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Evidence-based practice? The National Probation Service's work with alcohol-misusing offenders

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Policy briefing

This independent study by the Institute for Criminal Policy Research, King's College London, sought to describe and critically appraise the procedures adopted by the National Probation Service (NPS) for identifying and intervening with offenders who have alcohol problems.

A key priority for policy should be to increase the use of evidence-based alcohol interventions and treatment with offenders whose criminal behaviour is related to their use of alcohol. That priority should be addressed in the short term by sharing and disseminating emerging best practice and identifying effective strategies for ensuring more offenders commence and complete those programmes that are available. The longer term emphasis should be on developing the evidence base and then disseminating empirically informed advice and guidance about the appropriate targeting of interventions, and increasing further the range, capacity and funding of the NPS's alcohol-related work.

Improvements are still required in many areas to aspects of: alcohol screening and specialist assessment processes; the accessibility of specialist alcohol treatment services; and the level of training for probation staff on delivering brief interventions, specifically, and alcohol issues more generally.

There is scope for expanding provision for alcohol treatment requirements (ATRs) given existing levels of need, but continuing uncertainty and inconsistency around funding, targeting and the form this treatment should take need to be resolved as a matter of urgency by the Ministry of Justice (MoJ) and National Offender Management Service (NOMS).

The dearth of British research evidence means there is currently limited scope for developing empirically informed guidance to instruct senior probation managers and practitioners on key issues. These include the effective targeting of interventions within a criminal justice context and identifying which ones are likely to be most effective for whom e.g. different offender management tiers and those offenders presenting with hazardous, harmful or dependent drinking patterns. These and many other themes and issues (including assessing the impact and effectiveness of ATRs) should be given greater priority in any future research programme.

Research summary

This process study by the Institute for Criminal Policy Research (ICPR), King's College London, examined the National Probation Service's work with alcohol-misusing offenders by describing and critically appraising:

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

Approach

The study had a number of components and made use of a range of primary and secondary quantitative and qualitative data sources. These included data derived from:

- a telephone survey completed with the policy lead responsible for substance misuse, or the specialist responsible for co-ordination and delivery of services in 41 (of 42) probation areas in England and Wales;
- analysis of all ATR activity data for England and Wales during 2007/08;
- analysis of Offender Assessment System (OASys) data for six purposively[1] sampled case study sites;
- 185 random offender case file reviews in these six sites; and
- 64 in-depth interviews with various stakeholders and professionals from across these areas.

Results and implications

Probation work nationally with alcohol-misusing offenders

English and Welsh probation areas were, at the time of fieldwork, offering a broad range of alcohol-related interventions. At a national level, however, it seemed that efforts to ensure more effective commissioning and delivery had been hampered by a lack of:

- resources and dedicated funding for the provision of alcohol interventions and treatment;
- guidance and protocols to inform the targeting of available interventions;
- appropriate and accessible alcohol treatment provision;
- probation staff confidence, skills and knowledge around alcohol-related issues; and
- success engaging and influencing local commissioners to afford greater priority and resources to work with alcohol-misusing offenders.

1 This approach was adopted to ensure, for example, representation of areas from different regions, of different sizes and with varying population densities.

Being able to effectively deliver, manage and direct alcohol-related interventions should be considered a core offender management skill. However, while there are high levels of alcohol-related need within NPS caseloads, analysis of OASys data in six case study areas revealed that over 40% of all alcohol-related interventions had yet to start four to six months after a period of supervision had commenced[2]. A similar picture emerged at a national level with a sample of OASys-identified 'dependent'[3] drinkers under probation supervision. A key priority for policy should be to increase the use of evidence-based alcohol interventions and treatment with offenders whose criminal behaviour is related to their use of alcohol. That priority should be addressed, in the short term, by sharing and disseminating emerging best practice and identifying effective strategies for ensuring more offenders commence and complete those programmes that are available. The longer term emphasis should be on developing the evidence base and then disseminating empirically informed advice and guidance about the appropriate targeting of interventions. Finally, it will be necessary and important to increase further the range, capacity and funding of the NPS's alcohol-related work.

Levels of compliance with Models of care for alcohol misusers (MoCAM)

Data from both the national survey and in-depth interviews in six case study areas point towards a number of issues which policy makers and senior probation managers will need to address with regards to ensuring greater compliance with MoCAM. These include developing ways to facilitate improvements to:

- the quality, accuracy, consistency and timing of alcohol screening and specialist assessment processes;
- the accessibility of specialist alcohol treatment services to which offenders can be referred (both located within probation settings and externally);
- the scale and quality of training offered to offender managers to better equip them to more effectively deliver brief interventions to alcohol-misusing offenders; and
- monitoring of the extent to which probation staff involved in delivering, managing or directing alcohol interventions are trained and competent to the minimum relevant Drugs and Alcohol National Occupational Standards (DANOS).

The commissioning and delivery of alcohol treatment requirements (ATRs)

Demand for ATRs outstripped supply by some considerable margin. Only 8% of drinkers defined as 'dependent' using an OASys sample of offenders commencing community sentences during 2007/08 were estimated to have received an ATR (Moore, 2008)[4]. Despite some important caveats associated with using OASys to identify 'dependent' drinkers, this

2 We were unable to establish whether and to what extent these delays were due to problems accessing specialist treatment any earlier than this.

3 Defined by O-DEAT as achieving a section 9 (alcohol) score of six or more, these estimates need to be interpreted with caution as they are based on a subset of supervised offenders and are unlikely to reflect actual levels of alcohol dependency within probation caseloads.

4 Again, these estimates need to be interpreted with caution as they relate to a specific subset of the probation population and are unlikely to reflect actual levels of alcohol dependency within probation caseloads.

was consistent with stakeholder perspectives which indicated that there was significant scope for expanding ATR provision in order to meet existing levels of need. For example, ensuring treatment coverage for at least one in seven (15%) dependent drinkers is regarded as optimal by Alcohol Concern.

Resolving the impasse around ATR funding should be a priority for policy makers and senior managers. However, given that the finances of most English Primary Care Trusts (PCTs) are in deficit and probation budgets are expected to face some substantial cuts in the short term, all reasonable options should be explored as a matter of urgency (e.g. expanding the remit of local Pooled Treatment Budgets to include alcohol treatment).

There was considerable variability in how the treatment component of an ATR was being delivered. Only one in four of the areas reporting to the national survey that they were delivering ATRs were doing so in a manner consistent with existing guidance. The new NOMS Alcohol Interventions Guidance due for publication in September 2009 will need to add further clarity on this important issue. This will be a difficult task, however, given the limited availability of alcohol treatment services in some areas.

ATRs appeared to facilitate engagement with alcohol treatment services and contributed towards reducing alcohol-related needs (based on findings from the random review of case files). However, there also appeared to be scope for further refinement to the process of targeting ATRs and offering more timely interventions through increased treatment capacity.

The evidence base and emerging best practice

The dearth of British research evidence means there is currently limited scope for developing empirically informed guidance to instruct senior probation managers and practitioners about the effective targeting of interventions within a criminal justice context, or to identify which ones are likely to be most effective for whom (e.g. different offender management tiers and offenders presenting with hazardous, harmful or dependent drinking patterns). These and many other themes and issues (including assessing the impact of ATRs) should be given greater priority in any future research programme.

Given the lack of empirical research available to inform work with alcohol-misusing offenders, initiatives of the sort currently being developed by NOMS to provide support and funding (in the region of £250,000 to date to 15 projects) in an effort to help identify, develop and disseminate the numerous examples of emerging best practice should be commended, endorsed and encouraged.

1. Context

Alcohol consumption and its consequences

Alcohol occupies a central role in British social and cultural life. During 2006, nearly three-quarters (72%) of adult men in England and about three-fifths (57%) of women responding to the *Health Survey for England* reported drinking alcohol on at least one day in the week before interview (NHS Information Centre, 2008). Yet the prevalence of alcohol consumption in the UK varies considerably between different ethnic groups: over 90% 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. And although average weekly alcohol consumption is highest among 16- to 24-year-olds, alcohol consumption tends to peak in the early 20s and then fall with increasing age. Though the emerging evidence of drinking patterns amongst older groups is conflicting, it is becoming increasingly clear that the traditional differences in consumption patterns between men and women are narrowing. In addition, the UK ranks ninth in the world for alcohol consumption and has one of the highest rates of use in Europe (ACMD, 2006: 36; BMA, 2008: 1).

The most recent Local Alcohol Profiles for England estimate that one in five adults, aged 16 or over, are hazardous drinkers (equivalent to around eight million people) with 5% (just over two million people) drinking at harmful levels[5]. In 2008, the Department of Health (DoH) consulted with experts to agree a new description of categories of drinking based on risk. These descriptions, set out in Table 1.1, were intended to more meaningfully engage the public and non-specialist health professionals than the terms hazardous and harmful used in the World Health Organisation (WHO) classification.

Table 1.1: New description of categories of drinking based on risk

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

5 Fuller *et al*. describe hazardous, harmful and dependent drinking in the following ways: “Hazardous drinking is a pattern of alcohol consumption carrying risks of physical and psychological harm to the individual. Harmful drinking denotes the most hazardous use of alcohol, at which damage to health is likely. One possible outcome of harmful drinking is alcohol dependence, a cluster of behavioural, cognitive, and physiological phenomena that typically include a strong desire to consume alcohol, and difficulties in controlling drinking” (2009: 151).

The *Alcohol Needs Assessment Research Project (ANARP)* estimated that the prevalence of alcohol dependence in England during 2004 was 4% (which equated to 1.1 million people). It also calculated that only 6%, or one in 18, of the dependent drinking population were accessing appropriate alcohol treatment, but with wide regional variations: in the lowest access region (the North East) only one in 102 dependent drinkers were accessing treatment in a year (Drummond *et al*., 2005; cf. Fuller *et al*., 2009: 151). By contrast, 42% of the estimated problem drug-using population had accessed treatment in England during 2005/06 (UK Focal Point on Drugs, 2008: 4). Ensuring treatment for around one in seven (15%) dependent drinkers is regarded as optimal coverage according to Alcohol Concern (Soodeen and Shenker, 2008: 4).

There have been important changes to trends in patterns of consumption (as described above) and greater availability, affordability and strength of some drinks in recent years, coupled with some significant changes to the regulation of alcohol (e.g. greater flexibility in licensing laws). Given the limited accessibility and availability of appropriate treatment services in some areas like the North East, such changes are likely to have far-reaching social and public health implications in years to come – with a marked impact on both crime and criminal justice.

The costs of alcohol-related harms, including those associated with crime and anti-social behaviour, are considerable. Despite high levels of alcohol-related need being consistently identified among offender populations, work by the correctional services in England and Wales has, in line with political and policy imperatives, almost certainly attached far greater priority to the identification and treatment of drug misuse during recent years[6]. The links between alcohol and crime, and the development of criminal justice responses aimed at tackling these issues are considered in more detail in Appendix 1.

Policy responses

The Alcohol Harm Reduction Strategy for England, implemented in March 2004 and revised in June 2007 (as *Safe. Sensible. Social)* sets out the policy framework to tackle these issues across various government departments (The National Assembly for Wales has its own substance misuse strategy which covers alcohol). The National Alcohol Strategy was initially comprised of four main strands:

- education and communication;
- identification and treatment;
- alcohol-related crime and disorder; and
- supply and industry responsibility.

The revised Strategy targets three specific groups of problem drinkers who are considered to cause the most harm to themselves, their communities and their families:

6 It is difficult to assess this accurately since, for example, funding for the provision of treatment and rehabilitation of people with an alcohol dependency within the criminal justice system is not recorded (Hansard, 2007).

- young people under 18, in particular those aged between 11 and 15;
- young adults, especially 18- to 24-year-old 'binge' drinkers, who are responsible for a disproportionate amount of crime and disorder; and
- harmful drinkers whose patterns of drinking damage their physical and/or mental health and who may be causing substantial harm to others.

Models of care for alcohol misusers (Department of Health, 2006) was issued over three years after the National Treatment Agency for Substance Misuse (NTA) published Models of Care for the treatment of adult drug misusers (MoC). Although targeted at drug misusers, MoC specifically stated that its main framework elements were applicable to alcohol treatment. MoC and MoCAM were predicated on the basic concept that local areas should provide a treatment system, rather than a range of different loosely co-ordinated interventions. These framework elements were:

- A four-tiered system of treatment provision (see Table 1.2 below) with an expectation that every local area should provide access to services at every tier.
- Integrated care pathways – essentially a concept that every individual should receive a triage assessment at their first point of contact with the treatment system and then be directly matched to the most appropriate intervention without having to undergo repeated assessments.
- Care planning and co-ordination – putting the service user at the centre of a negotiated, clear care planning process which ensured continuity of care and a focus on outcomes.

Table 1.2: The four-tiered system of alcohol treatment and its key components

Tier 1: Mainstream	Tier 2: Mainstream or Specialist	Tier 3: Community specialist	Tier 4: Residential specialist
	Open access or outreach	Comprehensive assessment	
Targeted screening	Brief alcohol interventions and treatment	Care planned and co-ordinated treatment	Inpatient managed withdrawal and psycho-social treatment
Information and brief advice	Triage assessment and referral	Managed withdrawal	
Referral	'Shared care'	Psycho-social treatments	Residential rehabilitation
	Mutual aid groups e.g. Alcoholics Anonymous	Structured day programmes	

In an effort to ensure that probation areas deliver interventions in a manner consistent with MoCAM guidelines, an alcohol interventions service specification has recently been developed, but this is only applicable to the new probation trusts (however, the expectation is that all areas will gradually move over to trust status subject to them meeting a number of criteria). Centrally, NOMS has developed a strategy and supporting guidance which provides the framework within which alcohol related interventions are to be delivered and the minimum standards required of these, e.g. the Alcohol Information Pack and results from the best practice initiatives. There are also some alcohol treatment requirement related National Standards. It is anticipated that more detailed expectations will be agreed and set out in service level agreements between areas/trusts and their Directors of Offender Management (DOMs).

In addition, MoCAM also integrates the provision of alcohol treatment within the Department of Health's overall *Standards for Better Health* (2004). MoCAM sets out both core and developmental standards which range over seven key domains:

- safety;
- clinical and cost-effectiveness;
- governance;
- patient focus;
- accessible and responsive care;
- care environment and amenities; and
- public health.

Alcohol treatment requirements (ATRs)

While probation areas deliver a variety of interventions – from brief interventions, frequently delivered by offender managers during their routine interaction with offenders, to a range of structured accredited programmes (see Chapter 3), a key aim of the study was to critically describe and appraise arrangements for the commissioning and delivery of ATRs.

Introduced by the Criminal Justice Act 2003 and made available to the courts for offences committed on or after 4 April 2005 as a possible component of a Community Order (CO) or Suspended Sentence Order (SSO), an ATR can be imposed for between six months and three years as part of a CO and for a maximum of two years as part of an SSO, for offences committed by any adult aged 18 or over. Unlike previous provisions for an offender to receive alcohol treatment under a Community Rehabilitation Order or Community Punishment and Rehabilitation Order, the court does not have to be satisfied that alcohol caused or contributed to the offence in order to impose an ATR.

As with drug rehabilitation requirements (DRRs), the courts must, however, be satisfied that a number of criteria have been met before the imposition of an ATR, including establishing that:

- the offender is dependent on alcohol[7] (broadly defined in the original ATR guidance published in 2005 to include hazardous or harmful drinking);
- this dependency requires and is susceptible to treatment;
- arrangements have or can be made for the treatment specified in the order; and
- the offender expresses a willingness to comply with the requirements of the order.

As well as being determined by local availability of provision, published guidance stated that the type and intensity of the treatment delivered as part of an ATR should be tailored to the assessed needs of the offender taking into account the seriousness of the offence and any risk assessment. Unlike the DRR, regular testing and reviews are not permissible under the ATR. However, offenders can be tested on a voluntary basis at the discretion of the supervising officer or treatment provider when this is considered helpful as a way of assessing their progress in treatment (this applies to ATRs made as part of a CO or SSO). The court also has discretion to decide that an SSO be subject to periodic review, including those with an ATR.

Any probation staff involved in the provision of alcohol education or information, brief advice or support should also be trained and competent to the relevant Drugs and Alcohol National Occupational Standards (DANOS)[8] requirements (ibid: 6; National Probation Service, 2006).

Guidance acknowledged the likelihood of gaps in local community-based provision and encouraged Regional Offender Managers (ROMs)[9] to work in partnership with local Drug (and Alcohol) Action Teams[10] (D(A)ATs) and Crime and Disorder Reduction Partnerships (CDRPs). Where appropriate, areas were also encouraged to use available partnership funding streams and regional reducing re-offending resettlement strategies to help increase capacity and fill any gaps in local alcohol treatment provision (National Probation Directorate, 2005: 7).

Aims and objectives

The aims of this study were to describe and critically appraise:

- procedures adopted by the National Probation Service for identifying and intervening with alcohol-misusing offenders[11];

7 The Criminal Justice Act 2003 did not define 'dependence' in the context of the ATR. This wider definition has since been superseded by a much tighter and literal definition of dependency that was circulated as interim guidance (via email) by ISMG to relevant ACOs, ROMs and DOMs during December 2008 and will appear in new guidance due for publication in September 2009.

8 Launched in 2002 the Drugs and Alcohol National Occupational Standards (DANOS) aim to offer a framework of good practice and competence in the planning and delivery of services to substance misusers. There are over 100 DANOS units relating to service delivery and the management and commissioning of services. There are 11 key units relevant to service delivery; including helping substance users address their offending behaviour and helping them access substance misuse services.

9 Nine Directors of Offender Management (DOMS) with responsibility for the delivery of all NOMS services in England and Wales were appointed in February 2009.

10 Substance Misuse Action Teams (SMATs) in Wales.

11 Substance Misuse Action Teams (SMATs) in Wales.

- levels of compliance with MoCAM; and
- arrangements for the commissioning and delivery of ATRs.

The key objectives of the research were to:

- increase knowledge of how the NPS works with alcohol-misusing offenders;
- identify and disseminate emerging examples of best practice to probation areas and key stakeholders; and
- inform policy development aimed at ensuring that alcohol provision across NOMS is consistent with the existing evidence base.

Structure of this report

The methodological approach adopted by the research team is set out in Chapter 2. An overview of the main results of the study is then presented in Chapter 3. Here probation work with alcohol-misusing offenders is described and the extent to which these activities were compliant with key elements of MoCAM considered. The arrangements for the commissioning and delivery of ATRs are also critically assessed. Some emerging examples of best practice are described in Chapter 4 while Chapter 5 highlights some of the key gaps in our knowledge about effective approaches to working with alcohol-misusing offenders. Finally, Chapter 6 discusses some of the key findings and recommendations to emerge from the research.

2. Methods

Research procedures and ethics

The study benefited from the formation of a research steering group at an early stage which aimed to shape the overall direction of the project and inform its development by providing a forum for the exchange of knowledge, views and experiences of how best to meet the project's key aims and objectives. The steering group also commented on the scope and content of the various instruments developed by the research team.

Chaired jointly by the Offender Management and Sentencing (OMS) Analytical Services and Interventions and Substance Misuse Group (ISMG) within NOMS, the group invited representation from the Department of Health, the National Treatment Agency, Alcohol Concern, Merseyside Probation Trust, North Wales Probation Area and members of the research team.

The study also received ethical approval from the Kings' College Law Research Ethics Panel (reference: REP-L/07/08-5).

Methodology

The study had a number of components and made use of a range of primary and secondary quantitative and qualitative data sources. These included data derived from:

- a telephone survey completed with a nominated representative from 41 (of 42) probation areas in England and Wales;
- analysis of all ATR activity data for England and Wales;
- analysis of Offender Assessment System (OASys) data for six purposively selected case study sites;
- 185 case file reviews in these six sites; and
- 64 in-depth interviews with various stakeholders and professionals drawn from these areas.

National telephone survey

Guided by the content of relevant documents such as MoCAM and the NPS alcohol strategy, *Working with Alcohol-misusing Offenders*, a semi-structured questionnaire was developed by the research team in close consultation with the research commissioners and dedicated steering group (see Appendix 3 for a copy of the questionnaire). The survey included questions on current and recent activity across a number of domains.

Questionnaires were completed via telephone interviews with nominated representatives from 41 probation areas in England and Wales[12]. The telephone interviews were conducted

12 The research team were unable to secure an interview with a representative from one probation area due to staff shortages. Given the nature and size of the area in question it is not believed that its omission from the survey will have skewed or biased the results in any meaningful way.

between February and May 2008, though most (32) were completed in March 2008. The average length of each interview was 54 minutes (range 33 to 90 minutes). Depending on how responsibility for alcohol services was organised, the researchers sought to locate either the Assistant Chief Officer (ACO) with policy responsibility for substance misuse, or, if more appropriate, the specialist responsible for co-ordination and delivery of services at sub-area level. The aim was to identify someone who had both a policy overview and a grasp of practice on the ground. All the respondents were senior managers within the Probation Service with a remit around substance misuse issues and most operated at ACO level or equivalent (35).

Analysis of national ATR activity data

The researchers also conducted secondary analysis of all available routinely collected data on ATR activity in England and Wales between April 2007 and March 2008 in order to consider regional variations in commencement and termination rates and describe reasons for non-completion.

Data on ATR starts and completions are collected from areas' Form 20 returns by Offender Management and Sentencing Analytical Services (OMSAS) and are published by them as part of the Offender Caseload Management Statistics. Completions data from Form 20 is passed to the NOMS Performance Management Group and placed on the NOMS Performance Hub for use in calculating area performance against targets for ATR completions and other indicators.

Following the national survey of English and Welsh probation areas, the original research specification expressed a desire to explore emerging themes and issues relevant to the study's aims and objectives in greater detail across six case study sites. Full details of the sampling and selection criteria for these areas are set out in Appendix 4.

Analysis of OASys data

Howard describes the Offender Assessment System as "a structured clinical assessment tool used by adult correctional services in England and Wales. It was developed to assess offending-related needs, likelihood of reconviction and risk of serious harm. Offenders are assessed [across 12 offending-related domains, including alcohol] at pre-sentence stage, at the start of most community and custodial sentences[13] and at regular intervals during the sentences. These assessments aid effective management of offenders and targeting of interventions designed to reduce reconviction" (2006: 1).

13 OASys is only mandatory for Tiers 2, 3 and 4 community sentence offenders. It is important to note that in some cases up to half of all inmates are discharged from prison without being sentenced or after serving sentences of under 12 months so are never assessed using OASys. Also, OASys is mandatory for all prisoners serving more than 12 months but the assessment is often only undertaken approximately three months into their custodial sentence.

The OASys Data Evaluation and Analysis Team (O-DEAT) supplied ICPR with anonymised data for a three-month period (from 1 September to 30 November 2007)[14] in six purposively sampled case study sites in order to identify the nature and extent of alcohol-related needs and consider the extent to which alcohol interventions had been planned and delivered.

There are two key sections of the OASys tool which collate information about offenders' alcohol use:

- Section 2 provides offence details and notes any potential influences on offending behaviour, including alcohol use prior to the offence.
- Section 9 examines levels and frequency of previous and current alcohol use (including binge drinking or excessive use), violent behaviour linked to use and motivation to tackle misuse.

The dataset contained details of 17,183 OASys assessments completed during this period for 15,082 offenders. As a full OASys assessment is not undertaken with all offenders (e.g. Tier 1 cases under the Offender Management Model (OMM) only have an Offender Group Reconviction Scale (OGRS) score and risk of serious harm screening; a full Risk of Serious Harm analysis should only be completed if the screening raises serious issues), these data should not be read as representative of the entire probation caseload. In order to restrict the OASys samples to the most valid assessments in each individual 'period of contact', the researchers focussed on the first assessment for each offender completed during this three-month period. This ensures that each offender can appear only once in the analysis during a continuous period of supervision by the Probation Service in each site. In line with O-DEAT guidance, pre-sentence report (PSR) assessments were also removed unless the sentence code indicated a community sentence or a suspended sentence – as were invalid assessments (for an OASys assessment to be considered valid, a number of minimum standards of data completion will need to have been satisfied, e.g. each of the scored sections (1 to 12) within the core OASys assessment must have had at least four-fifths of their scored items completed – ensuring that each criminogenic need was assessed properly).

Case file reviews

Each case study site was asked to randomly select 30 case files in order to assist ICPR describe offender profiles and alcohol-related needs; provide sentencing details; consider any alcohol specific treatment or interventions planned and received; document the frequency and duration of these interventions; outline the degree of offender compliance and report any outcomes. The criteria for selecting the case files were: (i) the first 20 consecutive ATRs imposed after 1 September 2007 for offenders resident within a specified D(A)AT area(s) and (ii) the first ten consecutive non-ATR sentences imposed after 1 September 2007 for offenders resident within the same D(A)AT area with a section 9 (alcohol) OASys score of six or more.

14 This time frame was chosen to ensure consistency with the case file reviews in the same six areas.

The actual case file reviews across the case study sites were completed by the authors of this report. Relevant data were manually extracted on-site from paper case files, OASys and electronic case management systems (e.g. Delius, CRAMS) and entered onto an MS Excel spreadsheet containing a range of pre-defined fields.

Stakeholder interviews

A total of 64 in-depth interviews were undertaken with a range of stakeholders across the six case study sites between September and November 2008, including:

- the ACO with a lead for alcohol[15] (6);
- area probation managers (3);
- senior probation officers (8);
- offender managers (15);
- counsellors (11) and managers (6) of commissioned alcohol services;
- representatives from the Regional Offender Manager (ROM)[16] (5) and D(A)AT (5) office;
- a judge (1) and magistrates (2); and
- a consultant psychiatrist (1) and local community substance misuse team manager (1).

The sampling strategy used for qualitative interviews with professionals was theoretical or purposive in approach. In other words interviewees were selected in each site subjectively using a deliberative approach that sought to include those occupying diverse roles and representing a range of perspectives that were considered to be of relevance and interest. Each of the interviewed professionals had direct working knowledge and experience of alcohol provision within the same D(A)AT area from which the case files were assembled for review.

Again guided by the content of relevant documents such as MoCAM and the NPS alcohol strategy, and in consultation with both the research commissioners and dedicated steering group, a generic interview schedule was developed for use with stakeholders. The interviews covered a broad range of issues linked to the overall aims and objectives of the study.

Data analysis

All quantitative data (including responses to the national survey and results from the case file reviews) were subject to analysis using the Statistical Package for the Social Sciences (SPSS). During secondary analysis of OASys data levels of association between categorical variables were examined using chi-square tests. Associations between continuous variables were tested using Pearson correlations. The Independent-Samples T Test procedure was followed when comparing means between two groups of cases.

15 These in-depth interviews with ACOs in the six case study sites allowed for a range of themes and issues to be explored in greater detail than was possible during the earlier telephone survey.

16 From 1 April 2009 ROMs and Prison Area Managers were replaced by Directors of Offender Management (DOMs) who have responsibility for the delivery of all NOMS services in England and Wales.

Following transcription, qualitative interview data were coded under key headings and subject to thematic analysis with the support of a computer-assisted qualitative analysis program (QSR N6), thus allowing for the systematic identification of emerging themes and issues relevant to the study's aims and objectives.

3. Results

Probation work nationally with alcohol-misusing offenders

Based on responses gathered during both the national survey and stakeholder interviews, it seemed that efforts to ensure more effective commissioning and delivery of alcohol services had been hampered by a lack of:

- resources and dedicated funding for the provision of alcohol interventions and treatment;
- guidelines[17] and protocols to inform the targeting of available interventions;
- appropriate and accessible alcohol treatment provision;
- probation staff confidence, skills and knowledge around alcohol-related issues; and
- success engaging and influencing local commissioners to afford greater priority and resources to work with alcohol-misusing offenders.

As one respondent to the national survey observed:

> *"The scale of the task ahead cannot be underestimated. This must have long-term strategic and fiscal commitment from NOMS, the NHS, local authorities and community support groups."*

Half (49%) of all offender assessments in six case study areas identified alcohol as an influence on offending behaviour; the corresponding figure for drugs was 25 per cent. Despite this level of need (see Appendix 5 for the complete analysis of alcohol-related needs and interventions using OASys data), one in three probation areas in England and Wales responding to the national survey had not completed an alcohol needs assessment. An ongoing commitment to identifying local alcohol-related need is an important step towards improving knowledge, refining working practices and securing greater engagement (and possibly funding) from key strategic partners like PCTs and D(A)ATs[18].

Accredited programmes and structured interventions

On average, English and Welsh probation areas responding to the national survey were offering six of a possible 11 alcohol-related interventions (see Appendix 6 for full details of a selection of key interventions currently being delivered). While some of the measures described below are not directly alcohol specific interventions, a significant proportion of offenders with alcohol problems will commit violent offences (Howard, 2006: 2), for example, and therefore their offending behaviour will need to be addressed through attendance on a specific violence programme. Where alcohol is a factor, this would need to be sequenced

17 The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) Best Practice Portal describes guidelines as "systematically developed statements to assist practitioner and patient decisions about appropriate interventions for specific circumstances...Guidelines often include a set of recommendations or steps that can be followed when implementing an intervention. The content of guidelines are commonly based on available research evidence".

18 Or Local Health Boards and SMATs in Wales.

with an appropriate intervention(s) to address alcohol misuse. The programme which targets the greatest area of risk should be sequenced first. However, it will be for the offender manager to determine in individual cases.

Areas decide which interventions they need to offer in order to make up a comprehensive suite of provision. It is neither necessary nor desirable for areas to offer all 11 interventions as to do so would involve duplication of scare resources. This is particularly true for substance misuse and domestic violence programmes. Staff should be provided with the necessary training to deliver these interventions effectively and offered support with implementation and delivery, which follows a theoretical manual based approach. There is already some published guidance available to areas on the use of accredited programmes in conjunction with disposals like ATRs (National Probation Directorate, 2005) along with more recent specific advice on the sequencing of alcohol misuse and domestic violence programmes. More information will be provided in the Alcohol Interventions Guidance due for publication in September 2009.

Most of the work described below was being paid for through core NOMS funding. The most common forms of intervention being delivered at the time of interview[19] were:

- Drink Impaired Drivers scheme (DIDs) (41)
- Integrated Domestic Abuse Programme (IDAP) (34)
- Brief interventions (32)
- Alcohol Treatment Requirements (ATRs) (28)
- Offender Substance Abuse Programme (OSAP) (22)

It should be noted too that not all offices within a given area were able to offer certain interventions to every suitable offender. For example, one area reported that ATRs were only available in three of the five D(A)AT areas that it covered. The likelihood of a particular accredited programme being proposed or used was also influenced by a range of additional factors – typically accessibility. In one of the case study areas, for example, one senior probation manager described how the area was keen to promote the use of OSAP for alcohol-misusing offenders because: (i) there was an acute lack of suitable treatment available in the community; (ii) it was perceived as doing something constructive and useful with the offender; and (iii) there was a central target to achieve.

Offender managers in this particular area though were generally reluctant to use this option because, in their experience, many alcohol-misusing offenders are hesitant to commit to an intensive 26 session intervention and/or are unwilling to engage in group-based programmes

19 Interviews were conducted between February and May 2008. The range of interventions we asked respondents about was not exhaustive and excluded some such as Control of Violence for Angry Impulsive Drinkers (COVAID), as it had not been developed by NOMS and not all versions had been accredited at the time the questionnaire was being drafted.

of this sort (see McMurran and McCulloch (2007) for evidence of similar unease among some offenders about participation in group-based programmes). Offender managers also described a range of difficulties which, in their view, prevented them from using OSAP with alcohol misusers in this area: (i) the programme was only available in two locations and not during evenings or weekends; and (ii) it mainly targeted – albeit stabilised – problem drug users.

By contrast, fewer than half the areas responding to the national survey reported offering the following interventions to at least some of their offenders:

- Aggression Replacement Training (ART) (18 areas)
- Controlling Anger and Learning to Manage it (CALM) (16)
- Addressing Substance Related Offending (ASRO) (16)
- Lower Intensity Alcohol Programme (LIAP) (9)[20]
- Community Domestic Violence Programme (CDVP) (9)
- Programme for Reducing Individual Substance Misuse (PRISM) (1)[21]

There was, however, little variation between the different regions in terms of the average number (6) of interventions being offered.

Brief interventions

Respondents to the national survey were also asked about which stages in the sentencing process brief interventions were being delivered and what form these interventions took i.e. whether consistent with tier 1 (approximately five minutes of brief advice) or tier 2 (a series of structured interviews – between three and twelve – in general or non-alcohol specialist settings, each lasting approximately 30 minutes) of MoCAM. The responses, set out in table 3.1, indicate that around half the probation areas in England and Wales were offering brief interventions through an activity or supervision requirement of both a Community Order (23) and a Suspended Sentence Order (22), and through an ATR (20). Generally speaking the brief interventions that were being delivered via these orders were consistent with tiers 1 and 2 of MoCAM.

20 During the time the survey was conducted LIAP was only available in a small number of pilot areas.
21 PRISM has largely been superseded by OSAP and/or ASRO.

Table 3.1: Stages in the sentencing process at which brief interventions were delivered by probation areas and the form these took (N=41)

	Number of the 41 areas delivering brief interventions	Number of these areas delivering brief interventions equivalent to tier 1 of MoCAM (i.e. approx 5 minutes of brief advice).	Number of these areas delivering brief interventions equivalent to tier 2 of MoCAM (i.e. 3 or more repeat sessions each lasting approx 30 minutes).
At pre-sentence report stage.	13	13	7
Through an activity or supervision requirement of a community order.	23	23	23
Through an activity or supervision requirement of a suspended sentence order.	22	22	21
Through an ATR.	20	18	19
Post custody through an alcohol related licence condition.	18	16	17

Fewer areas were delivering brief interventions post custody through an alcohol-related licence condition (18). Again those that were tended to do so in a manner consistent with tiers 1 and 2 of MoCAM. Around one-third of the areas questioned (13) reported that they delivered brief interventions at the pre-sentence report stage. These tended to be much shorter interventions in line with tier 1 of MoCAM.

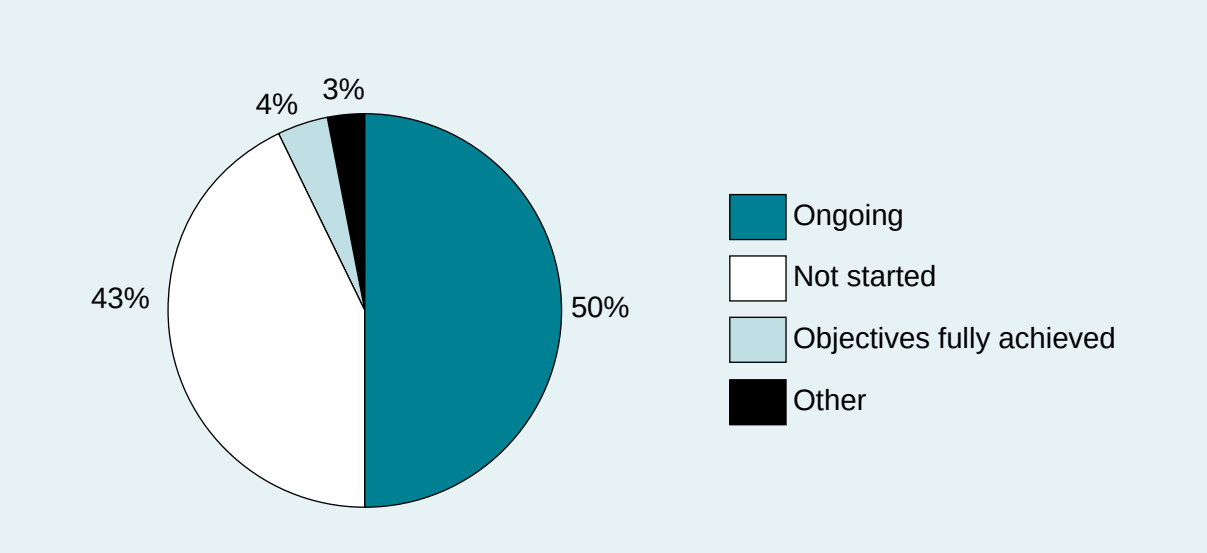
Overall, more than three-quarters of probation areas (32) were reportedly delivering brief interventions during at least one of these stages of the supervision process. Only six areas offered brief interventions at all five stages. The nine areas not reportedly offering brief interventions were nonetheless delivering an average (mean) of five other alcohol-related interventions (ranging from three to six).

The delivery of brief interventions is supported by NOMS through guidance and the dissemination of learning points and outputs, e.g. the Alcohol Information Pack and learning from the best practice projects (see Chapter 4). Two of the first phase projects piloted and evaluated distinct approaches to brief interventions. NOMS also encourages areas to ensure that staff involved in delivering brief interventions are trained and competent to the relevant DANOS benchmarks. In support of this, Avon and Somerset Probation Area were funded to develop training packages for tier 1 and 2 interventions linked to DANOS and the results from this were made available through the probation intranet.

Addressing alcohol-related needs

Our analysis of a subsample comprising 1,001 valid sentence plan reviews completed within four to six months of the sentence date in six case study areas revealed that half of all interventions (n=351) were still ongoing at this stage while 43% had yet to start (n=303). As figure 3.1 illustrates, in 4% of cases (n=31) the sentence planning objectives relating to alcohol had been fully met by first review. These findings are broadly consistent both with the observation that in many areas offenders are increasingly 'stacked' waiting to begin programmes or elements of requirements (Oldfield and Grimshaw, 2008), and with analysis of national commencement and completion figures for OASys-identified 'dependent'[22] drinkers during 2007/08 (Moore, 2008). Produced by O-DEAT and made available to the research team, these end of community sentence assessment data showed that alcohol-related interventions were recorded as fully achieved or ongoing for under half (44%) of all 'dependent' drinkers (see Appendix 5 for full details).

Figure 3.1: Alcohol-related interventions delivered at first (4–6 month) review in six case study areas (n=1,001)



Levels of compliance with Models of care for alcohol misusers (MoCAM)

Screening, referral and assessment

OASys was the main means of identifying offenders whose crime was linked to their alcohol use throughout probation areas in England and Wales. In addition, three-fifths (25) of the areas questioned as part of the national survey reported that they routinely screened offenders for harmful and/or hazardous drinking patterns. In those areas routinely screening

22 Defined by O-DEAT as achieving a section 9 (alcohol) score of six or more, these estimates need to be interpreted with caution as not all offenders are assessed at completion of sentence. The estimates therefore may not reflect actual levels of alcohol dependency within probation caseloads.

offenders the AUDIT[23] scale was the primary instrument used for this purpose. Once screened the general aim was then to intervene, signpost and refer on as appropriate.

Probation settings offer important opportunities then for the screening and identification of alcohol misuse using OASys and AUDIT, the delivery of brief interventions and, where appropriate, onward referral to specialist assessment and treatment. Nationally, many areas had developed local eligibility criteria for different levels of intervention based on OASys and AUDIT scores. There were though a number of points consistently raised during both the national survey and in-depth interviews across the six case study sites about screening, referral and assessment processes. As the quotes below illustrate, these tended to focus on concerns about:

- the quality of screening and assessments being undertaken (and the need for further training on this);
- whether screening was being done consistently as part of the NPS's routine interaction with all offenders;
- the accuracy of the screening processes being applied (e.g. concerns around AUDIT thresholds);
- delays in completing assessments and meeting court deadlines because of limited community-based provision and capacity;
- the accessibility of specialist alcohol treatment services to which offenders can be referred (both within probation settings and externally)[24]; and
- knowledge of the extent to which probation staff involved in delivering, managing or directing alcohol interventions are trained and competent to the relevant DANOS benchmarks.

> *"It doesn't seem to work well. We're not properly following up offenders for more detailed assessments".*

> *"There's nothing wrong with quality. It's getting access to support. There's a real dearth of alcohol services and 6–18 month waiting lists. We simply need more in terms of alcohol services as the lead-in time can be quite horrendous".*

> *"Getting offender managers to follow these processes can be difficult. It's not at the top of their agenda and it's all fairly new, too".*

23 Developed by the World Health Organisation, the Alcohol Use Disorders Identification Test (AUDIT) is a validated and approved ten-question screen which aims to provide an accurate indication of recent alcohol consumption in order to identify hazardous, harmful and dependent levels of use and alcohol-related problems.

24 In response to National Audit Office (NAO)/Public Accounts Committee (PAC) reports into the supervision of Community Orders in England and Wales, which were critical of the availability of specialist treatment, the Ministry of Justice set up an Alcohol Provision Working Group to lead a strategic review of provision and identify the action needed to close the gap between offender need and available treatment.

"There are some concerns about the screening instruments being used. The thresholds for AUDIT are regularly criticised by practitioners".

Probation staff training on alcohol issues

Many areas had provided some training on alcohol issues to some staff. Although two-thirds (27) of the respondents to the national survey reported that their areas had delivered specific training for staff in order to increase their ability to identify alcohol misuse and respond appropriately, these accounts contrasted starkly with those offered by probation staff in at least two of the six case study areas. Here practitioners tended to emphasise a distinct lack of training on alcohol issues.

"I've had no training on alcohol issues or drug awareness and I'm in my fifth year of practice. I've been told nothing about DANOS or Models of Care".

Furthermore, there seemed to be little knowledge or awareness among respondents to the national survey about the extent to which probation staff involved in delivering, managing or directing (tier 1 and 2) alcohol interventions were trained and competent to the relevant DANOS levels. Less than two-fifths (15) of the respondents were able to provide an estimate of this. The estimates that were offered ranged from no staff being trained and competent to the relevant DANOS standards (in 12 areas) to 100 per cent of staff (in three areas).

Treatment availability and arrangements for referring to specialists

The contribution of the Probation Service in driving the alcohol agenda forward and planning and implementing aspects of MoCAM[25] had been facilitated further by its active involvement – albeit to varying degrees – in local alcohol commissioning structures (e.g. Joint Commissioning Groups) in almost all areas responding to the national survey.

Three-quarters (30) of the areas questioned as part of the survey reported having arrangements in place for referring moderately and severely dependent drinkers to specialists. Around two-thirds (26) also reported some availability across all four tiers of alcohol provision as outlined in MoCAM. While this level of support may have been available to many, the ability of local areas to access this treatment and support in a timely manner, and the limited capacity of local services to meet the high levels of need and demand among criminal justice populations, were consistently raised as major concerns. These problems were particularly acute in relation to tier 3 and tier 4 provision (in 13 areas) and exacerbated further by the limited resources available to probation areas with which to purchase an enhanced level of intervention from local PCTs. The quality and continuity of provision offered to recently released prisoners (including those on licence) was generally considered to be variable and inconsistent too.

25 MoCAM has no direct influence on alcohol practice in Wales. The National Assembly for Wales has its own substance misuse strategy which covers alcohol.

The commissioning and delivery of alcohol treatment requirements (ATRs)

Targeting of ATRs

Demand for ATRs outstrips supply by some considerable margin and only 8 per cent of OASys-identified 'dependent' drinkers commencing community sentences during 2007/08 are estimated to have received one (see Appendix 7 for a profile of ATR sentences and their outcomes). While acknowledging the caveats and limitations associated with using OASys as a means of identifying levels of alcohol dependency, these figures and the accounts of stakeholders gathered during the study suggests that there is considerable scope for expanding ATR provision.

Most areas reported targeting ATRs at the most serious offenders posing the highest levels of risk and/or with high levels of alcohol dependency. For example, those serving ATRs in six case study areas were significantly[26] more likely to be convicted of summary motoring and violence against the person offences, have more criminogenic needs identified at assessment and a higher OASys raw score than those not serving such a requirement.

However, one in three offenders commencing community sentences during 2007/08 were assessed as 'dependent' drinkers. While this figure is equivalent to more than half those in alcohol treatment throughout England during April 2008, only one in 12 (8%) of these 'dependent' drinkers identified by O-DEAT had an ATR imposed during 2007/08. As previously noted, this is well below the optimum rate of one in seven (15%) previously proposed by Alcohol Concern. The proportion of assessed 'dependent' drinkers receiving an ATR varied considerably: from 1% in the North East (where, according to the ANARP study, only one in 102 dependent drinkers were able to access treatment each year) to 26% in London.

ATR commencements and completions

There were 5,145 ATR commencements between April 2007 and March 2008 – an increase of nearly 50% on the previous year. Two-thirds of all ATRs were made across three of the ten regions: London (1,359), Eastern (1,078) and the South East (1,052). By contrast, only 32 ATRs were commenced across the North East during this time. This is despite the fact that recent research suggests that the North East has amongst the highest percentage share of people in England with an alcohol use disorder, while those in London have the lowest identification rates for both hazardous/harmful drinking[27] and dependence (Drummond *et al*., 2005:16). This is another indication of how ATR availability, like access to specialist treatment provision, is not correlated with levels of need.

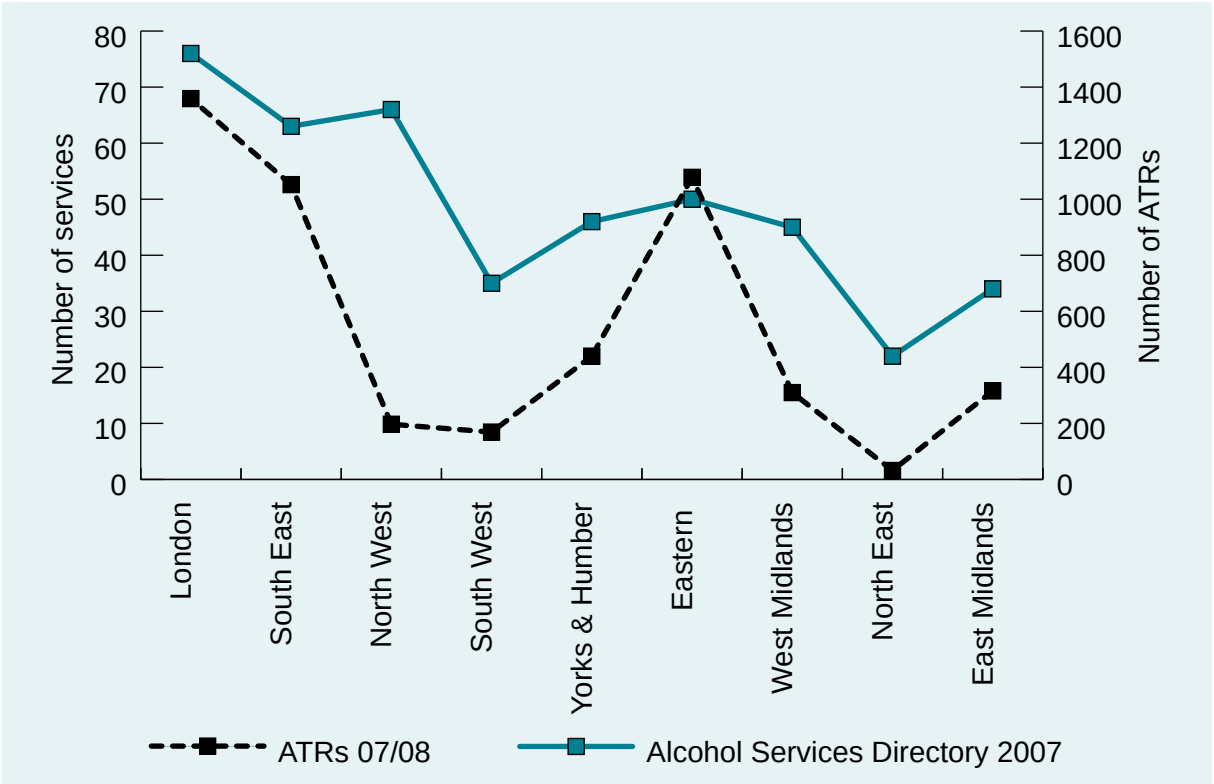
26 This refers to findings that are statistically significant at or below the 5% level ($p<0.05$). In other words the finding has a 95% or more chance of being true i.e. if you were to collect 100 samples and conduct a similar analysis, 95 of the samples would produce a similar result. The tests employed are described in Chapter 2.

27 These rates are also broadly consistent with the Local Alcohol Profiles for England (2008) that are published by the North West Public Health Observatory.

In fact, the variation in ATR commencements between London and the North East is somewhat consistent with both the distribution of community-based alcohol treatment agencies identified by the Alcohol Services Directory 2007[28] and the ANARP Prevalence Service Utilisation Ratio (PSUR), which indicated the extent to which the in-need alcohol dependent population were accessing alcohol treatment during 2004. This suggested that the North East had the lowest access rates to alcohol treatment while London had one of the highest (ibid: 21–22). More recent analysis, however, suggests that the situation may have improved considerably in the North East during the intervening period (Smith, 2008).

However, while acknowledging that both the population of dependent drinkers and the capacity of local services will vary considerably, Figure 3.2 illustrates how treatment availability and ATR provision during 2007 would appear to be associated to some degree in some areas, but less so in others – most notably in the North of England. Based on available data[29] the number of ATRs imposed by individual probation areas within the regions during 2007/08 also varied widely: from none in Surrey and Gloucestershire to 703 in Hampshire; thus reflecting the diverse stages of development which probation areas in England and Wales had reached with regards to ATR provision during the time of our fieldwork.

Figure 3.2: ATR starts (07/08) mapped against the distribution of community-based alcohol treatment agencies identified by the Alcohol Services Directory 2007



28 The researchers are grateful to Nicolay Sorensen, Director of Policy and Communications at Alcohol Concern, for providing these figures. It should be noted that the directory relates primarily to the 2007 calendar year while ATR figures are for the 07/08 financial year.

29 The researchers did not have data on throughputs at a borough level in the London area, for example.

There were 3,129 ATR terminations during this period. Just over half (56%) were completed, having either expired or for good progress. Around one-third (35%) were revoked. ATR completion rates varied considerably between different probation areas: from 31% in Yorkshire and Humberside to 60% in the North West[30]. Understanding the causes and drivers of this variability is important because completion of substance misuse programmes is associated with reduced rates of reconviction (Hough *et al*., 2003; Hollis, 2007; see also McMurran and Theodosi, 2007)[31].

ATR outcomes

Although there are no published data on specific outcomes for ATRs, the review of 185 randomly assembled case files (see Appendix 7 for the full results of this exercise) relating to offenders with an alcohol misuse need – 64% of them serving an ATR – showed that ATR cases were significantly more likely to access alcohol support than non-ATR cases (average 6.0 appointments vs. 0.6). While half the ATR cases (49%) had accessed support during the first month of supervision, around one in seven (17) failed to engage with any alcohol-related support during the first six months of supervision. Those completing an ATR (48) did so having attended an average (mean) of 7.3 sessions. Only five non-ATR cases received any alcohol-related intervention (8% of all cases or one in three of those with related requirements).

Most of the cases reviewed (165) had a subsequent OASys section 9 score (e.g. following review, completion or a new PSR), enabling changes over the period of supervision to be measured. These scores, which can range from zero to ten, are based on five alcohol specific questions (described in Chapter 2) with possible responses ranging from zero (no problems) to two (significant problems). While acknowledging a number of caveats and limitations associated with this approach, there was a small (minus one) reduction in overall section 9 scores. Half (85) showed reductions ranging from one to six points. ATR cases were significantly more likely to record a reduction (59% vs. 38%), but while the overall reduction in section 9 scores was greater for the ATR group (-1.38 vs. -0.93), this difference was not statistically significant. In addition, many cases (69) showed no change in their section 9 alcohol score; though non-ATR cases were significantly more likely to record this status (55% vs. 34%). For 11 of the cases reviewed (7% of them) overall section 9 scores increased by between one and three points over the period of supervision.

Funding and commissioning arrangements

It was a belief held by most respondents that the development of alcohol services had suffered as result of the political emphasis and considerable financial investment devoted to the drugs and crime agenda during the last ten years. These problems had been exacerbated by a

30 ISMG advised that data for 2008/09 show generally higher completion rates and a far greater consistency of ATR performance across NPS.

31 It is not clear to what extent these reductions in reoffending are related to treatment interventions or to differences between completers and non-completers.

perceived lack of 'ownership' over alcohol-related crime at a strategic level which had failed to ensure effective integration of services and responses, and perpetuated a sense of uncertainty about where responsibility rested for funding programmes of work in this particular area.

The original ATR guidance (National Probation Directorate, 2005: 7) acknowledged that areas might initially choose to use some of their partnership funding allocations to ensure access to appropriate services. However, the official position of NOMS on the funding of ATRs is that local probation areas should not have to pay PCTs for treatment which they have a statutory responsibility to provide in order to meet the needs of those residing within their catchment areas, regardless of whether some of those residents happen to be offenders (NAO, 2008b: 26). This is not to say that individual areas cannot purchase an enhanced service which ensures quicker access to treatment, longer and more intensive treatment than that delivered on a non-statutory basis and regular reports from providers on issues like attendance, compliance and progress.

As noted above, two-thirds (28) of areas responding to the national survey reported that they were delivering ATRs. Despite their best efforts, three in five (18) of these areas stated that they were also financing this provision exclusively or predominately using probation funds. It seems that most PCTs remained reluctant to increase capacity for criminal justice clients through the funding and resourcing of ATRs.

> *"If you talk to the commissioner about ATRs [s/he] says 'well, if criminal justice want that, criminal justice will have to pay', is [their] view, and the PCT are in dire straits with their budget, and things are extraordinarily tight here, and they're just not talking to us".*

In terms of commissioning provision, the use of small voluntary sector organisations and the purchasing of sessional time had rendered ATR provision vulnerable in at least two of the case study sites following prolonged periods of staff sickness and/or turnover. Such limited capacity within the local ATR provider meant that in both sites monitoring – and to a lesser extent enforcing – attendance in a meaningful way became extremely problematic. This in turn had implications for the willingness and confidence of the courts to impose new ATRs and rendered many existing requirements unenforceable for a period of time.

When questioning respondents about arrangements for funding ATR provision, comparisons were invariably made with the arrangements and substantial contributions made for the delivery of drug treatment for those under probation supervision, most notably through DRRs. The Ministry of Justice contributed £22 million in 2008/09 to the Pooled Treatment Budget (in addition to a £20 million permanent transfer to the Department of Health) to pay for the treatment and testing elements of these requirements in England. Probation areas were also broadly expected to spend £39 million funding their supervision and enforcement (Hansard, 2008).

By contrast, provision for those with alcohol misuse problems is commissioned at local probation area level – as had been the case with drug treatment prior to the introduction of DTTOs in 2000 - and details on the nature and/or cost of this treatment is not recorded centrally. However, based on recent NAO estimates (2008b: 27) using cost data from two probation areas, the 5,145 ATRs commenced during 2007/08 could cost somewhere in the region of £8.6 million (ranging from £2.9 to £14.2 million). Clearly such estimates need to be treated with caution and more work is needed to establish the unit costs of delivering ATRs.

Barriers to implementation

At the time the national survey of probation areas was undertaken those areas which had yet to offer ATRs (13) were asked to identify the main barriers preventing them from implementing and delivering this kind of support. While a small number had plans to introduce ATRs in the near future, four consistent key themes emerged:

- a lack of dedicated funding for ATRs.
- ongoing uncertainty about where responsibility lies for providing and funding this type of support.
- limited local treatment availability.
- a perceived lack of guidance on delivering ATRs

All probation areas in England and Wales have since agreed an ATR completion target for 2009/10.

Aims of the ATR

There appeared to have been at least some form of a consensus emerging in the case study sites about the main goals of the ATR. These were broadly articulated as working with the offender towards: (i) abstaining, reducing or controlling drinking levels; (ii) reducing related criminal activity; and (iii) promoting change and improvements in other areas of life. When making a judgement about the ability of the ATR to deliver these sorts of outcomes, respondents stressed that any such assessment should be mindful of the intensity (usually six hourly sessions) and duration (typically delivered as a six-month sentence) of a requirement aimed at a dependent drinking target group.

ATR treatment

There was considerable variability in how the treatment component of an ATR was being delivered. Just over one in four (8) of those offering ATR support when responding to the national survey described interventions which were consistent with tiers 3 and 4 of MoCAM. Four respondents stated explicitly that their ATR provision comprised solely of brief interventions. The remainder (16) reported a degree of inconsistency in how their ATRs were being delivered – combining both levels of intervention – depending on treatment availability and the assessed needs of the offender.

"Nothing is being done systematically in relation to ATRs at the moment and it's all very inconsistent. We're trying to tailor ATRs on an individual basis using informal agreements between the offender manager and a GP. But these are effectively brief interventions and not tier 3 and 4 level support".

This pattern was generally repeated across the six case study sites. Although these areas aspired to offer structured, evidence-based, psycho-social therapies delivered by specialist workers (i.e. tier 3 and 4 interventions), the frequency and intensity of this contact – typically six one-hour sessions – certainly for the researchers at least, blurred the distinction with extended brief interventions more consistent with tier 2 of MoCAM.

Improving provision

There was a general consensus that there was more scope for better targeting of ATRs, more accurately assessing motivation and offering more timely interventions. This was particularly important given the limited capacity within many local alcohol treatment providers to see people as soon as they were sentenced to an ATR and the lengthy waiting times to access specialist support, such as detoxification facilities. There were also some calls for clearer guidance around appropriate enforcement responses to different scenarios (e.g. instances where ATR cases present at their first treatment appointment – often many weeks after being sentenced – reporting either not drinking or experiencing any problems with alcohol).

Many respondents also referred to the substantial scope that should exist for transferring best practice learned from drug treatment and testing orders (DTTOs) and DRRs about effective approaches to joint commissioning, the use of dedicated and co-located teams, partnership working, enforcement strategies and pointers for effective engagement tactics to employ with an intractable group of offenders.

4. Emerging best practice

A key objective of this study was to identify and disseminate emerging examples of best practice to probation areas and key stakeholders. It was beyond the scope and resources of the study to validate or assess the impact of these different approaches. Nevertheless, some of the main developments in this area are set out below (and in more detail in Appendix 8).

During 2006/07 the Interventions and Substance Abuse Unit (ISAU) within NOMS made available £100,000 in an effort to help identify, develop and disseminate emerging best practice relating to the aims and objectives of the NPS alcohol strategy, *Working with Alcohol-misusing Offenders*. This funding was allocated to seven projects across NPS based upon the outcome of a competitive bidding process with a maximum of approximately £15,000 being made available for each project. In 2007/08 an additional £30,000 was made available to six of the seven projects for follow-up work.

As part of NOMS's continuing commitment to strengthening operational delivery to address alcohol-related offending, a total of £125,000 was made available to eight areas for new project work in 2008/09. Full details of this work can be found in Appendix 8.

Across the six case study sites there were four examples of practice which the researchers felt showed promise and are worthy of further exploration and possibly replication. These were:

- the integration of dedicated alcohol workers within probation offices;
- alcohol treatment staff routinely having direct access to probation case management systems;
- the use of three-way meetings between the offender manager, alcohol treatment worker and offender at the start, middle and end of the ATR; and
- both partners measuring and recording indicators of effectiveness in a consistent way.

These and other claims of emerging best practice are described in more detail below.

Promising practice in six case study areas

Across the six case study sites the focus on dedicated provision for alcohol-misusing offenders was universally welcomed, but considered long overdue, and there were numerous examples offered of what were considered by the respondents to be emerging best practice.

Four of the six areas had arrangements in place to ensure that those in need of more intensive intervention in the form of an ATR were referred for a specialist assessment, in line with national ATR guidance and MoCAM. Stakeholders in these four areas regularly reported that provider input into the assessment process at the pre-sentence reporting stage

had contributed towards ensuring that more appropriate and suitable referrals were made than might otherwise have been the case. Pre-sentence assessment by partnership workers in one site, for instance, and the use of AUDIT to target ATRs at dependent drinkers was regarded as a positive development by stakeholders and considered an example of best practice[32].

There was consistent evidence from stakeholder interviews and case file reads in all the case study areas that staff were applying motivational interviewing techniques and *model of change* knowledge and skills during their routine interaction with alcohol-misusing offenders (see McMurran, 2009).

Probation staff at one site also reported having access to an alcohol intervention practitioner to work with offenders who scored six or less on OASys section 9, thus offering an important brief intervention and outreach service for hazardous and harmful drinkers. The worker offered support over six sessions on a voluntary basis or as a condition of a specified activity requirement.

Across all six case study sites the integration of dedicated alcohol workers within probation offices – and the willingness of probation teams to facilitate these arrangements – was seen as a particularly positive development[33]. This, together with the routine use of feedback forms, helped ensure that there was direct and regular communication between offender managers and partnership staff in all sites.

> *"I've been really impressed with the way that I've been accepted within the Probation Service, and with the communication that's been going on between us. It's been really good, really helpful".*

There also appeared to be a clear delineation of operational roles and responsibilities. However, it was reported by only one of the six areas that it was possible for alcohol treatment staff to routinely have direct access to probation case management systems. (By contrast this was reportedly a much more regular feature of working arrangements between probation areas and providers in Wales.)

On the whole there were also good working relationships reported between managers of alcohol treatment services and probation middle managers across the six sites. These generally appeared to be mature, flexible and responsive having often been built on established historical links with existing partnership agencies.

32 But some offender managers acknowledged that this approach missed binge drinkers and those who deliberately downplayed their consumption levels at assessment.

33 While co-location was generally considered to be a positive thing, some questioned the impact seeing clients in a probation setting had on the development of a therapeutic relationship.

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 in one of the six sites as a means of establishing the aims and objectives of the requirement and monitoring progress towards achieving goals. Similar arrangements did not appear to be in place in the other five case study areas and the benefits and applicability of these meetings in other areas may be worthy of further consideration.

During the time of the fieldwork none of the six areas routinely collated and recorded alcohol screening and assessment information (e.g. results from AUDIT forms) in a way that could be used by the research team. However, new arrangements in one area aimed to ensure that providers measured the impact of alcohol interventions by routinely asking the same questions as those contained in section 9 of OASys. This meant that both partners were measuring and recording indicators of effectiveness in a consistent way.

5. Further research

Existing gaps in our knowledge

During the course of the study the researchers were alerted to the fact that most (32) areas were aware of local research and evaluation that had been or was being conducted in relation to alcohol-misusing offenders. These included local (often internal) audits, regional needs assessments and, in a few cases, external independent evaluations (e.g. Screening and Intervention Programme for Sensible drinking (SIPS) and one study looking to assess the impact of disulfiram (antibuse) on rates of treatment compliance and re-offending).

Yet despite this level of monitoring and evaluation the researchers were unable to locate any recent published and peer-reviewed British research specifically assessing the effectiveness of alcohol interventions delivered within a criminal justice setting in reducing both alcohol misuse and rates of reoffending (see Appendix 2). While there is some evidence to support the contention that participation in, and in particular completion of, accredited offending behaviour and substance misuse programmes leads to reduced rates of reconviction (Hollin *et al*., 2004; Hollis, 2007; McCulloch and McMurran, 2008), the study designs employed often do not allow inferences of cause and effect given the absence of well matched comparison groups or any consideration of dynamic risk factors (e.g. offender characteristics such as motivation and capacity for change). The various large-scale offender cohort studies that have been commissioned during recent years by Offender Management and Sentencing Analytical Services (OMSAS) – the Offender Management Community Cohort Study (OMCCS), Surveying Prisoner Crime Reduction (SPCR) and Juvenile Cohort Study (JCS) – should, however, help fill these considerable gaps in our knowledge.

In the meantime, there are opportunities for deploying innovative research designs using tight experimental controls and randomisation to assess the effectiveness of interventions aimed at alcohol-misusing offenders. There is, for example, likely to be considerable scope for assembling suitable experimental and comparison groups comprising dependent drinkers in many areas, given the low ratio of such drinkers being exposed to ATR provision (perhaps around one in twelve based on existing O-DEAT data). Comparison groups could consist of those offenders who are eligible for such a requirement, but are unable to access this support because of waiting times or limited provision.

Developing a better understanding of the factors driving variable ATR performance should also prove insightful for developing practice with alcohol-misusing offenders. Factors that any research would need to consider include variations in:

- treatment intensity, quality, availability and accessibility;

- area-level differences in the profile of those being sentenced to ATRs (including the length of ATRs being imposed); and
- area-level enforcement strategies.

There is also likely to be considerable scope for anonymously linking various administrative data including OASys, different case management systems, the Interim Accredited Programme Software (IAPS), National Drug Treatment Monitoring System (NDTMS) and Treatment Outcomes Profile (TOP) data currently collated by the NTA on engagement, retention and outcomes for alcohol treatment (in England), and criminal history data stored on the Police National Computer. The Ministry of Justice may wish to consider funding research to assess the feasibility of such work.

The specific gaps that remain in the evidence base supporting work with alcohol-misusing offenders are broadly consistent with those recently identified for drug misusing offenders specifically (McSweeney, *et al*., 2008; UKDPC, 2008) and those serving court sentences more generally (NAO, 2008b). In addition to the somewhat predictable call for facilitating more rigorous and robust evaluations of the effectiveness of different alcohol programmes and interventions, the cost-effectiveness and the value for money they offer, again specifically within a criminal justice context, also needs to be quantified and measured.

The development of empirically informed guidance to instruct senior probation managers and practitioners about the effective targeting of alcohol interventions is hindered by the dearth of British research evidence. There is also limited data about which existing interventions are likely to be most effective for whom e.g. different offender management tiers and those presenting with hazardous, harmful or dependent drinking patterns (see also McMurran, 2007; Bowes *et al*., 2009).

Other important issues and areas that should be given greater priority in any future research programme include:

- a comprehensive comparative outcome study to assess the impact of ATRs for different offender groups;
- comparative evaluations to consider the impact of different alcohol interventions for young offenders, women and Black and minority ethnic groups; and
- research to assess the processes and outcomes for alcohol-misusing offenders discharged from prison[34].

34 As part of the best practice initiative, the Leicestershire and Rutland Probation Trust commissioned a small-scale research project in 2008/09 with a view to identifying ways of improving the transition of alcohol-misusing offenders between prison and the community and between different screening, referral and treatment systems they encounter on route.

6. Discussion and recommendations

Screening and intervening with alcohol-misusing offenders

Findings from this research have shown that English and Welsh probation areas are offering a broad range of alcohol-related interventions to at least some of the offenders they supervise. However, data from a random review of offender case files and analysis of OASys data from six case study areas, together with O-DEAT analysis of OASys data at a national level, which was made available to the research team, all indicate that there were high levels of largely unmet alcohol-related need within NPS caseloads. The researchers think that a key priority for policy should therefore be to increase the use of evidence-based alcohol interventions and treatment with offenders whose criminal behaviour is related to their use of alcohol. That priority should be addressed by:

- (in the short term) sharing and disseminating emerging best practice;
- identifying effective strategies for ensuring more offenders commence and complete those programmes that are available;
- (in the longer term) developing the evidence base and then disseminating empirically informed advice and guidance about the appropriate targeting of interventions[35]; and
- increasing further the range, capacity and funding of the NPS's alcohol-related work.

Probation settings clearly offer important opportunities for the screening and identification of alcohol misuse, the delivery of brief interventions and, where appropriate, onward referral. However, data from this study highlight how improvements are still required in many probation areas to aspects of: alcohol screening and specialist assessment processes; the accessibility of specialist alcohol treatment services; and the level of training for probation staff on delivering brief interventions, specifically, and alcohol issues more generally.

Probation staff training

Given the levels of need consistently being identified among probation caseloads, data from both the national survey and in-depth interviews with stakeholders in six case study areas suggest there is considerable scope for improving the scale, quality and monitoring of training being offered to offender managers to better equip them to more effectively deliver brief interventions to alcohol-misusing offenders. A programme of training could be incorporated into existing arrangements in many areas; for example, one of the six case study sites was renegotiating contracts with its ATR providers to ensure they were actively involved in training probation staff around the delivery of brief interventions[36]. The knowledge and skills acquired during this sort of training, together with disseminating emerging best

35 As part of the best practice initiative, the North Wales Probation Area have developed a targeting matrix of alcohol interventions and programmes which has been disseminated across the NPS for use by other areas via the probation intranet.

36 A bespoke training package, developed by Avon and Somerset Probation Area as part of the best practice initiative, linked to the relevant DANOS competences to enable staff to deliver interventions consistent with tiers 1 and 2 of MoCAM, has also been promoted by NOMS and made available for areas to use.

practice from elsewhere, could be invaluable in those areas experiencing delays accessing accredited programmes and/or community-based alcohol treatment services.

The commissioning and delivery of ATRs

There is scope for expanding provision for alcohol treatment requirements given current levels of need, but continuing uncertainty and inconsistency around funding, targeting and the form this treatment should take need to be resolved as a matter of urgency by the Ministry of Justice and NOMS. The new Alcohol Interventions Guidance due for publication in September 2009 will need to add further clarity on these important issues.

Having been provisionally accredited by the Correctional Services Accreditation Panel (CSAP), it should now be possible for areas to refer many problematic drinkers to the Lower Intensity Alcohol Programme (LIAP). This welcome increase in the range of alcohol resources could allow the threshold for ATRs to be increased further still, thus focusing a scarce resource on those presenting with the greatest level of alcohol-related need.

Given the current economic climate and the fact that PCTs in six (of the ten) English Strategic Health Authorities were in deficit to the tune of a total of £389 million during 2006/07 (House of Commons Public Accounts Committee, 2008), it seems extremely unlikely that there will be any softening of position from PCTs on ATR funding in the short term. The Probation Service, like most other government agencies, can also expect to feel a considerable financial pinch in the coming years – despite increasing caseloads and demands (Fletcher, 2009: 2). As Oldfield and Grimshaw had observed prior to the current economic crisis:

> *"According to government plans, probation spending is set to fall by 3% over each of the next three years, a prospect that has been apparently modified in part by the recent announcement of an additional £40 million for the implementation of community orders…Despite increases in spending on probation, recent years have seen reductions in the service's budget and many areas have been struggling to cope with balancing a growing caseload involving more complex working practices with a decline in resources" (2008: 3).*

Resolving the impasse around ATR funding should be a priority for policy makers[37]. In addition to practical steps like providing more support and training for probation managers in their negotiations with PCTs and Joint Commissioning Groups, it is important that in the current economic environment all reasonable options should be explored as a matter of urgency, including, as Soodeen and Shenker have recently proposed, expanding the remit of local Pooled Treatment Budgets to include alcohol treatment (2008: 4).

37 During the course of this work a joint MoJ/DoH Alcohol Provision Working Group was established to consider this matter.

Developing the evidence base

A reoccurring theme throughout the report is how the limited evidence base in Britain limits any efforts to develop empirically informed guidance to instruct senior probation managers and practitioners on key issues relating to work with alcohol-misusing offenders. Crucially, this includes the effective targeting of interventions within a criminal justice context and identifying which ones are likely to be most effective for different types of offender. In the researchers' view these and many other themes and issues (including assessing the impact and effectiveness of ATRs) should be given greater priority in any future research programme.

In the meantime, given the lack of peer-reviewed research evidence, current support and funding by NOMS to identify, develop and disseminate emerging examples of best practice should be commended, endorsed and encouraged. This sort of work represents an important step towards increasing the use of evidence-based alcohol interventions and treatment with offenders whose criminal behaviour is related to their use of alcohol.

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Appendix 1: Alcohol, crime and criminal justice responses

The links between alcohol and crime

Government estimates produced for the first Alcohol Harm Reduction Strategy for England (Prime Minister's Strategy Unit, 2004) calculated that the cost of alcohol-related harm is up to £20 billion per annum, with related crime and anti-social behaviour accounting for over one third (£7.3 billion) of these costs. (This compares with the £15 billion in economic and social costs associated with Class A drug use in England and Wales during 2003 (Gordon *et al*., 2006).)

As with the use of some illicit drugs (primarily heroin and crack), the nature and extent of the links between alcohol and crime are complex (Deehan, 1999; Dingwall, 2005), but clearly there is a greater tendency towards alcohol-induced (crimes of violence or disorder committed while under the influence) or defined (e.g. drink driving) offences rather than inspired ones (crimes committed in order to raise money or obtain property to buy alcohol) (McMurran and Cusens, 2005).

Alcohol features in a number of driving-related offences. There were an estimated 14,480 casualties (6% of all road casualties) as a result of someone driving whilst over the legal limit for alcohol during 2007. The number of deaths was 460 (16% of all road deaths) during this period (Department for Transport, 2008). However, alcohol is most closely linked to violence and the night-time economy – the context in which most crime of this nature occurs (Finney, 2004a). According to the 2004/05 British Crime Survey, almost a half (48%) of all victims of violent crime believed the offender to be under the influence of alcohol. Victims were most likely to believe this in relation to stranger violence and wounding offences (Coleman *et al*., 2006: 21). However, due to a large fall in recorded levels of violence, the total number of offences where the offender is believed to be under the influence of alcohol has dropped by about a third since 1995. Recent research has also explored the extent of alcohol-related sexual violence and domestic violence (Finney, 2004b; 2004c).

Hopkins and Sparrow (2006: 390) note that "there is now a much greater recognition that alcohol misuse or abuse does not only refer to 'so-called' alcoholics or habitual drinkers but increasingly attention is becoming focused on the 'binge drinker." Richardson and Budd (2003) used findings from the Youth Lifestyles Survey to consider the association between binge drinking and offending behaviour. They described how 39% of the 1,376 young adults aged between 18 and 24 qualified as 'binge drinkers' (those who got very drunk at least once a month). These binge drinkers were found to be more likely to report involvement in crime or disorderly behaviour (60%) than other young adults in the sample described as 'regular' drinkers (25%). Richardson and Budd note that the link between drinking and offending was particularly strong for violent crimes. Related research by Engineer *et al*. (2003) identified an array of factors that young adults felt contributed to alcohol, crime and disorder. These included:

- the effects of binge drinking;
- attitudes and motivations;
- social and peer group norms; and
- the drinking environment.

Research in some areas suggests that alcohol is a factor in up to one third of all arrests (Man *et al*., 2002). Those arrested for alcohol-related offences spend significantly longer in custody, over half require medical attention and they are more likely to be aggressive or violent whilst in custody. These findings have led researchers to conclude that drunkenness and related anti-social behaviour represent a considerable burden on police resources. More recently in 2005/06, 57% of respondents in the Arrestee Survey[38] were assessed (using the Fast Alcohol Screening Test) as 'dependent' drinkers (Boreham *et al*., 2007: 50). Nearly two-fifths (38%) said they had got into a fight or used violence against someone after drinking alcohol and one in six (17%) said they had caused damage or vandalised a vehicle, house or some other building after drinking (ibid: 80). However, three-quarters (74%) of the arrestees who were frequent or problematic users of alcohol said they did not want treatment (ibid: 10).

The findings from a recent study describing the problems and needs of 1,457 prisoners before the start of their sentence indicated that 36 per cent could be classified as heavy drinkers (defined as consuming more than twice the recommended sensible daily drinking limits – three units for women and four for men – at least once per week) (Stewart, 2008).

Findings summarising reports from over 100,000 offenders supervised by the prison and probation services using the self-assessment component of the OASys assessment system revealed that drinking too much alcohol is perceived as a problem for one in four offenders (25%) while one in five (19%) linked alcohol to their offending (Moore, 2007: 3).

Alcohol and criminal justice responses

By the late 1980s the Home Office Standing Conference was articulating its concerns about the extent to which underage and binge drinking was contributing to alcohol-related crime and disorder (Hopkins and Sparrow, 2006: 392). Yet by the mid-1990s the first All Party group on alcohol misuse still had to recommend that alcohol services be made more accessible via the criminal justice system (Home Office, 1995). While the last decade has seen a much welcomed and substantial investment in the range and availability of treatment options for drug misusing offenders, the scale of support offered by the correctional services to alcohol misusers has, at best, been patchy and uneven (McMurran, 2006). This is symptomatic of the wider discrepancies that exist between the treatment expenditure per dependent drinker (£197) compared with that devoted to dependent illicit drug users (£1,744) during recent years (National Audit Office, 2008a: 17).

38 It should be noted that using the Arrestee Survey to gauge the extent of alcohol-related crime is likely to be subject to substantial bias and prove to be an under-estimate. For example, only 8% of those arrested for 'drunk/disorderly and other alcohol' offences in the sampled areas were interviewed (2007: 15).

Within the Probation Service this situation had been exacerbated by a tendency in the past for the courts to rely on the knowledge and enthusiasm of individual probation officers to broker and arrange alcohol-related support in the community, rather than making use of a range of accredited programmes and following the guidance set out in a service alcohol strategy (Singer, 1991; Raynor *et al*., 1994). Those serving custodial sentences had fared little better, although 6,400 prisoners had completed alcohol detoxification programmes while in custody during 2002/03 (and an estimated 7,000 more completed a detoxification for combined drug and alcohol misuse), a survey conducted around this time, involving half the prisons in England and Wales, was only able to identify one prison with a dedicated alcohol strategy (Prison Reform Trust, 2004).

But there has been some considerable progress made in recent years. In December 2004 the Prison Service launched its Alcohol Strategy for Prisoners (HM Prison Service, 2004). This was followed nearly 18 months later by the National Probation Service Alcohol Strategy – Working with Alcohol-misusing Offenders: A Strategy for Delivery (National Probation Service, 2006). These two documents effectively constitute the NOMS alcohol strategy. Along with the recent MoCAM guidance, these aim to provide a framework to complement the wider aims of the national strategy by better identifying and treating alcohol misuse. However, as a criminal justice agency, the National Probation Service (NPS) seeks primarily to reduce crime and related disorder by using a range of interventions to tackle alcohol misuse.

Barriers to the effective implementation of criminal justice responses

Although there has been no specific resourcing and funding devoted to the delivery of the Probation Service's alcohol strategy, NOMS has provided in the region of £250,000 to support a number of best practice projects over the last three years. Without dedicated funding to support implementation, the strategic focus has been and continues to be on improving consistency of delivery based upon evidence of best practice within existing resources.

Yet an inspection of seven probation areas found that alcohol service provision was underdeveloped, despite the number of offenders who misuse alcohol being double the number who misuse drugs (HMIP, 2006). The inspectors noted that offender managers experienced particular difficulties delivering the new ATR because of an absence of specialist treatment provision in many areas. It also expressed concern that the lack of commencements targets for ATRs (as is the case with DRRs) would mean that probation areas would afford them little priority.

There were two important reports published by the National Audit Office (NAO) during 2008 which have relevance for the Probation Service's work with alcohol-misusing offenders. The first, which examined arrangements for the supervision of Community Orders in England and

Wales, found that alcohol treatment was rarely available or used in just under half (19) of the 42 probation areas. Moreover, it cited previous findings from research conducted by King's College London which had established how alcohol accounted for just 1% of all requirements made between August 2005 and July 2006. This was despite alcohol being identified as a criminogenic need for 45% of offenders during this time. It is worth noting that the ATR is only intended for a relatively small number of offenders presenting with the most serious alcohol misuse and offending issues. These figures neglect the important work that is undertaken outside the ATR, such as delivery of brief interventions through an activity or supervision requirement or substance misuse interventions delivered through a programme requirement.

Nevertheless the NAO called for greater co-operation between the Ministry of Justice and the Department of Health to increase the provision of alcohol treatment for offenders in all probation areas (NAO, 2008b).

A second report considered measures aimed at reducing alcohol-related harm (NAO, 2008a). It found that each local Primary Care Trust (PCT) had spent, on average, £600,000 commissioning alcohol services in 2006/07. This was equivalent to 0.1% of a typical PCT's annual expenditure of £460million. It also reported that one in four responding PCTs had not accurately assessed the nature and extent of alcohol problems in their areas and that regional oversight of the NHS's response to alcohol misuse had been limited.

These findings are consistent with the conclusions reached recently by Alcohol Concern (Soodeen and Shenker, 2008). In their view the DoH had been powerless to insist that alcohol treatment is either considered or provided, even where the need for it has been most transparent. It identified ongoing problems with local treatment capacity and accessibility – with some areas reporting waits of up to a year to access any form of structured alcohol treatment. Furthermore, many PCTs did not have clear understanding of spending or levels of need at a local level. As a consequence, provision had been largely unplanned, underfunded and undervalued. They also concluded that MoCAM and related guidance had not improved commissioning or treatment provision at a local level.

While the Local Area Agreements (LAAs) process has provided probation areas with a platform on which to highlight levels of need and identify gaps in provision, the process can be a frustrating one for two reasons. Firstly, the focus of these targets (e.g. by seeking to reduce alcohol-related hospital admissions) has tended to be hazardous drinkers and those likely to present with acute physical injuries. Accordingly, the concern for probation areas is that the emphasis is likely to be on interventions delivered via primary care settings and accident and emergency departments rather than criminal justice ones. Such a target is therefore unlikely to develop provision for dependent drinkers in a meaningful way (Soodeen and Shenker, 2008: 3). Secondly, these targets are adopted from a range of optional domains and there are no direct sanctions or consequences for those areas performing badly

or failing to meet them (NAO, 2008a: 9). Since only some of those agencies involved in the LAA process will primarily be concerned with community safety issues, any limited success probation areas have had in exerting local influence may merely be indicative of a broader failure in partnership working between those agencies working within these structures.

Leaving aside issues relating to treatment commissioning, availability and accessibility – a problem by no means unique to the UK (Rabinovich *et al*., 2008), the evidence base for the effectiveness of different interventions in reducing levels of alcohol misuse is considered to be strong for a range of different treatment approaches (see Heather *et al*. (2006) for an extensive review). This evidence is considered briefly in Appendix 2.

Appendix 2: What do we know about effective alcohol treatment approaches?

As well as being effective in reducing levels of alcohol misuse, results from the United Kingdom Alcohol Treatment Trial (UKATT) suggest that treatment is also cost-effective: for every £1 spent on alcohol treatment, the public sector saves £5 (UKATT Research Team, 2005). Whilst there are many social and cultural influences on drinking behaviour, it has been estimated that, either directly or indirectly, treatment interventions account for around one-third of all improvements observed in drinking behaviour amongst treated populations (Heather *et al*., 2006: 15).

Cognitive behavioural approaches to specialist treatment are widely believed to offer the best chances of success. Evidence from meta-analyses of randomised controlled trials have shown that brief interventions, for example, of various types and delivered in a range of treatment settings, are effective in reducing to low levels (but not always eliminating) alcohol consumption amongst hazardous and harmful drinkers (ibid). Their effects on behaviour change can be enduring, lasting for up to two years after the intervention. The evidence from an extensive review by Heather and colleagues also suggested that treatment effectiveness is as much about how treatment is delivered (including procedures for screening, assessment and review, therapist characteristics and treatment settings) as it is about what particular form treatment takes (see also Imel and Wampold, 2008).

In addition to brief interventions, advice and support offered by offender managers during the supervision process, other programmes can also be delivered with a view to addressing alcohol use and misuse, including ASRO (Addressing Substance Related Offending), OSAP (Offender Substance Abuse Programme) and DIDs (Drink Impaired Drivers). Whilst not entirely indicative of a 'treatment effect', recent British research suggests that reconviction rates are significantly lower amongst those completing these substance misuse programmes than those failing to (Hollin *et al*., 2004; Hollis, 2007).

However, more studies – like the one that will measure the impact of the Screening and Intervention Programme for Sensible drinking (SIPS) – are needed to measure the effectiveness of brief interventions in various criminal justice settings (Heather *et al*., 2006: 7–8). The National Audit Office also highlighted major gaps in our knowledge about the effectiveness of specific requirements and provisions currently being delivered as part of community sentences, including the ATR (NAO, 2008b: 6). While there is certainly some limited British evidence for the effectiveness of alcohol-related pharmacotherapies delivered within a probation context (Brewer and Smith, 1983), a recent systematic review of the English-language literature published since 1990 commissioned by the Department of Health, concluded that "there has been no research on pharmacological treatments for alcohol misuse in offender settings" and that consequently "[t]here is a clear need to conduct clinical trials of new and existing alcohol-related interventions in the UK" (Roberts *et al*., 2007: 14).

Appendix 3: The national telephone survey

Assessing the effectiveness of the National Probation Service's work with alcohol-misusing offenders with evidence–based practice

About the study

At the end of January 2008 Roger Hill (Director of Probation) wrote to Chief Officers from each of the 42 probation areas in England and Wales asking for their co-operation with this study. The aim of this first phase of the research is to describe the 'state of play' nationally of probation work with alcohol-misusing offenders and to start assessing compliance with Models of Care for Alcohol Misusers (MoCAM).

The current research is critical to the ongoing development of an evidence based alcohol strategy, as it will help NOMS to identify what is working well, establish where gaps in provision exist and develop strategies for how these might be addressed.

The Institute for Criminal Policy Research (ICPR) at King's College, London is responsible for conducting the research. As an important part of this work we are asking senior managers within probation to describe their experiences of commissioning and delivering alcohol interventions for offenders under probation supervision.

The questionnaire covers a range of topics including:

- your role and responsibilities in relation to alcohol provision;
- needs assessment and commissioning;
- screening, referral and assessment processes;
- the availability of different interventions and how they are delivered;
- the use of ATRs;
- compliance with MoCAM;
- training and staff development;
- resettlement issues;
- diversity;
- monitoring and evaluation; and,
- the role of NOMS in assisting in the implementation, development and delivery of local alcohol interventions.

Interviewer initials		Date of interview	
Probation area		Length of interview	

1. Background

1.1 Please tell me your current job title and responsibilities.

1.2 Please describe your specific responsibilities in relation to alcohol.

1.3 What proportion of your time is currently devoted to alcohol issues?

% (estimate percent)

1.4 Has this increased since May 2006 (when the NPS alcohol strategy – 'Working with Alcohol-misusing Offenders' – was published)? (e.g. less, more, no change).

2. Needs assessment and commissioning

2.1 Has your probation area undertaken an alcohol needs assessment?

Yes ☐ No ☐ Don't know ☐

2.2 If yes, what were the main issues?

2.3 If no, why not?

2.4 Has your area (or NOMS on your behalf) analysed OASys or any other data about alcohol misuse and offending to inform your planning?

Yes ☐ No ☐ Don't know ☐

2.5 If yes, what did this reveal?

2.6 In designing your provision for alcohol-related offending, what role, if any, did MoCAM play?

2.7 In terms of designing and commissioning alcohol services for offenders locally, what has worked well?

2.8 What aspects of this process could be improved?

3. Screening, referral and assessment

Definitions (if any clarification is required)

Screening – Screening for alcohol problems, using a validated alcohol screening tool e.g. AUDIT, FAST (Tier 1 of Models of care for alcohol misusers (MOCAM), is a brief process usually undertaken in generic settings, to identify whether an individual has an alcohol problem (hazardous, harmful or dependent drinker); and, if so, whether delivery of a brief intervention or onward referral to a specialist treatment service for further assessment is the appropriate response. Within a probation setting, it will usually be undertaken on a targeted basis with those offenders for whom section 9 of OASys identified alcohol as an issue.

Assessment – A fuller assessment than that conducted at screening, triage (Tier 2 of MoCAM) and, for those with more complex needs, comprehensive assessment (Tier 3 of MoCAM) is undertaken by specialist alcohol treatment staff upon referral to identify the seriousness and urgency of an individual's problems, the most suitable type of intervention and, where appropriate, enable an individual care plan to be prepared.

3.1 How do you identify offenders whose crime is linked to alcohol use?

3.2 What happens once they have been identified?

3.3 Do you routinely screen offenders for harmful and/or hazardous drinking patterns?

Yes ☐ No ☐ (**Go to Q3.6**) Don't know ☐

3.4 If so, what tools are used?

3.5 If you screen, what happens once they have been identified?

3.6 Who completes the (subsequent) alcohol assessment? (Please tick all that apply)

Partner agency ☐ Probation Officer ☐ PSO ☐ Other ☐

3.7 Do(es) the individual(s) undertaking (a) the initial screening and (b) any follow-up assessment have the relevant DANOS competences?

	Yes	No	Don't know
Initial screening	☐	☐	☐
Follow-up assessment	☐	☐	☐

3.8 What aspects of the screening, referral and assessment process have worked well? (**INTERVIEWER PROMPT**: e.g. developed good links and regular feedback with other agencies, offenders increasingly aware of their needs in relation alcohol use and what options are available for them).

3.9 How (if at all) can the screening, referral and assessment process be improved? (**INTERVIEWER PROMPT**: e.g. it could be quicker, more information made available to offenders, offender managers and referring agencies in a more timely manner

4. Interventions – programmes delivered

I'd now like to ask you some questions about the following interventions/programmes.

	Is it available?	Who provides it?	How is it funded?	Do you routinely collect data on throughputs and/or outcomes?	Who is the most appropriate person to contact for end of year data?
4.1 Alcohol Treatment Requirements (ATRs)					
4.2 Brief Interventions					
4.3 Addressing Substance Related Offending (ASRO)					
4.4 Offender Substance Abuse Programme (OSAP)					
4.5 Programme for Reducing Individual Substance Misuse (PRISM)					

	Is it available?	Who provides it?	How is it funded?	Do you routinely collect data on throughputs and/or outcomes?	Who is the most appropriate person to contact for end of year data?
4.6 Drink Impaired Drivers Scheme (DIDS)					
4.7 Lower Intensity Alcohol Programme (LIAP)					
4.8 Integrated Domestic Abuse Programme (IDAP)					
4.9 Aggression Replacement Training (ART)					
4.10 Community Domestic Violence Programme (CDVP)					
4.11 Controlling Anger and Learning to Manage it (CALM)					

4.12 What are the criteria for deciding which programme an offender with alcohol issues is referred to? (**INTERVIEWER PROMPT**: e.g. level of risk, assessed needs, seriousness of the offence, availability)

4.13 Where provision is delivered by external alcohol treatment agencies, how were these agencies identified and commissioned?

5. Alcohol Treatment Requirements

(Only to be asked of those areas indicating above that they currently have ATR provision in place [Q4.1 above]. **If no ATR provision currently in place, Go to Q5.6**)

5.1 What is delivered as part of your ATR provision? (**INTERVIEWER PROMPT**: explore whether clinical/medical interventions – consistent with Tiers 3 and 4 of MoCAM – or brief interventions are mainly being delivered.)

5.2 What groups of offenders do you target ATRs at? (If not covered above)

5.3 Which groups (i.e. age, gender, offence type, severity of alcohol problem) tend to do well on ATRs?

5.4 Which groups do not do so well?

5.5 What do you think are the main reasons for offenders not completing ATRs?

5.6 If there is currently no ATR provision offered in your area, what are the main barriers preventing you from implementing and delivering this kind of support?

6. Brief Interventions

At what stage(s) in the sentencing process are brief interventions delivered and what form do these interventions take (please tick all that apply)?

	Brief Interventions delivered?		Brief Interventions equivalent to Tier 1 of MoCAM (i.e. approx 5 minutes of brief advice).		Brief Interventions equivalent to Tier 2 of MoCAM (i.e. 3 or more repeat sessions each lasting approx 30 minutes).	
6.1 At pre-sentence report stage.	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐
	If no, go to Q6.2					
6.2 Through an activity or supervision requirement of a community order.	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐
	If no, go to Q6.3					
6.3 Through an activity or supervision requirement of a suspended sentence order.	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐
	If no, go to Q6.4					
6.4 Through an ATR.	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐
	If no, go to Q6.5					
6.5 Post custody through an alcohol related licence condition.	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐

7. Interventions – treatment availability

In addition to the specific alcohol and offending interventions we have discussed, what range of treatment services are available to offenders locally? Which of the following are accessible to offenders in your area (please tick all that are available)?

7.1 Tier 1: Mainstream

(a) Targeted screening ☐

(b) Information and brief advice ☐

(c) Referral ☐

(d) Shared care' ☐

7.2 Tier 2: Mainstream or Specialist

(a) Open access or outreach ☐

(b) Brief alcohol interventions and treatment ☐

(c) Assessment and referral ☐

(d) 'Shared care' ☐

7.3 Tier 3: Community specialist

(a) Triage and/or comprehensive assessment ☐

(b) Care planned treatment ☐

(c) Managed withdrawal ☐

(d) Psycho-social treatments ☐

7.4 Tier 4: Residential specialist

(a) Inpatient managed withdrawal and psycho-social treatment ☐

(b) Residential rehabilitation ☐

7.5 What are your views on the Model of Care offered for alcohol users locally?

7.6 Are there any gaps in local alcohol provision?

8. Compliance with MoCAM

8.1 In relation to alcohol provision, to what extent has the probation service in this area helped establish:

	Completely	To some extent	Not at all	Don't know
(a) Simple, practical screening tools used by other local agencies	☐	☐	☐	☐
(b) Materials providing information and advice about the sensible use of alcohol	☐	☐	☐	☐
(c) Training in the provision of screening and brief interventions with alcohol misusers	☐	☐	☐	☐
(d) Arrangements for referring moderately and severely dependent drinkers to specialists	☐	☐	☐	☐
(e) An appropriate range of community-based and in-patient structured alcohol treatment interventions	☐	☐	☐	☐

8.2 Is the probation service involved in any alcohol commissioning or providers fora locally?

Yes ☐ No ☐ (**Go to Q8.4**) Don't know ☐

8.3 If so, how has the probation service been involved in planning and implementing MoCAM locally?

8.4 Have local protocols been established for how probation staff might refer and liaise with alcohol treatment staff (including information sharing protocols)?

Yes ☐ No ☐ (**Go to Q8.6**) Don't know ☐

8.5 If yes, how are they working?

8.6 Do any specialist alcohol treatment staff provide services on probation premises?

Yes ☐ No ☐ (**Go to Q8.8**) Don't know ☐

8.7 If yes, details of who, what and how often

8.8 In your view, what aspects of partnership work are effective?

8.9 And, what areas of partnership work could be improved?

9. Training and staff development

9.1 Has there been a training needs assessment around alcohol issues?

Yes ☐ No ☐ Don't know ☐

9.2 Has there been any specific training provided for staff to increase their ability to identify alcohol misuse and make an appropriate response?

Yes ☐ No ☐ Don't know ☐

9.3 Is there any alcohol specific training for trainee probation officers (TPOs)?

Yes ☐ No ☐ Don't know ☐

9.4 In your opinion, to what extent are probation staff competent to:

	Completely	To some extent	Not at all	Don't know
(a) Identify a problem with alcohol misuse	☐	☐	☐	☐
(b) Offer basic advice on safe drinking	☐	☐	☐	☐
(c) Challenge offenders about the impact drinking has on all aspects of their lives	☐	☐	☐	☐
(d) Know how and where to refer an individual with a problem	☐	☐	☐	☐

9.5 What proportion of probation staff involved in delivering, managing or directing (Tier 1 and 2) alcohol interventions in your area are trained and competent to the relevant DANOS standards?

☐ % (estimate percent) Don't know ☐

10. Resettlement

10.1 How are the needs of alcohol-misusing offenders released from prison catered for and what support do they receive?

10.2 How is the transition managed from prison to community?

10.3 Are any alcohol related conditions written into licence requirements?

Yes ☐ No ☐ Don't know ☐

10.4 Are there any links with the DIP/CARAT/PPO process for alcohol-misusing offenders?

Yes ☐ No ☐ Don't know ☐

10.5 How is information about the offender shared between these organisations (i.e. prison, probation and health services) and how effective are these arrangements?

10.6 Is the nature and intensity of interventions provided to released prisoners considered appropriate?

11. Diversity

11.1 Amongst the offenders that you supervise, to what extent do you think local alcohol treatment services cater for the following groups:

	Completely	To some extent	Not at all	Don't know
(a) BME and migrant groups	☐	☐	☐	☐
(b) Those with physical disabilities	☐	☐	☐	☐
(c) The homeless and rough sleepers	☐	☐	☐	☐
(d) Older people	☐	☐	☐	☐
(e) GLBT individuals	☐	☐	☐	☐
(f) Women	☐	☐	☐	☐
(g) Those affected by domestic abuse	☐	☐	☐	☐
(h) Individuals in rural communities	☐	☐	☐	☐
(i) Individuals with children	☐	☐	☐	☐
(j) Individuals with work commitments	☐	☐	☐	☐

11.2 Nationally, we know that women and members of BME communities are often under-represented in alcohol treatment. What has your area done to address these issues?

11.3 Are there any other groups of alcohol-misusing offenders for whom you have put in measures to engage and retain them in interventions?

12. Monitoring and evaluation

12.1 Do you collect routine monitoring data relating to the interventions you deliver to alcohol-misusing offenders (e.g. on offender demographics, programme throughputs, completion rates)?

Yes ☐ No ☐ (**Go to Q12.3**) Don't know ☐

12.2 If yes, how do you monitor this activity (e.g. have you developed your own software)?

12.3 Has your local area reviewed activity data on alcohol interventions to identify potential problems and devise appropriate remedial action?

Yes ☐ No ☐ (**Go to Q12.5**) Don't know ☐

12.4 If yes, please tell us more

12.5 Is activity data routinely monitored, to ensure that no group suffers under-representation or poor treatment outcomes due to services not being relevant or appropriate?

Yes ☐ No ☐ Don't know ☐

12.6 Is there any local research that has recently or is currently being conducted in relation to alcohol-misusing offenders?

Yes ☐ No ☐ (**Go to Q13.1**) Don't know ☐

12.7 If yes, please tell me more about this research

13. The role of NOMS

13.1 Could you please tell us any ways in which NOMS (previously NPD) has been helpful in supporting you to design and deliver interventions for alcohol-misusing offenders?

13.2 How could NOMS be more helpful in this area of work?

14. Finally…

14.1 As part of the study we aim to develop a national database of good practice: are there any particular experiences, models, approaches, interventions, training packages or evaluations that you'd like to share with us?

(a) Experiences

(b) Models

(c) Approaches

(d) Interventions

(e) Training packages

(f) Evaluations

14.2 Would you be happy for your area to be identified in respect of this good practice so that other areas may contact you for advice?

Yes ☐ No ☐ Don't know ☐

14.3 The next phase of this research involves an assessment of compliance with MoCAM in six case study areas and a review of the commissioning and delivery of ATRs in these sites (see Table 1 below for more information about what this would involve).

In principle, would your area be willing to participate in the next (and final) stage of the research as a case study site?

Yes ☐ No ☐ Don't know ☐

Table 1: Methods for 2nd phase of the research

Review of OASys data covering a three month period
Analysis of alcohol screening and assessment information for three month period
Review 30 case files of those requiring alcohol interventions or treatment for compliance with MoCAM
Review of routinely collected data on ATRs covering a six month period
Review 20 ATR case files for compliance with MoCAM
Interviews with 12 probation and intervention/treatment staff including DAT co-ordinator, probation lead for substance misuse and ROM
Interview 10 staff involved in the delivery of ATR (including the judiciary)

Thank you for your time

Appendix 4: Case study sites – sampling and selection criteria

The research sought to assemble a purposive sample enabling representation of areas from different regions, of different sizes and with varying population densities. It was initially thought important to include the three largest probation areas: London, West Midlands and Greater Manchester, as these areas were collectively responsible for supervising around a quarter of all offenders dealt with by the Probation Service. It was also politically important to include an area from Wales – not least because the strategic framework and delivery mechanisms are different from those in England, and South Wales was the first choice, having workloads three times those of the other three Welsh areas. The researchers were also keen to include a 'shire' area, such as Cambridgeshire, Bedfordshire or Leicestershire, and finally a geographically extensive area such as Devon and Cornwall.

Information gained during the national survey of probation areas was then used to refine the sampling criteria. Issues for consideration included whether:

- consent had been given by the area to be considered as a case study site;
- a well developed system of ATR provision was in place (informed using ATR activity and performance data);
- the areas represented a good geographic spread (i.e. a mix of urban/rural sites);
- a high degree of self-assessed compliance with MoCAM[39] was evident; and
- the chosen areas had given some indication that good data collection and monitoring systems were in operation.

Using these criteria it was possible to identify 11 areas with a reasonable level of self-assessed compliance with MoCAM (i.e. scoring five or more) that also delivered ATRs, with a further seven sites that had the requisite ATR throughput but a lower level of MoCAM compliance. Some of the initial preferences had by this stage fallen by the wayside, however, for failing to meet one or more of the criteria described above.

Finally, analysis of centrally collected ATR performance data (area commencements and completions) during the previous two years was undertaken and the ATR completion target agreed between the remaining candidates and their ROM for 2008/09 considered.

39 This was assessed based on responses to five statements on compliance with aspects of MoCAM. Responses range from zero (not at all/don't know), one (to some extent) and two (completely). The maximum score an area could achieve using this approach was ten.

Appendix 5: Alcohol-related needs and interventions delivered

The extent of alcohol-related need

Across the six case study areas under consideration for this study the average OASys section 9 (alcohol) score was 3.51 (ranging from 0–10). There was a statistically significant difference observed in the mean score between different areas: offenders in one of the six areas (n=2,781) had a significantly higher mean score than those in other areas (3.98), while those in another (n=3,383) had a lower mean score (3.09) ($p<0.05$). Work by O-DEAT on the associations between section 9 scores and re-offending suggests that re-offending rates are higher than the average re-offending rate for those who score six or more for this section of OASys and that "this can be seen as the tipping point at which the use of interventions to address the need becomes more beneficial" (Moore, 2008: 3). Thirty per cent of cases scored six or more (n=4,592). This compares with a figure of 33% gleaned from start of community sentence assessments completed throughout England and Wales between April 2007 and March 2008 (N=71,373) (ibid). Again, there was a statistically significant difference between case study areas in the proportion of cases reaching this threshold (e.g. from 36 to 27%; $p<0.001$).

Those scoring six or above in the sample were more likely to be: male ($p<0.01$); younger (18–20 were the peak ages) ($p<0.001$) and White ($p<0.001$). There were also large effect sized correlations between violence against the person ($r = .176$), criminal damage ($r = .052$) and other summary offences ($r = .047$) (all at $p<0.001$) and scoring six or more on OASys section 9. With the exception of summary motoring offences, which were positively correlated, but in a non-significant way, all other offence categories were negatively correlated with a section 9 score of six or more[40]. This group also had, on average, more criminogenic needs identified at assessment (5.47 vs. 3.42; $p<0.001$) and a higher OASys overall (raw) score (56.29 vs. 39.02; $p<0.001$) than those scoring five or less in section 9[41].

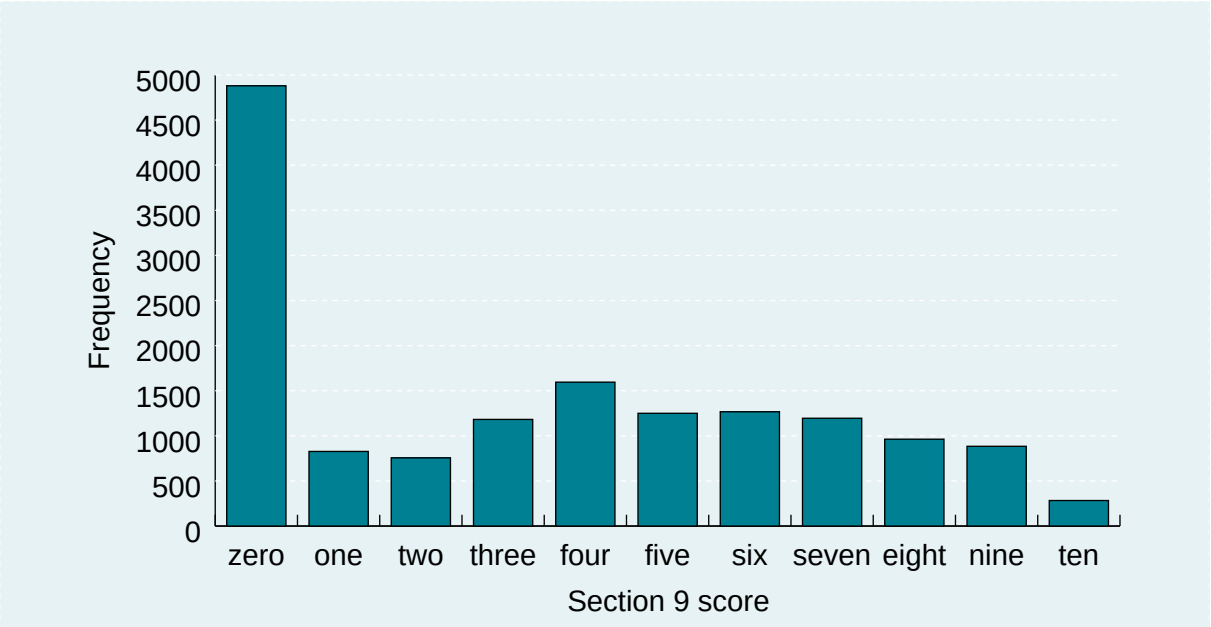
However, one-third of the sample scored zero for this section of the OASys form dealing with alcohol use, thus making it the most frequent score attained[42]. Figure 5.1 illustrates the distribution of section 9 scores in more detail.

40 Previous analysis of OASys data has found positive correlations between all criminogenic needs except for alcohol misuse and drug misuse (for which there is a negative correlation) (Howard, 2006: 3).

41 The alcohol misuse section score contributes to the total OASys raw score. O-DEAT have advised that alcohol misuse is the most highly weighted dynamic risk factor in the new OASys Violence Predictor (OVP), which were recently launched as part of OASys 4.3.1.

42 Section 9 is one of two sections in OASys for which there is some 'question routing' (the responses to certain questions are fixed by the responses to earlier questions). Questions 9.4 and 9.5 are scored zero when questions 9.1, 9.2 and 9.3 have all been scored zero. Layer 2 of the revised OASys will not however ask questions 9.3, 9.4 and 9.5.

Figure 5.1: Distribution of OASys section 9 scores across six case study areas (Sept – Nov 07) (N=15,082)



In half (49%) of all assessments alcohol was identified as an influence on offending behaviour using the relevant scored criminogenic needs section of OASys (the corresponding figure for drugs was 25%). In around one-third of cases (31%) the offender identified that they drunk too much alcohol and just under one in four (23%) linked this consumption to their offending during self assessment[43].

The extent to which alcohol interventions are planned and delivered

Because the OASys data under consideration in the case study sites only relates to a three-month period it was not possible to measure whether any alcohol interventions that had been planned for an individual were subsequently delivered over the course of their entire sentence. For example, once interventions have been recorded as fully achieved on OASys, they do not pass on to later assessments. Therefore, in order to assess any progress that has been made, it would be necessary to look across an individual offender's series of assessments over the entire period of supervision. Given the content (weekly counselling appointments over a 6- to 12-week period) and length of most ATRs imposed (six months) in these six areas, the researchers could therefore reasonably expect most alcohol-related interventions to have been either started or be near completion by the time of the first sentence plan review.

Of the 15,082 cases that made up the sample, a sub-sample comprising 1,001 valid sentence plan reviews that were completed using OASys within four to six months of the sentence date was selected (i.e. the first sentence plan review) to explore the extent to which

43 Restricted to valid self assessment responses only (n=6,412).

alcohol-related interventions[44] were planned, delivered and related goals achieved up to this point. Just under half (46%; n=458) the sentence plans considered indicated that an alcohol-related intervention had been planned. Three in four offenders (n=335; 73%) were assessed as having a criminogenic need around their use of alcohol, indicating that in most cases these interventions were being appropriately targeted.

The analysis of the first OASys sentence plan review data for this cohort indicates that marginally more offenders had revised objectives involving at least one form of alcohol-related intervention than had been envisaged during the original sentence planning stage (47%; n=467)[45]. In total, 709 forms of intervention were identified at first review (ranging from one to four), with an average (mean) of 1.5 per offender. In keeping with those interventions identified during sentence planning, the most common forms of alcohol support identified during the early stages of supervision again included 'alcohol advocacy' (28%), the Drink Impaired Drivers scheme (DIDs) (17%) and 'alcohol counselling' (12%).

However, these OASys reviews, completed four to six months post-sentence, indicate that half of all interventions (n=351) were still ongoing at this stage while 43% had yet to start (n=303). In 4% of cases (n=31) the sentence planning objectives relating to alcohol been fully met by first review[46].

These findings are broadly consistent with recent analysis by O-DEAT involving a sample of 35,039 end of community assessments completed in England and Wales between April 2007 and March 2008 (Moore, 2008)[47]. These OASys data indicated that just under one-third (31%) of offenders were assessed as 'dependent' drinkers (defined by O-DEAT as those with a section 9 (alcohol) score of six or more), with 6 per cent of these cases receiving an ATR. Alcohol 'advocacy', treatment, counselling and relapse prevention were included in 71% of ATR review sentence plans. However, these interventions were recorded as fully achieved or ongoing in under half (44%) of all cases. Across the six case study areas the proportion of planned alcohol 'advocacy', treatment, counselling or relapse prevention interventions that were either fully achieved or ongoing by the end of sentence assessment ranged from 18% to 71% across the six case study sites.

44 This includes the following interventions: 'alcohol advocacy', 'alcohol counselling', 'alcohol treatment', 'relapse prevention skills', ART, ASRO, CALM, CDVP, DIDS, IDAP, LIAM, OSAP and PRISM.

45 O-DEAT advised the researchers that these data may need to be interpreted with caution as they do not necessarily reflect what was planned at the start of sentence as the relevant variables can be revised during the review itself.

46 O-DEAT advised that completion of interventions were under-recorded within OASys.

47 Total numbers only reflect those assessed – some groups of offenders are unlikely to be assessed. Differences in profiles and outcomes may reflect variations in practice rather than differences in the 'true' profile. The sample was restricted to valid, de-duplicated end of community sentence assessments.

Appendix 6: Key alcohol-related interventions delivered by NOMS

The Probation Service has a wide range of provision available for alcohol-misusing offenders under statutory supervision, consistent with the offender's assessed level of drinking problem, seriousness of offence and risk of harm. Within an overall sentence which reflects offence seriousness, the alcohol-related intervention(s) should primarily be determined by assessed need.

The **alcohol treatment requirement** 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 MoCAM e.g. day programmes, detoxification, residential rehabilitation and integrated care involving a range of agencies. Their offending will usually be alcohol related, of medium to high seriousness and violent in nature.

Extended brief interventions (3–12 structured sessions of 20–30 minutes) are delivered to harmful or binge drinkers, either in-house by probation areas or in partnership with the voluntary sector, **through an activity requirement or as part of a supervision requirement** and are available in most probation areas. Some areas have 'marketed' these to courts as an Alcohol Specified Activity Requirement (ASAR).

Simple brief interventions (generally around five minutes of brief advice) are targeted at hazardous drinkers and usually delivered by Offender Managers immediately following screening at the pre-sentence report (PSR) stage or during supervision. This approach is in line with the NTA's guidelines on effective practice in delivering a planned and integrated treatment system for adult alcohol misusers, as described in MoCAM.

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

Addressing Substance Related Offending (ASRO), accredited in 2001 and involving 20 sessions each of 2.5 hours duration, and the **Offender Substance Abuse Programme (OSAP)** comprising 26 sessions of 2.5 hours, are targeted at those medium to high-risk offenders recognised as having a significant (harmful or very harmful) alcohol problem or for whom the misuse of alcohol has been assessed as a significant factor in their offending behaviour.

The **Drink Impaired Drivers (DID)** scheme is aimed at those who have committed a drink driving offence but have not otherwise been involved with crime. DID involves 14 weekly sessions of 2.5 hours.

The **Lower Intensity Alcohol Programme (LIAP),** primarily aimed at those whose alcohol misuse and offending needs are not sufficient to lead to a referral to ASRO/OSAP, has been piloted in eight areas, provisionally accredited by the Correctional Services Accreditation Panel (CSAP) in October 2008, and is now available for all probation areas to use as part of their suite of programme provision.

There are another two alcohol programmes which NOMS has developed recently which have been accredited by CSAP, but are solely for use in prisons. In partnership with the Rehabilitation of Addicted Prisoners Trust (RAPt), NOMS developed an **Alcohol Dependency Treatment Programme (ADTP)** which was accredited in March 2008. The intensive six-week programme is based around the 12 step model of recovery with assistance and support offered from Alcoholics Anonymous and continues to be run at HMP Bullingdon to ensure continuous development.

The **Alcohol Related Violence Programme (ARVP)** is a medium intensity cognitive behavioural group programme which aims to reduce re-offending in young men who have been imprisoned for alcohol-related crimes of violence, and who are hazardous drinkers – i.e. those who engage in binge drinking but are not alcohol-dependent. The programme was originally piloted at HMP Featherstone and received provisional accreditation. On recommendation from CSAP, the programme was piloted in a further four sites (HMPs Hull, Forest Bank, Glen Parva and Chelmsford) and received full accreditation from CSAP in December 2008.

In addition, **Control of Violence for Angry Impulsive Drinkers (COVAID)**, which targets those drinkers who are aggressive or violent whilst intoxicated and is primarily for young men rather than those who are alcohol dependent is being run in at least another four establishments (and at least a couple of probation areas) and has received full CSAP accreditation. However, this programme was developed externally rather than by NOMS.

Offenders subject to statutory supervision on release from prison may be made subject to a licence condition requiring them to address their alcohol problems. This condition can require the offender to, for example, attend a substance misuse accredited programme.

Appendix 7: ATR profiles and outcomes

Are ATRs reaching their target group of 'dependent' drinkers?

O-DEAT analysis of 71,373 start of community sentence assessments[48] between April 2007 and March 2008 across England and Wales (Moore, 2008) indicated that one third of offenders were assessed as 'dependent' drinkers (defined by O-DEAT as achieving a section 9 (alcohol) score of six or more), ranging from 26 per cent in London to 37 per cent in the South West. This is equivalent to more than half the 44,467 people in alcohol treatment reported to the National Drug Treatment Monitoring System during April 2008.

In fact, a number of respondents in the case study sites expressed scepticism about this issue and questioned whether, given current levels of investment and capacity within both probation and alcohol treatment services, the level of alcohol-related need that is being identified using indicators like OASys could realistically be met:

> *"At the moment, it's only the people with the more serious alcohol issues that you'd be putting through an ATR, and obviously there's a lot of people for who alcohol acts as an disinhibitor, and it's a feature in their offending, but they might not have scored 16 points for the ATR. And if everybody that we had with alcohol issues we put through [the provider] as an activity or a treatment requirement, the waiting list would be huge, which we can't, you know, we couldn't meet that demand at the moment".*

One in 12 (8%) of these 'dependent' drinkers identified by O-DEAT had an ATR imposed during 2007/08. There was again significant variation between the regions in the proportion of assessed 'dependent' drinkers receiving an ATR: from 1% in the North East to 26% in London. Similar trends were also observed within regions: for example, in the East of England the proportion of 'dependent' drinkers receiving ATRs ranged from none in Suffolk to 31% in Essex.

Eighty-seven per cent of the ATRs imposed on 'dependent' drinkers in England and Wales during 2007/08 had planned interventions around alcohol 'advocacy' (48%), treatment (20%), counselling (23%) and/or relapse prevention (1%). (See Appendix 5 for details of the extent to which planned alcohol-related interventions were subsequently delivered.)

ATR offender profiles

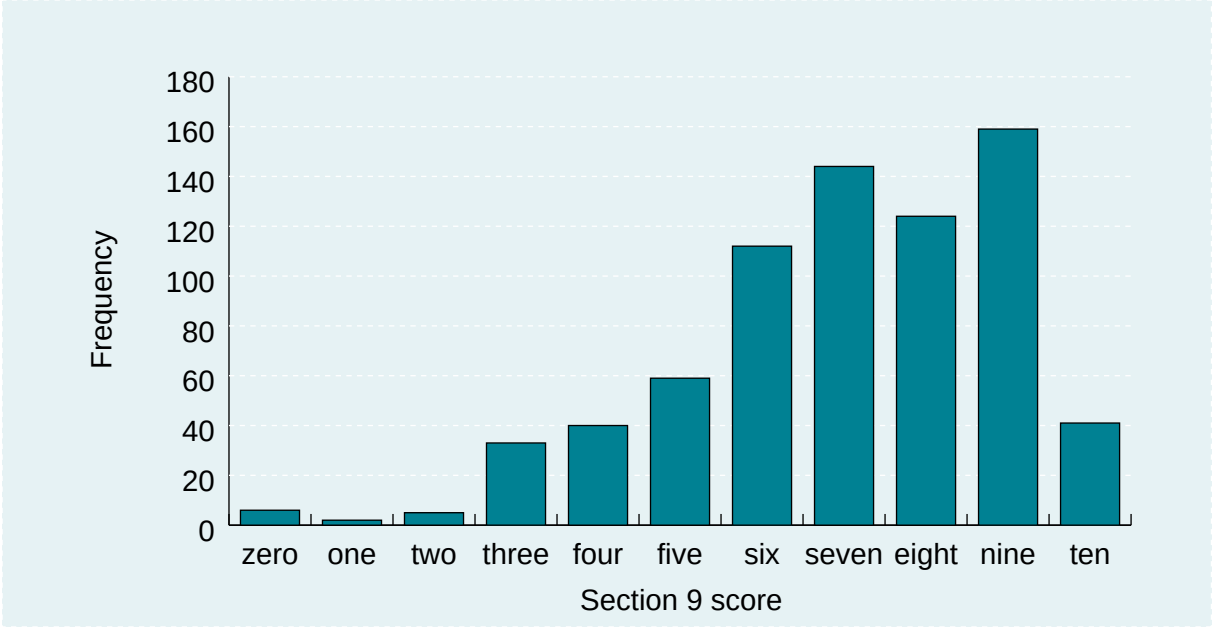
There are currently no published figures describing the characteristics of those receiving ATRs. Based on the analysis of a subsample of OASys data for six case study sites, 725 ATRs – equivalent to 5% of sentences imposed – were active across these areas during the three-month period under consideration, ranging from 278 in one site to 30 in another[49]. The

48 Total numbers only reflect those assessed – some groups of offenders are unlikely to be assessed. Differences in profiles and outcomes may reflect variations in practice rather than differences in the 'true' profile. The sample was restricted to valid, de-duplicated start of community sentence assessments.

49 This is likely to be an underestimate as data for 14,276 cases were missing in the relevant ATR variable.

average (mean) section 9 OASys score for those serving an ATR was seven (range from 0 to 10), compared with a score of 3.3 for non-ATR cases (p<0.001), and there was no significant differences between the six areas in this regard. The most common section 9 score attained was nine (n=159) while 80 per cent of those serving an ATR scored six or above. Figure 7.1 illustrates the distribution of OASys section 9 scores for those receiving an ATR in these areas during this time.

Figure 7.1: Distribution of OASys section 9 scores for those receiving ATRs in six case study areas (Sept – Nov 07) (N=725)



Those ATR cases with lower scores (five or below) were less likely to be assessed as having alcohol linked to their offending behaviour (88% vs. 98%) or linked to a perceived risk of serious harm (33% vs. 74%) (both at p<0.001).

Those serving ATRs[50] in these areas during this period were more likely to be: female (p<0.05); older (aged 25–40) (p<0.05) and White (p<0.05). There were also large and medium effect sized correlations observed for those convicted of summary motoring (r = .060) (p<0.001) and violence against the person offences (r = .040) (p<0.001) and serving an ATR. By contrast, there was a large effect sized negative correlation between drugs offences and serving an ATR (r = - .056) (p<0.001), meaning that those convicted for drugs offences were the least likely group to be serving an ATR. However, as noted above, there is already an established negative correlation between the drug misuse and alcohol misuse criminogenic needs (Howard, 2006: 3). The ATR cohort also had, on average, more criminogenic needs identified at assessment (4.69 vs. 4.01; p<0.001) and a higher OASys raw score (49.02 vs. 44.04; p<0.001) than those not serving such a requirement.

50 These analyses have been undertaken on the assumption that none of the 14,276 cases where data are missing were serving an ATR.

Comparing ATR and non-ATR interventions and outcomes

There are no published data which consider ATR interventions and outcomes against those for offenders identified as alcohol misusers, but not receiving an ATR. The random review of 185 offender case files[51] (64% (n=119) of them ATRs) in six case study areas revealed most of those identified with alcohol issues were White British (87%) and male (80%). ATR offenders were older than non-ATR cases (32.8 years vs. 28.2) ($p<0.01$) and more likely to be convicted of driving offences (22% vs. 9%) ($p<0.05$), but no significant differences in the number of previous convictions, rates of imprisonment, OGRS scores or section 9 OASys scores were found between the two groups. However, it was observed that ATR cases were more likely to be assessed as having a significant problem with alcohol (81% vs. 48%) ($p<0.001$) and to self-assess alcohol as an issue (60% vs. 41%) ($p<0.05$) when compared with non-ATR cases. There were no significant differences between the groups in the extent to which they both had problems with their motivation to tackle these issues (69% ATR vs. 77%).

Details of AUDIT scores were found in just under half the ATR files (54). Scores ranged from six to forty, with an average (mean) of 27. There were no details on AUDIT found in any of the non-ATR files reviewed.

The main disposals passed on this cohort by the courts were community orders (163) and/or suspended sentences (42). Sentence lengths ranged from three (for licence conditions) to 36 months, with an average (median) of 12 months. There was no difference in sentence length between the groups. ATRs ranged in length from six to twenty-four months. Two-thirds (82) of the ATRs were imposed for six months (median), however. Eighteen files did not record the length of the ATR that had been imposed.

The 185 files reviewed had a total of 227 requirements attached to them – 60 per cent (136) were for alcohol-related interventions. However, 76 per cent of the non-ATR cases (50) had no alcohol-related requirements imposed on them.

In total there were 3,248 supervision appointments attended during the first six months of contact – an average (mean) of 17.7 appointments per offender. There were no differences between the two groups (17.9 ATRs vs. 17.3 non-ATRs) in the number of supervision contacts made over this period. By contrast, there were 710 contacts with alcohol treatment services during this six-month period, with an average (mean) of 4.6 sessions attended. However, ATR cases were significantly more likely to access alcohol treatment than non-ATR cases (average 6.0 appointments vs. 0.6) ($p<0.001$).

While most ATR cases (49%; n=56) accessed support during the first month of supervision, around one in seven (n=17) failed to engage with any alcohol treatment during the first six

51 The sample was intended to be illustrative rather than representative. That said, we have no reason to believe that these case files reviewed were atypical.

months of supervision. Those completing an ATR (n=48) did so having attended an average (mean) of 7.3 treatment sessions. Only five non-ATR cases received any alcohol-related intervention (8% of all cases or one in three of those with related requirements). Most ATR-related interventions appear to have taken the form of structured counselling sessions. However, very few of the reviewer case files/management systems appeared to hold any detailed information on the precise nature and extent of alcohol treatment being delivered, or recorded these data in a systematic way.

Around one-third of the 185 cases were still ongoing at the time of the review (64). A similar proportion had completed (having run their full course or being terminated for good progress) (70). One in seven terminated for failure to comply (27) or following reconviction (17).

Non-ATR cases were significantly more likely to have had their orders terminated for failure to comply than those serving an ATR (22% vs. 11%) ($p<0.05$). It seems that around one in four (44) re-offended during their period of supervision, although there was no significant difference between the groups in the likelihood of this happening.

Most of the cases reviewed (165) had a subsequent section 9 score (e.g. following review, completion or a new PSR) enabling measurement of changes over the period of supervision. However, as O-DEAT have already stressed, "interpreting changes in OASys scores should be done with caution as we do not yet know the extent to which OASys is a reliable and valid measure of change" (Moore, 2008: 5)[52]. With this caveat in mind there was a small (-1) overall reduction in overall section 9 scores.

Half (85) showed reductions ranging from one to six points. ATR cases were more likely to record a reduction (59% vs. 38%) ($p<0.05$), but while the overall reduction in section 9 scores was greater for the ATR group (-1.38 vs. -0.93), this difference was not statistically significant. In addition, many cases (69) showed no change in their section 9 alcohol score; though non-ATR cases were more likely to record this status (55% vs. 34%) ($p<0.05$). For 11 of the cases reviewed (7% of them) overall section 9 scores increased by between one and three points over the period of supervision.

52 As Moore (2008: 5) also notes "Some OASys score changes may reflect more information having become available, known as the 'disclosure effect', rather than any real differences in the offenders' circumstances… In addition, we would advise against attributing the cause of any score changes to the 'effects' of any interventions as this conclusion has not yet been rigorously tested"

Appendix 8: NOMS best practice projects

The national picture[53]

During 2006/07 ISAU within NOMS made available £100,000 in an effort to help identify, develop and disseminate emerging best practice relating to the aims and objectives of the NPS alcohol strategy. Allocated to seven projects across NPS based upon the outcome of a competitive bidding process, with a maximum of approximately £15,000 being made available for each project, the successful bids represented a good geographical spread and a diverse range of different projects were supported. These included:

- **Avon and Somerset**: the development of tier 1 and 2 training packages linked to relevant DANOS competences to better enable probation staff to undertake screening, deliver brief interventions and make appropriate referrals into treatment.

- **Gloucestershire:** development of a training manual for staff to deliver a three-session Brief Motivational Enhancement Intervention based upon the intervention evaluated in the United Kingdom Alcohol Treatment Trial.

- **Greater Manchester:** an Alcohol Bail Condition Scheme to support the effective targeting and delivery of ATRs.

- **The North East region:** a regional conference with voluntary and community sector providers with a view to promoting and developing shared agendas and specific outcomes for improving provision (e.g. establishing an alcohol pathway and advisory group).

- **Northamptonshire:** a pilot to implement an alcohol screening tool and deliver a programme of one-to-one work and group-based interventions.

- **Thames Valley:** development of a practice manual and training material to support the roll-out of an approved liaison model for working with Alcoholics Anonymous.

- **North Wales:** production of a comprehensive targeting matrix for alcohol provision and programmes and the development of a process map for offender managers.

A conference was held in October 2007 to disseminate the lessons and best practice experiences from these seven projects[54] in order to better inform the wider development of alcohol provision across NPS. Various reports, manuals and guidance from the projects were made available on the probation intranet (EPIC) in late February 2008.

53 The researchers are grateful to Robert Stanbury from NOMS ISMG for providing an overview of current initiatives to promote good practice.

54 Copies of the presentations made by the seven areas at the conference can be viewed at: http://www.noms.homeoffice.gov.uk/news-publications-events/publications/guidance/Alcohol_best_practice_conf_07/

In 2007/08 an additional £30,000 was made available to six of the seven projects for follow-up work. A best practice seminar was held in June 2008 at which representatives from all the best practice projects provided NOMS with an update on developments with Phase 1 of their projects (using 2006/07 funding) since the first National Conference and outlined progress that had been made during Phase 2 with reference to milestones and projected outcomes.

As part of NOMS's continuing commitment to strengthening operational delivery to address alcohol-related offending, £125,000 was made available to eight areas for new project work in 2008/09. The areas and nature of the work supported included:

- **Avon and Somerset:** piloting and evaluation of an Alcohol Counselling project using an intervention based on tiers 1 and 2 of MoCAM over the telephone in two sites (Mendip and Minehead).

- **Cheshire:** commissioning an independent research organisation to evaluate the impact of Cheshire Probation Area's Alcohol Strategy in reducing alcohol related harm and re-offending rates among those who have received alcohol extended interventions and the ATR.

- **Devon and Cornwall:** implementing a developmental ATR model in Plymouth and Cornwall involving the delivery of detoxification (detox) preparation and post-detox motivational supportive counselling by offender managers and supervisors.

- **Gloucestershire:** developing and piloting the Community Reinforcement Approach (CRA) for use within ATRs.

- **Suffolk, Hertfordshire and Norfolk:** conducting a user survey across the three probation areas to provide direct offender feedback on the value and benefits of the alcohol interventions delivered there to support a best value review of alcohol interventions across the sub-region.

- **Leicestershire and Rutland:** commissioning an independent research project to improve end-to-end practice with and transition of offenders between prison and the community and between different screening, referral and treatment systems.

- **North Yorkshire:** analysis exploring the reasons for the attrition of women offenders subject to ATRs and development of ways to make the ATR more responsive to their complex needs.

- **Surrey:** developing, in conjunction with the Rehabilitation for Addicted Prisoners Trust (RAPt), a Correctional Services Accreditation Panel (CSAP) accredited programme aimed at meeting the needs of alcohol dependent offenders.

A second national alcohol best practice conference, *Same Again? Break the Cycle*, was held during November 2008 and two events are planned in September 2009 at which findings/outputs from the second phase of the original projects and early findings from the new projects will be disseminated to probation managers and practitioners and other key stakeholders.

Respondents to the national survey were also asked whether they had any particular experiences, models, approaches, interventions, training packages or evaluations which they felt could contribute towards good practice and were worthy of sharing for the benefit of other areas.

Nineteen areas[55] highlighted their particular experiences of partnership working arrangements (11), their screening and assessment processes (4), how they have commissioned providers (3) and their particular approach to treatment (2) as possible models of best practice.

Six areas commented on particular models they had adopted in relation to ATRs, the targeting of interventions, the use of co-located multi-agency teams, an approach to providing tier 1 and 2 level support using Alcoholics Anonymous, and the development of a structured day care programme.

Addressing the needs of alcohol-misusing offenders via the social exclusion agenda, developing more responsive forms of intervention, forming a strategic alcohol group and adopting an award winning strategy for partnership working were considered to be potentially useful approaches in five areas worthy of further exploration.

Seven areas also reported on training packages they had developed and delivered for tier 1 and 2 level brief interventions.

55 One area highlighted more than one aspect of their work which they felt could contribute towards developing models of good practice.

Ministry of Justice Research Series 13/09

This process study by the Institute for Criminal Policy Research (ICPR), King's College London, examined the National Probation Service's work with alcohol-misusing offenders by describing and critically appraising the procedures in place for identifying and intervening with offenders who have alcohol problems; the extent to which this work complied with the principles set out in Models of care for alcohol misusers (MoCAM); and arrangements for the commissioning and delivery of alcohol treatment requirements. The study had a number of components and made use of a range of primary and secondary quantitative and qualitative data sources.

The research concluded that a key priority for policy should be to increase the use of evidence-based alcohol interventions and treatment with offenders whose criminal behaviour is related to their use of alcohol. That priority should be addressed in the short term by sharing and disseminating emerging best practice and identifying effective strategies for ensuring more offenders commence and complete those programmes that are available. The longer term emphasis should be on developing the evidence base and then disseminating empirically informed advice and guidance about the appropriate targeting of interventions, and increasing further the range, capacity and funding of the NPS's alcohol-related work.

The research also concluded that improvements are still required in many areas to aspects of: alcohol screening and specialist assessment processes; the accessibility of specialist alcohol treatment services; and the level of training for probation staff on delivering brief interventions, specifically, and alcohol issues more generally. It also argues that there is scope for expanding provision for alcohol treatment requirements (ATRs) given existing levels of need, but continuing uncertainty and inconsistency around funding, targeting and the form this treatment should take need to be resolved as a matter of urgency by the Ministry of Justice (MoJ) and National Offender Management Service (NOMS). The dearth of British research evidence means there is currently limited scope for developing empirically informed guidance to instruct senior probation managers and practitioners on key issues. These and many other themes and issues (including assessing the impact and effectiveness of ATRs) should be given greater priority in any future research programme.

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