Screening and assessment

There is significant evidence that early detection and intervention is effective in reducing alcohol-related harm[1]. *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 drinker[2]) 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 threshold[3]. 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

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

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

3 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 alcohol …..14% 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 Organisation[4] 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);

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4 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'[5]. 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') offences[6]. 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

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

6 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 OASys[7]. 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 Centre[8] 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

7 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.

8 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)[9], 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*[10]. 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.

9 http://www.sips.iop.kcl.ac.uk/

10http://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 EPIC[11] 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.

11http://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'[12]. 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

12 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.[13]

13http://npsintranet.probation.gsi.gov.uk/index/service_delivery/offender_management/video_conference_technology_-_directory_for_courts__prisons_and_probation_areas.htm