of alcohol dependence and thus advice and brief interventions are often suitable to meet the needs of both these groups. Drinking behaviour categorised as ‘dependent’ includes those with an increased drive to use alcohol and difficulty controlling its use despite negative consequences; with severe dependence associated usually with physical withdrawal symptoms upon cessation. Given growing evidence around drinking patterns and the social and economic impact it is unsurprising, although worrying, to know that the UK is reported to hold eighth position in the ‘hard drinking’ nations of Europe (British Medical Association, 2008). Furthermore, on a regional level, the highest levels of binge drinking, drinking with increasing risk and alcohol dependency, were found to be in the northern regions of England in particular in Yorkshire and Humberside, (Yorkshire and Humber Public Health Observatory 2005; 2010). In this paper we explore the delivery and
Criminal justice and coercive treatment

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 £21 billion a year (Home Office 2012a). Hence, finding a way to reduce the social and economic cost of alcohol misuse has become a political imperative. However, 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. Nonetheless, the shift towards crime prevention and coercion has been growing in popularity since innovations such as the Drug Treatment and Testing Orders (DTTO), now Drug Rehabilitation Requirement (DDR), were introduced in Britain over a decade ago (Turnbull et al. 2000). 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.

In response to the growing levels of alcohol misuse in the UK (BMA, 2008) coercive treatment has been broadened out to address alcohol related offending. Community sentencing in the form of the Alcohol Treatment Requirement (ATR) was introduced in the UK via the Criminal Justice Act 2003. The ATR became one of the possible requirements of a community order for offenders who had committed an alcohol related offence. For an ATR to be granted by the courts there are several criteria that have to be fulfilled before such a requirement can be made available. Section 212(2) of the Criminal Justice Act 2003, states that the court must be satisfied that the offender is ‘dependent’ on alcohol in line with drinking patterns identified in MOCAM (NTA, 2006). Also, the court needs to be satisfied that the offender may be susceptible to treatment and thus is ‘willing to comply’ with the requirements of the order. Hence a full assessment of an offender’s drinking pattern is undertaken alongside an evaluation of their susceptibility to change. The latter requirement raises a somewhat interesting perspective when considered alongside the coercive element of a treatment programme such as the ATR. To what extent can any objective assessment of susceptibility and willingness to comply with treatment be measured when set against the potential outcome of a prison sentence if suitability is not demonstrated?

Unsurprisingly, 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 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? Indeed, would those sentenced to treatment engage in the process to the same extent as those who
participate on a voluntary basis? Would coerced individuals show any improvements following treatment? The last question may indeed be the most important. Due to the coercive element those on the ATR might outwardly engage in the treatment process. However, will this be public compliance rather than any lasting commitment to change?

Together with concerns around the coercive element it is crucial to realise that the ATR is designed and delivered in a different format when compared with coercive treatment for illegal drug misuse. For example unlike the DRR the ATR does not rely on punitive drug testing that can result in sanctions. With coercive 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 considers ‘controlled drinking’ as an appropriate treatment goal for some individuals. It is important to stress that attendance on the ATR is mandatory and non-attendance can result in breach and a return to court for sentencing. However, the more open and flexible nature of the ATR has tentatively been presented as a significant factor relating to the success of the program (Ashby, Horrocks and Kelly, 2011). Therefore in this paper we aim to present research that centres on the delivery of mandatory sentencing within a treatment relationship; exploring the nature of engagement and interaction during treatment.

**The Study**

The research presented in this paper is drawn from a wider study which looked at a broad range of indicators on the ATR. The original study had three phases. Phase one involved a detailed review of treatment files and probation records. Here offenders’ records were analysed showing that the vast majority of those sentenced to the ATR were young persistent, predominantly white, male offenders whose drinking patterns were categorised as ‘dependent’ (see Ashby et al 2011 for more detailed information regarding the wider study). Notably, the most common offence category was violence against the person. The second phase involved qualitative participant observations of treatment sessions; and finally the third phase involved narrative interviews with offenders sentenced to the ATR. We report here on phase two; observations of the treatment sessions. Phase two and three of the research acknowledged that looking at the process of the ATR using treatment files and probation records gives only a limited perspective. Therefore having the opportunity to observe the treatment setting enabled a detailed and extended contextualisation of how the ATR was being delivered within a treatment based interaction.

**Observing treatment sessions**

The majority of treatment on the ATR was delivered at two probation sites where the offender met with their alcohol treatment worker; both of whom were female. Assessment for the ATR and the delivery of alcohol treatment took place in probation interview rooms with the researcher granted permission to observe treatment sessions involving the offender and the alcohol treatment worker. The inherent expectations in carrying out these particular observations were that the researcher would simply observe
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the flow of events with no interruption or intrusion. However it needs to be acknowledged that the act of observation may have influenced those being observed (Emmerson, Fretz and Shaw, 2000). Moreover, although informed consent was gained at the beginning of each observation session, without doubt offenders could have been reluctant to talk about their offending or their drinking during such times that the researcher was present. Aiming to reduce the potential impact of what might be experienced as an obtrusive observation; rather than remaining outside the treatment interaction the researcher did at times participate in the process, in that if spoken to she replied and supported the process with positive reinforcement if appropriate. Hence the researcher was to a certain extent a participant observer.

As much detail as possible was written into the field notes, including: verbatim conversations and descriptions of body language etc. These field notes were often shared with the alcohol treatment workers in order to help with their completeness and accuracy. This supports Lofland and Lofland’s (1995:93) view that field notes are primarily ‘a running description of events, people, things heard and overheard, conversations among people and conversations with people’. However, it should not be assumed that writing and describing an observation is a straightforward and transparent process. As Coffey (1999:120) explains;

‘like any other text field notes are themselves literary creations authored and crafted ... In taking and making field notes we are involved in the construction and production of representations of a social reality which we are a part’.

Adding to this Harré and Moghadam (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 approach the field notes, as it offered a useful way of understanding the ATR in relation to what occurs during the ‘treatment’ interaction. For example, how do the offenders talk about their drinking? How do they position themselves and others? As the research developed the processes of writing field notes became more focussed, shifting from gathering factual data (how many units offenders were drinking, previous offence history, mental health history) to focussing on the social interaction between the female alcohol worker and the male offender enabling a consideration of how individuals appear to co-construct their ‘selves’ through discursive action. Twenty three individual treatment sessions were observed; generating over 150 typed and hand written pages of field notes.

Analysis

Gender and hegemonic positioning
As explained earlier those on the ATR, and participating in this research, were predominantly male offenders (91%, n=74); the majority (59%, n=48) were between 18-35
years of age with a high proportion sentenced for a violent offence (40%, n=32). Evidence shows that in general, men are more likely to consume alcohol than women and the relationship between men and alcohol is often portrayed as one of excess (Stimson et al. 2007; de Visser and Smith, 2007; Gelfer 2010). Work surrounding the relationship between men and alcohol has drawn specifically on drinking behaviour in relation to masculine identities as ‘hegemonic’ (Connell, 2003) in that the dominant ideal of masculinity is often surrounded by a discourse of ‘emotional toughness’ (de Visser and Smith, 2007) ’macho masculinity’ (McVittie and Wilock, 2006) and ‘male bonding’ (Garvey, 2005). Moreover Gelfer (2010:132) suggests that ‘the consumption of large amounts of alcohol is an integral part of hegemonic masculine performances, and men may view such consumption as a way of reaping the benefits of being part of the hegemonic order’. Therefore alcohol is argued to be embedded into hegemonic forms of masculinity and is also viewed as an important resource in the social construction of masculine identities. Indeed de Visser and Smith (2007:609) found that a large majority of men believed that being able to ‘hold your drink’ was an important indicator of masculinity.

Given the offender characteristics (young, male and many with evidence of past violence) one might expect the offender to perform the hegemonic position during treatment. Thus they might resist being positioned as someone who is expected to comply with treatment and succumb to a level of control exerted by a female treatment worker. The field notes below present a rare glimpse into this complex interaction. For example, the following field note excerpt is representative of similar evidence in the wider corpus of data and clearly presents the normalised gender identity that might be prevalent in the lives of those sentenced to treatment.

Field notes: ‘Susan meeting Wayne’

I followed Susan down to the interview rooms in order to sit in and observe her session with an offender called Wayne. She went to collect Wayne and the following conversation ensued:

**Wayne:** ‘hello sweetheart’

**Susan:** ‘I am not your sweetheart, from now on you call me Susan’

**Wayne:** ‘oh sorry, Susan’

There is further evidence of expected gender positioning during the interaction between Amy and Dave in the following field notes. It is clear that Dave initially discursively positions himself as ‘abandoned’ with ‘no hope’ perhaps anticipating that Amy as a woman will sympathise with his story.

Field notes: ‘Amy and Dave’

Dave 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, four different mums ... he’s a knob head’

At this point in the interview Amy glances over at me. 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.

During the interaction Amy resists being discursively positioned as the ‘caring female’ as she effectively takes control by promptly asking him Likert scale questions about his drinking. She is not drawn into a conversation about his depression. Indeed her resistance to take up the caring role may appear unfeeling and unresponsive but she is effective in engaging Dave and therefore successful in completing his assessment. Thus we begin to observe Dave complying with treatment:

‘**Amy and Dave continued …..**’

**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’

**Amy:** ‘talk me through a typical day’

With Amy’s continuing to complete Dave’s assessment, further positions of control are once again negotiated. In the interaction Amy needs to traverse delicately in order to sustain Dave’s engagement and also begin to set realistic goals for him. Dave becomes intensely frustrated with Amy’s questioning about his drinking and discursively positions her as ‘the expert’ by exclaiming ‘how am I supposed to explain it?’ However during this interaction Amy does not lose sight of trying to gain important information about his drinking behaviour and his goals. His final attempts to gain Amy’s sympathy are again resisted as Amy stays focussed on his drinking behaviour.

In the field notes there is much evidence that offenders on the ATR seem to initially be expectant of a relationship that is acquiescent with stereotypical, hegemonic gender positioning. However, what they encounter is a relationship that refutes simplistic gender positions requiring engagement with treatment expectations that is focussed on drinking patterns and behaviour change. Indeed, the analysis of this interaction reveals a complex
relationship founded upon issues of control and compliance. Importantly, while attendance is mandatory, participation during the treatment interaction is negotiated. The field notes reveal the on-going work and skills necessary in order to focus on the ATR’s aims around achieving controlled drinking and harm reduction. It may be important to consider the extent to which the outcome of treatment is reliant upon the skills and expertise of the treatment worker. The spotlight is often upon the offender and notions of susceptibility to change – a more relational and interactive analysis supersedes such individualising notions offering a more shared and situated approach to understanding behaviour change.

**Active engagement with treatment**

Engagement with treatment is often measured retrospectively as an outcome of treatment success (Miller, Walters and Bennett, 2001). Early evidence regarding the effectiveness of the ATR, in relation to attendance and completion, has been found to be comparatively high compared to other offender treatment programs (Ashby et al, 2011). While such evidence is encouraging, providing an indication that the majority of the offenders in this study were engaging with treatment, it is fair to say that attendance and completion rates do not provide insight into how engagement occurred or the nature of engagement. Therefore, having the opportunity to qualitatively observe the treatment setting of the ATR provided valuable data regarding the relational aspect of treatment delivery and engagement. Importantly, ‘therapeutic expectations’ embedded within the process and treatment of addictions is often a result of operating within a counselling approach to behaviour change (Miller and Rollnick, 2002; Soravia and Barth, 2008; DiClemente and Velasquez, 2002). Consequently, within this framework it is argued and generally accepted that individuals are more likely to adopt healthy behaviours if ‘they want to change rather than if they ought to or have to change’ (Botelho, 2004: 27). In this sense any notion of ‘control’ is argued to negatively jeopardise an individual’s desire and subsequent commitment to change (Meier and Davis, 1993). Therefore with the ATR research it was of interest to explore the extent to which the alcohol treatment workers engaged and utilised this therapeutic framework, given that treatment was coercive and attendance mandatory. This section of the analysis therefore presents data that further reveals the interactive and relational complexity of offender engagement.

**Field notes – ‘Susan and Carl’**

Carl is 20 years old and has been assessed as a dependent drinker. This is his second month of a 6 months ATR order. Susan begins to look through Carl’s drink diary (where offenders can record alcohol units consumed on a daily basis) and praises Carl for the evident effort in beginning to reduce his daily alcohol units.

**Carl:** ‘Yeah someone had stopped me other day and thought I’d been beaten up because I looked better’.

Susan reminded Carl that in order to detox he needed to be drinking less than 23 units per day. Carl said that from Monday he was considering cutting his units down further. He talked to Susan about the Crest lager he used to drink which was 10.5% and only cost £1.10
and described it as ‘like drinking tar’ (shaking his head). Indeed they both enter into a chatty light hearted conversation about this ‘new lager’. Nevertheless Susan quickly returns to focus on Carl’s drink diary and asks him to change his 8.5% cans of lager to 5% lager in order to suggest ways of reducing his units further. Susan then goes on to announce to Carl that she will be booking him in for a detox in 2 weeks’ time. They then begin to go over the finer details of the detox process and Carl seems to respond well to this.

Most of treatment sessions observed had similar conversations around consumption of alcohol. Shown is how Susan is able to engage Carl in treatment by focussing on levels of alcohol consumption. This simple yet effective approach in dealing with Carl’s alcohol consumption relies on facts (alcohol units) and figures (amount reduced daily) and provides Carl and the treatment worker with an accessible discursive framework where behaviour can be considered and potentially changed. Possibly, reflecting the idea that men have a very functional view of their bodies thus responding better to treatment interventions that offer facts and figures (White, 2001). While recognising the somewhat stereotypical implications; within this framework, alcohol consumption is mutually understood and consequently both are positioned as ‘knowledgeable’. This mutual understanding is signified by the ‘chatty conversation’ regarding new strong lagers that ensues between Susan and Carl. Indeed Carl appears to demonstrate new understanding as he shakes his head whilst reminiscing on his past drinking behaviour. This positive engagement enables Susan to shift Carl’s treatment goals swiftly as she talks about further reductions in his alcohol units. Thus Carl is positioned by Susan as someone who is ‘capable’ of taking the necessary steps forward in order to become alcohol free. Carl does not resist nor challenge Susan’s direction, rather he accepts the news that he could be potentially alcohol free in the near future. Treatment engagement in this instance, and many others analysed, is influenced less by a focus on an individual readiness to change and more on a shared interaction and goal setting. Yet, as with most of the treatment sessions observed, the treatment worker maintained her position as one controlling the interaction. There was a sustained focus on alcohol consumption with the coercive element of treatment in relation to expected compliance evident throughout. Would Carl be at this point so early on in his treatment without Susan’s efforts to remain within the boundaries of coercive treatment in relation to control and compliance? More importantly would Carl be considering detox if Susan took a more ‘empathetic, collaborative planning’ approach inherent in the counselling relationship and often advocated in addiction treatment (Miller & Rollnick, 2002; Myers and Salt, 2012). It is difficult to provide any absolute response to such speculation. It is reasonable to claim that treatment on the ATR operates at the relational level with the treatment workers’ ability to build rapport and respect evident. This said the relationship is one where the treatment worker retains control being situated within a criminal justice, coercive relationship. Mill, Brooks and Davies’ (2007) research regarding the DTT0 make reference to the relationship between the worker and the offender with an acknowledgment of the importance of relationship-based working. What we hope we have done here is demonstrate how this relationship is made up of a series of positioning acts that are negotiated and remain focussed upon change.
Malignant positioning: control and resistance
We have presented how the treatment sessions are openly focussed on drinking patterns, control and behaviour change. It might be anticipated that during these treatment sessions as part of the ATR offenders would be expected to acknowledge the offence that resulted in their being sentenced to treatment. However, 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. Arguably such positioning may not bring about a positive relational interaction and subsequent desired compliance and behaviour change. Yet, some of the offences committed did prompt deliberation in relation to the treatment relationship and interaction and the potential need to challenge the acceptability of violence when intoxicated. For example Sean (male offender; dependent drinker with past history of domestic violence) explained to his treatment worker that he hit his partner because ‘She wound me up, the things that she said while I was drunk. I’m not a violent lad, I’m a big soft lad, I always have been’. During this particular encounter malignant positioning is clearly being resisted in Sean’s attempts to rationalise the violence and portray himself as a non-violent person. Indeed he is positioning himself as the victim of his partner’s abuse who should be blamed for his outbursts, ‘she shouldn’t say things when I am drunk’. By not challenging such accounts there is a danger of almost colluding and supporting unacceptable levels of gendered violence.

The following field notes taken from the observation of Ricky’s treatment session offer an indication of what might be seen as Ricky discursively resisting malignant positioning and the treatment worker’s responsive interaction. Ricky, similar to Sean, tries to avoid being positioned as a perpetrator of domestic abuse, rather he positions himself as someone whose violent behaviour is attributed to the inevitable consequence of drinking. He personally is not an angry man it is the drink that causes the anger:

Field notes – ‘Amy and Ricky’

Further on in the interview Ricky says that he doesn’t want to give up drinking

**Ricky:** ‘no I’ll never stop drinking, I just want to control it. I can’t see meself not drinking. I’m being honest about this’

Amy asks about the positive aspects of his drinking. Ricky 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 it’s got me into now’. Ricky goes on to reflect on the offence,

**Ricky:** ‘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 it’s 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’
Ricky: ‘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 ‘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 argued that people construct and resist certain positions; as with Sean and Ricky people constantly adopt and defend their positions and accept or confront the positions of others. Throughout the treatment session Amy appears to remain almost indifferent. She does not at any point respond to any of Ricky’s talk in an emotional, enraged or sympathetic way. Ricky 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 knowledgeable expert someone who knows what’s good for him ‘I just want to control it’. By telling him quite clearly that if he did enter treatment he would need a period of abstinence, Amy reasserts her authority. Indeed Ricky is required to talk about the negative aspects of his drinking. Throughout this interaction there is an obvious taking and resisting of power; an interplay that demonstrates efforts to resist any malignant positioning. McMurran (2012) draws attention to the ways in which treatment interventions for offenders are often either targeting substance use or violence but not the two together. The ATR is one such targeted intervention focussing on those who are dependent drinkers aiming to reduce the level of alcohol consumption and by association the requisite societal and individual costs associated with drink dependency. Although it is evident in the data that both offender and treatment worker are aware of the potentially negative attribution that violence, in particular domestic violence, carries for those convicted of such offences the focus remains on alcohol consumption. Perhaps the treatment encounter offered a place to have such behaviours spoken about and while the treatment worker remained focussed on alcohol consumption and behaviour change the treatment workers’ refusal to lend any level of support to their rationalisations may have had an impact. Even so, as McMurran (2012) advocates, teaching offenders awareness skills around reduced attentional capacity and self-awareness, and strategies for coping with perceived provocation when under the influence of alcohol may have been useful. There was a great deal of talk around pre-planning for times when alcohol would be available and strategies for managing situations that might arise but this was predominantly about planning around consumption. Incorporating some of the alcohol related violence intervention approaches outlined by McMurran and colleagues (Walton et al., 2010) may be something that those developing the ATR might consider given the profile of those ‘sentenced to treatment’.

Conclusions

The wider study did show positive outcomes with regard to engagement and completion of the ATR. Yet, finding solutions to alcohol related offending, which continues to incur
huge consequences for society, requires more knowledge regarding the process and impact of planned interventions. In aiming to understand the delivery of the ATR as an alcohol treatment intervention specifically targeted at reducing the potential to reoffend, and thus reduce harm to others, this paper has explored the relational aspect of behaviour change. The observational data gathered during coercive treatment sessions shows how treatment involves a series of complex manoeuvrings and negotiations. The positionings of alcohol treatment workers and male offenders are situated within broader hegemonic ideals, professional boundaries and ATR related expectations. However, the clear message from the observation data is that the treatment sessions remained strongly focussed on alcohol consumption and reducing the harm of alcohol related behaviour. This persistent attention to the ATR aims did appear to ensure that treatment sessions fulfilled expectations for both the treatment worker and the offender. The resistance of any other positioning that might relate to a more caring or therapeutic relationship did appear to be effective in terms of engaging with the treatment aims of the ATR. Yet, as McMurran (2012) suggests other opportunities for a broader level of engagement around violence related offending and the impact of some of the hegemonic masculinity related issues appeared to be missed and might be something to work on as the programme develops.

Nonetheless, this analysis has 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 treatment worker and treatment aims. Treatment on the ATR clearly situates interaction and engagement as more important features of behaviour change with compliance anticipated rather than required and punitively measured as with the DRR. Indeed it seems that the professional role occupied by the alcohol treatment workers has been shown to be effective in building and developing positive interactions that enable change at the very least to be considered.

Without doubt alcohol is one of the most harmful drugs overall in the UK, leading Nutt et al. (2010:1564) to conclude that ‘aggressively targeting alcohol harms is a valid and necessary public health strategy’. The data from the treatment sessions challenges the notion of coercion as a somewhat problematic strategy. This analysis has shed light on earlier questions concerning the potential for offenders to effectively engage and improve under coercive conditions. Indeed it has provided considerable insight into how young male persistent offenders can be effectively managed through the care and control of female alcohol treatment workers. There is certainly more work to be undertaken to consider the gender related implications within the data. It was clear that these young men responded well to the directional straight-forward goal setting offered by the treatment workers. This may have implications when considering the adoption of more specialised treatment modalities such as Cognitive Behavioural Therapy (Soravia and Barth, 2008) or Motivational Interviewing (Miller and Rollnick, 2002) that are currently widely adopted in the substance misuse treatment field. Indeed 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 relational nature of change and the role of the treatment workers in enabling change to occur as illustrated in this research.
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