

POLICY

Centre for
Mental Health



A label for exclusion

Support for alcohol-misusing offenders

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Executive summary

The development of alcohol interventions for offenders is a challenging area with implications for both health and criminal justice agencies. Effective responses are complicated by the fact that, unlike drugs, the use of alcohol is both legal and widely socially sanctioned and that there are complex links between alcohol misuse and offending. Nevertheless, the misuse of alcohol has major implications for public health, mental wellbeing, community safety and re-offending, as well as costs to wider society.

This policy paper identifies areas and practical examples of how, in a changing and uncertain policy and commissioning landscape, the joint commissioning and delivery of alcohol interventions for offenders in the community might be productively developed. It is intended to be read by all who are responsible for the commissioning or delivery of alcohol services whether from health, criminal justice or other agencies. The paper has been produced in partnership with the Department of Health South West and based on extensive interviews and focus groups with commissioners, managers, front line workers and the users of services within the South West, with input from central policy leads within the National Offender Management Service, the Department of Health, the Ministry of Justice and other specialist national agencies.

We have identified a number of key issues and challenges relating to the joint commissioning and provision of alcohol interventions.

Under-resourcing of alcohol provision. Demand for all types of intervention and treatment exceed supply across all four Models of Care for Alcohol Misusers (MoCAM) tiers in both general health care and in offender-specific settings.

Variations in joint commissioning practice. Responsibility for the development of local offender alcohol strategies and the commissioning of alcohol interventions to offenders vary from area to area and are contested in some cases.

Misalignment between the objectives and targets of health and criminal justice commissioners. Despite the expectation that health and criminal justice agencies will work collaboratively to commission and provide alcohol and other offender health services, there

are significant barriers to this taking place in practice.

Concerns about the sustainability of services. Many health and criminal justice commissioners observe that the funding for general and offender-specific alcohol services is precarious and often ‘kept afloat’ by the extraordinary efforts of highly committed commissioners and front line staff. The current absence of joint DH/ NOMS commissioning guidance about alcohol interventions was identified as a particular obstacle to securing the sustainability of services.

Lack of equivalence between alcohol and drug commissioning. Although drug treatment has been prioritised and commissioned in a standardised manner for several years via the Drug Interventions Programme (DIP) in the community and the Integrated Drug Treatment System (IDTS) in prisons, there is not an equivalent arrangement for alcohol even though the latter is generally considered to be the larger problem in terms of both health and offending. Further, the requirement, often quoted by the National Treatment Agency for Substance Misuse (NTA), that no monies designated for drug misuse via the pooled treatment budget can be invested for alcohol interventions (where there is primary alcohol need) is considered to present a significant obstacle to improved provision.

A variety of ways to improve and develop offender alcohol interventions have been identified and we have developed the following 10 recommendations for commissioners, agencies and practitioners.

- 1. As the process for commissioning alcohol interventions for offenders remains unclear and contested, commissioners from different sectors need to respond pragmatically and creatively to improve services.** A number of approaches are recommended:
 - making use of political support (where it exists) and strategic leadership;
 - building upon existing frameworks, including wider implementation of MoCAM; the development of local alcohol care pathways involving both health and criminal justice agencies using the *Local Routes* model; deploying pooled budgets locally through place-based budgeting; targeting alcohol misusers via Integrated Offender

Management initiatives; and developing the responses of Community Safety Partnerships;

- the sharing of human resources and skills between agencies;
- exploring innovative methods for the future funding of interventions, for example through social impact bonds and payment by results.

2. The evidence base for offender alcohol interventions needs to be developed.

A number of means are identified to improve the evidence base to inform future commissioning:

- mandatory collection of Alcohol Use Disorders Identification Test (AUDIT) scores for all offenders entering the criminal justice system and the monitoring of interventions using standardised tools;
- developing a business case for targeted local joint commissioning, identifying overall efficiencies and cost-benefits of earlier interventions;
- drawing upon emerging evidence of the effectiveness of alcohol arrest referral initiatives;
- the commissioning of independent, methodologically rigorous peer-reviewed research.

3. Service users should be involved in the commissioning and review of interventions.

Input from ‘experts by experience’ provides strength and credibility to all stages of the commissioning process.

4. Preventive interventions form a vital component of any local alcohol strategy.

A variety of ‘pre-criminal justice’ responses should be considered, including:

- promoting public awareness of the harm and risks associated with alcohol misuse;
- population level responses including minimum pricing/unit pricing of alcohol to reduce the aggregate levels of alcohol consumption and subsequent alcohol-related harm and offending;
- the regulation of the night-time economy of pubs and clubs in urban areas through strong partnership working between agencies, the licensing trade and communities, including credible enforcement for both individuals and problem premises.

5. All front line staff need basic alcohol awareness and some professionals require specific training.

The following general training needs are identified:

- basic alcohol awareness for all front line staff in health, social care and criminal justice settings, to enable the delivery of effective basic level interventions;
- specialist training for GPs, magistrates and other court staff as key ‘gatekeepers’ of services and treatment;
- training around managing multiple needs and multi agency practice to ensure that those with the most complex needs are able to access appropriate services.

6. All front-line agencies should provide Identification and Brief Advice (IBA). All workers in front line services should be trained to provide MoCAM recommended tier 1 alcohol interventions including:

- opportunistic case identification;
- AUDIT screening;
- brief advice;
- referral to specialist agencies.

7. Alcohol misuse should not be a label for exclusion.

The following methods can help ensure that alcohol misusers are not excluded from mainstream services:

- improving risk management and clinical governance processes within accident and emergency, GP surgeries and community mental health services;
- utilising a portfolio of abstinence and non abstinence-based models ensures access to services for individuals with different drinking patterns and needs;
- adopting the health trainer model can be a particularly effective means of engaging with ‘hard to reach’ groups;
- improving partnership working between the police and NHS is important to ensure that Section 136 of the Mental Health Act is appropriately used in cases involving alcohol misusers;
- improving anti-social behaviour (ASB) responses to take into account underlying alcohol issues and ensure referral where necessary to appropriate services;
- integrating referral pathways to drugs, alcohol and mental health services enabling multiple needs to be better addressed;
- providing appropriate responses for rural settings, for example telephone counselling

and advice services where long travel distances and low caseload density are significant factors;

- considering the development of alternative court disposals to the Alcohol Treatment Requirement or the Alcohol Specified Activity Requirement.
- 8. Appropriate alcohol interventions should be provided at all stages of the criminal justice pathway.** It is essential that alcohol interventions are available at all stages of the criminal justice pathway, and that consideration is given to address the ‘cliff edges’ between points in the system:
- pre-arrest interventions through the involvement of police neighbourhood teams;
 - at point of arrest through arrest referral services and alternatives to court prosecution;
 - at court through the Alcohol Treatment Requirement (ATR) and Alcohol Specified Activity Requirement (ASAR);
 - in prison through extending the remit of Counselling, Assessment, Referral, Advice and Throughcare (CARAT) teams to include alcohol assessment and brief interventions;
 - the need for better continuity of support on release from prison for alcohol misusers is identified as a significant area for future development.
- 9. Services should be responsive to a number of key groups.** Individual and joint responses to the following groups need to be taken into account when planning services:
- perpetrators of domestic violence;
 - women;
 - younger adults;
 - black and minority ethnic groups.
- 10. Charitable and voluntary sector agencies add value and expertise.** Voluntary sector organisations can often engage with both statutory agencies and the users of services in ways which mainstream services find difficult. In relation to alcohol these can include:
- providing flexible service responses which operate outside of standard working hours and utilise peer support;
 - facilitating involvement from the wider community through voluntary action;
 - developmental expertise to coordinate and improve alcohol interventions for offenders;

- providing expertise by experience to inform the commissioning process.

With resource concerns paramount, it is clear that a primary focus of future development in alcohol and criminal justice must not simply be about creating more services (as important as this is), but improved evidencing of need at both individual and population level coupled with improved joint commissioning and outcome measurement, and more effective service delivery. An important aspect for future development needs to be that of improving wider workforce alcohol awareness within health, criminal justice and allied agencies.

Taking into account the global costs of alcohol misuse within society, and the evidence base for population level interventions, there is a very strong case for health, criminal justice and other agencies collaborating to commission preventive and early interventions. From a public health perspective, better and earlier education about harm and a focused aim to challenge wider norms and values in relation to alcohol are also needed to limit the demand for services and ultimately to reduce alcohol related harm and offending within society.

Introduction

The development of alcohol interventions for offenders is a challenging area with implications for both health and criminal justice agencies. Effective responses are complicated by the fact that, unlike drugs, the use of alcohol is both legal and widely socially sanctioned and that there are complex links between alcohol misuse and offending. Nevertheless, the misuse of alcohol has major implications for public health, mental wellbeing, community safety and re-offending, as well as costs to wider society.

Defining and measuring alcohol misuse and dependence

Despite its widespread use within society, alcohol is a toxic substance which if used excessively or over a prolonged period of time can damage physical and mental health and create dependence. Two main factors for identifying misuse are the number of units consumed, typically on a weekly basis, and scoring via the Alcohol Use Disorders

Identification Test (AUDIT), a scale which was originally developed by the World Health Organisation to be used in both clinical and non clinical settings (Babor *et al.*, 2001).

Key terms for alcohol misuse are defined by the Department of Health's *Alcohol Needs Assessment Research Project* (Drummond *et al.*, 2005). This defines hazardous drinking as weekly alcohol consumption of 21-50 units per week for men and 14-35 units per week for women (or with an AUDIT score of 8-15). Harmful drinking is defined as weekly alcohol consumption of more than 50 units for men and 35 for women (carrying an AUDIT score of 16+). Binge drinking is defined as the consumption of 8 units of alcohol for men or 6 units for women over the course of a day. Alcohol dependency is defined as a range of behaviours, thinking patterns and other symptoms which develop after repeated heavy use and can be mild, moderate or severe (WHO, 1992).

In 2008, the Department of Health identified new descriptions of categories of drinking based upon risk. Higher risk is defined as more than 8 units of alcohol a day or 50+ units a week for men and more than 6 units daily or 35 units a week for women; increasing risk is more than 3-4 units daily for men or 2-3 units daily for women but below the respective higher risk thresholds; and, lower-risk drinking is defined as no more than 3-4 units daily for men or 2-3 units a day for women.

The extent of need

Figures for alcohol misuse in the general adult and offending populations and for alcohol-related offending are very high.

- In England, 24.2% of the general population (33.2% of men and 15.7% of women) are hazardous drinkers (McManus *et al.*, 2009).
- The overall level of mild, moderate or severe alcohol dependence is 5.9% of the general population with 9.6% of men and 3.4% of women (Ibid).
- During the year before prison, 63% of sentenced males and 39% of sentenced females were harmful or hazardous drinkers (Singleton *et al.*, 1998).
- Of the 44% of probation clients recorded as having an alcohol problem, 48% were found to binge drink, 41% have displayed violent behaviour linked to alcohol use and 48%

have a criminogenic need directly related to alcohol misuse (NOMS, 2008).

- In 63% of incidents of wounding, 55% of assault with minor injury and 50% of assault without injury, victims believed offenders to be under the influence of alcohol (Home Office, 2010a).
- Alcohol is estimated to be consumed before 73% of domestic violence cases, while 48% of those convicted of domestic violence are dependent upon alcohol (Gilchrist *et al.*, 2003).

Economic impact

Updating figures published by the Department of Health in 2008 (Department of Health, 2008), it is estimated that the overall costs of alcohol misuse in England in 2009/10 amounted to £23.1 billion (Knapp *et al.*, forthcoming). This includes: costs of £3.0 billion falling on the NHS; output losses in the economy due to sickness absence, reduced employment and premature mortality totalling £7.2 billion; and costs of alcohol-related crime of £12.9 billion.

The full cost to the NHS is actually higher than shown above, as nearly 10% of the costs allocated to crime fall on the health service, mainly covering the costs of treatment for injuries suffered by the victims of alcohol-related violence.

Based on data in the Sheffield Alcohol Policy Model (Brennan *et al.*, 2009), it is estimated that each individual drinking at hazardous levels imposes annual costs of £1,332 and that each individual drinking at harmful levels imposes annual costs of £4,534.

The evidence base for interventions

Although there is a growing body of evidence about the effectiveness of interventions for health outcomes, only limited evidence exists about how to reduce alcohol related reoffending.

Alcohol Concern identifies the single biggest gap in alcohol service provision to be an adequate pathway from prison to community treatment for alcohol dependent offenders (Alcohol Concern, 2010).

A national review of the effectiveness of treatment for alcohol problems concludes that the evidence base for the effectiveness of interventions is strong, with cognitive

behavioural approaches to specialist treatment offering the best chances of success. It also argues that treatment for alcohol problems is cost effective, where for every £1 spent on treatment, £5 is saved elsewhere (i.e. to health, social care and criminal justice systems) (Heather *et al.*, 2006).

The National Institute for Health and Clinical Excellence (2010) demonstrates that a combination of population-level and clinical interventions are required to reduce alcohol related harm. Based upon findings from a study conducted by Sheffield University (Pursehouse *et al.*, 2009), NICE recommends that the most cost effective way of reducing alcohol related harm (and offending) would be national policy changes to increase the unit price of alcohol, along with restrictions to the availability and advertising of alcohol in order to reduce the overall amount of alcohol consumed within society. In addition, NICE recommends the resourcing of alcohol screening and brief interventions for both adults and young people (NICE, 2010).

Brief interventions in primary care settings (e.g. GP surgeries) can achieve an average 12.3% short term reduction in alcohol consumption per individual supported (Kaner *et al.*, 2007).

Economic analysis carried out for the Department of Health demonstrates a robust case for low-cost interventions in primary care in reducing alcohol-related harm, with potential savings exceeding costs by a factor of nearly 12 to 1 (Knapp *et al.*, forthcoming). Estimated savings in the NHS alone exceed costs by more than 2 to 1.

The Department of Health has recommended a number of evidenced ‘high impact changes’ for health services to adopt in order to reduce alcohol related harm. These include:

- working in partnership with local authorities and criminal justice agencies to coordinate local responses;
- making use of existing legislation such as the Licensing Act (2003) and the Violent Crime Reduction Act (2006) to minimise alcohol related harm locally;
- utilising high profile champions within health services, local authorities or criminal justice agencies to provide local leadership;

- improving the effectiveness and capacity of specialist treatment by appointing specialist alcohol staff in each major acute hospital;
- providing brief interventions in all clinical and criminal justice settings;
- developing social marketing around alcohol with the aim of influencing those drinking at higher risk to reduce their use of alcohol to within lower risk levels (Department of Health, 2009a).

Models of care

Since 2006, Models of Care for Alcohol Misusers (MoCAM) has presented a national standard specification for the commissioning and delivery of alcohol treatment in England (National Treatment Agency, 2006a). MoCAM is adapted from the Models of Care format (MoC) for drug treatment (National Treatment Agency, 2006b) and includes structured care planning and care pathways alongside a ‘stepped care’ model of provision in four tiers.

Tier 1 services are basic interventions which can be provided in a variety of specialist or non-specialist settings, for example basic information and advice, AUDIT screening, providing simple brief interventions, and referral of individuals to more specialist services.

Tier 2 services are specialist support provided by designated agencies. These are generally open access and fall below the threshold of alcohol treatment. Examples of Tier 2 services include extended brief interventions or motivational counselling.

Tier 3 services are structured and care-planned treatment programmes, including detoxification and rehabilitation programmes delivered in community settings.

Tier 4 services are specialist inpatient treatment and residential rehabilitation provision.

Probation trusts are committed to the provision of alcohol services within the MoCAM framework (Home Office, 2006). Drugs and Alcohol National Occupational Standards (DANOS), the underlying performance standards for both drug and alcohol services, encompass various aspects of service delivery, management and commissioning (Skills for Health, 2008).

Interventions for offenders

Alcohol interventions available to offenders include those designed for the general population and commissioned via Primary Care Trusts (PCTs) and those designed for offenders in either custodial or community settings and either singly or jointly commissioned by a variety of agencies including PCTs, NOMS or other agencies.

The Alcohol Treatment Requirement (ATR) is a court disposal, introduced in the Criminal Justice Act 2003, where an individual agrees to undergo a course of clinical alcohol treatment (at Tier 3 or 4) as an alternative to imprisonment. To issue an ATR, the court must be satisfied that an offender is alcohol dependent and will benefit from treatment, that arrangements will be made for the treatment to take place, the requirement is suitable, and that the offender expresses willingness to comply. The duration of ATRs for community orders is between six months and three years, with six months to two years for suspended sentence orders.

The Alcohol Specified Activity Requirement (ASAR) is another court disposal; in this case an 'activity requirement' appended to a community order or suspended sentence order. An offender subject to an ASAR is required to attend a Tier 2 service for an agreed period of time with the objective of supporting them to reduce and more effectively manage their alcohol use, thereby both improving health and reducing the risk of future offending.

There are a range of other specialist offender alcohol interventions which are accredited by NOMS for delivery in prison and probation settings. The Lower Intensity Alcohol Programme (LIAP) is a Tier 2 intervention designed to address alcohol related offending behaviour for problematic, but not dependent, drinkers. Control of Violence for Angry Impulsive Drinkers (COVAID), Alcohol Related Violence (ARV) and the Integrated Domestic Abuse Programme (IDAP) are accredited to address alcohol-related violence and domestic abuse. The Drink Impaired Drivers Scheme (DIDs) targets those convicted of drink-driving.

Commissioning and policy

The policy and commissioning environment with regards to offender alcohol interventions has been, and remains, uncertain and unstable. NOMS *Alcohol Interventions Guidance* (2010) confirms that lead commissioning responsibilities for offender alcohol treatment, including for the ATR, rests with PCTs. Probation does have the option to contribute funds to enable targeted and timely interventions for designated offenders.

The NHS White Paper, *Equity and excellence: liberating the NHS* (Department of Health, 2010) has set out plans to phase out PCTs and strategic health authorities and create general practitioner consortia with responsibilities for the local commissioning of health services. In this context, it is unclear where responsibility for commissioning offender alcohol interventions will be vested or how the responsibilities of the National Treatment Agency regarding alcohol will change once it becomes re-integrated into the structure of the proposed 'Public Health Service'.

Similarly, since the end of the system of Public Service Agreements and National Indicators, it is not yet clear how local commissioning authorities will be guided or incentivised. Joint Strategic Needs Assessments (JSNAs) will remain in some form, and those involved with commissioning will need to consider offender alcohol interventions alongside generic and 'population level' responses.

Nevertheless, there are a number of positive policy developments in relation to offending and alcohol. Two recommendations from the Bradley Report (Department of Health, 2009b) on criminal justice diversion will be of particular relevance if implemented by the new government:

- improved services for prisoners who have a dual diagnosis of mental health and drug/alcohol problems should be urgently developed;
- joint care planning between mental health services and drug and alcohol services should take place for people resettling from prison.

The justice green paper (Ministry of Justice, 2010) identifies alcohol as being a significant factor in offending behaviour and recommends the exploration of payment by results in

the commissioning of offender alcohol interventions.

The Government’s Drug Strategy, 2010 (HM Government, 2010) includes severe alcohol addiction within its focus, and identifies that directors of public health in the future will have oversight of the local commissioning of both drug and alcohol services. It also states that a consultation will be undertaken around the integration of drug and alcohol treatment within a single revised Models of Care framework with a greater focus upon recovery.

The ‘Total Place’ pooled budgeting pilot initiated by the last administration, and accepted as a model for future development by the current government, may point the way to more effective joint responses to alcohol and offending. ‘Place-based budgeting’, as it is now known, seeks to identify how local public agencies can work together to deliver front-line services more effectively by mapping flows of public spending in local areas and making links between services. The HM Treasury evaluation of this initiative clearly recommends alcohol related offending as a field for coordinated action by public agencies via shared targets and pooled budgeting (HM Treasury, 2010).

Community Safety Partnerships (CSPs) are statutorily constituted bodies bringing together managers and commissioners within local areas to develop joint responses to community safety issues. Typically, they have worked to address alcohol-related crime and disorder and put in place measures to regulate the ‘night economy’ of pubs and clubs in urban areas. Since April 2010, they have also assumed a statutory responsibility for the reduction of reoffending, thereby increasing their potential as a means of developing local responses to alcohol related offending. The Government is also currently reviewing the Licensing Act (2003) to identify how alcohol related crime and disorder may be addressed through stronger enforcement of licensed premises (Home Office, 2010b).

Issues and challenges

Through contact with agencies and users of services in the South West for this project, some key issues and challenges relating to the joint commissioning of alcohol interventions for offenders have been identified.

Under-resourcing of alcohol provision

Both commissioners and users of services observed an overall under-resourcing of alcohol provision. Demand for all types of intervention and treatment exceeded supply across all four MoCAM tiers in both general health care and offender-specific settings.

Variation to joint commissioning practice

Responsibilities for the development of local offender alcohol strategies and the commissioning of alcohol interventions to offenders varied from area to area and were contested in some cases. Probation has historically acted as sole commissioner of offender alcohol interventions in some areas. In others this role has been shared with Drug and Alcohol Action Teams (DAATs) and PCTs. Significant variation in both levels and type of services provided was also evident.

Misalignment between the objectives and targets of health and criminal justice commissioners

Despite the expectation that health and criminal justice agencies will work collaboratively to commission and provide alcohol and other offender health services, there are significant challenges to this taking place in practice. The issue of ‘cost shunting’, where targets in one sector become resourced by another, was identified as a significant potential obstacle to closer strategic partnership working.

We found that the requirement of criminal justice agencies to commission targeted and timely interventions addressing the causes of crime can clash with the commitment of PCTs to provide freely available health care services to the general population. For example, some NHS commissioners oppose commissioning offender-only alcohol services due to the perceived unfairness of offenders receiving services not generally available to all members of the community. Conversely, some criminal justice commissioners stress the unfairness of offenders on occasion being unable to receive targeted alcohol interventions, and cited the potential global cost implications for all sectors of not providing this group with appropriate interventions.

On occasions, these differences hinder the local commissioning of the Alcohol Treatment Requirement (ATR). Probation requires targeted and timely interventions to ensure effective offender management and secure the confidence of sentencers to issue disposals. PCTs acting as lead commissioners are accountable for achieving different targets, in particular the reduction of alcohol-related hospital admissions. The need to improve understanding between health and criminal justice commissioners of their differing roles and responsibilities to create a 'level playing field' in relation to alcohol commissioning was frequently asserted.

Concerns about the sustainability of services

Many health and criminal justice commissioners observed that funding for general and offender-specific services is precarious and often 'kept afloat' by the extraordinary efforts of highly committed commissioners and front line staff. Concerns were expressed about the sustainability (and replicability) of some much valued projects. The current absence of joint DH/NOMS commissioning guidance around alcohol interventions was identified as a particular obstacle to securing the sustainability of services.

Lack of equivalence between alcohol and drug commissioning

Although drug treatment has been prioritised and commissioned in a standardised manner for several years via the Drug Interventions Programme (DIP) in the community and the Integrated Drug Treatment System (IDTS) in prisons, there has not been an equivalent arrangement for alcohol, universally perceived to be the larger problem, in terms both of health and of offending.

The requirement, often quoted by the National Treatment Agency for Substance Misuse (NTA), that no monies designated for drug misuse via the pooled treatment budget can be invested for alcohol interventions (where there is primary alcohol need) was considered by many commissioners to present a significant obstacle to improved provision. A reported perverse consequence of subsequent limited funding for alcohol interventions is that in cases of

desperate need, actual or invented cannabis use has been cited by staff or offenders in order to obtain support from 'drug-only' services.

"Without proper funding you have to cheat your way in by saying you smoke dope or whatever. You want an honest treatment programme. Lying to get into treatment is not how it should be."

Service user

Despite the contested environment in which alcohol services are commissioned and delivered, the commissioners, managers, front line practitioners and users of services we interviewed all demonstrated a strong willingness to improve and develop offender alcohol interventions. They have also identified a variety of ways this can be achieved.

Recommendations for development

Based on our discussions, we have developed 10 recommendations for commissioners, agencies and practitioners.

1. As the process for commissioning alcohol interventions for offenders remains unclear and contested, policy makers and commissioners from different sectors need to work pragmatically and creatively to improve services.

A number of practical examples were identified of how existing structures might be creatively and pragmatically built upon to improve outcomes involving a range of sectors and commissioners.

Utilising political interest and strategic leadership

The presence of political interest, either from a Member of Parliament or through local councillors, was identified as being a spur to action. Strong strategic leadership was also cited as being necessary in securing the support from public agencies. This is illustrated well in Devon where strong interest from a local MP and leadership from the county's Director of Public Health has enabled senior officers in different sectors to engage with the issue.

Wider implementation of MoCAM

It was recommended that MoCAM provides a strong basis for future service development. To promote the MoCAM agenda in Wiltshire, DAAT meetings have adapted their focus to direct as much attention on alcohol as on drugs (while maintaining required reporting requirements around drugs).

Local Routes

The DH guidance document *Local Routes* (Department of Health, 2009c) outlines a framework for developing multi-agency care pathways for alcohol services from initial referral to provision of specialist treatment. As such it was recommended as a basis for developing offender alcohol pathways involving both criminal justice and health care agencies.

Place-based budgeting

The deployment of pooled budgets in local areas through place-based budgeting (as employed within the 'Total-Place' pilot at Swindon), was identified as a possible future way of coordinating the work of health, criminal justice and other agencies towards jointly targeted interventions addressing alcohol and offending.

Targeting alcohol misusers via Integrated Offender Management

Local Integrated Offender Management (IOM) programmes were thought to present an opportunity for closer working between criminal justice, health, housing and social care agencies to jointly address alcohol related offending. To have the greatest impact in relation to alcohol, it was argued that IOM programmes would need to target the Automatic Unconditional Release (AUR) population, and not purely focus on prolific and priority offenders or drug users engaging with Drug Interventions Programme (DIP) services.

Community safety partnerships

A sub-group of the Safer Devon Partnership, which combines responses of Community Safety Partnerships in the county, is currently exploring how responses to anti-social behaviour, alcohol misuse and youth offending can be more closely aligned.

Sharing human resources and skills

In Dorset, Drug and Alcohol Action Teams (DAATs) collaborate with probation to provide alcohol assessments. It was also recommended that as a potential area of good practice, commissioners from different sectors should be enabled to spend time shadowing or fulfilling the role of their counterpart through secondment.

Utilising innovative methods for funding interventions

The use of social impact bonds and payment by results were recommended as possible future means of resourcing offender alcohol interventions. This approach is currently being piloted with offenders at HMP Peterborough and in post-release settings in the community.

The development of 'self-financing' schemes was also recommended. An example of this is in Devon where the Safer Devon Partnership has commissioned Druglink to run an intervention targeting individuals who have been issued with a Penalty Notice for Disorder (PND). Introduced as part of the Criminal Justice and Police Act 2001, PNDs are fines which can be issued by the police for a variety of minor disorder offences in place of court action. This scheme is funded through diverted fine payments from individuals issued with PNDs who agree to attend an alcohol awareness session.

2. The evidence base for offender alcohol interventions needs to be developed.

"The cost to individuals, families and wider society of alcohol abuse needs to be clearly recognised. Resources must be given to alcohol treatment to stop the damage from happening."
Service user

One frequently cited obstacle to more widespread commissioning of offender alcohol interventions is the limited evidence base for service outcomes and cost effectiveness. Although some commissioners stated they were not in a position to even consider commissioning services targeted at offenders without a clear evidence base for health or re-offending outcomes, some established evidence was demonstrated, along with practical suggestions as to how the evidence base could be extended.

Collection of local data and service monitoring

To improve the evidence base to inform local commissioning of alcohol interventions, it was recommended that local targets should be set for mandatory collection of data, particularly collection of AUDIT scores for all offenders entering the criminal justice system. This could then be used as an evidence base to commission services. The need to monitor interventions success using standardised tools and outcome monitoring, including service user feedback, was also identified.

Developing a business case for targeted local joint commissioning

Recognising the high global costs of alcohol related harm and offending, and the mis-alignment between the targets of health and criminal justice agencies, some commissioners noted that more work needs to be undertaken to provide a business case for local joint commissioning for targeted earlier interventions. Assessing total alcohol-related costs to services and identifying the potential benefits and efficiencies which could be gained through jointly commissioned interventions spanning health, criminal justice and other areas (for example housing and education) was considered to be an essential element of a local alcohol strategy.

Alcohol Arrest Referral

In Wiltshire, the Alcohol Referral Programme for Offenders and Victims (ARPOV) arrest referral programme has evidenced a 14% reduction in alcohol-related offending over three years. This programme is based upon a long standing alcohol arrest referral project in Gloucester, currently under evaluation, which anecdotally reports a very high level of success. Positive feedback from both locations strongly indicates the benefits of earlier interventions to promote both wellbeing and reduce re-offending.

Formal evaluation

It was also observed that the evidence base for service effectiveness and the cost of alcohol interventions for offenders should be extended through independent, methodologically rigorous peer-reviewed research.

3. Service users should be involved in the commissioning and review of interventions.

“Basically, you’re asking the customer for their views. We can say if the service is working or not so we provide real-time feedback from the streets to the commissioners.”

Member of WASP

Both commissioners and users of services stated that individual service users and representative groups should be closely involved in the commissioning of alcohol interventions. For commissioners in both health and criminal justice settings, the input of ‘experts by experience’ was considered to be a ‘reality check’ ensuring that appropriate and effective services are delivered. For users of services, involvement in service planning was also described as being both empowering and a vital part of their recovery process.

Wiltshire Addiction Support Project (WASP) provides a range of support and advocacy services for drug and alcohol misusers in the county. It works closely with the county’s joint commissioning group to ensure that service users are involved in the review of services and in strategic planning decisions. Commissioners and providers have responded to service user pressure on a number of issues, including access to services and waiting times.

“As a result of service user pressure, the whole system has been re-structured and ... now there is an alcohol treatment system where before there wasn’t in reality.”

Member of WASP

4. Preventive interventions should form a vital component of any local alcohol strategy.

To address significant levels of alcohol related harm and offending, many of those we interviewed stressed the need for preventive or ‘pre-criminal justice’ interventions to be developed and implemented in local areas, including increased public awareness, the implementation of population level responses and the management of the night time economy. A number of commissioners and senior managers from PCTs, probation and the prison service expressed a strong willingness

to engage with the police and local authorities via Community Safety Partnerships (CSPs) to develop such interventions in local communities.

Public alcohol awareness

“Why don’t we educate the young about alcohol?”

Service user

It was widely observed that limited public awareness of the harm and risks associated with alcohol misuse can be a contributory factor to both harm and offending. Improving the awareness of young people and young adults through education and social marketing about the dangers of alcohol misuse was seen as the basis for ‘pre-criminal justice’ engagement.

The Swindon Health Ambassadors initiative, funded by Swindon PCT, provides healthy living advice in deprived communities delivered by trained non-professionals. Alcohol is covered in this programme, which also maintains links with probation and other statutory services.

Population level responses

“The pricing of alcohol needs to change. Alcohol in supermarkets is cheaper than water – it is ridiculous!”

Service user

The ready availability of cheap or below-cost alcohol was identified by both the users of alcohol services and professionals as a major barrier to recovery and a significant contributor to alcohol-related offending. The universal view of both groups was that population level measures, such as unit pricing, the restriction of the number of licensed premises and the advertising of alcohol, as advocated by NICE, are necessary to reduce the overall level of alcohol consumed and to limit alcohol-related harm and offending.

Regulation of the night time economy

“Breweries are like giant dealers. They hook people in and have a customer for life. They need to have more responsibility. Things like happy hours, two for one deals, extended hours, single girls getting the first drink free etc. need to stop.”

Service user

All sectors identified the night time economy of pubs and clubs in local areas as a major contributory factor to crime and disorder, and a resource drain for health and criminal justice agencies, particularly at weekends. The effective management of this environment was considered to depend upon a number of factors, including strong partnership working between criminal justice agencies, the licensing trade and communities, effective public education and communications and credible enforcement for both individuals and premises.

The Best Bar None initiative is organised by the licensing industry and supported by the Home Office to reduce alcohol related crime and disorder in town centres nationally. It works to achieve this by promoting local contact between the licensing trade and the police, and promoting responsible management and operation of licensed premises. In the Weymouth and Portland areas of Dorset, the police have established a Drink Street Safe Scheme to rate local licensed premises in terms of public safety, prevention of crime and disorder and other criteria.

Community Safety Partnerships (CSPs) have a clear role in the development of local responses to regulating the night economy, by bringing together representatives from the police, probation, local authorities and other agencies. In Wiltshire, a sub-committee of the Community Safety Partnership, with representation from probation and the PCT, is charged with identifying action relating to ‘problem premises’ up to and including enforced closure. Additionally, the Community Safety Partnership is represented on the county’s joint commissioning group, along with the police and probation, to enable the future development of preventative measures.

5. All front line workers need basic alcohol awareness and some professionals require specific training.

Through engagement with service managers, front line workers and the users of services, it is clear that while some workers from health and criminal justice agencies are highly experienced at identifying needs, carrying out referrals and making assessments relating to alcohol, many lack basic skills and confidence in this area. Also, considering that alcohol misuse is inextricably linked to a range of need in other

areas (for example housing, family relationships, physical and mental health, learning disability, education, employment and offending), the capacity of individual workers to signpost or refer to other agencies was frequently considered to be limited. Many front line staff also reported that some of the key skills required to work effectively with drug users were different to those required for working with alcohol misusers.

“I was on anti-depressants, and never went to the GP without smelling of alcohol. I asked for more sick notes and more anti-depressants, but he never asked me anything about my drinking.”
Service user

Fearful, disrespectful or hostile attitudes to alcohol misusers from health, criminal justice, social care and other agencies were reported to be widespread by service users. However, they noted and welcomed occasions where thoughtfulness and respect were demonstrated by workers.

“On one or two occasions the police have said ‘why don’t you sort yourself out?’ and those times have stuck with me. The police should be able to signpost repeat offenders and lever in help at the right time.”
Service user

A number of areas for workforce development were identified.

Basic alcohol awareness

The provision of basic alcohol awareness (to DANOS standard) for all front line staff in health, social care and criminal justice settings was considered to be a prerequisite for engagement with clients who misuse alcohol in order for them to be able to deliver Tier 1 interventions.

Specialist training for gatekeepers to treatment services

The limited level of alcohol awareness within GP training was noted by service users to be a significant obstacle to receiving appropriate primary care services. GP alcohol training remains a significant area for development. Additionally, specialist training was identified as being necessary for court staff and magistrates

to ensure that they are able to effectively issue ATRs and ASARs.

Managing multiple needs and multi-agency practice

There was felt to be a particular need for workforce development in managing individuals with multiple needs, including alcohol. It was observed that such individuals present particular challenges to coordinating the responses of different agencies and that workforce development for multi-agency and multidisciplinary practice is particularly important to break down barriers for accessing appropriate services.

Involvement of alcohol specialists

It was identified that specialists working in criminal justice or health settings have a clear role in the training of colleagues about alcohol. In so doing they would be able to empower their colleagues to engage alcohol misusers and free up their time to work more effectively. The role of current and former service users acting in the role of experts by experience was also identified as significant.

Utilisation of national information resources

A number of key online resources are recommended for information about provision, commissioning and policy in the field of alcohol.

- Alcohol Learning Centre is a website sponsored by DH providing online resources and learning for commissioners, planners and practitioners.
- Hub of Commissioned Alcohol Projects (HubCAPP), part of the Alcohol Learning Centre, provides details of specific alcohol interventions and their commissioning arrangements throughout England and Wales.
- Alcohol Policy UK is an independent blog covering news and development in the field of alcohol.

6. All front-line agencies should provide Identification and Brief Advice (IBA).

While provision of Tier 1 interventions across services was identified to be a foundation of effective alcohol services, it was widely

observed that many agencies fail to provide early alcohol interventions. It was further reported that designated alcohol workers based at arrest referral or probation frequently spend a disproportionate amount of time carrying out Tier 1 interventions – for example conducting AUDIT assessments – which could be conducted by non-specialist staff. Service users also stressed the need for workers in front line services to be trained and encouraged to act on their instincts and broach the subject when they suspect that someone may be misusing alcohol so that support can be offered.

Identification and Brief Advice (IBA) is a Tier 1 intervention recommended within MoCAM to be delivered by non-specialist staff in health, social care and criminal justice settings. It consists of opportunistic alcohol case identification, screening using the Alcohol Use Disorders Identification Test (AUDIT), the delivery of brief advice and informed referral to specialist agencies. It should be a part of standard practice for all agencies engaging with offenders.

To complement a more widespread use of IBA, the development of flexible referral pathways for alcohol was identified by some commissioners to be a priority. In Devon and Cornwall, multi agency work is under way to establish such a pathway to ensure that individuals are able to access specialist alcohol services from a range of different agencies via Tier 1 interventions.

7. Alcohol misuse should not be a label for exclusion.

“Attitudes change when you disclose your illness. You go to the bottom of the queue because you’re just an alcoholic.”

Service user

Managers, practitioners and users frequently stated that a label of alcohol misuse, coupled with offending or contact with criminal justice agencies, all too often leads to exclusion from services. It was also very strongly argued that reliance upon ‘abstinence-only’ approaches in policy and commissioning would have the potential to exclude many people for whom abstinence is not an appropriate or realisable goal.

A number of means were proposed to counter the exclusion of alcohol misusers from services.

Improved risk management

One of the most frequently stated reasons why offenders who are potentially dependent on alcohol do not access services was perceived risk to staff, particularly in relation to accident and emergency, GP surgeries and community mental health services. It is clear, therefore, that clinical governance and risk management procedures should be developed to ensure that services are accessible to individuals who are potentially alcohol dependent.

Utilising a portfolio of abstinence and non-abstinence-based models

To ensure accessibility of services to individuals with different drinking patterns, needs and levels of dependence, it was widely recommended that a ‘portfolio’ of different interventions should be supported for offenders with both abstinence based and non-abstinence based services. The Self Management and Recovery Training (SMART) model of peer-led cognitive behavioural-based interventions was recommended as complementing traditional Alcoholics Anonymous (or 12 step) approaches, and ensuring that non-abstinent alcohol misusers can also benefit from services. Appropriate services for non-dependent binge drinkers were also identified as a necessary provision.

Use of the Health Trainer model

This was another means identified for delivering healthcare interventions to ‘hard to reach’ groups, as is the case with alcohol misusing. Experienced former users of services are recruited and trained to deliver mentoring and signposting services to current users. As well as providing a useful intervention, this model also strengthens links to employment, training and employment pathways for the users of services and provides opportunities for a group at high risk of unemployment and social exclusion.

Improved partnership working between police and the NHS

Improved partnerships between the police and A&E services were also identified as requiring development to ensure that alcohol misusers who are brought to hospital for an urgent assessment under Section 136 of the Mental

Health Act receive appropriate treatment. The partnership working between Dorset Police and PCT which has led to NHS commissioning of police custody healthcare services across the county was identified as opening the door to future closer collaboration around alcohol.

Improved anti-social behaviour (ASB) responses

It was widely observed that ASB arrangements in local areas frequently do not seek to address underlying problem drinking. Interviewees recommended that the ASB escalation process should include, as a matter of course, alcohol screening, brief intervention, sign posting to services and multi-agency interventions to reduce both ASB and the escalation of offenders into the criminal justice system.

Integrated referral pathways

The need for arrest referral services to integrate responses to drugs, alcohol and mental health was recommended. In North Devon, close partnership working between separate alcohol and drug arrest referral services has been developed. In the past, when funding was available, this arrangement had also incorporated a mental health and multiple needs strand.

Appropriate provision for rural settings

There should be provision for long travel distances and low caseload density. The Telephone Counselling service established by Avon and Somerset Probation was identified as a successful way of taking into account rurality in the development of offender alcohol interventions.

Considering the development of alternative court disposals

While the Alcohol Treatment Requirement (ATR) and Alcohol Specified Activity Requirement (ASAR) were both identified as successful interventions targeting need across MoCAM tiers, a wish to explore alternative court disposals based upon experience in other countries was also expressed. The application of the 'Dakota Model' from the United States, where people convicted of drink-driving have sentences suspended by agreeing to be breathalysed daily, was raised, but also

acknowledged as potentially contentious within a UK context.

8. Appropriate alcohol interventions should be provided at all stages of the criminal justice pathway.

Commissioners, providers and service users clearly stated that current levels of alcohol service provision across the offender pathway are low and that there is limited continuity of care for offenders with complex needs or whose primary need is alcohol-related. The very high level of alcohol detoxification conducted in prison, coupled with the need for more effective screening, was also noted.

Particular concern was expressed about a 'cliff edge' for alcohol misusing offenders at point of release from prison, especially for those completing sentences of less than 12 months and those who are unable to engage with abstinence-based services, leading to increased risk of relapse and re-offending. While some examples of good practice of offenders receiving continuity of alcohol support from prison through to the community were identified, this appeared to take place at the margins, and be carried out by dedicated staff in addition to their designated roles.

Despite the clear limitations to current provision, commissioners expressed strong enthusiasm for commissioning alcohol interventions. Across the South West Region, there were clear examples of innovative and flexible provision which was either singly or jointly commissioned.

Pre-arrest

Involvement of neighbourhood police. The involvement of police neighbourhood teams in the identification and referral of problem drinkers they come into contact with was recommended. In Devon and Cornwall, police carry a card containing referral details for alcohol services.

At point of arrest

Arrest referral. A range of established alcohol arrest referral initiatives was highlighted. This included a long standing scheme in Gloucestershire which is jointly commissioned by the PCT and the Home Office and another in

Devon commissioned by the DAAT and provided by Addaction. Wiltshire Council and PCT are in the process of jointly re-tendering for their established Alcohol Referral Programme for Offenders and Victims (ARPOV) arrest referral scheme which utilises both group work and one-to-one engagement models.

Alternatives to court prosecution. The scheme mentioned earlier where the Safer Devon Partnership has commissioned Druglink to deliver a programme targeting individuals who have been issued with a Penalty Notice for Disorder is an good example of an early intervention intended to ‘divert’ people at risk of becoming more entrenched within the Criminal Justice System. Fines are halved for individuals willing to attend an alcohol awareness course with the lesser fee going towards the cost of the programme.

At court

ATRs and ASARs: The Tier 3/4 Alcohol Treatment Requirement (ATR) and the Tier 1/2 Alcohol Specified Activity Requirement (ASAR) were identified as very effective interventions. The use of Alcohol Specified Activity Requirements as part of Tier 2 delivery was cited as an area for future development. One probation commissioner suggested that they could potentially reach 5% of their caseload through ATRs but 45% through ASARs.

In prison

Extended remit for Counselling, Assessment, Referral, Advice and Throughcare (CARAT) teams. After receiving formal clearance, CARAT teams operating in South West prisons now assume responsibility for alcohol assessment in addition to their traditional role with drugs. This was seen as a positive development as it provides an additional opportunity for providing brief interventions and signposting.

9. Services should be responsive to specific groups.

It was identified that offender alcohol services should be responsive to the needs of particular groups, including perpetrators of domestic violence, women, younger adults and Black and Minority Ethnic (BME) groups.

Domestic violence

Major links between alcohol and domestic violence were reported. It was expressed that there was a real need to link alcohol into established multi-agency domestic violence pathways and safeguarding arrangements in local areas.

“When I was last arrested it was a DV case and they asked my partner if she wanted to press charges. She said she just wanted me to get help but they couldn’t offer that help so they banged me up for the night. They didn’t know what to do.”

Service user

Women

It was stated that the particular needs and experiences of women need to be considered when formulating alcohol interventions, for example how to manage underlying trauma which may trigger alcohol misuse and offending needs to ensure that services are effective. As part of a NOMS pilot, Gloucestershire Probation is currently developing a model for providing alcohol interventions specifically designed for women completing the ATR.

Young adults

Alcohol services were widely observed not to be attracting younger adults (those aged 18-25) nor offering them services that meet their specific needs. There was also perceived to be limited connectivity between agencies to support the transition from accessing young person’s services to adult services. A significant need for the establishment of alcohol arrest interventions for young people was noted.

In Plymouth, the Harbour drug and alcohol service has tripled the number of young people accessing the service in the last year after a young person’s worker recently joined the team and improved engagement with this group. The key to engagement for this group was to find out what type of service they would be most likely engage with and trust and then locate the service there. In Wiltshire, a young person’s version of the established ARPOV arrest referral service has been commissioned.

BME groups

The accessibility of services to individuals from BME groups was also identified as requiring consideration. It was noted that in some cultures alcohol use is either disapproved of or is ‘swept under the carpet’. One recommendation for more inclusive practice in such circumstances was to facilitate self-referral into Tier 2 interventions based on perceived need (either by the individual or a family member) instead of or in addition to relying on AUDIT scores. Also, the particular alcohol needs of Eastern European/EU Accession migrants were also identified as requiring fuller local assessment.

10. Charitable and voluntary sector organisations add value and expertise.

Commissioners noted that the ‘grassroots’ connections of many voluntary sector organisations allow them to creatively engage with both alcohol misusers and statutory agencies in ways which mainstream services find difficult. They were, therefore, felt to add value to mainstream responses when commissioned or supported to fulfil specialist roles.

Providing flexible service responses

Wiltshire Addiction Support Project (WASP) organises a peer support service which draws upon the voluntary commitment of its members both inside and outside of normal working hours.

“Drug and alcohol services close at 4.30 pm, aren’t open at weekends, bank holidays or Christmas. Addiction doesn’t go on holiday. At WASP we have introduced the ‘buddy phone’ – it’s important to offer out of hours support. We give our time and energy out of hours voluntarily. Services need to be responsive. We can jump when we need to, accompany someone to court the same morning if needs be.”

Service user

Facilitating involvement from the wider community

Street Pastor schemes are faith-based groups of trained volunteers working with the police and local health services to support individuals requiring assistance in urban drinking areas.

These initiatives have been established in a number of locations in the South West including Swindon, Bath and Weston Super Mare.

Developmental expertise

Devon and Cornwall Probation Trust, the Safer Devon Partnership and the DAAT have jointly commissioned Addaction, a drug and alcohol service provider, to employ a criminal justice alcohol lead to co-ordinate and improve alcohol interventions for offenders in Devon. This role also assists in gathering evidence of need, developing effective interventions, linking up existing services such as alcohol arrest referral, prison interventions, probation interventions, IOM and links with other services, such as housing, mental health and drugs services.

Expertise by experience

Wiltshire Addiction Support Project (WASP) also works to ensure that service users are involved in strategic planning decisions and is represented on the county’s joint commissioning group.

Conclusion and next steps

From our contact with strategic leads, commissioners, front line agencies and the users of services in the South West it is clear that, across the criminal justice pathway and tiers of provision, alcohol interventions are under-resourced. Inadequate provision at all stages of the offender pathway is further exacerbated by misalignment between health and criminal justice objectives and a lack of equivalence between alcohol and drug service commissioning.

Nonetheless, despite these challenges and a changing and uncertain policy and commissioning landscape, stakeholders from all sectors have expressed a very strong willingness to tackle the situation and have identified a range of possible means for improving alcohol outcomes. However with resource concerns paramount, it is clear that a primary focus of future development in alcohol and criminal justice must not simply be about creating more services (as important as this is), but improved evidencing of need (at both individual and population level) coupled with improved joint

commissioning and outcome measurement, and more effective service delivery. An important aspect for future development needs to be that of improving wider workforce alcohol awareness within health, criminal justice and allied agencies.

Taking into account the global costs of alcohol misuse within society, and the evidence base for population level interventions, there is a very strong case for health, criminal justice and other agencies collaborating to commission preventive and early interventions. From a public health perspective, better and earlier education about harm and a focused aim to challenge wider norms and values in relation to alcohol is also needed to limit the demand for services and ultimately to reduce alcohol related harm and offending within society.

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References

- Alcohol Concern (2010) *Investing in Alcohol Treatment: Reducing Costs and Improving Lives*. London: Alcohol Concern.
- Babor, T., Higgins-Biddle, J., Saunders, J., Monteiro, M. (2001) *The Alcohol Use Disorders Identification Test: Guidelines for Use in Primary Care*, World Health Organisation.
- Brennan, A. et al. (2009) *Modelling to assess the effectiveness and cost-effectiveness of public health related strategies and interventions to reduce alcohol attributable harm using the Sheffield Alcohol Policy Model version 2.0*. SCHARR: University of Sheffield.
- Department of Health (2008) *Safe, Sensible, Social – Consultation on further action: Impact Assessments*. London: Department of Health.
- Department of Health (2009a) *Signs for Improvement – Commissioned Interventions to Reduce Alcohol-Related Harm*. London: Department of Health.
- Department of Health (2009b) *The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system*. London: Department of Health.
- Department of Health (2009c) *Local Routes: Guidance for developing alcohol treatment pathways*. London: Department of Health.
- Department of Health (2010) *Equity and excellence: liberating the NHS*. London: Department of Health.

- Drummond, C., Oyefeso, A., Phillips, T., Cheeta, S., Perryman, K., Winfield, H., Jenner, J., Cobain, K., Galea, S., Saunders, V., Fuller, T., Pappalardo, D., Baker, O., Christouopoulos, A. (2005) *Alcohol Needs Assessment Research Project (ANARP): The 2004 national Alcohol Needs Assessment for England*. London: Department of Health.
- DWP (2009) *State of the Nation Report: Poverty, Worklessness and Welfare Dependency in the UK*. London: Department for Work and Pensions.
- Gilchrist, E., Johnson, R., Takriti, R., Weston, S., Beech, A., Keibell, M. (2003) *Findings 217: Domestic violence offenders: characteristics and offending related needs*. London: Home Office.
- Heather, N., Raistrick, D., and Godfrey, C. (2006) *Review of the Effectiveness of Treatment for Alcohol Problems*. London: National Treatment Agency for Alcohol and Substance Misuse.
- HM Government (2010) *Drug Strategy 2010*. London: HM Government.
- HM Treasury (2010) *Total Place: A Whole Area Approach to Public Spending*. London: HM Treasury.
- Home Office (2006), *Working with Alcohol Misusing Offenders – A Strategy for Delivery*. London: Home Office.
- Home Office (2010a) *Crime in England and Wales*. London: Home Office.
- Home Office (2010b) *Rebalancing the Licensing Act: A Consultation on Empowering Individuals, Families and Communities to shape and determine local licensing*. London: Home Office.
- Kaner, E., Dickinson, H., Beyer, F., Campbell, F., Schlesinger, C., Heather, N., Saunders, J., Burnand, B., Pienaar, E., (2007) *Effectiveness of brief alcohol interventions in primary care populations*. Cochrane Database of Systematic Reviews 2007 (2).
- Knapp, M., McDaid, D. and Parsonage, M. (editors) (forthcoming) *Mental Health Promotion and Prevention: the Economic Case*. London: Department of Health.
- McManus, S., Meltzer, H., Brugha, T., Bebbington, P., Jenkins, R., (2009) *Adult Psychiatric Morbidity in England, 2007: Results of a Household Survey*. NHS Information Centre for Health and Social Care.
- McSweeney, T., Webster, R., Turnbull, P.J., Duffy, M. (2009) *Evidence Based Practice? The National Probation Service's work with alcohol-misusing offenders*. London: Ministry of Justice.
- Ministry of Justice (2010) *Breaking the cycle: Effective punishment, rehabilitation and sentencing of offenders*. London: Ministry of Justice.
- National Treatment Agency (2006a) *Models of Care for Alcohol Misusers (MoCAM)*. London: National Treatment Agency for Substance Misuse.
- National Treatment Agency (2006b) *Models of Care for Treatment of Adult Drug Misusers: Update 2006*. London: National Treatment Agency for Substance Misuse.
- NICE (2010) *Alcohol Use Disorders, Preventing Harmful Drinking*. London: National Institute for Health and Clinical Excellence.
- NOMS (2008) *Criminogenic Needs (OASys) assessments, 2008*.
- Prime Minister's Strategy Unit (2004) *Alcohol Harm Reduction Strategy for England*. London: Prime Minister's Strategy Unit.
- Purshouse et al. (2009) *Modelling to assess the effectiveness and cost effectiveness of public health related strategies and interventions to reduce alcohol attributable harm in England using the Sheffield Alcohol Policy Model version 2.0 – Report to the NICE Public Health Programme Development Group*. University of Sheffield.
- Singleton N, Meltzer H, Gatward R (1998) *Psychiatric Morbidity among Prisoners in England and Wales*. London: National Audit Office.
- Skills for Health (2007) *DANOS Guide*. Bristol: Skills for Health.
- World Health Organisation (1992) *The ICD-10: Classification of Mental and Behavioural Disorders*. Geneva: World Health Organisation.

Online resources

Alcohol Learning Centre:

www.alcohollearningcentre.org.uk

HubCAPP: www.hubcapp.org.uk

Alcohol Policy UK: www.alcoholpolicy.net

A label for exclusion

Support for alcohol-misusing offenders

Rob Fitzpatrick and Laura Thorne

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