Addressing diversity and complexity of need

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

A significant proportion of alcohol misusing offenders have multiple needs e.g. mental health problems[1]. It is difficult for practitioners, particularly non-alcohol specialist staff, to accurately identify and assess multiple needs and to co-ordinate treatment effectively across services which are often not very well 'joined-up. *Models of care for alcohol misusers* (MoCAM) places an emphasis on care plans in structured care and more explicit co-ordination of care for people with multiple issues e.g. dual diagnosis.

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

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

Chapter 11 – *Women and alcohol*
Chapter 12 – *Young people and drinking*
Chapter 13 – *When problem drinking affects your family*
Chapter 14 – *Alcohol and black and minority ethnic communities*
Chapter 15 – *Alcohol and mental health*
Chapter 18 – *Contact numbers (support services)*

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

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

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

Women

Evidence of differing need

The *Alcohol Needs Assessment Research Project (ANARP)* (2004)[2], the first alcohol needs assessment in England undertaken on a national scale, found that, although the prevalence of alcohol use disorders was lower in women than in men[3], there was a high level of alcohol related need across all categories of women drinkers. 15 per cent of women were classed as hazardous or harmful alcohol users[4]; 9% as binge drinkers and 2% as alcohol dependent, with considerable overlap between those drinking above sensible daily and weekly benchmarks. Evidence suggests that the proportion of women drinking above low risk levels has increased in recent years. 3.6 million women (17%) reported drinking in excess of 14 units a week in 2002, an increase of 70% since 1988[5].

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

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

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2http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4122341

3 38 per cent of men and 16 per cent of women (age 16–64) were found to have an alcohol use disorder (26 per cent overall)

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

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

suggests that individual triggers play a greater or lesser role at different stages in a woman's life cycle[6]. Understanding of these risk factors is essential to developing appropriate forms of treatment targeted at women.

Studies also suggest that women are highly responsive to the emotional and social contexts in which they drink and it is possible to identify a number of key situations where women are vulnerable and at risk of developing problem drinking[7]. For instance, heavy or frequent drinking may be linked to the difficulties of juggling work and heavy domestic responsibilities, or it can be associated with established patterns of socialising around the workplace e.g. working in a male orientated environment can result in the development of patterns of heavy drinking.

Women have different substance using careers to men. Generally, they start later and respond better to treatment[8]. However, a review by Jarvis (1992) concluded there are only small differences across a variety of treatment modalities and settings in the effectiveness of treatment for women compared to men but, notably, women are likely to do less well in mixed group therapy because of the unfavourable gender dynamics[9]. Furthermore, women who have been abused tend to prefer a female therapist but women who have not identified themselves as having experienced violence from men do equally well with male or female therapists[10].

Women are more likely to have higher rates of physical and psychiatric co-morbidity than men, which may complicate treatment[11]. Research has found that problem drinking women with co-morbidity were often single, on a low income, likely to experience a greater severity of problem drinking and to binge drink, and to be regular smokers and cannabis users[12].

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

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

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

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

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

11 36% of women remand prisoners and 39% of sentenced women prisoners have a history of hazardous drinking which is frequently linked to mental ill health (33 - ONS, 1999).

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

Women may be more reluctant to admit that they have an alcohol problem[13]. This may be because they think people will judge them or that it will affect their children (if they have any).

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

This will have implications for the point at which current use is considered a problem in OASys[14] and the scoring of any more specific alcohol screening undertaken thereafter. For example, a score of eight or above in the Alcohol Use Disorders Identification Test (AUDIT) classifies drinking as increasing risk or worse, although this is sometimes amended to eight for men and seven for women, to take account of women's greater vulnerability to the effects of alcohol.

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

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

It is important to understand that women are not to blame for violence by partners. There is support available, including specialist services available to help survivors of domestic violence. Given the number of women offenders who currently have or who have had abusive partners (which may or may not involve alcohol use)[15], it is dangerous not to pay due regard to this. Furthermore, the full

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

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

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

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

For partners who are abusive and violent, addressing the drinking will not be sufficient to address the full range of behaviours which encompass domestic violence. This is really important in terms of women's safety – for many women the period of detoxification/recovery can be the most dangerous time for them and they may remain in a relationship because they think their partner's abuse will stop when the drinking has been addressed. Women who report that their partners are violent and abusive when drunk also report that their partners are violent and abusive when sober[16]. The Respect phoneline (0845 122 8609) is the national phoneline for men who wish to seek help for their abusive behaviour[17].

Female alcohol misusers may value the personal responsibility involved in self-initiated change and may be more motivated to change than men due to the greater stigma attached to problem drinking by women[18]. Less-intensive treatment (condensed form of cognitive behavioural therapy) seems especially suited to female service users with a mild or moderate level of alcohol dependence, who are suitable for a moderation drinking goal if they wish to pursue it.

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

Known difficulties

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

- There is a low awareness of the range of alcohol-associated health problems and an assumption that drinking only harms people if they are addicted
- A tendency to see alcohol as an issue which concerns society rather than the self
- Women obtain social and psychological benefits from drinking alcohol that appear to outweigh negative consequences[19].

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

17 www.respect.uk.net

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

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

Sanctions are greater for women with chronic drinking problems and research shows that alcohol-dependent women are more likely than alcohol-dependent men to be deserted by their spouses. The fact that a large proportion of women ***believe*** that society is more disapproving of female problem drinking continues to act as a barrier to women seeking help[20]. For instance, women are stigmatised for drinking in the home, as this conflicts with an ideology of women and motherhood as being self-denying and nurturing of both men and children.

Research[21] suggests that there are a number of factors that discourage women from seeking help for an alcohol problem including:

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

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

Women may be intimidated by the dynamics of a mixed therapy group and not feel able to participate as they might in an all female group. Women whose drinking problem is associated with male abuse or domestic violence may be intimidated by the presence of men[22].

There are increasing levels of drunken violence in which women are involved as victims and perpetrators[23], although the number of such offences remains comparatively very low among female offenders (compared to males). Provision for working with violent women offenders is currently less available than for men – e.g. accredited programmes.

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

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

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

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

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

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

Examples of good practice

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

Review of the effectiveness of alcohol treatment found that:-

- Brief interventions are equally effective among men and women, although there is no specific evidence as yet that brief interventions reduce alcohol consumption among pregnant women.

- With the exception of women who have been abused, women do well with mainstream services provided co-morbidity needs are addressed.

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

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

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

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

Information Pack for Offenders[24]. This includes contact details for the National Domestic Violence Helpline, Rape Crisis and the Respect phoneline.

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

Improving compliance

Women offenders will not engage successfully with interventions which do not enable them to manage their child care responsibilities, especially in cases where they are the primary carer[25]. In line with a recommendation from *The Corston Report: a review of women with particular vulnerabilities in the criminal justice system*[26], OMs should take into account domestic arrangements, childcare and other issues in sentence planning to facilitate engagement and compliance and therefore increase the likelihood of successful outcomes.

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

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

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

24http://npsintranet.probation.gsi.gov.uk/index/service_delivery/interventions/drugs__alcohol/alcohol_information_pack.htm

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

26 http://www.homeoffice.gov.uk/documents/corston-report/

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

The YWCA recently launched a report, *Young women and binge drinking: breaking the habit*[27], with conclusions and recommendations from a piece of research.

Young adult offenders

A minority of 18-24 year old binge drinkers are responsible for the majority of alcohol-related crime and disorder[28]. 44% of 18-24 year olds admit to binge drinking, and 14% of them committed violent crimes in the previous year. Young male binge drinkers (16%) are more than twice as likely to commit a violent offence as other young male regular drinkers (7%), and are also likely to get involved in other criminal and disorderly behaviour[29].

Young people aged 16-24 are more likely to report increasing risk drinking patterns – this doesn't just refer to their level of drinking but also covers associated behaviour such as impulsivity, risk taking or becoming involved in arguments or having accidents[30]. Therefore, most young adult offenders (YAOs) aged 18-21 under probation supervision are more likely to require brief interventions (simple or extended) than specialist treatment through an ATR.

Research suggests that the needs of young people are different from those of adults. Evidence suggests that substance misuse in young people is multi-faceted and those young people often have multiple antecedent and co-occurring mental, social and educational problems[31]. This age group also has a lack of awareness of the long-term risks of substance misuse and are susceptible to peer influences and social settings[32].

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

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

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

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

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

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

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

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

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

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

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

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

Provisions for 16-17 year olds

The Criminal Justice Act 2003 (CJA 2003) does not currently apply to offenders

under 18 year of age. This means 16-17 year olds will continue to be made subject to pre-CJA 2003 orders for offences committed on or after April 4th 2005. Areas/trusts need to discuss arrangements for this age group with local youth offending teams (YOTs). The Youth Justice Board has advised, however, that juveniles should continue to be proposed for juvenile sentences. Youth Rehabilitation Orders (YROs) were introduced in November 2009 and there can be a treatment element to a YRO.

Black and Minority Ethnic (BME) offenders

The prevalence of alcohol consumption in the UK varies considerably between different ethnic groups: over 90 per cent of those of Pakistani and Bangladeshi origin are believed to be non-drinkers while fewer than one in ten of the White British population abstains from alcohol[33].

The *Alcohol Needs Assessment Research Project (ANARP)* found that BME groups had a considerably lower prevalence of hazardous and harmful alcohol use, but a similar prevalence of alcohol dependence compared to the white population. However, a Home Office study examining the substance misuse treatment needs of minority prisoner groups found that half of males from minority ethnic groups were assessed as drinking at increasing and higher risk levels, with just over a third classified as both harmful drinkers and dependent on drugs[34].

Many people from the ethnic minorities feel disinclined to approach alcohol services, which are perceived to be unreceptive to their needs[35]. These needs include providing services in the person's first language, being sensitive to religious responsibilities/traditions and cultures, and recruiting more ethnic minority workers into the treatment sector[36]. Other reasons include the need to conceal substance use from parents and family, being reported to their parents if seen at a treatment agency, fear of unusual and severe punishments if caught, and avoiding the intolerance of the minority community[37]. Help-seeking is strongly influenced by the experience of psychosocial problems, particularly if these are interpersonal, and by encouragement to enter treatment[38].

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33 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.

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

35 Purser, B., et al, (2001) *Drinking in second and subsequent generation black and asian communities in the English midlands*. Alcohol Concern.

36 National Offender Management Service (2006) *Working with Alcohol Misusing Offenders – a strategy for delivery*. London: Home Office

37 Kahn, F., Ditton, J. & Hammersley, R. (2000). *Ethnic minority use of illegal drugs in Glasgow, Scotland: Potential difficulties for service provision*. Addiction Research, 8, 27–49.

38 Tucker, J. A. & King, M. P. (1999). *Resolving alcohol and drug problems: Influences on addictive behavior change*

There is some research evidence that the family network may make spontaneous recovery more likely among ethnic minorities[39] – family honour and religious re-affiliation were frequently cited as reasons for stopping drinking – and which suggests that the Asian community felt the need for substance misuse workers of the same cultural background most strongly. *Review of the effectiveness of treatment for alcohol problems* found that 'individuals from ethnic minorities tend to divide according to their degree of religious allegiance and there is a stronger case for novel ways of engaging ethnic minorities than for providing separate services.'

Black and minority ethnic population groups may require approaches that are sensitive to cultural or religious attitudes to alcohol. Staff should be trained in the skills and sensitivity needed to identify and work with all minority groups. Minority group treatment programmes should be funded where these would improve access to treatment and where there could be proper evaluation of the service.

Provision should be made for the BME section of the *NOMS Alcohol Information Pack* and a number of the basic sections to be translated into different languages. Also, for the delivery of interventions e.g. Eastern Europeans (Poles, Lithuanians) receiving Drink Impaired Drivers (DID) materials in their own language. Alcohol information should also be made available in formats suitable for people with visual impairments and with learning difficulties.

Poly substance misuse

A significant number of offenders misuse both drugs and alcohol and their use is often intertwined[40]. However, consumption of alcohol often has vastly different situational factors than illicit drug use (i.e. in a public rather than private place) and the types of crime which alcohol misuse is linked with are also very different (violent crime or public disorder rather than acquisitive crime)[41].

The *National Treatment Outcome Research Study* (NTORS)[42] found that drug treatment services were having little or no impact on drug service users' drinking behaviour, despite half having identified alcohol problems, and that where drug users reduced their heroin use, alcohol use increased.

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and help-seeking processes. In J. A. Tucker, D. M. Donovan & G. A. Marlatt (Eds.), *Changing Addictive Behavior: Bridging Clinical and Public Health Strategies*. New York: Guilford Press.

39 Cameron, D., Manik, G., Bird, R. & Sinorwalia, A. (2002) *What may we be learning from so-called spontaneous remission in ethnic minorities?* Addiction Research and Theory, 10, 175–182.

40 Data from a 2004/05 study showed that up to 1 in 5 CARATs clients regarded alcohol as their primary main problem drug/substance.

41 McMurran, M. and Cusens, B. (2005) *Alcohol and acquisitive offending.* Addiction Research and Theory, 13 (5): 439–443.

42 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4084908

Around 40 per cent of injecting drug misusers in drug treatment in 2004 were hepatitis C virus infection positive. Alcohol misuse is the single biggest contributory factor to those with hepatitis C virus infection developing fatal liver disease[43].

If an individual has other physical or mental health conditions or drug misuse problems in addition to requiring alcohol intervention or treatment, these issues can be crucial in deciding on appropriate alcohol treatment and treatment goals. The *Review of the effectiveness of treatment* found that people misusing drugs and alcohol may have different needs from those misusing alcohol alone and may require a different approach to treatment.

*M*oCAM advises that 'drug users in treatment should have their alcohol use and treatment needs routinely and continually assessed, and it is good practice for drug users in treatment to have their alcohol problems treated in the same setting where possible. Referrals to specialist alcohol treatment, and guidance from specialist alcohol workers, should be a routine feature in the treatment and care of drug misusers. Where drug misusers are already attending a combined drug and alcohol treatment service, where external referral may not be needed, it is vital that the management of alcohol misuse is clearly identified for action as part of the service user's formal care plan.'

Dual diagnosis

It is rare for an offender with a serious alcohol problem to have no other significant physiological and psychological problem. Aside from alcohol-related medical conditions such as cardio-vascular or liver disease, many offenders have mental health problems that may require a specialist mental health service[44]. It is estimated that 10% of people with alcohol problems have a severe mental illness, 50% have a personality disorder and up to 80% have a milder mood disorder[45].

Alcohol-specific services are limited across National Offender Management Service and NHS domains. Guidance on practice in the management of co-existing alcohol and mental health problems is provided by Department of Health[46] [47] [48]as part of universal advice on mental health, substance misuse and

43 Department of Health/National Treatment Agency for Substance Misuse (2006) *Models of care for alcohol misusers (MoCAM)*. London: DH/NTA.

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

45 Ashworth, M. and Gerada, C. (1997) *Addiction and dependence-alcohol*. British Medical Journal 315(7104), 358-360. Health Education Authority (1997) Health update: alcohol. London: Health Education Authority.

46 DH (2002) *Mental Health Policy Implementation: Guide Dual Diagnosis Good Practice Guide*. London; Department of Health

dual diagnosis. Guidance for prisons is contained in the Department of Health dual diagnosis guide[49] and in the prisons clinical substance misuse guidance.[50] Wales has a module of the Substance Misuse Treatment Framework (SMTF) covering co-occurring substance misuse and mental health but nothing specific for prisons.

Mainstream approaches to 'dual diagnosis' recommend that mental health services should take the lead in the treatment of people with serious mental health problems who also have substance misuse problems with close liaison and support from substance misuse services to deliver an integrated package of care. To facilitate this, areas/trusts and providers should ensure that clear and agreed integrated care pathways and joint working protocols are in place for offenders with dual diagnosis.

The Home Office have recently issued guidance to Drug Intervention Programme practitioners on the management of clients with dual diagnoses[51]. Problem drinking among offenders with no problematic drug use lies outside the function of DIP but the principles set out in the guidance may still be informative.

A court may also issue a mental health treatment requirement (MHTR). The response of the courts to offenders with mental health problems has been the subject of *Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system*[52], which was published on 30 April 2009. The very high level of mental health problems among problem drinkers appearing before the courts ensured that Lord Bradley paid particular attention to the type of services and interventions that should be available. He recommended:-

- The Department of Health, NHS and other relevant government departments should work with voluntary organisations to ensure the adequate provision of alcohol and mental health treatment services across the country
- Improved services for prisoners who have a dual diagnosis of mental health and drugs/alcohol problems should be urgently developed
- Joint care planning between mental health services and drug and alcohol services, should take place for prisoners on release

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47 DH (2007) *Drug misuse and dependence: UK guidelines on clinical management*

48 DH (2008) *Refocusing the Care Programme Approach: Policy and Positive Practice Guidance*

49 DH (2009) *A Guide for the Management of Dual Diagnosis for Prisons*

50 DH (2006) *Clinical management of drug dependence in the adult prison setting*

51 Drummond C, Phillips T & Boland W (2008) *Substance misusing clients with mental health problems: A brief practitioner's guide for Criminal Justice Integrated Teams*. Specialist Clinical Addiction Network

52 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_098694

In its response[53], the Government committed to publishing a national delivery plan, which will outline how it will take forward his recommendations including making the necessary system reforms to tackle barriers to the provision of mental health treatment across probation areas/trusts. *Improving Health, Supporting Justice*[54], the National Delivery Plan of the Health & Criminal Justice Programme Board, was published on November 17th 2009. The plan seeks to bring justice and health sectors together to optimise access to treatments. Action on alcohol is included, which builds on existing Primary Care Trust (PCT) plans for improving access to alcohol treatment. This includes progress towards a minimum level below which access to treatment should not fall and issuing guidance to PCTs on commissioning alcohol services to ensure they meet the needs of offenders[55].

The ten-year National Service Framework (NSF) for mental health was launched in 1999. The NSF strategy highlighted that around half of those reporting any substance misuse disorder have experienced other mental health problems. The document also recommended that 'assessments of individuals with mental health problems, whether in primary or specialist care, should consider the potential role of substance misuse and know how to access appropriate specialist input.'

The NSF has been superseded by the recently published *New Horizons: A Shared Vision for Mental Health*[56], which sets out a cross-government programme of action to improve the mental health and well-being of the population and the quality and accessibility of services for people with poor mental health.

Family issues

There is evidence of the potential value in appropriately engaging and involving families in the treatment and resettlement processes[57] [58]. It can also be an important component in addressing the key strategic themes of NOMS Drug[59] and Alcohol Strategies (i.e. reducing substance related harm to individuals and communities; building effective through-care arrangements).

NOMS, in partnership with the charity Adfam, produced a family toolkit, *Partners*

53 http://www.justice.gov.uk/publications/bradley-mental-health-cjs-gov-response.htm

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

55 There is no comparable Offender Health & Social Care Strategy published or planned in Wales.

56 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_109705

57 Sisson, R. W. & Azrin, N. H. (1993). *Community reinforcement training for families: A method to get alcoholics into treatment*. In T. J. O'Farrell (Ed.), *Treating Alcohol Problems: Marital and Family Interventions*, (pp. 34–53). New York: Guilford Press.

58 Copello, A., Orford, J., Hodgson, R., Tober, G. & Barrett, C. on behalf of the UKATT Research Team (2002). *Social behaviour and network therapy: Basic principles and early experiences*. Addictive Behaviors, 27, 354–366.

59 http://www.justice.gov.uk/publications/noms-drug-strategy-2008-2011.htm

in Reduction[60]*,* for prisons in 2005. This toolkit provides prison staff with comprehensive advice on how to effectively engage the families of drug and alcohol misusers in prison. It is founded upon the growing evidence of the positive role families can play in support of those undergoing drug and alcohol treatment. The *Alcohol Treatment Interventions Good Practice Guide*[61] also sets out guidance about how to work with families and highlights relevant issues and the alcohol video – *Alcohol: a prisoners' perspective* has a specific section on the effects of alcohol misuse on families.

The National Drug Strategy, *Drugs: Protecting families and communities*[62], published in February again recognises the evidence that families are both affected by and can have an influence on drug and alcohol misusers. It is recognised that recovery from alcohol dependence is a long-term process and benefits from appropriate family/social support.

An Addaction report, *Closing the Gaps*[63], states that family support should become integrated into drug and alcohol treatment services, because of the improvement in results when families are included in treatment. In the case of children affected by parental substance misuse, integrated working and effective communication is essential to outline action to help families and better inform parents.

Inappropriate support can undermine recovery. Some families might want to break ties with an offender in order to get away from substance misuse and its related problems. Some women offenders will need support to break away from partners, ex-partners or family members who are violent, abusive or are reinforcing their offending behaviour. In these cases they are likely to require on-going support from expert, women-centred organisations in the community.

Strong local partnerships are needed to ensure women offenders can access support and advice to help them manage family concerns, particularly around their children, including working with universal services like children's centres and extended schools, family support services for substance misusers and Third Sector providers.

Safeguarding children

Offender Managers should address both the safeguarding and the well-being of offenders' children. While alcohol (or other substance) misuse does not necessarily lead to problems or poor parenting, neglect or abuse of children, OMs should consider the impact of parental alcohol misuse on the welfare of

60 http://www.adfam.org.uk/index.php?content=news&include=yes&action=edited&id=33

61 http://www.hmprisonservice.gov.uk/resourcecentre/publicationsdocuments/index.asp?cat=88

62 http://drugs.homeoffice.gov.uk/drug-strategy/

63 http://www.addaction.org.uk/?page_id=1594

children in their care. Recent evidence from Child Death Reviews showed a significant correlation with alcohol use.

The Lord Laming recommended in *The Protection of Children in England: A Progress Report*[64] that 'All police, probation, adult mental health and adult drug and alcohol services should have well understood referral processes which prioritise the protection and well-being of children. These should include automatic referral where domestic violence or drug or alcohol abuse may put a child at risk of abuse or neglect.'

MoCAM advises that 'if a professional has concerns about the welfare or safety of the children of alcohol misusers, from assessment or indeed at any point during treatment, they should follow local joint working arrangements as agreed by the local safeguarding children boards (formerly area child protection committees). This would normally mean involving social services.'

OMs need to work in partnership with local authority children's services where the children of offenders are being cared for by extended family, friends or in the children-in-care system.

Department of Health and the Regional Public Health Office for the South East have developed a violence and abuse framework that incorporates a range of interventions to safeguard children, young people and adults.

Areas/trusts will wish to be aware of the *Joint Guidance on Development on Local Protocols between Drug and Alcohol Treatment Services and Local Safeguarding and Family Services*[65] developed by Department for Children, Schools and Families (DCSF), Department of Health (DH) and National Treatment Agency for Substance Misuse (NTA) and published on 3rd November.

Social deprivation and homelessness

Research suggests a significant association between social deprivation, psychological morbidity and substance misuse[66]. It also indicates that social factors such as accommodation, finances and employment have a large impact on rates of re-offending[67]. Addressing employment and family problems can lead

64http://publications.everychildmatters.gov.uk/default.aspx?PageFunction=viewtoptenproducts&PageMode=publications&Type=TopTen&

65 http://www.drugscope.org.uk/resources/goodpractice/treatment/guidance.htm

66 Farrell, M., Howes, S., Taylor, C., Lewis, G., Jenkins, R., Bebbington, P., et al. (1998). Substance misuse and psychiatric comorbidity: An overview of the OPCS National Psychiatric Morbidity Survey. Addictive Behaviors, 23, 909–918.

to changes in substance use and securing employment means that the offender has less unstructured time and encourages responsible attitudes to drinking. Therefore, it would seem sensible to address these needs in conjunction with other approaches.

Homeless people, those who lack social support or those who have had previous unsuccessful attempts at withdrawal in the community may require inpatient treatment. There is evidence to support the need for specialist services, typically residential and non-hospital, as a safety net and pathway to long-term rehabilitation[68]. However, there has been a move away from services for homeless problem drinkers to more holistic services for the homeless.

Housing and hostel provision for homeless alcohol misusers will need to be considered in tandem with alcohol treatment and brief interventions. This provision is not within the remit of probation areas/trusts but there is scope for them to influence housing providers through participation in local strategic partnerships.

Research suggests the importance of case management aimed at improving the financial and residential stability of service users and reducing their use of alcohol on successful outcomes[69].

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67 Research evidence suggests that employment reduces the risk of re-offending by between one third and one half: Lipsey 1992; The extent and frequency of offending diminishes when offenders gain employment: Sarno et al 2000

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

69 Cox, G., Walker, R., Freng, S., Short, B. A., Meijer, L. & Gilchrist, L. (1998). *Outcome of a controlled trial of the effectiveness of intensive case management for chronic public inebriates*. Journal of Studies on Alcohol, 59, 523–532.