

## 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 delivered<sup>1</sup>. 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 employment, thinking skills and accommodation), are likely to be most successful<sup>2</sup>.

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

2 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.

## **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 levels<sup>3</sup>.

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 women reducing their drinking levels from hazardous and harmful to low risk each year when delivered by competent, trained staff<sup>4</sup>.

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'<sup>5</sup>.

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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.

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

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

5 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.

## **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*<sup>6</sup> or the *How much is too much?*<sup>7</sup> pack. These should include a 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*<sup>8</sup> 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

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

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

8 [http://npsintranet.probation.gsi.gov.uk/index/service\\_delivery/interventions/drugs\\_\\_alcohol/alcohol\\_information\\_pack.htm](http://npsintranet.probation.gsi.gov.uk/index/service_delivery/interventions/drugs__alcohol/alcohol_information_pack.htm)

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)*<sup>9</sup>:-

- 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 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 EPIC<sup>10</sup>.

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

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<sup>9</sup> The new qualification framework is updating the PSO units (work by consortia on DANOS/PSO units).

<sup>10</sup>[http://npsintranet.probaton.gsi.gov.uk/index/service\\_delivery/interventions/drugs\\_\\_alcohol/alcohol\\_best\\_practice\\_projects.htm](http://npsintranet.probaton.gsi.gov.uk/index/service_delivery/interventions/drugs__alcohol/alcohol_best_practice_projects.htm)

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 use<sup>11</sup>. 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**.

#### ***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 USA<sup>12</sup> 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<sup>13 14</sup>.

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

12 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.

13 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.

14 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.

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 drinking<sup>15</sup>. 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.
- 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

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15 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.

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 EPIC<sup>16</sup>:-

- 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 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.

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<sup>16</sup>[http://npsintranet.probation.gsi.gov.uk/index/service\\_delivery/interventions/drugs\\_\\_alcohol/alcohol\\_best\\_practice\\_projects.htm](http://npsintranet.probation.gsi.gov.uk/index/service_delivery/interventions/drugs__alcohol/alcohol_best_practice_projects.htm)

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 competences<sup>17</sup>:-

- 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 EPIC<sup>18</sup>.

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*

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<sup>17</sup> The new qualification framework is updating the PSO units (work by consortia on DANOS/PSO units).

<sup>18</sup>[http://npsintranet.probaton.gsi.gov.uk/index/service\\_delivery/interventions/drugs\\_\\_alcohol/alcohol\\_best\\_practice\\_projects.htm](http://npsintranet.probaton.gsi.gov.uk/index/service_delivery/interventions/drugs__alcohol/alcohol_best_practice_projects.htm)

(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.
- 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 optimal<sup>19</sup>.

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.

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<sup>19</sup> Rush, B. (1990) *A systems approach to estimating the required capacity of alcohol treatment services*. British Journal of Addiction, 85: 49–59.

- 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.

Independent research suggests that many areas/trusts have developed ATR provision consisting mainly or exclusively based around the delivery of Tier 2 extended brief interventions<sup>20</sup>. 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 West<sup>21</sup>) 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.

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20 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.

21 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.

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. 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 Match<sup>22</sup> 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<sup>23</sup>.'

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 fortnight. Home detoxifications are generally regarded as suitable when the patient can ensure there is someone else at home with them. Often it involves

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

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

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 intervention<sup>24</sup>.

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 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

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<sup>24</sup> Shakeshaft, A. P. et al. (2002) *Community-based alcohol counselling: a randomized clinical trial*. *Addiction* 2002, 97, p. 1449-1463

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 about<sup>25</sup>:

- 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
- 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.

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<sup>25</sup> See *Whose responsibility* section on page 21 for information about disclosure and NHS Code of Conduct.

## 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 Standards<sup>26</sup> 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.

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 well .....as a means of establishing the

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<sup>26</sup> 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.

aims and objectives of the requirement and monitoring progress towards achieving goals.<sup>27</sup>

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.

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.

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27 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 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-C<sup>28</sup>, 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

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<sup>28</sup> 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)

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*.