



Ministry of
JUSTICE

National Offender
Management Service

**NOMS Alcohol Interventions Guidance including
revised guidance on *Managing the Alcohol
Treatment Requirement (ATR)* -
Update of Annex B to Probation Circular 57/2005**

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Acknowledgements

This guidance was developed following two extensive consultation periods which involved Assistant Chief Officers (ACOs) with policy responsibility for substance misuse across the 42 probation areas/trusts in England and Wales, Directors of Offender Management (DOMs) and other key stakeholders from within and outside Government. These included NOMS Offender Assessment and Management Group (OAMG) (Offender Management Team and OASys Data, Evaluation and Analysis Team (O-DEAT)); NOMS Performance Management Unit; Specification, Benchmarking and Costing (SBC) Programme; Ministry of Justice (Offender Management and Sentencing Analytical Services (OMSAS); Partnerships and Health Strategy Unit; Women and Third Sector Unit); Department of Health (Alcohol Policy Team, Offender Health and the Alcohol Improvement Programme); National Treatment Agency for Substance Misuse; Home Office Alcohol Strategy Unit; Alcohol Concern; representatives from the alcohol treatment sector; Alcoholics Anonymous; Adfam; the Alcohol Education Research Council (AERC) Alcohol Academy; the Welsh Assembly Government and the Scottish Government.

We would like to thank in particular Don Lavoie and Dave Marteau (Department of Health); Wulf Livingston (North Wales Probation Area); Diana Johnson (West Yorkshire Probation Area); Dezlee Dennis (London Probation Area); Nicola Smith (Sheffield Alcohol Advisory Service); Bobbie Jones, Karen MacLeod and Sarah Winwin Sein (NOMS Offender Management Team); Tim McSweeney (Institute for Criminal Policy Research, King's College London); Dr. Dorothy Newbury-Birch (Institute of Health and Society, Newcastle University) and Peter Blomley (NOMS South West) for their helpful input during the consultation process.

We are also grateful to Sue Brown (Merseyside Probation Trust); Peter Jones (Cheshire Probation Area); Paul Yates (former Assistant Chief Officer, Derbyshire Probation Area); Mike Ruffles (previously Devon & Cornwall Probation Area); Don Shenker (Alcohol Concern); Trevor McCarthy (ex-National Treatment Agency); and all those who have contributed to the success of NOMS Alcohol Best Practice Projects Initiative since its inception in 2006 for their advice and support during the lengthy gestation period of the guidance.

Glossary

ATR *Alcohol Treatment Requirement*

A requirement that a court may attach to a community order or suspended sentence of imprisonment

AUDIT *Alcohol Use Disorders Identification Test*

A standardised and validated screen for problem drinking

CARATs *Counselling, Assessment, Referral, Advice and Throughcare services*

A drug treatment and case management service for prisoners

CDRP/CSP *Crime & Disorder Reduction Partnership/Community Safety Partnership*

A partnership of criminal justice, local authority, health and social care organisations, which has a statutory duty to tackle crime and anti-social behaviour, including the impact of drugs and alcohol use. In England these are known as CDRPs; in Wales as CSPs. In Wales, CSPs have lead responsibility for the planning/commissioning of substance misuse services in their area.

CO *Community Order*

A community sentence to which courts may attach elements, drawn from a total of 12 requirements set out under the Criminal Justice Act 2003

DIP *Drug Interventions Programme*

A national network of criminal justice integrated teams (CJITs) that provide case management and access to services for adult problematic drug treatment across the justice sectors

DA[A]T *Drug [and Alcohol] Action Team*

In England, a local strategic group of criminal justice, local authority, health and social care organisations that addresses the management of drug and alcohol problems; sometimes subsumed within a CDRP

DRR *Drug Rehabilitation Requirement*

A requirement that a court may attach to a community order or suspended sentence

DANOS *Drugs and Alcohol National Occupational Standards*

A framework of good practice and competence in the planning and delivery of services to substance misusers. There are over 100 DANOS units relating to service delivery and the management and commissioning of services. There are 11 key units relevant to service delivery; including helping substance users address their offending behaviour and helping them access substance misuse services.

IBA *Identification and Brief Advice*

A screening and brief intervention that is intended to help someone reduce his or her drinking

IDTS *Integrated Drug Treatment System*

A prison drug treatment service that combines CARATs and health teams

JSNA *Joint Strategic Needs Assessment*

An annual assessment of the health and social care needs of their local population, carried out by a Primary Care Trust and Local Authority

LAA *Local Area Agreement*

In England, a three-year agreement between central government and a local authority and its partner organisations

LHB *Local Health Board (Wales)*

Single local health organisations, created by the reorganisation of NHS Wales, which are responsible for delivering all healthcare services within a geographical area

LSP *Local Strategic Partnership*

In England, the collective body that generates Local Area Agreements, led by the local authority

MoCAM *Models of care for alcohol misusers*

In England, the national service specification for the treatment of problem drinking. In Wales, guidance on relevant alcohol provision is generated by the Welsh Assembly Government and its Substance Misuse Treatment Framework (SMTF).

MHTR *Mental Health Treatment Requirement*

A requirement that a court may attach to community order or suspended sentence

NAO *National Audit Office*

The organisation that audits most public-sector bodies in the UK, and examines the value for money of the implementation of government policies

NOMS *National Offender Management Service*

A single service that brings together the work of probation and prisons

NTA *National Treatment Agency for Substance Misuse*

A special health authority tasked with increasing the availability, capacity and effectiveness of treatment for drug misuse in England.

NWPHO *North West Public Health Observatory*

One of nine regional organisations, providing public health data and information

OASys *Offender Assessment System*

The standardised prison and probation IT-based risk and needs assessment and sentence planning tool

PAC *Public Accounts Committee*

A body that examines the expenditure of public money agreed by parliament

PCT *Primary Care Trust*

A local NHS authority in England

SHA *Strategic Health Authority*

A regional NHS authority in England

SSO *Suspended Sentence Orders*

A custodial sentence that is suspended for a period ranging from six months to two years to which courts may attach elements, drawn from a total of 12 requirements set out under the 2003 Criminal Justice Act

YOT *Youth Offending Team*

A local team, comprising criminal justice, social care, education, health and substance misuse services that co-ordinates the work of the youth justice services

Introduction

Purpose

Best practice guidance for probation staff, in particular Assistant Chief Officers (ACOs), Senior Probation Officers (SPOs), Offender Managers (OMs), Offender Supervisors and interventions staff who work with substance misusers, on the effective commissioning, management and delivery of a range of interventions for alcohol misusing offenders. This includes updated advice on the implementation of alcohol treatment requirements (ATRs).

The guidance:

- defines requirements for managing offenders with alcohol related needs and in matching evidence based interventions to need
- provides more detailed advice on the appropriate targeting, delivery and enforcement of ATRs to contribute towards greater standardisation of the probation service's work with alcohol misusing offenders
- clarifies the distinction between offence seriousness and treatment need in developing pre-sentence report (PSR) proposals and updates guidance on tiering
- includes further advice on working with women offenders with alcohol misuse issues, in line with the *Offender Management Guide to Working with Women Offenders*¹

This guidance updates Annex B to PC 57/2005², *Managing the Alcohol Treatment Requirement (ATR)*, to better reflect *Models of care for alcohol misusers (MoCAM)*³ and the *Review of the Effectiveness of Treatment for Alcohol Problems*⁴, which the existing guidance pre-dated. It also addresses specific queries raised by probation areas/trusts and issues that NOMS has identified centrally.

The focus of the revised guidance is on improving provision within existing resources based upon evidence of what has been found to be effective and, most importantly, cost-effective. Improved targeting of interventions; swifter and more accurate identification of alcohol and offending needs; more timely and appropriate advice and information and referral into structured treatment, where indicated; increased availability and accessibility of a wide range of evidence based interventions and greater continuity between what is delivered in prison and the community should all lead to cost savings.

1 <http://noms.justice.gov.uk/news-publications-events/publications/guidance/OM-Guide-Women>

2 <http://npsintranet.probation.gsi.gov.uk/index/pc57-2005.htm>

3 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4136806

4 <http://www.nta.nhs.uk/publications/publications.aspx?CategoryID=6>

The guidance was informed by: -

- *Evidence based practice? The National Probation Service's work with alcohol misusing offenders*⁵ published on 28th October 2009
- implementation guidance developed locally by probation areas/trusts
- work undertaken as part of NOMS Alcohol Best Practice Projects Initiative⁶
- ATR workshops held at two national alcohol conferences⁷
- analysis of responses to ATR questionnaires issued to all probation areas
- feedback from, *Improving local alcohol provision for offenders under probation supervision*, an Alcohol Treatment Providers Consultation Event held jointly with Alcohol Concern⁸

It is not expected that staff will read the entire document but rather use it as a reference guide to assist with specific problems.

Typology of drinking

Sensible drinking

Sensible drinking is defined as regularly consuming less than the recommended daily limits.

The government advises⁹ adult women not to drink more than 2–3 units (1 unit is 10 ml of pure alcohol) and adult men not more than 3–4 units of alcohol a day on a regular basis, to reduce their risk of alcohol-related harm.

At least one day a week should be alcohol-free and two days should be alcohol-free following a heavy drinking session.

Women who are pregnant or trying to conceive should avoid drinking alcohol but if they choose to drink should not drink more than 1 -2 units once or twice a week and should not get drunk.

The risk of harm from drinking above sensible levels increases the more alcohol that you drink and the more often you drink over these levels.

5 <http://www.justice.gov.uk/publications/alcohol-misusing-offenders-research-report.htm>

6 http://npsintranet.probation.gsi.gov.uk/index/service_delivery/interventions/drugs__alcohol/alcohol_best_practice_projects.htm

7 NPS Alcohol Strategy Implementation Events held in Bath and Sheffield in October 2006.

8 http://npsintranet.probation.gsi.gov.uk/document_library/index/alcohol_treatment_provider_event_report_7th_december_2006.htm

9 *Safe. Sensible. Social. The next steps in the National Alcohol Strategy* (2007)

Categorisation of alcohol misuse

There is no single or scientific method of categorising individuals requiring intervention or treatment for alcohol misuse.

World Health Organisation (WHO)

The World Health Organisation (WHO)'s tenth revision of the *International classification of diseases (ICD-10)*¹⁰ defines:-

- **hazardous** use of a psychoactive substance, such as alcohol, as an 'occasional, repeated or persistent pattern of use...which carries with it a high risk of causing future damage to the medical or mental health of the user but which has not yet resulted in significant medical or psychological ill effects.'¹¹
- **harmful** use of a psychoactive substance, such as alcohol, as 'a pattern of use which is already causing damage to health. The damage may be physical or mental.'¹²
- **dependence**¹³ as 'a cluster of physiological, behavioural, and cognitive phenomena in which the use of a substance or a class of substances takes on a much higher priority for a given individual than other behaviours that once had greater value. A central descriptive characteristic of the dependence syndrome is the desire (often strong, sometimes overpowering) to take psychoactive drugs (which may or may not have been medically prescribed), alcohol, or tobacco. There may be evidence that return to substance use after a period of abstinence leads to a more rapid reappearance of other features of the syndrome than occurs with nondependent individuals.'

Drinkers falling into the later category can be further classified as having mild, moderate and severe levels of dependence.

¹⁰ <http://www.who.int/classifications/icd/en/>

¹¹ Hazardous drinking is defined as consuming more than 14 or 21 units per week (women and men respectively) but not yet experiencing harm.

¹² Harmful drinking is defined as consuming more than 35 or 50 units per week (women and men respectively) and/or experiencing the harmful effects of alcohol consumption but not alcohol dependence (Examples of harmful effects include an alcohol-related accident, acute alcohol poisoning, hypertension or cirrhosis).

¹³ Dependence is difficult to define, as it is not a single entity, but a constellation of behaviours and internal processes that combine to cause a chronic problem.

Models of care for alcohol misusers (MoCAM)

MoCAM (using the WHO classification) identifies four main categories of alcohol misusers: hazardous drinkers; harmful drinkers; moderately dependent drinkers; and severely dependent drinkers.

Hazardous drinkers – drink 'at levels over the sensible drinking limits, either in terms of regular excessive consumption or less frequent sessions of heavy drinking. However, they have so far avoided significant alcohol-related problems.'

Harmful drinkers – usually drink 'at levels above those recommended for sensible drinking, typically at higher levels than most hazardous drinkers', however they show clear evidence of some alcohol-related harm.

Moderately dependent drinkers – have a level of psychological dependence 'with an increased drive to use alcohol and difficulty controlling its use, despite negative consequences.'

Severely dependent drinkers – have a severe level of psychological dependence and often have physical withdrawal upon cessation. They may have formed the habit of drinking to stop withdrawal symptoms. Their drinking is likely to comprise 'habitual significant daily alcohol use or heavy use over long periods or bouts of drinking.'

Department of Health

In 2008, the Department of Health (DH) consulted with experts to agree a new description of categories of drinking based on risk. This resonated better with the public and non-specialist health professionals than the terms hazardous and harmful used in the WHO classification.

WHO	DH	MEN	WOMEN
Sensible levels	Lower Risk	No more than 3-4 units per day on a regular basis	No more than 2-3 units per day on a regular basis
Hazardous levels	Increasing Risk	More than 4 units per day on a regular basis	More than 3 units per day on a regular basis
Harmful levels	Higher Risk (this category includes all dependent drinkers)	More than 8 units per day on a regular basis or more than 50 units per week	More than 6 units per day on a regular basis or more than 35 units per week

Binge drinking

*Safe. Sensible. Social. The next steps in the National Alcohol Strategy*¹⁴ defines ***binge drinking*** as 'drinking too much alcohol over a short period of time, e.g. over the course of an evening, and it is typically drinking that leads to drunkenness. It has immediate and short-term risks to the drinker and to those around them.'

Trends in binge drinking are usually identified in surveys as consuming **more than twice** the Government's recommended daily limit **in a single session** (i.e. 8 units for men and 6 units for women) but many binge drinkers consume substantially more than this level or drink this amount more rapidly. Binge drinking cuts across the 'Lower Risk', 'Increasing Risk' and 'Higher Risk' categories.

The WHO classification is used in this document, whenever appropriate, for reasons of historical accuracy e.g. reference to past research studies. The NHS is being guided to use the new DH terminology and therefore, to facilitate partnership working, probation staff are encouraged to adopt these definitions rather than continue to refer to WHO categories such as hazardous and harmful.

¹⁴ <http://www.homeoffice.gov.uk/documents/alcohol-strategy-2007>

Drinking Categories

Drinking Category	Definitions
Abstainers	Men and women who have not drunk alcohol in the past year
Lower risk	For men: not regularly drinking > 3-4 units per day For women: not regularly drinking > 2-3 units per day
Increasing risk	For men: regularly exceeding > 3-4 units per day > – but not drinking at levels incurring the highest risk For women: regularly exceeding > 2-3 units per day >– but not drinking at levels incurring the highest risk
Higher risk	For men: regularly drinking > 50 units per week or regularly drinking > 8 units per day For women regularly drinking greater than 35 units per week or regularly drinking > 6 units per day
Binge drinking	Drinking too much alcohol over a short period of time, e.g. over the course of an evening and it is typically drinking that leads to drunkenness. The Office for National Statistics (ONS) uses the measure of consuming more than twice the lower-risk levels in one day (>6 units for women and > 8 units for men). (Sub-set of Lower, Increasing and Higher risk groups)
Dependence	Dependence is characterised by: <ul style="list-style-type: none"> • A strong desire or sense of compulsion to drink alcohol • Difficulty in controlling drinking (stop/start) • A physiological withdrawal state (e.g. tremor, sweating, anxiety, seizures, disorientation, hallucinations) when drinking has ceased or reduced • Drinking to relieve or avoid such withdrawal states • Evidence of tolerance • Persisting with alcohol use despite harmful consequences (ICD-10, WHO) <p style="text-align: center;">(Sub-set of Higher risk drinking group)</p>

Models of care for alcohol misusers (MoCAM)

In 2005, the Department of Health commissioned the National Treatment Agency for Substance Misuse (NTA) to develop and publish *Models of care for alcohol misusers* (MoCAM). This document provides best practice guidance on a framework for commissioning and providing interventions and treatment for adults affected by alcohol misuse.

Alcohol treatment services are categorised into 4 tiers of intervention in MoCAM. The tiers represent a stepped approach to alcohol problems (starting with a very brief intervention and intensifying efforts in case of no success), and range from low-intensity interventions for modest alcohol problems (Tier 1) to intensive specialist treatment for severe alcohol dependence (Tier 4).

- **Tier 1: Alcohol-related information and advice; screening; simple brief interventions; and referral.** This is defined as the identification of hazardous, harmful and dependent drinkers; the provision of information on sensible drinking; simple brief interventions to reduce alcohol-related harm; and referral of those with alcohol dependence or harm for more intensive interventions. Tier 1 interventions include alcohol advice and information; targeted screening and assessment for those drinking in excess of DH guidelines on sensible drinking; provision of simple brief interventions to hazardous and harmful drinkers; and referral of those requiring more than simple brief interventions for specialised alcohol treatment. These are delivered in health settings (e.g. in primary care, A&E departments) and in generic settings by offender managers and other non-specialists with the necessary Drugs and Alcohol National Occupational Standards (DANOS) competences.¹⁵

- **Tier 2: Open access, non-care-planned, alcohol specific interventions.** This is defined as provision of open access facilities and outreach delivering alcohol-specific advice, information and support; extended brief interventions to reduce alcohol-related harm; and assessment and referral of those with more serious alcohol-related problems for care-planned treatment. Interventions provided include triage assessment; brief treatment and mutual aid groups e.g. Alcoholics Anonymous. Tier 2 provision may be offered in a probation setting where staff have the required DANOS competences or through referral to specialist alcohol services and are generally appropriate for hazardous and harmful drinkers who have not responded to simple brief interventions.

¹⁵ Available at www.skillsforhealth.org.uk

- **Tier 3: Community-based, structured, care-planned treatment.** This is defined as specialised alcohol misuse assessment, and alcohol treatment that is care co-ordinated and care-planned. Interventions include comprehensive substance misuse assessment; evidence based prescribing interventions, including for medically assisted alcohol withdrawal (detoxification)¹⁶ and to reduce risk of relapse; structured evidence based psychosocial therapies and support; and structured day programmes and care-planned day care. These interventions are usually provided within specialised alcohol treatment services and are generally appropriate for moderately dependent drinkers.

- **Tier 4: Alcohol specialist inpatient treatment and residential rehabilitation.** This is defined as residential, specialised alcohol treatments which are care-planned and co-ordinated to ensure continuity of care and aftercare. Tier 4 includes in-patient assisted withdrawal – typically a relatively brief intervention lasting 7-10 days (and sometimes less if treatment starts as an in-patient and is completed in the community). In-patient assisted withdrawal is indicated when service users would be at risk if treatment was provided in the community. Assisted withdrawal can also be provided at the start of a residential treatment placement. Tier 4 interventions are likely to be suitable for those who have severe dependence or alcohol dependence with other problems, and may be provided in specialised statutory, independent or voluntary sector inpatient facilities or residential rehabilitation units by medical staff with specialist competences.

MoCAM Tiers

Tier	Interventions	Target Drinking Category	Who can provide these interventions?
1	Alcohol-related information, identification and brief advice; and referral to specialist services	Increasing-risk Binge drinking	GPs, EDs, other health and social care professionals, arrest referral schemes, probation, prisons
2	Open access, non-care-planned, alcohol-specific advice and counselling	Increasing-risk Binge drinking	Drop-in centres, homelessness services, domestic violence services, criminal justice settings
3	Community-based (outpatient), structured, care-planned alcohol treatment <ul style="list-style-type: none"> • counselling services • day treatment programmes 	Higher-risk Dependence	NHS Mental Health Trusts/Health Boards and third-sector alcohol treatment community organisations

¹⁶ Otherwise known as 'prescribed medication.'

4	Alcohol specialist inpatient treatment and residential rehabilitation	Dependence	NHS Mental Health Trusts/Health Boards and third-sector alcohol treatment residential providers
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Offender Management Model Tiers

The NOMS Offender Management Model (OMM)¹⁷ defines a four tier classification structure for the management of offenders under supervision. The tiered approach coupled with systematic assessment of offenders is designed to ensure that the level of probation resources and services applied to the supervision of individual offenders is commensurate with the assessed levels of risk of serious harm to the public and assessed likelihood of re-offending behaviour. The OMM is designed to be progressive – subsequent tiers building on the preceding tier. The primary purpose and approaches required at each tier are:

Tier	Primary Purpose	Offender Management Approach
Mode Label	Description of Mode	
1. PUNISH	The primary purpose of Offender Management at Tier 1 is to ensure that the sentence requirements imposed by the Court or prison licence are carried out as intended and to ensure that the Offender complies with them.	
	Arrangements made for the implementation of the sentence requirements, with due regard for decency, health and safety and the preservation of citizenship; monitor risk factors; 'signpost' to helping resources.	Hands-off; administrative; organising; monitoring; signposting to resources.
2. HELP	The primary purpose of Offender Management at Tier 2 in addition to ensuring that sentence requirements are carried out as intended is to motivate and refer Offenders to resources providing practical help to address particular circumstances or situations linked to offending, to reduce the likelihood of re-offending.	
	Motivation; referral to resources providing practical help addressing circumstances, or situation – typically employment, accommodation, basic and life skills; support and encouragement of participation.	Hands-on; motivating; encouraging; referring; supporting; problem solving.

¹⁷ <http://noms.justice.gov.uk/news-publications-events/publications/strategy/offender-management-model-1.1>

3. CHANGE	The primary purpose of Offender Management at Tier 3 is to extend the Tier 2 arrangements by motivating Offenders to take advantage of specialist resources providing treatments and interventions designed to produce behavioural change which will lead to reduction in frequency and/or seriousness of re-offending.	
	Implementation of carefully planned programme designed to achieve personal change, typically including Offending Behaviour Programmes, drug and alcohol treatment, some social skills.	Hands-on; treatment (usually) to complement or as part of a specialist treatment programme; co-ordination of all inputs to complement one another. Sometimes referred to as 'therapeutic'.
4. CONTROL	The primary purpose of Offender Management at Tier 4, and in particular those Offenders classified as Prolific and other Priority Offenders (PPOs) , is for the Area/Trust to use best endeavours to ensure that these Offenders are managed safely within prisons and the community and, where appropriate, to take all necessary actions in partnership with MAPPA partners and other agencies to: <ul style="list-style-type: none"> • minimise risk of serious harm to Offenders and the public at large • respond expeditiously to any developing threats • work with Offenders to radically reduce the frequency and seriousness of re-offending • ensure that breaches of sentence and/or licence result in appropriately swift return to court or recall to custody 	
	Intensive, inter-agency, multi-faceted programmes to control and monitor behaviour, including surveillance and intelligence work. Typically, Prolific Offender Schemes and dangerous offender MAPPA 'packages'.	Hands-on; risk management; inter-agency co-ordination; high level of teamwork.

Alcohol related offending and the sentencing framework

Offenders with identified alcohol misuse needs sentenced to either a community order or suspended sentence of imprisonment can receive alcohol related interventions in a number of different ways dependent upon their assessed level of drinking problem, seriousness of offence and risk of re-offending/harm.

The **Alcohol Treatment Requirement (ATR)** is one of the 12 requirements which can be included in a community sentence for adult offenders (offenders aged 18 or above) for offences committed on or after 4th April 2005. The ATR is targeted at those offenders assessed as alcohol dependent and provides access to intensive, specialist, care-planned treatment (Tiers 3 and 4 of MoCAM), with

the aim of reducing or eliminating the offender's dependency on alcohol. An ATR can be made part of a community order for a minimum of six months and maximum of three years and a suspended sentence of imprisonment for a minimum of six months and maximum of two years. The court has discretion to decide that a suspended sentence order be subject to periodic review, including those with an ATR.

Alcohol-specific information, advice and support (a.k.a. brief interventions)

- Extended brief interventions or brief motivational counselling typically takes between 20-30 minutes to deliver and can involve a small number of repeat sessions (Tier 2 of MoCAM). This is delivered to higher risk (excluding those assessed as dependent) or less persistent binge drinkers who do not meet the dependency test of the ATR, either in-house by probation areas/trusts or in partnership with the voluntary sector, through an ***activity requirement*** or as part of a ***supervision requirement***. Some areas/trusts have 'marketed' the former to courts as an Alcohol Specified Activity Requirement (ASAR).
- Simple brief interventions (generally around 5 minutes of structured brief advice) (Tier 1 of MoCAM) are targeted at increasing risk drinkers and usually delivered by Offender Managers or Offender Supervisors competent to the relevant Drugs & Alcohol National Occupational Standards (DANOS) immediately following screening at the pre-sentence report (PSR) stage or during supervision.

Alcohol related offending behaviour is addressed through substance misuse accredited programmes and delivered through a ***programme requirement***.

- ***Addressing Substance Related Offending (ASRO)*** or the ***Offender Substance Abuse Programme (OSAP)***, targeted at offenders recognised as having a significant (higher risk or dependent) alcohol problem with a medium to high risk of re-offending or for whom the misuse of alcohol has been assessed as a significant factor in their offending behaviour, are available in nearly all probation areas/trusts.
- The ***Lower Intensity Alcohol Programme (LIAP)*** aimed at those whose alcohol misuse and offending needs are not sufficient to lead to a referral to ASRO/OSAP or whose primary need requires referral to an accredited programme e.g. violence but where there is still a need for alcohol related offending to be addressed. LIAP has been piloted in eight areas, provisionally accredited by the Correctional Services Accreditation Panel (CSAP) and is now available for all probation areas/trusts to use as part of their suite of programme provision.

- The ***Drink Impaired Drivers (DID)*** scheme aimed at those who have committed a drink drive offence but have not otherwise been involved with crime.

Where offenders with identified alcohol misuse needs are due to be released from prison and will be subject to statutory supervision on licence (sentenced to 12 months and over), their offender managers are responsible for ensuring there is an appropriate licence condition which requires those offenders to address their problems with alcohol. This condition may, for instance, require the offender to attend a substance misuse accredited programme.

Offenders can also access community alcohol services under general licence conditions or be referred on a voluntary basis.

Alcohol and Wales

MoCAM and the NTA have no direct influence or bearing on operational practice in Wales.

The Welsh Assembly Government Substance Misuse Strategy, *Working Together to Reduce Harm*¹⁸, launched in November 2008, includes the misuse of alcohol alongside the misuse of illegal drugs. Community Safety Partnerships (CSPs) have responsibility for the delivery of the Strategy. This focuses attention on the community safety and crime and disorder aspects of alcohol misuse.

As part of the changes being made as a result of the reconfiguration of the NHS in Wales, the new Local Health Boards (LHBs) are a 'responsible authority' within the CSPs. This will mean that the new LHBs will share the statutory responsibilities for tackling substance misuse in their area with the CSPs. The new NHS Trust, Public Health Wales, will become a 'body with whom the responsible authorities should co-operate' at the same time. It is also intended that the Probation Service will become a 'responsible authority' within CSPs early next year. These changes will ensure that all bodies responsible for planning and commissioning substance misuse services will be formal members of CSPs.

Guidance on relevant alcohol provision is generated by the Welsh Assembly Government and its existing Substance Misuse Treatment Framework (SMTF)¹⁹. The Framework is being published in modular form as guidance of good practice; those already published include Alcohol Treatment and Managing Alcohol Misuse in the Workplace. The Planning and Provision of Substance Misuse Services to Children and Young People in the Care of Youth Offending Services and Treatment of Offenders with substance misuse problems have also been

¹⁸<http://wales.gov.uk/about/programmeforgovernment/strategy/publications/socialjustice/substancemisuse/?lang=en>

¹⁹<http://wales.gov.uk/topics/housingandcommunity/safety/substancemisuse/treatmentframework/?lang=en>

published and include guidance on treatment for both drug and alcohol misuse. An Alcohol Education and Prevention in Further and Higher Education Organisations module is currently being developed and will be published in spring 2010.

Commissioning alcohol interventions & treatment

The current position

Community alcohol treatment is almost exclusively funded by NHS Primary Care Trusts (PCTs) in England. These Trusts act either as a single funding entity or less commonly as the member of a partnership such as a Drug (and Alcohol) Action Team (D(A)AT) joint commissioning group (JCG).

In Wales, because of the joint alcohol and drugs strategy, responsibility is shared between NHS Local Health Boards (LHBs), Substance Misuse Action Teams (SMATs) and Criminal Justice Agencies (although see later sub-section for information about changes to the arrangements for *the planning and commissioning of substance misuse services in Wales* from April 2010 with the introduction of Area Planning Boards).

Some elements of residential alcohol rehabilitation programmes (i.e. 'rehab') are funded by local authorities, following approval via a community care assessment.

Probation is well-connected at a strategic level but delivery problems exist at the practical level e.g. in influencing PCT commissioning of alcohol treatment services and/or clear care pathways formulated between generic alcohol services and probation. This has led to some probation areas/trusts financing alcohol treatment requirement (ATR) assessments and treatment exclusively or predominately using probation funds.

Whose responsibility?

Models of care for alcohol misusers (MoCAM) makes clear that in England 'as part of NHS provision, commissioning alcohol interventions and treatment is the responsibility of local Primary Care Trusts (PCTs).' This includes provision for offenders under statutory supervision and is a particular issue for those subject to ATRs, who require access to specialist treatment. As part of their statutory duties, probation areas/trusts are responsible for meeting supervision and enforcement costs of a community sentence or licence but should not be funding mainstream health provision i.e. paying for interventions or treatment for offenders under their supervision no better than that which should be available to all residents of the locality.

Areas/trusts may wish to consider making a contribution towards an enhanced level of interventions or treatment e.g. fast track access, longer or more intensive than that delivered on a non-statutory basis, regular reports (within the bounds of consent²⁰) from providers on issues like attendance, compliance and progress,

²⁰ See Department of Health (2003) *Confidentiality: NHS Code of Practice*

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4069253

where this is necessary to meet the requirements of the alcohol related component of a court order. The same principle applies where alcohol liaison workers (ALWs) operate on probation premises or are embedded within probation teams e.g. deliver brief interventions, comprehensive assessment and referral to a tier 3 or 4 service, as needed, and provide a service to offenders under probation supervision which exceeds that which we would expect to be available to those same individuals were they not offenders. Areas/trusts also have the option to commission or contract services for specific activities which fall outside those that offenders might reasonably expect to access through mainstream services.

MoCAM tasks commissioners with ensuring ‘that all tiers of interventions are commissioned to form a local alcohol treatment system to meet local population needs.’ Senior probation managers should work closely with their PCTs, D(A)ATs and other strategic forums with responsibility for the provision of drug, alcohol and supporting services in seeking to ensure that:-

- the four tiers of interventions in MoCAM are available to alcohol misusing offenders under probation supervision
- alcohol interventions and treatment for offenders meet the requirements of *National Standards for the Management of Offenders*²¹ and this guidance and is delivered to the standards outlined in MoCAM
- provision of alcohol treatment for offenders is understood as a key part of a spectrum of alcohol services within local alcohol strategies
- where probation areas/trusts contribute to the commissioning of treatment and other alcohol related interventions for offenders, these are managed within service level agreements and service specifications. These should detail relevant information about ATR delivery and processes and be robust enough for effective performance management.

Areas/trusts need to make sure that they understand the local commissioning structure and treatment planning cycle and approach commissioners at the appropriate point in the cycle with evidence of:-

- the nature and extent of identified need within the local offender population
- the effectiveness and cost-effectiveness of interventions in reducing alcohol-related harms amongst the target group
- the responsibility of Crime & Disorder Reduction Partnerships (CDRPs) to address alcohol-related offending

The NHS Code of Practice is strict on disclosure. Under common law, staff are permitted to disclose personal information (to, for instance, an offender manager) in order to support detection, investigation and punishment of serious crime and/or to prevent abuse or serious harm to others where they judge, on a case-by-case basis, that the public good that would be achieved by the disclosure outweighs both the obligation of confidentiality to the individual patient concerned and the broader public interest in the provision of a confidential service.

21 <http://www.probation.homeoffice.gov.uk/output/page32.asp#GuideWwO>

- the contribution that can be made to NHS/Local Authority Joint Strategic Needs Assessments (JSNAs)²²(as this is where it is possible to link health needs to crime and disorder and opportunities to reduce the risk of re-offending)
- the projected impact of this on relevant Public Service Agreement (PSA) targets and alcohol related indicators in local area agreements (LAAs) and PCT operational plans e.g. reducing the number of alcohol-related hospital admissions

Areas/trusts should develop a business case for funding in partnership with PCTs rather than independently. The approach should be to steer PCTs to ensure that current services cater for the needs of the offending population, not to put pressure on PCTs to provide funding for new alcohol services specifically for offenders.

Offender needs assessment

It is important that areas/trusts undertake a comprehensive assessment of offender need to: -

- increase their knowledge and understanding of the offender (drinking) profile, including segmented data e.g. for women offenders
- increase the correlation between identified alcohol need and service provision
- influence externally commissioned alcohol services to reflect offender need

This information should comprise analysis of data from the Offender Assessment System (OASys) and alcohol screening tool e.g. Alcohol Use Disorders Identification Test (AUDIT)/specialist assessment data to demonstrate both the level of offending related alcohol need (or 'criminogenic need') and the epidemiology of problem drinking among offenders. The intended outcome is an INFORMED and INTEGRATED approach to service provision.

Areas/trusts may find informative:-

- the work North Wales Probation Area has undertaken as part of NOMS Alcohol Best Practice Projects Initiative in producing a *Profile Analysis of Offenders who have received Secondary Screening for Alcohol*²³ using the Alcohol Use Disorders Identification Test (AUDIT)

²² Department of Health (2009) *Signs for Improvement: Commissioning interventions to reduce alcohol-related harm*

²³ To be available on EPIC shortly at

http://npsintranet.probation.gsi.gov.uk/index/service_delivery/interventions/drugs__alcohol/alcohol_best_practice_projects.htm

- data from an *Assessment of alcohol need amongst offenders within probation and prison services in North East England* undertaken by the Institute of Health and Society, Newcastle University
- the Alcohol Strategy Local Implementation Toolkit²⁴ developed by the Home Office to assist local areas to assess the needs of their populations, including those involved with the criminal justice system, and encourage PCTs to address any identified shortfalls in treatment capacity
- the North West Public Health Observatory (NWPHO)²⁵, which provides local health profiles incorporating data on crimes attributable to alcohol to assist PCTs, the NHS and their partners at a local level to understand their needs and develop planning

Effectiveness and cost effectiveness

In the prevailing economic climate, our focus has to be on improving provision based upon evidence of what is effective and, most importantly, cost-effective within budgetary constraints. There is evidence that a lot of the interventions NOMS delivers or refers offenders into are effective in reducing alcohol related harm to health, as set out in the *Review of the effectiveness of treatment for alcohol problems* or its more accessible summary. For example:-

- The United Kingdom Alcohol Treatment Trial (UKATT) found that **for every £1 spent on treating problem drinkers** (social behaviour and network therapy and motivational enhancement therapy) **£5 is saved on costs to health, social and criminal justice services**²⁶. This is likely to be an underestimate as it does not include loss of productivity or measure the full social costs of either alcohol related violence or the effects of alcohol problems on family and friends.
- **Brief interventions** are effective in reducing alcohol consumption among hazardous and harmful drinkers to low-risk levels.
- **Cognitive behavioural** approaches to specialist treatment offer the best chances of success.
- People with **more severe alcohol problems** and levels of **dependence** should be encouraged to attend specialist treatment services.
- **Planned and structured aftercare** is effective in improving outcomes following the initial treatment episode among those with more severe alcohol problems.

²⁴ <http://www.crimereduction.homeoffice.gov.uk/drugsalcohol/drugsalcohol097.htm>

²⁵ www.nwph.net/alcohol

²⁶ <http://www.bmj.com/cgi/content/full/331/7516/544>

- **Alcoholics Anonymous (AA)** appears to be effective for those alcohol misusers who are suited to it and attend regularly and is a highly cost-effective means of reducing alcohol related harm.

More specifically, we can point to:-

- Increasing ATR commencement and completion rates:
 - Commencements increased from 4708 in 2007 to 6545 in 2008 (a 39% rise)²⁷
 - 3509 ATRs were completed in 2008/9 more than double the target (1635) introduced in the NOMS Performance Metrics²⁸
- The increasing capacity of the probation service e.g. through use of the Alcohol Information Pack to deliver more **brief interventions** in-house for the large numbers of offenders who have alcohol misuse and offending needs but don't require specialist treatment. We know from research that these are effective in reducing alcohol consumption among hazardous and harmful drinkers to low-risk levels²⁹.
- Recent research demonstrating that overall **re-offending rates fall by almost 7%** for offenders placed on substance misuse programmes (ASRO & OSAP)³⁰.
- A backdrop of **increasing numbers of completions for all accredited behaviour programmes**. The total number of completions in 2006-07 was 19,867, an increase of 18% compared with performance in the previous year³¹.

As yet, little is known about the effectiveness of UK interventions/programmes in reducing alcohol-related crime. However, given the large number of offenders under statutory supervision who have an alcohol related criminogenic need³², reducing the alcohol consumption of this group to low risk levels through evidence based and appropriately targeted interventions should have a significant impact in reducing their likelihood of re-offending.

27 Offender Management Caseload Statistics 2008 <http://www.justice.gov.uk/publications/prisonandprobation.htm>

28 NOMS Annual Report and Accounts 2008/9 <http://www.justice.gov.uk/publications/noms-annual-report-08-09.htm>

29 Raistrick, D., Heather, N., and Godfrey C. (2006) *Review of the Effectiveness of Treatment for Alcohol Problems*. London: National Treatment Agency for Substance Misuse.

30 Hollis V. (2007) *Reconviction Analysis of Programme Data using Interim Accredited Programmes Software (IAPS)* <http://www.probation2000.com/>

31 NOMS ISAU Accredited Programme Delivery Annual Report 2006-7

32 A factor directly linked to their offending and potentially to their risk of reconviction.

*Evidence based practice? The National Probation Service's work with alcohol misusing offenders*³³, a study by the Institute for Criminal Policy Research (ICPR), King's College London, commissioned by the Ministry of Justice, describes and critically appraises:

- the procedures in place for identifying and intervening with offenders who have alcohol problems
- the extent to which this work complied with the principles set out in *Models of care for alcohol misusers (MoCAM)*
- arrangements for the commissioning and delivery of alcohol treatment requirements (ATRs)

The report, published on 28th October 2009, makes several recommendations aimed at strengthening the future commissioning and delivery of services. Findings from the research have influenced development of this guidance, the implementation of which will improve working practice. This is consistent with NOMS focus on improving provision based upon evidence of what is effective and, most importantly, cost-effective.

The Ministry of Justice's Offender Management and Sentencing Analytical Services (OMSAS) research programme includes three major cohort studies to track large and representative samples of offenders on custodial and community sentences. These studies will be following the same group of offenders from the beginning of their sentences and catching up with them at various points (for example, at mid-point of sentence and at end of sentence). These studies are at various stages of implementation/development:

- The Offender Management Community Cohort Study (OMCCS) will explore the relationship between the delivery of offender management and outcomes in a nationally representative sample of offenders receiving a community order. The research intends to provide information about offenders' needs, what they are receiving in terms of offender management and interventions (including alcohol interventions) and how these factors are associated with short and long term outcomes (including impact on re-offending). Initial results are anticipated in 2013.
- The Surveying Prisoner Crime Reduction (SPCR) study looks in detail at the needs and problems of prisoners as they arrive in prison across the full range of re-offending pathways. It examines the range of interventions they received during their time in custody to address these. SPCR will track the sample of prisoners after they leave prison to monitor various outcomes in the community including reconviction. Thus, it is anticipated that SPCR will provide useful evidence on the effectiveness of a range of

33 <http://www.justice.gov.uk/publications/alcohol-misusing-offenders-research-report.htm>

interventions across the re-offending pathways including those relating to problem alcohol use. Preliminary profile of needs and problems has been published³⁴. The entire data series is expected to be collected by mid-2010, with analysis of the data expected to be ongoing over the next few years.

- The Juvenile Cohort Study (JCS) will track around 10,000 young offenders (aged 10 to 17 years old) from 30 different Youth Offending Teams (YOTs) over a period of approximately 2 years to explore the experiences of different types of young offenders within the criminal justice system. The JCS will be looking at the impact of interventions and combination of interventions that are associated with a reduction in re-offending (including frequency and severity) in different types of young offenders subject to the criminal justice system. Although it would be possible to explore the experiences of young people subject to the specific orders included in the sample it will not be possible to assess effectiveness of sentences. Information will be collected on substance misuse needs and interventions planned/received to address these needs.

Public Service Agreements (PSAs) and alcohol indicators

The 2007 Comprehensive Spending Review set the key priority outcomes the Government wants to achieve in the next spending period (2008-2011). The outcomes, expressed as Public Service Agreements (PSAs), include the first ever cross-Government PSA on **Alcohol & Drugs** published in October 2007.

PSA 25 aims to reduce the harm caused by alcohol and drugs to:

- the community as a result of associated crime, disorder and anti-social behaviour
- the health and well-being of those who (use drugs or) drink harmfully
- the development and well-being of young people and families

There are five performance indicators within the PSA covering drugs and alcohol and, with respect to the latter, the PSA commits the Government to reduce:-

- the rate of hospital admissions per 100,000 for alcohol related harm (Indicator 2) (Department of Health lead) - the first ever commitment to monitor how well the NHS is tackling alcohol-related harm; and
- the percentage of the public who perceive drunk or rowdy behaviour to be a problem in their areas (Indicator 5) (Home Office lead).

³⁴ <http://www.justice.gov.uk/publications/problems-needs-prisoners.htm>

Addressing alcohol misuse is also particularly relevant to delivery of the reducing re-offending indicators in **PSA 16 Increase the proportion of socially excluded adults in settled accommodation and employment, education or training**, for which offenders under probation supervision are one of four client groups, and wider crime priorities set out in **PSA 23 Make Communities Safer**.

The new shared PSAs on reducing the harm caused by drugs and alcohol, tackling social exclusion and making communities safer provide joined up targets across Government which will help partners at national, regional and local levels work together to reduce alcohol related harm, and improve access to local mainstream services for offenders and their families.

Local Strategic Partnerships and Local Area Agreements

The most important local delivery mechanism for PSAs is the local area agreement (LAA). LAAs provide local authorities and partners with the flexibility and capacity to deliver the best solutions for their areas through a redefined relationship between central and local government. A local area agreement is a three year agreement that sets out the priorities for a local area. The agreement is made between Central Government, represented by the Government Office (GO), and a local area, represented by the lead local authority and other key partners through local strategic partnerships (LSPs). LSPs bring together different parts of the public sector as well as the private, business, community and voluntary sectors at a local level, so that initiatives and services support each other and work together.

In tackling crime and re-offending, addressing the health inequalities that exist within communities and improving access to healthcare, partnership working is essential. LSPs offer the best means of tying priority setting, commissioning and delivery of services for offenders into community-wide initiatives. They bring together the different sectors of communities to develop plans and shape actions to meet priorities.

Joint Strategic Needs Assessments

Many of these priorities are identified through a Joint Strategic Needs Assessment (JSNA). The JSNA is the means by which PCTs and local authorities describe the future health, care and well-being needs of local populations and the strategic direction of service delivery to meet those needs. JSNAs form the basis of a duty to co-operate for PCTs and local authorities that is contained in the Local Government and Public Involvement in Health Act.

JSNAs take account of data and information on inequalities between the differing, and overlapping, communities in local areas and support the meeting of statutory requirements in relation to equality audits.

Priorities highlighted by the JSNA find their expression in the LAA, however the identification of the treatment needs of offenders are not incorporated within the Department of Health (DH) 2007 *Guidance on Joint Strategic Needs Assessment*³⁵.

The JSNA process and the development of LAAs provide the mechanism by which PCTs and NOMS partners can identify and plan for the treatment of offenders with alcohol and alcohol-related health problems. It is vital that PCT commissioning is informed about the needs of offenders, including systematic and periodic health needs assessments, and that PCTs and Local Authorities include the needs of offenders in their area (both in the community and prisons) within their assessments for the alcohol component of the JSNA and address any problems arising in incorporating offenders needs for alcohol services into the JSNA.

National indicators relating to alcohol and offending for PSA targets 2007-2010

From April 2008 a single set of 198 national indicators³⁶ for English local authorities (LAs) was introduced, which flow from the priorities identified in PSAs and underpin the targets. LAAs include a maximum of 35 priority indicators drawn from this national indicator set but LAs are required to monitor the whole set.

The three indicators which directly address alcohol are:-

- NI 39 Alcohol-harm related hospital admission rates
- NI 41 Perceptions of drunk or rowdy behaviour as a problem
- NI 115 Substance misuse by young people.

In addition, at least another 50 of the indicator set have a direct link with alcohol misuse. The most relevant for probation are:-

- NI 15 Reduce the most serious violence, including tackling serious sexual offences and domestic violence
- NI 17 Perceptions of anti-social behaviour
- NI 18 Adult re-offending rates for those under probation supervision
- NI 20 Assaults with injury crime rate
- NI 32 Repeat incidents of domestic violence
- NI 47 People killed or seriously injured in road traffic accidents
- NI 143 Offenders under probation supervision in settled and suitable accommodation at the end of their order or licence

³⁵ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081097

³⁶ 10 indicators were subsequently dropped leaving 188 indicators in the National Indicator Set as at February 2009.

- NI 144 Offenders under probation supervision in employment at the end of their order or licence

A significant number of LAAs have adopted alcohol related indicators as priority indicators. For example:-

- **75 local authorities have chosen NI 39 the new alcohol related hospital admissions indicator** as a local priority - setting out local targets and plans for reducing the rate of rise in alcohol related admissions.
- **In 81 areas, NI 20 ‘assault with injury’** (which is a proxy for alcohol-related violent crime) has been agreed by Government Offices and local areas as a target indicator.
- **51 areas have chosen NI 17 ‘perceptions of anti-social behaviour’**, which includes ‘perceptions of drunk or rowdy behaviour’ (PSA 25 Indicator 5), one of the seven strands that comprise anti-social behaviour.

The indicators in LAAs frequently mirror those in the operational plans of partner agencies. For example, 99 PCTs have chosen the new alcohol related hospital admissions indicator in their 2008-11 operational plans, including 46 of the 50 PCTs with the highest rate of admissions and in 32 of these it is in the corresponding LAA. PCTs will be performance managed by their Strategic Health Authorities (SHAs) and the Healthcare Commission (HCC) against national and local indicators.

Vital Signs Indicators

The NHS Operating Framework for 2008/09³⁷ sets out three tiers of ‘vital signs’

- Tier 1 - applies to all PCTs and details the ‘should dos’. This will involve central monitoring and performance management by SHAs
- Tier 2 - are national priorities, agreed locally and signed off by the SHAs
- Tier 3 - are local actions to be agreed at local level and not performance managed

Concern about the number of alcohol-related hospital admissions and the rising trend led DH to put in place a national Vital Signs Indicator for the NHS from April 2008 that measures change in the rate of alcohol related hospital admissions (VSC 26).

This is the best indicator to demonstrate levels of alcohol misuse and related ill-health for conditions with a significant association with alcohol. The indicator was

³⁷ http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081094

set at Tier 3 within the above Operating Framework however so SHAs do not have to monitor alcohol as a Vital Sign.

The Vital Signs Indicator (VSC 26) is also included as an indicator in the National Indicator Set for Local Authorities and Local Authority Partnerships (NI 39) and both form part of the plan to deliver PSA 25.

Department of Health is not in a position to set targets for the NHS and is not encouraging Primary Care Trusts to increase treatment just for offenders. Rather DH can only issue guidance and encourage PCTs to review their situation and try their best, within the limited budgets available, to make improvements to the situation.

PSA targets 2007-2010 relating to alcohol and offending and component National Indicators

PSA	Relevant Indicators for mental health, offenders and health inequalities	National Indicators	Number of Local Areas with LAA
PSA Delivery Agreement 25: Reduce the harm caused by alcohol and drugs	Indicator 1: Percentage change in the number of drug users recorded as being in effective treatment. It also includes clinical drug treatment in prisons. Indicator 2: The rate of drug related offending, defined as those in contact with the CJS who are identified as misusing Class A drugs (currently heroin and cocaine/crack).	NI 20 Assault with injury crime rate NI 39 Rate of Hospital Admissions per 100,000 for Alcohol Related Harm NI 41 Perceptions of drunk or rowdy behaviour as a problem	81 of 150 75 8
PSA Delivery Agreement 16: Increase the proportion of socially excluded adults in settled accommodation and employment, education or training	The most socially excluded adults are in settled accommodation Indicator 1: Proportion of former care leavers aged 19, who had left care aged 16 or over, who are in suitable accommodation. Indicator 2: Proportion of offenders under probation supervision living in settled accommodation at the end of their order or licence.	NI 143 Offenders under probation supervision living in settled and suitable accommodation at the end of their order or licence NI 144 Offenders under probation supervision in employment at the end of their order or licence	2 10
PSA Delivery Agreement 23: Making Communities Safer	Indicator 2: Continue to make progress on serious acquisitive crime through a focus on the issues of greatest priority in each locality and the most harmful offenders – particularly drug misusing offenders Indicators 5 and 6: Reduction in re-offending rates	NI 15 Serious violent crime NI 16 Serious acquisitive crime NI 17 Perceptions of anti-social behaviour NI 18 Adult re-offending rates for those under probation supervision NI 19 Rate of proven re-offending by young offenders NI 21 Dealing with local concerns about anti-social behaviour and crime issues by the local council and police NI 26 Specialist support to victims of a serious sexual offence NI 28 Serious knife crime rate NI 29 Gun crime rate NI 32 Repeat incidents of domestic violence NI 34 Domestic violence – murder NI38 Drug related (Class A) offending rate	49 97 56 23 49 54 4 1 3 73 0 20

Plotting a course through the commissioning landscape

Probation's ability to engage fully in partnership arrangements is vital to access resources for offenders who need alcohol treatment. Local partnership Alcohol Strategies and the priority being given to alcohol in LAAs and operational plans provide probation areas/trusts with considerable opportunity to demonstrate the impact of their work in helping to achieve targets. Areas/trusts need to use targeted messages e.g. how addressing the alcohol related problems of offenders under probation supervision will lead to reductions in the number of people with alcohol related problems passing through GP surgeries; the number of assaults in Accident and Emergency departments; city centre crime and disorder. For example, before approaching PCTs/LHBs areas/trusts should ask themselves:-

- What impact are you having in reducing the burden of disease to the NHS?
- What impact could you have without further investment?
- Who have you told?

The biggest push within the health sector to meet the new PSA 25 national indicator to reduce alcohol-related hospital admissions is to advocate for the widespread implementation of opportunistic alcohol case Identification and the delivery of Brief Advice (IBA)³⁸. To provide more help for people to drink less through the implementation of IBA is one of seven High Impact Changes³⁹ which DH has identified as the most effective actions for those local areas that have prioritised the reduction in alcohol-related harm. Research has shown that this is effective in 1 in 8 cases in reducing drinking back to low-risk levels⁴⁰ and at St. Mary's Hospital, Paddington, that IBA is effective in reducing repeat visits to A&E⁴¹.

DH is very supportive of probation areas/trusts and other arms of the Criminal Justice System offering IBA. Probation staff and arrest referral schemes are going to pick up a number of individuals drinking at increasing risk and higher risk levels that will not be picked up in the health care system, as offenders may not visit their GP very often or even be registered with a GP. Also, the Screening and Intervention Programme for Sensible drinking (SIPS) has identified that a disproportionate number of offenders under statutory supervision are hazardous and harmful drinkers in need of a brief intervention.

38 Also known as Screening and Brief Interventions (SBI) for alcohol use.

39 <http://www.alcohollearningcentre.org.uk/Topics/Browse/HIC/>

40 Moyer et al (2002) *Brief interventions for alcohol problems: a meta-analytic review of controlled investigations in treatment-seeking and non-treatment-seeking populations*

41 Patton, R., Hilton, C., Crawford, M.J. & Touquet, R. (2004). *The Paddington Alcohol Screening Test: A short report*. Alcohol and Alcoholism, 39, 266–268

A key contribution to achieving the PSA target will be increased provision of alcohol interventions and treatment. Alcohol treatment is one of the most effective ways of reducing admissions (the 1 million plus dependent drinkers in England who need treatment are often repeatedly admitted to hospital until they receive treatment). In general, offenders on an ATR should be less likely to be referred or present to hospital in need of being admitted because of the progress they have made in addressing their problems while in treatment on an ATR. Therefore, evidence of compliance with and retention on ATRs, successful ATR completions, reductions in quantities of alcohol consumed and/or related harm to health (using alcohol screening tool e.g. AUDIT/section 9 OASys data sentence plan review/outcome data) are indicative of a reduced burden to the NHS.

Positive impact on offender health and behaviour change (taking account of gender, age, ethnicity and disability) can also be evidenced by:-

- Treatment Outcome Profile (TOP)⁴² data currently collated by the National Treatment Agency (England) or Welsh Assembly Government (Wales) on engagement, retention and outcomes for alcohol treatment
- changes to alcohol related risk of violent re-offending (measured by OASys data)⁴³
- improvements in social wellbeing e.g. family life, accommodation, employment status, etc. (by following-up individuals upon completion of intervention)
- reduction in the seriousness and frequency of alcohol related offending during the duration of the intervention and over a follow-up period of one or two years in line with the revised national re-offending measures (subject to funding for research being available).

Areas/trusts will come under increasing pressure to deliver more ATR completions without a significant increase in specialist treatment provision to refer offenders into. Areas/trusts should use the ATR completion target, which has been negotiated locally and included in service level agreements (SLAs) with their Directors of Offender Management (DOMs), as a lever with commissioners to drive up ATR commencements and completions.

Finally, areas/trusts need to engage with PCTs (Area Planning Boards and Substance Misuse Action Teams (SMATs) in Wales) at Chief Executive level and local authorities under the developing 'Total Place' agenda⁴⁴ in the coming year

42 http://www.nta.nhs.uk/areas/outcomes_monitoring/default.aspx

43 In the new OASys predictors of re-offending, alcohol misuse contributes to the OASys violent re-offending predictor (OVP) but not the general re-offending predictor (OGP).

44 The 'Total Place' initiative seeks to identify how local public agencies can better work together to deliver front-line services more efficiently. It will map flows of public spending in local areas and make links between services to identify where public money can be spent more effectively. There are 13 pilots, one of which in Leicester City and Leicestershire will scrutinise spend, impact and any overlaps or gaps in tackling alcohol and drug abuse

to stand a better chance of success in advocating for increased access to treatment. If they have not already done so, areas/trusts may wish to consider inviting commissioners to visit probation offices to find out more about the work probation does with offenders with alcohol problems; the range of effective provision available and the impact this can have on achieving health targets.

It is better to have access to a range of provision across the Tiers which offenders can access based upon need and at different points in the treatment cycle e.g. stepped care model rather than commission an inflexible 'one size fits all' package of provision which may not be suitable for many.

Wider holistic needs

Some areas/trusts have been very proactive within LSPs and other partnerships in identifying alcohol misusing offenders as an important target group within the wider social inclusion agenda. This approach is particularly helpful in resourcing work to meet the more holistic needs of offenders subject to ATRs, including women offenders who may have more complex needs.

Treatment planning and commissioning should take account of the needs of women, including specialist maternity services, dual diagnosis. Specialist provision within the local treatment system to meet these needs should be available to women offenders and local protocols should be developed to govern this. Areas/trusts will need to ensure that the recommendations from *The Corston Report: a review of women with particular vulnerabilities in the criminal justice system*⁴⁵ are well understood and incorporated by commissioners. *The Offender Management Guide to Working with Women Offenders*⁴⁶ provides more information. One Stop Shops for women offenders and those at risk of offending provide an integrated and holistic approach to addressing their needs in a women-only environment. Referral should be considered especially for those women who are vulnerable and/or have complex needs.

Areas/trusts may develop links with projects/provision in the community which are not primarily targeted at offenders, but which nonetheless are very appropriate to addressing the wider needs of offenders, and particularly women offenders (sex worker projects, domestic violence support groups, women's centres etc). Attendance at such projects could form a valuable part of the supervision plan, and count towards the contact hours on the order (although not the ATR). Such arrangements can be difficult, particularly where probation is seeking enforceable contacts and areas/trusts will have to develop protocols locally with such organisations/projects. The Corston Report recommends wider use of mainstream facilities for women and integration with non-offending women.

⁴⁵ <http://www.homeoffice.gov.uk/documents/corston-report/>

⁴⁶ <http://noms.justice.gov.uk/news-publications-events/publications/guidance/OM-Guide-Women>

Parental alcohol misuse can have a damaging impact on the welfare of children in their care. Probation has responsibilities to safeguard and promote the wellbeing of children. This is particularly relevant given the Lord Laming's report, *The Protection of Children in England: A Progress Report*⁴⁷, resulting from the Baby P case.

Recent developments and future plans

In England the NHS World Class Commissioning programme⁴⁸, designed to improve PCTs' commissioning capabilities, incorporates new DH guidance on the commissioning of alcohol services. World Class Commissioning (WCC) includes a nationally consistent, locally applied annual assurance process for PCTs, under which they will need to demonstrate that local commissioning relates directly to local needs. DH issued *'Signs for Improvement – commissioning interventions to reduce alcohol-related harm'*⁴⁹ in July. This commissioning guidance to PCTs sets a level of ambition that PCTs should provide services to at least 15% of their alcohol dependent population.

Both the National Audit Office (NAO) and Public Accounts Committee (PAC) reports, *The National Probation Service: the supervision of community orders in England and Wales*⁵⁰, recommended that Ministry of Justice work with DH to increase treatment provision with the aim of making the ATR available as a sentencing option for all those offenders with the most serious alcohol and offending problems. In response, a cross-Government senior officials' alcohol policy working group (APWG) has undertaken a strategic review of provision to identify the action needed to close the gap between offender need and available treatment. Policy and delivery recommendations from the APWG are being taken forward in the context of *Improving Health, Supporting Justice*⁵¹, the National Delivery Plan of the Health & Criminal Justice Programme Board, which was published on November 17th 2009.

Action on alcohol builds on existing PCT plans for improving access to alcohol treatment. Amongst the key deliverables are to progress towards a provision of alcohol treatment for a minimum of 15% of offenders identified as potentially alcohol dependent across all regions; and by February 2010 to issue joint DH/NOMS guidance to PCTs on commissioning alcohol services to ensure they meet the needs of offenders. This document will incorporate guidance on:

47 <http://publications.everychildmatters.gov.uk/default.aspx?PageFunction=viewtoptenproducts&PageMode=publications&Type=TopTen&>

48 <http://www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Worldclasscommissioning/index.htm>

49 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/DH_102813

50 http://www.nao.org.uk/publications/0708/the_national_probation_service.aspx

<http://news.parliament.uk/2008/11/community-orders/>

51 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_108606

- Assessment of population needs of offenders, in the community and in prisons, as part of the Joint Strategic Needs Assessment
- A framework for criminal justice agencies and PCTs to work together within Local Strategic Partnerships
- The construction of pathways for individual assessment and treatment of offenders with alcohol misuse problems securing specialist assessment of individual need for alcohol treatment where individuals are referred by probation.
- How PCTs may use World Class Commissioning benchmarks to monitor progress.

Other key deliverables are to:-

- work with regional offender health colleagues, local PCT commissioners and probation trusts to ensure that the health needs of residents are identified and included in PCT/Local Authority Joint Strategic Needs Assessments and in PCTs local planning arrangements throughout **2009 and 2010.**
- provide guidance to PCTs on offender health commissioning that puts the specific commissioning issues within a WCC context. It will bring the priorities, including PSAs and best practice into a single usable document **by April 2010.**
- develop systems to facilitate the collaborative commissioning that will lead to integrated liaison and diversion services **by Autumn 2011.**

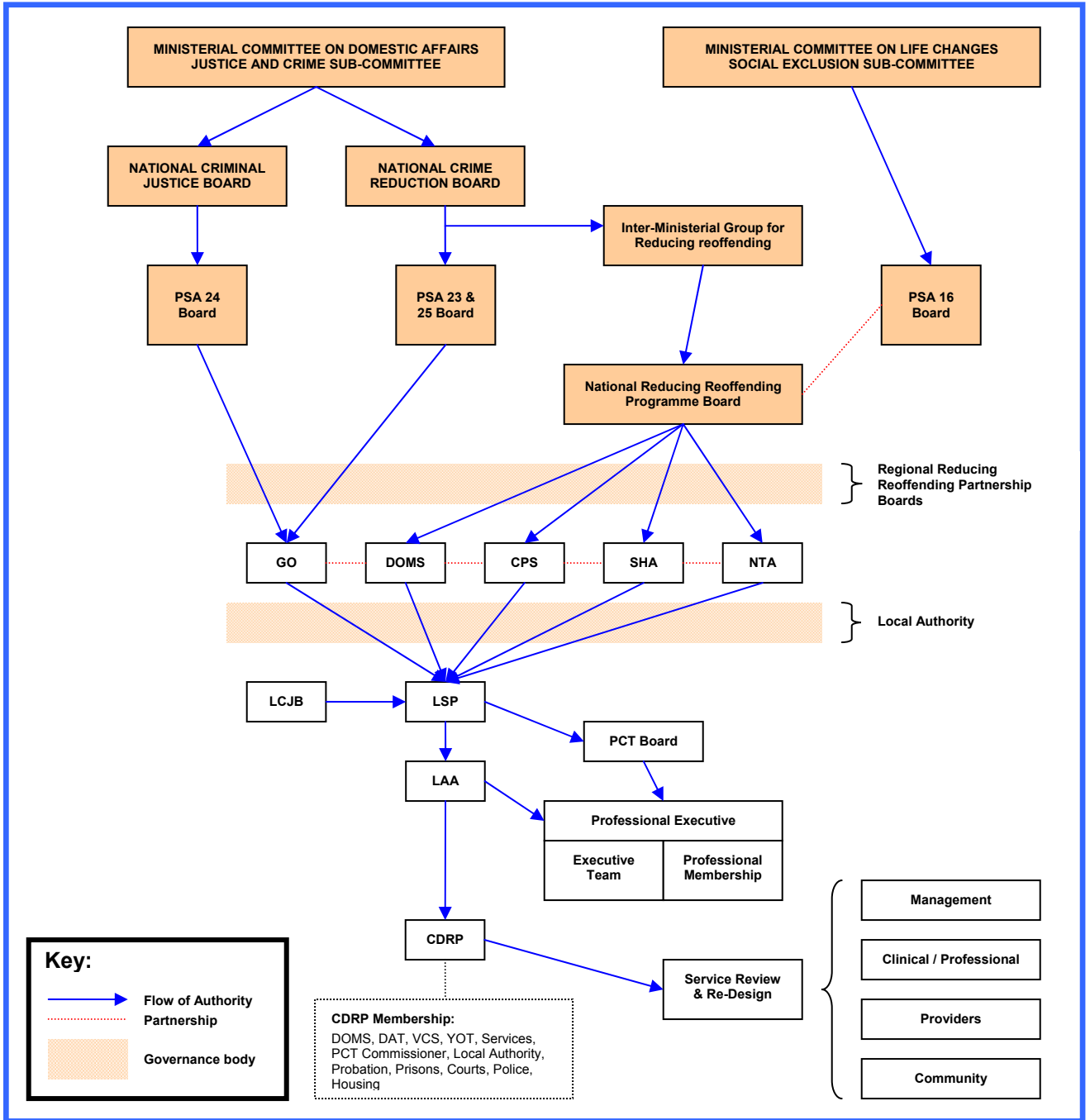
The Plan can only be delivered through joined-up commissioning between health and CJS partners. DOMs and Probation Trusts (as the key regional and local commissioners for offenders) will have a particularly important role.

Drug [and Alcohol] Action Teams are often amalgamated with Crime & Disorder Reduction Partnerships (CDRPs), which provide the policy forum where initiatives and interventions to address health and offending alcohol-related problems can be considered, informing local commissioning. As Local Authorities become increasingly responsible for devising an alcohol strategy and Probation becomes a Responsible Authority in relation to CDRPs from April 2010, Probation should have stronger influence over how resources to mitigate alcohol-related offending are used. Clearly defined outcomes should be defined and monitored via regional NHS and offender management performance assurance mechanisms.

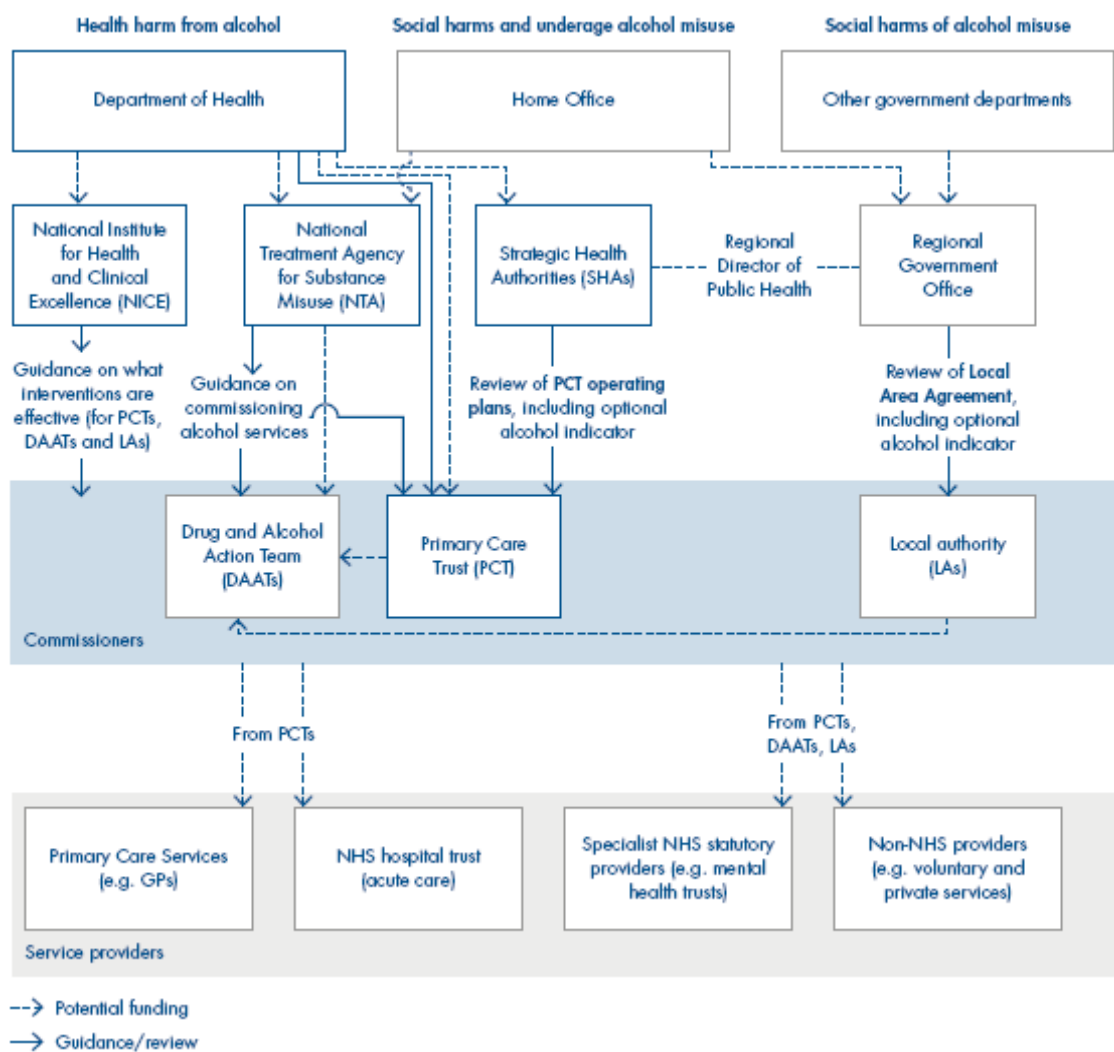
As the role and importance of LSPs develops and LAAs are increasingly used to strengthen local accountability, commissioning for offenders should be carried out within the framework of the LSP.

The Regional Offender Health and Well Being Boards in England are crucial to a joined up approach to dealing with all health needs and can be the gateway into other commissioning bodies.

Commissioning and delivery model for interventions to address drinking problems



Commissioning Framework for alcohol treatment in England (Source: NAO, 2008)



The planning and commissioning of substance misuse services in Wales

From 2010-11 Substance Misuse Area Planning Boards will be established in Wales, which will enable, where appropriate, the planning and performance management of substance misuse services to be undertaken across each of the areas covered by the new Local Health Boards (LHBs) established as a result of NHS reconfiguration. These arrangements will build on, and encompass the regional arrangements that are already operating for some substance misuse services, including the Drug Intervention Programme.

A key role for the new Substance Misuse Area Planning Boards will be to take decisions on the allocation of the resources for substance misuse services that form part of the NHS funding. Initially funding which had formed part of the discretionary allocation to the 22 LHBs in Wales (known as the 0.4%) will be pooled at Area Planning Board level and the Boards will be responsible for taking decisions on how these resources are spent for 2010-11 onwards. In addition, the Home Office DIP resources and the Substance Misuse Action Fund capital budget will also be allocated to the new Area Planning Boards. Ultimately, the intention is for partners to move towards agreeing wider arrangements for the pooling of resources for tackling substance misuse at Substance Misuse Area Planning Board level, including Social Services Departments, other Welsh Assembly Government funding streams, the Home Office and criminal justice agencies. SMATs will be encouraged to also consider where they feel the need to contribute to cross authority and regional commissioning through the Area Planning Board framework.

Following the establishment of these new arrangements, Welsh probation areas/trusts⁵² will be operating in a very clear joint commissioning environment. Probation will be a key partner at Area Planning Board level and, as such, areas/trusts will need to be represented by individuals with the authority to make decisions and commit resources on behalf of their organisation. Where Welsh probation areas/trusts currently directly commission substance misuse services, including alcohol, outside of regional joint partnerships they will be encouraged to bring these into the Area Planning Board arrangements.

A range of partners, including Public Health Wales are currently working with the Welsh Assembly Government on the development of guidance to support the new Area Planning Boards. The guidance will set out minimum standards for substance misuse services; models for integrated care pathways and also cover the arrangements for area-based planning in more detail. The guidance will be available in draft form in the Autumn in time to inform the Boards' work later this year.

⁵² The four Welsh areas are currently in the middle of an application to establish a single All Wales Probation Trust, effective from March 2010

A suite of Key Performance Indicators covering substance misuse services are already in place against which the Welsh Assembly Government monitors the performance of CSPs in tackling this agenda. The budget holders within the new Area Planning Boards are all tied into the achievement of these KPIs via their organisation's role within CSPs. However, the priority that the Welsh Assembly Government attaches to this agenda will be reinforced by the inclusion of relevant indicators within the new NHS performance framework, local authority performance frameworks and the priorities set for Public Health Wales. For non devolved bodies, these targets all support the delivery of PSA targets set by the Home Office and Ministry of Justice.

Local Service Boards

Local Service Boards (LSBs) are where the leaders of local public and third sector organisations come together to take collective action to ensure public services are effective and citizen focussed.

LSBs:

- Improve the quality of life and joined-up service delivery for citizens in their areas;
- provide the leadership to ensure that difficult issues across public services are confidently managed not avoided or ignored;
- stimulate integration, co-ordination and co-operation between local, regional and national public sector organisations;
- set an example of innovative, citizen-focused leadership at the heart of the local partnership and delivery system;
- ensure an effective whole system response to the needs of citizens by pooling resources;
- 'unblock blockages' by removing bureaucracy or other obstacles

Each Local Service Board (LSB) has selected a number of collaborative projects to drive forward. These projects have been selected on the basis of local needs assessments and engagement with citizens. They are drawn from the Community Strategy and other existing local plans and strategies. The purpose of the Local Delivery Agreement (LDA) is to describe the problem being solved, demonstrate the citizen benefits and to set out clearly the direction of travel, key project milestones and how success will be measured.

Local Delivery Agreements:

- should be a rolling programme of work based on the community strategy action plan that require the commitment of organisations to integrate their delivery and pool their resources to do so

- will have a different balance of projects building on the foundation of the community strategy and reflecting the Boards evaluation of where they need to intervene to support improvement and innovation
- comprise of a small number of projects which need leadership at the strategic level to move them forward and/ or significant projects that the LSB should sponsor it until it is complete
- will not be a solution to solve all of the public service delivery issues in an area

The performance management system 'Ffynnon' can support LSBs in delivering their LDAs by providing the capacity to capture, share and benchmark performance across stakeholder organisations.

Health, Social Care and Well-Being Strategies

Since April 2003, local authorities and local health boards have been required to formulate and implement a Health, Social Care and Wellbeing Strategy for their local area.

The regulations require the partners to undertake a health and wellbeing needs assessment prior to Strategy formulation. The purpose of the needs assessment is to assist the local authority and local health board to jointly set the Health, Social Care and Well-being Strategy priorities.

The needs assessment will identify unmet health, well-being and social care needs of the population in a systematic way.

The Strategy should span the whole spectrum from preventative action and regulation to improve health and reduce the risk of ill-health through to care services provided by the local authority, the NHS, the voluntary sector and the private sector. This will include primary health care, community health services, hospital and specialist health services, long term domiciliary or nursing and residential care, and services for children and for carers including young carers. The local Strategy will embrace public health at local level. It will reflect the need to tackle the underlying factors which lead to poor health: for example poor housing and other environmental factors, poor education, substance misuse, community safety issues and unemployment. In so doing, it will contribute to the improvement of health, well-being and prosperity as well as to reduce health inequalities. It will provide the strategic context within which more detailed service delivery and operational plans will be taken forward by all partners.

Targeting

This section of the guidance draws heavily on the comprehensive guidance framework for targeting alcohol provision and programmes developed by North Wales Probation Area under the Best Practice Projects Initiative. This framework or targeting matrix seeks to provide probation staff with a range of information that will assist them in being able to more accurately match offender intervention needs with a more exact understanding of drinking problem and service provision. Although the screening tool used in North Wales and the interventions available to address alcohol related offending may differ from those in use in other areas/trusts, the underlying principles which informed the matrix are relevant to all areas/trusts. Therefore, if they have not already done so, areas/trusts should develop a local targeting matrix/eligibility criteria for different levels of intervention based upon the North Wales model and this guidance, fully integrate it within area alcohol policy/delivery and ensure that external providers are working to the same criteria. The matrix is available on EPIC⁵³.

There is a great complexity and diversity of drinking and offending profiles amongst offenders under supervision, range of wider holistic needs and variety of available provision both internal and external. This guidance cannot adequately cover each scenario with an identikit solution but provides a guide as to the type of provision most likely to be suitable for offenders whose patterns of drinking and offending fall within specified criteria. It is not intended to be a substitute for the professional judgement of offender managers (OMs) in individual cases. As such, OMs need to use it flexibly and intelligently.

Treatment need vs. seriousness of offending

The targeting of interventions to address alcohol related harm should be based upon the:-

- Nature and extent of an offender's alcohol problems
- Seriousness of offending and the role played in this by alcohol
- Risk of re-offending/risk of harm
- Wider rehabilitation and other considerations

Within an overall sentence which reflects offence seriousness, the alcohol related intervention(s) should primarily be determined by assessed need. The Offender Assessment System (OASys) can identify offenders for whom alcohol misuse is linked to their offending behaviour but is an insufficient tool to accurately identify the full nature and extent of an offender's alcohol problems, particularly where their alcohol problems are not related to their offending behaviour. Therefore,

⁵³http://npsintranet.probation.gsi.gov.uk/index/service_delivery/interventions/drugs__alcohol/alcohol_best_practice_projects.htm

areas/trusts need to use a validated alcohol screening tool e.g. Alcohol Use Disorders Identification Test (AUDIT), Fast Alcohol Screening Test (FAST), to compliment OASys. For the purpose of this advice on targeting, it is assumed that areas/trusts are using AUDIT, which was developed by the World Health Organisation and is widely regarded as the 'Gold Standard' of alcohol screening tools.

There are four bands of scoring in AUDIT:-

0- 7 This score indicates lower risk drinking for which no alcohol intervention is required

8-15 This score indicates increasing risk (formerly *hazardous*) drinking

16-19 This score indicates higher risk (formerly *harmful*) drinking

20+ This score indicates complex/dangerous/dependent or very *harmful* drinking

The AUDIT score is indicative of the appropriate level of provision but should be used in conjunction with Offender Group Reconviction Scale (OGRS3) scores and other information available to OMs to assess severity and need of intervention. As a self-administered questionnaire, the results can be distorted by exaggeration or understatement and OMs need to be happy that the AUDIT score is consistent with other information.

Offenders who have Class A drug misuse as their primary problem are excluded as they will be targeted for a drug rehabilitation requirement (DRR).

Alcohol Treatment Requirement (ATR)

Since the publication of PC 57/2005, NOMS has determined that the alcohol treatment requirement (ATR) of a community order or suspended sentence of imprisonment should be targeted at those offenders who are assessed as alcohol dependent and need intensive, specialist, care-planned treatment in Tiers 3-4 of *Models of care for alcohol misusers* (MoCAM) e.g. day programmes, detoxification, residential rehabilitation. They will often have complex co-existing needs e.g. mental health, social and housing problems, that require integrated care across a range of agencies.

There are both legislative and pragmatic reasons which determine ATR targeting. Firstly, under Section 212 of the Criminal Justice Act 2003, a court can impose an ATR provided the offender is **dependent** on alcohol and this **dependency** is such as requires and may be susceptible to treatment. Unlike the DRR, courts cannot make an ATR if the offender is non-dependent but has a 'propensity to misuse' alcohol.

Secondly, most offenders with alcohol problems under probation supervision neither require specialist treatment nor an intervention lasting as long as six months, which is the minimum duration of an ATR.

In law, there is no list of relevant trigger offences and the offender's alcohol dependency does not have to be linked to the index offence(s) for an ATR to be made. However, in practice, the offending will usually be alcohol related, of medium to high seriousness and probably violent in nature. Where treatment availability is limited, probation areas/trusts will wish to consider adopting a gatekeeping strategy and restrict the ATR to those **dependent** drinkers who have committed the most serious offences e.g. physical violence, domestic violence, racially aggravated offences, sex offences, serious public order offences, and/or present the greatest risk.

In summary, ATR provision is intended for a relatively small cohort of offenders who will generally be: –

- AUDIT >20
- OGRS3 >50
- Tiers 2, 3 and 4 (if likely to commit a very serious offence unless immediate alcohol treatment is received) of the Offender Management Model (OMM)
- Seriousness of Harm Medium/High
- Likelihood of re-offending is very high **and** will happen if alcohol use is not addressed immediately

In addition, offenders should have been assessed as suitable for specialist treatment following a comprehensive assessment conducted by specialist treatment staff and have expressed their willingness to comply with the ATR by giving their signed consent.

Brief Interventions

Evidence suggests that interventions in Tiers 1 and 2 of MoCAM e.g. alcohol specific information, advice and support, simple and extended brief interventions (BIs), are generally most appropriate for those individuals assessed as increasing risk or higher risk (excluding dependent) drinkers⁵⁴ and, if targeted appropriately, encourage responsible drinking, reduce risks to health and can help to reduce offending related to alcohol misuse.

⁵⁴ Heather, N., Raistrick, D. and Godfrey C. (2006) *Review of the Effectiveness of Treatment for Alcohol Problems*. London: National Treatment Agency for Substance Misuse.

Simple brief interventions or structured brief advice (Tier 1)

This is generally 5 minutes of structured brief advice usually delivered immediately following screening at the pre-sentence report (PSR) stage or during supervision.

It is targeted at offenders who have a pattern of drinking *above* lower risk drinking limits but where there is no consistent link between their drinking and offending. They are at medium risk of experiencing harmful consequences for themselves and possibly others e.g. getting into arguments, accidents or unwanted situations. They may not have come to any harm so far and if they cut down they should be able to avoid serious problems.

The target group is:-

- AUDIT 8-15
- OGRS3 <35
- Tiers 1 & 2 of the OMM

Extended brief interventions or brief motivational counselling (Tier 2)

A small number of structured sessions of between 20-30 minutes usually delivered through an activity requirement or as part of a supervision requirement.

There will be clear evidence of some alcohol related harm (to self and others) because of regular excessive consumption or because of bouts of heavy drinking and alcohol will have been a factor in any offence of violence, including any domestic violence related offending, or public order act offences.

Targeting criteria are:

- An AUDIT score of 16-19 or a pattern of regular binge drinking
- OGRS3 35-49
- OMM Tiers 2/3
- Offence was part of an established pattern
- Violent behaviour linked to alcohol use
- Low score in attitudes, thinking & behaviour (ATB) section
- Work and shift patterns exclude them from other interventions

Accredited Interventions

Offender suitability for an accredited programme needs to be assessed separately from suitability for an ATR or brief intervention but this section of the guidance offers some inclusion criteria for specific programmes in the context of AUDIT scores (Accredited programmes have specific OGRS3 criteria and areas/trusts have specific targets in conjunction with these. Areas/trusts do have

small amounts of discretion to use AUDIT information to override such scores but these cases will be exceptional rather than normal and require senior manager approval).

Addressing Substance Related Offending (ASRO)/ Offender Substance Abuse Programme (OSAP)

Anecdotal evidence suggests that Addressing Substance Related Offending (ASRO) and the Offender Substance Abuse Programme (OSAP) have been used most commonly for offenders with Class A drug misuse issues. However, these programmes are suitable for those medium to high-risk adult offenders recognised as having a significant (higher risk or dependent) alcohol problem and for whom the misuse of alcohol has been assessed as a significant factor in their offending behaviour.

Offenders who score AUDIT >16 and Offender Group Reconviction Scale (OGRS3⁵⁵) >50, which would entail significant previous convictions indicating an established criminal lifestyle, or OASys General Re-offending Predictor (OGP) 100-point scores of 39+ (OGP 2-year percentage 33+) should be considered against the Substance Misuse Related Offending Behaviour Programme SELECTION MATRIX. Where an individual scores 75 and above on OGRS3 (equivalent is OGP 100-point score 60+; OGP 2-year percentage 65+) the sentence plan should identify additional work to reflect the higher need.

The selection criteria for OSAP and ASRO are based on risk of reconviction and need, not the type of substance misused. Offenders also need to be sufficiently stable and motivated.

The exclusion criteria relate to issues that might prevent the potential participant assimilating the programme material e.g. through acute drug or alcohol intoxication, serious mental illness, severe learning disability, organic impairment, deficits in basic skills, or other more pressing needs (e.g. homelessness).

It is conceivable that an ATR may be sequenced prior to an OSAP/ASRO programme, in a lengthy sentence, where the ATR is used as part of a range of measures that ensure the offender's alcohol use and motivation is then consistent with programme expectations.

⁵⁵ OGRS3 predicts, from a limited number of criminal history and demographic factors, the probability that an offender will be resanctioned (reconvicted or given a caution, reprimand or final warning) within two years of release from prison or from the start of a community penalty for any standard list offence.

Lower Intensity Alcohol Programme (LIAP)

The Lower Intensity Alcohol Programme (LIAP) is the first dedicated programme to address alcohol related offending behaviour. It is targeted at those offenders whose:

- alcohol misuse and offending needs are not sufficient to lead to a referral to one of the existing substance misuse programmes
- primary need would require referral to another accredited programme but where there is still a need for alcohol related offending to be addressed (There are strong links between the potential target group for LIAP and those offenders who should be referred to the violence and domestic violence programmes. It is envisaged that LIAP could enhance the work on these programmes where alcohol is a major risk factor but for domestic violence offenders a full assessment should be made and the other areas of risk and need addressed.)

LIAP has been provisionally accredited by the Correctional Services Accreditation Panel (CSAP) for use with problematic drinkers **not dependent drinkers** (as is the case with the other substance misuse programmes).

*Suitability for Accredited Interventions*⁵⁶ issued by NOMS Interventions and Substance Misuse Group (ISMG) in May 2009, along with *Changes to the psychometric test batteries for accredited programmes delivered in the community and custodial settings*, has LIAP specifically at OGRS3 35-75 (OGP 100-point score 28-60; OGP 2-year percentage 21-65) creating a significant overlap with OSAP/ASRO. This means that for those in OGRS3 50-75 the AUDIT score becomes the additional information that helps decide.

Generally, offenders whose OGRS3 score exceeds 50 but who score 16-19 on AUDIT should be considered in the first instance for ASRO/OSAP rather than LIAP.

Those scoring 20+ on AUDIT are NOT normally appropriate for LIAP unless scoring very low OGRS3 (35-49).

Offenders who regularly abuse alcohol along with other drugs should be referred to OSAP and ASRO.

Drink Impaired Drivers (DID)

The Drink Impaired Drivers (DID) programme targets those who have committed a drink drive offence but have not otherwise been involved with crime or who

⁵⁶ http://npsintranet.probaton.gsi.gov.uk/index/service_delivery/interventions/programmes.htm

have no other criminogenic need. DID combines education with cognitive behavioural interventions and is targeted at the more persistent offender. It is not aimed at the first time offender unless there is an aggravating feature such as a very high (double the legal limit) alcohol/blood level or accident. DID is also unlikely to be suitable for offenders with more than four previous convictions who are likely to have a wider range of criminogenic needs better addressed by a general/cognitive skills programme.

The programme has a specific targeting schedule (UNCOPE). AUDIT should replace UNCOPE however for assessing levels of alcohol dependency, with scores of 20+ indicating a need to also consider a treatment intervention and/or appropriate sequencing of the programme requirement.

DID should not be used in conjunction with OSAP, ASRO or LIAP.

Where OGRS3 is over 50, OMs should consider referral to the Thinking Skills Programme (TSP) instead.

Targeting criteria are:

- AUDIT 16-19
- OGRS3 under 50 (OGP 100-point score 28-38; OGP 2-year percentage 21-32)
- OMM Tier 2/3

Control of Violence for Angry Impulsive Drinkers (COVAID)

Control of Violence for Angry Impulsive Drinkers (COVAID) is a structured, cognitive-behavioural intervention for use with non-dependent drinkers who are aggressive or violent when drunk, which has been fully accredited by CSAP for England and Wales

Offenders are targeted for COVAID if:

- They are over 18 years of age
- They have a history of repeat violent offences
- They have a problem with anger/aggression
- Their drinking precipitates or exacerbates aggression or violence
- Their violence is not cold blooded, calculated or planned
- They have committed three or more acts of alcohol-related aggression or violence in the past two years
- They are at medium to high risk of re-offending
- They have basic literacy and comprehension ability

Offenders should have been assessed as suitable for the programme using the specific COVAID selection criteria matrix and have given their consent.

COVAID is a resource that should be matched against very specific need. It is not a default alcohol provision for all those offenders who do not fit in to the other alcohol provisions. OMs need to be very clear about the existence of an intrinsic relationship between alcohol and offences of serious impulsive violence. Cases should be discussed with a COVAID tutor prior to any court proposal.

Violence/Domestic Violence

An ATR with an appropriate accredited programme – Aggression Replacement Training (ART) or Controlling Anger and Learning to Manage it (CALM) – should be considered where an offender scores 4 or more in Section 9 of OASys⁵⁷, has an Audit score of 20+ and the offence is one of violence.

Many offenders with alcohol misuse problems will have committed an index offence(s) of domestic violence and be suitable for a DV programme (separate criteria apply).

The LIAP pilot project (2006-2008) specifically excluded DV offenders (and sex offenders) from its scope. In response to concerns raised by areas involved in the pilot, we have introduced some flexibility reflected in recently issued *Domestic Abuse and substance misuse programmes (including LIAP)* principles and guidelines. These should be considered in all cases where offenders have alcohol misuse and dv issues.

According to the guidelines, 'each intervention should be targeted according to its own criteria and any associated matrix e.g. the targeting for LIAP does not alter when it is sequenced with another intervention making it a higher risk option and assessed separately e.g. the outcome of the alcohol screening and assessment process will determine the appropriate alcohol intervention to run alongside IDAP'.

Where a domestic abuser registers an audit score of 20+ (and a score of 15 or 16 on questions 2, 3, 4 and 6), an ATR may be appropriate in conjunction with a domestic abuse intervention e.g. Integrated Domestic Abuse Programme (IDAP), Community Domestic Violence Programme (CDVP).

⁵⁷ Following the recent changes to OASys, the criminogenic need cut-off point remains 4+, but this is now on a 0-8 rather than 0-10 scale and fewer offenders meet the threshold than previously.

Drinking Type	Intervention	MOCAM Tiers	OMM Tiers
<p><i>Increasing Risk (Hazardous)</i></p> <p>AUDIT 8-15 OGRS3 up to 34 No consistent link between drinking and offending</p>	<p>OM intervention supported by NOMS alcohol information pack (often as part of supervision requirement)</p>	1	1/2
<p><i>Higher Risk (Harmful)</i></p> <p>AUDIT 16-19 OGRS3 35-49 Offence part of an established pattern</p>	<p>Extended brief interventions delivered in-house or by external health provider (Specified activity requirement) LIAP DID</p>	2	2/3
<p><i>Dangerous and Dependent</i></p> <p>AUDIT 20+ OGRS3 50+ All crimes alcohol related Violent alcohol crimes</p>	<p>Likely need for detoxification stabilisation prior to other requirement implementation ATR ASRO/OSAP COVAID</p>	3/4	3/4

Screening and assessment

There is significant evidence that early detection and intervention is effective in reducing alcohol-related harm⁵⁸. *Working with Alcohol Misusing Offenders*, issued in May 2006, requires that 'once alcohol misuse has been identified as an issue by OASys....the offender should be screened using a specific alcohol screening tool to assess the health aspects of alcohol misuse'. This is because the Offender Assessment System (OASys) is a risk assessment and sentence planning tool which looks at alcohol misuse as a factor associated with offending but doesn't assess clinical need. Therefore, the alcohol section of OASys (section 9) should act as a signpost to specific alcohol screening and, where necessary, follow-up specialist assessment to identify the nature and extent of the offender's alcohol problem (increasing risk, higher risk or dependent drinker⁵⁹) and the type of intervention likely to be most appropriate to address it.

Under the new release 4.3.1, the OASys assessment is considerably shorter. This affects the alcohol misuse section, and indeed all dynamic risk sections. The new Standard (Layer 2) OASys, which Tier 2 offenders receive, contains only questions 9.1 and 9.2, and no longer has a criminogenic need measure. The new Full (Layer 3) OASys, applicable to Tier 3 and 4 offenders, contains all the same questions, but question 9.4 is no longer part of the scoring of criminogenic need, which therefore leads to a score of 0-8 with need scored at 4+. So, among Layer 3 offenders, the percentage with a criminogenic need will fall, as it's now 4+ out of 8 rather than 4+ out of 10.

To identify those with alcohol needs associated with higher than average risk of re-offending and in line with the new layered approach to OASys, OMs should screen **all** Tier 3 and 4 offenders who score 4 or more using 4 questions within the alcohol section of OASys (excluding the violence question) as a minimum but, subject to time and resource constraints, may wish to consider adopting a lower threshold⁶⁰. For example, it can be difficult to identify increasing risk drinkers unless they have committed an alcohol related offence because evidence of existing problems is likely to rely on the offenders own account (there is no outward evidence of alcohol related harm) and recognition and motivation to change is likely to be low thereby keeping the score in OASys section 9 below 4.

A lower threshold is also supported by research undertaken by the University of Newcastle, commissioned by the then North East Regional Offender Manager, which found that 'around 40% of individuals who were either hazardous, harmful

58 Heather, N., Raistrick, D. and Godfrey C. (2006) *Review of the Effectiveness of Treatment for Alcohol Problems*. London: National Treatment Agency for Substance Misuse.

59 The OASys online help is currently being amended with reference now being made to the WHO and DoH categories.

60 Offenders scoring less than 4 have below average re-offending rates.

or possibly dependant drinkers using the AUDIT were not identified using OASys' and 'when comparing the AUDIT results to OASys scores for alcohol14% of individuals who were classed as possibly dependant on the AUDIT scored under 4 on OASys.' A profile analysis of offenders who had undertaken secondary screening in North Wales Probation Area even found 'some offenders who scored zero in section 9 of OASys who subsequent investigation revealed had a range of drinking problems, including in a few cases dependent drinking.'

The use of AUDIT in cases where the offender scores less than 4 in section 9 i.e. where alcohol consumption is not identified as a criminogenic need but the offender may nevertheless have a drink problem not necessarily directly linked to their offending can be justified on grounds other than health. This is because, in order to make informed proposals to court, it is necessary to know whether or not an offender is a dependent, higher risk or increasing risk drinker and thereby identify the type of intervention(s) which is likely to be most effective in addressing the problem and requirement most suitable for delivery, within an overall sentence which reflects offence seriousness. This is where AUDIT and, where appropriate, triage and comprehensive assessment are needed to supplement OASys. For example, a court can only make an alcohol treatment requirement if it is satisfied, among other things, that the offender is **dependent** on alcohol and this **dependency** is such as requires and may be susceptible to **treatment**. This **dependency** does **not** have to have contributed to the offence(s) for which he has been convicted.

The World Health Organisation⁶¹ states that a definite diagnosis of dependence should usually be made only if three or more of the following have been present together at some time during the previous year:

- A strong desire or sense of compulsion to take the substance;
- Difficulties in controlling substance-taking behaviour in terms of its onset, termination, or levels of use;
- A physiological withdrawal state when substance use has ceased or have been reduced, as evidenced by: the characteristic withdrawal syndrome for the substance; or use of the same (or closely related) substance with the intention of relieving or avoiding withdrawal symptoms;
- Evidence of tolerance, such that increased doses of the psychoactive substance are required in order to achieve effects originally produced by lower doses (clear examples of this are found in alcohol- and opiate-dependent individuals who may take daily doses sufficient to incapacitate or kill non tolerant users);

61 WHO International Classification of Diseases and Health Problems, tenth revision (ICD-10) Diagnostic guidelines
http://www.who.int/substance_abuse/terminology/definition1/en/index.html

- Progressive neglect of alternative pleasures or interests because of psychoactive substance use, increased amount of time necessary to obtain or take the substance or to recover from its effects;
- Persisting with substance use despite clear evidence of overtly harmful consequences, such as harm to the liver through excessive drinking, depressive mood states consequent to periods of heavy substance use, or drug-related impairment of cognitive functioning; efforts should be made to determine that the user was actually, or could be expected to be, aware of the nature and extent of the harm.

We know from research that brief interventions 'are effective in reducing alcohol consumption among hazardous and harmful drinkers to low-risk levels'⁶². Given the target group and the limited number of sessions involved, these are more appropriately delivered through an activity requirement or as part of a supervision requirement than an ATR.

A score of 2 in response to question 9.5 of OASys – *Motivation to tackle alcohol misuse* - may mean the offender is **not** susceptible to treatment and therefore does not meet the criteria for an alcohol treatment requirement (ATR). The 'readiness to change' questionnaire should be used to confirm this (*see section on motivation*).

There is an insufficient number of questions in section 9 of the standard OASys, which Tier 2 offenders receive, to use the score to determine whether there is a link between alcohol use and offending behaviour. Therefore, it is left to the practitioner's clinical judgement to decide if the offender has an alcohol problem requiring further investigation using AUDIT or similarly validated tool.

Alcohol misuse is the most highly weighted dynamic risk factor in the new OASys Violence Predictor (OVP), which has been launched in the release 4.3.1 of OASys. Research has found that the OVP greatly improves prediction of: violence against the person; weapons; robbery; criminal damage; and public order ('violent-type') offences⁶³. Alcohol misuse problems, scored from questions 9.1 and 9.2, account for 10 of the 100 points used to score OVP. By contrast, alcohol misuse is zero-weighted in the OASys General re-offending Predictor (OGP), which predicts non-violent re-offending, reflecting the lack of a predictive association between alcohol and non-violent re-offending. All offenders assessed in the new versions of OASys receive both an OGP and OVP score. Therefore, tackling alcohol misuse is a key means of achieving reductions in OVP scores over the course of a sentence/order. OVP scores are in turn a key factor in

62 Heather, N., Raistrick, D. and Godfrey C. (2006) *Review of the Effectiveness of Treatment for Alcohol Problems*. London: National Treatment Agency for Substance Misuse.

63 Howard P. (2009) *Improving the prediction of re-offending using the Offender Assessment System*. Research Summary 02/09

making risk of serious harm decisions, so the new scoring system should 'lock in' the importance of tackling alcohol misuse.

Not all offenders subject to probation supervision have a full OASys⁶⁴. At the pre-sentence stage OASys is not completed for those offenders who have been shown by a screening process to present a low risk of serious harm and who have a low likelihood of reconviction. Similarly after sentence, probation national standards do not require OASys to be completed in the most straightforward, low risk cases, but all are subject to a screening process and have a sentence plan prepared.

Offender Managers should consider use of an alcohol screening tool in cases where OASys has not been completed (Tier 1 offenders) or has not identified an alcohol problem (section 9 score of less than 4 for Tier 3 and 4 offenders) but where from other available information they have reason to suspect alcohol misuse. This is particularly relevant for offenders sentenced to a standalone unpaid work requirement following an oral report.

Generally, the screening should be carried out by suitably competent probation staff (of any level) immediately following the OASys assessment. The offender should be made aware of the purpose of the screening, the screening and assessment process and the specific roles of those undertaking the assessment at the outset. When broaching the subject of alcohol and screening, discussions should be sensitive to an offender's culture and faith and tailored to individual needs.

Unlike across the prisons estate, where the use of the Alcohol Use Disorders Identification Test (AUDIT) is recommended, NOMS doesn't recommend that a specific alcohol screening tool be used across probation. This is consistent with *Models of care for alcohol misusers (MoCAM)* which makes clear that 'local commissioners should work with local providers to develop *local systems for screening and assessment*, with three levels of assessment: **screening, triage and comprehensive**' and encourages local agencies to agree which tool(s) to use. The use of the same screening tool as other agencies should lead to more accurate identification and appropriate referrals and less duplication.

There are presently a number of validated alcohol **screening** tools available e.g. AUDIT, Fast Alcohol Screening Test (FAST)), which are realistic (only take approximately five minutes to complete), require minimal training to use and are cost-effective. Information on different screening tools is available from the Alcohol Learning Centre⁶⁵ and their efficacy is compared in the *Review of the Effectiveness of Treatment for Alcohol Problems*. The latter concludes that 'the AUDIT should be considered as the screening instrument of first choice in

64 Tier 1 cases only have an Offender Group Reconviction Scale (OGRS) score and risk of serious harm screening unless the screening raises serious issues when a full Risk of Serious Harm analysis should be completed.

65 <http://www.alcohollearningcentre.org.uk/Topics/Browse/BriefAdvice/>

community settings’ but also that ‘the FAST (Fast Alcohol Screening Test) offers a rapid and efficient way of screening for hazardous and harmful alcohol consumption that can be used in a variety of settings’. However, the evidence on which this assessment was based comes from health rather than criminal justice settings. This will be addressed by the Screening and Intervention Programme for Sensible Drinking (SIPS)⁶⁶, which will, among other things, compare the relative effectiveness of two initial screening tools (Modified Single Alcohol Screening Question (M-SASQ) and FAST) with AUDIT for use in a probation setting. Findings from the study will inform the development of a toolkit of validated screening and brief intervention packages appropriate to a probation setting and protocols for their use. In the interim, if an offender is positive on either initial screening tool, it is recommended that the remaining questions of AUDIT be administered to obtain a full score.

AUDIT and an explanatory guide to interpreting the scoring are available within sections 16.3 and 16.4 of the NOMS *Alcohol Information Pack for Offenders under Probation Supervision*⁶⁷. As AUDIT is a self administered questionnaire, offenders with literacy needs will have to be supported in filling in the questionnaire. Relevant specialists should be consulted when it is not appropriate to use an English language-based screening questionnaire e.g. when dealing with people whose first language is not English or when people have a learning disability.

Offenders assessed through screening as increasing risk or higher risk drinkers should be provided with structured brief advice immediately after screening (MoCAM Tier 1). Those higher risk drinkers scoring 18-19 in AUDIT (the higher scoring range of what was formerly harmful drinking) should be referred for triage assessment, along with those offenders identified by the initial alcohol screening as alcohol dependent (20+ in AUDIT) and therefore likely to be suitable for the ATR, in accordance with the local Care Pathway.

The North Wales profile analysis found that ‘there is some positive correlation between higher Alcohol Use Disorders Identification Test (AUDIT) and higher OASys scores... however a number of significant anomalies occur.’ This can arise for a number of reasons e.g. results can be distorted by the offender’s caution in self disclosure associated with potential sentence implications or exaggeration. Therefore, staff should be happy that the final AUDIT score is consistent with other information presented throughout the PSR process. Where this is not the case the inconsistency needs to be explored with the offender and explained.

66 <http://www.sips.iop.kcl.ac.uk/>

67 http://npsintranet.probation.gsi.gov.uk/index/service_delivery/interventions/drugs__alcohol/alcohol_information_pack.htm

The AUDIT score will generally be a more accurate indicator of alcohol problems than OASys but it is still only a guide and not a substitute for an OM's professional judgement. Where there is evidence that the offender presents a greater risk than suggested by AUDIT or has a known history of alcohol related offending, the offender should generally be referred to an alcohol worker for a triage assessment. A more detailed examination of the responses to the specific questions on symptoms of dependence (4-6) may also be helpful in deciding whether or not to make a referral.

Triage assessment is a Tier 2 intervention which generally takes place when an individual first contacts an alcohol treatment service but can be carried out by suitably competent probation staff. It is a fuller assessment than the initial screening the purpose of which is to identify the seriousness of an individual's problems, the urgency with which these need to be addressed and the most appropriate type of intervention.

Offenders who may require structured treatment and those with more complex needs should be subject to a **comprehensive assessment**, which should be carried out by specialist treatment staff. This will more precisely determine the nature and extent of the offender's alcohol and other problems, and thereby suitability for an ATR, and enable an individual care plan to be prepared.

Issues around dual diagnosis (i.e. both enduring mental health and substance misuse problems present) need to be addressed at the assessment stage. As much information as possible should be obtained about an offender's mental health (if this appears to be an issue) e.g. contact with relevant mental health professionals, access to psychiatric reports etc., in order to fully assess if an ATR is a suitable requirement.

Areas/trusts should be sure that treatment and probation staff are working to the same criteria regarding suitability and that they liaise regarding the outcome of the assessment. In the unlikely event that there is disagreement between probation and treatment staff regarding the suitability of an offender for an ATR, the matter should be raised with respective line managers.

In line with MoCAM, areas/trusts should develop information sharing protocols and agreed processes for joint working with agencies to which they refer offenders for specialist assessment. These will set out minimum expectations regarding the information that should be provided, when and to whom. The initial referral will often be by a telephone call to the alcohol worker and followed up by information being faxed including a referral form, copy of the completed AUDIT and risk information. The telephone call should identify a date and time for the assessment (within next 2 days, wherever possible, and identified slots should be reserved each day). It will be the PSR writer's responsibility to convey this information to the offender. Upon completion of the assessment, the assessor will provide a written assessment report and completed offender compact form

and forward these papers to the PSR writer by the agreed date.

Offenders assessed as suitable for an ATR should be fully briefed as to the legal and treatment implications of such and be able to give their informed consent. They need to sign prior to sentence that they consent to the requirement/order and suggested good practice would be for this to be done at the end of the assessment process. Implicit to an offender agreeing to be made subject to an ATR is their agreement to information being shared with contracted ATR treatment providers (and they should be informed of this at assessment). All offenders have to sign a waiver for information sharing. Offender managers should work to gain offender consent to an ATR and, where applicable, should proactively promote ATRs to offenders.

Areas/trusts should also ensure that they provide 'adequate training to staff carrying out screening and assessment.' To facilitate this, NOMS provided Avon & Somerset Probation Area with funding to develop a bespoke modular training package linked to relevant Drug and Alcohol National Occupational Standards (DANOS) competences, which is available for other areas/trusts to download from EPIC⁶⁸ and utilise. Probation staff's level of DANOS competence can be quality assured through on the job assessment by an independent assessor and staff can work towards a qualification e.g. NVQ.

There should be a process for ongoing assessment of quality of delivery. This is a particular issue of concern for Directors of Offender Management who need to be satisfied regarding the quality of delivery and that it will lead to expected outcomes e.g. reduction in alcohol related offending, alcohol consumption and harms to health, improvement in social wellbeing/functioning.

Offender Managers should take into consideration an offender's motivation; level of awareness of their drinking and offending behaviour; and 'positive resources' available to them to address it during the screening and assessment process.

Motivation

One of the objectives of an ATR should be to generate motivation to engage in treatment (OMs are trained in motivational interviewing so an ATR should be about MI+ and specialist motivational and engagement approaches). Therefore, lack of offender motivation should not generally be a reason for failing to propose an ATR. Unless an offender makes it very clear that they have no interest in changing and will not comply, an ATR should be proposed if the other criteria are met and there are no other factors e.g. mental health of sufficient seriousness that would preclude the offender's suitability.

⁶⁸http://npsintranet.probation.gsi.gov.uk/index/service_delivery/interventions/drugs__alcohol/alcohol_best_practice_projects.htm

Before engaging in structured treatment (the core ATR intervention), the offender should demonstrate a reasonable level of motivation to address their substance misuse and offending behaviour. It has been found that where individuals lack the appropriate motivation the chances of modifying or changing their behaviour and completing the sessions are greatly decreased.

The Readiness to Change Questionnaire is an additional tool which can be used when working with offenders with alcohol misuse problems. It is a self-explanatory form, which is filled in by offenders themselves. This form will enable staff to assess motivation to engage in treatment, particularly counselling.

To engage in treatment the offender should be assessed as at least contemplative or action on the Readiness to Change questionnaire. It has been identified that individuals in this stage are aware of the potential benefits of change or the potential risks of continuing their behaviour. As such, they are beginning to weigh up the costs and benefits of change and seek information to help them in their decision.

At the pre-contemplative stage it has been found that individuals are not interested in changing their risky lifestyle and as such are not even thinking about change. This being the case they are not open to therapeutic interventions and the process of change is unlikely. Therefore, offenders scoring pre-contemplative on the Readiness to Change questionnaire should be engaged in some prior One to One motivational work as preparation for the core ATR intervention.

There is some evidence that motivational enhancement therapy (MET) is 'especially effective for service users showing a high level of anger at entry to treatment and possibly for those with low levels of readiness to change'⁶⁹. Also, achieving high self-esteem is thought to be important to the process of moving round the stages of change. This is where OMs have a key role to play.

The offender should also demonstrate a basic awareness of the historical development and contextual process of their drinking and offending behaviour.

The offender could verbally indicate what positive resources they have or demonstrate a reasonable level of motivation to obtain some. The most important resources have been found to be:

- A 'safe' environment in which to live
- Interests that can be conducted outside of drinking situations

69 Heather, N., Raistrick, D. and Godfrey C. (2006) *A Summary of the Review of the Effectiveness of Treatment for Alcohol Problems*. London: National Treatment Agency for Substance Misuse.

- A reliable support system in which the individual can be encouraged to develop a chosen lifestyle, whether it is abstinence or controlled drinking

During the screening and assessment process, OMs should make all offenders who present with alcohol misuse problems aware of Alcoholics Anonymous (AA) and the possibility that this may be a source of help that they have not considered. Each area should ensure that they have developed links with their local AA inter-group and have access to up to date local contact and meeting information, which they can make available to offenders upon request.

For women the impact of their drinking on their children can be an important part of their motivation to address their alcohol misuse. This needs to be carefully considered by offender managers alongside safeguarding concerns.

Assessment is not a one-off static process and there needs to be appropriate ongoing assessment of alcohol (and related) needs and matching intervention to need throughout the sentence or period of a licence. Indeed, an OASys review may shed light on a hitherto undiscovered problem or identify a need that develops during the course of supervision, in which case this need should be met within the sentence or terms of the licence if flexibility allows e.g. brief interventions within a supervision or activity requirement or the offender should be referred to treatment on a voluntary basis.

Assessments in custody

Areas/trusts need to ensure they have some flexibility to be able to offer assessments in custody, given the risks of self-harm, offender deaths in the days post-release linked to the use of alcohol and the need to sustain the benefits of alcohol abstinence while the offender was in custody.

Wherever possible, assessments should be conducted face to face however video conferencing could be offered to treatment providers. The quality of video link technology is improving and, as it does, it will allow increasing degree of treatment interpretation. The Video Conference (VC) Directory lists all known VC equipment available in courts (HMCS), prisons and probation areas/trusts and can be accessed on EPIC.⁷⁰

⁷⁰http://npsintranet.probation.gsi.gov.uk/index/service_delivery/offender_management/video_conference_technology_-_directory_for_courts__prisons_and_probation_areas.htm

Court proposals and the sentencing framework

Determining the correct proposal

General principles

The type, intensity and duration of the alcohol related intervention should primarily be determined by assessed need i.e. the outcome of the alcohol specific screening e.g. Alcohol Use Disorders Identification Test (AUDIT) and, where necessary, specialist assessment, provided the ***overall restriction on liberty imposed by the community order (CO) or suspended sentence order (SSO) in its totality is commensurate with the seriousness of the offence(s)***. Other more punitive requirements can be added to a CO or SSO, where necessary, to reflect offence seriousness.

Taking the alcohol treatment requirement (ATR) as an example (although the same principles apply to offenders assessed as suitable for brief interventions (BIs) - delivered through an activity requirement or as part of a supervision requirement), offenders who have committed a high seriousness offence (Tiers 3 & 4 of the Offender Management Model) and are suitable for an ATR will often have an ATR with at least two other requirements (usually a supervision and programme requirement) and occasionally more e.g. an activity requirement to meet the courts need for punishment. For medium seriousness offences, the ATR will often be accompanied by a supervision and programme requirement.

In line with PC 08/2008 - *National Rules for Tiering Cases and Associated Guidance*, a proposal for an ATR should usually be accompanied by a proposal for a supervision requirement. It is unlikely that an offender who is suitable for an ATR will have only a single problem – alcohol – and the supervision requirement provides a clear legal authority to address the other issues. This supersedes the guidance in Annex B to PC 57/2005 which advised that ‘the ATR can be used as a stand alone requirement for those in the lowest band of the community sentence.’

Whilst the length of the treatment or brief intervention should reflect individual need, the total length of all the requirements i.e. the restriction on liberty should be commensurate with the seriousness of the offence and risk. Therefore, again using the ATR for demonstration purposes, although the principle holds equally well for delivery of BIs, examples of potential pre-sentence report (PSR) proposals are:-

- A shorter length ATR, but possibly a longer punishment and/or other rehabilitation requirement, could be proposed for an offender with a high seriousness of offence but a low-medium treatment need.

- A longer ATR with shorter other requirements could be proposed for an offender with a medium seriousness of offence but a high treatment need.
- An offender with a high treatment need but low seriousness of offence should have a short ATR proposed but be encouraged to remain in treatment on a voluntary basis at the end of the ATR where there is a continuing treatment need.

In cases where the court does not give a provisional indication of offence seriousness, the PSR author should make an assessment of the seriousness of the offence and make a proposal about the intensity of the ATR or other alcohol related intervention and any other requirements which is commensurate. Previous related offences should be taken into consideration by the PSR writer, as this could show an escalation of alcohol misuse and harm to others which may underpin the correct allocation to a specialist alcohol worker.

Requirements as part of a suspended sentence should be less demanding than those of a community order given the more serious sanction for non-compliance.

The court should be made aware in the PSR of all cases where sequencing of requirements is likely and this should also be stated in the sentence plan.

Alcohol treatment requirements (ATRs)

The ATR is available to courts as a sentencing option for offences committed on or after 4 April 2005 by offenders aged 18 or over. Pre-Criminal Justice Act 2003 measures continue to be in force for offenders committing offences before 4 April 2005 and for juveniles.

An ATR can be made part of a community order for a minimum of six months and maximum of three years and a suspended sentence order for a minimum of six months and maximum of two years (Annex B to PC 57/2005 incorrectly stated that the maximum duration of an ATR made as part of an SSO was three years).

An ATR can be proposed wherever the PSR author is satisfied that the requirements of section 212 of the Criminal Justice Act 2003 are met.

Under Section 212 of the Act, a court can impose an ATR provided it is satisfied that:

- the offender is **dependent** on alcohol (this does not have to have caused or contributed to the offence(s) for which he has been convicted)
- this **dependency** is such as requires and may be susceptible to **treatment**

- arrangements have been or can be made for the **treatment** intended to be specified in the order (including arrangements for the reception of the offender where he is to be required to submit to **treatment** as a resident) and
- the offender expresses his willingness to comply with its requirements.

The ATR obliges the offender to submit to '**treatment** by or under the direction of a **specified person** having the necessary qualifications or experience with a view to the reduction or elimination of the offender's **dependency** on alcohol.'

The **treatment** required by an ATR for any particular period should be either:

- as a resident in such institution or place as may be specified in the order
- as a non-resident in or at such institution or place, and at such intervals, as may be so specified or
- by or under the direction of a person having the necessary qualification or experience as may be so specified

but the nature of the **treatment** shall not be specified in the order except as above.

Dependency and treatment

A court can impose an ATR only if it is satisfied, among other things, that the offender is **dependent** on alcohol and this **dependency** is such as requires and may be susceptible to **treatment**. Unlike the drug rehabilitation requirement (DRR), courts cannot make an ATR if the offender has a 'propensity to misuse' alcohol.

Whilst neither dependent/dependency or treatment are defined in the Act, the World Health Organisation's tenth revision of the *International classification of diseases* (ICD-10) defines **dependency** as characterised by 'psychological dependence' with an increased drive to use alcohol, difficulty controlling its use, despite the consequences, and in more severe cases physical withdrawals upon cessation of use. This definition of dependency is adopted in *Models of care for alcohol misusers* (MoCAM).

MoCAM identifies moderate and severely **dependent** drinkers as 'the main groups of alcohol users who clearly may benefit from specialist alcohol **treatment**' and makes a clear distinction between the provision of these **treatment interventions** and **brief interventions** 'for those drinking excessively but not requiring treatment for alcohol dependence.' This approach is supported by the comprehensive *Review of the effectiveness of treatment for alcohol problems*.

Specified person

An ATR should be carried out by or under the direction of a '**specified person**' having the necessary qualifications or experience.

Legal advice suggests that 'specified person' does not necessarily mean a named individual but can be construed more widely to mean a group or type of individual(s), such as an offender manager, with the necessary skills or experience.

As an offender manager is required for formal supervision of the order, enforcement and general compliance, the person specified in the order to deliver or direct the delivery of the ATR could be '**a suitably qualified or experienced offender manager**'. Alternatively, as the treatment is usually carried out by a treatment provider under contract or service level agreement, it could be '**a suitably qualified or experienced member of staff from the contracted treatment provider**'.

Specified person should not be interpreted to mean the organisation by which the offender manager or alcohol worker is employed i.e. the supervising probation area or contracted treatment provider.

The proposal could read 'The offender be made subject to a community order/suspended sentence order with the following requirement(s): An Alcohol Treatment Requirement for a maximum of months to submit to treatment by or under the direction of (INSERT AS APPROPRIATE) having the necessary qualifications or experience with a view to the reduction or elimination of the offender's dependency on alcohol and.....'.

Alternatively, the proposal should specify that the offender submit to:

- treatment as a resident in a **specified institution or place**; or
- treatment as a non-resident in or at a **specified institution/place** at **specified intervals**.

Use of activity and supervision requirements to deliver brief interventions

An activity or six month supervision requirement is more appropriate than an ATR for those assessed as needing brief interventions rather than specialist treatment. It is for PSR authors to determine which of these two requirements is more appropriate in specific cases but in doing so they may wish to take the following general principles into consideration.

Supervision requirement

Seriousness levels

Low	= up to 12 months
Medium	= 12 – 18 months
High	= 12 – 36 months (max 24 months for SSO)

- The purpose of the supervision requirement is for ‘rehabilitation’.
- The flexible contact levels of a supervision requirement are appropriate for the delivery of brief interventions but contact has a more general focus than an activity requirement and runs throughout the order.
- Supervision can involve contact⁷¹ to:
 - undertake work to promote personal and behavioural change
 - deliver individual counselling
- Normally the supervision contact would be individual and brief interventions are delivered on an individual basis.
- Contact within a supervision requirement can be delegated by the Offender Manager to another person, and this arrangement might be used to provide the offender with specialised support or advice. In this way the requirement can be used to address particular issues which may arise after sentence without amendment of the order to include an activity requirement.
- Women, especially those assessed as vulnerable, should be offered the option of women supervisors and where available women-only provision.

Activity requirement

Activity (Sentencing Guidelines Council seriousness levels):

Medium: 20 – 30 days
High: up to 60 days

- Where issues are identified prior to sentence which will require a significant input of a specialised service or support this should be

⁷¹ When the OM specifications are implanted NOMS Offender Assessment and Management Group intend to issue guidance on the use of supervision requirements.

delivered through an activity requirement included in the order in addition to the supervision requirement.

- The general principle of the Criminal Justice Act is that specific interventions should be itemised within the order and delivered within appropriate and separate requirements.
- The use of an activity requirement allows participation in the specific activity to be explicitly included in the PSR and sentence plan. It helps to ensure offenders are clear about the expectations placed upon them, and the intentions of the court can be clearly enforced.

In general, we would advise that:-

Simple brief interventions or structured brief advice (generally around 5 minutes) usually delivered by the offender manager/supervisor e.g. using material from the *Alcohol information pack for offenders under Probation supervision* (NOMS 2008) and suitable for those with low alcohol needs e.g. increasing risk drinkers scoring 8-15 on AUDIT are most appropriately delivered within the **supervision** element of the order.

Extended brief interventions or brief motivational counselling (usually a small number of 20-30 minute sessions), such as motivational enhancement therapy, motivational interviewing, etc. (Tiers 2/3 of MoCAM), delivered either in-house by probation areas/trusts or in partnership with the voluntary sector to those with moderate alcohol needs (higher risk or binge drinkers scoring 16-19 on AUDIT) are better delivered through an **activity requirement**. Some areas/trusts have 'marketed' these to courts as an Alcohol Specified Activity Requirement (ASAR).

Areas/trusts should ensure that offender eligibility and suitability for specified activity requirements is OASys risk assessed (including risk of serious harm) such that offenders are duly prioritised and pre-prepared to undertake designated activities.

Discussion should take place with the partnership agency as to the number of days required to meet identified needs but at the very least the area/trust should ensure activity providers are properly informed of court requirements.

An activity requirement should not normally be used by itself but combined with a supervision requirement. Contact through the supervision requirement will provide the necessary support and motivation to ensure the activity is completed, and provide follow-up and reinforcement work to maximise the benefits of the activity, within the context of a broader programme of rehabilitation.

The proposal should read 'The offender be made subject to a community order/suspended sentence order with the following requirement(s): Aday

Alcohol Specified Activity Requirement and’ While it is preferable for an exact number of days to be specified in the order, where possible, an alternative option is for the order to be worded ‘for up to xx days’ to give greater flexibility.

Programme requirement

Alcohol misusing offenders should be considered for a **programme requirement** where:-

- alcohol related offending behaviour needs to be addressed;
- the use of the requirement can be justified by the seriousness of the offence; and
- the offender meets the criteria for that programme.

A programme requirement is unlikely to be sufficient on its own to tackle the wide range of needs of the more serious alcohol misusing offenders. In view of this, a community order plus an accredited substance misuse programme (ASRO or OSAP) without an ATR should be proposed in relatively limited circumstances.

Programmes, such as ASRO/OSAP, should generally only be used alongside an ATR for offenders in the medium/high seriousness community sentencing band.

The Lower Intensity Alcohol Programme (LIAP) is appropriate for use with problematic drinkers, not dependent drinkers. As such, it should not be used in conjunction with an ATR, which is targeted at alcohol dependency, or with the Drink Impaired Drivers (DID) scheme. It is acceptable for orders to have requirements for both LIAP and a violence or domestic violence programme e.g. IDAP.

Offenders who have committed drink drive offences are suitable for DID. Those at the medium and high seriousness levels should be considered for a programme requirement for DID (subject to suitability), a supervision requirement; and, if assessed as suitable, an ATR. An ATR should only be added where this can be justified by the seriousness of the offence and offender need.

Details of the accredited programme should be specified in the PSR and sentence plan.

PSR authors should refer to offender eligibility and suitability for accredited programmes when making proposals in PSR reports using OASys and the targeting and risk management tools specified in the relevant programme manuals.

Use of unpaid work requirement

Where alcohol misuse has been identified as an issue, an unpaid work requirement will probably be limited to those offenders with low treatment needs

and a high seriousness of offence. However, each case needs to be looked at individually and should be balanced against the offender's level of needs/intervention and an assessment as to his/her realistic capacity to comply with the requirement.

The AUDIT score will help to indicate where an unpaid work requirement may be unsuitable due to alcohol misuse. Scores of 20+ indicating dependent drinking need serious consideration as to whether the offender will be suitable for unpaid work for Health and Safety reasons and/or because the extent of their alcohol problem is likely to affect their ability to attend. As such, it is unlikely that an unpaid work requirement will be proposed in conjunction with an ATR.

The court process

Alcohol misusing offenders may be assessed via an oral report, a Fast Delivery Report (FDR) or a Standard Delivery Report (SDR).

PC 06/2009 *Determining Pre-Sentence Report Type* provides guidance on determining which type of report to use. The PC seeks to ensure that SDRs 'are only used where it is not possible to provide sufficient information to meet the needs of the court within the fast delivery report (FDR) format.' In line with a recommendation from the specification, benchmarking and costing (SBC) report, PC 06/09 aims to increase the proportion of FDRs used in Magistrates Courts from around 40% to a minimum of 70% and also provide for increased usage in Crown Courts.

Offenders identified through the use of OASys and an alcohol screening tool e.g. AUDIT as increasing risk, higher risk (except those non-dependent drinkers at the higher end of the scoring range) or less persistent binge drinkers who don't meet the dependency test of the ATR can be recommended for a supervision or activity requirement involving the delivery of brief interventions without the need for further assessment unless:-

- there is evidence that the offender presents a greater risk than suggested by the screening or has a known history of alcohol related offending or
- there are co-existing problems e.g. serious mental health issues requiring liaison and specialist assessment.

Otherwise, subject to the criteria set out in PC 06/09, such cases will usually be suitable for an oral report or a FDR.

Where resources allow, when an oral report or FDR has been requested and alcohol use has not been identified previously, areas/trusts should consider using an alcohol screening tool e.g. AUDIT in order to try and ensure they do not miss alcohol misuse. This can be administered by suitably competent court staff. The completed screening assessment e.g. AUDIT form should then form part of the

oral report assessment or FDR pack. A request for adjournment will need to be made for the offender to be referred for a specialist assessment where:-

- dependent drinking or the higher end of higher risk drinking (18-19 on AUDIT) is indicated by the screening
- there is evidence that the offender presents a greater risk than suggested by the screening
- the offender has a known history of alcohol related offending

and treatment staff are not available to undertake the assessment at court.

PC 06/09 advises that a full SDR is usually required for the *Alcohol treatment Requirement (ATR)* unless arrangements are in place for specialist assessments to be completed within the timescale of the FDR. However, 'areas may have separate resources available to enable specialist assessment for specific sentencing options, such as Drug Rehabilitation Requirement (DRR) or Alcohol Treatment Requirement (ATR). Efforts should be made to engage treatment providers in making resources available, since speedy sentencing expedites the justice process and provides a quicker route into supervision and/or treatment.'⁷² If arrangements are in place for assessment at court it may be possible for a community order with an ATR to be proposed on the day of request. If not the case could be adjourned for five days or longer where local negotiations provide a more flexible timescale in order for an ATR assessment to be prepared and the outcome of the assessment submitted as an addendum to the FDR.

Given the links with alcohol misuse, it is important to note that a SDR will normally need to be prepared in cases where any of the following are applicable:-

- Current violent/sexual offence which indicates likelihood of Risk of Serious Harm (RoSH) or offender history of serious harm requiring further assessment
- Current domestic violence offence which indicates likelihood of RoSH or offender history of serious harm requiring further assessment.
- Safeguarding children/child protection issues
- Serious mental health issues are indicated by the offence/history and multi-agency liaison is required.

Pre-Sentence Reports (PSRs)

Screening and assessment should always take place pre-sentence to inform PSR recommendations.

⁷² London Probation Area is piloting to divert specialist assessment resources to courts.

Those offenders identified by OASys and the initial alcohol screening as alcohol dependent and likely to be suitable for the ATR should be referred at the PSR stage for a triage and/or comprehensive assessment undertaken by specialist treatment staff, as per *Models of care for alcohol misusers (MoCAM)*. The OM should ask for an adjournment when the assessment cannot be completed within the usual timescales.

Where the assessment cannot be undertaken in court, the referral should be by a telephone call to the assessor which will identify a date and time for the assessment (it will be the PSR writer's responsibility to convey this information to the offender). This should be followed up by a fax containing relevant information, including a referral form, section 9 of OASys, a copy of the completed AUDIT or other validated screening questionnaire, risk of harm assessment and any child protection concerns.

The assessor will provide a written assessment report and completed offender compact form and forward these papers to the PSR writer/court duty officer by the agreed date. The assessment appointment and report should ideally be available within 10 working days of the referral date. It is therefore important for PSR writers to expedite referral of the offender for an assessment report if the PSR is to be prepared within the three week PSR adjournment stage.

A 6 month ATR would normally be considered sufficient time to complete a treatment plan in the community, although residential rehabilitation or detoxification may require a longer period. The recommendation is that generally ATRs are made for no more than 6 months with a longer period of supervision or other requirements, where appropriate.

Report writers should generally only make proposals for ATRs when the case has a risk/needs profile equivalent to tier 2 or above and the requirement should always be accompanied by a supervision requirement.

Offenders not assessed as suitable for an ATR or who decline consent to an ATR should be considered for alternatives, which might include a community order with an activity requirement to complete extended brief interventions or/and a programme requirement for ASRO/OSAP if the normal criteria for this option is met. It should be made very clear to offenders who are not prepared to consent that any requirement(s) imposed instead of an ATR are likely to be as restrictive and equally punitive.

It is important that PSR authors agree any other requirements that they are considering proposing with those probation staff managing ATRs. Similarly, probation staff should liaise with treatment providers regarding any additional requirements that are being considered, especially the inclusion or otherwise of a substance misuse accredited programme.

Where high intensity orders are proposed for women, PSR authors should take account of the circumstances of individual women, particularly in relation to child care needs and transport. The sentence plan should reflect those needs and communication between the OM and the treatment provider will be crucial in delivering the order.

Contents of PSR

In addition to the requirements set out in National Standards, a SDR or FDR recommending an ATR should include:

- the results of assessments undertaken (OASys, alcohol screening tool e.g. AUDIT and triage/comprehensive assessment) indicating that the offender is dependent upon alcohol and that this dependency requires and may be susceptible to treatment
- a treatment plan, including the type of treatment (residential or non-residential), the name and address of the provider and for non-residents suggested intervals of treatment, if appropriate
- evidence that arrangements for this treatment are in place or can be put in place post-sentence
- a signed statement from the offender to confirm that the requirements of the order and the consequences of a failure to comply have been fully explained by the responsible officer, that he fully understands these and that he is willing to comply with the order and consents to the order being made
- the suggested length of the ATR taking into account the views of the provider
- an indication as to when the ATR will start (including, where known, the date of the first appointment with the treatment provider and the date of the first appointment with the offender manager) and, if there is likely to be any delay, the work that will be done with the offender in the interim
- any anticipated sequencing with other requirements of the order

Sentencing Guidelines

Advice on the use of ATRs and alternative requirements within community sentencing to address alcohol related crime was included in the definitive guideline on *Theft and Burglary in a building other than a dwelling* issued by the Sentencing Guidelines Council (SGC) in December 2008. The guidelines state that:-

'Many offenders convicted of acquisitive crimes are motivated by an addiction, often to drugs, **alcohol** or gambling. This does not mitigate the seriousness of the offence, but an offender's dependency may properly influence the type of sentence imposed. In particular, it may sometimes be appropriate to impose:

- a drug rehabilitation requirement (which can be part of a community order within all the community sentencing bands from low to high seriousness), or

- ***an alcohol treatment requirement (for dependent drinkers), or***
- ***an activity or supervision requirement including alcohol specific information, advice and support (for harmful and hazardous drinkers)***

as part of a community order or a suspended sentence order in an attempt to break the cycle of addiction and offending even if an immediate custodial sentence would otherwise be warranted.'

These guidelines have a wider applicability than simply for cases involving acquisitive crime.

It is important to keep a close eye on the concordance rate to check if the ATR and other requirements within which alcohol related interventions can be delivered are being used 'appropriately' by the court in accordance with the SGC guidelines. Areas/trusts will need to address any issues via their court liaison arrangements.

Delivery of interventions

The amount and type of treatment delivered under an alcohol treatment requirement (ATR) or alcohol related intervention e.g. brief interventions delivered through a supervision or activity requirement of a community order (CO) or suspended sentence order (SSO) should be tailored to the offender's assessed need providing the overall restriction on liberty imposed by the order in its totality is commensurate with the seriousness of the offence(s).

The intensity and duration of the intervention should be increased if required, in accordance with the stepped model of care prescribed in *Models of care for alcohol misusers* (MoCAM) or any instructions of the court. A stepped care approach (starting with a very brief intervention and intensifying efforts in case of no success) should improve effectiveness and save resources.

Staff should apply motivational interviewing techniques and model of change knowledge and skills in their routine interaction with offenders to engage, motivate and retain offenders with alcohol misuse issues in interventions or treatment.

Offenders under the influence of alcohol can be unpredictable and present a risk to staff. Risk of intoxication should be mitigated by knowledge of the offender's propensity to violence, use of the environment and non-confrontational dialogue. Staff should have brief human engaged conversations with intoxicated offenders but recognise the inappropriateness of working with them. They should then be given another appointment. It is at the subsequent appointment that the inappropriateness of the drunkenness should be challenged.

Women under the influence of alcohol are known to be at greater risk of harm e.g. from assault. Care should be taken therefore to ensure that all reasonable steps are taken to prevent harm occurring.

A recent review of community based interventions for alcohol problems suggested that treatment effectiveness may be as much about how treatment is delivered as about what is delivered⁷³. Moreover, some treatments may be more effective with some types of service users than others. This review was focused on alcohol *use levels* rather than re-offending, but it is plausible that the same is true for various outcomes. The broader research base also shows that offenders typically have a range of criminogenic needs, of which substance misuse is just one. This suggests that '**multi-modal**' approaches, or packages of interventions tackling a range of criminogenic **needs** (such as education, training and

⁷³ Raistrick, D., Heather, N., and Godfrey C. (2006) *Review of the Effectiveness of Treatment for Alcohol Problems*. London: National Treatment Agency for Substance Misuse.

employment, thinking skills and accommodation), are likely to be most successful⁷⁴.

Brief interventions

Evidence from the *Review of the effectiveness of treatment for alcohol problems* suggests that brief interventions (BIs) 'of various forms and delivered in a variety of settings, are effective in reducing alcohol consumption among hazardous and harmful drinkers to low-risk levels'.

BIs alert people to the risks of drinking too much by offering clear and consistent information, addressing the physical, psychological and social harms of alcohol; health promotion and harm minimisation; and 'triggers' for drinking.

MoCAM advises that 'brief interventions should be followed up to ensure that service users have benefited from them and to identify those for whom further, perhaps more intensive or extended, interventions are required.'

Simple brief interventions or structured brief advice (Tier 1 of MoCAM)

Brief advice is a short intervention (usually around 5 minutes) delivered opportunistically. It can be used to raise awareness of, and assess a person's willingness to engage in further discussion about, healthy lifestyle issues. Brief advice is less in-depth and more informal than an extended brief intervention and usually involves giving information about the importance of behaviour change and simple advice to support that behaviour change.

Evidence

Timely identification of higher risk levels, followed by brief reduction-orientated advice, has been shown to reduce the consumption of one in eight drinkers to lower risk levels⁷⁵.

An important analysis of brief advice concluded that if consistently implemented across the UK, simple alcohol advice would result in 250,000 men and 67,500

74 Gaes, G.G., Flanagan, T.J., Motiuk, L. and Stewart, L. (1999) *Adult Correctional Treatment*. In Tonry, M. and Petersilia, J. (Eds.), *Crime and Justice: A Review of Research*, 26, 361-426. University of Chicago Press: Chicago.

Webster, R., Hedderman, C., Turnbull, P.J. and May, T. (2001) *Building Bridges to Employment for Prisoners*. London: Home Office Research Study 226. London: Home Office.

Chitty, C., and Harper, G. (Eds) (2005) *The impact of corrections on re-offending : a review of 'what works'*. Home Office Research Study 291. Research, Development and Statistics Directorate.

75 Department of Health (2008) *Safe. Sensible. Social. - Consultation on further action Impact Assessment* London: Department of Health.

women reducing their drinking levels from hazardous and harmful to low risk each year when delivered by competent, trained staff⁷⁶.

Evidence suggests that brief, single-session personalised feedback comparing the individual's drinking or drink-related risks to population norms, delivered without any further therapeutic guidance 'appear to be a viable and probably cost-effective option for reducing problem drinking'⁷⁷.

Target group

Brief advice should be targeted primarily at those offenders identified through OASys and alcohol screening as increasing risk drinkers (those who scored 8–15 on the AUDIT questionnaire).

When should it be delivered?

Immediately after screening, usually at the pre-sentence report stage, or routinely as part of a supervision requirement

What it should consist of

Structured advice should be based on FRAMES principles (feedback, responsibility, advice, menu, empathy, self-efficacy) and should include:

- Information about the nature and effects of alcohol and its potential for harm
- Structured and personalised feedback on risk and harm
- Emphasis on the offender's personal responsibility for change
- Attempts to increase the offender's confidence in being able to reduce their alcohol consumption (self-efficacy).
- Goal setting e.g. start dates and daily or weekly targets for drinking
- Written self help material for the offender to take away containing more detailed information on the consequences of excessive drinking and tips for cutting down on consumption
- Consideration of diverse needs e.g. of women offenders
- Signposting to available local services, where indicated
- Arrangements for follow-up monitoring

Staff should have access to recognised, evidence-based packs, such as the *Drink-less pack*⁷⁸ or the *How much is too much?*⁷⁹ pack. These should include a

76 *Safe. Sensible. Social. The next steps in the National Alcohol Strategy* (2007)

77 Riper H., van Straten A., Keuken M. et al. (2009) *Curbing Problem Drinking with Personalised-Feedback Interventions: a Meta-Analysis*. *American Journal of Preventive Medicine*: 2009, 36(3), p 247–255.

78 DH6 Centre for Drug and Alcohol Studies (1993) *The drink-less programme*. Sydney: Sydney University.

79 Institute of Health and Society (2006) *How much is too much?* Newcastle: Newcastle University. Available from www.ncl.ac.uk/ihs/enterprise

short guide on how to use the intervention; questionnaires; visual presentations (comparing the person's drinking levels with the average); self-help leaflets; and possibly a poster for display in probation offices.

Published in February 2008 and updated in August 2008, the *NOMS Alcohol Information Pack for Offenders under Probation Supervision*⁸⁰ provides offender managers with clear guidance and tools to identify offenders with alcohol related needs, deliver brief interventions to individuals with lower level alcohol problems and offer support and onward referral to those who may need more intensive intervention. The pack can be used with low risk drinkers and with higher risk drinkers – both abstainers and those who want to change their behaviour. It also contains advice about accessing specialist services and relevant contact information. The pack is intended for use with a 'motivational interviewing' approach.

Advice in the pack can be used to deliver structured brief advice and guidance on which sections of the pack are likely to be most applicable for this purpose is contained in the accompanying *Offender Managers Guide*. However, OMs are best placed to decide which material is likely to be most helpful to meet the needs of individual offenders under their supervision.

OMs should be aware that the Internet offers ample opportunities to deliver personalised feedback interventions on a broad scale, and problem drinkers are known to be amenable to Internet-based interventions.

Who delivered by

Tier 1 interventions, including alcohol education or information, brief advice and support, should be delivered by Offender Managers or Offender Supervisors competent to the relevant *Drugs & Alcohol National Occupational Standards (DANOS)*⁸¹:-

- AA1 Recognise indications of substance misuse and refer individuals to specialists
- AF1 Carry out screening and referral assessment
- AH10 Carry out brief interventions with alcohol users
- AB2 Support individuals who are substance misusers
- AB5 Assess and act upon immediate risk of danger to substance misusers.

Competence to deliver simple brief interventions does not require extensive training. Probation staff should have the core interpersonal skills necessary but one or two sessions of training may be required covering the aims and rationale

⁸⁰http://npsintranet.probation.gsi.gov.uk/index/service_delivery/interventions/drugs__alcohol/alcohol_information_pack.htm

⁸¹ The new qualification framework is updating the PSO units (work by consortia on DANOS/PSO units).

of brief interventions; the types of drinkers to whom they should be offered; the benefits that are likely to follow; an introduction to the different stages of change in the Prochaska and Di Clemente Stages of Change Model; and possibly some role-play practise in delivering advice with feedback on performance. A one day bespoke training package linked to DANOS competences has been developed by Avon & Somerset Probation Area under the best practice projects initiative and is available on EPIC⁸².

Unpaid work supervisors should be confident in discussing alcohol issues and should be pro-social. As such, they are likely to benefit from training in the delivery of structured brief advice (tier 1 of MoCAM) and should be familiar with and confident in using material from the *NOMS Alcohol Information Pack*.

Former offender Health Trainers (HTs) operate in many English prisons and probation settings across the regions on peer behaviour change management around lifestyle advice. Referral rates to this service are generally very high and retention rates good. Identification and Brief Advice (IBA) isn't built into the official HT remit but HTs could identify an alcohol problem, provide brief advice, signpost to services, where appropriate, and support the offender e.g. attend an initial appointment as part of a health pathway approach. It is thought that people in contact with criminal justice are more likely to engage positively with peers, and these peers can progress their rehabilitation by being part of a recognised health career structure. This approach is presently being tested in the Eastern region in three prisons and in Hampshire Probation Area (ex-offenders now employed by probation funded by the Primary Care Trusts) in order to show that HTs are an effective way to contribute towards dealing with the extensive problems offenders experience with alcohol use⁸³. The one year pilots will be evaluated on the effectiveness of training given to ex-offenders; the application of training; and the reduction in offending achieved. If the findings are positive and the approach validated wider implementation will be considered. The evaluation report is due in March 2010.

Extended brief interventions or brief motivational counselling (Tier 2 of MoCAM)

Extended brief interventions (BIs) are structured therapies which typically take 20-30 minutes to deliver and often involve a small number of repeat sessions. These are most appropriately delivered through an **activity requirement** or as part of a **supervision requirement**.

82 http://npsintranet.probation.gsi.gov.uk/index/service_delivery/interventions/drugs__alcohol/alcohol_best_practice_projects.htm

83 <http://www.alcohollearningcentre.org.uk/Topics/Browse/OffenderHealth/Pilot/>

Target group

The *Review of the effectiveness of treatment for alcohol problems* advises that an extended brief intervention 'should be directed towards harmful drinkers whose levels of alcohol-related harm indicate a need for it and who are willing to accept it. It may also be suitable for hazardous drinkers in the contemplation stage of change, who are ambivalent about their drinking and wish to discuss it....., or for those who do not respond to simple advice and want further assistance in reducing drinking to safer levels.'

The majority of binge drinkers do not meet the criteria for more intensive alcohol treatment, but there is some evidence from USA⁸⁴ that a brief advice intervention can reduce the consumption of alcohol among binge drinkers, although none of these studies were centred on offenders, and two were restricted to student participants^{85 86}.

It has been found, however, that the section of the population that shows the best response to brief interventions – those individuals that drink at increasing risk levels – tend to under-report episodes of binge drinking⁸⁷. This indicates that brief interventions may be more effective in reducing consumption among binge drinkers than is commonly thought.

What it should consist of

The extended BI should:-

- Explore the offender's current drinking behaviour and how alcohol has influenced his offending behaviour.
- Examine the costs and benefits of alcohol use.
- Take account of the diversity of needs.
- Provide facts and information about alcohol which will include alcohol units, safe reduction planning, healthy drinking limits and the physical effects of drinking alcohol at unsafe levels.
- Provide the offender with the opportunity to set goals for controlling their drinking or for abstinence.

84 Fleming, M. F., Mundt, M. P., French, M. T., Manwell, L.B., Stauffacher, E. A. & Barry, K. L. (2002). *Brief physician advice for problem drinkers: Long-term efficacy and benefit-cost analysis*. *Alcoholism, Clinical and Experimental Research*, 26, 36–43.

85 Kypri, K., Saunders, J. B., Williams, S. M., McGee, R. O., Langley, J. D., Cashell-Smith, M. L., et al. (2004). *Webbased screening and brief intervention for hazardous drinking: A double-blind randomized controlled trial*. *Addiction*, 99, 1410–1417.

86 Borsari, B. & Carey, K. B. (2000). *Effects of a brief motivational intervention with college student drinkers*. *Journal of Consulting and Clinical Psychology*, 68, 728–733.

87 Shakeshaft, A. P., Bowman, J. A. & Sanson-Fisher, R. W. (1998). *Comparison of three methods to assess binge consumption: One week retrospective drinking diary, AUDIT and quantity/frequency*. *Substance Use*, 19, 191–203.

- Look at the offender's personal history and ask him to complete a drink diary (section 16.7 of the Alcohol Information Pack refers).
- Explore high risk situations, feelings, thinking, places, people and behaviours.
- Look at how to deal with negative moods, conflict and social pressures, to stop any of these leading to further offending.
- Help the offender develop coping strategies to deal with what can happen as he withdraws from alcohol e.g. cravings, sleep problems, boredom and social isolation.
- Look at how to deal with anxiety around change and explore ways of relaxing other than drinking alcohol.
- Cover aggression, negative belief systems/assertiveness skills and relationship problems where needed.
- Explore how to avoid lapse and how to deal with a lapse should it happen in order to help the offender prevent a relapse back to problematic drinking.

A programme of sessions should begin with the offender's current situation and end by signposting to available local services, where indicated. It should be delivered in an empathic, non-confrontational counselling (motivational interviewing) style and begin with an introduction to each session and end with a recap.

The *NOMS Alcohol Information Pack* was primarily designed for use with those higher risk (and some increasing risk) drinkers identified as needing extended brief interventions. Offenders released from custody subject to a licence condition to address their alcohol problem may also benefit from working through chapters, as a follow-up to interventions received in prison. Guidance on which sections of the pack are likely to be most applicable is contained in the accompanying *Offender Managers Guide*.

Two projects funded by NOMS under the Best Practice Projects Initiative developed bespoke extended brief intervention packages which are available on EPIC⁸⁸:-

- Gloucestershire Probation Area developed a 3 session *Brief, Motivational Enhancement Intervention for Alcohol Misusing Offenders* based upon that evaluated in the United Kingdom Alcohol Treatment Trial (UKATT) for delivery through a supervision requirement. An independent evaluation found that the brief intervention seems to be identified by offenders as being connected with decreased drinking and offending (For completers - 44 out of 92 or 48% - the mean OASys and AUDIT scores reduced pre

⁸⁸http://npsintranet.probation.gsi.gov.uk/index/service_delivery/interventions/drugs__alcohol/alcohol_best_practice_projects.htm

- and post-intervention indicating a reduction in self-reported risk of re-offending and alcohol consumption).
- Northamptonshire Probation Area piloted a six session package which is now being delivered through an Alcohol Specified Activity Requirement (ASAR). This model has subsequently formed the basis of ASARs developed in other probation areas/trusts.

In 2008-9 Avon & Somerset Probation Area received funding to pilot and evaluate an Alcohol Counselling project using an intervention based on tiers one and two of MoCAM over the telephone. This could be especially useful in rural areas/trusts where face to face counselling may neither be practical nor cost effective. An off-the-shelf independently evaluated programme of six 45 minute sessions of alcohol-specific interventions for delivery over the telephone will appear on EPIC later in 2009-10 for use by other areas/trusts, along with a report which evaluates the delivery process; and the effectiveness and cost effectiveness of two models for telephone counselling (with initial assessment by phone or in person) compared with face to face counselling in reducing alcohol related harm and re-offending.

The *Review of the Effectiveness of Treatment for Alcohol Problems* found that there is 'mixed evidence on whether extended brief interventions in healthcare settings add anything to the effects of simple brief intervention'. The *Screening and Intervention Programme for Sensible Drinking (SIPS)* is examining the relative effectiveness of three forms of brief intervention of different intensity and duration (a client information leaflet control condition; 5 minutes of simple structured advice; and 20 minutes brief lifestyle counselling by an alcohol health worker) in a probation setting. Outcomes including alcohol consumption, alcohol related problems and offending behaviour will be assessed at 6 and 12 months after intervention. A report from the criminal justice pilot will be published in February, with results from the main study published on a staged basis during 2010 and 2011.

Extended BIs can either be delivered by Offender Managers/Supervisors, contracted alcohol liaison workers (ALWs) operating on probation premises or external providers in accordance with the MoCAM framework. Where BIs are being delivered by an external provider, explicit criteria for referral, thresholds and trigger points should be agreed and specified within service level agreements (SLAs) and contracts.

It is consistent with the Offender Management Model (OMM) for OMs to deliver BIs as part of their role and responsibilities, not simply to monitor compliance and initiate enforcement action, where required. Treatment agencies generally see their role as delivering Tier 3 and 4 interventions under MoCAM. It is reasonable for them to expect probation to deliver Tier 1 and, possibly, some Tier 2 provision particularly in light of the limited capacity and long waiting lists in many areas.

Providers are then better able to focus scarce resources on those with the greatest need who require specialist help.

Practitioners engaged in the delivery of extended BIs should have the following DANOS competences⁸⁹:-

AB2 Support individuals who are substance users

AB5 Assess and act upon immediate risk of danger to substance misusers

AF2 Carry out assessment to identify and prioritise needs

AG1 Plan and agree service responses which meet individuals' identified needs

AH10 Carry out brief interventions with alcohol users.

A three day bespoke training package (for those delivering Tier 2 interventions) linked to DANOS competences has been developed by Avon & Somerset Probation Area under the best practice projects initiative and is available on EPIC⁹⁰.

Where external providers are delivering the brief intervention, the principles set out in the *Information Sharing Protocols* and *ATR process* sub-sections of this guidance apply, although some of the detail will vary. Following a triage assessment, the provider will contact the offender manager to make appropriate arrangements for brief intervention work (i.e. time, dates, location of appointments). The provider will report back on attendance, involvement, outcomes and any changes in perceived risk. As long as the brief intervention work is detailed within the sentence plan, all appointments are enforceable.

Alcohol treatment requirements (ATRs) (Tiers 3 & 4)

Target group

The alcohol treatment requirement (ATR) is targeted at offenders assessed as alcohol dependent, who will often have complex co-existing needs e.g. mental health, social and housing problems, and require intensive, specialist, care-planned treatment in Tiers 3-4 of *Models of care for alcohol misusers* (MoCAM) e.g. day programmes, detoxification, residential rehabilitation and integrated care involving a range of agencies.

The *Review of the effectiveness of treatment for alcohol problems* found that:-

- There is no evidence that brief interventions (BIs) are effective among people with more severe problems e.g. dependence.
- People with more severe alcohol problems and levels of dependence should be encouraged to attend specialist treatment services.

⁸⁹ The new qualification framework is updating the PSO units (work by consortia on DANOS/PSO units).

⁹⁰http://npsintranet.probation.gsi.gov.uk/index/service_delivery/interventions/drugs__alcohol/alcohol_best_practice_projects.htm

- Cognitive behavioural approaches to specialist treatment offer the best chances of success.
- Effectiveness is as much about how treatment is delivered e.g. by a trained and competent practitioner in accordance with best practice, within a therapeutic alliance, as about what is delivered.

Who delivered by

Whilst ATRs can be co-ordinated and managed by internal probation or external provider specialist staff, the substantial majority of the treatment interventions should be delivered by treatment services commissioned by Primary Care Trusts individually, or as part of a joint commissioning group, including Drug and Alcohol Action Teams in England or by Area Planning Boards or Substance Misuse Action Teams (SMATs) in Wales. These services are likely to be a combination of NHS trust and specialist third sector providers, although newer-generation organisations such as social enterprises are also now providing specialist alcohol services.

There should be a clearly defined pathway from probation into treatment services for alcohol misuse but Western nations' public health policy makers generally accept that the majority of dependent drinkers neither want nor will accept alcohol treatment. A treatment coverage of one in five (20%) of all dependent drinkers is regarded as optimal⁹¹.

Women should be offered where possible delivery of the intervention in a women-only environment.

What should be delivered

Treatment delivered under an ATR should be primarily structured treatment as outlined under MoCAM:-

- Tier 3: Community based care-planned treatment. This may include psychosocial therapies and support, interventions for assisted alcohol withdrawal 'detoxification' and cognitive based treatment to address alcohol misuse i.e. suitable for moderately/severely dependent drinkers and delivered by Specialist Alcohol Workers.
- Tier 4: Residential/inpatient care-planned treatment. This is likely to be suitable for those who have severe dependence who cannot be managed or may be at risk if they were to be managed in the community.

⁹¹ Rush, B. (1990) *A systems approach to estimating the required capacity of alcohol treatment services*. British Journal of Addiction, 85: 49–59.

Independent research suggests that many areas/trusts have developed ATR provision consisting mainly or exclusively based around the delivery of Tier 2 extended brief interventions⁹². These should not be delivered routinely as a core component of an ATR but be used where there is likely to be a delay in the offender accessing structured treatment (see below).

NOMS wants to introduce a greater consistency of ATR provision with ATRs reserved for the appropriate target group i.e. those dependent drinkers who actually need specialist treatment, as opposed to those increasing risk and higher risk drinkers who don't (particularly important as treatment is a scarce resource). The difficulty will be the speed of change, as areas/trusts have existing SLAs/contracts in place. To avoid undermining arrangements that areas/trusts have already made, there will be a transitional period of 12 months, where appropriate, for areas/trusts to move towards the more structured ATR package specified in this guidance in the longer term.

Preparatory work

Preparatory work for the core ATR intervention may include motivational work, 'drink diaries', referrals to prescribing agencies, detoxification etc., where applicable.

Specialist services are perceived as mainly working with those who want stability or change but many offenders are chaotic and not ready or willing to change their drinking or drug use. The lack of motivation displayed by many offenders (49% showed no motivation according to OASys data in *A Needs Assessment of Alcohol Treatment Services for Offenders in the South West Criminal Justice System* undertaken for the Government Office for the South West⁹³) suggests the need for motivational interventions to bring them to the point of readiness to change before they can engage successfully with alcohol treatment.

A motivational interview should be integrated into initial contact to improve retention and outcomes. At the same time OMs should make an assessment of whether the offender, despite being motivated to attend may be blocked by lack of stability, resources or social pressures/obligations. Offenders may need intensive, practical assistance to clear away obstacles.

The preparation phase can be a key element of the ATR process during which the offender will begin to address their alcohol use (or continue to address it). It will be motivating and enable the offender, probation and treatment provider to form a trusting relationship empowering personal change.

92 McSweeney, T., Webster, R., Turnbull, P. J., and Duffy, M. (2009) *Evidence based practice? The National Probation Service's work with alcohol misusing offenders*. Ministry of Justice Research Series 13/09. London: Ministry of Justice.

93 Walsh, A. (2007) *A Needs Assessment of Alcohol Treatment Services for Offenders in the South West Criminal Justice System*. Government Office for the South West.

It could usefully include one or more of:

- An initial three way appointment with the offender and ATR worker during which the process should be explained to the offender i.e. preparation work, the core programme and the partnership between probation and treatment provider, the offender will be introduced to probation's expectations and have the opportunity to identify any anxieties he or she has about the process and/or programme.
- Drink diaries – These are a tool to enable an offender to help keep track of how much they are drinking and spending on alcohol. This, together with monitoring any situations the offender encounters that triggers urges and temptations to drink, helps the offender identify and develop more helpful coping strategies and alternatives. The information gained will be used within the core programme and the reduction programme.
- An individual reduction programme based upon material in the *NOMS Alcohol Information Pack* for offenders under probation supervision to follow who have little knowledge or incentive to reduce their alcohol use safely.
- Short 1:1 meetings held fortnightly to review the drink diary and the reduction programme.
- In addition to the reviews, monthly programme entry group meetings until the start of the core programme (or 1:1 if more appropriate). These groups should cover group rules and contract, relapse prevention, group dynamics, information on what to expect in the core programme.

Account should be taken of the specific needs of women offenders including consideration of women-only services.

If, during this preparation period, concerns are raised by the treatment provider, the offender or OM about the suitability of the offender to attend the core ATR programme, the treatment provider will discuss this directly with the OM and agree a course of action.

Core interventions

This should include one or more of the following:-

- comprehensive assessment (ATRs like DRRs will require a pre-sentence assessment for suitability by a treatment provider – for more information see the *Screening & Assessment* section of this guidance)
- care planning with key worker
- reduction programme

- structured day and care planned programme
- ongoing monitoring
- liaison with medical and psychiatric services
- fast tracking to clinical prescribing services and detoxification (residential or community based)
- residential rehabilitation

Community based care planned case management

This should focus on alcohol use, health and psychological well-being, offending behaviour, life skills, accommodation issues, and social functioning. This will be guided by a care plan, which should be incorporated into the sentence plan, and is under the direction of a treatment provider and the OM so that post sentence-completion continuity can be provided.

Structured day care

A formal care planned programme of day care will focus on issues such as relapse prevention, personal development, life skills, problem solving and other practical and emotional support e.g. accommodation etc.

Psychosocial interventions

Most treatment for alcohol dependence and alcohol-related problems includes structured, evidence-based, therapies delivered by specialist workers (i.e. tiers 3 and 4 of MoCAM) to support the individual's psychological and social development.

Psychosocial interventions are designed to help alcohol misusers change their behaviour in some way. These also often help alcohol misusers develop new skills, allowing them to handle high-risk drinking situations without relapsing in the future.

The *Review of the effectiveness of treatment for alcohol problems* identified a wide range of treatments shown to be effective in research studies including:-

- cognitive-behavioural therapy
- motivational enhancement therapy
- 12-step facilitation therapy
- coping and social skills training
- community reinforcement approach
- social behaviour and network therapy
- behavioural self-control training
- cognitive-behavioural marital therapy

Both Project Match⁹⁴ and the United Kingdom Alcohol Treatment Trial (UKATT) concluded that the outcomes from distinct psychosocial therapies differed little overall, and that there were few indications that certain types of patient benefited more from one therapy than another, but both treatment groups reported substantial reductions in drinking and associated problems and improved mental health.

Evidence-based effective treatment can be delivered well within the six months duration of an ATR. The UKATT Trial was dealing with dependent drinkers and the interventions - social behaviour and network therapy (SBNT) and motivational enhancement therapy (MET) - were brief (3 – 8 sessions). Both UKATT treatments produced statistically significant improvements in alcohol consumption, alcohol dependence, alcohol-related problems and aspects of general functioning. It is extremely unlikely that such changes would have occurred as a result of natural recovery processes. UKATT found that 'social behaviour and network therapy (SBNT) as a novel and socially based treatment was no less effective over all service users in the trial than motivational enhancement therapy, an established, motivationally based treatment'⁹⁵.

Gloucestershire has piloted the more extensive community reinforcement approach (CRA) as part of an ATR under NOMS Best Practice Projects Initiative. This could be delivered over perhaps one to two months of the ATR period with the subsequent sessions dealing with relapse prevention. Offenders for whom that treatment did not work could legitimately be referred to community services for more complex treatment.

The *Review of the effectiveness of treatment for alcohol problems* found that the CRA:

- is an effective treatment modality, particularly relevant to service users with severe alcohol dependence; and
- has proved especially impressive with socially unstable and isolated service users with a poor prognosis for traditional forms of treatment, including those who have failed in treatment several times in the past.

Substitute prescribing and detoxification (residential or community based)

Bearing in mind the ATR targeting criteria, it is likely that many offenders will need medical support to help them manage any withdrawal symptoms upon cessation of their drinking. In most cases, this will be home detoxification, overseen by a community psychiatric nurse, and lasting for around a week to a

94 <http://www.commed.uchc.edu/match/>

95 Raistrick, D., Heather, N., and Godfrey C. (2006) *Review of the Effectiveness of Treatment for Alcohol Problems*. London: National Treatment Agency for Substance Misuse.

fortnight. Home detoxifications are generally regarded as suitable when the patient can ensure there is someone else at home with them. Often it involves the prescription of medication and a full schedule of delivery, usually administered by the clinician on home visits.

The normal post-sentence sequence of ATR activity would look something like:

- Brief intervention to sustain the service user prior to detox. commencement.
- Detox. preparation delivered by treatment provider staff
- Detox. – primarily via community detox. – 14 days [residential detox. will be used where the treatment provider identifies the need and funding is agreed]
- Post detox. motivational supportive counselling for 12 weeks
- Ongoing supervisory intervention including a post-detox. relapse prevention tool
- End of requirement signposting/referral to community provision as required

Devon & Cornwall Probation Area has been funded by NOMS to implement a developmental ATR model in Plymouth and Cornwall, involving the delivery of detox. preparation and post-detox. motivational supportive counselling by OMs and offender supervisors. This model offers the opportunity to enhance the training and effectiveness of existing staff whilst health partners expand MoCAM Tier 3 capacity concurrently, at little or no additional cost to the probation area, to ensure sufficient prioritisation for ATR referrals.

Residential Rehabilitation

The main criterion determining suitability should be severity of dependence and associated health and social problems. Generally, ATRs with residential treatment as the main treatment modality/intervention would fall within the high seriousness of offence sentencing band given the restriction of liberty residential rehabilitation involves.

It may be appropriate to propose a minimum length ATR in cases when offenders have a low seriousness of offence but a high treatment need and they themselves wish (and could possibly already be in the process of applying) to access residential treatment. Areas/trusts may wish to draw the court's attention to the fact that the 'punishment' was more restrictive and not commensurate with the original offence if the offender subsequently breaches the ATR e.g. unplanned exit from the rehab facility.

Where an offender moves to another area for residential treatment, it is the area where the treatment takes place that holds the order. These cases cannot be supervised temporarily and the order should be formally transferred to the area where the offender is residing (see PC 25/2007 for more guidance on case transfers). A new Probation Instruction (PI) is being written which will change some of these aspects of transfer.

Post Programme Work

Work can be undertaken with offenders following the core intervention which both enables the ATR six months minimum to be met and evidence suggests should improve outcomes.

OMs may wish to consider holding regular (fortnightly reviews of 30-60 minutes) reducing in frequency, if appropriate, and agreed by all parties until the end of the ATR. These should be focussed on:

- Continuation of learning from programme
- Development of aftercare plan and goals

Relapse prevention will often be an important component of the work undertaken on completion of the agreed treatment programme. Material from the *NOMS Alcohol Information Pack* can be used for this purpose. This should cover:-

- 1 Using the drinks and urges diaries, identification of triggers and patterns of behaviour that leads to alcohol misuse
- 2 Binge drinking and sustained use
- 3 Identifying alternative coping mechanisms and avoidance of triggers where possible
- 4 Understanding 'how much is too much' for the individual
- 5 Overdose prevention (in the case of poly substance users)
- 6 Know what to do in an overdose emergency situation (self and others)
- 7 The risks of withdrawal/safe reduction

Additional sessions could also involve less intensive treatment, motivational work or re-referral for treatment in the event of a relapse.

National Standards

The only National Standards specific to ATRs are:-

2d.10.1 The offender manager makes arrangements for the offender to commence the specified alcohol treatment within the timescales indicated to the court at the time of sentence.

2d.10.2 The offender is instructed to attend for treatment in accordance with the treatment schedule specified in the PSR.

Commencement

The legislation is silent regarding when an ATR should commence, although as ATRs can be made by courts not only if arrangements for treatment have been made but also if such arrangements **can be made** there would appear to be some leeway on this issue inherent in the Criminal Justice Act 2003 and in 2d. 10.1 of National Standards. Given that the target group is dependent drinkers for whom the need will frequently be urgent on health grounds, particularly those requiring detoxification, treatment should ideally begin as soon as possible after sentence but, with limited availability and lengthy waiting lists in many areas, realistically this won't always be achievable.

It is incumbent upon offender managers to ensure that the offender is supported where immediate access to specialist treatment is not available. Interventions providing information and brief advice, drink diaries, etc should be delivered in the interim to help people reduce their drinking. Individuals don't change if they are just waiting for a treatment appointment and there are things offender managers can do to support and bolster offenders' motivation even if specialist treatment can't start immediately.

Evidence supports routinely offering assessment and a relatively brief intervention to new alcohol treatment or counselling patients with low to moderate dependence and problems. This ensures that even those who later drop out have received a potentially effective intervention⁹⁶.

Materials from the *NOMS Alcohol Information Pack* can be used with offenders on ATRs who are waiting to access specialist treatment and to supplement such treatment.

Work can also be done with the offender relating to other requirements until the ATR component can begin within the timings of the community order. This will need to be reflected in the sentence plan.

Women offenders should be offered the option of a female offender manager and where available should be referred to a One Stop Shop.

Ongoing contact

There are no minimum contact levels for an ATR, as the required hours are primarily met by the treatment provider (depending on local treatment delivery

⁹⁶ Shakeshaft, A. P. et al. (2002) *Community-based alcohol counselling: a randomized clinical trial*. *Addiction* 2002, 97, p. 1449-1463

arrangements) and based on offenders' treatment need.

Under National Standards, levels of contact on a community order are dependant upon the community sentencing band (high, medium, low) and also the particular offender management tier the offender falls into.

National Standards are minimum reporting requirements and offender managers should assess what level of contact they personally have with offenders (there may be locally agreed guidance on this). This contact needs to be sufficient to manage risk, enforce the order and monitor the offender's progress. OMs also have a role in working to increase and maintain offender motivation and in increasing retention. Levels of OM contact with offenders should reflect these aims and be detailed in case management recording systems.

Additional factors, such as offenders living in rural areas who have to travel many hours to get to a treatment delivery centre, should be considered on an individual basis and a decision made locally regarding how many travelling hours can be counted towards contact time.

Arranging appointments to meet the six months minimum

The majority of offenders assessed as suitable for an ATR will require less than six months treatment. Wherever meeting the six months minimum for an ATR presents a problem, areas/trusts should consider arranging a frequency of appointments with the treatment provider which allows the total treatment episode to be spread over the minimum ATR duration. For example, a 12 weeks treatment programme could be delivered on a fortnightly basis for six months. In this scenario, to meet the minimum National Standards contact requirements, OMs would need to schedule additional appointments for the first 16 weeks with offenders in the medium/high seriousness band of the community sentence to take place in weeks in which there were no treatment appointments. Also, preparatory or post programme work can count towards meeting the six months minimum.

Annex B to PC 57/2005 advised that 'under an ATR, anything specified in the supervision plan can be counted as contact providing there is an audit trail.' This was not strictly correct as the ATR is a treatment requirement and anything which does not constitute treatment for alcohol problems does not count towards the ATR (although it can count towards the order as a whole). This is in contrast to the DRR which is a rehabilitation requirement and where non-treatment interventions can contribute towards DRR contact hours. Work on related activities such as housing, finance, etc can be counted as ATR contact, however, when incorporated in care-planned treatment.

Information sharing protocols

Areas/trusts should ensure that local protocols are in place to cover the sharing of information between providers and other relevant agencies.

The overriding principle is that all relevant parties should be aware of:-

- Any risk issues that an offender poses to the public, staff or themselves and how these risks are to be managed in the community
- The offender's criminogenic needs and who is addressing each of these
- The offender's treatment needs and how these are to be addressed

As a minimum, the following information should be shared with the contracted treatment provider:-

- the PSR
- OASys and completed AUDIT or other validated screening tool
- previous convictions
- a copy of the court order
- the risk assessment and actions to manage any risks
- information about self harm
- risk to the offender of violence from partner
- any other relevant information relating to the management of the licence or order

It may not always be relevant to send the whole OASys assessment but copies of the relevant sections should be shared with treatment providers. This ensures that all parties are aware of the offender's needs and is the basis for planning who will address which needs. Depending on the level of detail in the OASys assessment it may be more helpful to provide external agencies with a summary of information drawn from OASys.

The local protocols should specify what information probation areas/trusts expect to receive from treatment providers which should also be in service specifications. As a minimum these should include information about⁹⁷:

- Attendance
- Participation and motivation
- Progress against the sentence plan and care plan objectives
- Any information which is relevant to assessing and managing risk of harm

⁹⁷ See *Whose responsibility* section on page 21 for information about disclosure and NHS Code of Conduct.

- Any information which is relevant to assessing and managing likelihood of re-offending
- Results of any tests (undertaken on a voluntary basis)
- Information for any review reports that may be required by the courts (where the ATR is part of an suspended sentence order)
- Any additional support needs that become apparent during the ATR

Protocols should also specify that the provider will pass on any information that is shared with the treatment provider that is important but has not previously been disclosed to the OM.

The OM and contracted treatment provider staff should share the sentence plan and care plan. Both plans should reflect each others treatment intervention(s) and goals. It should be apparent who has responsibility for delivering other parts of the sentence plan e.g. accommodation, basic skills, education, training and employment (ETE), etc.) so that the offender is clear and to avoid any duplication of effort and/or resources.

The ATR process

Court staff should ring probation and the treatment provider and advise that the order has been made and confirm first appointments.

The sentenced outcome should be recorded in the case management system e.g. CRAMs and OASys on the day notified.

The OM should liaise with provider treatment staff about the implementation of the treatment plan and provide treatment staff with the following documents within 2/5 working days of the sentence:-

- Copy of court order
- Pre-sentence report (PSR)
- OASys risk assessment
- The outline sentence plan in the PSR

The OM should contact the ATR case manager to confirm details of the treatment plan prior to completion of the initial sentence plan.

The OM should complete the sentence plan within required timescales under National Standards⁹⁸ and give a copy to the treatment provider within one day of completion. The OM should also communicate issues connected to risk management with the treatment provider.

⁹⁸ National Standards require that a written sentence plan is prepared within 5 days of sentence for Tier 4 cases or PPOs and 15 days for offenders in other Tiers.

The first meeting with the offender should be a three way meeting with both the treatment provider and offender manager present to gain agreement from all parties to the aims and structure of the ATR. The offender should be made aware of the fact that the ATR objectives will be part of the sentence plan and reminded of the requirements e.g. reporting, conditions of attendance, so they fully understand what will be expected of them and the possible sanctions if they fail to comply. At the three way meeting, the treatment provider assumes care management of the requirement for the duration of the ATR, whilst the OM retains case responsibility (for compliance and enforcement).

There should be further three way meetings at the half-way point of the ATR and at the end of treatment to confirm progress and identify and agree any ongoing work and support needs e.g. further referral or relapse prevention work. These will either be provided by probation or a partner as part of the ATR or recommendations will be made to the individual who can choose to access this support outside of the requirement.

Research found that 'the use of three-way meetings between the offender manager, alcohol treatment worker and offender at the start, middle and end of the ATR was reportedly working wellas a means of establishing the aims and objectives of the requirement and monitoring progress towards achieving goals.'⁹⁹

Offenders should be contacted shortly before appointments to remind them of the time and motivate attendance. Such initiatives commonly improve retention and outcomes, sometimes even when attendance is unaffected. They also deepen the individual's commitment by demonstrating concern, responsiveness and preparedness not to let them slip through the net.

Following each appointment, the ATR case manager should fax a written update, regarding attendance, next appointment, and progress towards objectives, to the OM or in his/her absence the duty officer on the day of the appointment/within 24 hours using the proforma/contact sheet provided.

If the ATR case manager rearranges any appointments with the offender, these should be notified to the OM in advance or on the day of the original appointment at the latest.

Treatment providers/specialist alcohol workers and OMs should arrange review meetings with the offender in all medium to high seriousness cases every month/six weeks until the Order is completed. These joint meetings are especially important with complex offenders or with challenging or non-compliant offenders.

⁹⁹ McSweeney, T., Webster, R., Turnbull, P. J., and Duffy, M. (2009) *Evidence based practice? The National Probation Service's work with alcohol misusing offenders*. Ministry of Justice Research Series 13/09. London: Ministry of Justice.

If, at any time, during the ATR it is apparent that the offender has additional support needs, the offender manager should be notified and a plan of action agreed. For example, if an offender in groupwork needs additional 1:1 support, this should either be addressed as a short meeting after or before the group, or if more intense support is needed, the offender should be referred to alternative Tier 3 support outside of the ATR.

Treatment delivered within an ATR should not be withdrawn from an offender subject to an ATR without prior discussion with the OM, except when the offender poses a risk to others or is abusive or threatening to staff or other persons receiving treatment.

OMs will advise treatment staff and other agencies involved in the delivery of interventions of decisions to breach the offender for any requirement of their order as well as the outcome of any breach proceedings. The breach report should contain a description of the offender's general co-operation with all requirements of the order and therefore the importance of consultation with all agencies involved in the delivery of treatment is important in order to reach a balanced assessment and sentencing outcome.

If the offender fails to co-operate with treatment (e.g. leaving a residential detoxification programme, failing to keep appointments with the treatment provider) the staff reporting the breach will provide Section 9 witness statements if required. This should be specified in SLAs/contracts.

The ATR case manager should inform the OM at the completion of the core treatment programme, and prepare a written report detailing the work done, engagement, strengths of the offender over the period of the requirement, along with details of onward referrals where required, which should be filed in the offender file. At this point the ATR case manager should arrange a three way between the OM, the ATR case manager, and the offender to review progress. As far as possible, this should take place prior to planned reviews of the sentence and care plans, and these should be updated accordingly. If the three way meeting has not been arranged at the point of sentence plan review, the OM should contact the ATR case manager for an update. At the three way meeting, the ATR case manager will identify any work that remains to be done for the remainder of the ATR period.

At the end of the ATR, a second AUDIT should be carried out to measure changes in patterns of alcohol consumption from the PSR stage or the start of an order to the end of statutory supervision. 5 of the 10 questions in AUDIT cover the last year and ask about the problems or effects of alcohol use rather than what has been consumed. Therefore, a shorter version known as AUDIT-C¹⁰⁰,

¹⁰⁰ AUDIT-C is being used to measure reductions in alcohol consumption at 6 and 12 months after intervention as part of the Screening and Intervention Programme for Sensible drinking (SIPS)

which consists simply of the first three AUDIT questions on **current** alcohol consumption, may be preferred simply as a means to measure change in the amount and frequency of use. The score achieved at the end of the order would then be measured against the score derived from those same 3 questions when the full AUDIT was undertaken at the PSR stage (AUDIT-C is insufficient for use as a screening tool pre-sentence).

Accredited interventions

Addressing Substance Related Offending (ASRO) & the Offender Substance Abuse Programme (OSAP)

ASRO and OSAP are modular group work programmes that aim to teach offenders the skills required to reduce or stop substance misuse. The programmes consist of 20 sessions of 2.5 hours each and 26 sessions of 2.5 hours each respectively delivered between one and three times a week.

OSAP and ASRO include sessions on:

- motivational engagement and goal setting
- managing the risks linked to alcohol misuse
- coping skills
- social skills training
- relapse prevention and management

Additionally, OSAP has pre-programme psychometrics, three pre-programme sessions, and four post programme maintenance sessions with an offender manager, which are conducted on a one-to-one basis. Where available, offenders who have completed OSAP/ASRO may also go on to undertake the Relapse Prevention Programme intervention.

ASRO, OSAP or any other programme should not count as part of an ATR but should be delivered as a programme requirement of a CO or SSO either separate to or alongside an ATR. These should be delivered in accordance with National Standards and NOMS programme performance standards.

ASRO/OSAP are fine for binge drinkers but offenders need to be stable and sober enough to be able to attend and benefit from attendance so severe dependence is likely not to be suitable. Provision should be made for dependent drinkers whose alcohol problems are too severe to undertake a group to undertake pre-programme work prior to starting a group to ensure that they are sufficiently stable and motivated.

Mixed groups with differing experiences can have a positive impact. Peer support can prove a valuable element of alcohol treatment programmes. What is crucial in determining the effectiveness of the programme is the quality of delivery and the skills of the tutors. A well delivered programme with skilled tutors should

mean that the peer dynamic is well managed and more vulnerable participants are enabled to have a positive experience. Both programmes are subject to quality assurance processes, although these are based on self-reporting.

Lower Intensity Alcohol Programme (LIAP)

LIAP is a programme of 14 sessions delivered to groups of between 8 and 12 offenders assessed as having problematic (not dependent) patterns of alcohol use and a low to medium risk of reconviction.

The programme's design aims for sessions to be participatory and interactive with the facilitator taking on the role of a provider of information. The sessions aim to provide participants with the opportunity to choose what they want to take on board in relation to controlling their drinking and ceasing their offending behaviour.

The group sessions incorporate a variety of methods to assist the active participation, engagement and learning process of group members:

- role play exercises
- brain storming
- walking and talking through models of behaviour/thinking (e.g. the stages of change model, Triggers do get (TDG), Green Amber Red (GAR), and ABC models)
- overheads
- worksheets (which are completed individually and as a group)
- decisional balances (designed to enhance motivation)

In addition to these, LIAP participants are required to complete a drink diary. During the course of the programme, the diaries increase in intensity in terms of the amount of information a participant needs to record. The use of drink diaries is intended to provide participants with insight into their drinking behaviour and assist in the enhancement of motivation and self-efficacy.

LIAP is now available for all probation areas/trusts to use as part of their suite of programme provision.

Drink Impaired Drivers (DID)

DID consists of 14 group based sessions of 2.5 hours delivered on a weekly basis.

The programme combines cognitive behavioural and educational approaches and is based on the idea that offenders' lack of knowledge about alcohol and safe driving, their anti-social and pro-criminal attitudes towards drink driving, poor problem solving and thinking deficits result in drink driving offences.

DID should only run alongside an ATR where this can be justified by the seriousness of the offence and offender need.

Control of Violence for Angry Impulsive Drinkers (COVAID)

COVAID is a structured, cognitive-behavioural intervention for use with non-dependent drinkers who are aggressive or violent when drunk. It consists of 10 core 2 hour sessions plus specified selection, pre-session, and booster-sessions (the latter can be delivered in the community following secure site core delivery).

COVAID is a private programme that was taken independently to the Correctional Services Accreditation Panel (CSAP) and is fully accredited. Areas/trusts can purchase the programme if they see fit. Any completions will count towards targets.

Domestic violence

The Integrated Domestic Abuse Programme (IDAP) or Community Domestic Violence Programme (CDVP) is the key intervention for domestic violence. However, where alcohol is linked to the violence, IDAP or CDVP should be supported with brief interventions, delivered through an activity requirement or as part of a supervision requirement, or an ATR to address the alcohol problem and/or LIAP, ASRO or OSAP to tackle the alcohol related offending behaviour.

The programme which targets the greatest area of risk should be sequenced first. This principle is for all substance misuse programmes whatever the state of dependence.

The ideal sequencing is that both the DV programme and LIAP are run together particularly if there is current problematic drinking inhibiting progress or a DV programme followed by LIAP. If LIAP (or indeed ASRO or OSAP) was delivered first, alcohol could be used as an excuse for DV, increase the risk of further DV and/or make it less likely that the offender will complete IDAP/CDVP. However, it will be for the OM to determine in individual cases when the offender has a sufficient degree of insight to begin LIAP.

It would be a strong indicator of dependent drinking if an offender needs to have their drinking addressed before being able to participate in a programme. As such, it will often be appropriate for an ATR, which consists of specialist treatment, to precede IDAP/CDVP, with ASRO/OSAP either running alongside IDAP/CDVP or post completion.

If the DV is assessed as lower risk it is still important that DV is monitored and addressed by the OM as part of the sentence plan within a supervision requirement and that the offender's use of alcohol is still seen as a 'trigger' or 'contributor' to DV and not a cause. LIAP should never be used as a stand alone requirement for DV offenders.

OMs should be careful not to collude with an offender who tries to deny personal responsibility and blames alcohol. The alcohol intervention is in recognition that it is a contributory factor and not the main reason why the violence occurred. All those who deliver LIAP, ASRO or OSAP, including partners, should be aware of the relationship between alcohol and DV and should receive basic DV awareness to include this message.

There is overlap with women safety workers in domestic violence programmes.

Post completion

On completion of any ATR or alcohol related licence condition OMs should liaise with the treatment provider(s) to ensure, wherever possible, that any ongoing treatment needs are met. As a minimum, OMs should offer advice to offenders on the further treatment and support available to them once their sentence has ended. For example, going to a local alcohol service or local advice centre or attending a self-help group such as Alcoholics Anonymous.

Self-help groups

Alcoholics Anonymous

Alcoholics Anonymous (AA) and similar mutual aid and self-help groups have an important role to play in helping NOMS to achieve our strategic aims and objectives, particularly, as MoCAM makes clear, in providing ongoing care and support to individuals who have completed treatment programmes and/or post sentence, to help prevent relapse and stabilise recovery, which can be vital to achieving successful outcomes in the long term.

There are significant gaps in current provision such as the availability of services during evenings and weekends when offenders are most vulnerable and at risk, and how best to continue motivational work with individuals completing programmes. AA is available nationally 24 hours a day, 7 days a week and offers a highly integrated model of ongoing support and care using the 12 step approach. Many UK addiction treatment centres follow the 12 step approach and introduce their clients to AA.

The *Review of the Effectiveness of Treatment for Alcohol Problems* found that AA:

- appears to be effective for those alcohol misusers who are suited to it and attend meetings regularly; and
- is a highly cost-effective means of reducing alcohol related harm.

It is clear that, in general, links between probation and AA are underdeveloped compared with those which exist between AA and prisons. Therefore, under the NOMS Alcohol Best Practice Projects Initiative, Thames Valley Probation Area

has developed a nationally approved model of liaison with AA which has created referral routes into self help to support and consolidate work undertaken via other interventions. A manual and training material for OMs is available on EPIC to facilitate wider implementation.

The key elements of the liaison model are:

- The establishment and maintenance of active on-going contact between the AA intergroup probation liaison officer and the designated offender manager (OM).
- OMs are provided with a list of AA members willing to sponsor offenders. AA volunteers will meet offenders on probation premises and sometimes take them to an AA meeting that same day. Volunteers will also call people or visit them in their own homes.
- Local guidelines for AA sponsors and OMs.
- The availability of a chit system where proof of attendance is required. Passive and inflexible on its own, the chit system has been found to be particularly useful as part of actively supported liaison arrangements.
- A questionnaire to aid OMs to distinguish the alcoholic from the heavy drinker.

Probation staff are also encouraged to attend an open AA meeting as an observer so they know more about what AA has to offer.

Where no formal arrangements presently exist, areas/trusts should make contact with their local AA inter-group in order to develop a process for referring offenders based around the principles of the Thames Valley Link Scheme Model but adapted, where necessary, to suit local circumstances.

While offenders may be referred on a voluntary basis, attendance at AA is not enforceable as part of a court order. This is because even where a system of self-reported proof of attendance e.g. the chit system operates an AA member cannot inform on another member so would not give evidence in court at breach proceedings.

Probation should be willing to engage in dialogue with AA to discuss issues of confidentiality and risk (AA is generally reluctant to be given information, which is a particular dilemma in pointing high risk offenders to AA, and to pass on information) which can be a barrier to referral.

SMART Recovery

SMART (Self Management and Recovery Training) is a peer-support model based on a cognitive behavioural alternative to Alcoholics Anonymous.

SMART goes much wider than substance use/misuse and tackles the underlying behaviour associated with problematic alcohol use. It looks at:

- Building Motivation
- Coping with Urges
- Problem Solving
- Lifestyle Balance

In partnership with Alcohol Concern, NOMS has piloted and evaluated a prisoner befriending scheme in seven London prisons based on the SMART model. An evaluation report reviewing the pilot will be published shortly.

Department of Health has awarded a grant to Alcohol Concern to further develop self-help groups in the community using the SMART approach and pilots are underway in eight sites.

Monitoring and evaluation will be an integral part of the two year pilot programme. This will equip service providers and their commissioners with key information on:

- The effectiveness of the Smart Recovery programme
- The benefits of an alternative self-help programme
- The achievements of individual recovery
- Raising expectation of client recovery
- The role of self-help as an aftercare provision
- How to enable and sustain source of peer support for those recovering from alcohol problems
- The impact on the immediate and local community

Information about individual self-help and alternative mutual aid approaches e.g. Women for Sobriety, Moderation Management, is contained in the *Review of the effectiveness of treatment for alcohol problems*.

Managing the sentence

Alcohol misusing offenders subject to community orders or released from custody on licence should be case managed in accordance with the Offender Management Model (OMM), National Standards and other operational requirements and relevant probation circulars.

Core activities are:-

- To prepare and manage sentence and release plans with the purpose of reducing re-offending and alcohol misuse.
- To supervise and monitor offenders on the alcohol treatment requirement (ATR), other requirements involving the delivery of alcohol related interventions, and those on licence.
- To effectively manage the risk of harm (including self-harm).

Tiering

PC 08/2008: *National Rules for Tiering Cases and Associated Guidance* requires that:-

- Report writers should only make proposals for treatment requirements when the case has a risk/needs profile equivalent to tier 2 or above
- The treatment requirement should usually be accompanied by a supervision requirement
- All cases with a treatment requirement should be managed at tier 2 or above.

This amends Annex B to PC 57/2005 which stated that 'the ATR can be used as a stand alone requirement for those in the lowest band of the community sentence but an OM will still be needed for enforcement and general compliance with the order.'

Although an ATR should not usually be proposed without a supervision requirement, the court may impose a standalone ATR. As a minimum, these cases should still be managed at tier 2.

Offenders subject to an ATR assessed as posing a high or very high risk of serious harm or who are Prolific and other Priority Offenders (PPOs) should be managed in tier 4 regardless of the number, type or intensity of requirements.

Some probation areas/trusts have made arrangements so that the intervention provider e.g. external Alcohol Advisory and Treatment Service provides the whole ATR and the only expectation placed upon the offender manager (OM) is to make the arrangements for attendance (or ensure that those arrangements are made), monitor compliance and take enforcement action, if required.

However, the expectation is that the ATR is embedded into a longer period of case management, in which work is undertaken with the offender to complement the core intervention. This should prepare the offender, support, consolidate, assist with 'homework' etc. Therefore, whilst many of the weekly contacts will be carried out by the treatment provider(s), there should additionally be sufficient frequency of contact to maintain the offender's commitment to the ATR and to maximise the offender's chances of completing the order.

Irrespective of the offender tier the OM should have sufficient contact with the treatment provider (over and above receiving attendance sheets) so they are aware of how the offender is progressing. This is particularly important in a suspended sentence order (SSO) case subject to court reviews.

Sentence planning

Information obtained from the pre-sentence screening and assessment process will help the OM to produce a sentence plan of the work that will be done with the offender after the court has passed its sentence.

OMs should ensure that sentence plans specify how alcohol misuse will be addressed through the appropriate tier of alcohol provision under *Models of care for alcohol misusers (MoCAM)*, along with related offending e.g. substance misuse programme and wider needs, which may necessitate a more holistic assessment of the offender - both positives and negatives – post-sentence.

Careful consideration, within the sentence planning process, needs to be given to the sequencing of interventions (see section on sequencing).

Where the assessment flags up criminogenic needs without the capacity to meet those needs leaving OMs holding the risk e.g. limited alcohol treatment provision delaying the start of the ATR; capacity to start offending behaviour programmes; work can be done with the offender e.g. brief interventions, relating to other requirements, until the relevant components can begin within the timings of the community order. This will need to be reflected in the sentence plan.

In ATR cases the care plan should cover the entire period of the requirement and this should be reflected in the sentence plan.

Examples

1. Treatment should be spread over the length of the requirement however frequency may vary e.g. a 12 week treatment plan could be delivered fortnightly over a six month period (weekly contact is not necessary for the whole six month period of a supervision requirement running concurrently with an ATR apart from at Tier 4 to comply with National Standards).

or

2. Set weekly sessions for 12 weeks with relapse prevention or re-referral built into care plan for remainder of requirement period.

Sequencing

The sequencing of interventions e.g. ATR and programmes should primarily be determined by the use of the selection matrix. Waiting lists for treatment and programmes could also have an impact on the order interventions are undertaken.

For orders with a number of requirements consideration should be given to sequencing the interventions to maximise the impact of the order on the rehabilitation of the offender. This may be particularly relevant to offenders on ATRs who may need to have their alcohol problem addressed before being able to realistically comply with the other requirements.

It is particularly important for those leaving prison to ensure that there is the right kind of follow up to interventions begun in custody and that progress made is maintained upon release, although in prisons, as in the community, alcohol services have not developed as comprehensively as for illicit drugs. This is likely to require close links with CARAT teams and the Drug Interventions Programme (DIP) for those with polysubstance misuse (including alcohol) problems. Also, OMs should ensure that all alcohol interventions, whether delivered directly or brokered from other providers, should routinely be followed up to determine whether or not they have been effective and if further intervention will be needed.

Recording

It is crucial that the OM records all contacts (arranged and achieved) properly across all the requirements of the order.

Home visits

A home visit should be undertaken by the OM within 10 working days of sentence or release if the risk of harm posed by the offender is identified as high or very high. This should be subject to local guidance on health and safety/risk and home visiting. Particular attention should be paid to the potential effects of alcohol on the domestic situation especially in relation to any children of the household and or any victim issues.

Missed appointments

Where offenders are given acceptable absences, the number of appointments they are required to attend should only be extended to compensate for those they have missed where necessary to the integrity of the overall treatment episode i.e. where the composition of each session is such that it is essential that these are undertaken in a particular order and completed in entirety (programmes such as the Lower Intensity Alcohol Programme (LIAP) which have a modular structure). In such cases, it is reasonable to expect an offender to attend catch-up sessions or, if this is not possible, to start the whole course again.

Where it is not possible to re-arrange treatment sessions that have been missed so that the whole programme is completed within the duration of the original requirement, then it would be possible to extend the duration of the requirement (see below). Unless this is done, appointments scheduled outside the duration of the requirement (this should be specified in the order at point of sentence, although it does not necessarily have to start from the date the order is made, as long as it is completed before the order expires) would not be enforceable. Otherwise, if there is a continuing treatment need at the end of the requirement, whether all the planned sessions have been completed or not, then the offender should be encouraged to remain in treatment on a voluntary basis.

The solution is not to seek longer ATRs from the outset e.g. nine months instead of the usual six months duration if this cannot be justified by the specific treatment need within an overall package of requirements commensurate with offence seriousness, particularly as the option to seek an extension in length of the requirement is available if needed.

Post-sentence, under Schedule 8 Part 4 paragraph 18 of the Criminal Justice Act 2003 (CJA 2003), if the medical practitioner or other specified person by whom or under whose direction the offender is receiving treatment is of the opinion that:-

- **the treatment specified in the order should be continued beyond the period for which the requirement has effect;**
- the offender needs different treatment;
- the offender is not susceptible to treatment;
- the offender does not require further treatment; or
- if he/she is for any reason unwilling to continue to treat or direct the treatment of the offender

he/she **should** make a report in writing to that effect to the responsible officer i.e. an officer of a local probation board appointed for or assigned to the petty sessions area specified in the order and the officer **should** apply under paragraph 17 – *Amendment of requirements of community order* - to the court responsible for the order for variation or cancellation of the requirement. In

response to such an application, the court may cancel the requirement or replace it with a requirement of the same kind which the court could include if it were then making the order e.g. a longer alcohol treatment requirement (ATR), with different treatment or delivered by a different provider, although in the case of a mental health requirement, drug rehabilitation requirement or ATR only with the prior consent of the offender to the proposed change. Should the offender fail to consent then the court may revoke the order and re-sentence for the original offence, including where appropriate, to custody.

As a last resort, the order could be taken back to court on the basis that the number of acceptable absences had made the requirement 'unworkable'. In these circumstances, the OM could make an application to the court for either the order to be revoked and/or the offender re-sentenced, if it appears to the court that 'having regard to circumstances which have arisen since the order was made, it would be in the interests of justice' to do so (Schedule 8 Part 3 paragraphs 13 & 14 of the CJA 2003); or for the order to be amended by cancelling a requirement or replacing a requirement of the order (Schedule 8 Part 4 paragraph 17 of the CJA 2003). If the offender fails to agree to the ATR as proposed to be amended by the court, then the court can revoke the order and re-sentence.

Change of treatment provider

Where the treatment provider assesses that treatment can be better or more conveniently carried out by another suitably qualified provider not specified in the ATR e.g. in-patient or community based detoxification, then he may with the consent of the offender make arrangements for such treatment to be provided. The person making the arrangements should notify the supervising officer of the change, specifying where and by whom the treatment is now being carried out, and the officer apply to the appropriate court under paragraph 17 for variation of the requirement. For residential treatment, the guidance on case transfers set out in PC 25/2007 applies.

Transfer of cases

ATRs involving offenders in residential treatment should be transferred to the area where the residential facility is located as specified in PC 25/2007. Transfers should be properly planned. Formal planning for transfer should also include arrangements for planned or unplanned discharge from the residential treatment where the offender may return to the home area.

The referring probation area/trust should inform the new area of the impending transfer and discuss the case with them **prior** to the ATR being made. Similarly there should be discussion between the home area/trust and the area/trust to which the order is being transferred if an offender is being referred to an out of area rehabilitation facility after an ATR has been made. Prior liaison will help

ensure that offenders are not placed in inappropriate residential treatment facilities, including those that the local area/trust would not use.

Revocation for good progress

The supervising officer or offender may apply for the ATR to be revoked early for good progress or for responding satisfactorily to supervision or treatment where this is applicable.

The whole order can be revoked on the grounds of good progress (Schedule 8 paragraph 13 (2)(3) of the CJA 2003). Alternatively, an ATR can be cancelled on the grounds of good progress even if other requirements of the order are still operational:-

‘The appropriate court may, on the application of the offender or the responsible officer, by order amend a community order – (a) by cancelling any of the requirements of the order’ (Schedule 8, part 4, section 17 (1) (a)) of the CJA 2003).

Closing ATRs

Areas/trusts need to ensure that ATRs are closed on completion even if other requirements of the order e.g. supervision are still operational. Initially, ATRs should be recorded properly on case management systems so that OMs are aware of the end date of the ATR.

Responsibilities regarding notification of DVLA

In the interests of road safety, those who suffer from a medical condition likely to cause a sudden disabling event at the wheel or who are unable to safely control their vehicle from any other cause should not drive.

The Driver and Vehicle Licensing Agency (DVLA) has produced an *At a glance Guide to the current Medical Standards of Fitness to Drive*¹⁰¹. The information in this booklet is intended to assist doctors in advising their patients whether or not they should inform DVLA of their medical condition and what the outcome is likely to be.

DVLA have advised that:-

- Anyone who has been in detoxification for alcohol use is classed as being ‘alcohol dependent’ and their licence is revoked for 12months.

¹⁰¹ <http://www.dvla.gov.uk/medical/ataglance.aspx?keywords=fitness+to+drive>

- Anyone who has received treatment only is classed as an alcohol misuser and their licence is revoked for 6 months.

As with any medical conditions which could impede a person's ability to drive, it is the licence holder's responsibility to contact the DVLA. However, OMs can do this by writing to the DVLA directly on an offender's behalf. Also, where the OM is aware that the offender intends to drive he/she has a responsibility to inform DVLA/Police.

This has clear implications for PSR writers recommending an ATR knowing the difficulty in accessing services other than by road in more rural areas.

Addressing diversity and complexity of need

Many people with alcohol problems find it difficult to approach services for a variety of reasons. All face the stigma of having an alcohol problem and possibly ambivalence about addressing it but there are often additional problems such as language, childcare, cultural issues, etc. which can act as a barrier to accessing treatment.

A significant proportion of alcohol misusing offenders have multiple needs e.g. mental health problems¹⁰². It is difficult for practitioners, particularly non-alcohol specialist staff, to accurately identify and assess multiple needs and to co-ordinate treatment effectively across services which are often not very well 'joined-up'. *Models of care for alcohol misusers* (MoCAM) places an emphasis on care plans in structured care and more explicit co-ordination of care for people with multiple issues e.g. dual diagnosis.

Alcohol treatment pathways: guidance for developing local integrated care pathways for alcohol is a companion publication to MoCAM, which explains the concept and purpose of developing local pathways for alcohol treatment. As well as pathways for access to alcohol interventions and treatment, the guidance addresses the issue of developing detailed pathways for vulnerable service users with complex needs, including alcohol problems, for example individuals with mental health problems, those affected by domestic violence, homeless people and drug misusers.

The *NOMS Alcohol Information Pack*, which focuses on changing attitudes and behaviour, includes material developed for Offender Managers (OMs) to use with specific offender groups to provide targeted low-level information and advice, deliver brief interventions and refer offenders, where appropriate, to specialist services. The most relevant chapters of the pack are:-

Chapter 11 – *Women and alcohol*

Chapter 12 – *Young people and drinking*

Chapter 13 – *When problem drinking affects your family*

Chapter 14 – *Alcohol and black and minority ethnic communities*

Chapter 15 – *Alcohol and mental health*

Chapter 18 – *Contact numbers (support services)*

There are specific equality duties for all delivering public services to promote equality and eliminate unlawful discrimination e.g. in relation to women making sure that their specific needs are taken into account.

¹⁰² Singleton, N., Farrell, M., & Meltzer, H. (1999) *Substance misuse among prisoners in England and Wales, Further analysis of data from the ONS survey of psychiatric morbidity among prisoners*. Office for National Statistics

Areas/trusts should have in place arrangements to undertake equality audits and equality impact assessments to ensure that provision is appropriate and relevant to the needs of different groups and that outcomes are equitable.

Women

Evidence of differing need

The *Alcohol Needs Assessment Research Project (ANARP)* (2004)¹⁰³, the first alcohol needs assessment in England undertaken on a national scale, found that, although the prevalence of alcohol use disorders was lower in women than in men¹⁰⁴, there was a high level of alcohol related need across all categories of women drinkers. 15 per cent of women were classed as hazardous or harmful alcohol users¹⁰⁵; 9% as binge drinkers and 2% as alcohol dependent, with considerable overlap between those drinking above sensible daily and weekly benchmarks. Evidence suggests that the proportion of women drinking above low risk levels has increased in recent years. 3.6 million women (17%) reported drinking in excess of 14 units a week in 2002, an increase of 70% since 1988¹⁰⁶.

Women differ significantly from men in the way that they handle the metabolism of alcohol. They have a lower volume of body fluid in which to distribute alcohol and higher blood alcohol concentrations than in males drinking similar amounts. This makes them more vulnerable to risk from cancer, stroke, hypertension, liver disease, obesity, osteoporosis, coronary heart disease, and reduced fertility. Other serious implications of excess drinking for women include higher incidences of unsafe sex, unwanted pregnancies, disproportionate vulnerability to attack and increased mental health and social problems.

Psychological risk factors that trigger problem drinking in women include a history of drinking in the family; depression; sexual problems and poor coping responses to stressful life events e.g. drinking as a result or cause of separation or divorce. Low self-esteem among women, particularly young women who have experienced sexual or physical abuse, may be a trigger to heavy drinking. Childhood problem behaviours related to impulse control and early use of nicotine, alcohol and poly-drug use are other associated risk factors. Research

103 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4122341

104 38 per cent of men and 16 per cent of women (age 16–64) were found to have an alcohol use disorder (26 per cent overall)

105 The World Health Organisation's tenth revision of the *International classification of diseases* (ICD-10) defines:- hazardous use of a psychoactive substance, such as alcohol, as an 'occasional, repeated or persistent pattern of use...which carries with it a high risk of causing future damage to the medical or mental health of the user but which has not yet resulted in significant medical or psychological ill effects'; and harmful use of a psychoactive substance, such as alcohol, as 'a pattern of use which is already causing damage to health. The damage may be physical or mental.'

106 Alcohol Concern (2004) *Women and Alcohol Factsheet 2: Summary*. London: Alcohol Concern

suggests that individual triggers play a greater or lesser role at different stages in a woman's life cycle¹⁰⁷. Understanding of these risk factors is essential to developing appropriate forms of treatment targeted at women.

Studies also suggest that women are highly responsive to the emotional and social contexts in which they drink and it is possible to identify a number of key situations where women are vulnerable and at risk of developing problem drinking¹⁰⁸. For instance, heavy or frequent drinking may be linked to the difficulties of juggling work and heavy domestic responsibilities, or it can be associated with established patterns of socialising around the workplace e.g. working in a male orientated environment can result in the development of patterns of heavy drinking.

Women have different substance using careers to men. Generally, they start later and respond better to treatment¹⁰⁹. However, a review by Jarvis (1992) concluded there are only small differences across a variety of treatment modalities and settings in the effectiveness of treatment for women compared to men but, notably, women are likely to do less well in mixed group therapy because of the unfavourable gender dynamics¹¹⁰. Furthermore, women who have been abused tend to prefer a female therapist but women who have not identified themselves as having experienced violence from men do equally well with male or female therapists¹¹¹.

Women are more likely to have higher rates of physical and psychiatric co-morbidity than men, which may complicate treatment¹¹². Research has found that problem drinking women with co-morbidity were often single, on a low income, likely to experience a greater severity of problem drinking and to binge drink, and to be regular smokers and cannabis users¹¹³.

107 Thom, B. (1997) *Women and alcohol issues for prevention: A literature review*. Health Education Authority, London.

108 Alcohol Concern (2004) *Women and Alcohol Factsheet 2: Summary*. London: Alcohol Concern

109 Raistrick, D., Heather, N., and Godfrey C. (2006) *Review of the Effectiveness of Treatment for Alcohol Problems*. London: National Treatment Agency for Substance Misuse.

110 Jarvis, T. J. (1992). *Implications of gender for alcohol treatment research: A quantitative and qualitative review*. *British Journal of Addiction*, 87, 1249–1261.

111 Connors, G. J., Carroll, K. M., DiClemente, C. C., Longabaugh, R. & Donovan, D. M. (1997). *The therapeutic alliance and its relationship to alcoholism treatment participation and outcome*. *Journal of Consulting and Clinical Psychology*, 65, 588–598.

112 36% of women remand prisoners and 39% of sentenced women prisoners have a history of hazardous drinking which is frequently linked to mental ill health (33 - ONS, 1999).

113 Ross, H. & Shirley, M. (1997). *Life-time problem drinking and psychiatric co-morbidity among Ontario women*. *Addiction*, 92, 183–196.

Women may be more reluctant to admit that they have an alcohol problem¹¹⁴. This may be because they think people will judge them or that it will affect their children (if they have any).

Alcohol affects women and men differently. It takes longer for a woman's body to get rid of alcohol than a man's. So women run greater health risks than men if they drink similar amounts. That is why the government advice is that women should not regularly drink more than **2-3 units** of alcohol a day compared with men who should not regularly drink more than 3 - 4 units a day. This also applies to the definition of binge drinking, which is generally accepted as 'in excess of eight units a day in men and six units a day in women'. This quantity puts an individual at increased risk of harm even though some may not exceed the lower risk weekly level. In short, the same amount of alcohol is liable to get a woman more drunk more quickly and, if she exceeds sensible limits, may harm her more.

This will have implications for the point at which current use is considered a problem in OASys¹¹⁵ and the scoring of any more specific alcohol screening undertaken thereafter. For example, a score of eight or above in the Alcohol Use Disorders Identification Test (AUDIT) classifies drinking as increasing risk or worse, although this is sometimes amended to eight for men and seven for women, to take account of women's greater vulnerability to the effects of alcohol.

Government advice is that women who are pregnant or trying to conceive should avoid drinking alcohol. Pregnant women can put their unborn child at increased risk if drinking a lot, particularly if drinking is combined with smoking and poor diet. This can be linked to a range of foetal disorders.

Given the risk of harm to the unborn foetus from a mother's excessive drinking, the detection of alcohol misuse among pregnant women is of major importance. Two screening tools, both taking approximately one minute to complete, have been developed to screen for increasing risk and higher risk drinking among pregnant women: T-ACE (tolerance, annoyed, cut down, eye-opener) and TWEAK (tolerance, worried, eye-opener, amnesia, k(c)ut down).

It is important to understand that women are not to blame for violence by partners. There is support available, including specialist services available to help survivors of domestic violence. Given the number of women offenders who currently have or who have had abusive partners (which may or may not involve alcohol use)¹¹⁶, it is dangerous not to pay due regard to this. Furthermore, the full

114 Sanchez-Craig, M., Spivak, K. & Davila, R. (1991). *Superior outcome of females over males after brief treatment for the reduction of heavy drinking: Replication and report of therapist effects*. British Journal of Addiction, 86, 867-876

115 Amendments being made to the OASys online help refer to the WHO and DoH categories, including their distinctions between men and women.

116 National Offender Management Service (2008) *The Offender Management Guide to Working with Women Offenders*

extent of abuse involved extends beyond physical violence. OMs have safeguarding duties when working with victims of domestic abuse.

For partners who are abusive and violent, addressing the drinking will not be sufficient to address the full range of behaviours which encompass domestic violence. This is really important in terms of women's safety – for many women the period of detoxification/recovery can be the most dangerous time for them and they may remain in a relationship because they think their partner's abuse will stop when the drinking has been addressed. Women who report that their partners are violent and abusive when drunk also report that their partners are violent and abusive when sober¹¹⁷. The Respect phoneline (0845 122 8609) is the national phoneline for men who wish to seek help for their abusive behaviour¹¹⁸.

Female alcohol misusers may value the personal responsibility involved in self-initiated change and may be more motivated to change than men due to the greater stigma attached to problem drinking by women¹¹⁹. Less-intensive treatment (condensed form of cognitive behavioural therapy) seems especially suited to female service users with a mild or moderate level of alcohol dependence, who are suitable for a moderation drinking goal if they wish to pursue it.

The network of women-only One Stop Shops (OSSs) provide a safe and woman-focused environment in which to address a range of needs in a holistic and integrated way. Many OMs use the OSSs for the delivery of most aspects of the sentence plan and many other needs identified by women.

Known difficulties

Women are aware that it is not good for them to drink heavily but can be slow to acknowledge a personal problem with alcohol because:

- There is a low awareness of the range of alcohol-associated health problems and an assumption that drinking only harms people if they are addicted
- A tendency to see alcohol as an issue which concerns society rather than the self
- Women obtain social and psychological benefits from drinking alcohol that appear to outweigh negative consequences¹²⁰.

117 National Offender Management Service (2008) *The Offender Management Guide to Working with Women Offenders*

118 www.respect.uk.net

119 Sanchez-Craig, M., Spivak, K. & Davila, R. (1991). *Superior outcome of females over males after brief treatment for the reduction of heavy drinking: Replication and report of therapist effects*. *British Journal of Addiction*, 86, 867–876

120 Alcohol Concern (2004) *Women and Alcohol Factsheet 2: Summary*. London: Alcohol Concern

Sanctions are greater for women with chronic drinking problems and research shows that alcohol-dependent women are more likely than alcohol-dependent men to be deserted by their spouses. The fact that a large proportion of women **believe** that society is more disapproving of female problem drinking continues to act as a barrier to women seeking help¹²¹. For instance, women are stigmatised for drinking in the home, as this conflicts with an ideology of women and motherhood as being self-denying and nurturing of both men and children.

Research¹²² suggests that there are a number of factors that discourage women from seeking help for an alcohol problem including:

- the stigma attached to admitting the problem appears to be greater for women and women are affected by family pressure not to admit to the problem
- mis-diagnosis of the problem, as women often attribute their drinking problems to underlying causes, e.g. bereavement, and tend to seek help from agencies that fail to identify the alcohol problem
- fear of the consequences of making the problem public e.g. loss of child custody
- practical problems of organising time to attend treatment.

Until recently, the majority of alcohol services and treatment programmes have been aimed at and for men. However, in response to more women coming forward for help with their drinking problems, treatment services are having to readdress their facilities and approaches to make them more accessible for women.

Women may be intimidated by the dynamics of a mixed therapy group and not feel able to participate as they might in an all female group. Women whose drinking problem is associated with male abuse or domestic violence may be intimidated by the presence of men¹²³.

There are increasing levels of drunken violence in which women are involved as victims and perpetrators¹²⁴, although the number of such offences remains comparatively very low among female offenders (compared to males). Provision for working with violent women offenders is currently less available than for men – e.g. accredited programmes.

121 Williams, C. N. and Klerman, L. V. M. cited in Thom, B. (1997) *Women and alcohol issues for prevention: a literature review*. Health Education Authority, London.

122 Alcohol Concern (2004) *Women and Alcohol Factsheet 2: Summary*. London: Alcohol Concern

123 Institute of Alcohol Studies (2007) *Women and Alcohol Factsheet*

124 Institute of Alcohol Studies (2007) *Women and Alcohol Factsheet*

Many women suffer from 'mood disorders' which may not formally attract a 'dual diagnosis' but nevertheless can seriously affect their intention to restrict their drinking.

There is also a high incidence of alcohol misuse (frequently self-reported dependent drinking) seen amongst those women who find themselves in prison, as part of a poly-drug using lifestyle.

Examples of good practice

Practitioners in the field recommend that programmes to combat problem drinking among women should contain prevention and screening programmes to intervene before the onset of severe alcohol problems or dependency and women-focused services including varied treatment approaches and the provision of women only services where appropriate e.g. women only detoxification units.

Review of the effectiveness of alcohol treatment found that:-

- Brief interventions are equally effective among men and women, although there is no specific evidence as yet that brief interventions reduce alcohol consumption among pregnant women.
- With the exception of women who have been abused, women do well with mainstream services provided co-morbidity needs are addressed.

A modern alternative to written self-help materials is computer-based or internet-based programmes for home use. The appeal of self-help via the internet is that it allows privacy and flexibility of access. This may be particularly important for women who are more sensitive to the possible stigma of admitting alcohol misuse than men.

Offender managers should help women offenders get in touch with services that are specifically geared towards the needs of women. These may be:

- Women only
- Sensitive to cultural and religious beliefs
- Confidential
- Able to offer child care facilities
- Open at times that suit

Information about services which are women specific, including more specialist women only services and/or domestic violence and substance misuse workers and how these could be actively sought out is contained in the *NOMS Alcohol*

*Information Pack for Offenders*¹²⁵. This includes contact details for the National Domestic Violence Helpline, Rape Crisis and the Respect phonenumber.

Currently there is only limited evidence regarding the effectiveness of mixed gender groups and single gender programmes; this tentatively concludes that overall, women can do as well in groups that are mixed gender as women only groups. What has been highlighted is that the importance of the style of delivery of the intervention is responsive to the members of the group, as is addressing relevant deficits, subject to an assessment of the woman's wishes and concerns. It is generally considered poor practice to have a lone female in a group. The offender manager should consult with the programme provider about any concerns they may have about a female offender attending a group programme. They will be able to help identify additional support that will assist the offender's attendance and participation. For some women a mixed group will not be appropriate; an offender manager may wish to consult with the programme manager to assist in making this assessment. This includes recommendations for programmes attached to DRRs or ATRs.

Improving compliance

Women offenders will not engage successfully with interventions which do not enable them to manage their child care responsibilities, especially in cases where they are the primary carer¹²⁶. In line with a recommendation from *The Corston Report: a review of women with particular vulnerabilities in the criminal justice system*¹²⁷, OMs should take into account domestic arrangements, childcare and other issues in sentence planning to facilitate engagement and compliance and therefore increase the likelihood of successful outcomes.

There is evidence to show that unpaid work delivered through a One Stop Shop improves compliance for women offenders. The role of the family especially children can also be a powerful force.

The *NOMS Alcohol Information Pack* contains a specific section on *Women and alcohol*. In response to Corston, it has been revised to make it even more appropriate to the needs of women offenders, as indicated in the *Offender Management Guide to Working with Women Offenders* published in May 2008.

Under the best practice projects initiative, North Yorkshire Probation Area has commissioned research to undertake an analysis of reasons for the attrition of women offenders subject to alcohol treatment requirements (ATRs) and

¹²⁵http://npsintranet.probation.gsi.gov.uk/index/service_delivery/interventions/drugs__alcohol/alcohol_information_pack.htm

¹²⁶ Ministry of Justice/National Offender Management Service (2008) *National Service Framework: Improving Services to Women Offenders*

¹²⁷ <http://www.homeoffice.gov.uk/documents/corston-report/>

development of ways to make the ATR more responsive to their complex needs. This will produce a report with recommendations regarding additional support for women and a revised treatment package more appropriate to women's needs. There will also be an evaluation of attrition post-implementation of the treatment package.

The YWCA recently launched a report, *Young women and binge drinking: breaking the habit*¹²⁸, with conclusions and recommendations from a piece of research.

Young adult offenders

A minority of 18-24 year old binge drinkers are responsible for the majority of alcohol-related crime and disorder¹²⁹. 44% of 18-24 year olds admit to binge drinking, and 14% of them committed violent crimes in the previous year. Young male binge drinkers (16%) are more than twice as likely to commit a violent offence as other young male regular drinkers (7%), and are also likely to get involved in other criminal and disorderly behaviour¹³⁰.

Young people aged 16-24 are more likely to report increasing risk drinking patterns – this doesn't just refer to their level of drinking but also covers associated behaviour such as impulsivity, risk taking or becoming involved in arguments or having accidents¹³¹. Therefore, most young adult offenders (YAOs) aged 18-21 under probation supervision are more likely to require brief interventions (simple or extended) than specialist treatment through an ATR.

Research suggests that the needs of young people are different from those of adults. Evidence suggests that substance misuse in young people is multi-faceted and those young people often have multiple antecedent and co-occurring mental, social and educational problems¹³². This age group also has a lack of awareness of the long-term risks of substance misuse and are susceptible to peer influences and social settings¹³³.

Barriers to addressing substance misuse in the YAO group include that:

128 http://www.ywca.org.uk/resources/Young_women_and_binge_drinking

129 Department of Health, Home Office, Department for Education and Skills, Department for Culture, Media and Sport (2007) *Safe. Sensible. Social. The next steps in the National Alcohol Strategy*

130 Matthews, S., and Richardson, A. (2005) *Further analysis of survey data: Findings from the 2003 Offending, Crime and Justice Survey: alcohol related offending*. Home Office Findings 261.

131 Alcohol Concern (2004) *Young People's Drinking Factsheet 1: Summary*. London: Alcohol Concern

132 Home Office (2001) *The Substance of Young People's Needs*

133 Borrill, J., et al. (2003) *The substance misuse treatment needs of minority prisoner groups: women, young offenders and ethnic minorities*. Home Office Development and Practice Report 8.

- Young people have an experimental 'pick and mix' approach to drugs - they may not acknowledge they have a problem and so engagement of this group can be difficult.
- Young people have a tendency to concentrate on the here and now and thus cannot be influenced by understanding the long-term effects of substance misuse.
- Drinking is seen as part of youth culture and for many young people all of their peer group will be engaged in similar activities.
- Young people also have other diversity issues and may be members of more than one social identity group.
- Within some communities, religious restrictions can lead to hidden drinking and shame which prevents disclosure of the problem.
- Different service provisions for both drug and alcohol services can have age specific criteria, which can complicate effective throughcare.

Assessments for YAOs will need to provide an initial indication of the offender's motivation to address their offending behaviour. This is particularly important for the YAO age group and the use of open questions, summarising and reflective listening should, crucially, be used during this stage.

There are no drug or alcohol interventions designed specifically for YAOs. The needs of young people are often too multi-faceted to be treated by a single approach. Therefore, a variety of different measures are required on different levels to begin to address identified need incorporating:-

- Ongoing motivational work (YAOs need to be engaged and that engagement maintained)
- Identification with pro-social attitudes and behaviours
- Skills development
- Interactive
- Work that is personally meaningful
- Visual types of learning
- Support from significant others, including enhanced involvement of families where appropriate
- Peer support or the use of mentoring
- The use of young offenders as 'messengers'

The delivery of provision for YAOs may be different to the style most effective for delivery of a wider age group. This needs to be taken into account in the provision of a workforce skills strategy.

Provisions for 16-17 year olds

The Criminal Justice Act 2003 (CJA 2003) does not currently apply to offenders under 18 year of age. This means 16-17 year olds will continue to be made subject to pre-CJA 2003 orders for offences committed on or after April 4th 2005.

Areas/trusts need to discuss arrangements for this age group with local youth offending teams (YOTs). The Youth Justice Board has advised, however, that juveniles should continue to be proposed for juvenile sentences. Youth Rehabilitation Orders (YROs) were introduced in November 2009 and there can be a treatment element to a YRO.

Black and Minority Ethnic (BME) offenders

The prevalence of alcohol consumption in the UK varies considerably between different ethnic groups: over 90 per cent of those of Pakistani and Bangladeshi origin are believed to be non-drinkers while fewer than one in ten of the White British population abstains from alcohol¹³⁴.

The *Alcohol Needs Assessment Research Project (ANARP)* found that BME groups had a considerably lower prevalence of hazardous and harmful alcohol use, but a similar prevalence of alcohol dependence compared to the white population. However, a Home Office study examining the substance misuse treatment needs of minority prisoner groups found that half of males from minority ethnic groups were assessed as drinking at increasing and higher risk levels, with just over a third classified as both harmful drinkers and dependent on drugs¹³⁵.

Many people from the ethnic minorities feel disinclined to approach alcohol services, which are perceived to be unreceptive to their needs¹³⁶. These needs include providing services in the person's first language, being sensitive to religious responsibilities/traditions and cultures, and recruiting more ethnic minority workers into the treatment sector¹³⁷. Other reasons include the need to conceal substance use from parents and family, being reported to their parents if seen at a treatment agency, fear of unusual and severe punishments if caught, and avoiding the intolerance of the minority community¹³⁸. Help-seeking is strongly influenced by the experience of psychosocial problems, particularly if these are interpersonal, and by encouragement to enter treatment¹³⁹.

134 McSweeney, T., Webster, R., Turnbull, P. J., and Duffy, M. (2009) *Evidence based practice? The National Probation Service's work with alcohol misusing offenders*. Ministry of Justice Research Series 13/09. London: Ministry of Justice.

135 Borrill, J., et al. (2003) *The substance misuse treatment needs of minority prisoner groups: women, young offenders and ethnic minorities*. Home Office Development and Practice Report 8.

136 Purser, B., et al. (2001) *Drinking in second and subsequent generation black and asian communities in the English midlands*. Alcohol Concern.

137 National Offender Management Service (2006) *Working with Alcohol Misusing Offenders – a strategy for delivery*. London: Home Office

138 Kahn, F., Ditton, J. & Hammersley, R. (2000). *Ethnic minority use of illegal drugs in Glasgow, Scotland: Potential difficulties for service provision*. *Addiction Research*, 8, 27–49.

139 Tucker, J. A. & King, M. P. (1999). *Resolving alcohol and drug problems: Influences on addictive behavior change and help-seeking processes*. In J. A. Tucker, D. M. Donovan & G. A. Marlatt (Eds.), *Changing Addictive Behavior: Bridging Clinical and Public Health Strategies*. New York: Guilford Press.

There is some research evidence that the family network may make spontaneous recovery more likely among ethnic minorities¹⁴⁰ – family honour and religious re-affiliation were frequently cited as reasons for stopping drinking – and which suggests that the Asian community felt the need for substance misuse workers of the same cultural background most strongly. *Review of the effectiveness of treatment for alcohol problems* found that ‘individuals from ethnic minorities tend to divide according to their degree of religious allegiance and there is a stronger case for novel ways of engaging ethnic minorities than for providing separate services.’

Black and minority ethnic population groups may require approaches that are sensitive to cultural or religious attitudes to alcohol. Staff should be trained in the skills and sensitivity needed to identify and work with all minority groups. Minority group treatment programmes should be funded where these would improve access to treatment and where there could be proper evaluation of the service.

Provision should be made for the BME section of the *NOMS Alcohol Information Pack* and a number of the basic sections to be translated into different languages. Also, for the delivery of interventions e.g. Eastern Europeans (Poles, Lithuanians) receiving Drink Impaired Drivers (DID) materials in their own language. Alcohol information should also be made available in formats suitable for people with visual impairments and with learning difficulties.

Poly substance misuse

A significant number of offenders misuse both drugs and alcohol and their use is often intertwined¹⁴¹. However, consumption of alcohol often has vastly different situational factors than illicit drug use (i.e. in a public rather than private place) and the types of crime which alcohol misuse is linked with are also very different (violent crime or public disorder rather than acquisitive crime)¹⁴².

The *National Treatment Outcome Research Study*(NTORS)¹⁴³ found that drug treatment services were having little or no impact on drug service users’ drinking behaviour, despite half having identified alcohol problems, and that where drug users reduced their heroin use, alcohol use increased.

Around 40 per cent of injecting drug misusers in drug treatment in 2004 were hepatitis C virus infection positive. Alcohol misuse is the single biggest

140 Cameron, D., Manik, G., Bird, R. & Sinorwalia, A. (2002) *What may we be learning from so-called spontaneous remission in ethnic minorities?* *Addiction Research and Theory*, 10, 175–182.

141 Data from a 2004/05 study showed that up to 1 in 5 CARATs clients regarded alcohol as their primary main problem drug/substance.

142 McMurrin, M. and Cusens, B. (2005) *Alcohol and acquisitive offending*. *Addiction Research and Theory*, 13 (5): 439–443.

143 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4084908

contributory factor to those with hepatitis C virus infection developing fatal liver disease¹⁴⁴.

If an individual has other physical or mental health conditions or drug misuse problems in addition to requiring alcohol intervention or treatment, these issues can be crucial in deciding on appropriate alcohol treatment and treatment goals. The *Review of the effectiveness of treatment* found that people misusing drugs and alcohol may have different needs from those misusing alcohol alone and may require a different approach to treatment.

MoCAM advises that 'drug users in treatment should have their alcohol use and treatment needs routinely and continually assessed, and it is good practice for drug users in treatment to have their alcohol problems treated in the same setting where possible. Referrals to specialist alcohol treatment, and guidance from specialist alcohol workers, should be a routine feature in the treatment and care of drug misusers. Where drug misusers are already attending a combined drug and alcohol treatment service, where external referral may not be needed, it is vital that the management of alcohol misuse is clearly identified for action as part of the service user's formal care plan.'

Dual diagnosis

It is rare for an offender with a serious alcohol problem to have no other significant physiological and psychological problem. Aside from alcohol-related medical conditions such as cardio-vascular or liver disease, many offenders have mental health problems that may require a specialist mental health service¹⁴⁵. It is estimated that 10% of people with alcohol problems have a severe mental illness, 50% have a personality disorder and up to 80% have a milder mood disorder¹⁴⁶.

Alcohol-specific services are limited across National Offender Management Service and NHS domains. Guidance on practice in the management of co-existing alcohol and mental health problems is provided by Department of Health^{147 148 149} as part of universal advice on mental health, substance misuse

144 Department of Health/National Treatment Agency for Substance Misuse (2006) *Models of care for alcohol misusers (MoCAM)*. London: DH/NTA.

145 Singleton, N., Farrell, M., & Meltzer, H. (1999) *Substance misuse among prisoners in England and Wales: Further analysis of data from the ONS survey of psychiatric morbidity among prisoners*. Office for National Statistics.

146 Ashworth, M. and Gerada, C. (1997) *Addiction and dependence-alcohol*. British Medical Journal 315(7104), 358-360. Health Education Authority (1997) *Health update: alcohol*. London: Health Education Authority.

147 DH (2002) *Mental Health Policy Implementation: Guide Dual Diagnosis Good Practice Guide*. London; Department of Health

148 DH (2007) *Drug misuse and dependence: UK guidelines on clinical management*

149 DH (2008) *Refocusing the Care Programme Approach: Policy and Positive Practice Guidance*

and dual diagnosis. Guidance for prisons is contained in the Department of Health dual diagnosis guide¹⁵⁰ and in the prisons clinical substance misuse guidance.¹⁵¹ Wales has a module of the Substance Misuse Treatment Framework (SMTF) covering co-occurring substance misuse and mental health but nothing specific for prisons.

Mainstream approaches to 'dual diagnosis' recommend that mental health services should take the lead in the treatment of people with serious mental health problems who also have substance misuse problems with close liaison and support from substance misuse services to deliver an integrated package of care. To facilitate this, areas/trusts and providers should ensure that clear and agreed integrated care pathways and joint working protocols are in place for offenders with dual diagnosis.

The Home Office have recently issued guidance to Drug Intervention Programme practitioners on the management of clients with dual diagnoses¹⁵². Problem drinking among offenders with no problematic drug use lies outside the function of DIP but the principles set out in the guidance may still be informative.

A court may also issue a mental health treatment requirement (MHTR). The response of the courts to offenders with mental health problems has been the subject of *Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system*¹⁵³, which was published on 30 April 2009. The very high level of mental health problems among problem drinkers appearing before the courts ensured that Lord Bradley paid particular attention to the type of services and interventions that should be available. He recommended:-

- The Department of Health, NHS and other relevant government departments should work with voluntary organisations to ensure the adequate provision of alcohol and mental health treatment services across the country
- Improved services for prisoners who have a dual diagnosis of mental health and drugs/alcohol problems should be urgently developed
- Joint care planning between mental health services and drug and alcohol services, should take place for prisoners on release

150 DH (2009) *A Guide for the Management of Dual Diagnosis for Prisons*

151 DH (2006) *Clinical management of drug dependence in the adult prison setting*

152 Drummond C, Phillips T & Boland W (2008) *Substance misusing clients with mental health problems: A brief practitioner's guide for Criminal Justice Integrated Teams*. Specialist Clinical Addiction Network

153 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_098694

In its response¹⁵⁴, the Government committed to publishing a national delivery plan, which will outline how it will take forward his recommendations including making the necessary system reforms to tackle barriers to the provision of mental health treatment across probation areas/trusts. *Improving Health, Supporting Justice*¹⁵⁵, the National Delivery Plan of the Health & Criminal Justice Programme Board, was published on November 17th 2009. The plan seeks to bring justice and health sectors together to optimise access to treatments. Action on alcohol is included, which builds on existing Primary Care Trust (PCT) plans for improving access to alcohol treatment. This includes progress towards a minimum level below which access to treatment should not fall and issuing guidance to PCTs on commissioning alcohol services to ensure they meet the needs of offenders¹⁵⁶.

The ten-year National Service Framework (NSF) for mental health was launched in 1999. The NSF strategy highlighted that around half of those reporting any substance misuse disorder have experienced other mental health problems. The document also recommended that 'assessments of individuals with mental health problems, whether in primary or specialist care, should consider the potential role of substance misuse and know how to access appropriate specialist input.'

The NSF has been superseded by the recently published *New Horizons: A Shared Vision for Mental Health*¹⁵⁷, which sets out a cross-government programme of action to improve the mental health and well-being of the population and the quality and accessibility of services for people with poor mental health.

Family issues

There is evidence of the potential value in appropriately engaging and involving families in the treatment and resettlement processes^{158 159}. It can also be an important component in addressing the key strategic themes of NOMS Drug¹⁶⁰ and Alcohol Strategies (i.e. reducing substance related harm to individuals and communities; building effective through-care arrangements).

NOMS, in partnership with the charity Adfam, produced a family toolkit, *Partners*

154 <http://www.justice.gov.uk/publications/bradley-mental-health-cjs-gov-response.htm>

155 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_108606

156 There is no comparable Offender Health & Social Care Strategy published or planned in Wales.

157 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_109705

158 Sisson, R. W. & Azrin, N. H. (1993). *Community reinforcement training for families: A method to get alcoholics into treatment*. In T. J. O'Farrell (Ed.), *Treating Alcohol Problems: Marital and Family Interventions*, (pp. 34–53). New York: Guilford Press.

159 Copello, A., Orford, J., Hodgson, R., Tober, G. & Barrett, C. on behalf of the UKATT Research Team (2002). *Social behaviour and network therapy: Basic principles and early experiences*. *Addictive Behaviors*, 27, 354–366.

160 <http://www.justice.gov.uk/publications/noms-drug-strategy-2008-2011.htm>

*in Reduction*¹⁶¹, for prisons in 2005. This toolkit provides prison staff with comprehensive advice on how to effectively engage the families of drug and alcohol misusers in prison. It is founded upon the growing evidence of the positive role families can play in support of those undergoing drug and alcohol treatment. The *Alcohol Treatment Interventions Good Practice Guide*¹⁶² also sets out guidance about how to work with families and highlights relevant issues and the alcohol video – *Alcohol: a prisoners' perspective* has a specific section on the effects of alcohol misuse on families.

The National Drug Strategy, *Drugs: Protecting families and communities*¹⁶³, published in February again recognises the evidence that families are both affected by and can have an influence on drug and alcohol misusers. It is recognised that recovery from alcohol dependence is a long-term process and benefits from appropriate family/social support.

An Addaction report, *Closing the Gaps*¹⁶⁴, states that family support should become integrated into drug and alcohol treatment services, because of the improvement in results when families are included in treatment. In the case of children affected by parental substance misuse, integrated working and effective communication is essential to outline action to help families and better inform parents.

Inappropriate support can undermine recovery. Some families might want to break ties with an offender in order to get away from substance misuse and its related problems. Some women offenders will need support to break away from partners, ex-partners or family members who are violent, abusive or are reinforcing their offending behaviour. In these cases they are likely to require on-going support from expert, women-centred organisations in the community.

Strong local partnerships are needed to ensure women offenders can access support and advice to help them manage family concerns, particularly around their children, including working with universal services like children's centres and extended schools, family support services for substance misusers and Third Sector providers.

Safeguarding children

Offender Managers should address both the safeguarding and the well-being of offenders' children. While alcohol (or other substance) misuse does not necessarily lead to problems or poor parenting, neglect or abuse of children, OMs should consider the impact of parental alcohol misuse on the welfare of

161 <http://www.adfam.org.uk/index.php?content=news&include=yes&action=edited&id=33>

162 <http://www.hmprisonservice.gov.uk/resourcecentre/publicationsdocuments/index.asp?cat=88>

163 <http://drugs.homeoffice.gov.uk/drug-strategy/>

164 http://www.addaction.org.uk/?page_id=1594

children in their care. Recent evidence from Child Death Reviews showed a significant correlation with alcohol use.

The Lord Laming recommended in *The Protection of Children in England: A Progress Report*¹⁶⁵ that 'All police, probation, adult mental health and adult drug and alcohol services should have well understood referral processes which prioritise the protection and well-being of children. These should include automatic referral where domestic violence or drug or alcohol abuse may put a child at risk of abuse or neglect.'

MoCAM advises that 'if a professional has concerns about the welfare or safety of the children of alcohol misusers, from assessment or indeed at any point during treatment, they should follow local joint working arrangements as agreed by the local safeguarding children boards (formerly area child protection committees). This would normally mean involving social services.'

OMs need to work in partnership with local authority children's services where the children of offenders are being cared for by extended family, friends or in the children-in-care system.

Department of Health and the Regional Public Health Office for the South East have developed a violence and abuse framework that incorporates a range of interventions to safeguard children, young people and adults.

Areas/trusts will wish to be aware of the *Joint Guidance on Development on Local Protocols between Drug and Alcohol Treatment Services and Local Safeguarding and Family Services*¹⁶⁶ developed by Department for Children, Schools and Families (DCSF), Department of Health (DH) and National Treatment Agency for Substance Misuse (NTA) and published on 3rd November.

Social deprivation and homelessness

Research suggests a significant association between social deprivation, psychological morbidity and substance misuse¹⁶⁷. It also indicates that social factors such as accommodation, finances and employment have a large impact on rates of re-offending¹⁶⁸. Addressing employment and family problems can

165 <http://publications.everychildmatters.gov.uk/default.aspx?PageFunction=viewtoptenproducts&PageMode=publications&Type=TopTen&>

166 <http://www.drugscope.org.uk/resources/goodpractice/treatment/guidance.htm>

167 Farrell, M., Howes, S., Taylor, C., Lewis, G., Jenkins, R., Bebbington, P., et al. (1998). Substance misuse and psychiatric comorbidity: An overview of the OPCS National Psychiatric Morbidity Survey. *Addictive Behaviors*, 23, 909–918.

lead to changes in substance use and securing employment means that the offender has less unstructured time and encourages responsible attitudes to drinking. Therefore, it would seem sensible to address these needs in conjunction with other approaches.

Homeless people, those who lack social support or those who have had previous unsuccessful attempts at withdrawal in the community may require inpatient treatment. There is evidence to support the need for specialist services, typically residential and non-hospital, as a safety net and pathway to long-term rehabilitation¹⁶⁹. However, there has been a move away from services for homeless problem drinkers to more holistic services for the homeless.

Housing and hostel provision for homeless alcohol misusers will need to be considered in tandem with alcohol treatment and brief interventions. This provision is not within the remit of probation areas/trusts but there is scope for them to influence housing providers through participation in local strategic partnerships.

Research suggests the importance of case management aimed at improving the financial and residential stability of service users and reducing their use of alcohol on successful outcomes¹⁷⁰.

168 Research evidence suggests that employment reduces the risk of re-offending by between one third and one half: Lipsey 1992; The extent and frequency of offending diminishes when offenders gain employment: Sarno et al 2000

169 Raistrick, D., Heather, N., and Godfrey C. (2006) *Review of the Effectiveness of Treatment for Alcohol Problems*. London: National Treatment Agency for Substance Misuse.

170 Cox, G., Walker, R., Freng, S., Short, B. A., Meijer, L. & Gilchrist, L. (1998). *Outcome of a controlled trial of the effectiveness of intensive case management for chronic public inebriates*. *Journal of Studies on Alcohol*, 59, 523–532.

Compliance and enforcement

OMs have a duty to provide effective and timely enforcement of alcohol treatment requirements (ATRs), other requirements involving the delivery of alcohol related interventions and licence conditions.

Existing National Standards apply in respect of attendance and behaviour. The order is taken as a whole for the purpose of breach, with an unacceptable failure to comply in relation to any requirement counting as one unacceptable failure to comply with the whole sentence. A failure to report etc. is considered as an unacceptable failure to comply only once in respect of any one day, regardless of the number of contacts arranged for that day.

All enforcement decisions should be discussed with the treatment provider(s) i.e. acceptable/unacceptable absences and decisions regarding whether or not to propose revocation or to continue the order. This may have more significance with ATR cases, as the breach may be in respect of another requirement and not specifically about treatment.

There may be differences in opinion regarding the proposed outcome of breach proceedings between probation and treatment providers. If this is the case, any unresolved differences in opinion should be taken to the respective line managers. However, in all cases, offender managers (OMs) have the overriding decision in matters regarding enforcement.

Protocols should be developed between probation and treatment agencies regarding the information required for breach purposes e.g. evidence of attendance. Further information about what should be included in these protocols is contained in *Information sharing protocols* within the *Delivery of interventions* section of this guidance.

Treatment staff are required to report all contacts with the offender or when the offender fails to report to the OM on the day/within 24 hours of the appointment. The OM will log on the case management system all failures to attend or other unacceptable failures to comply e.g. offenders who are not in a fit state to adhere to programmes due to being under the influence of alcohol and/or are disruptive as a result of being inebriated and, where appropriate, instigate breach proceedings in line with National Standards. The specialist alcohol liaison workers/case managers will be required to provide Section 9 witness statements and may on occasions have to attend court to give evidence if the breach is contested.

Treatment provider staff may be quite apprehensive around court appearances in breach cases. Areas/trusts may wish to consider developing a memorandum of understanding around ATRs setting out the roles and responsibilities of all agencies involved in delivering interventions. This could be supported by an

inter-agency training day where probation prosecutors attend and facilitate a role play around the type of questions a staff member would be asked. This approach is being rolled-out across London Probation Area for DRRs where it has been well received and reduced the anxiety of staff who may be summoned to court to testify to an offenders missed treatment appointment.

Only appointments detailed within the sentence plan are enforceable. Where services are not delivered under a contract/service level agreement (SLA) managed by probation and there are no protocols with the various treatment providers to provide evidence in breach cases, appointments do not count towards National Standards and are not enforceable. If an offender does not co-operate with these non-enforceable appointments but is otherwise compliant and therefore cannot be breached, the OM will need to take a view whether treatment needs can be met without the non-enforceable elements. If not, the order should be returned to court for the ATR to be revoked on the basis that it is unworkable.

Section 220 of the Criminal Justice Act 2003 (CJA 2003) prescribes that the duty of offenders to keep in touch with their OM as directed and notify the OM of any change of address 'is enforceable as if it were a requirement imposed by the order'.

The use of small voluntary sector organisations and the purchasing of sessional time can make monitoring and enforcing attendance extremely problematic where there is limited capacity within providers due to prolonged periods of staff sickness and/or turnover. This may have implications for the willingness and confidence of the courts to impose new requirements and render many existing requirements unenforceable for a period of time. Where orders cannot be properly monitored and no alternative arrangements can be put in place, the order may be considered unworkable and returned to court.

There may be instances where offenders on an ATR present at their first treatment appointment – often many weeks after being sentenced - reporting either not drinking or experiencing any problems with alcohol. An individual, offender or otherwise, cannot be compelled to engage in any form of alcohol or drug treatment. However, the pre-sentence report (PSR) should contain an outline sentence plan, including the type of treatment to be specified in the order based upon the outcome of the specialist assessment, and a signed statement from the offender that he/she is willing to comply with the ATR. Under the terms of the court order, the offender should attend for treatment as instructed in accordance with the treatment plan and breach action can be taken for unacceptable failure(s) to comply with that treatment.

If at any point in the order the OM believes the offender may no longer need treatment, he should ask the provider to undertake a further assessment of the offender's condition. Following this the OM and provider should sit down and discuss the offender's susceptibility to, suitability for and response to treatment

and agree whether the treatment agreed between them following assessment at the PSR stage continues to be appropriate. Should they be of the opinion that the offender does not require further treatment or needs different treatment or is not susceptible to treatment, the provider **should** make a report in writing to that effect to the OM, and the OM **should** apply to the court responsible for the order for variation or cancellation of the requirement under Schedule 8 Part 4 paragraph 18 (1) of CJA 2003.

Neither the OM nor the provider should act unilaterally. Where there is disagreement, if raising this through the line management chain doesn't have the desired effect in forging a consensus, the OM could make the relevant reservations known to the court if receipt of a report from the provider requires an application for the variation or cancellation of the requirement i.e. the OM does not concur with the views expressed in the provider's report for x or y reasons and has tried without success to resolve the differences but has made the application because of the obligation to do so under Para. 18(1). In these circumstances, the OM may be able to find an alternative provider willing to provide comparable treatment (if available) or subject to the outcome of the court proceedings have to accept that the requirement (not necessarily the order) is now unworkable.

Breach

Under CJA 2003, a court cannot take 'no action' on a breach or use a financial penalty as a means of dealing with a breach. It can only amend the community order so as to impose more 'onerous' requirements or revoke and re-sentence.

The Act does not stipulate or give any guidance on what 'onerous' means. In effect, it could be an extension to current requirement(s) or the imposition of an additional requirement(s), within the legislative restrictions on the operational periods allowed for each type of requirement and the overall length of the order.

If the court revokes the order it can impose a custodial sentence of up to 51 weeks even if the original offence was not punishable by imprisonment.

The removal of a fine or 'no action' as options for breach may have a significant impact on the ATR target group.

The proposed outcome of the breach should be based on an offender's compliance, response to and progress on an order and the point in the order where the breach occurs.

OMs should not generally recommend to the court that the ATR be revoked and the offender re-sentenced on the first or second breach, unless of course the offender indicates he/she will not comply with the order and there are significant risk issues or the order is clearly not working. This is consistent with Sentencing

Guidelines Council (SGC) advice that:-

'Custody should be the last resort, reserved for cases of **deliberate** and **repeated** breach where all reasonable efforts to ensure that the offender complies have failed'.

The SGC also advise that 'there may be cases where the court will need to consider re-sentencing to a differently constructed community sentence in order to secure compliance with the purposes of the original sentence, perhaps where there has already been partial compliance or where events since the sentence was imposed have shown that a different course of action is likely to be effective.'

OMs should deal with breaches where the order could be allowed to continue by proposing:-

- One of a residence, prohibited activity, curfew or exclusion requirement.
- Any other requirements, if relevant, or
- An extension in the length of one or more of the original requirements (if this is an ATR the offender should consent to any amendment).

The length of any proposed extension to a requirement should be commensurate with the seriousness of the breach e.g. a very short extension for a minor breach.

Any amendment to the requirements should not exceed the maximum length available for that particular requirement e.g. an ATR cannot be extended beyond 3 years (2 years for suspended sentence orders).

An ATR may be appropriate for breach of lower level interventions following escalation in drinking.

In some areas/trusts breach reports have been used to prove the breach as well as propose options for sentencing should the offender plead guilty or be found guilty. This may be supplemented by a short oral report. Areas/trusts are encouraged to adopt this practice which avoids further adjournment.

Self-reported proof of attendance at Alcoholics Anonymous

The chit system has been established in Alcoholics Anonymous (AA) as an approved mechanism for members to provide self-reported proof of attendance to an outside authority, such as the probation service. The offender asks for a chit from the chair of an AA meeting to give to his/her OM to show that (s)he has attended.

Not all AA inter-groups have been willing to adopt the chit system, however, because they view it as collusion with the probation service and, even where a mechanism for monitoring attendance exists, OMs are unable to obtain feedback regarding the offender's progress because this would run counter to the anonymity of engagement with AA.

Appointments at AA are not enforceable as part of a requirement of a court order because an AA member cannot inform on another member, so could not give evidence in court if the offender was breached, for example, for non-attendance. Where appropriate, however, OMs should refer offenders under statutory supervision to AA, to supplement other treatment delivered under the terms of a community sentence or post-sentence for ongoing care and support, which can be vital to achieving a successful outcome in the long term.

Court reviews

Unlike the DRR, court reviews are **not** applicable to the ATR as part of a community order but the court has discretion to decide that a suspended sentence order be subject to periodic review, including those with an ATR¹⁷¹.

¹⁷¹ Section 5.6 of the *National Implementation Guide* provides advice on Reviews of Orders.

Testing

Legal position

Unlike the drug rehabilitation requirement (DRR), the mandatory testing of offenders is not permissible as part of an alcohol treatment requirement (ATR) or any other requirement of a community order (CO) or suspended sentence order (SSO) through which alcohol related interventions are delivered. This is because consumption of alcohol is lawful in most circumstances for those over 18 years of age, whereas that is not the case with illegal drugs. There are likely to be human rights issues associated with imposing mandatory testing for any substance that an individual is legally entitled to consume (although these could possibly be mitigated if the individual gave his/her informed consent to be tested) particularly if the intention is to enforce abstinence.

There is also no provision in law for offenders to be tested at the pre-sentence stage and the results used as evidence that they are trying to abstain from alcohol or reduce their intake which could then be taken into account when sentence is passed.

Testing on a voluntary basis

Offenders may be tested on a voluntary basis as a means of gauging their progress in reducing their use of alcohol to low risk levels or moving towards total abstinence, whichever is the agreed treatment goal. Offender managers (OMs) need to be aware, however, that alcohol is metabolised comparatively quickly (at the rate of approximately 7g per hour) so it would be possible for an individual to consume a substantial amount and still test negative the following morning. Therefore, it would be difficult to accurately measure reductions in alcohol use or be certain that an individual isn't drinking unless testing was very frequent. This would be very costly, both in terms of time and resources, particularly if a number of tests required laboratory verification, and may render it impractical.

The direct measurement of pure alcohol (ethanol) levels can be achieved using a breathalyser¹⁷² (blood tests are too invasive and urine alcohol concentration is a crude measure although it may conveniently be tested for along with other drugs of misuse). NOMS does not have any specific guidelines in place regarding the use of breathalysers to test offenders in a probation setting. Testing is more of an issue for prisons to deter the supply and use of alcohol within prison establishments and detect illicit alcohol use. The Prison Service Alcohol testing manual of policy and procedures, *Alcohol Testing for Prisoners - Manual of Policy and Procedures*¹⁷³, which describes policy, procedures and good practice

172 Breath testing is an approach used by some clinicians providing alcohol detoxification, to assess levels of intoxication and subsequent withdrawal.

173 <http://www.hmprisonservice.gov.uk/resourcecentre/publicationsdocuments/index.asp?cat=88>

relating to alcohol testing and the equipment recommended for use by establishments, includes a preferred specification for the purchase of approved breath testing equipment and advice about chain of custody standards.

Alcohol Testing for Prisoners advises that ‘the limit above which there is considered to be incontrovertible evidence that some alcoholic drink has been consumed has been set at 9 micrograms of alcohol in 100 millilitres of breath – normally written as 9 µg% or 9µg/100ml.’

Testing offenders prior to programme sessions

Testing should stand the test of being reasonable and proportionate, in order to comply with administrative law and the Human Rights Act 1998. The testing of every offender for alcohol before each session of a programme meets neither of these criteria. Paragraph 3.3 on page 10 of *Alcohol Testing for Prisoners* is instructive when it states that:-

‘It is also important to ensure that any response to alcohol misuse is proportionate to the harm caused and the circumstances of the individual prisoner. Patterns of behaviour often provide firmer grounds to take robust action than one-off incidents. A fixed and inflexible response gives the impression of a ‘blanket’ approach not designed to match individual circumstances and should be avoided.’

The fact that before being accepted on to a programme every offender should sign a declaration at the pre-sentence report (PSR) stage agreeing to be tested could overcome the aforementioned human rights objections on the basis that informed consent had been given. However, this would depend on precisely how the declaration was worded and that the individual understood what he/she was signing. Even with signed consent, however, testing offenders without reasonable suspicion may constitute an infringement of their human rights under Article 8 of the European Convention (the right to freedom from interference with his/her physical integrity).

Testing all offenders for alcohol is also a waste of scarce resources, when testing positive for alcohol, even on several occasions, is not grounds, in itself, for breach. It will usually be apparent if an individual is unable to participate in sessions and/or is disruptive as a result of being inebriated without the need for a breath test e.g. violent or unpredictable behaviour; smell of alcohol on an offender’s breath; unsteady gait; elated behaviour beyond the point of self control.

Testing in approved premises

Testing for alcohol should be based on a clear link to alcohol-related offending and would normally only apply where alcohol consumption was prohibited and

where alcohol is a known disinhibiting factor in previous offending or there is a likelihood of disorder.

Paragraph 2.6 of PC 05/2006 - *Approved Premises: Drug Testing of Residents* advised that 'testing for alcohol.....should be on reasonable suspicion and where there is concern about possible outcomes (such as where alcohol is a known disinhibiting factor in previous offending or there is a likelihood of disorder in the hostel). Residents with a previous history of alcohol-related offending can be tested randomly.'

Paragraph 3.12 stipulated that hostel rules should have in place:

- A prohibition of alcohol, solvents and controlled drugs
- Provision to test residents for alcohol, on reasonable suspicion
- Provision to test randomly those residents who have a previous history of alcohol-related offending

The legal basis for testing for alcohol in approved premises is National Standards, the statutory basis for which is The Offender Management Act 2007 (Commencement No. 2 and Transitional Provision) Order 2008, and related guidance e.g. PC 05/2006. These specify that on arrival the rules and requirements of residence (which should include prohibition of alcohol use and provision for testing in prescribed circumstances) and the consequences of any failure to comply should be explained to the offender, who then signs a copy of the rules confirming that these have been explained and are accepted. This informed consent to abide by the rules provides the basis for any infringements to result in a caution, if not too serious, or withdrawal of a place, 'which is normally treated as a breach requiring immediate enforcement action.'

The need for signed consent was highlighted and reinforced in the *National Rules for Approved Premises* (see PC19/2007) which, along with prohibiting the use of alcohol and drugs on the premises, states that a resident should undergo drug and/or alcohol testing if required to do so by staff (Clarification of the need to enforce the Approved Premises (AP) rules in relation to substance misuse can be found in the *National Standards for the Management of Offenders 2007*).

The AP Performance Improvement Standard (2008) stated:

AP Standard 7 – Managing Illegal Drugs & Alcohol

AP has a policy and procedure for dealing with residents who are using illegal drugs and/or alcohol. All APs will have facilities for on-site drug and alcohol testing and supporting policies, procedures and protocols.

Evidence of how the criteria will be met

- 1 AP has drugs and alcohol policy and procedures
- 2 AP has a policy regarding the role of the unit in the provision of drug and alcohol treatment
- 3 Staff are aware of the AP procedures
- 4 The requirement for drug and alcohol testing is incorporated in AP documentation (such as National Rules) which is made available to offenders, prisons and key stakeholders
- 5 Management Committees will incorporate drug testing into their Annual Business Plan/report and all APs will have facilities and equipment for on site drug testing
- 6 Probation areas/Management Committees will require reports on testing and treatment from AP managers and partners
- 7 Staff will receive training and support in the administration of testing
- 8 Arrangements will be in place with partner agencies to facilitate entry into treatment
- 9 Staff are trained and receive briefings on working with misusers of alcohol and illegal drugs
- 10 AP will have in place a policy and supporting procedures for the disposal of any illegal drugs and alcohol found in AP
- 11 Appropriate action is taken if illegal drugs or alcohol are found on the premises or in a resident's possession, or a resident is under their influence

The legal basis for AP Rules is:

OFFENDER MANAGEMENT ACT 2007 (APPROVED PREMISES) REGULATIONS 2008 – General duties

7.—(1) Each local probation board and other body should—

(c) prepare **house rules** for the Approved Premises, governing the conduct of residents, which should comply with any requirements of the Secretary of State as to the content of such rules; and

(d) bring the **house rules** to the attention of every resident of the Approved Premises and take all appropriate measures to ensure that they are complied with by all such residents.

Also – National Standards for Offender Management:

2d.12	Approved Premises	Implementation Guidance 2007
General Provisions		
2d.12.1	APs maintain a set of house rules	<ul style="list-style-type: none"> · The prohibition on controlled drugs does not extend to prescribed drugs, provided that these are notified to the AP staff · The rules cover the elements prescribed by national guidance, and may be supplemented by additional rules to reflect local condition

When the guidance in PC 05/2006 was issued, we considered that the initiative would 'comply with the Human Rights Act because residents agree to abide by the hostel rules', which specified that testing would only take place on reasonable suspicion or randomly if the offender had a previous history of alcohol related offending. We know of no instances where an offender has challenged testing as an infringement of his/her human rights under Article 8 of the European Convention (the right to freedom from interference with his/her physical integrity) and would be very surprised if any succeeded, because of the consent aspect. We also believe that such a challenge could be countered by the APs' need to manage risk (of harm) to each resident, other residents, staff, visitors, contractors, the public, especially in the case of a resident (offender) whose criminal behaviour was linked to alcohol.

The equipment used to undertake testing in APs is similar to the breathalyser which the police use to test for alcohol by the roadside. That is good enough to permit arrest and the Department for Transport (DfT) is so confident in the efficacy of the technology that the Government plans to abolish the right of drivers who fail a breathalyser test to demand a blood test except for those who cannot complete the roadside breath test, such as those with breathing problems. As such, corroborative tests (requiring different equipment) would not need to be used in approved premises. If there was doubt about someone being intoxicated, the better course would be to avoid breach/recall unless absolutely necessary and give the offender a warning instead.

Alcohol testing is necessary in APs because alcohol is banned (without ways of checking for alcohol on-site we may as well not have the prohibition). Offenders don't have to be indulging in unacceptable behaviour for that to amount to a breach of the rules - the mere fact of having alcohol on-site is a breach in itself. Having said that, though, being under the influence is probably not enough for a breach, so long as there are no other problems and the alcohol was consumed off-site. In those circumstances, the focus should mainly be on the resulting behaviour, rather than on the core fact of intoxication although that might itself give indications as to risk. However, we can envisage situations where staff think that an offender is intoxicated *and* should have access to

alcohol on-site simply because they've not been anywhere else. Testing the resident might be a useful way to decide whether to conduct a search.

In summary, APs should have alcohol testing equipment available, but shouldn't necessarily use it very intensively. This represents a permissive rather than prescriptive approach, which gives the power to test residents where staff think it will be helpful to reinforce the rules and maintain order but recognising that there's a whole range of behaviour for which offenders are breached without test results of any kind.

The costs of testing equipment would have to be met by probation areas/trusts, as testing in this context would not fall within the alcohol provision commissioned through Primary Care Trusts or other local commissioning forums.

The 2009 Approved Premises Handbook¹⁷⁴ contains more information about testing.

¹⁷⁴ http://npsintranet.probation.gsi.gov.uk/approved_premises_policy

Improving continuity of care

The immediate post-release period is a time when alcohol-misusing offenders are particularly vulnerable and susceptible to re-offending and the risk of self harm. The quality and continuity of provision offered to recently released prisoners (including those on licence) is often inconsistent and there are particular risks for offenders returning to the community after a period of abstinence from alcohol use.

Whilst systems should be in place to 'fast track' drug using offenders to post-release treatment, and repeat offenders should routinely be picked up by Drug Intervention Programme (DIP) services, arrangements for alcohol misusing offenders are frequently 'ad-hoc'. Provision is generally dependent on the local availability of specialist community alcohol treatment services and the identification and awareness of an offender's needs. For short-term prisoners (less than 12 months), the lack of post-sentence supervision requires access to relevant alcohol treatment services at the point of release into the community to be negotiated through services within the prisons, where available.

The latest version (11/08/09) of the directory of accredited programmes/interventions that are currently being delivered across custody and the community is available on the probation intranet (EPIC)¹⁷⁵.

Other issues affecting the quality of continuity of care include:-

- High turnover in many prisons
- Lack of prison alcohol treatment services
- Lack of community services
- Lack of communication between prisons and probation and between health care staff and substance misuse workers
- Drug services are usually only funded to deliver services to alcohol misusers where there are also drugs needs
- CARATs (substance misuse) teams in prisons do not take on offenders with alcohol problems unless they also have a drug problem
- Lack of knowledge of what is available, both in custody and community
- Absence of consistent guidance for staff in prisons to enable prisoners with identified alcohol related problems to be referred to community based treatment services
- Dispersal policies which make reintegrating released prisoners with community based treatment services problematic

¹⁷⁵ http://npsintranet.probation.gsi.gov.uk/index/service_delivery/interventions/programmes.htm

This section of the guidance provides advice on more fully integrated and effective resettlement arrangements and access to treatment services for alcohol misusing offenders moving from prison to the community. This requires a particular focus on post-sentence and pre-release information transfer; point of release hand-over arrangements where resources allow; and the importance of prison-based assessments and reports being used to inform community-based risk assessments and management plans.

Evidence base

The *Review of the effectiveness of treatment for alcohol problems* found that 'planned and structured aftercare is effective in improving outcomes following the initial treatment episode among those with more severe alcohol problems.'

Models of care for alcohol misusers (MoCAM) emphasises care planning and co-ordination, putting the service user at the centre of a negotiated, clear care planning process which ensures continuity of care and a focus on outcomes. This is of particular relevance for offenders moving from custody into the community.

The role of the offender manager

The role of the offender manager (OM) with regard to sentence planning should be considered for the following:

1. offenders in scope (phase 2 and 3)
2. offenders serving prison sentences of 12 months or more
3. offenders subject to supervision on licence/notice of supervision for some young offenders

For offenders serving less than 12 months, local arrangements will apply e.g. Integrated Offender Management (IOM).

1. **Offenders in scope:** OMs are responsible for assessment and sentence planning including chairing sentence planning meetings. This would include identifying alcohol treatment needs and interventions that could be included in the Sentence Plan to meet those needs. This is of particular importance where alcohol use is linked to risk of serious harm and/or risk of re-offending e.g. violent offences, domestic abuse. For those cases in scope, the offender supervisor (OS) in the prison has a crucial role in ensuring the agreed sentence plan objectives are progressed whilst in custody. The OS also has a key part to play in supporting pre-release planning and, where appropriate, building links with treatment providers in prison, who should support liaison with local services towards the end of the custodial period.

2. **Sentences of 12 months or more:** OMs have a role in contributing to the assessment and sentence planning process. Priority will be given to cases where there are concerns of risk of serious harm and/or re-offending.
3. **Cases requiring statutory supervision:** OMs have a role in ensuring pre-release planning takes account of alcohol-related health needs and offending related needs.

OMs will be aware of those offenders who will continue to be supported through work with DIP, Prolific and other Priority Offenders (PPO) or IOM schemes and those offenders who will be managed through Multi-Agency Public Protection Arrangements (MAPPA). OMs should ensure they are aware of local community resources for the treatment of alcohol misuse and support links between CARATs and local providers, where appropriate.

Local Alcohol Strategies need to ensure the needs of offenders are understood and met through local provision.

OMs should be alert to any risks of self harm or risk to others, including increased levels and likelihood of risky behaviours at the point of release.

Preparation for release

Prison Service Order (PSO) 3050 details the processes to be followed by healthcare teams to secure continuity of healthcare for prisoners.

Pre-release planning arrangements will be determined by the nature of the offender e.g. PPO, MAPPA, in scope etc. Guidance is available elsewhere which should be followed regarding timescales and the need to involve other agencies, including treatment providers, where appropriate to the individual case.

As part of preparing the prisoner's release plan, the following aspects should be considered:

- risk management factors
- accommodation
- benefits/ finance
- education, training and employment
- treatment needs
- health issues
- other support needs specific to the prisoner

Where there are alcohol services available in the prison, they should contribute to the pre-release planning process and, where resources allow, liaise with services in the community and the OM if applicable.

There may be circumstances where a prisoner may be on medication relevant to alcohol needs and there would need to be arrangement in place for continuity of care between the prison health care and the community e.g. DIP or GP. This includes for offenders going to approved premises especially as these will be high risk of serious harm cases.

For some cases, it will be relevant to consider arrangements to meet the offender at the prison gate and it is expected that those prisoners judged to be at greater risk of re-offending and serious harm after release should be prioritised.

As local circumstances permit, areas/trusts may wish to consider establishing a protocol with suitable Third Sector providers e.g. AA to assist with the pick-up of prisoners from the prison gate. Commissioning such services should be considered as part of wider local partnership commissioning arrangements in line with the local partnership Alcohol Strategy and LAA priorities, including that to reduce reoffending.

Where other agencies form part of the release plan and there are changes prior to the prisoner's exit from prison, then this should be communicated to those involved. This is of particular importance where arrangements may have been made for the offender to be met on release and the date of release may have been changed.

For those prisoners who are clients of the CARATs service who have a release plan that changes prior to the prisoner's exit from prison, then the CARATs team should inform the OM in writing within 24 hours of the change occurring.

The release arrangements for all drug service clients leaving an adult prison are set out in the NOMS 2009 prisons continuity of care guidance¹⁷⁶.

Where offenders with identified alcohol misuse needs are due to be released from custody and will be subject to statutory supervision on licence (sentenced to 12 months and over) or notice of supervision for relevant young offenders, their offender managers (OMs) should:-

- liaise with any treatment providers within the prison and, if there is a continuing treatment need and subject to the offender's agreement, refer the offender to appropriate provision on release to achieve consistency of treatment
- ensure there is an appropriate licence condition which requires those offenders to address their problems with alcohol where proportionate and relevant to risk. The licence period should build on any treatment that offenders have received in custody. This licence condition cannot be used

¹⁷⁶ http://www.nta.nhs.uk/areas/criminal_justice/idts_key_documents.aspx

to compel offenders to submit to drug or alcohol treatment as a condition of their licence. This would run counter to the general principle that an individual should give their prior consent to engage in medical treatment, which is necessary before a court can make an alcohol treatment requirement (ATR) or drug rehabilitation requirement (DRR) of a community order or suspended sentence of imprisonment. However, an offender may be made subject to a licence condition requiring him or her to address a drug or alcohol problem. This condition may, for instance, require the offender to attend a substance misuse accredited programme. Annex A of PC 29/2007 specifies the wording to be used from a list of possible additional licence conditions:-

'To comply with any requirements specified by your supervising officer for the purpose of ensuring that you address your alcohol/drug/sexual/gambling/solvent abuse/anger/debt/prolific/offending behaviour problems at the [NAME OF COURSE/CENTRE].'

- ensure work with offenders with alcohol needs includes: brief information, advice and support (frequently delivered by the OM); access to treatment in line with MoCAM; and/or participation in a substance misuse accredited programme (Addressing Substance Related Offending (ASRO) or the Offender Substance Abuse Programme (OSAP)) or the Lower Intensity Alcohol Programme (LIAP), as appropriate.

Other options for meeting the needs of alcohol-misusing offenders released from prison include a referral to self help groups in the community such as Alcoholics Anonymous (AA); support delivered where resident in approved premises; or through multi-agency shared care arrangements. The network of One Stop Shops for women offenders, which provide packages of support for women being released from prison, will often visit prior to release and provide through the gate contact.

Offenders with identified and ongoing alcohol misuse needs who will **not** be subject to statutory supervision on licence upon release from custody (those sentenced to less than 12 months) should be referred to an appropriate community alcohol treatment service subject to availability. Responsibility for this will fall either to staff/organisations operating in the prison or, where relevant, Integrated Offender Management arrangements. It is particularly important to ensure that there is effective follow-up provision for prisoners who undergo detoxification while in prison.

Information transfer

Successful implementation of effective sentence planning and resettlement provision, particularly as offenders move between community and prison, is dependent on seamless case management with the right people sharing the right information at the right time so that treatment and support can be targeted and delivered effectively.

Where an OASys is available, this will pass automatically to the prison on sentence¹⁷⁷. The OASys should include relevant information regarding previous access to treatment services. If there is other information of relevance e.g. self harm risk, the OM should ensure this is communicated in writing at the earliest opportunity.

Whilst under supervision on licence

Offenders released on licence should be screened at first contact using the Alcohol Use Disorders Identification Test (AUDIT) or similarly validated tool unless an equivalent assessment has been undertaken in custody just prior to release.

AUDIT asks for information about current use or use in last year so this won't be applicable for offenders who have been in prison for 12 months or more. Where alcohol screening would be helpful on release to inform sentence planning (either the offender wasn't screened at all while in prison because the use of AUDIT is optional or there is no reliable recent screening data) AUDIT should be used but the questions about current use and use in last year adapted to ask the offender to reflect the position in the four months before he/she entered custody. The limited availability of interventions specifically to address alcohol misuse across the prisons estate (AA excepted) means that, in many cases, the fundamental nature of the offender's drinking problem could well be unchanged since before admission along with the type of intervention(s) needed to address it.

Offenders with ongoing alcohol treatment needs should be actively encouraged to continue treatment voluntarily at the end of the licence period.

Where do mutual aid groups e.g. AA fit in?

AA runs groups in about half of prisons and NOMS is encouraging more prisons to become involved. The work starts at induction, with a rapid referral to AA, and continues through to release and beyond so that offenders are linked to an AA sponsor to help with resettlement where needed. This can include collection from the prison gates where appropriate.

The section of this guidance on delivery of treatment provides more information about AA's role as an adjunct to formal treatment and the Thames Valley Model as the preferred mechanism for offenders under probation supervision to be referred into AA.

¹⁷⁷ Some adult short-term prisoners will have had an initial OASys prepared by the National Probation Service, prior to writing a pre-sentence report.

Post-release provision

Areas/trusts should look into the feasibility of post release relapse prevention programmes (more material on relapse prevention is in the section of this guidance on delivery of treatment). Ways to help prevent relapse and stabilise recovery include medications, professional psychosocial support, and/or the encouragement of self-help group attendance.

Areas/trusts should seek to audit existing provision and referral practice and agree an action plan based on audit findings. There should be a locality approach to commissioning resources to meet local needs and to accessing and providing services as part of a continuum of care.

Post community sentence

Offender managers should provide offenders with advice on the further treatment and support available to them once their sentence has ended. This should include information about local alcohol services or local advice centres or attending self-help groups such as AA. Offenders with ongoing alcohol treatment needs should be actively encouraged to continue treatment voluntarily at the end of an alcohol treatment requirement (ATR).

Women

In response to Corston, the Government committed that 'revised guidance on the use of the Drug Rehabilitation Requirement and Alcohol Treatment Requirement will stress that Offender Managers should take account of domestic arrangements, childcare and other issues in sentencing planning.'

In August 2008, the *NOMS Alcohol Information Pack for Offenders under Probation Supervision* was revised to make it even more appropriate to the needs of women offenders e.g. information about specialist women only services, as indicated in the *Offender Management Guide to Working with Women Offenders* published in May.

For women in prison, visiting arrangements should be child-friendly with regular special child-centred visits and services should work in partnership to provide suitable housing and other support on release, so women can be re-united with their children where this is in the child's interest.

Some women who have children will be re-establishing contact and care responsibilities, others will have lost and want to re-establish contact. This process needs to be managed and be supported by good multi-agency cooperation and coordination. This will be particularly complex for women with an alcohol problem and needs careful planned management

Prison Service Order 4800, which aims to ensure that women are held in conditions and within regimes that meet their gender specific needs and which facilitate their successful resettlement, includes gender specific guidance on addressing drugs and alcohol.

Young Adult Offenders

There is a marked differential in services provided between the young person's regime and the services available for offenders aged 18 or over whose misuse is solely around alcohol. Continuity can be problematic as Youth Offending Teams (YOTs) and Young People's Substance Misuse Services no longer have responsibility for the young person once they have moved into adult services, leaving the offender to access the services provided to the wider adult offender population. Whilst CARATs services are available, the danger is a break in specialist care for Young Adult Offenders (YAOs) who are sole alcohol misusers, where treatment is started in the young people's estate and then transferred to the adult correctional services.

Young offenders will have a notice of supervision upon release from custody but there are challenges because of the sometimes short period (3 months) of supervision and therefore the need to ensure continuity of care and support for access to services where appropriate to ongoing needs.

Partnerships should map local provision with a focus on YAOs to identify blockages and improvements that can be made, particularly to linkages and information sharing between criminal justice agencies. Information regarding the needs of YAOs should be shared with PCTs/local authority partners as part of probation's contribution to Joint Strategic Needs Assessments (JSNAs) (see the commissioning section of this guidance) so as to highlight gaps for commissioners and providers.

Addressing wider resettlement needs

Offenders often have complex, interconnected needs, including unemployment, a lack of qualifications, unstable accommodation, substance misuse, psychological and health problems, which require careful and skilled assessment. Sentence plans in both custody and the community should take account of these needs so that progress made in custody or while on a community sentence will be maintained.

OMs have a crucial role in signposting and facilitating access to services and sequencing interventions in order to achieve best outcomes.

Getting offenders into **accommodation** is the foundation for successful offender management and can be critical to helping offenders to stay off drugs and alcohol. Offenders' accommodation needs need to be taken fully into account

during the development of local strategies. These need to ensure that local partnerships are being developed between prisons and probation, housing authorities and other housing providers, which recognise the priority that should be given to those offenders. Some areas/trusts have housing advice workers in place who assist offenders in making applications for housing and district managers also sit on the Supporting People commissioning bodies, where accommodation related support for substance misusing offenders is high on the agenda.

Guidance on securing accommodation for drug users in the criminal justice services can be found in, *Improving Practice in Housing for Drug Users*¹⁷⁸.

Ensuring offenders have **work** is also fundamental. Areas/trusts should make contact with employers – across the public, private and third sectors - to make links on vocational training, and with Job Centre Plus and other agencies offering ETE services. In some areas/trusts, there is an ETE worker based in the probation office, who works with offenders to get them into employment once they are felt to be job ready.

Maintaining **family ties** is also associated with reduced re-offending¹⁷⁹. The work that Adfam have done in prisons has already helped many families of drug misusing prisoners through their issues so that they can in turn have a more practical and positive influence on their rehabilitation. Local Authorities can help cross government work by recognising that most offenders' families are socially excluded and by ensuring they have equality of access to services, such as children's centres and schools.

Ministry of Justice and Department for Children, Schools and Families recently issued a framework for improving the local delivery of support for the families of offenders, *Reducing re-offending: supporting families, creating better futures*¹⁸⁰.

178 <http://drugs.homeoffice.gov.uk/publication-search/dip/improving-practice-housing/>

179 *Factor linked to re-offending: a one year follow-up of prisoners who took part in the Resettlement Surveys 2001, 2003, 2004*, Research Summary 5 2008

180 <http://www.justice.gov.uk/publications/reducing-reoffending-supporting-families.htm>

Drug Interventions Programme (DIP)

The programme extends across England and Wales via a network of local Criminal Justice Integrated Teams (CJITs). The principal purpose of DIP is the reduction of drug-related crime via engagement through custody, court, sentencing and beyond into resettlement of problematic drug using offenders in drug treatment and facilitation of access to ongoing support from wraparound services.

DIP will be relevant for those who use alcohol as part of poly-drug misuse but problem drinking among offenders with no problematic drug use, some of whom may also have significant mental health problems, are not the responsibility of the DIP scheme. However, lessons learned from DIP are starting to bring about some improvements in using the case management approach which is also relevant to working with offenders who have alcohol misusing problems.

Areas/trusts may find informative:-

- *PC36/2007 - Managing Drug Misusers under Probation Supervision: Guidance for Probation, CJITs and CARAT Teams*; and
- *Drug Misusing Offenders: Ensuring the continuity-of-care between prison and community*¹⁸¹, which provides specific guidance on managing the continuity-of-care journey that drug misusing offenders follow on entering prison from the community, whilst in prison, and exiting prison.

The future

As part of the Alcohol Best Practice Projects Initiative, NOMS funded Leicestershire & Rutland Probation Trust (LRPT) to commission an action research project to improve end to end practice with and the transitional experience of offenders with alcohol problems as they move between prison and the community and the different screening, referral and treatment systems they encounter on route. A final report providing empirical and indicative evidence of need and the extent to which current services, and their degree of connectedness, align with the key requirements of best practice will be available on EPIC later in 2009-10.

The development of a service model that identifies best practice care pathways and associated referral and case management procedures should make a significant contribution to the planning and commissioning of services and the implementation of effective end-to-end practice under the Offender Management Model (OMM). The study should also evidence whether or not the absence of probation supervision for released short-term prisoners has particular implications for continuity of service provision and what, if any,

181 <http://drugs.homeoffice.gov.uk/drug-interventions-programme/guidance/continuity-of-care/>

substitute arrangements might be put in place to alleviate the problem and associated issues. Therefore, the findings will have potential national application.

The Director of Offender Management for the South East, Roger Hill, has commissioned a flagship alcohol project which aims:

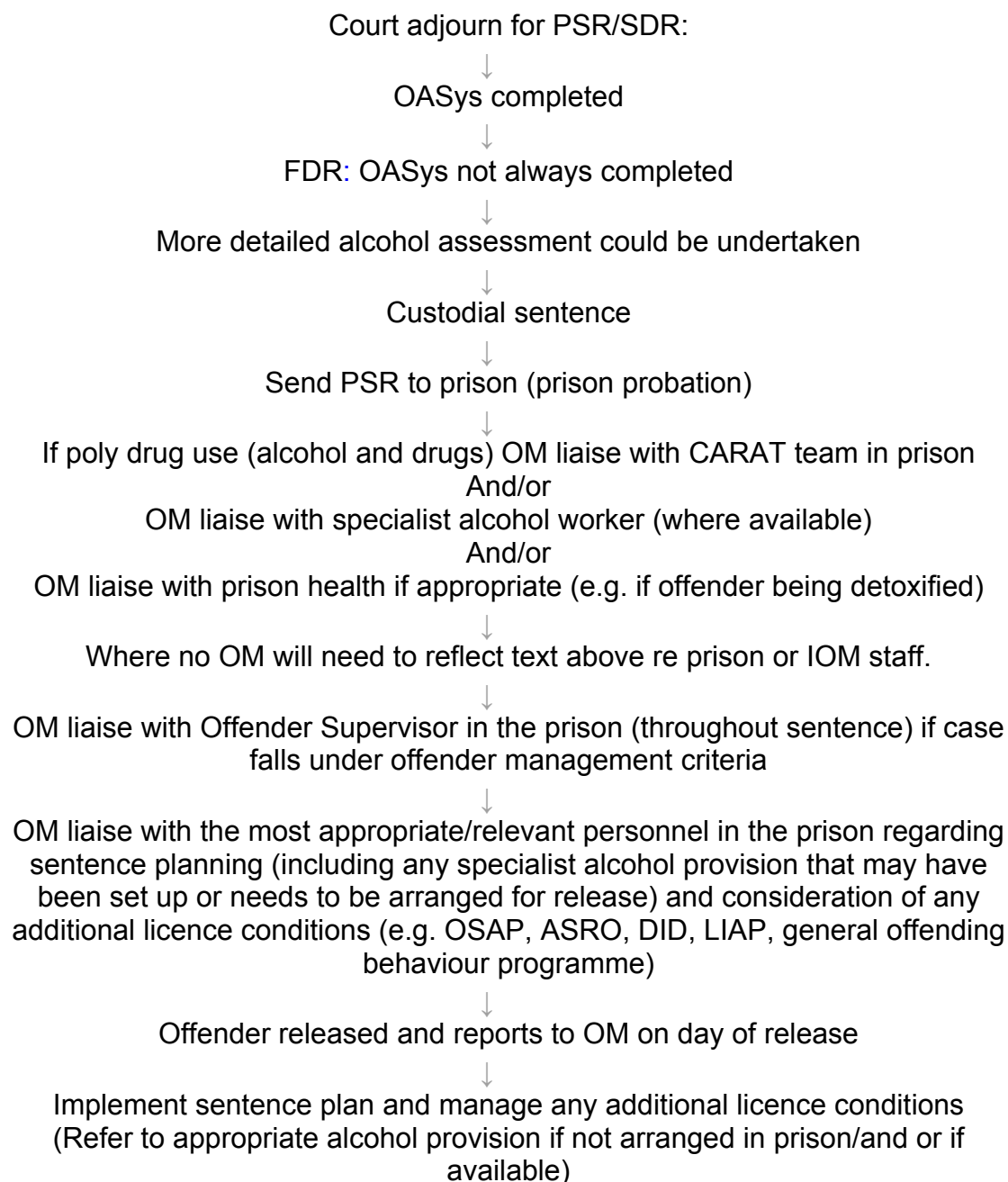
- To improve access to good quality, cost effective alcohol services in custody and the community
- To identify how community and custodial services can be better joined up or aligned.

To support the next stage of this project, NOMS has funded Hampshire Probation Area, on behalf of South East Region, to examine:

- What arrangements exist for planning across release from custody for short, medium and longer term prisoners
- How ongoing care is actually delivered for drugs and alcohol
- How far the arrangements actually meet the needs of offenders
- Outcomes for offenders (comparison for the areas where good arrangements exist and where they don't)
- What are the impediments to good pick up (provision etc.)?
- How do alcohol and drugs differ?

The Patel review was commissioned by Government in response to the Pricewaterhouse Coopers review of prison drug treatment funding. Although its scope is confined to prisons, a key element of long-lived conditions such as problematic substance use and mental illness involves continuity of care both into and out from prison custody. Like DIP, the prisons drug treatment and key-working system is largely closed to problem drinkers (services for 15-17 year-olds being an exception). The Patel review will consider dual diagnosis and the way in which problem drinking (as part of a poly-substance pattern) should be treated in prisons.

Alcohol Pathway for offenders receiving custodial sentences and subject to statutory supervision upon release



Where no OM responsibility for referring the offender to an appropriate community alcohol treatment service, subject to availability, will fall either to staff/organisations operating in the prison or, where relevant, Integrated Offender Management arrangements.

Working in partnership

Effective local partnerships at strategic and operational level are critical to addressing variability in the range and accessibility of alcohol services across the country and ensuring that appropriate and effective services are delivered to those who need them, when they need them.

In some parts of the country, health partners are now much more persuaded of the benefits of working together to achieve joint strategic aims in improving health outcomes, targeting best use of finite resources and reducing re-offending, as well as harm to communities. Elsewhere there are still tensions between health and criminal justice around outcomes and expectations; concerns about offenders getting preferential treatment and court-mandated treatment cutting across the concept of freewill; and issues regarding confidentiality and information sharing.

The section of the guidance on *Commissioning alcohol interventions and treatment* provides advice on improving working relationships at the strategic level, particularly with Primary Care Trusts (PCTs)/Local Health Boards (LHBs), Crime and Disorder Reduction Partnerships (CDRPs)/Community Safety Partnerships (CSPs) and Local Authorities. This includes the benefits of contributing to Joint Strategic Needs Assessments (JSNAs) and their usefulness in informing LAA priorities and action plans in England. Also, the role of probation within local Alcohol Strategies, as a mechanism to connect cross-cutting agendas and priorities. Therefore, this section will focus on better partnership working at an operational level.

Multi-agency working has to ensure that the offender gets the best possible service by striving towards seamless working and that services are complementary to each other. This is particularly important as alcohol is also often linked to a number of other problems, which may be a result of drinking or have been a trigger for it, that may need to be treated by a relevant specialist service.

The essential elements of effective partnership working are:

- A sense of ownership from both organisations at a strategic and operational level
- Clarity around the model of delivery
- Co-location of services
- A close working alliance between the offender manager and treatment provider

More specifically, this means:-

- Shared goals but clear boundaries and monitoring of outcomes

Probation areas/trusts and treatment providers should seek to develop a shared understanding of outcomes but respective roles and responsibilities for

specific activities within the partnership arrangements should be clearly defined with lines of accountability.

There should be an agreed performance framework against which to measure progress and evaluation and monitoring of outcomes should be built into Service Level Agreements (SLAs) and contract reviews.

- Information sharing protocols

Where not already in place, protocols should be developed for information sharing setting out precisely what information needs to be shared and the arrangements needed for sharing and performance reporting. It is important that practical issues around data management and the compatibility of IT systems are overcome. This should include consideration being given to some alcohol treatment staff having direct access to probation case management systems (on a 'need to know' basis), which the Institute for Criminal Policy Research (ICPR) found was a regular feature of working arrangements between probation areas and providers in Wales.

- Agreed referral processes

Areas/trusts and providers should ensure that there are clear and agreed integrated care pathways and joint working protocols/arrangements in place based upon identified best practice. Meetings should be held with services on a quarterly basis where these protocols can be discussed and, if necessary, amended.

- Provider staff based in probation offices

Probation and treatment providers should establish arrangements for specialist alcohol staff from partner agencies to provide services on probation premises. Such arrangements are thought to increase the accessibility of services, reduce rates of attrition and enhance levels of inter-agency working and communication.

Together with the routine use of feedback forms, the co-location and integration of specialist alcohol workers within probation offices helps ensure that there is direct and regular communication between offender managers and partnership staff. It also allows specialist workers to advise probation staff and provide expert assessments and deliver extended brief interventions, where needed. Co-location also increases engagement with the offender, as the offender doesn't have to come back at another time or go elsewhere for a meeting. Specialist workers can also refer and broker access to other local treatment organisations for treatment.

The lessons and experiences from Drug Treatment and Testing Orders (DTTOs)/Drug Rehabilitation Requirements (DRRs) highlight the potential benefits of co-located, multi-agency teams.

- Clear lead agency on each case

There should be a clear delineation of operational roles and responsibilities for managing offenders who misuse alcohol. The agreed responsibilities for alcohol treatment requirements should be:-

<u>Activity:</u>	<u>Lead Responsibility:</u>
Offender supervision (overall management)	Probation
Offending behaviour programmes	Probation
Offender treatment delivery	Provider(s)
Treatment (health) commissioning Board/Substance Misuse Action Team (SMAT) in Wales	PCT or Area Planning
Treatment delivery and integrity	Provider
Performance management (Area Planning Board/SMAT in Wales)	DAAT or Primary Care Trust

In addition, each probation area/trust should have an alcohol policy lead responsible for establishing contact and maintaining links with local alcohol services and self-help groups. This person should visit local services to better understand the types of services available and also act as the main contact point for services. In England the probation area/trust alcohol policy lead should work closely with Regional Alcohol Managers, who are based in Regional Government Offices.

- Joint training/skills sharing

There should be more cross-fertilisation of knowledge and skills between probation and provider staff through the greater use of joint training, skills sharing, job shadowing etc. This should ensure that more probation staff are competent to accurately identify an alcohol problem and provide a swift and appropriate response e.g. deliver brief advice or extended interventions; know how to refer an offender for structured treatment; and that provider staff have a greater understanding of the criminal justice process, the role and responsibilities of probation and the requirements pertaining to it (e.g. National Standards reporting).

- Regular case conferences/inter-agency meetings

Where an offender is receiving structured alcohol treatment, there should be a minimum of 3 three-way meetings between the offender manager, alcohol treatment worker and offender at the start, middle and end of an order as a means of establishing the aims and objectives of the sentence and monitoring progress towards achieving goals. Joint meetings between the provider, offender manager and offender should be more regular (every month/six

weeks) for medium to high seriousness cases, those with complex needs, offenders who are non-compliant or when there has been any significant change, especially where risk of serious harm has increased.

- Feedback from providers and service users

Feedback from providers is essential to the effective management and enforcement of the order and to confirm that services are appropriate and relevant to individual need, of the required standard (as set out in the service specification and the SLA) and achieving desired outcomes.

Service users, carers and families (as appropriate) where they add protective elements to supporting the offender, should be consulted and actively involved at all stages of service development, from planning to service delivery and evaluation. Findings from the user survey conducted by Suffolk, Hertfordshire & Norfolk Probation Areas to provide direct offender feedback on the value and benefits of the alcohol interventions delivered there and support a best value review of alcohol interventions across the sub-region due later in 2009-10 may be informative.

- Arrangements for end of order

It is important to notify the agencies involved in the treatment of the offender of the termination of NOMS' involvement if drug, alcohol or mental health treatment is to continue beyond the period of the sentence so that responsibilities and duties remain clear and can be strengthened to support the re-integration of the offender post-sentence.

Please refer to the *Delivery of interventions* section of the guidance for more about the information that should be shared between Offender Managers and contracted treatment providers and the limits of sharing treatment information.

Training and development

Offender Managers (OMs) are very good at identifying alcohol issues, however lack of training at all levels can cause difficulties with workers feeling unskilled in what is sometimes seen as a specialist role. The Institute for Criminal Policy Research (ICPR) research concluded that 'there is considerable scope for improving the scale and quality of training being offered to OMs to better equip them to more effectively deliver brief interventions to alcohol misusing offenders'.

Basic training for all staff working with alcohol misusing offenders should allow them to:-

- develop motivational skills (motivational interviewing)
- put in place techniques for working with offenders with different needs
- develop an understanding of the nature of addiction
- understand procedures for assessment and referral of offenders into treatment

This could be achieved through specific alcohol awareness training run in-house; shadowing a provider or going on job secondment; having specialist workers providing the training; or on a multi-agency basis as part of strategic workforce planning.

A programme of training could be incorporated into existing arrangements; for example, Essex Probation Area has renegotiated contracts with its alcohol treatment requirement (ATR) providers to ensure they are actively involved in training probation staff in the delivery of brief interventions. This is likely to be particularly important where there may be delays in accessing alcohol treatment or accredited programmes.

Staff training, DANOS competences and qualifications

Staff who are working with alcohol misusing offenders should be competent in line with the Drugs and Alcohol National Occupational Standards (DANOS) or working towards competency. DANOS has been developed for those working with drug and alcohol users and sets out the range of knowledge and skills to which staff in the drugs and alcohol field should be working.

Adherence to DANOS will ensure:

- Development of appropriate job descriptions and person specifications
- Recruitment of staff with the necessary knowledge, skills and experience
- Appropriate induction and training

All staff who during the course of their core duties are likely to need to deliver Tier 1 interventions as described in *Models of care for alcohol misusers*

(MoCAM) should have or be working towards the associated DANOS competences¹⁸². As a minimum, staff need to be able to:-

- Identify a problem with alcohol misuse
- Offer basic advice on low risk drinking levels
- Challenge offenders about the impact that drinking has on aspects of their lives
- Use an alcohol screening tool e.g. AUDIT
- Know how to refer an individual with a problem for more detailed assessment

Areas/trusts should be increasing their capacity to deliver extended brief interventions (Tier 2 of MoCAM) in-house, although the number and grade of staff who need to be competent to this level is a matter for areas/trusts to decide based upon an assessment of offender need and any other arrangements that they may have in place with other agencies to deliver Tier 2 work etc.

Wherever possible, training should be linked to DANOS. As part of NOMS Alcohol Best Practice Projects initiative, Avon & Somerset Probation Area (ASPA) developed 1 (for Tier 1 interventions), 3 (for those delivering Tier 2 interventions) and 5 day (this was considered too long and has since been conflated into the original 3 day package) bespoke training packages linked to DANOS competences to enable probation staff to gain the basic knowledge, understanding and skills necessary to undertake initial screening, provide simple and extended brief interventions to those who need them and refer offenders for specialist assessment, where appropriate. Powerpoint slides, student and trainer manuals from the ASPA project are available on EPIC for other areas/trusts to download and use¹⁸³.

For professional development and quality assurance purposes, staff could be asked to demonstrate that they have the necessary DANOS competences by working towards achieving a recognised qualification or award. This would be based upon an assessment by a registered assessor of a portfolio of evidence put together by the participants; require a commitment of 3-4 hours per month for 12 months and would need to be built in to each staff member's Learning and Development plan.

NOMS gave further funding to ASPA in 07-08 to provide the opportunity for a number of staff who attended the Tier 2 training to gain an NVQ in Working with Substance Misuse (award and certificates), as recommended by Skills for Health. Qualifications in Working with Substance Misuse are on the Qualifications and Credit Framework and therefore nationally recognised and prove competence against National Occupational Standards (NOS) relevant to Substance Misuse workers including DANOS, Youth Justice, Health and

182 The new qualification framework is updating the PSO units (work by consortia on DANOS/PSO units).

183 http://npsintranet.probation.gsi.gov.uk/index/service_delivery/interventions/drugs__alcohol/alcohol_best_practice_projects.htm

Social Care and Community Justice. The achievement of qualifications which have been derived from DANOS and other NOS relevant to substance misuse workers is supported by NOMS and therefore this 'pilot' project will provide experience from both the assessors and the students about how this approach could be implemented more widely across probation.

It is important to note that, whilst DANOS will relate to many aspects of the role undertaken by those working with substance misusing offenders, staff should also be competent in line with Criminal Justice Occupational awards or equivalent (CQSW, DipSW).

More generally, NOMS is planning to commission a piece of work to develop the skills of probation managers in their negotiations with PCTs and Joint Commissioning Groups. The first stage will need to be a review of the current level of staff competence.

Alcohol Learning Centre

Whilst Identification and Brief Advice (IBA) is not esoteric or complex, research has showed that practitioners are often reluctant to discuss alcohol with individuals because they are not clear how to broach the subject.

Partner organisations across criminal justice, health and social care are being encouraged to make strides in implementing 'High Impact Changes' to impact on the rate of alcohol related harms. This includes:

'Developing Identification and Brief Advice (IBA) in criminal justice by persuading the Crime Reduction Partnerships of the importance of IBA to delivering crime reduction and savings across the public sector'

The Department of Health has developed an on-line resource, the Alcohol Learning Centre (ALC)¹⁸⁴ to support organisations taking action to reduce alcohol related harms. The ALC is a one-stop-shop which collates, co-ordinates and disseminates learning and promising practice from across the NHS and the Third Sector. It contains alcohol specific policy documents, guidance and tools and provides training resources to support frontline practitioners in delivering IBA.

The Alcohol Learning Centre (ALC) is part of the Alcohol Improvement Programme. It is the repository of policy and promising practice identified through:

- Screening and Intervention Programme for Sensible Drinking (SIPS)¹⁸⁵
- Hub of Commissioned Alcohol Projects and Policies (HubCAPP) – a database of local implementation strategies and initiatives¹⁸⁶

184 <http://www.alcohollearningcentre.org.uk>

185 <http://www.alcohollearningcentre.org.uk/Topics/Browse/BriefAdvice/SIPS/>

186 <http://www.alcohollearningcentre.org.uk/Topics/Browse/LocalInitiatives/>

- the e-learning module to train health and social care professionals to deliver Identification and Brief Advice (IBA)¹⁸⁷ (This module will be modified later in 09/10 for Offender Managers).

An Offender Health section has recently been added to the website¹⁸⁸.

The Alcohol Education and Research Council (AERC) Alcohol Academy

The AERC Alcohol Academy¹⁸⁹ is a new Community Interest Company (CIC, or 'social enterprise'¹⁹⁰) that has been set up, and is hosted, by Ranzetta Consulting¹⁹¹, with a grant from the Alcohol Education and Research Council (AERC).

The aim of the Academy is to promote excellence in local alcohol harm reduction by training and supporting local alcohol coordinators and strategic leads for alcohol. The intention is to provide a very targeted service to the people – the local alcohol coordinators – who have to translate policy and guidance into effective action on the ground.

There may also be a role for the Academy in training ACOs how to influence local strategic partnerships and commissioners so that offenders' needs are better met (alcohol coordinators have to be good at influencing other people's agendas so this is an area of expertise the Academy could offer).

Under the NOMS Alcohol Best Practice Projects Initiative, the Academy is also working with London Probation Area to deliver training to Offender Managers (OMs) to familiarise them with the *NOMS Alcohol Information Pack* and this Guidance; and develop OMs' skills in working with and engaging offenders who misuse alcohol (a joint project with West Midlands Probation Area).

187 <http://www.alcohollearningcentre.org.uk/eLearning/>

188 <http://www.alcohollearningcentre.org.uk/Topics/Browse/OffenderHealth/>

189 www.alcoholacademy.net

190 Social enterprises are businesses with primarily social objectives whose surpluses are principally reinvested for that purpose in the business or in the community it serves.

191 Ranzetta Consulting specialise in local alcohol strategy development, and have delivered consultancy and research since 2001.

Performance management

Why do we collect data?

Areas/trusts need performance data to:-

- review and assess the effectiveness of existing provision e.g. impact of interventions on engagement, retention and completion
- measure performance against agreed targets and other indicators and minimum requirements prescribed in service specifications and in contracts/service level agreements (SLAs) with providers or commissioners e.g. meets National Standards and is delivered to the quality standards outlined in *Models of care for alcohol misusers (MoCAM)*
- inform future decisions about the commissioning and delivery of services, including supporting the assessment of the impact on equality.

Areas/trusts should also use data to identify any potential problems and devise appropriate remedial action. Amongst other things, activity data on alcohol interventions can be used to:

- improve the targeting of interventions
- monitor waiting times
- explore the reasons behind differential programme completion rates e.g. the composition of groups
- inform the work of various steering groups

Data should also be routinely monitored in an effort to ensure that no group suffers under-representation or poor outcomes due to services not being appropriate.

Advice about the data that is needed to accurately assess offender need; demonstrate how probation supports the delivery of Public Service Agreement (PSA) targets and local area agreement (LAA) indicators; and how this might be presented to commissioners to influence their decisions is contained in the *Commissioning alcohol interventions and treatment* section of this guidance. This section focuses primarily on the data needed to assess and manage performance, with detail on the minimum requirements for effectively managing individual cases e.g. information sharing protocols set out in the *Delivery of interventions* section.

Need for improvement

The Institute for Criminal Policy Research (ICPR) found that most areas collected 'routine monitoring data relating to the interventions they deliver to alcohol misusing offenders (e.g. on offender demographics, programme throughputs, completion rates)' but there were details of Alcohol Use

Disorders Identification Test (AUDIT) scores in only just under half of the alcohol treatment requirement (ATR) case files they examined.

Whilst recognising the operational burden of additional data collection, it is important that alcohol screening and assessment information (e.g. results from AUDIT) is routinely recorded, collated and is readily accessible alongside data from the Offender Assessment System (OASys). Detailed information on the precise nature and extent of alcohol related interventions and treatment being delivered should also be recorded in a systematic way in case files/management systems.

It is important that partners measure and record indicators of effectiveness in a consistent way. Probation areas/trusts and treatment providers should have an agreed performance framework - outputs and outcomes – specified in SLAs and contracts against which to measure progress and monitoring of outcomes should be built into SLA and contract reviews.

What should be collected?

NOMS Performance Metrics and implications for Target/Measure in SLA

From April 2008 an ATR completion target was introduced into the NOMS performance metrics to drive up commencements and completions nationally - *the number of ATR completions to be at least X.*

From 09/10 the main ATR metric is now the completion rate with a supporting volume completions diagnostic measure.

The target-setting guidance allowed local flexibility for this indicator i.e. NOMS did not specify a minimum number of completions per area or region but within nationally agreed parameters:-

- Completion rate – Minimum of 40% in each area
- Volume – Minimum 100% increase on aggregated 08/9 target (1876).

The locally negotiated target was included in SLAs/contracts between the Directors of Offender Management (DOMs) and areas/trusts.

Performance monitoring is a significant issue for the DOMs. ATR completions data represents the minimum requirement. Some DOMs may have chosen to prioritise alcohol interventions as part of their SLAs/contracts with areas/trusts. As a result, areas/trusts may have agreed additional alcohol related targets/measures with their DOMs and the resulting data requirements will depend upon precisely how these are worded in SLAs.

How a completion is measured

ATR completions are measured from the Form 20 terminations data submitted by probation areas/trusts on a monthly basis.

A successful completion of an ATR is one which is recorded in the Form 20 return as having terminated for either of the following two reasons:

- 50 - Expired (normal)
- 51 - Completed (early good progress)

The completion rate is calculated by dividing the number of successful terminations (as defined above) in a given period by the total number of successful and unsuccessful terminations in the same period and expressing as a percentage i.e.

$$a / (a + b) \times 100$$

where

- a = total number of successful terminations; and
- b = total number of unsuccessful terminations

Unsuccessful terminations are those which are terminated for the following reasons:

- 52 - Expired (breach listed)
- 53 - Revoked (further offence)
- 55 - Revoke (failure to comply)
- 57 - Incomplete (requirement not started)

ATRs terminated under the following reasons are excluded from the calculation as 'neutral' (i.e. neither successful nor unsuccessful):

- 54 - Revoked (on application to Court)
- 56 - Revoked (failure to comply on another requirement/condition)
- 58 - Terminated (death)
- 59 - Terminated (other reasons)
- 61 - Not known - not NPS supervised

Other useful data

We have continually stressed that performance measures should not exclusively be ATR focussed. For example, where practicable, areas/trusts should monitor the number of supervision and/or activity requirements where alcohol brief interventions are delivered and the number of alcohol misusers on Addressing Substance Related Offending (ASRO) or the Offender Substance Abuse Programme (OSAP).

Areas/trusts should also have arrangements in place to monitor:-

- The accuracy and speed with which alcohol and offending related needs are identified during contact with probation and referral to and delivery of appropriate interventions.

- The effective delivery of sentence plans in order to maximise the outcomes of interventions and treatment.
- Reductions in alcohol-related problems during the course of supervision e.g. from initial assessment at PSR stage to follow up assessments to inform sentence planning using alcohol screening tool (AUDIT) and section 9 OASys data sentence plan review/outcome data.

National Alcohol Treatment Monitoring System (NATMS)

In 2008, the DH commissioned the National Treatment Agency (NTA) to expand the existing National Drug Treatment Monitoring System (NDTMS) to include the collection of alcohol treatment information¹⁹². Up to this time, there was no routine national collection of the numbers entering into alcohol treatment. The National Alcohol Treatment Monitoring System (NATMS) is now collecting information on the number of patients receiving specialist alcohol treatment. NATMS identifies referrals received from criminal justice sectors, including community sentencing.

Alcohol information has only begun to be collected since 1 April 2008, which means that there are likely to be some reservations about data quality and reliability because of teething problems and imperfect coverage (NDTMS does not cover Wales). The alcohol data is being reported on nationally for DH and for local commissioners, however the reporting is based on PCT of residence and it probably won't be possible to cross correlate with probation data. However, in future, there is likely to be considerable scope for anonymously linking various administrative data including OASys, different case management systems (e.g. IAPS), NDTMS and Treatment Outcome Profile (TOP) data currently collated by the National Treatment Agency on engagement, retention and outcomes for alcohol treatment (in England) and criminal history data stored on the Police National Computer.

Identification and assessment

The performance of Offender Management teams in enabling offenders to access interventions associated with alcohol related need should be subject to regular scrutiny through OASys profiling. Offender Management teams should be allocated annual targets for accessing alcohol interventions (including group work provision) based on historical need profiles.

To support profiling, additional monitoring systems in association with AUDIT or another validated alcohol screening tool should be utilised by Offender Management teams, to inform understanding about effectiveness in accessing relevant provision. This will lead to a greater understanding of the patterns of use and associated need within the offender group and scrutiny of individual offender management practice in accessing offenders to appropriate provisions/interventions associated with an alcohol need.

¹⁹² http://www.nta.nhs.uk/areas/ndtms/monitoring_specialist_alcohol_treatment.aspx

Specialist alcohol staff should be required to provide monthly reports detailing the:-

- Number of individuals referred for ATR assessment each month.
- Number of individuals assessed for an ATR each month.
- Number of individuals who enter into treatment through an ATR each month

A summary report will be required at the end of each quarter.

The NATMS could record the number assessed for an ATR and the number who enter into treatment as a result of an ATR.

Delivery of sentence plans

The Sentence Plan Outcomes Shadow Measure uses data from OASys to focus on the requirement for sentence plans to 'deliver against needs' by addressing the needs which are most likely to reduce re-offending.

- Initial sentence plans – The number/percentage of offenders with a criminogenic alcohol need identified by OASys at start of sentence where this was reflected in their sentence plan and with a relevant intervention planned to address the need.
- Sentence Plan outcomes - The number/percentage of corresponding interventions recorded within the final eight review sentence plans, as well as the final recorded status of the intervention e.g. ongoing, fully achieved, and any changes in the OASys section score over the course of the sentence

Regional plans have used OASys data to develop a gap analysis demonstrating where alcohol was an identified criminogenic need, the need was identified in the sentence plan and where there was a recorded intervention in the sentence plan.

Reductions in alcohol related problems

Areas/trusts should also seek to evidence the impact of interventions on offender health and behaviour change (taking account of gender, age, ethnicity and disability) by:-

- high rate of compliance and retention
- satisfactory completion of the intervention and any associated community order/suspended sentence order/licence requirement(s) (from criminal justice and treatment agency records)
- changes in the level of alcohol use and/or related harm to health (measured by AUDIT/OASys Sentence Plan review/outcome data)
- Treatment Outcome Profile (TOP) data currently collated by the National Treatment Agency on engagement, retention and outcomes for alcohol treatment (in England)

- improvements in offender health and social wellbeing e.g. family life, accommodation, employment status, etc.
- changes to alcohol related risk of violent re-offending (measured by OASys data)

Evaluations/review systems should be geared to assess the effectiveness of interventions delivered and to provide feedback to both service users and offender managers. User self assessment and feedback should form an integral part of this system, along with established systems associated with participation in accredited programmes. In cases where all or part of an intervention is delivered by an external agency, evaluation should form part of the agreed delivery requirements on the partner.

Areas/trusts may wish to devise a standardised feedback form for the final session to include feedback from the offender and recalculation of OASys¹⁹³/AUDIT scores. Areas/trusts should record AUDIT scores and weekly alcohol unit consumption pre and post intervention and treatment worker feedback and Offender Manager (OM) feedback.

Data should be collated from case management systems to measure concordance between the number of proposals made in pre-sentence reports (PSRs) for an ATR and ATRs made by the courts. It is important to keep a close eye on the concordance rate to see if the ATR and alternative requirements within which alcohol related interventions can be delivered are being used 'appropriately' by the court/in accordance with the Sentencing Guidelines Council (SGC) guidelines. Areas/trusts will need to address any issues via their court liaison arrangements.

¹⁹³ *National Standards for the Management of Offenders 2007* requires that 'the assessment and plan is reviewed and revised immediately if new information arises which may significantly affect the validity of the existing assessment and/or plan'. OASys completion at the conclusion of a requirement is thus dependant upon it significantly affecting the validity of the sentence plan.

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PC 19/2007 *Implementation of National Rules for Approved Premises*

PC 25/2007 *Case Transfers – Community Orders, Suspended Sentence Orders and Licences*

PC 29/2007 *Post Release Enforcement - Licence Conditions*

PC 36/2007 - *Managing Drug Misusers under Probation Supervision: Guidance for Probation, CJITs and CARAT Teams*

PC 08/2008 *National Rules for Tiering Cases and Associated Guidance*

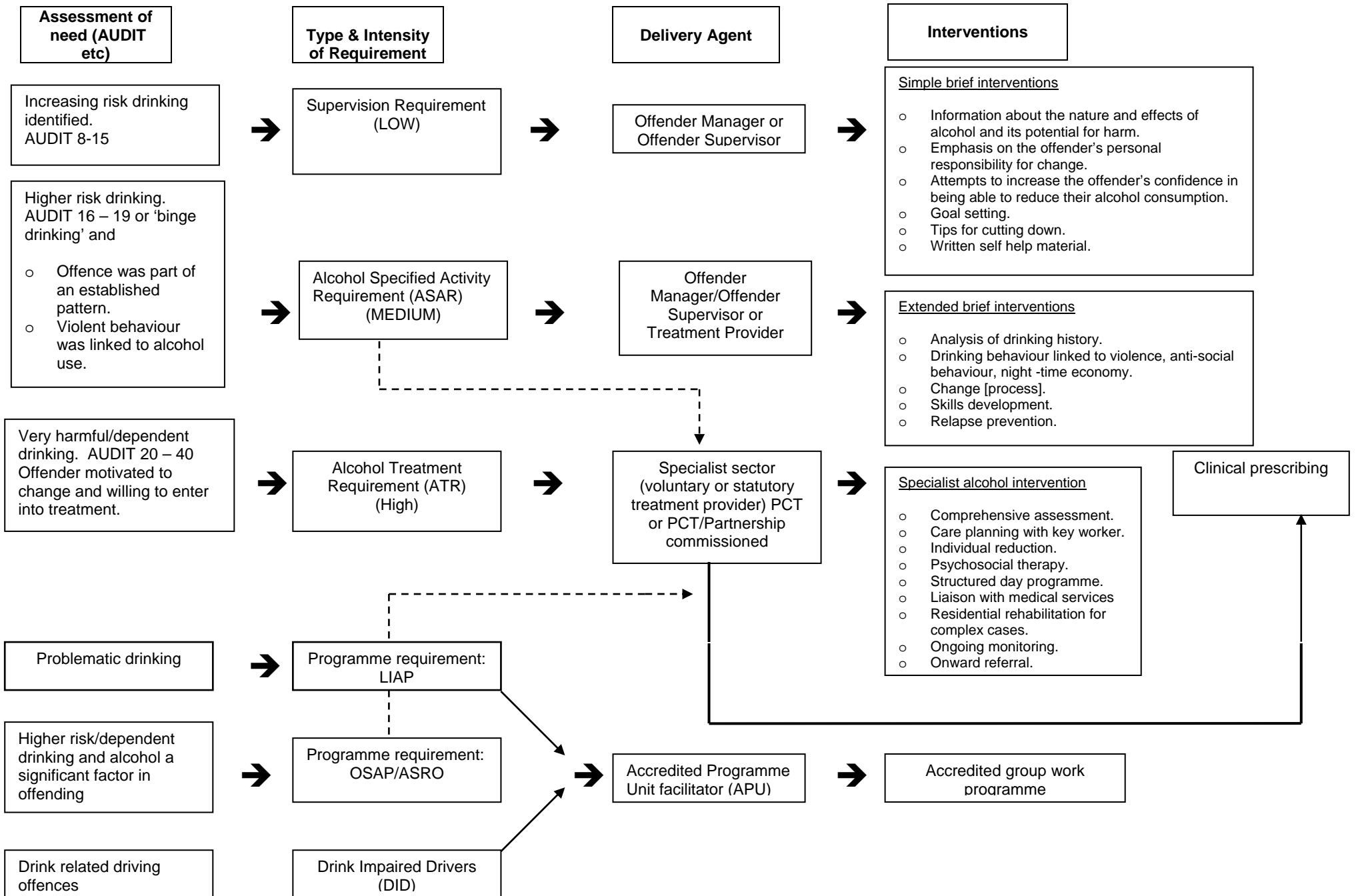
PC 06/2009 *Determining Pre-Sentence Report Type*

Prison Service Orders (PSOs)

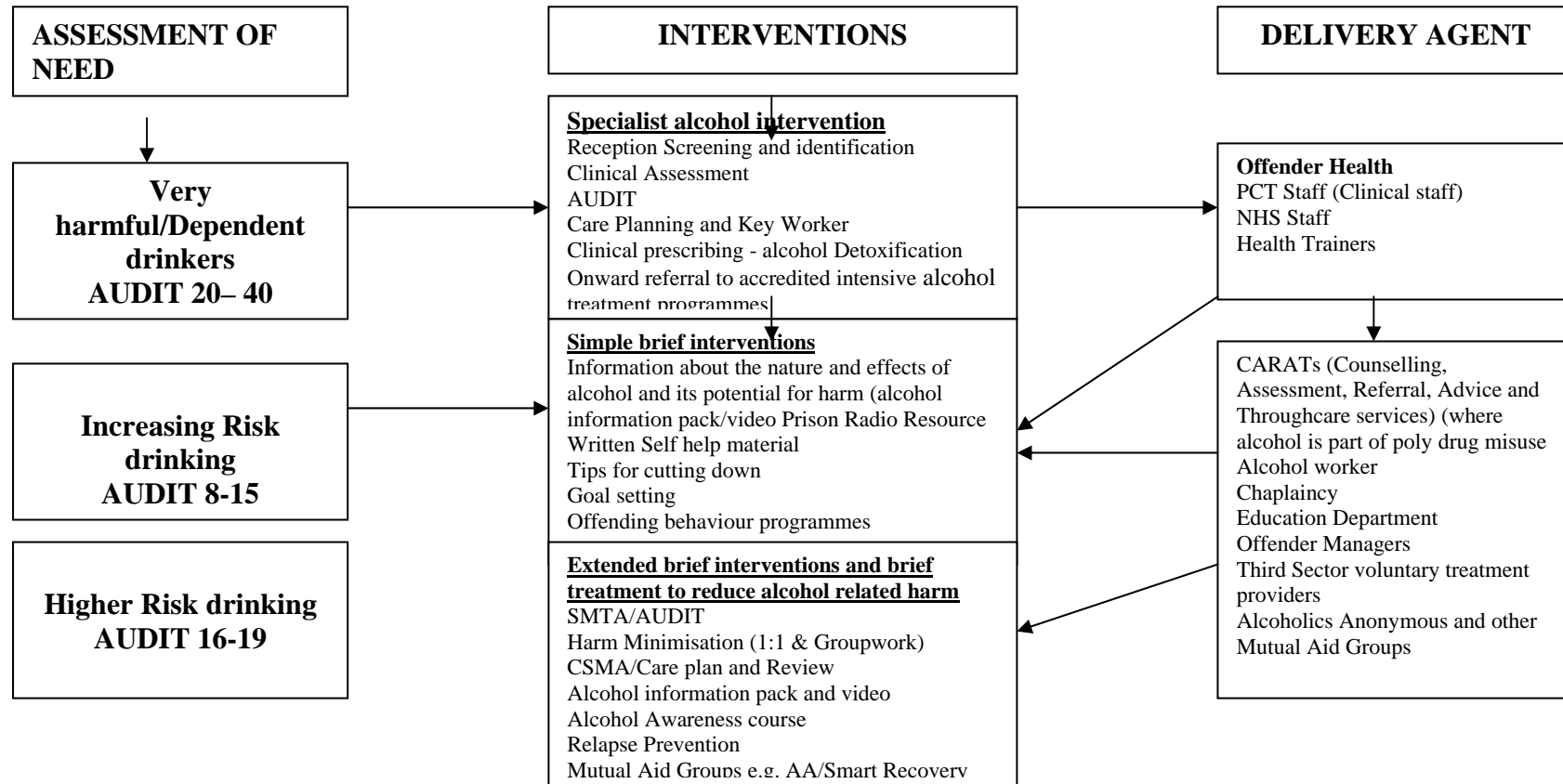
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Issue No. 254

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ALCOHOL INTERVENTION PATHWAY: COMMUNITY



Annex B - ALCOHOL INTERVENTIONS PATHWAYS: CUSTODY



**Annex C: NOMS Alcohol Best Practice Projects
2006-08**

<u>Probation Area/Trust</u>	<u>Project Summary</u>	<u>Deliverables</u>	<u>Contact</u>
Avon & Somerset	<p>To develop a training package, guidance and promotional materials to enable staff to undertake initial screening, provide advice and intervention and refer for full assessment, where appropriate.</p> <p>To pilot the 3 day training course and provide the opportunity for a number of staff who attended the Tier 2 training to gain Qualifications in Working with Substance Misuse.</p>	<p>3 training packages comprised of Powerpoint slides, student & trainer manuals for:</p> <ul style="list-style-type: none"> - 1 day Tier One course; - 3 day Tier 2 course; and - 5 day Tier 2 course. <p><i>Alcohol Reduction</i> offender leaflet available in hard copy form.</p>	<p>Frank Meadows, Partnership Development Manager</p> <p>Tel: 01278 727101</p> <p>Mobile: 07711 128590</p> <p>frank.meadows@avon-somerset.probation.gsi.gov.uk</p>
Gloucestershire	<p>To develop a practice manual and training package for staff to deliver a 3 session brief intervention (BI) based upon that used in the United Kingdom Alcohol Treatment Trial (UKATT).</p> <p>To commission an independent evaluation of the brief intervention.</p>	<p><i>Brief, Motivational Enhancement Intervention for Alcohol Misusing Offenders</i> Report.</p> <p><i>Training Manual for Motivational Enhancement Therapy</i> (adapted from the UKATT MET Manual).</p> <p>Evaluation report.</p>	<p>Garry Holden, ACO External Development</p> <p>Tel: 01452 389212</p> <p>Mobile: 07909 686470</p> <p>garry.holden@gloucestershire.probation.gsi.gov.uk</p>
Greater Manchester	<p>To lay the foundations for an ATR pilot in Salford through the appointment of an alcohol worker providing continuity with the local arrest referral scheme and specialist alcohol training to the offender management unit.</p>	<p><i>Implementing Alcohol Bail Conditions and Alcohol Treatment Requirements (ATRs) in Salford</i></p> <p>Progress Report.</p> <p><i>Salford Alcohol Treatment Bail Condition</i> process guidelines; process map and offender bail condition booklet.</p>	<p>Michael Ventris, Senior Probation Officer</p> <p>Tel: 0161 736 6441</p> <p>michael.ventris@manchester.probation.gsi.gov.uk</p>

	To commission an independent evaluation of alcohol bail conditions and ATRs in Salford.	Evaluation report.	
North East Region	To plan, hold and evaluate a regional one day conference, engaging voluntary and community sector providers, to develop shared agendas for improving provision and a shared understanding of desired outcomes.	<i>North East Region Conference Summary</i> , including results from automated response data and presentations from the conference.	Carina Carey, Director of Offender Management Tel.: 0191 383 9083 Carina.Carey@durham.probation.gsi.gov.uk
Northants	To run a pilot with Aquarius to implement an alcohol screening tool to be used by staff where OASys has identified an alcohol need and for the Alcohol Liaison Worker to deliver a programme of one to one and group interventions. To develop leaflets, presentations and deliver structured training events with the aim of developing an alcohol specified activity requirement.	<i>Probation Aquarius Alcohol Project Evaluation</i> report. Practice Guidance for Probation Staff.	Andy Pemberton Tel: 01604 658000 Andy.Pemberton@northamptonshire.probation.gsi.gov.uk
Thames Valley	To produce training material and a practice manual to facilitate the roll-out of the Thames Valley Probation/AA Liaison Model.	<i>Thames Valley Link Scheme Manual</i> . Training materials for 1.5 days OM course.	Gabriel Amahwe Assistant Director/ACO Tel: 0118 9560466 Mobile: 07717 200585 gabriel.amahwe@thames-valley.probation.gsi.gov.uk
North Wales	To produce a comprehensive targeting matrix for alcohol provision and programmes. To conduct a profile analysis of offenders who received secondary screening for alcohol	Summary of findings. <i>North Wales Probation Area Alcohol Matrix</i> . <i>AUDIT Report October 2005 – September 2007</i> . Research report.	Wulf Livingston Area Manager Interventions Tel: 01492 524029/530600 Mobile: 07748 300984 Wulf.Livingston@north-wales.probation.gsi.gov.uk

<u>Probation Area/Trust</u>	<u>Project Summary</u>	<u>Deliverables</u>	<u>Contact</u>
Avon & Somerset	To pilot and evaluate an Alcohol Counselling project using an intervention based on tiers one and two of MoCAM over the telephone in 2 sites (Mendip and Minehead).	<p>An off-the-shelf independently evaluated programme of six 45 minute sessions of alcohol-specific interventions for delivery over the telephone.</p> <p>A report at the termination of the project which evaluates the delivery process; and the effectiveness and cost effectiveness of the 2 models for telephone counselling (with initial assessment by phone or in person) compared with face to face counselling in reducing alcohol related harm and re-offending.</p>	<p>Frank Meadows, Partnership Development Manager</p> <p>Tel: 01278 727101</p> <p>Mobile: 07711 128590</p> <p>frank.meadows@avon-somerset.probation.gsi.gov.uk</p>
Cheshire	To commission an independent research organisation to evaluate the impact of Cheshire Probation Area's Alcohol Strategy in reducing alcohol related harm and re-offending rates in offenders who have received Alcohol Extended Interventions and the Alcohol Treatment Requirement	<p>Interim report at the half way stage of the project (July 2009).</p> <p>Full research report at project end (December 2009).</p>	<p>Peter Jones, Substance Misuse Manager</p> <p>Tel: 01244 394500</p> <p>Mobile: 07871 658880</p> <p>peter.jones@cheshire.probation.gsi.gov.uk</p>
Devon & Cornwall	To implement a developmental ATR model in Plymouth and Cornwall, involving the delivery of preparation for detox. and post-detox. motivational supportive counselling by Offender Managers and Supervisors	An ATR model in which health staff train, mentor and support Offender Managers and Supervisors to develop the necessary DANOS competences to deliver MoCAM compliant pre and post-detox services for offenders on ATRs	<p>John Tucker External Contracts & Procurement Manager</p> <p>Tel: 01752 827579</p> <p>Mobile: 07921 934143</p> <p>john.tucker@devon-cornwall.probation.gsi.gov.uk</p>

Gloucestershire	To develop and pilot the Community Reinforcement Approach [CRA] for use within Alcohol Treatment Requirements (ATRs).	A manual for delivery of 5-8 session CRA intervention for ATRs. Process chart for ATRs. Project report, including learning points from pilot.	Garry Holden, ACO External Development Tel: 01452 389212 Mobile: 07909 686470 garry.holden@gloucestershire.probation.gsi.gov.uk
Leicestershire & Rutland	Research project to improve end to end practice with and transition of offenders between prison and the community and between different screening, referral and treatment systems they encounter on route.	Research report providing empirical and indicative evidence of need and the extent to which current services, and their degree of connectedness, align with the key requirements of best practice.	Malcolm Jones (MJ) / Trevor Worsfold (TW) Tel: 0116 2423272 (MJ) & 0116 2423202 (TW) Mobile: 07718 905907 (MJ) malcolm.jones@leicestershire.probation.gsi.gov.uk
North Yorkshire	Analysis of reasons for the attrition of women offenders subject to ATRs and development of ways to make the ATR more responsive to their complex needs.	Report with recommendations regarding additional support for women. Revised treatment package more appropriate to women's needs which reflects recommendations of report Evaluation of attrition post-implementation of package.	Joanne Atkin Tel: 01904 698920 Mobile: 07717 630791 joanne.atkin@north-yorkshire.probation.gsi.gov.uk
Suffolk, Hertfordshire & Norfolk	To conduct a user survey across the three probation areas to provide direct offender feedback on the value and benefits of the alcohol interventions delivered there to support a best value review of alcohol interventions across the sub-region.	User survey questionnaire designed and delivered by an independent contractor following a procurement exercise. Final project report incorporating findings from the user survey and focus group and an action plan developed by a 'quality circle' of key local partners for the improvement and greater consistency of the delivery of alcohol interventions.	Julia Sharp Assistant Chief Officer, Suffolk Probation Area Tel: 01473 480130 Julia.Sharp@suffolk.probation.gsi.gov.uk

Surrey	To develop, in conjunction with the Rehabilitation for Addicted Prisoners Trust (RAPt), a Correctional Services Accreditation Panel (CSAP) accredited programme aimed at meeting the needs of alcohol dependent offenders.	Programme, Theory, Training and Assessment Manuals that gain CSAP accreditation for delivery in a probation setting.	Steve Niechcial, Area Manager (Interventions) Tel: 01483 860191 Mobile:077687 23863 Steve.Niechcial@surrey.probaton.qsi.gov.uk
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2009-10

<u>Probation Area/Trust</u>	<u>Project Summary</u>	<u>Key deliverables</u>	<u>Contact</u>
Gloucestershire	To design and evaluate a specific service for women subject to alcohol treatment requirements (ATRs).	An ATR service design for women, informed by needs analysis and consultation with relevant partners i.e. commissioners, women's groups and women offenders. Evaluation report of delivery of women's specific service to include proposals to improve practice.	Garry Holden, ACO External Development Tel: 01452 389212 Mobile: 07909 686470 garry.holden@gloucestershire.probation.gsi.gov.uk
Hampshire on behalf of South East Region	To improve continuity of alcohol treatment provision for offenders passing through prison establishments in the Region and being released into the community.	Final report with recommendations for developing 'through the gate' treatment pathway(s).	Barrie Crook, Chief Officer Tel: 01962 842203 Mobile: 07771 506444 barrie.crook@hampshire.probation.gsi.gov.uk
Leicestershire & Rutland	To commission a research study to evaluate the effectiveness of ATRs.	Report with findings and recommendations in suitable format for planning and commissioning services.	Malcolm Jones (MJ)/ Trevor Worsfold (TW)/ Carrie Peters (CP) Tel: 0116 2423 272 (MJ), 0116 2423 202 (TW) & 0116 2423 204 (CP) Mobile: 07718 905 907 (MJ) malcolm.jones@leicestershire.probation.gsi.gov.uk
London (1)	To deliver training to Offender Managers (OMs) to familiarise them with the NOMS Alcohol Information Pack and the new NOMS Alcohol Interventions Guidance; and develop OMs' skills in working with and engaging offenders who misuse alcohol	Training package, including train-the trainers materials. Final evaluation report.	Robin Latimer, Drug and Alcohol Development Manager Tel: 020 7740 8518 Mobile: 07717 766319 robin.latimer@london.probation.gsi.gov.uk

London (2)	To explore whether alcohol interventions delivered at the pre-programme stage, to support programme delivery and post programme have any impact on engagement and completion rates for the Integrated Domestic Abuse Programme (IDAP) and on reduced re-offending.	Preliminary and final evaluation reports.	Carl Ferguson Senior Probation Officer Brent/Barnet/Enfield Business Support Unit Tel: 020 8366 6376 Mobile: 07921 937900 carl.ferguson@london.probation.gsi.gov.uk
North Wales	To roll-out across Wales and evaluate the North Wales Targeting Matrix – Alcohol Provision and Programmes.	Training programme. Evaluation report on processes and findings.	Stephen Ray Assistant Chief Officer Tel: 01492 513413 Mobile: 07799 697501 stephen.ray@north-wales.probation.gsi.gov.uk
South Wales	To provide offenders subject to Intensive Supervision and Control (ISAC) community orders with alcohol activity requirements (AARs) with access to a Chartered Forensic Psychologist clinic and peer mentoring.	A model of delivery and research report.	Christine Ace Assistant Chief Officer (ACO) – Interventions Tel: 01656 674790 Mobile: 07810 854286 christine.ace@south-wales.probation.gsi.gov.uk
West Midlands	To improve the skills of front line practitioners to deliver brief interventions to alcohol misusing offenders to Drugs & Alcohol National Occupational Standards (DANOS) through training linked to use of the NOMS Alcohol Information Pack.	Training materials including podcast version.	Neil Appleby ACO Interventions Tel: 0121 248 2680 neil.appleby@west-midlands.probation.gsi.gov.uk

<p>West Yorkshire</p>	<p>To ensure that problem drinking among young adult offenders (18 to 25), women offenders and black and minority ethnic (BME) offenders who are to be released on licence to Approved Premises is appropriately highlighted in sentence planning and that resources are properly coordinated 'through the gate' to ensure a seamless service based upon identified need.</p>	<p>Offender leaflets and guidance, designed in consultation with service users and partner organisations, for the day of release.</p> <p>Training materials designed for and delivered to Approved Premises staff.</p> <p>Report of evaluation of project.</p>	<p>Diana Johnson, Assistant Chief Officer</p> <p>Tel: 01924 885300</p> <p>Mobile: 07921 934114</p> <p>diana.johnson@west-yorkshire.probation.gsi.gov.uk</p>
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