EVALUATION OF LIVERPOOL'S CRIMINAL JUSTICE ALCOHOL TREATMENT PILOT

Interim Report

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Executive Summary

This is the second interim report produced by the Centre for Public Health at Liverpool John Moores University to present an update on the progress and findings of their evaluation of Liverpool's Criminal Justice Alcohol Treatment Pilot, commissioned by Liverpool DAAT. The pilot has encompassed the Alcohol Treatment Requirement (ATR), a court mandated requirement to attend alcohol treatment for a six-month period and the Alcohol Treatment Programme (ATP), a voluntary programme for offenders contacted through alcohol arrest referral or on non-ATR Probation supervision. The Lighthouse Project has been responsible for the provision of alcohol treatment to offenders who have accessed the scheme via these two referral pathways. The pilot aims to engage offenders who have committed an alcohol-related offence, and who have been identified as alcohol dependent, in treatment specifically designed to tackle their alcohol misuse and in turn reduce the likelihood of them re-offending.

Measures of clients' drinking, offending, health and related behaviours, recorded by the Lighthouse Project Alcohol Treatment workers using a standard assessment tool, were collected for clients who consented to participate in the evaluation. Comparisons were made between these measures taken at the initial assessment stage and the three- and six-month review stages. Qualitative outcome measures were obtained through follow-up semi-structured interviews conducted with clients. A stakeholder consultation provided insight into the process and running of the scheme in addition to its perceived benefits and limitations.

Recruitment of participants for the evaluation ended in June 2008 and the six-month treatment period for all ATR clients was complete by September 2008. This report focuses on the findings from the data for the ATR clients but reference is made to the ATP element through findings from the stakeholder interviews.

The key interim findings are as follows:

- The numbers of clients receiving an ATR was low (19), however, treatment was offered to a larger number of offenders (61) via the ATP route.
- Communication between Probation and Lighthouse Project staff was effective and had improved since the previous ATR pilot. Role boundaries were felt to be clearly defined, yet the areas of advice provided by the two services, as reported by clients, continued to overlap which could become problematic if the ATR were to be expanded.
- There were inconsistencies relating to decisions around eligibility for an ATR, though evidence of alcohol dependency among the client group suggested they had been

appropriately selected for the pilot. The application of the breach procedure also varied which meant it was not always initiated following unacceptable absences.

- Stakeholders recommended increased use of Interim Accredited Programme Software (IAPS) to evidence the work carried out by the Alcohol Treatment workers and to standardise the recording of sessions, further aiding communication between Probation and Lighthouse Project staff.
- The pairing of Probation and treatment sessions was convenient for clients and should continue in the interests of engaging clients and achieving good attendance rates.
- In-depth on-to-one discussions between Alcohol Treatment workers and clients were fundamental in building trusting relationships and promoting positive changes in clients' attitudes and behaviours. The consistency and dependability of workers were also important factors.
- Clients' relationships with Probation Offender Managers were contrasting; some were equally as effective as clients' relationships with their Alcohol Treatment workers but others appeared to be none-existent due to the irregularity of staff seen and a lack of time dedicated for discussion.
- The take-up rate for referrals to other services was not as high as it could have been. Despite a previously identified need for a full-time counselling service for the ATR clients, some who were offered appointments were reluctant to attend due to personal concerns or because they didn't believe it would benefit them.
- There were clear improvements in clients' drinking behaviour according to outcome measures. Statistically significant reductions in clients' AUDIT scores were found and there is evidence to show that positive changes took place during the first three months of clients' orders.
- Examination of re-conviction data has proved inconclusive and more time must pass before an accurate comparison of pre- and post-intervention conviction rates can be made.
- There is little evidence that clients made a clear association between their drinking behaviour and offending and clients made greater reference to improvements in their health following treatment than to any impact on their criminal behaviour.
- Clients who completed their order were confident and optimistic about their future and in continuing to tackle their problems with alcohol beyond the ATR period, however a formal framework for aftercare needs to be established in order to ensure continued support is available to those who require it, to minimise the risks of relapse and further conviction.

1.0 Introduction

1.1 Impact of Alcohol Use

Over 90% of adults in the UK population, nearly 40 million people, drink alcohol and the majority do so with no problems most of the time (Cabinet Office, 2003). However, alcohol dependence and misuse are common and costly. In 2000 the estimated prevalence of alcohol dependence in the United Kingdom was 11.9% among men and 2.9% among women (Singleton et al, 2001). Drinking above recommended levels can be dangerous to health with alcohol misuse being connected to a variety of health complaints including coronary heart disease, stroke, cancers and liver disease. Recently, the *Interim Analytical Report* prepared by the Cabinet Office's Strategy Unit (Cabinet Office, 2003) estimated that between 15,000 and 22,000 deaths per year were associated in some way with alcohol misuse. According to Alcohol Concern (1999), alcohol is also closely linked with preventable harm associated with: pregnancy, mental illness, accidents and violence and other crimes (offenders have been found to be intoxicated in 30% of sexual offences, 33% of burglaries and 50% of street crime). In terms of financial burden, it has been estimated that alcohol misuse is now costing around £20 billion a year (Cabinet Office, 2003). Similarly, Leontaridi (2003) estimates the public costs of heavy drinking in England and Wales to be between £18 and £20 billion.

1.2 Alcohol Treatment

Seeking treatment is typically a consequence of experiencing prolonged alcohol-related problems and stress, notably related to health, relationships and finances (NTA, 2006). There is a choice of effective treatments to suit the variety of potential service users: 7.1 million hazardous or harmful drinkers may benefit from brief interventions, while 1.1 million dependent drinkers may benefit from more intensive treatment given by specialist workers (NTA, 2006). The nature and delivery technique of treatment dictate the effectiveness, with the cognitive behavioural approach to specialist treatment highlighted by the NTA as offering the best chances of success. It is commonly accepted that treatment for alcohol problems is highly cost effective, with the NTA estimating for every £1 spent on treatment, £5 is saved predominantly in health and social care systems and the criminal justice system (NTA, 2006). Treatment in Tiers three and four are distinguished mainly by the point of delivery, with Tier three treatments predominating in the community, including design of care plans and counselling, while Tier four treatments are largely inpatient and residential treatments but should include aftercare for clients returning to the community.

The evidence base for the effectiveness of alcohol treatment interventions is strong, although with new advances in treatment techniques there is value in reviewing recent findings. Self-help groups are the most commonly sought source of help for alcohol-related problems (Humphreys et al, 1999). Although Alcoholics Anonymous (AA) appears to produce positive outcomes in many of its members (Emrick, 1993; Humphreys, 1997) its efficacy has rarely been assessed in randomized clinical trials (Tonigan, 1995). One randomized study of patients entering employee assistance programs compared inpatient treatment combined with AA with referral to AA alone (Walsh, 1991). This study found that inpatient treatment, a combination of professional treatment and AA, will achieve better results for more people than AA alone (Walsh, 1991). The beneficial effects of AA may be attributable in part to the replacement of the participant's social network of drinking friends with a fellowship of AA members who can provide motivation and support for maintaining abstinence (Humphreys, 1999; Longabaugh, 1998).

Motivational enhancement therapy (MET) begins with the assumption that the responsibility and capacity for change lie within the client (Project MATCH Research Group, 1997; Miller, 1999). Working closely together, therapist and patient explore the benefits of abstinence, review treatment options, and design a plan to implement treatment goals. Analysis suggests that MET may be one of the most cost-effective of available treatment methods (Cisler, 1998). Evidence also indicates a treatment program of couples therapy can improve patient participation rates and increase the likelihood that the patient will alter drinking behaviour after treatment ends (Steinglass, 1999). Many persons with alcohol-related problems receive counselling from primary care physicians or nursing staff in the context of five or fewer standard office visits (Fleming & Manwell, 1999). Such treatment, known as brief intervention, generally consists of straightforward information on the negative consequences of alcohol consumption along with practical advice on strategies and community resources to achieve moderation or abstinence (NIAAA, 2000, 2002; DiClemente, 1999). A decade of systematic reviews has supported the effectiveness of brief interventions to reduce excessive levels of alcohol consumption in non-dependent individuals (Bien, Miller & Tonigan 1993; Kahan, Wilson & Becker 1995; Wilk, Jensen & Havighurst 1997; Poikolainen 1999; Moyer *et al.*, 2002). Brief interventions were developed to avoid a high prevalence of alcohol related health problems by intervening at early stages of alcohol misuse. As evidence mounts regarding the efficacy of these interventions, attention has turned to implementing them successfully. New modes of delivery, such as via computers and interactive multimedia presentations, may help to surmount some of the challenges of wide dissemination, such as strains on expertise, time and resources (Moyer & Finney, 2005). Other potential barriers to brief intervention implementation, as identified by the WHO study, include a potential lack of

knowledge, skills, time, financial incentives, professional reward to the implementer and the organisation of the healthcare system and the lack of diagnostic aids for alcohol related problems (Babor & Higgins-Biddle, 2000).

Tier four treatments, such as residential rehabilitation, are key to integrated care and can be an effective treatment for a range of alcohol misusers at different stages in their treatment journeys. However, residential rehabilitation has not experienced the same growth as community-based treatment options, and there is a need to increase the use of residential treatment (Best et al, 2005). Residential rehabilitation is principally rehabilitative or supportive but may vary according to specific aims, client type and length of stay. Programmes typically provide a structured, care-planned programme of therapies and are suitable for clients with medium or high dependence on alcohol. Rehabilitative programmes may be long or short stay, with short stay programmes varying in intensity and typically lasting less than 12 weeks. Supportive programmes tend to be suited to less dependent individuals with lower care needs. Residential rehabilitation for drug misusers has demonstrated improved outcomes in a series of research studies (Bennett and Rigby, 1990; Gossop *et al.*, 1999; De Leon et al, 1982). Evidence suggests that clients with more severe problems will experience better outcomes from treatment stays of 90 days or longer (Simpson, 1997).

Recent research has focused on the development of medications that may assist with detoxification and withdrawal amongst alcohol dependents and misusers. Pharmacological treatment may be used in combination with psychosocial treatments, although there is a need for clinical trials to identify patients who may benefit from such an approach, appropriate medications for patient needs, optimal dosage and strategies for enhancing patient compliance (NIAAA, 2000).

1.3 Alcohol Treatment in Liverpool

Liverpool DAAT and its partners have commissioned a variety of interventions to identify, assess and treat individuals who have a variety of problems with the use of alcohol. These interventions cover all four of the treatment tiers identified in Models of Care for Alcohol Misusers (MoCAM) (Department of Health, 2006). This sort of response is necessary as evidence would suggest that there are substantial issues to be tackled in the Borough. In 2005/6 Liverpool had a higher rate of adult alcohol-related hospital admissions, months of life lost due to alcohol, alcohol specific mortality, mortality related to related to liver disease and hazardous, harmful or binge drinking than the North West and England averages. The rate

of alcohol related recorded crime was also higher than the national and regional levels although figures were a reduction on the previous two years (NWPHO, 2008).

In 2007 Liverpool DAAT was selected as one of the areas for the Home Office Alcohol Arrest Referral Pilot Scheme. Liverpool's pilot looks to use Conditional Cautioning (CC), arrest referral and police bail as routes by which clients arrested for alcohol related offences can be encouraged to undertake an alcohol brief intervention session. If during assessment it is identified that these individuals have drinking at levels that require structured treatment appropriate referrals will be made. In addition Liverpool is piloting the Alcohol Treatment Requirement (ATR) through the Community Justice Centre (CJC) in Kirkdale. The ATR is a court mandated requirement to attend alcohol related treatment of a type deemed suitable after assessment by a trained Alcohol Treatment worker. In Liverpool this treatment lasts for a set period of six months and can cover all modalities depending on client need. This is the second time that the ATR has been piloted in Liverpool. In autumn 2007 Liverpool secured monies from the Neighbourhood Renewal Fund to consolidate and expand their alcohol treatment provision. As such Lighthouse Project have been commissioned to provide an overarching service through which they will be the point of referral for clients requiring alcohol treatment coming through the criminal justice system. This includes clients from the Home Office Alcohol Arrest Referral Pilot, the ATR and also any other clients that are referred in particular from the CJC and from the Probation Service. Lighthouse Project will be the central point of contact although they may not be the agency providing all the treatment for these clients.

The Centre for Public Health at Liverpool John Moores University has been commissioned by Liverpool DAAT to undertake an evaluation of the scheme. The aims of this evaluation are to:

- examine outcomes for clients treated through the scheme in terms of alcohol use, health and offending.
- examine whether the scheme's set up and ongoing implementation is effective.
- provide recommendations for the future implementation of the scheme.

2.0 Methodology

2.1 Client Outcomes

Scheme entry – All clients entering the scheme across a six month period were assessed on a number of measures:

- The alcohol AUDIT – A short assessment of a client's alcohol use developed through the World Health Organizations Collaborative Project on rapid alcohol assessment and brief interventions (Saunders et al., 1993).
- 12 item General Health Questionnaire – A validated measure of general mental health (NFER-Nelson, 1992).
- Lighthouse Project Assessment and Monitoring Tool – A comprehensive assessment tool put together by Lighthouse Project for this scheme which, as well as collecting useful client demographic and background information, includes several measures which can be utilised for evaluation purposes including the Leeds Dependence Questionnaire, a number of analogue readiness to change scales, a drink diary, drug and alcohol consumption questions and some questions around alcohol related behaviour.
- Treatment Outcome Profile (TOP) – National Treatment Agency produced documentation to measure progress of clients whilst in treatment.
- OASys (ATR clients only) – ATR clients also received an OASys assessment performed by Probation staff.

The measures outlined above were used as the basis for an examination of client outcomes. In addition, at the assessment stage clients' contact details were taken and also consent to allow clients to be followed up at a later stage for evaluation purposes.

Three month follow-up – At three month follow-up the same measures were used to assess change over time. In addition, qualitative questions examining the types of care received and satisfaction with it, as well as assistance still required, were administered. It was anticipated having OASys data available to assess the progress of the ATR clients through these measures however the correct information could not be obtained for this interim report. Not all clients were still engaged at this point because they had completed their programme of care or because they had dropped out. Follow-up attempts were made with these clients as well and interviews, where possible, conducted either in client's homes or over the telephone. Interviews for clients who had an unplanned discharge examined the reasons for

this. Interviews with clients who had completed their treatment regime focused on clients' behaviour change and their need for any further intervention.

Six month follow-up – As for three months with some additional questions regarding next steps for clients.

As re-imbursement for the time that clients put into the research they were provided with a £10 high street voucher at both three and six month follow up stages.

Re-conviction analysis - Police National Computer (PNC) data was used to track whether clients had been re-convicted in the six months after their intervention and whether their rate of conviction was comparable to that in the six months before intervention.

2.2 Process Elements

Examination of existing data sources – including records of client attendance, details regarding compliance with care plans, referral points and outcomes.

Interviews with key stakeholders - These included:

- National Probation Service - Merseyside/National Offender Manager Service staff inc: ATR specific staff, CJC based staff, strategic leads
- CJC staff
- Lighthouse Project staff including alcohol project lead, treatment workers and strategic leads
- DAAT Strategic leads
- Other key stakeholders identified by commissioners.

Interviews were run in two stages one at beginning of the research period and one after six months to see if the project tackled barriers and progressed.

As each individual interviewed had a very different perspective, the project interviews were semi-structured to allow for discussion of the topics that each individual felt were most pertinent to them. Interviews were taped to allow for accurate recording of responses. Interviews addressed:

- Awareness of the various aspects of the scheme e.g. ATR, Conditional Caution, arrest referral and the ability to refer other clients not falling into these specific schemes

- Barriers to referrals
- Impact on offenders
- Evidence base for this perception
- Communication (day to day and strategic).

Observation sessions

A variety of observation sessions were conducted to examine the various stages of the scheme. Observations were carried out in a number of treatment sessions including one on one Alcohol Treatment worker appointments and Probation case management appointments.

This report details progress so far against these methodologies and as such outlines key findings from the key stakeholder interviews conducted both at the start of the project and six months later. In addition, it provides information regarding the recruitment of participants for the outcome elements of the evaluation including the numbers recruited, the data collected and the follow-up rate achieved. A detailed examination of the information collected at intake and during the three- and six-month reviews is also provided. Through comparison of the measures of alcohol use/misuse, offending and health taken at these three stages, changes over time have been demonstrated. Insights into clients' perceptions and experiences of their treatment gained through the follow-up interviews provide further indications of the impact of the treatment for these clients. Only ATR clients have been included as the data collection and follow-up phases for this client group are complete.

3.0 Key Findings from Stakeholder Interviews

The following section outlines some of the key findings to emerge from the first round and six month follow up key stakeholder interviews. A thematic analysis was undertaken to group key findings.

A number of roles were included in the ATR pilot drawing on specific skills and expertise from both treatment and criminal justice staff. Stakeholders from both took part in interviews to examine the pilot in its initial stages and then again six months later.

For the first round of interviews 21 stakeholders participated, the same individuals were asked to take part in the follow up interview. The majority of stakeholders remained in the same post and were available for follow up interviews. Three members of staff from Probation had changed roles, but were still employed within Probation and were available for interview. One member of staff from Lighthouse Project and one member of Probation based at the Community Justice Centre (CJC) had left post and were unable to take part. One member of staff from Probation could not be contacted. Green Lane and Crown Street Probation Offices were invited to participate as a number of ATP clients were based there.

The four stakeholders who took part in the first but not the second interview were:

- 1 Probation Offender Manager based at the Community Justice Centre
- 1 Probation Offender Manager from Kirkdale Probation Office
- 1 Probation Offender Manager from Green Lane Probation Office
- 1 Alcohol Treatment worker from Lighthouse Project

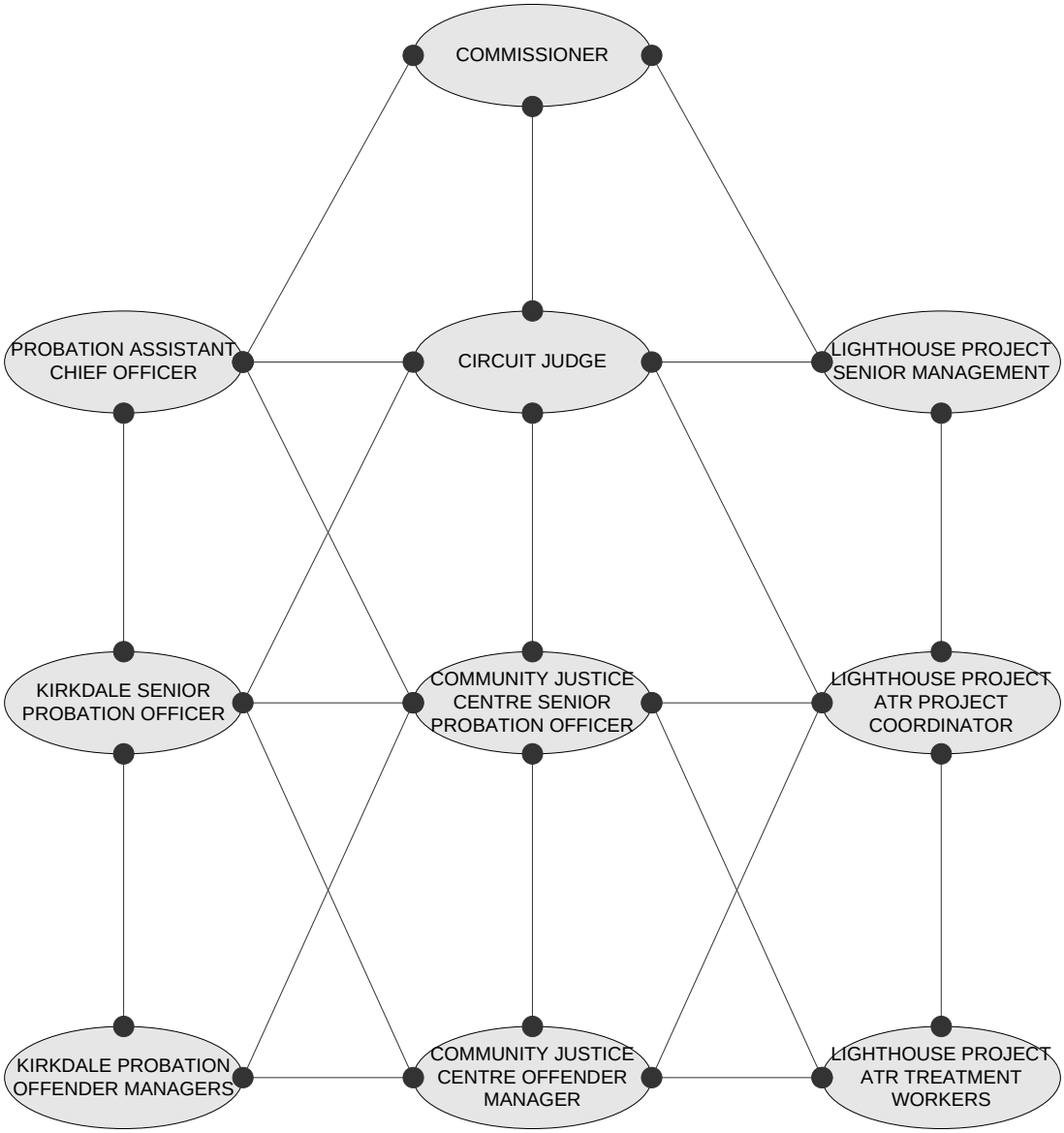
The 17 stakeholders who participated in both interviews were:

- 1 Circuit Judge
- 1 Senior Probation Officer based at the Community Justice Centre
- 5 Probation Offender Managers from Kirkdale Probation Office
- 1 Senior Probation Officer from Kirkdale Probation Office
- 1 Probation Assistant Chief Officer
- 4 Alcohol Treatment workers from Lighthouse Project (including Nurse and Psychological Therapist)
- 1 Team Coordinator from Lighthouse Project
- 2 senior management staff from Lighthouse Project
- 1 Commissioner

One additional stakeholder who participated in the follow up interview:

- 1 Probation Offender Manager from Crown Street Probation Office

Figure 1: Flowchart representing the network of stakeholders involved in the pilot (excluding clients)



3.1 Aims and Objectives of the ATR Pilot

There was a general agreement on the aims of the pilot amongst Offender Manager's from Probation and the Alcohol Treatment workers from Lighthouse Project during both interviews. It was agreed that the ATR is a Government multi-agency approach managed by the Offender Manager and the Treatment Provider.

'A twin approach by the offender manager and the treatment provider to address both the alcohol issues and the associated offending.'

The pilot aimed to offer specific alcohol treatment for offenders who had been identified as having an alcohol need linked to their offending, with a view to address and reduce their alcohol use and provide a route into treatment, and therefore reduce the risk of re-offending.

Key objectives included:

- To provide an opportunity to give individuals an insight into their alcohol intake and the effects it has on them and others
- To minimise risks and potential harm to the individual and to the community caused by alcohol misuse.

'The ATR model was built on NTA guidance and offers everything.'

3.2 Comparison to Previous ATR Pilot

During the first interview the previous ATR pilot in Liverpool was discussed. A small number of interviewees were involved in the first pilot, and although successful in meeting its aims with low breach rates and a positive impact on re-offending, there were a number of problems identified:

- Only selected Probation Offender Managers had a case load of ATR clients, which potentially caused problems if the Offender Manager's were absent from work or on annual leave. For this pilot all members of Probation staff were assigned cases rather than a selected few.
- Problems with the management structure of the scheme, with several managers in place which wasn't always consistent for staff.

- Communication and role boundaries were cited as a problem, it was reported that Lighthouse Project became involved in accommodation and benefit referrals, which was a Probation role.
- Some Probation Offender Managers felt they were not fully informed of the scheme.
- Inpatient detoxification was a focus which wasn't suited to all individuals.

'I don't think we were informed enough of what the actual pilot was. I think it is fantastic knowing what it is now, I know more about it than I did last time in terms of how relevant it is and how they must comply with the order.'

Communication, organisation, efficiency and effectiveness were all felt to have improved from the last pilot, with a clear definition of roles and boundaries being implemented for this pilot. Hard work from the onset, structure, consistency and solid management were all noted as contributing factors. Having Alcohol Treatment workers from Lighthouse Project based at the Probation office this time was also cited as improving communication and liaison between the treatment provider and Offender Managers. A full time Nurse and Psychological Therapist were employed for the current pilot in response to an identified need for a full time medical post and psychological assistance.

'I think at first there was a bit of apprehension on both sides due to the last pilot's problems, but the boundaries have been clearly laid out, we have had a manager who's on the ball and has been quick to deal with any problems that did arise early on, so they were nipped in the bud very early on, everyone has settled into their roles and been happy to get on with their part in the process.'

3.3 Success of Aims

Due to ATR cases potentially being allocated to all staff based at Kirkdale some Probation Offender Managers only had one case, even at the time of the follow up interviews, and felt unable to comment on success against aims. At the first round of interviews stakeholders from both Probation and Lighthouse Project felt that numbers were low and it was too early on in the pilot to discuss whether it was successful in achieving its aims. However, due to the success of the previous pilot in terms of reducing alcohol and offending there was confidence in the current pilot achieving its aims.

Initially at the first interviews, clients were reported as having engaged well with regular and consistent attendance and a good working relationship with their Lighthouse Project Alcohol

Treatment worker. It was agreed that the assessment process was well structured, comprehensive and completed in a timely fashion. The introduction of a full time Nurse post was felt to have had a positive impact in terms of health, liaising with GPs and ensuring clients received health assessments and screening for liver function tests.

The Community Justice Centre was identified as the best court to deliver the ATR as it was decided the ATR was most likely to succeed there due to the consistency of ongoing supervision:

> *'We identified the CJC because it is operating a sort of problem solving model, so if it was going to succeed anywhere because of his (Judge) consistency of supervision of individuals coming through his court. That's the place it is most likely to succeed in.'*

Six months on, stakeholders believed that the pilot was continuing to meet these aims. All stakeholders stated that clients who had engaged with the ATR had either reduced their alcohol consumption, with some abstaining altogether. Increased awareness of alcohol use and drinking patterns, a reduction in AUDIT score and positive impact on client confidence were also noted.

3.4 Impact on Offending

The majority of staff involved from both Probation and Lighthouse Project felt that the impact of offending would depend on the individual and how serious they are about addressing their alcohol use and how they put what is discussed in the sessions into practice. It was hoped that it would have a positive impact on services such as the Police and A&E departments.

For the individuals it is effective for, it was hoped it would provide an opportunity for:

- a reduction in offending
- a reduction in alcohol related offending
- positive changes in drinking patterns

Based on the previous pilot it was felt that this ATR pilot would have an impact on the number of arrests for the individuals on the order. At the initial interview stage it was reported that none of the ATR clients were thought to have breached their order and one member of staff reported that none of her case load of clients had committed further crimes, and at the end of the six months it was reported that two clients had breached their ATR order, and a further two had re-offended and received a custodial sentence.

'*As far as I know none of my clients have offended while they've been on the treatment. Certainly none of them have been arrested and gone back to court'.*

3.5 Implementation

The majority of Probation and Lighthouse Project staff reported very few implementation problems and believed this was due to lessons learnt from the previous pilot. Procedures, structures and communication pathways were put in place to ensure a smoother running of this pilot. A clear definition of roles and boundaries in addition to well organised, professional and flexible working has ensured this.

Of those implementation issues discussed, the short time period to recruit to the pilot, three months, was considered to be a factor contributing to the low number of clients who have received an ATR. Also to begin with, a potential problem around joint working was staff rearranging each others appointments, this was rectified and all appointments had to be arranged with accordance between treatment staff, probation and the client. This barrier had been resolved early on and was not discussed as a problem during the follow up interviews.

One problem reported during the first interviews was that it was not anticipated that other Probation Offices would be involved in the current pilot. It was decided that the feeder Probation Office to the Community Justice Centre would be Kirkdale Probation Office; however a small number of individuals sentenced to an ATR were allocated to Green Lane and Crown Street Offices (North and South Liverpool Offices). As this was unforeseen, staff at other Probation Offices had not received adequate briefing and training, although this was quickly identified and rectified, and was not noted at the follow up interview.

Another problem reported was the communication of attendances. Probation Offender Managers recorded attendances using Interim Accredited Programme Software (IAPS) and Lighthouse Project Alcohol Treatment workers recorded attendances on a handwritten contact sheet. There was a concern that non-attendances may be missed as they were reported separately. It was agreed that both Treatment and Probation staff have good communication, but because Alcohol Treatment workers are not permanently based in the same building as Probation, there was the potential for this information to be missed initially. It was noted during the follow up interviews that attendance information is vital when processing a breach.

'I think an ATR worker should get permission to access IAPS. At the moment we are told to just put it in as attended, but there is so much more work going on that should be recognised if it's audited, so it's a downfall.'

During the first round of interviews it was believed that this problem had been resolved by Lighthouse Project Alcohol Treatment workers notifying Probation reception staff of attendances or non-attendances and Probation reception staff recording this and notifying Probation Offender Managers. However it appeared this problem was still ongoing at the follow up interview stage, which will be discussed further on.

3.6 Examples of Good Practice within the Pilot

Many individual examples of good practice within the pilot were identified and remained the same during both interviews; the main points included the efficiency and immediacy of the assessment process and referral into treatment. The assessment form was noted as very thorough and measurable by Lighthouse Project. The assessment process was carried out at short notice which is of great benefit to the Community Justice Centre. At the six month stage, management from both Probation and Lighthouse Project reported receiving positive feedback from all involved and believed that clients engaged well which was represented by the low breach rate. At the first interview stage another highlighted area was the early onset of the order at the initial point of the sentence rather than further down the line, resulting in alcohol use being addressed as early as possible. The consistency of supervision and reviews at the Community Justice Centre was also noted briefly during the first interview, however was discussed in more detail at the time of follow up as more clients had attended reviews at this stage. Great benefit was also ascribed to having Lighthouse Project Alcohol Treatment workers based at the Probation office which allowed unscheduled contact between staff and encouraged efficient information sharing and promoted effective communication. This was noted at both interviews and co-location was highlighted as a key to success, with staff feeling part of one team.

'If you can see you both working towards a common aim then it's much easier.'

Probation reported that Alcohol Treatment workers built up a rapport with clients, and were helpful and supportive. Alcohol Treatment workers attended Probation offices to see clients and made allowances for clients so they didn't have to attend separate buildings and on separate occasions. Alcohol Treatment workers were reported as being flexible in meeting

clients needs and Probation were noted as having embraced the ATR and ATP, although discussed in both interviews, this aspect was particularly praised at the six month stage.

Communication was highlighted as a definite example of good practice throughout both rounds of interviews and was viewed as an area that had seen substantial improvement since the previous pilot. During the first round of interviews Lighthouse Project Alcohol Treatment workers were praised for their commitment, availability and professionalism. The willingness to pass on information and discuss what happens during treatment sessions was also noted during the follow up interviews. However comments on this area were in some cases contradictory, with some stakeholders claiming that they would like more information on job roles.

'I am impressed with the whole thing because I have not come across anything like this before for people with alcohol issues.'

3.7 Benefits

During the first round of interviews, it was perceived that clients would benefit from an increased awareness of alcohol, the opportunity to examine their alcohol use and provision of alcohol information they would not otherwise have received. They would also benefit from an insight into their drinking related behaviour and begin to identify a link between their drinking and offending.

'*It will help give them a greater understanding of triggers and a greater awareness of the link between their alcohol misuse and offending.'*

It was agreed that the pilot would provide information on the long term health risks of alcohol. It would give the opportunity for clients to receive a medical assessment, screening and early access into treatment, in particular inpatient detoxification. Interviewees also hoped that clients would benefit from a reduction in their alcohol use, improved social and family networks, stability and improved accommodation.

When asked about client progress six months later it appeared that clients had and were continuing to benefit from some of the above. Clients remained engaged, had complied with the order and reported benefits, including a reduction in alcohol and in some cases abstinence. According to stakeholder clients who had accessed inpatient detoxification and residential rehabilitation had remained abstinent for a period of time during their ATR order.

'I have seen massive changes for some clients who have taken the purpose of the ATR on board and have engaged well.'

Stakeholders also reported repaired family relationships, improved confidence and self esteem and an essential opportunity for clients to have their health looked at by the Nurse and during inpatient detoxification.

'For the problematic drinkers who have never had treatment before, I have seen a bigger difference initially, it could be later on for a dependent drinker when they have had assessment for detoxification, health check and then into detoxification. The biggest difference will be when they come out because they haven't drank for 2-4 weeks, and for some that's the first time they have gone without drink in years.'

3.8 Communication

As previously mentioned, communication was identified as the strongest aspect of the pilot. All services involved with the pilot reported having a good working relationship and liaising with each other by telephone, email and visits.

'Communication is important because although we are working with the same aims and objectives we are coming at it from different angles, there has been a new respect grown from both sides.'

To improve communication from the previous pilot, Probation and Lighthouse Project developed process maps to ensure frameworks such as three way meetings were followed.

'Clients can then see that there is a consistent approach there and they can't play staff off against each other, and that can be a big issue with offenders so it has worked really well.'

To deliver their role Lighthouse Project Alcohol Treatment workers communicated with Probation Offender Managers, the Community Justice Centre and referral agencies. Lighthouse Project Alcohol Treatment workers work closely with other members of the team including the Nurse and Psychological Therapist, the team manager and senior management. Staff also link into other Lighthouse Project teams including the extended medical team and Harm Reduction Nurse. Lighthouse Project had a team meeting once a week, were issues and barriers were discussed.

The communication between Lighthouse Project Alcohol Treatment workers and the Community Justice Centre was also felt to be very effective; Probation Offender Managers based at the Community Justice Centre had access to the Alcohol Treatment workers' mobile numbers and the workers explained the AUDIT score and alcohol specific items of the assessment to the Judge and Probation Offender Managers.

The Probation Offender Managers based at Kirkdale Probation Service communicated with the Community Justice Centre regularly for reviews to update the court on the client's progress. They also needed to communicate if any clients were breached. They kept in contact via email and phone, and noted that buildings were based near each other therefore communication was reported as effective.

When sentencing an offender the Judge sets review dates for the offender to come back to court to discuss their progress on the order they receive. As the ATR is considered a complex order, reviews would normally be monthly throughout the order. Attendance, progress and future plans are discussed, not in court, but in a meeting room at the CJC, and consist of the client, Probation and the Judge from the CJC. Offender Managers complete a written report to be discussed at the review, they do not need to attend reviews and would liaise with Probation staff at the CJC, although a number did report attending if their caseload allowed it as they felt it provided support to the client. Alcohol Treatment workers are not invited to attend, but do provide a report to the Offender Manager to feedback, however, it has been suggested that it would be beneficial for them to attend in person.

The communication between Lighthouse Project Alcohol Treatment workers and the Probation Offender Managers was quoted as *'the key to success of the pilot so far'.* It was reported that having a Lighthouse Project Alcohol Treatment worker based at Kirkdale Probation service provided the opportunity to discuss client progress and answer any questions; telephone contact was also maintained. Lighthouse Project Alcohol Treatment workers were reported as having a very visible presence and always being available to help. Three-way meetings were also undertaken between the offender, Probation Offender Manager and Lighthouse Project Alcohol Treatment worker at the onset of the order, review stages and at the end of the order. At the six month interview, it was noted that Offender Managers and Alcohol Treatment workers conducted three way meetings much more often than this. This was believed to demonstrate a dual commitment to the order and strengthen communication. The ATR Treatment Manager and Alcohol Treatment workers attended a Probation team meeting and conducted a presentation at the beginning of the pilot to

introduce themselves and discuss the work that they do. This was highlighted as effective by some staff, however others felt they would benefit from more involvement in team meetings.

Communication at management level was delivered through steering group meetings, it was reported that due to everything running so smoothly on the ground level management communication had been kept to a minimum and had been sufficient. Lighthouse Project did suggest combining the ATR and ATP steering group meetings although at Probation's request it was decided to keep them separate.

'You tend to want to meet up when there are problems and there wasn't, we had regular contact over the phone also although due to no problems it did taper off.'

Any problems were reported to Lighthouse Project Management and Senior Offender Managers, were kept at management level and then fed down to staff.

'This time communication has been at a management level as it should be.'

When asked if communication could be improved the majority of staff involved believed it was effective, although some probation staff suggested more information on what Lighthouse Project Alcohol Treatment workers offer would be beneficial, however it must be noted that other stakeholders felt they had received this information. This discrepancy was noted at the follow up interview. Suggestions at the first round of interviews included a half day training session and presentations during team meetings. During follow up interviews, having Alcohol Treatment workers attend a Probation team meeting at the onset of the ATR pilot was noted as beneficial. Other staff felt all the necessary information had been provided for them with explanations about the AUDIT score, provision of information and attendance at a team meeting.

3.9 Barriers

The majority of staff involved in the pilot didn't have any concerns and senior staff reported that they had not received any negative feedback during both rounds of interviews. Of those discussed the main barrier identified was that numbers of clients on the ATR order were low due to the original sentencing period at the Community Justice Centre being short. Stakeholders from both Probation and Lighthouse Project also highlighted future 'uncertainty' due to it being a pilot.

'Lost staff because of uncertainty, we had invested time and money in training.'

Another concern was the fact that it was only the appointments with the Alcohol Treatment worker from Lighthouse Project and Probation Offender Manager which were mandatory and it was optional to attend additional treatment sessions with the Psychological Therapist, Nurse and appointments with referral agencies. Stakeholders felt this may contribute to poor attendance at those sessions.

The contact form was both criticised and praised. As previously discussed, Lighthouse Project Alcohol Treatment workers document attendance and work completed during the session on a handwritten contact sheet, this was then left in the pigeon hole of the Offender Manager. Some Probation Offender Managers found this very useful, others did not. One perceived problem with the sheet at the fist interview stage was their legibility as they were handwritten and sometimes this was difficult to read. It was believed this could result in non-attendances and other vital information potentially being missed.

IAPS is the case management system used by Probation. All client attendances at Probation are entered onto this system by the Probation Offender Manager. Lighthouse Project Alcohol Treatment staff do not have access to this system and therefore Probation Offender Managers, who reported that they already have their own paperwork, would have to input the Alcohol Treatment work from the contact sheet. A problem noted was that for other clients at Probation alcohol work would be documented on IAPS, but for ATR clients all alcohol work would be done by the Alcohol Treatment worker. Therefore if this was not entered onto IAPS the ATR clients would have a lack of documented work. It was noted at the follow up interview that Probation have to ensure all contact with clients is evidenced on IAPS and keep everything logged. Probation need signed consent of attendances to use as evidence in court if the client is breached and therefore missed information on non attendances could affect the breach process.

'Generates work for probation staff who need to evidence everything, I brought that up but nothing was changed.'

It was suggested that a member of staff with an administration role with access to IAPS would be beneficial to input this information. This problem remained ongoing through the pilot.

‘Administration is so important in managing statutory requirements.’

During the six month follow up interview, a few issues arose regarding access to residential rehabilitation. Lighthouse Project had hoped that clients would be able to come out of the inpatient detoxification at Hafan Wen and go straight into a local residential rehabilitation. However a number of clients were refused access to rehabilitation after testing positive for prescription drugs, the medication used during their inpatient detoxification. Lighthouse Project felt it was important for the client to move smoothly from one intervention to the other and were concerned that a break could result in a relapse.

‘I had a client relapse because there were issues trying to get straight into rehab from detoxification. A lot of hard work that went into getting him to that stage was undone.’

‘What’s important is that people are supported when they come out of treatment, ensuring relapse prevention work is undertaken, that’s when people are at their most vulnerable and that’s why it’s so important. Really important to support them through that process.’

Another problem raised at the follow up interview was that Alcohol Treatment workers do not have access to ‘fobs’ to allow them access to move around the building at Green Lane and Crown Street and therefore had limited access to mix with Offender Managers.

3.10 Client Group

Probation Offender Managers reported seeing clients every week for the first 16 weeks of their order which is the National Standard from the Home Office. After this, depending on attendance, behaviour, risk and progression, it can be reduced to fortnightly and monthly. If a client is ‘low risk’ they would be seen weekly for four weeks and then monthly for the rest of the order if deemed suitable. Probation Offender Managers often remained in contact with the ATR client once the ATR treatment element had ceased as the supervision element often exceeded the six month ATR. Lighthouse Project Alcohol Treatment workers saw clients every two weeks for the six month order. Appointments with the Nurse and Psychological Therapist were as frequent as determined in discussion with the client. Attendance was reported as good by both Probation and Lighthouse Project at the follow up interview, with a small number of breaches highlighted.

Considering client contact, Probation Offender Managers felt the level of contact with the ATR clients was substantial. It was felt that some individuals may benefit from more frequent treatment sessions with Lighthouse Project Alcohol Treatment workers, whereas others believed fortnightly sessions were enough for some clients. Also if individuals were seeing the Psychological Therapist or Nurse this could be arranged on alternative weeks to the session with the Alcohol Treatment worker therefore giving them weekly contact with Lighthouse Project. Both Probation and Lighthouse Project reported that having the ability to have both treatment and Probation appointments on the same day was a benefit to clients.

At the six month stage Offender Managers reported having between one to three ATR orders on their caseload. Not all Offender Managers were allocated ATR orders. Probation have an allocation system, and whoever was next to receive an allocation did so regardless of the type of order, which explains why some staff had as many as three. ATR treatment workers had seven to eight ATR clients on their case load.

Offender Managers felt that between one to three ATR clients would be manageable on a case load at any one time, and it was felt that there should be a fair allocation system put in place specifically for ATR orders, to provide all staff with the opportunity to experience the ATR. Alcohol Treatment workers reported that the optimum number of clients to have on a treatment caseload would be between 15-18, however, this includes a combination of ATR and ATP clients. This point highlights that often stakeholders discussed the ATR and ATP in terms of one pilot, and many viewpoints referred to both sets of clients.

'More than 18 clients and you would struggle to spend enough time with each client.'

The majority of stakeholders felt that six months was an adequate time period for the ATR order. Some felt that additional flexibility would be beneficial for those who require longer than six months.

'If you are going to get any kind of response out of someone six months is a good window.'

The majority of stakeholders believed that the pilot did target the right individuals because it targeted both dependent and binge drinkers. It was felt that interventions suited drinkers following different routes through treatment, from one to one sessions for alcohol education

to detoxification and rehabilitation for those wanting total abstinence. This was highlighted as beneficial during both rounds of interviews.

The decision to sentence someone to an ATR is not a quick decision; there is a three way process involving a decision from the Judge, Probation and Lighthouse Project to identify if an individual is suitable, plus the offender must also agree. Appropriateness is also determined through a comprehensive assessment and the AUDIT score is cross checked against the Probation OASYS score, so therefore it was felt that clients have been identified well and the scheme targeted the right individuals.

'Because it includes binge drinking, in terms of violent offending and sometimes those groups can be excluded. It is important to nip these in the bud as these can be the problems of the future.'

'I think that is good because it intervenes right at the start of their criminal career and hopefully if they get the right support now that will be enough to stop that now, to get them before they get to the stage of dependence.'

It should be noted that during the first round of interviews there was a discrepancy in the reporting of the eligibility for the ATR. This was found right across Probation and Lighthouse Project with some reporting that an individual must score 16 or more on the AUDIT scale and others reporting 20 or more. If all individuals had a score of 20 or over on the AUDIT scale all ATR clients would have been defined as dependent drinkers. If a number of individuals with a lower score of between 16 and 20 were sentenced to an ATR this would allow for those defined as harmful drinkers to receive the ATR, this was felt to be useful for a number of clients. As this issue emerged as part of the assessment process it is unknown if this is an ongoing barrier as ATR assessments were not being undertaken at the time of the follow up interviews. If the ATR was to run again this would need to be considered.

'The aim of the ATR is to provide specific alcohol treatment for offenders who have been identified as having an alcohol need which is linked to their offending and who score four and above on the alcohol section of the OASYS or 16 and above on the AUDIT.'

'I think having the score is good because you might get people who are unsuitable otherwise. On the chart it is 16, the Community Justice Centre tends to go around 20.'

When asked if other individuals should be included on an ATR two groups were identified; lower level offenders and individuals sentenced at different courts.

It was felt that treatment available for ATR clients should be available for lower level offences including Drunk and Disorderly although it is unlikely that in most cases these lower tariff offences would warrant the imposition of a community order of any sort. A potential concern of having an opportunity to include lower tariff offences was that this may result in inappropriate referrals for an ATR being made, causing more breaches and resulting in individuals receiving custodial sentences for offences which would not normally carry a heavy sentence. At the follow up interview it was also suggested that it should have been extended to cover young people sentenced at the youth court.

It was reported that having the pilot based at just one court has the potential to be perceived as a postcode and criminal justice lottery, because the ATR could only be sentenced at the Community Justice Centre and treatment was only available for those on a community order. All staff felt that the pilot should be extended to include other courts thereby giving all offenders meeting the ATR requirements a chance of benefiting from the treatment offered.

'We just weren't getting numbers through the door through such a small court, it should have gone through Liverpool Magistrates to see the full potential of what it could do.'

However, it was recognised that this may cause problems. Some felt that although only using one court had resulted in lower numbers, it was appropriate for the pilot as it was tight and more manageable. Some stakeholders from both Probation and Lighthouse Project felt that it worked well and targeted the right people as it was a pilot. More resources such as additional staff and premises would have been needed if the scheme had been expanded to other courts. It was also suggested that expansion brought with it the risk of inappropriate referrals being made.

'If it had been opened out to magistrates would have been overwhelming.'

3.11 The Breach Process

All staff involved in the pilot reported that they had a clear understanding of the breach process and could reiterate the process and rules. According to stakeholders, clients can only breach their order for non compliance. One missed appointment on any order will result in a final warning; a second failure to attend will initiate the breach process. This is subject to

it being an unacceptable absence. The acceptable absence policy requires that clients provide evidence to support their absence and if they fail to do this the absence can be classed as unacceptable. Clients will be breached for two missed appointments whether for treatment or Probation. Appointments with the Nurse and Psychological Therapist are not enforced and non-attendance would not result in a breach. Clients can also breach an order for unacceptable and threatening behaviour, if they attend intoxicated under the influence of alcohol or drugs and for failure to notify the Probation Offender Manager of a change of an address. However, it must be noted clients cannot be breached for re-offending.

Probation Offender Managers have overall responsibility for enforcing the order, they action and initiate the breach procedure. Lighthouse Project Alcohol Treatment staff provided information to the Probation Offender Manager if the client failed to attend an appointment with them. Lighthouse Project also provided information for reviews and for the breach process. Once a client has breached a letter was sent out to them with three further appointments for Probation. The Probation Offender Managers then completed the relevant paperwork and passed the information on to administration staff who put it on a breach tracker and requested a summons to court. Once the client had been given a court date, Probation would encourage the client to continue to attend in the interim. The court date was usually within 20 days and clients could often be back in court within a week. Probation Offender Managers could recommend that the client continues with the ATR if they have continued to engage following the breach. If they did not continue to comply and a recommendation wasn't made they would be re-sentenced. The client would then need to attend more regular reviews at the Community Justice Centre following a breach.

'The Community Justice Centre is good because they will put the clients on a review after a breach and bring them back every month or six weeks, they have a watchful eye which is quite motivating for some people.'

Breaches were felt to be an appropriate response to non-compliance. It was felt breach can be effective for those who need to be breached initially for them to understand the importance and seriousness of compliance; it can help get them back on track. A breach is considered appropriate because:

'It is a court order and you have broken the law and you have to be penalised for that and take responsibility.'

It was discussed that the breach process could be limiting because a missed appointment with Probation and Lighthouse Project on the same day would count as two missed appointments and result in a breach. Probation Offender Managers reported that initiating the breach can take three to four hours to complete the paperwork, and then if the client produces documented evidence for an acceptable absence the breach proceedings are withdrawn. Therefore the breach process can take up a large amount of time.

Also it was noted during the first interviews that joint working can mean members of staff may have different tolerance levels of what they would consider a breach and this may cause inconsistencies. It was noted that although staff are aware of breach rules they have individual working practices.

'No one has been breached too soon, a couple that maybe going by the rules should have been breached, however taking mitigating circumstances into account they haven't.'

At the fist interview, one particular client was eligible for a breach after a number of missed appointments. However, they were not breached and whilst the client had then engaged it was felt that client should have been breached if guidelines had been followed rigidly. Also as mentioned earlier, with the recording of appointments being done on paper by Lighthouse Project Alcohol Treatment workers, non attendances may be missed. A mechanism was developed to avoid this and reception staff based at Probation were asked to record client attendances with Lighthouse Project Alcohol Treatment workers. However this issue continued throughout the six months.

At the end of the six months, two clients were reported by stakeholders as breaching their ATR order for non attendance and non compliance, whilst a further two committed further offences and were remanded in custody.

'The breach rates are low and what that shows is that if your individual needs are targeted and you as an individual feel supported then you are going to come in and follow terms of compliance.'

Because the counselling with the Psychological Therapist was voluntary, guidelines were put in place whereby three non attendances would result in the client needing to be re-referred for counselling. If this happened on a number of occasions they would be asked to attend the

support group to test their commitment (the support group is discussed in more detail in section 3.13).

3.12 The Effect of the ATR Pilot on Workload and Capacity

The effect on workload was perceived by the Probation Offender Managers quite differently at both interview stages. The majority felt that the ATR had a minimal effect on their workload and it assisted their work as they no longer had to cover alcohol and could focus on other issues. Probation Offender Managers felt supported by having the Alcohol Treatment workers there to specialise in alcohol issues. It was also felt that Probation Offender Managers would see the clients anyway as they would receive some sort of community order and therefore having an ATR meant they had the support to deal with the alcohol side effectively. Other Probation staff felt the ATR had increased their workload due to having to spend more time on paperwork and inputting the handwritten sheets onto IAPS.

Both Probation Offender Managers and Lighthouse Project Alcohol Treatment workers felt that capacity was used as effectively as it could be. Whilst Alcohol Treatment workers reported that capacity was wasted as only small numbers came through the CJC. It was felt that a combination of ATR and ATP clients used capacity more effectively. Probation Offender Managers reported they were currently working to full capacity as they have a case load of clients on various supervision orders, only some of which have an ATR.

3.13 Treatment Interventions

The Nurse provided a full medical assessment, supported community detoxification, health education, harm reduction, full screening for Hepatitis and HIV, sexual health advice, blood tests, liver function tests and referrals for inpatient detoxification. The health assessment consists on an hour long session looking at physical and mental health and medical history.

The Psychological Therapist provided structured Cognitive Behavioural Therapy. Clients can be referred to counselling by their Alcohol Treatment worker. The counselling was introduced into this pilot following the observation that psychological assistance was needed during the first ATR pilot, however as reported in the first interview, to begin with counselling was under used. To improve attendance, the Psychological Therapist attended sessions with Alcohol Treatment workers and with the Nurse to have an informal introduction with clients. Once engaged the Psychological Therapist always phoned clients prior to their appointment to confirm attendance.

Since the first stakeholder interviews took place Lighthouse Project have developed a support group. The support group began a month prior to the follow up interviews. The group is for those clients who are waiting for detoxification or have successfully completed inpatient detoxification and require continuing support.

During the first round of interviews, a lack of knowledge among Probation Offender Managers was identified in terms of what interventions were being offered and delivered by the Alcohol Treatment workers. There also appeared to be some confusion around what residential rehabilitation and inpatient detoxification constitute and the difference between the two. This manifested in the finding that some interviewees felt that there was adequate access to residential rehabilitation whilst others felt that it was not an option that was available at all. Clients did have access to an inpatient detoxification at Hafan Wen Drug and Alcohol Treatment Unit. This facility provides a two to five week residential pharmacological detoxification rather than residential rehabilitation. After six months, both Probation and Lighthouse Project were clear on what was involved with the inpatient detoxification and stakeholders reported that clients had taken this up. A condition of treatment required all clients to see the Nurse for a full health assessment prior to inpatient detoxification. A criticism of the fist pilot was that the majority of clients were referred for an inpatient detoxification when it was not always suitable, this issue did not arise during this pilot. Lighthouse Project could also deliver a community detoxification, although this was not taken up by any of the clients.

'Loads took up inpatient, we used all of the funding that we had and most of the time we had a waiting list of people that wanted to go in.'

At the end of the order, Alcohol Treatment workers were offering clients a referral on to another treatment service. Despite this, they reported that not many clients had taken up this offer. However those already accessing treatment outside at services such as the Together Women Project continued to do so. Alcohol Treatment workers also provided clients with details of services for further support.

The majority of stakeholders reported that there were a number of different treatment interventions on offer to suit individual needs, such as inpatient detoxification for the more dependent drinkers, and counselling and health interventions for those wanting further interventions and a full care package was offered. Lighthouse Project Alcohol Treatment workers would also like to be able to provide acupuncture and alternative therapies. Clients

did have access to such therapies at different Lighthouse Project locations, but the Alcohol Treatment workers reported wanting their own location to be able to provide such treatment themselves. Others felt that it would be beneficial to expand the support groups, to have one solely for aftercare and another for those preparing for inpatient detoxification. Others would like to see a service that provided more long term aftercare.

3.14 Service Improvement and Expansion

There is the possibility of a two years contract starting in April 2009 to continue the ATR across Liverpool. Stakeholders were asked if they thought ATR should continue, and if it could be expanded and improved in any way.

All stakeholders reported that the ATR has been a positive pilot and that it should continue.

'We have the law there so it is a scandal not to use it everywhere.'

Staff from both Probation and Lighthouse Project felt that the ATR should be opened up to include all courts and Probation Offices in the future.

If the ATR was utilised more often it would have an effect on the capacity and workload of both Probation and Lighthouse Project staff. If inappropriate referrals were made, clients may be less motivated to attend, therefore increasing the amount of breaches leading to increased paper work which would affect Probation Offender Managers. There was also a concern about the impact on resources and whether there would be enough inpatient detoxification places available.

The main treatment issue that arose concerned provision for aftercare in particular at the end of the six months of the order. It was also suggested that rapid access to more local detoxification units such as the Windsor Clinic would be beneficial. Although Hafan Wen worked effectively, it was based in Wrexham and a more local service would be beneficial for inpatient detoxification. This would reduce staff travelling time and costs as well as ensuring clients were not far away from home if they didn't want to be.

Other improvements included the use of a 'dry house', a less supervised accommodation than residential rehabilitation that individuals could stay at following their time at the inpatient detoxification, this improvement was suggested at both interview stages.

'It's about facilities and co-locating teams and drawing on the positives of this pilot and to learn from that and take it forward.'

3.15 The Non-ATR Element (Alcohol Treatment Pilot, ATP)

3.15.1 The introduction of the ATP

At the time of conducting the first round of interviews there did not appear to be a clear understanding of what the non-ATR element of the pilot involved (the opportunity for clients involved within the Criminal Justice System who do not have an ATR as part of their order or who have come through the alcohol arrest referral pilot, to access the same treatment as ATR clients). At Lighthouse Project these clients are referred to as ATP (Alcohol Treatment Pilot) clients. The availability and scope of the ATP did not appear to have been fed through effectively from commissioners and strategic leads to all staff and therefore there was not enough knowledge on what the ATP was, who it was available for and what interventions were offered. Some Probation Offender Managers had heard about the service but didn't have any direct involvement.

'Don't expect to hear a lot on knowledge about it because that won't have filtered through yet.'

Despite inconsistent knowledge, the ATP aspect was being utilised at this early stage and when the process was outlined, all participants felt this was a beneficial opportunity for clients.

At the six month stage, the information regarding the ATP had been more widely circulated, with the majority of Offender Managers interviewed utilising this service, however it must be noted that when discussing both ATP and ATR the majority of stakeholders spoke about the pilot as one and directed most answers to both the ATR and ATP clients, due to the same care pathway being available for both.

The ATP aspect was introduced to Probation via emails sent out to Offender Managers. No documents were provided for ATP. Lighthouse Project Alcohol Treatment workers also notified Offender Managers of the ATP whilst at the probation office visiting ATR clients.

Lighthouse Project Alcohol Treatment staff carry out assessments for potential ATP clients at their Probation Office. Lighthouse Project Alcohol Treatment staff reported that when the

ATR began there was interest from probation and solicitors for other clients who were not eligible for the scheme, and therefore being able to utilise the ATP was important. This demand has continued throughout the six months.

3.15.2 Clients

Probation Offender Managers reported having between one and four clients accessing the ATP and Lighthouse Project Alcohol Treatment workers had between eight and 12 ATP clients on a caseload. There was a quicker turnover reported of ATP clients than ATR due to a number disengaging. Clients are referred to ATP from three Liverpool Probation Offices; Crown Street, Green Lane and Kirkdale. There was more flexibility with ATP clients than ATR clients allowing for weekly sessions if needed.

When asked at the six month follow up stage, it was believed that the ATP did target the right individuals, again stakeholders believed the ability to have interventions for dependent and binge drinkers was beneficial.

> *'It has been shown with the volume of calls and people trying to refer into us, that the need is out there'.*

The ATP is generally voluntary and clients can attend treatment for three to six months. Because the ATP is generally not enforceable, attendance was not as good for ATP as it was for ATR. Processes were put in place to try to minimise non attendances and prevent clients from disengaging. Offender Managers and Alcohol Treatment staff worked together to ensure treatment appointments were before or after Probation appointments, benefitting from the fact that Probation appointments are mandatory to attend. Some Offender Managers reported using the ATP as the compulsory activity on the community order to ensure compliance with treatment. By the second interview Lighthouse Project had developed a contract to improve attendance, by which clients had to be re-referred for treatment if they missed two treatment appointments without an acceptable absence. This is in line with the Probation breach process outlined earlier. Both Probation and Lighthouse Project reported having ATP clients who did successfully complete treatment although both noted that a large amount did disengage.

3.15.3 Good Practice

The ATP was discussed as an invaluable tool, especially during the pilot when ATRs could only be sentenced at the CJC. Having the ATP means that clients who have been sentenced

through the magistrates and other courts can still have access to treatment whilst on a community order. The ATP was also praised for being tailored to meet the clients' needs. The non enforcement aspect of the ATP was discussed as both a positive and negative. It was reported that it was a barrier to the completion of treatment as clients could disengage from treatment without breaching their Probation order. Others felt that the fact it was non enforceable benefited clients, as they had no pressure to attend and could do so voluntarily.

Probation Offender Managers appreciated the speed of response by Lighthouse Project Alcohol Treatment workers once a referral had been made. They also felt they benefited from Lighthouse Project's involvement, because they were aware of the appropriate services to make referrals to and had quicker access to such services. As for the ATR, having Lighthouse Project Alcohol Treatment workers based at Probation offices was reported as beneficial, as it was an easy way to make referrals for ATP and discuss client's progress. Stakeholders reported the same benefits for ATP clients as ATR clients in particular a reduction in alcohol consumption.

3.15.4 Communication

Communication between Offender Managers and Alcohol Treatment workers regarding ATP clients was felt to be effective, with three way meetings taking place.

> *'We have trust in each other, we have meetings and have a good understanding of each others jobs, and everyone has embraced it.'*

Communication at management level is facilitated through a steering group which deals with the ATP and the Home Office Alcohol Arrest Referral Pilot.

3.15.5 Barriers

Potential barriers to the delivery of the ATP highlighted were that as it becomes more popular (please note the ATP was still running at the second interview stage), clients may not be seen as quickly as is currently the case i.e. they can have an assessment the same week as being referred. Another concern highlighted was that numbers may become too high therefore leading to unavailability if Lighthouse Project Alcohol Treatment staff reach full capacity. At the first interview stage numbers of clients referred to ATP was steadily increasing and at the follow up, stakeholders reported that the ATP was stopped for a period for time due to high numbers and limited capacity, but had been reinstated. Probation staff interviewed felt they had missed the potential referral route of the ATP during this period.

'Alcohol was one area of his lifestyle were I didn't have to be the front runner.'

3.15.6 Treatment

ATP clients could access exactly the same treatment as ATR clients discussed previously. It was believed that having access to appointments with the nurse and health checks provided clients with an informed choice as to whether they wanted to volunteer for ATP. Both Probation and Lighthouse Project noted the benefit of having access to the inpatient detoxification, which was highlighted as providing clients with much needed respite, in terms of their health.

'The time in detoxification gave him the opportunity to be drink free and give his body a rest. It was good to take him away from his life for 5 weeks. Showed him that he can do it, it gave him the chance to be drink free for 5 weeks.'

3.15.7 Future of the ATP

When asked if the ATP could be improved the majority of staff utilising it felt that it couldn't. However suggestions for improvement included ensuring information about the scheme is circulated more thoroughly amongst Probation; team visits and relevant literature packs were suggested. Although at the second interview this had been circulated, it was felt it could have been done earlier. Again, Lighthouse Project Alcohol Treatment workers felt if they had their own base they could have capacity for more ATP clients. Other future improvements included having an Alcohol Treatment worker available for evening treatment sessions. Probation offices are open during an evening to allow for appointments for clients who work full time, and Probation felt having this option for treatment as well would be beneficial.

Lighthouse Project reported that the ATP didn't need expanding in terms of client base, as referrals can come from three of the Liverpool based Probation offices. Probation would like to see a service available for lower level drinkers, such as a harm reduction service and brief interventions. Some form of positive reinforcement was also suggested, although a specific example was not given.

'If a negative reinforcement could not be used as a requirement it could have an incentive as a positive reinforcement to attend'.

4.0 Recruitment of Clients for Outcome Evaluation

In total 19 ATR clients were referred to Liverpool's criminal justice alcohol treatment pilot between 3rd January and March 31st 2008. Two additional offenders were assessed for an ATR during this period but were recommended as unsuitable; one scored only six on the AUDIT scale and the other breached their bail conditions before being sentenced and was therefore deemed unlikely to attend any treatment appointments. Meanwhile during the recruitment period for the ATP (3rd January to 30th June 2008), 61 offenders were voluntarily referred onto the scheme.

4.1 Data Collected

Initial assessment and consent forms were received from Lighthouse Project for 14 of the 19 ATR clients. Of the remaining ATRs, three refused to take part in the evaluation and two had mental health issues which meant their participation was regarded as inappropriate by their Alcohol Treatment worker. Initial assessment and consent forms were received for 30 of the ATP clients.

Three-month review forms were received for 13 of the ATR clients who agreed to take part – the remaining one had been breached by this stage. Six-month review forms were received for nine ATR clients as a further client had breached their order by this stage, two had been taken into custody and one missed their final review. Review forms for the ATP clients are still being collected.

The data received for the ATR clients was mostly complete although five risk assessments and an LDQ were missing or incomplete at the initial assessment stage and three GHQs, one AUDIT and one TOP form were incomplete at the three-month review stage. The median scores shown in the charts in the following section have been calculated from the number of complete responses available for each question or questionnaire, rather than the total number of all clients who were assessed or reviewed at that stage. Charts showing percentages indicate where there was incomplete or missing data. None of the data gathered were normally distributed therefore median values are presented instead of means and to account for the skewed data and small sample sizes non-parametric tests of statistical significance have been applied.

4.2 Follow-up Interviews

Follow-up interviews were conducted with 11 of the ATR clients approximately three months after they had been referred to the scheme. The clients who couldn't be followed up included the two clients who breached and one of the clients who was given a custodial sentence. Eight ATR clients were followed up six months into their treatment. The clients who became non-contactable between their three- and six-month follow-ups included the second client to be taken into custody and two who did not attend their final treatment appointments. Follow-ups with ATP clients are ongoing.

5.0 Findings from ATR Assessment and Review Data

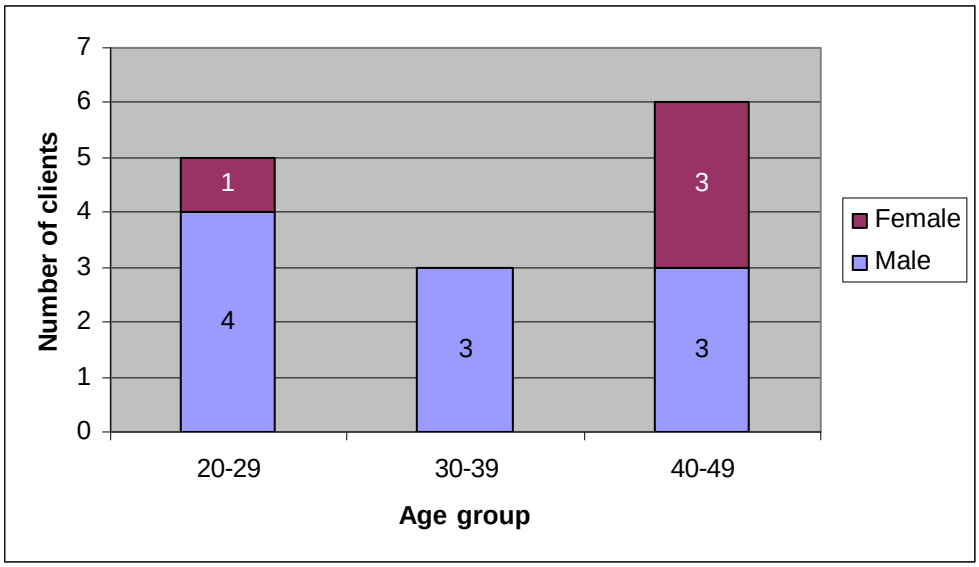
In this section findings from data collected during clients' initial assessments will be presented and a comparison will be made between the measures contained in these assessment forms with those repeated in the three- and six-month review forms, in order to assess any change over time in clients' alcohol use, offending and other related behaviours.

5.1 ATR Client Profile

Gender and age

Ten of the ATR clients were male and four were female. On the date of their comprehensive assessments the clients were aged between 25 and 48 years. Figure 2 shows the distribution of the clients across the age groups; the largest proportion (43%) fell into the 40-49 age group.

Figure 2: Gender and Age Group (n=14)



Ethnicity and religion

All clients were of White British origin. Eight clients were Christian, five had no religion and one client did not state a religion.

Offending

The most common offence that led to clients being given their ATR was Assault (43%), followed by Criminal Damage (21%). Percentages in Table 1 add up to more than 100% as some clients had committed more than one offence, for example four clients (29%) had been charged with Drunk and Disorderly in addition to their higher level offence (though no clients were referred following a Drunk and Disorderly offence alone).

Table 1: Offences that Led to Order (n=14)

Offence	Number of clients	% clients
Assault	6	43
D&D	4	29
Criminal Damage	3	21
Possession of an Offensive Weapon	2	14
Theft	1	7
Possession of Class A Drug	1	7
Intervening with a Vehicle	1	7
Breach of Probation Order	1	7
Obstruction	1	7

Treatment history

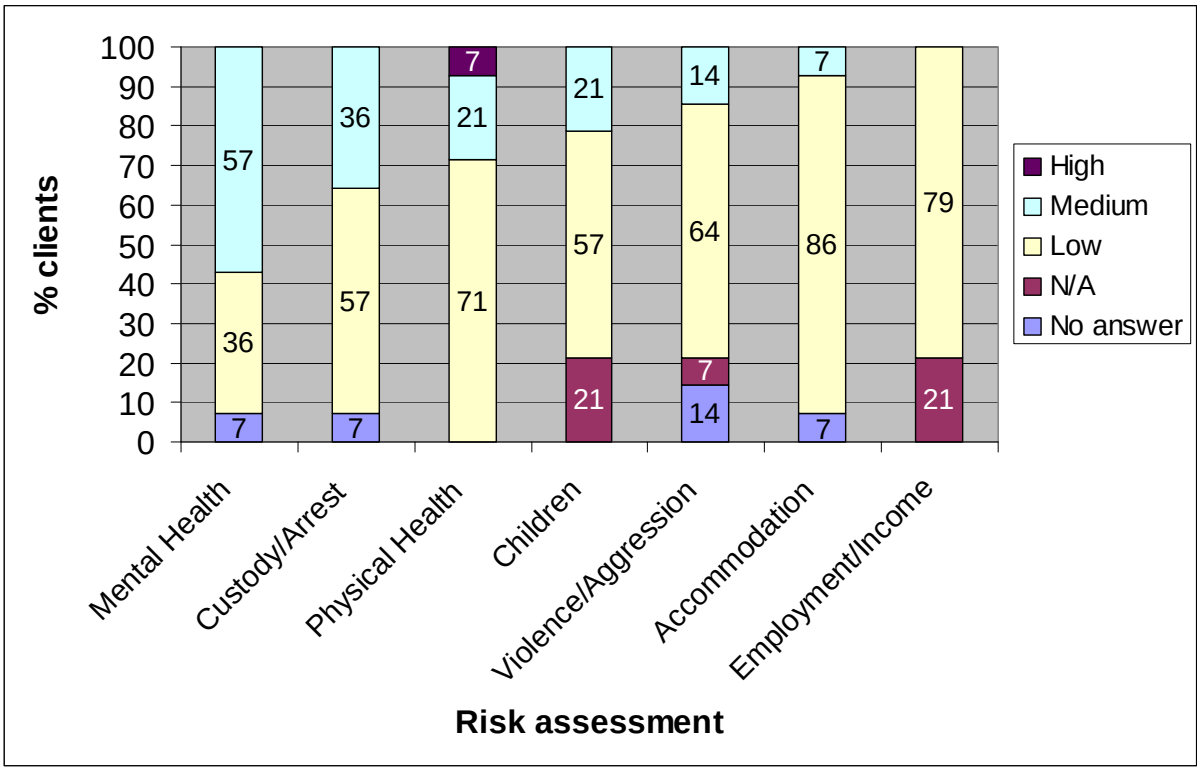
Several clients had previously been engaged in treatment according to the treatment history data contained in their initial assessment forms, including community detoxification and residential rehabilitation, though not all had successfully completed their programmes. Some clients had attended counselling and support groups.

5.2 Risk Assessments

As part of their initial assessments clients were risk assessed in relation to seven areas of their lives; physical health, mental health, custody/arrest, violence/aggression, children and employment/income. Following discussion with clients around these issues Alcohol Treatment workers recorded whether they considered clients to be at high, medium or low risk in each of the seven areas.

In terms of physical health, one client was considered to be at high risk and three (21%) at medium-level risk (Figure 3). Mental health was a medium-level risk for more than half (57%) of the clients. Meanwhile, five clients (36%) were believed to be at medium risk of being arrested and/or returned to custody – three of whom were later arrested and/or given a custodial sentence. There were concerns for the welfare of children belonging to three clients (21%).

Figure 3: Results of Risk Assessments (n=14)



5.3 Readiness to Change Scales

These scales were useful as a baseline measurement at the assessment stage to show how ready clients felt they were to change their drinking behaviour on a scale of 0 to 100 (the higher the score the more ready the client to change). However once clients begin making positive changes this scale loses its value as the questions are no longer necessarily relevant e.g. if someone feels they are 'not at all ready to change now' this may simply reflect the desired changes having already taken place rather than suggesting the client is not ready to address an alcohol problem. Clients' readiness to change their drinking behaviour at the outset of their orders will therefore be discussed here without comparison to readiness to change scores taken at review.

For the most part these scales have produced categorical measurements rather than scores that exist along a continuous scale of 0 to 100 i.e. almost all scores were divisible by 10, probably due to the formatting of the scales in the assessment tool. Mean or median values have therefore not been calculated.

Scale 1: How ready are you to change right now?

Nine (64%) of the clients scored over 50 on this scale, indicating that they were ready to change to some degree – four of these clients scored the maximum value of 100 suggesting

they were definitely ready for an immediate change. The remaining five clients were either unsure whether they were ready or felt less than ready.

Scale 2: How important is it to change your drinking or drug use?
The majority of the clients (11 out of 14) scored 100 on this scale and the remaining three clients also scored highly (80 or 95). These responses reveal that at the initial assessment stage, clients regarded changing their drinking or drug use as very important.

Scale 3: *How much better will life be if you change your drinking or drug use?*
Clients also scored highly on this scale (minimum score=70) with 71% scoring 100, thereby indicting that they believed their life would be substantially better if they changed their drinking or drug use.

Scale 4: *How confident are you that you can change right now?*
Eleven clients (79%) scored more than 50 on this scale suggesting the majority had some confidence that they could 'change right now'.

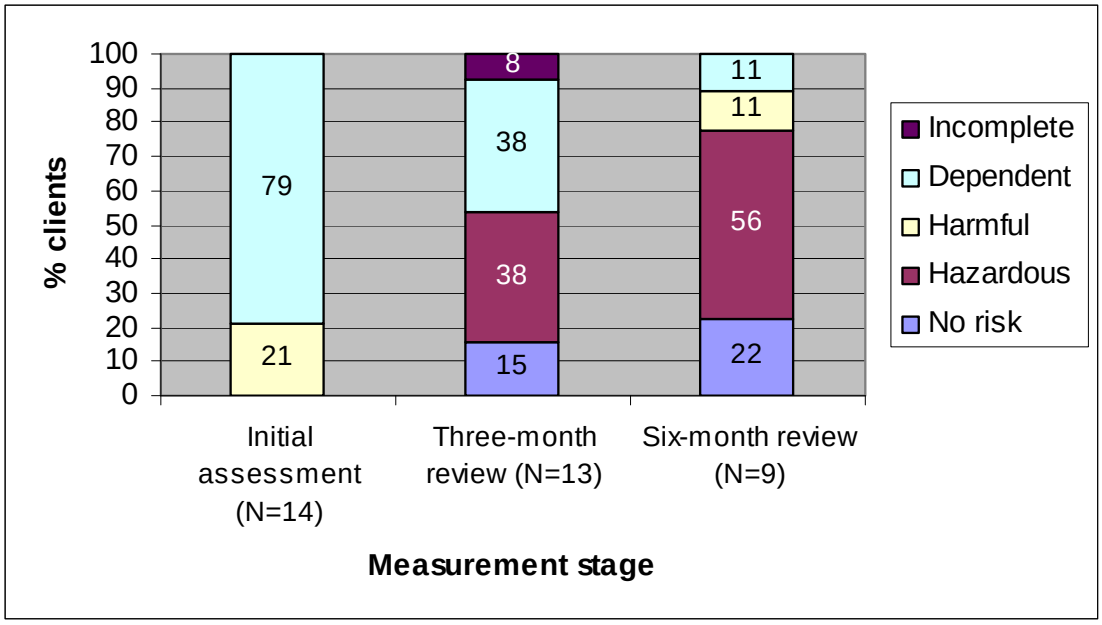
Together the scales indicate that clients felt it important to change their drinking or drug use and believed their lives would be much better if they did. However while some clients felt they were ready to change and confident that they could do so, others appeared less motivated.

5.4 Measures of Alcohol Use/Misuse

Alcohol Use Disorders Identification Test (AUDIT)

The AUDIT provided strong evidence for a reduction in clients' drinking levels during the course of their order. Eleven (79%) were categorised as 'dependent' drinkers according to their AUDIT score at the time of referral. This proportion had decreased to 38% by the three-month review stage and to just 11% upon completion. As clients' AUDIT scores fell throughout the course of their order, larger proportions became 'hazardous' drinkers or were classed as 'no risk' (Figure 4).

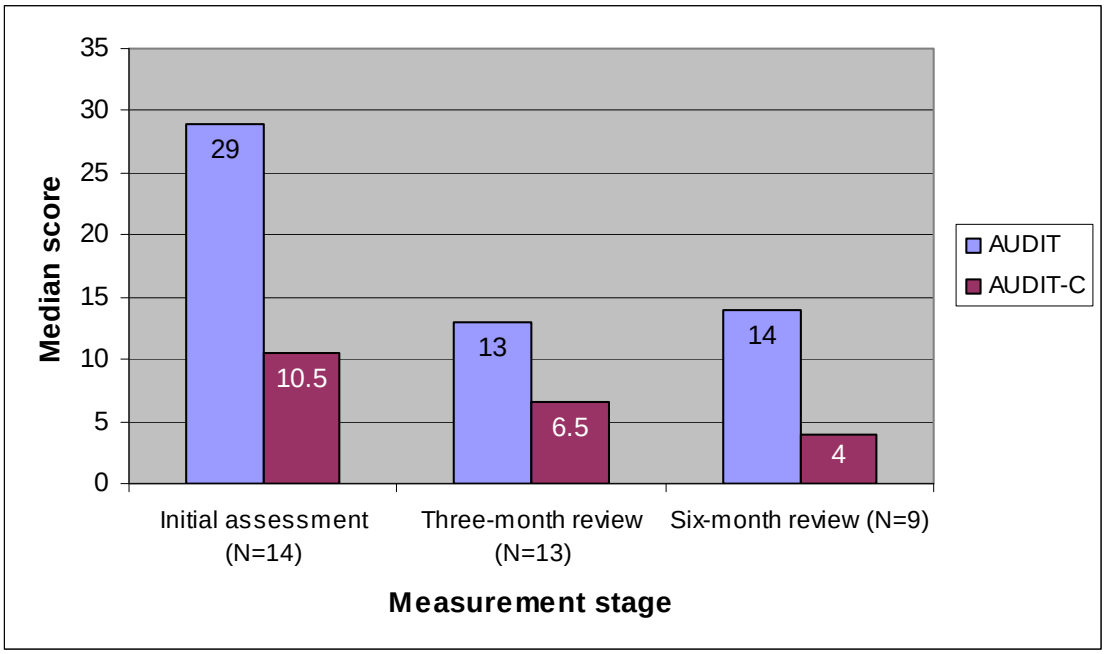
Figure 4: AUDIT Categories



Median AUDIT scores were significantly lower at the three- and six-month review stages compared to the initial assessment stage ($p<0.01$ and $p<0.05$ respectively). However there was no further reduction in median AUDIT scores between the review stages (Figure 5).

The AUDIT-C is a short version of the AUDIT consisting solely of its three consumption items and is approximately equal in accuracy to the full AUDIT (Reinert & Allen 2007). Again there was a significant reduction in median AUDIT-C scores between initial assessment and both review stages ($p<0.05$ and $p<0.01$ respectively) but here a significant reduction is also apparent between the three- and six-month review stages ($p<0.05$), revealing that alcohol consumption by clients had actually continued to decrease during the second half of their treatment period. The other questions on the AUDIT scale relate to alcohol use over longer time periods therefore seem to have masked this trend.

Figure 5: Median AUDIT and AUDIT-C Scores

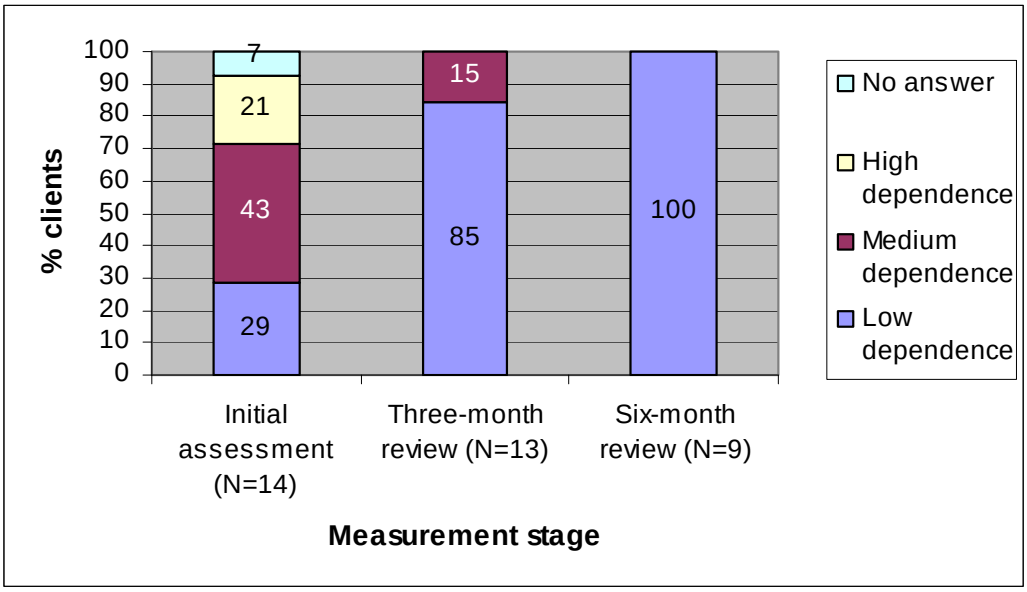


It should be noted however that by their six-month review four (44%) of the ATR clients still had an AUDIT-C score that fell above the recommended cut-off of four points, used to determine active alcohol abuse or dependence (Bush et al, 1998). Yet according to this measure of alcohol consumption all 14 clients were above the dependence threshold at the initial assessment stage. This overall reduction in dependency among the client group over the six-month period is therefore a notable achievement.

Leeds Dependency Questionnaire (LDQ)

LDQ scores for the ATR clients provide additional evidence of them becoming less dependent on alcohol as they progressed through their order. The median LDQ score was 13 at the assessment stage, which dropped to zero by the three- and six-month review stages. Significant differences were found between 0 and 3 months ($p<0.01$) and 0 and 6 months ($p<0.01$) but not between 3 and 6 months as there was no change. At initial assessment 21% of clients were identified as highly dependent and 43% were of medium-level dependence, at the three-month review 15% were of medium-level dependence (none were highly dependent) and by the six-month review all clients had become classed as 'low dependence' (Figure 6). This was a substantial reduction in alcohol dependency, even by the time clients were just half-way through their order.

Figure 6: LDQ Categories

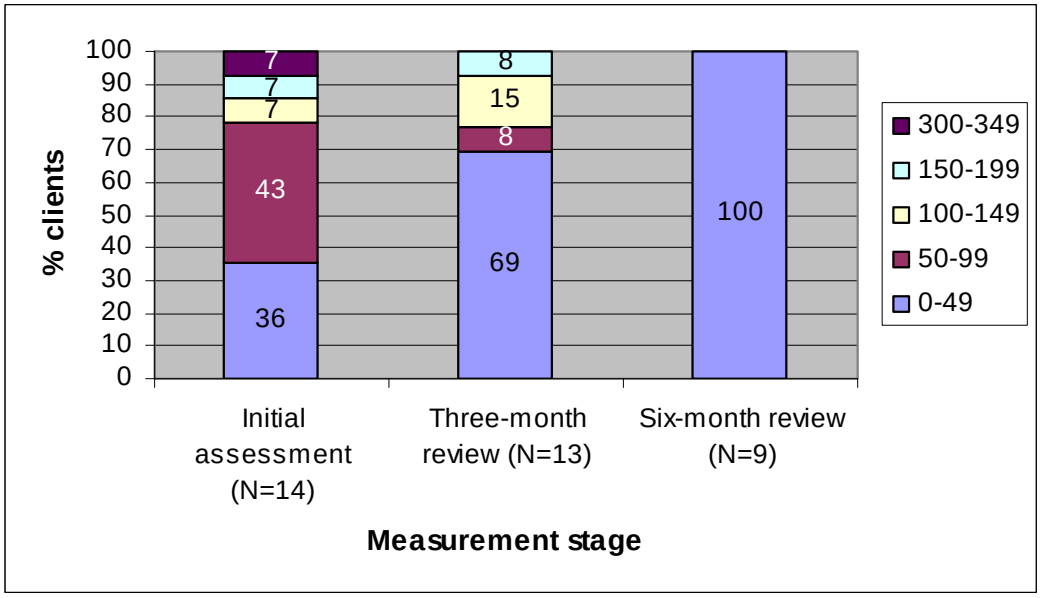


Seven day drink diary

Alcohol Treatment workers completed a drink diary with their clients to examine what alcohol they had consumed during the past week. The median number of units being consumed weekly by clients upon referral was 79.6 units – almost three times the recommended weekly amount of 28 units for males. This median amount had reduced substantially to 12 units by the three-month review stage and to only 4.5 units upon completion of clients' orders. The reduction between the initial assessment and final review were statistically significant ($p<0.05$).

The most notable finding is that after six-months in treatment all clients reviewed had consumed less than 49 units of alcohol in the previous week and only one of these clients, who recalled consuming 38 units, had drank over the recommended weekly amount (Figure 7). Some caution should be taken in interpreting this data however as the two clients who reported consuming the highest number of units upon referral (330 and 182 units) were not followed up at the six-month stage due to one breaching and the other being in custody. For those who remained engaged there were considerable reductions in consumption.

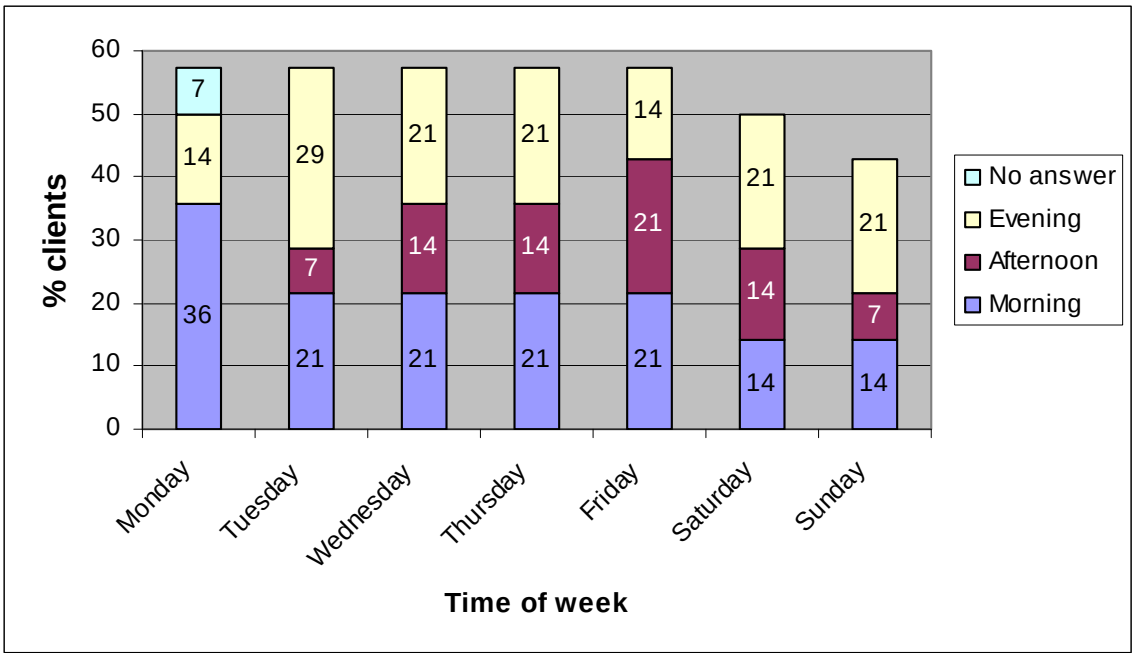
Figure 7: Total Units Consumed Weekly



According to the diaries clients began drinking less frequently during their time in treatment; the median number of drink-free days increased from three days a week at assessment to six days at three-month review and had remained at six days by six-months. The difference between the assessment and the six-month review stage was significant ($p<0.05$).

Using the drink diaries, Alcohol Treatment workers also recorded the time of day clients began drinking alcohol for each day of the week that they drank. Morning was defined as being between 5am and 11:59am, afternoon was defined as 12noon to 4:59pm and evening was defined as 5pm to 11:59pm (no clients began drinking between 12midnight and 4:59am). At assessment there was no clear pattern to clients' drinking times, although slightly more clients drank mid-week rather than at the weekend and five clients (36%) started drinking alcohol in the morning at some point during their week (Figure 8). This distribution across the time of week/day reflects the clients' alcohol dependency upon referral, which was confirmed by the reasons they gave for drinking including 'physical need to drink', 'withdrawal', 'to stop shaking' and 'habit'. Other clients said they started drinking out of boredom, to be social or because they 'felt like it'.

Figure 8: Time of Day/Week of Drinking at Assessment (n=14)



On each day of the week prior to clients' three-month reviews there were lower proportions of clients drinking in comparison to the week prior to their initial assessments (Figure 9). Fewer clients appeared to have starting their drinking sessions in the morning although two clients (15%) had continued to drink every morning. Missing data at this stage also makes comparison difficult.

Figure 9: Time of Day/Week of Drinking at Three Months (n=13)

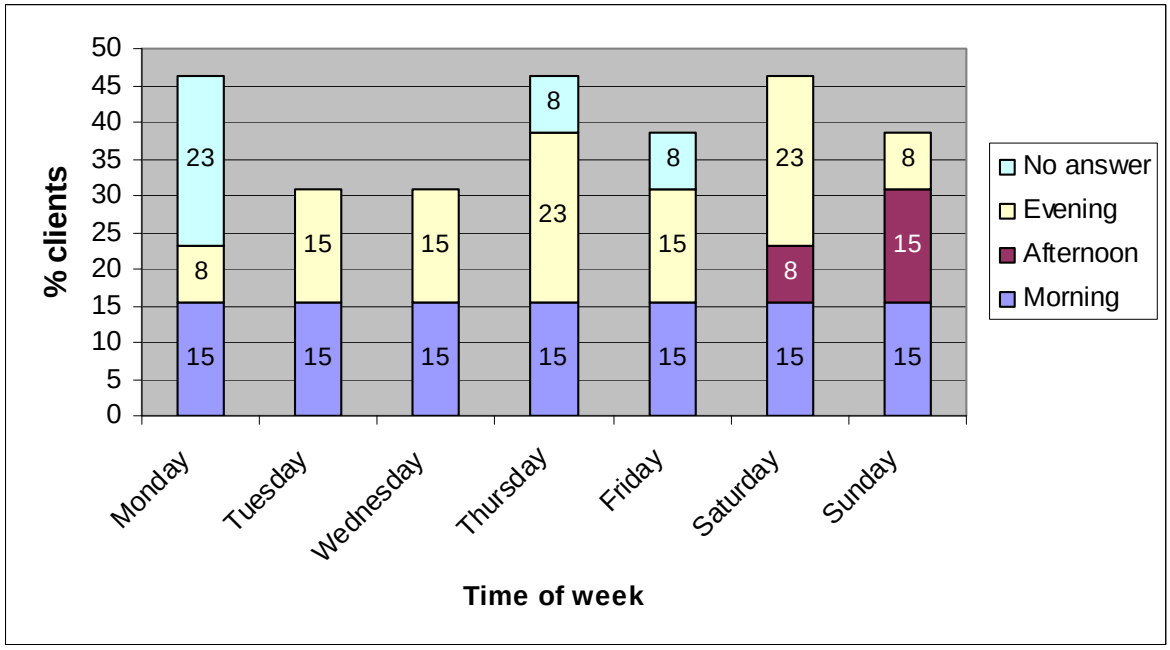
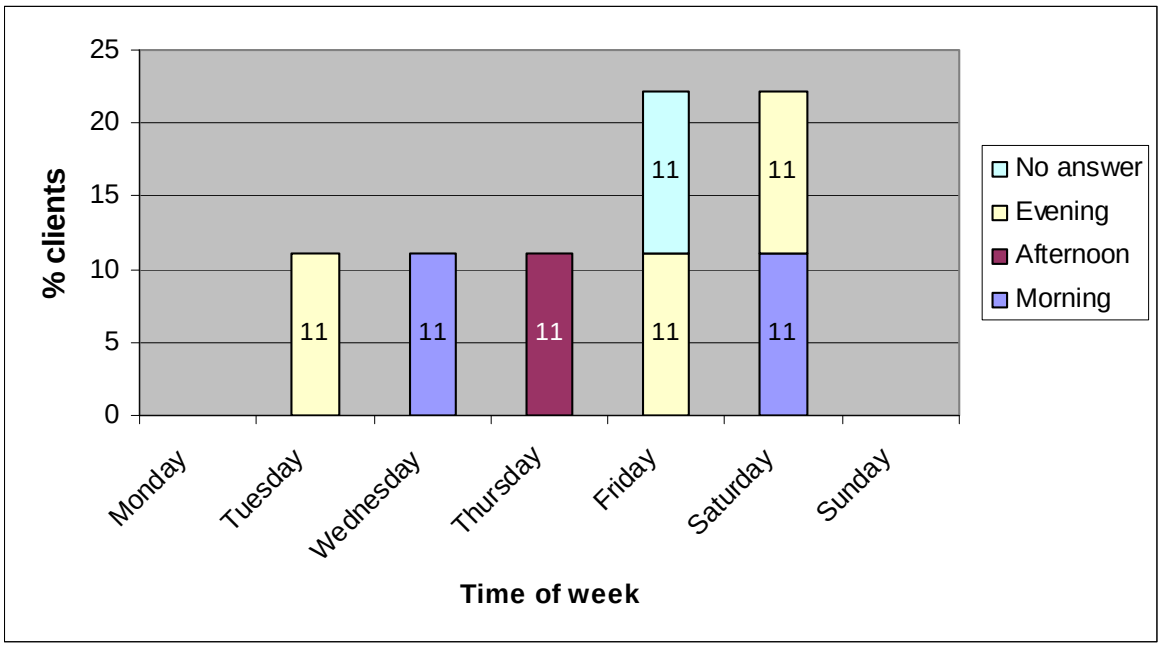


Figure 10 shows a reduction in drinking prevalence upon completion of clients' orders. The largest proportion of clients drinking on any one day was 22% (just two clients), compared to 46% at three-months and 57% upon referral. Further, most drinking occurred on a Friday and/or Saturday rather than mid-week. From these positive changes in drinking patterns that show clients were spending less of their time drinking, it may be deduced that alcohol was beginning to have less of impact on their everyday lives. It must still be taken into account however that the two heaviest drinkers at referral could not be followed-up at the six-month review stage.

Figure 10: Time of Day/Week of Drinking at Six Months (n=9)



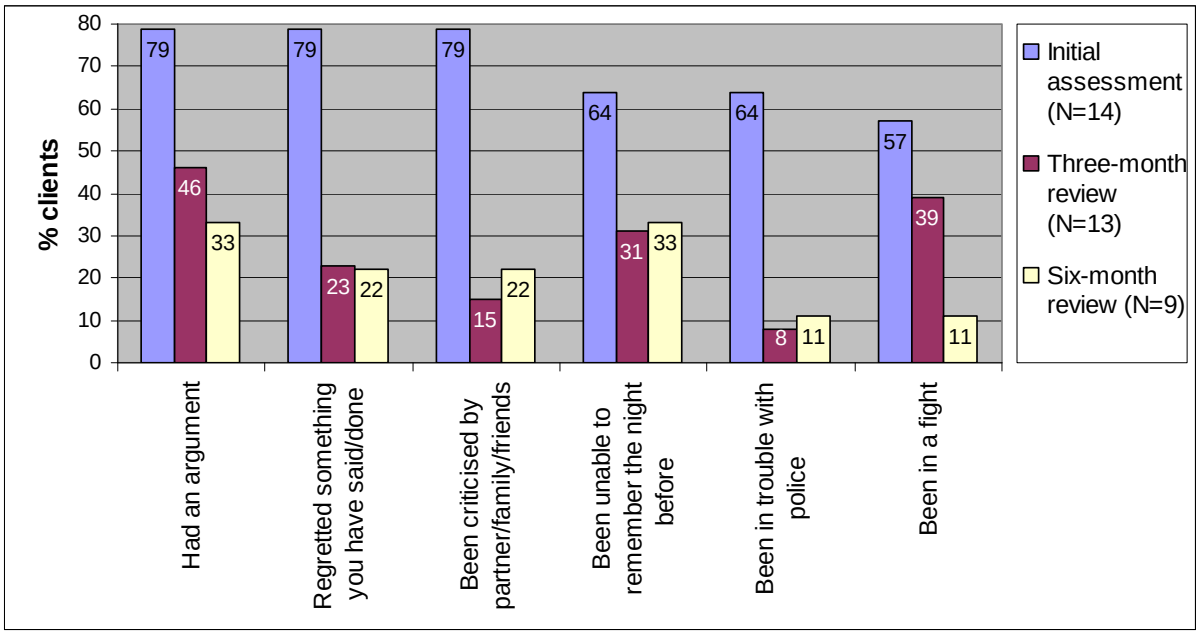
Behavioural questions

Clients were asked to state how many times certain scenarios had happened to them after drinking in the three months prior to their assessment or review. Figure 11 compares the proportions of ATR clients who said they had found themselves in each alcohol-related situation at least once during the three month period (data is presented for those situations recalled by more than 50% of clients at assessment). The order of prevalence of these alcohol-related scenarios varied between measurement stages but each type was experienced by lower proportions of clients as they moved through their order.

Most notably, the proportion of clients saying they had been in trouble with the police in the last three months fell substantially from nine clients (64%) at initial assessment to just one client at the three- and six-month review stages (8% and 11% respectively). It is assumed

that clients were asked this question in relation to any offending excluding the offence that led to them being arrested as otherwise this proportion at assessment would be 100%.

Figure 11: Prevalence of Alcohol-Related Behaviours



Treatment Outcome Profile (TOP) forms

According to TOP data the proportion of clients drinking alcohol in the past four weeks fell by 36% between assessment and final review (Figure 12). An estimate of the average number of units consumed by clients on days when they had drank alcohol over the previous four weeks was also provided; the median number of units decreased from 20 at assessment to 10 at three-month review and six at six-month review. Further, the median number of days on which clients had drank over the past four weeks had decreased from 16 to eight days between assessment and three-month review, down to one day by their six-month review (Figure 13). These trends concur with the findings from the drink diaries and AUDIT scale.

Also recorded on TOP forms were clients' uses of other substances over the past four weeks which provided evidence of crack and opiate use by some clients. There were mixed findings in relation to this substance misuse, with an overall reduction in the proportion of clients using opiates or crack between assessment and final review (Figure 12) but at the same time an increased frequency of use by those clients who continued using (Figure 13).

Figure 12: Proportions of Clients Using Substances (in past four weeks)

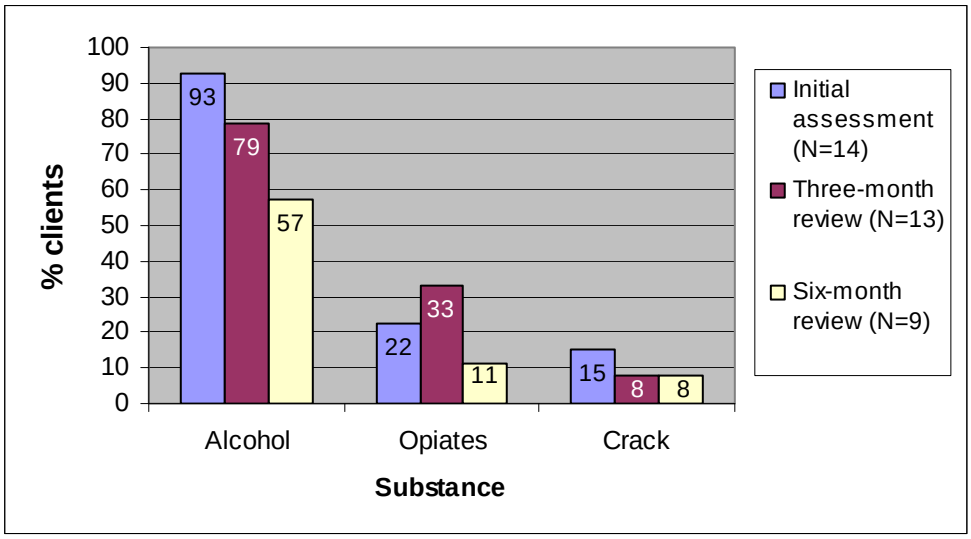
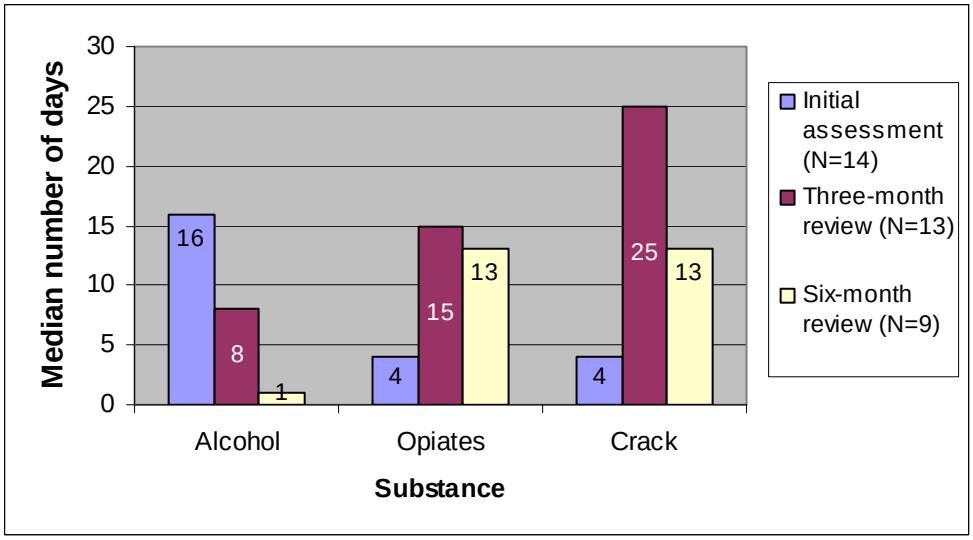


Figure 13: Frequency of Substance Use (in past four weeks)



Readiness to change and measures of alcohol use

Correlations were examined between clients' readiness to change scores at assessment and changes in their AUDIT scores, AUDIT-C scores, LDQ scores and alcohol units consumed weekly between the assessment and review stages. Higher client ratings on Scale 2 (*How important is it to change your drinking or drug use?)* were significantly associated with:

- improvements in AUDIT scores between assessment and six-month review (r_s= -0.728, $p<0.05$)
- improvements in AUDIT-C scores between assessment and six-month review (r_s= -0.725, $p<0.05$)

- improvements in LDQ scores between assessment and three-month review (r_s= -0.589, p<0.05)

Higher ratings on Scale 4 (*How confident are you that you can change right now?*) were associated with:

- improvements in AUDIT-C scores between assessment and three-month review (r_s= -0.587, p<0.05).

No other correlations were statistically significant.

5.5 Measures of Offending

Risk assessments

At the time of assessment it was established that seven of the clients (50%) had a history of acquisitive type offending and 12 (86%) had a history of other offending. Further, six (43%) had a history of violent behaviour including domestic violence and three (21%) had a criminal record for assault or violent behaviour.

TOP forms

According to the TOP forms three clients had committed assault or violence in the four weeks prior to their initial assessment (again it is assumed that this excludes the offences resulting in clients receiving their ATRs although these offences may have taken place more than four weeks prior to their assessment). At the three-month review stage only one client said they had committed 'other property theft or burglary' in the last month. No other offending was reported by the clients who were reviewed.

5.6 Measures of Health

General Health Questionnaire (GHQ)

Responses to the GHQ were scored using the most recent scoring method developed for it (Goodchild & Duncan-Jones, 1985). The median score remained at six for the first two measurement stages then halved to three by the six-month review stage, suggesting a decrease in psychiatric morbidity among the group, though differences were not statistically significant.

TOP forms

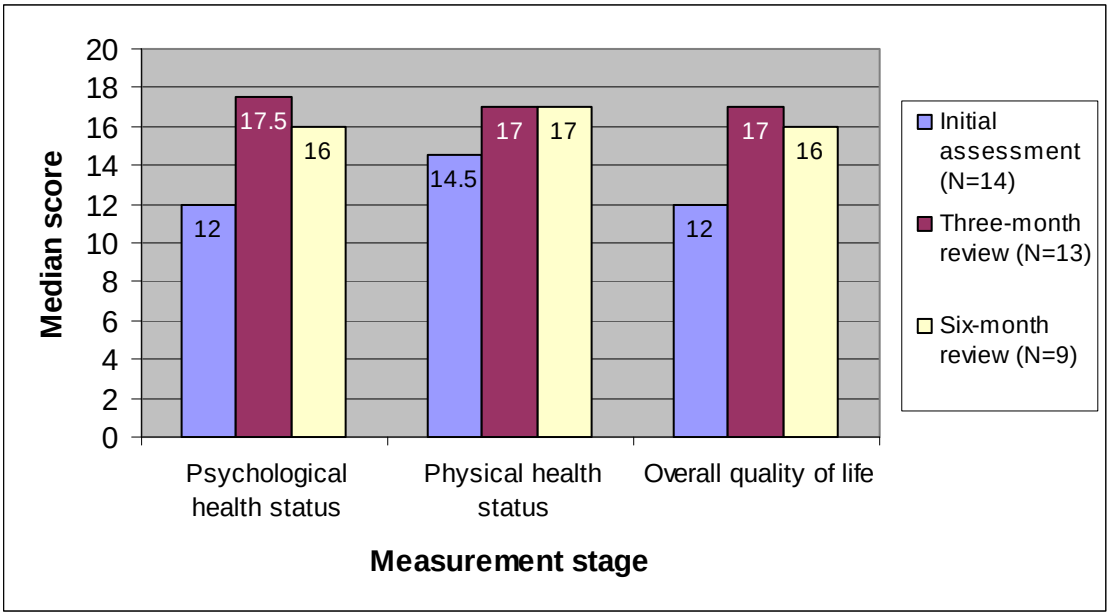
The TOP forms contain three self-report scales designed to measure clients' health and social functioning. Between initial assessment and six-month review, median scores on these measures had increased; clients considered themselves to have enhanced

psychological and physical health and an improved overall quality of life by the end of their orders (Figure 14).

Interestingly these health ratings were highest at the three-month review stage rather than at the six-month review stage, which was perhaps a reflection of the positive impacts and optimism felt by clients during the first half of their treatment before emotions levelled out as clients put into practice the things they had learnt. This could also be related to changing expectations; as clients began to recover they realised the extent of their health problems and addressing their ill-health became a higher priority for them.

Differences in median scores on the scale for psychological health were significant between initial assessment and three-month review ($p<0.01$) but there were no other significant differences for this scale or for the remaining two scales.

Figure 14: Median Scores on Health and Social Functioning Scales



6.0 Findings from Follow-up Interviews with ATR Clients

Information provided by clients during their three- and six-month follow-up interviews with a researcher gave insight into their experiences of the pilot scheme, specifically in relation to the types of care they received, their satisfaction with the service, the perceived impacts of their treatment and any assistance they felt they still required. The questionnaire used was semi-structured to obtain a series of quantitative measures alongside qualitative personal accounts.

6.1 Process

Treatment intervals

Over half (55%) of the clients interviewed at three months remembered having their comprehensive assessment with Lighthouse Project within a week of receiving their ATR in court, while two clients said it took two to three weeks. The estimated time it then took for clients to have their first full one-to-one session following their assessment was most often one to two weeks.

After being in treatment for three months, all but one of the clients interviewed were seeing their Alcohol Treatment worker on a fortnightly basis. The remaining client was attending appointments weekly but during their final three months the appointments became fortnightly. Clients continued to see their Alcohol Treatment workers fortnightly throughout the second half of their order except one who had been seen less than monthly as a result of being ill.

Probation intervals

The majority (82%) of clients had weekly appointments with Probation during the first three months of their order and one client had been seen fortnightly. The remaining client complained at having seen his Probation Offender Manager less than monthly which he understood had been partly due to him moving Probation centres. Meanwhile one of the clients who began attending Probation weekly had been put on fortnightly appointments during the first three months of his order.

Six months into their orders only half of the clients interviewed (four) were on weekly appointments while one attended fortnightly, two monthly and one less than monthly. Reasons given by clients for seeing their Probation Offender Managers less than fortnightly included further changes in Probation staff and personal illness. During the final three months of their orders appointment intervals were again purposefully altered, with two clients being moved from weekly to monthly appointments and one going from weekly to fortnightly.

These changes suggested Probation Offender Managers were satisfied with these clients' progress and no longer felt the need to meet with them as regularly.

6.2 Treatment and Support Received

All ATR clients reported having one-to-one treatment sessions with their Alcohol Treatment worker. Several also reported receiving a health check with the Nurse which would often involve a liver function test and three clients attended at least one session with the Psychological Therapist.

Counselling

The counselling received positive feedback from clients who had clearly benefited from their sessions and who had either had regular contact with the Psychological Therapist or had understood they could return for further sessions if they felt they needed to. One of the clients who attended had preferred to see a female counsellor and was being referred to Community Integrated Care (CIC) by Probation for this reason. A further three clients were offered counselling but they either felt they weren't ready for counselling or they didn't need it.

> *'I came from seeing [the counsellor] and felt like a huge weight had been lifted.'*
> *'I was offered a referral to see the counsellor but I didn't feel ready for that.'*

Onward referrals

For the clients interviewed, referrals were made by the Alcohol Treatment workers to the Together Women's Project (TWP), Alternatives, the Gateway, CIC and the CJC (for advice on housing). Some of these clients were offered referrals to external services, including TWP and inpatient detoxification, but turned them down because they didn't feel they needed them or they lacked the confidence to go. Stakeholders spoke of ATR clients who had been referred for detoxification, however it has not yet been confirmed which clients these were. Arrangements were also made for clients to be prescribed medication including Subutex. Such a range of referrals demonstrates there has not been only one referral pathway for these ATR clients but that they had a range of individual needs that required additional support from a multiplicity of external services. TWP was however a common point of referral for the female clients.

6.3 Treatment Sessions and Relationship with Alcohol Treatment Worker

The one-to-one treatment sessions consisted predominantly of discussions between Alcohol Treatment worker and client around alcohol use and related issues. Clients recalled talking in depth about their drinking levels and how they felt when they drank. There was evidence

that clients had become more alcohol aware as a result of the advice and guidance provided by the Alcohol Treatment workers and discussion around units and recommended levels seemed to be the main point of learning for many clients, who explained their reduction in alcohol consumption in terms of units. This confirmed the value in completing alcohol scales and drink diaries with clients at regular intervals throughout their treatment which made visible any changes they had made. Clients also reported learning coping strategies, examining triggers to their drinking and determining ways to make step-by-step lifestyle changes with the support from their Alcohol Treatment worker.

'It's helped me cut down a lot - I drink less units.'
'I'm given options - what steps I can take to get things done.'

Clients appeared to have gained a great deal from having someone to talk to and spoke fondly of their Alcohol Treatment workers with whom they had clearly developed a close and constructive relationship. Clients described them as easy to talk to, relaxed, down-to-earth, interested, understanding and non-judgemental. They had enjoyed sharing experiences and 'had a laugh' with them, had been made to feel at ease and felt able to discuss their problems openly and honestly.

'We get on well. He isn't just interested in my drinking. He asks me how I am and how my life is going. We cover lots of things and chat.'
'She's really down to earth. I feel like I can talk about any problems and worries.'

Clients also appreciated the continual commitment and encouragement shown by the treatment team. Two clients said they had regular phone contact with their Alcohol Treatment workers and understood they could call them at times when they felt they needed help. One client told of how their Alcohol Treatment worker had offered to drive them to a doctor's appointment and had visited them while undergoing a detoxification programme. Consistency was felt to be key by clients who said their Alcohol Treatment worker had been dependable and available at all times.

'I can phone her anytime if I have a problem so I have extra support through that.'
'I have always had the same worker and he did my assessment in court, I have not had to swap and change – it's important to have the same person.'

6.4 Probation Sessions and Relationship with Probation Offender Manager

Experiences of Probation sessions varied considerably between clients. For some, these sessions provided an opportunity for clients to discuss their offending and drinking behaviour and seek advice on benefits, debts, legal issues and housing, while for others Probation appointments consisted solely of signing an attendance sheet. Those clients who had had regular contact with the same member of staff described their Probation Offender Manager as friendly and helpful and found they were able to open up to them.

> *'I can talk to him about anything. I can ring anytime if I need to speak to him and I can come in to see him if there is something wrong and I don't have an appointment with him.'*

Such consistency was felt to be missing by other clients whose Probation Offender Managers had varied due to reasons including staff moving jobs, absences from long-term sickness or annual leave. In these cases clients would often see a duty officer who it doesn't appear was always in a position to give the same amount of time or level of support.

> *'I have had two probation offices and different probation officers…The person who gets me to sign the attendance form asks if I have got any problems but I don't want to talk about my problems to strangers.'*

6.5 Understanding of Order and Treatment

Clients had a good understanding of their order and the consequences of not attending their appointments; they understood that a breach would result in them being given a custodial sentence and/or additional hours of community service. The treatment being offered was seen by many clients as a 'wake up call' or opportunity for them to address their alcohol issues and offending. The experience of being arrested and attending court had seemingly contributed to two clients' motivation to change.

Alcohol Treatment workers were said to have explained the aspects their treatment to them well and provided clear advice for them to act upon. All clients followed-up after three months said they had always understood what had been said to them by their Alcohol Treatment worker and at six months 88% said they had always understood (one client had changed their response from 'always' to 'sometimes' between follow-ups). Clients were also aware that they had access to a number of different treatment options if required.

High proportions of clients also said they had always understood what had been explained to them by their Probation Offender Manager at both follow-ups (82% at three-months and 88% at six months). The remaining clients said they had sometimes been clear about what they had been told by their Probation Offender Manager.

Correspondence

Nine out of the 14 ATR clients (64%) said they had received letters from Lighthouse Project or Probation at some point during their order and all of these people said they had fully understood the information contained in them. Half of the clients had been given information leaflets which were also felt to be fully comprehensible.

6.6 Rating of Service

The majority of clients interviewed at both the three- and six-month stages (73% and 88% respectively) rated the quality of the service they had received from Lighthouse Project as 'excellent' and those remaining said it had been 'good'.

When asked whether they had received the kind of service they had wanted just over half (55%) of the eight clients interviewed after three months answered 'yes, definitely' while just under half (45%) felt they had 'generally' received the kind of service they had wanted. By the six-month stage all but one of the clients interviewed (88%) felt they had definitely received the kind of service they had wanted from Lighthouse Project, suggesting additional benefits were gained during the final three months of treatment and perceptions of treatment had improved.

At both follow-up stages all clients except one said that they were very satisfied with the amount of help they had received. The remaining client was mostly satisfied.

A measure of overall satisfaction with the service received from Lighthouse Project revealed that large proportions of clients were very satisfied at both follow-up stages (82% at three-months and 88% at six-months). All other clients said they were mostly satisfied i.e. nobody said they were dissatisfied.

Clients also appreciated their treatment sessions being arranged to coincide with the time and location of their Probation appointments for their convenience.

6.7 Needs Met/Unmet

The majority (10) of the 11 clients interviewed after three months stated that either 'almost all' or 'most' of their needs had been met (55% and 29% respectively). The remaining client felt that 'only a few' needs had been met but by the time of completion this client felt that most their needs had been met.

Around three-quarters of clients interviewed at three- and six-months said the services they had received had helped them 'a great deal' to deal more effectively with their problems (73% and 75% respectively). Other clients felt the services had helped them 'somewhat' to tackle their problems.

Figures 15 and 16 illustrate clients' specific needs during the first and second halves of their order and whether or not they had received relevant support from their Alcohol Treatment worker or Probation Offender Manager. During the first three months the most common needs related to housing, employment/skills, family relationships and drug advice. Advice on family relationships and drugs was readily offered, even to some who did not think they had necessarily needed it. However one client who stated having housing needs within the first three months of their order did not recall receiving assistance in this area and support and/or referrals were not provided for three clients (21%) who had employment/skills needs within the first three months of their order.

Figure 15: Percentage of Clients who Needed, Received and were Referred for Help in Different Areas during the First Three Months of their Order (n=13)

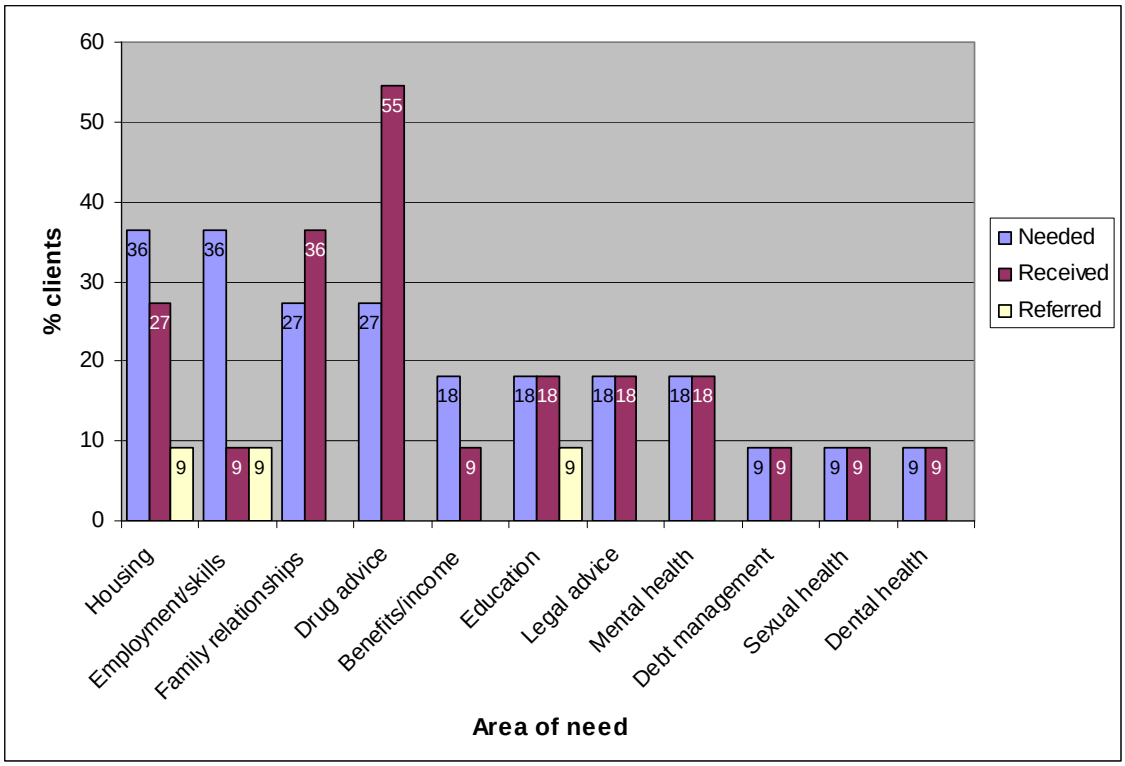
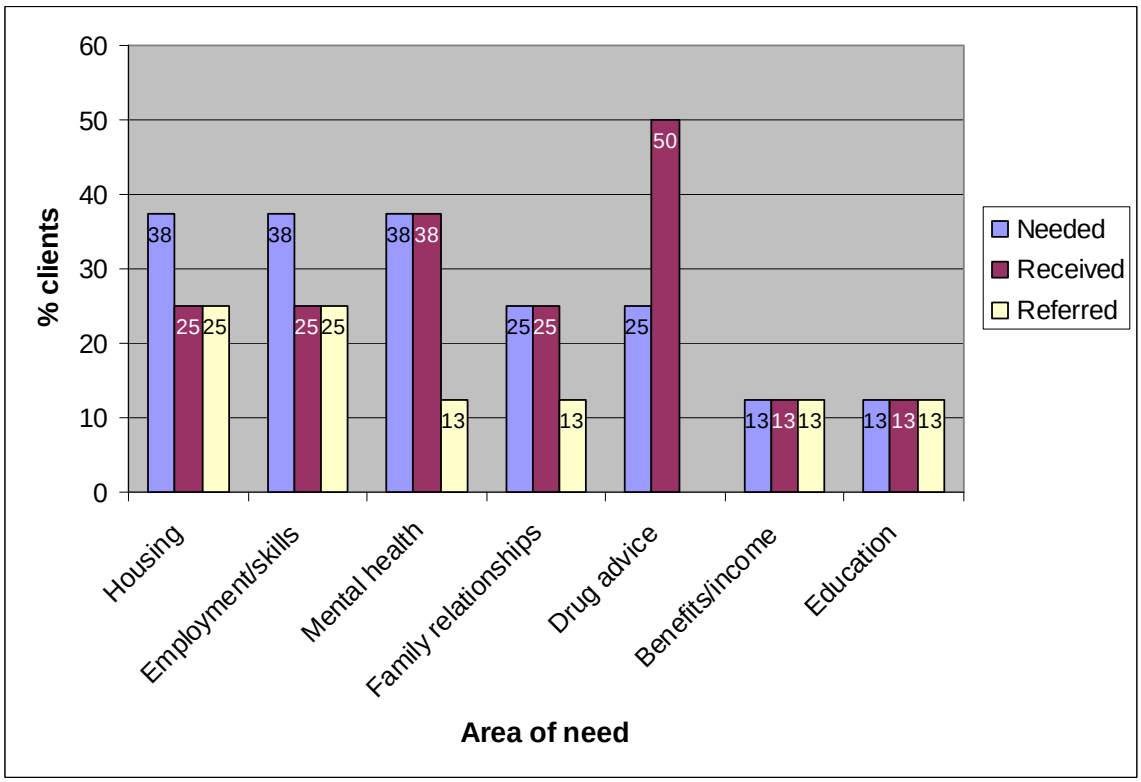


Figure 16: Percentage of Clients who Needed, Received and were Referred for Help in Different Areas during the Final Three Months of their Order (n=9)



Mental health had become a concern for a greater proportion of clients during the final three months of their treatment (20% more clients). Rather than being an indication of increased prevalence of mental health problems, this is more likely a reflection of how clients became increasingly aware of the role their mental health played in their drinking behaviour and its consequences, as discussion around the emotional triggers of drinking and the feelings they associated with alcohol were often central to the one-to-ones.

> *'I drank last night at a party because of the incident with my brother - I was feeling down, my depression is still there.'*
> *'We talked about how it feels when I drink.'*

All clients who had required help with mental health had received it from their Alcohol Treatment worker or Probation Offender Manager. Housing needs and employment/skills needs remained unaddressed for one client. Meanwhile, clients' needs for support in the areas of debt management, legal advice, dental health and sexual health appeared to have been fully met by the second half of their order.

In response to an open-ended and unprompted question about needs a small proportion of the ATR clients reported having individual needs relating to mental and physical health (such as asthma, sleep deprivation and depression) as well as employment that were so far unresolved. This represents a variety of deep-seated individual problems that exist among this client group that possibly could not be resolved within the time limit imposed by the order.

Clients were also asked to specify whether they had received each type of support from their Lighthouse Project Alcohol Treatment worker or their Probation Offender Manager. Housing, benefits/income and debt management support was specific to Probation while dental and sexual health advice were offered only by Lighthouse Project, nevertheless there was considerable overlap in the support provided by the two services (Table 2).

Table 2: Source of Support

Area of support	Provided by Lighthouse Project	Provided by Probation
Housing	No	Yes
Benefits/income	No	Yes
Debt management	No	Yes
Employment/skills	Yes	Yes
Mental health	Yes	Yes
Family relationships	Yes	Yes
Drug advice	Yes	Yes
Education	Yes	Yes
Legal advice	Yes	Yes
Dental health	Yes	No
Sexual health	Yes	No

6.8 Outcomes

Drinking behaviour

Follow-up interviews with the ATR clients provided evidence that their order had had a substantial impact on their alcohol use and related behaviour. All clients followed up after three and six months agreed that their alcohol use had reduced over the past three months, with three-quarters saying that they 'strongly agreed' this was the case (73% and 75% respectively – see Figure 17 below).

Although clients were often still drinking on a regular basis they had reportedly reduced their overall alcohol consumption, more specifically they felt they had cut down on binge drinking and the number of days on which they drank alcohol and were consciously changing the types of alcohol they drank.

'I'd say I've reduced my drinking by 30%. Now I just drink weekly, at the weekends.'
'I haven't drank vodka in eight weeks, vodka was my main problem.'

Clients acknowledged that seeing evidence of progression in their responses to the alcohol measurements acted as a reinforcer of positive change for them. It is also clear that the commitment shown by the Lighthouse Project staff and clients' knowledge that their Alcohol Treatment worker was available for help contributed to their motivation to change.

'I don't lie and I didn't want to disappoint my treatment worker so I had to try really, so knowing that helped.'
'I can't go on a binge because I have to come in here and talk about it.'

Offending behaviour

Almost all clients said they agreed or strongly agreed that they had been less involved in crime in the three months prior to their interview (Figure 17). A reduction in arguing and fighting was a common theme that emerged among clients who felt they had learned to gain control of their temper. Two clients perceived their order to be a success in preventing them from committing crime where non-ATR Probation orders hadn't worked for them previously. They attributed this to their increased confidence, ability to control drinking in social situations, good relationship with their Alcohol Treatment worker and the consistency of the support they had received.

> *'Before the ATR I used to get into trouble for drunk and disorderly all the time and now I haven't been in trouble for that once. I think it is really good, it should be given to people earlier before they commit anymore crimes.'*

One client admitted to offending in the three months prior to their three-month follow-up and again before the six-month follow-up, though this excludes the clients who breached or were taken into custody and could not be followed-up.

Health

Changes in lifestyle had led to improvements in clients' physical and mental health. There were accounts of improved self-confidence, reduced frequency of panic attacks and a release of stress and anxiety after talking through problems with an Alcohol Treatment worker.

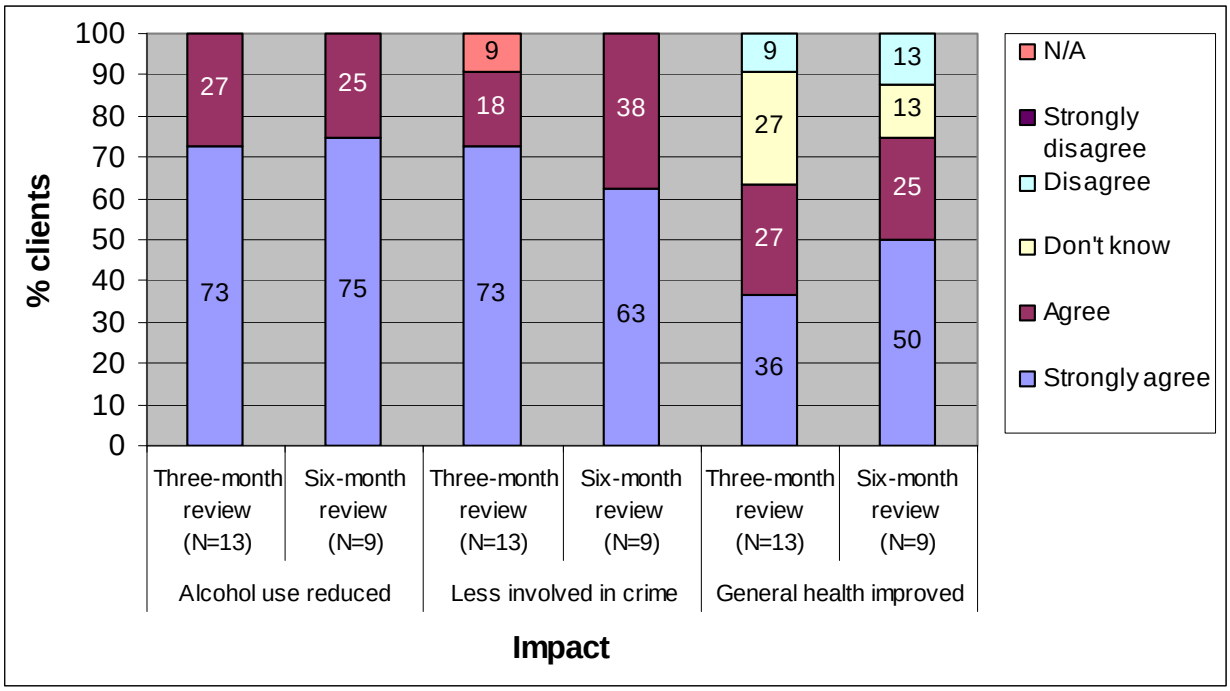
> *'I had so many things bottled up, it's a release, a breath of fresh air. They listen and explain things back to you.'*

Clients believed they were physically stronger and fitter since changing their drinking behaviour. Healthy eating was a desirable outcome for two clients who said they had begun eating better and/or had gained weight when they hadn't previously realised their diet had been poor.

Quantitative data showed feelings were mixed in relation to health impacts (Figure 17). Almost two-thirds (64%) interviewed at three months agreed or strongly agreed that their general health had improved during the first half of treatment, while the remaining clients either didn't know (27%) or disagreed (9%) that there had been improvements in their general health. Responses were similar upon completion but with a larger proportion (75%)

stating they agreed or strongly agreed that their general health had improved over the last three months.

Figure 17: Clients' Perceived Impacts of Treatment



Relationships with others

Reintegration into family and social networks occurred for some clients during the course of their intervention. In particular some clients had got back together or were getting along better with their partner. Referrals by Alcohol Treatment workers to other services meant some clients were enjoying activities they wouldn't otherwise have become engaged in, providing opportunities for clients to socialise in ways that didn't involve drinking.

> *'It's got me into projects to get away from drink. I was living on my own and drinking on my own.'*
>
> *'It has helped me to socialise, meet people and feel more confident.'*

Employment

At the three-month follow-up stage employment was a priority for clients who had either recently returned to work or were actively seeking work with assistance from employment agencies.

'I've reduced my drinking and have gone back to work full-time.'
'I am looking for work because I drink out of boredom, I've started applying for jobs and going to interviews.'

Changes in self

Changes in attitudes towards drinking and lifestyle were apparent. Overall clients seemed to have a positive outlook, had become more accepting of outside help and were beginning to see alcohol as a hindrance to pursuing their personal goals. Some recognised the financial benefits of consuming less alcohol and considered drinking excessively to be a waste of money.

'I want to change my life around…I've had enough, I want to complete it - I don't want to go to jail or get more hours. I want to get a good relationship back with my family. I'm doing it for myself.'

Almost all clients showed high levels of alcohol awareness, particularly in terms of how to calculate how many units they were consuming, knowing their own limits and having the knowledge and skills required to be able to react appropriately to situations where alcohol is present. Such self awareness had clearly developed as result of their time spent with the Alcohol Treatment workers. Strategies adopted by some clients, which they said had been suggested by their Alcohol Treatment workers, included drinking soft drinks and going home earlier from a night out.

'I could go to the pub over the road now and order a lemonade with ice no problem.'
'I get off home at a reasonable time - it's difficult at times.'

These principal changes in clients' perceptions which were enabling them to modify and control their behaviour suggested a degree of adaptability among these clients, who were adjusting a new way of life that did not involve problematic drinking. Two clients commented that the first three months of their order had been predominantly about becoming familiar with their Alcohol Treatment worker and learning how to tackle their alcohol problem, then during the final three months they put into practice the information and strategies they had learnt and worked to maintain the positive changes they had made. The structure and routine of the order was another aspect considered by the clients to be central to their progress.

'I wake up and don't think about drinking anymore.'
'I think the first three months of the order were more effective…that's when I learnt all the stuff that helped me to stop drinking. The second part I used what I had learnt.'

6.9 Attendance and Confidence of Completion

Despite all clients interviewed being fully informed of the consequences of them not attending appointments and not completing their order, the vast majority declared missing at least one appointment during the six month period. Reasons given for non-attendances included illness, forgetfulness or missing buses and while clients knew what could result they felt their absences were justified.

'Yes I am confident I will because of my good relationship with my ATR worker. If he suggested I attend for longer I would do, I will do anything to keep on the straight and narrow.'

Almost all clients interviewed at the three-month stage maintained they were confident they would complete their order, suggesting the knowledge and skills they had learned and the respect they had for their Alcohol Treatment workers had instilled a large amount of self-belief, even when they were only half-way through their treatment period.

6.10 Aftercare

All ATRs interviewed at the six-month stage upon completion of their order felt confident in dealing with their alcohol and related problems. On the whole they appeared optimistic about their future and planned to work towards their intermediate and longer-term personal goals which included starting a college course, returning to work, continuing to engage in new activities and working towards seeing their children. Clients were of the understanding that should they need to re-contact Lighthouse Project for further support they would be able to do so.

When asked whether they would return to Lighthouse Project for treatment in future if they were to seek help again upon completing their order, seven out of the eight interviewed said they would definitely return and the final one said that generally they would. Only one client interviewed at three months said they would not be likely to return for help. All clients interviewed said they would definitely recommend Lighthouse Project to a friend if they were in need of similar help.

It wasn't clear from the interview data however what arrangements had been made for clients' aftercare following completion of their six-month treatment period. While some clients planned to continue accessing services such as TWP voluntarily there didn't appear to be any defined formal referral pathways for the ATRs once they had come to the end of their order to ensure they had long-term support in place. If clients were to contact their Alcohol Treatment workers directly in future for further support there is no guarantee that they would be in the same post or that the same type of service would be available to them.

7.0 Additional Data

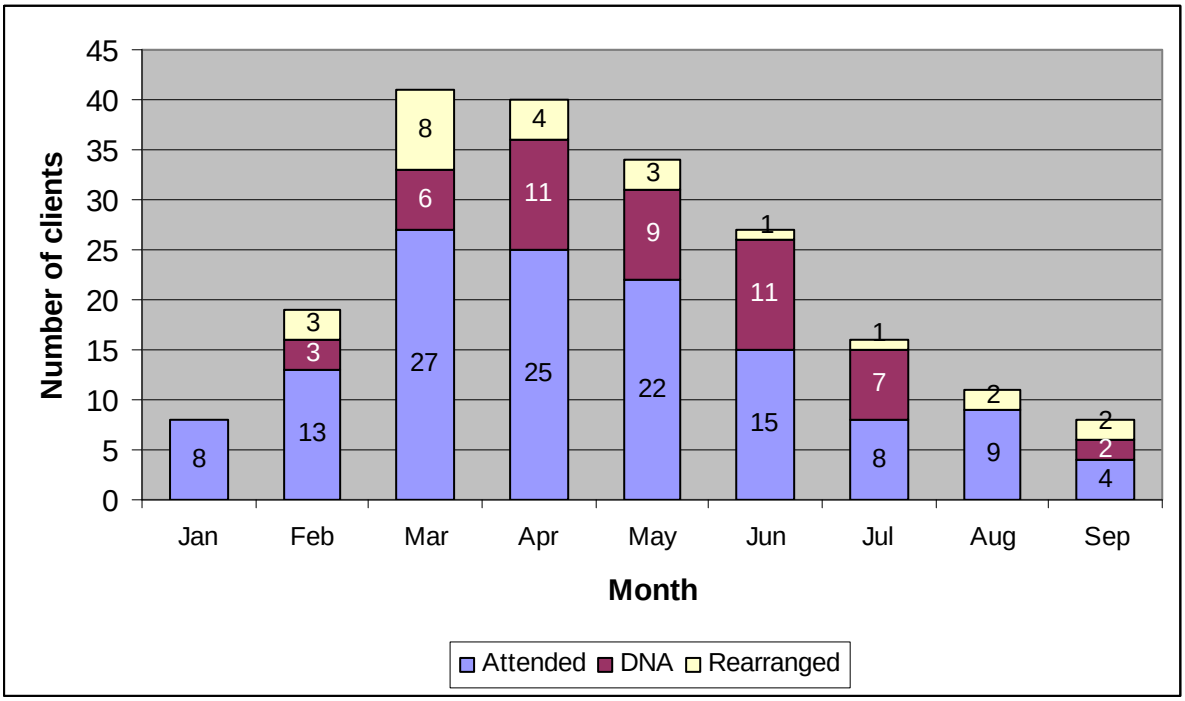
7.1 Attendance Data

Alcohol Treatment worker sessions

According to attendance data received from Lighthouse Project, of the 204 one-to-one Alcohol Treatment worker appointments made for the ATR clients in total, 131 (64%) were attended, 49 (24%) were DNAs and 24 (12%) were rearranged.

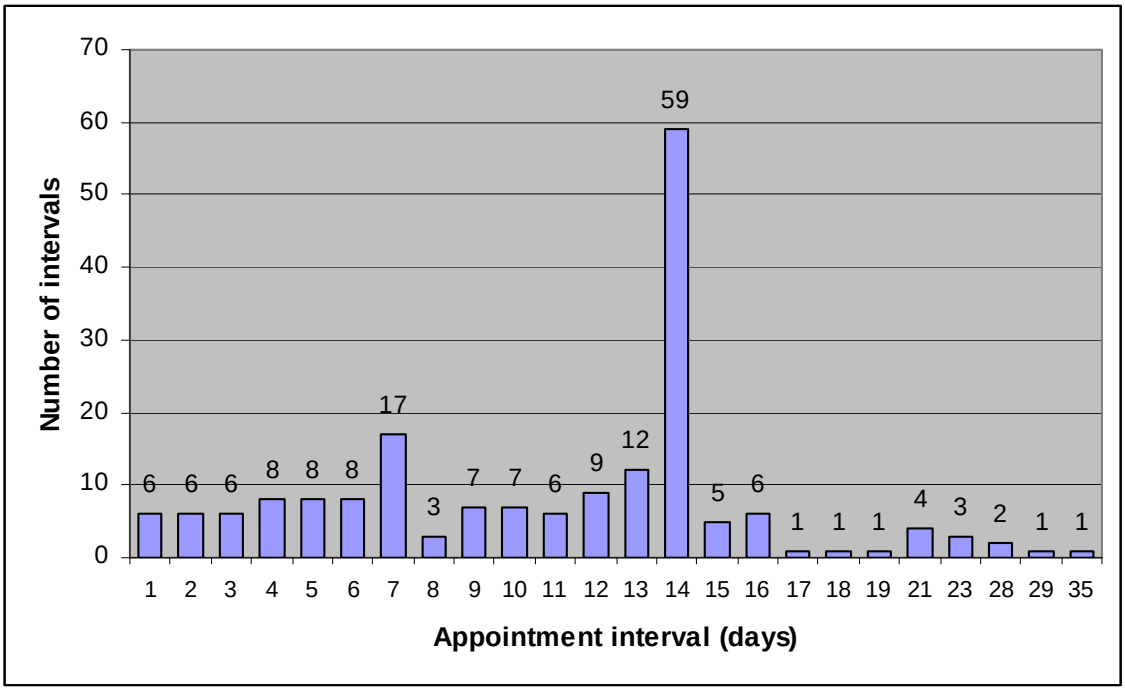
There was a steady decline in numbers of appointments after March (the end of the referral period) which reflects the disengagement of some clients and the reduced frequency of appointments for those who remained engaged – orders were also being completed from July (Figure 18).

Figure 18: Number of Appointments and Attendance Status by Month



The one-to-one treatment session intervals ranged from 1 to 35 days, with the median appointment interval being 13 days. Clients were most commonly seen fortnightly, while many others were seen weekly (Figure 19).

Figure 19: Treatment Appointment Intervals



Counselling sessions

Attendance records kept by the Psychological Therapist show four ATR clients took up counselling, one of whom had attended seven individual sessions and a group session. Of all counselling appointments made for ATR clients, 12 were attended and 10 were missed or cancelled. A further five ATR clients were referred for counselling but they either did not attend or cancelled their appointments.

7.2 Re-conviction Data

Re-conviction data was obtained from the Community Justice Centre for 13 of the 14 ATRs – the remaining client did not appear in the Police National Computer database.

The majority of these clients (11 of the 13) had only been convicted of one offence during the six months prior to their order (this offence would have been the one that led to their order). The remaining two clients had each been convicted three times during this period. During the six months after receiving their order, nine ATR clients did not have any convictions but the level of conviction was greater for the remaining four clients in comparison to the six months before their order. This was consistent with self-report measures for those who were followed-up. In total there were 19 convictions during the six months pre-order and 12 convictions during the six months post-order.

These figures may be interpreted as being positive in that the overall level of offending has dropped but negative in that four clients have actually increased their convictions – these were the clients who did not complete their order due to either breaching following DNAs or being taken into custody. According to the re-conviction data most of the group have a history of offending, however this offending is not prolific as in many cases clients' convictions are spread out over a long period of time. For other clients, the ATR had been received at the start of their offending career. Therefore it would be necessary to look over a much longer period of time in order to suitably compare re-conviction rates pre- and post-order.

8.0 Conclusions and Recommendations

Key Stakeholder Interviews

Stakeholder interviews were conducted at the beginning of the pilot and then again for a follow up at six months. Discussions around good practice and barriers remained mostly the same during the two interviews. There was agreement between staff who had been involved in the previous ATR pilot that the process had significantly improved for the current pilot, and this was referred to during both rounds of interviews. Previous problems reported during the first pilot included communication and role boundary issues. A tighter management structure and effective communication were emphasised as improvements for the current pilot. Communication was highlighted as effective by all members of staff from both Probation and Lighthouse Project during both rounds of interviews. However, there were discrepancies surrounding the initial introduction of the pilot. During both rounds of interviews some staff reported having Lighthouse Project Alcohol Treatment workers attend a Probation team meeting as beneficial, whilst others reported a need for more information sharing and further attendances at team meetings. It may be the case that not all staff were present during the team meeting and missed this opportunity. In addition, during both rounds of interviews, having the ATR treatment workers based at Kirkdale Probation Office was praised as this facilitated unscheduled contact between staff. The employment of a Nurse and a Psychological Therapist was also felt to be valuable and was noted during the first interviews in comparison to the previous pilot which didn't have this resource, however as reported in the first interview, to begin with counselling with the Psychological Therapist was under used, with less clients accessing it than anticipated.

Barriers discussed in the first interviews, which appeared to be resolved at the time of the follow up interviews included uncertainty about what was involved with inpatient detoxification and the need to re-arrange appointments in a more robust manner, with the involvement of all parties. Ongoing barriers that emerged during interviews included the need for Alcohol Treatment workers to have access to Probation's computer system IAPS to ensure all attendance and intervention information is evidenced.

During the first round of interviews it became apparent that Probation Offender Managers were not aware of, or were not utilising, the ATP aspect of the scheme, suggesting that information around this element had not been disseminated as quickly or as effectively as it could have been. However, during the follow up interviews it was reported that this information had been circulated, with all Offender Managers having ATP clients or being

aware of the ATP aspect of the pilot. It should be noted that for most stakeholders interviewed, the ATP and ATR aspects of the pilot were discussed as one.

Although communication was praised during both interviews, as discussed there were also discrepancies with some stakeholders stating they would like more information about interventions delivered by the Alcohol Treatment team. The Lighthouse Project ATR Manager and Alcohol Treatment workers did attend a Probation team meeting early on within the pilot, however not all stakeholders involved within the pilot were in attendance, and others felt it would be beneficial to have done this more often.

Recommendation: It may be possible to increase the knowledge of the work conducted by both teams by ensuring all staff have the opportunity to attend each others team meetings (this opportunity has already been made use of but some individuals may have missed it).

The paper contact sheet completed by Lighthouse Project Alcohol Treatment workers was reported to be both useful and a barrier. This problem was discussed during the first round of interviews, and although noted in the previous interim evaluation report, appeared to still be a barrier at the follow up interviews. Some Probation Offender Managers found it useful to have a detailed sheet of what happened during the treatment session. Others felt that due to the contact sheet being handwritten it was not always easy to read, and therefore important information may be missed. This information was not fully entered on the Probation case management system (IAPS) and it was perceived that this would lead to a lack of documented evidence for work carried out with clients. During follow up interviews it was noted that this lack of documented evidence could also affect the breach process, as without documented attendance information it may not be possible to process a breach.

Recommendation: A discussion is needed around the contact form that Lighthouse Project Alcohol Treatment workers complete. Managers and strategic leads should examine possibilities for improving this process possibly through clerical assistance and access to IAPS.

Aftercare was highlighted as an area for future improvement by the majority of stakeholders. At the end of the six month order Alcohol Treatment workers offered clients a referral to another service or signposted appropriate services, however it was reported that not many clients took this up. It was felt that a structure should be put in place to ensure clients can access support quickly following the completion of their ATR order if they need to do so.

Recommendation: Develop a framework to put in place at the end of the six month order to ensure sufficient aftercare is provided, and to ensure clients continue to have support available to them if needed. Additional funding will need to be secured to fulfil this as further resources will be required.

It was reported that a number of clients had difficulty accessing residential rehabilitation following their inpatient detoxification as they tested positive for substances (the medication used for the detoxification). As a care pathway had not been incorporated into the pilot (as done with the inpatient detoxification) this had not been anticipated and resulted in clients having a break between the two interventions and in some cases relapsing.

Recommendation: Develop a contract with residential rehabilitation to ensure clients can move smoothly from inpatient detoxification into rehabilitation. Incorporate residential rehabilitation into the care package. Again additional funding may be needed in order to make residential rehabilitation an option for the larger numbers of clients that could arise from any wider ranging roll out of the scheme. Additional work and the assistance of the DAAT may be needed to overcome the barrier around access to residential rehabilitation immediately after inpatient detoxification.

At the time of sentencing the Judge sets review dates for the client to come back and discuss their progress, currently Probation Offender Managers are invited to attend if they wish to do so. The Offender Managers provide a report for the review and include an update from the Alcohol Treatment worker. It was felt that it would be beneficial for the Alcohol Treatment worker to have the opportunity to attend reviews.

Recommendation: If the scheme is to be rolled out permanently a more consistent role for the Lighthouse Project Alcohol Treatment workers in client reviews at the CJC should be considered.

A discrepancy in the reporting of the eligibility for the ATR was noted during the first interviews. The AUDIT scale is completed as part of the initial assessment and the score determines whether a client is eligible for the order. Discrepancies were found right across Probation and Lighthouse Project with some reporting that an individual must score 16 or above on the AUDIT scale and others reporting 20.

Recommendation: If the ATR is to be extended, a framework will need to be put in place to ensure all stakeholders follow the same criteria. Eligibility criteria must be clear in order to ensure that inappropriate referrals are avoided thereby maintaining the integrity of the scheme and maximising its positive impacts on clients.

A current theme throughout stakeholder interviews was that the ATR and ATP aspects of the pilot were viewed and discussed as one scheme. Clients followed the same care pathway for treatment interventions and therefore it would be beneficial to combine the steering groups to ensure the management is consistent for both aspects.

Recommendation: Combining the ATR and ATP steering groups should be considered.

Outcome Evaluation

Client Profile

In total 14 ATR clients gave their consent and were able to participate in this evaluation. The majority were male, all were aged between 25 and 48 and all classed themselves as White British.

Responses collected during the initial assessment indicated high levels of alcohol consumption, dependence and associated risks among the ATR clients. Together with reports of withdrawal symptoms and regular morning drinking, this provided substantial evidence of the need for pharmacological detoxification and other interventions aimed at tackling dependency. Therefore despite the inconsistency in criteria used to determine a client's suitability for an ATR (with some staff using an AUDIT score of 16 as a cut-off rather than the recommended 20) the group of clients given an ATR consisted mainly of dependent drinkers which was the intention of the pilot.

The risk assessments carried out showed clients were most at risk of having mental health problems, developing serious physical health issues or re-offending. Two clients were indeed taken into custody before completing their orders.

Treatment sessions

Clients commented that the arrangement of their treatment sessions to coincide with the time and location of their Probation appointments had been convenient for them and this is likely to have contributed to the attendance rate achieved. Meanwhile the Lighthouse Project

Alcohol Treatment workers felt that a central base in which to deliver acupuncture and other alternative therapies, alongside the medical assistance and counselling provided, would be beneficial to the clients and increase the efficiency of the service.

Recommendation: If a central treatment location is to be provided for Lighthouse Project to deliver additional treatments, such as appointments with the Nurse and Psychological Therapist, the Probation offices should still provide a base for the Alcohol Treatment workers to conduct their one-to-one sessions in attempt to increase attendance rates, particularly for those who prove difficult to engage. This would also ensure the opportunities for unscheduled contact between Probation and Lighthouse Project staff continue.

The large discussion element of the one-to-one sessions was clearly key for the clients who were grateful for having someone to listen to them and were full of praise for their Alcohol Treatment workers.

Recommendation: Future alcohol interventions must continue to place strong emphasis on in-depth discussions taking place between the Alcohol Treatment worker and client, as this aspect has been crucial in motivating the clients in this pilot and achieving positive changes in their attitudes and behaviours.

Clients' responses to the Readiness to Change Scales revealed that some did not initially feel ready or confident in their ability to change their drinking behaviour, despite their acknowledgement that such change was important and would greatly improve their life.

Recommendation: Alcohol Treatment workers should continue to focus on motivating clients to change their drinking in the early stages of their treatment, particularly for those who score lower on these scales.

Communication and referrals

Successful referrals were made for a number of clients but unwillingness among several clients to take up referrals, particularly counselling, suggested they had reservations about attending or felt a service simply 'wasn't for them'. The need for an in-house Psychological Therapist was identified during the last pilot and this service was again considered to be appropriate for a number of the clients in this pilot. Informal introductions increasing clients' understanding of counselling and dispelling any misconceptions about the type of sessions offered and what they entail might promote a higher rate of uptake.

Recommendation: Informal introductions to the Psychological Therapist already taking place should continue to provide opportunities for clients to become familiar with him, consider the benefits of counselling and ask questions. This introduction would be even more important if attending counselling sessions became mandatory, as suggested by some stakeholders, to ensure such uncertainties or worries did not lead to clients being breached. Lighthouse Project might also consider seeking the services of a female counsellor for clients who feel uncomfortable discussing personal issues with, or feel they can't relate to, a male counsellor.

According to risk assessments conducted by Lighthouse Project the wellbeing of clients' children was considered a risk in three cases.

Recommendation: It is essential that strong communication exists between Lighthouse Project, Probation, Social Services and other relevant agencies to prevent clients' children from coming to any harm as a result of their parents' drinking and lifestyle. These communication and referral pathways should be examined to ensure they are clearly defined and that all team members have knowledge of them.

Although the Alcohol Treatment workers and Probation Offender Managers felt that their role boundaries to have been clearly defined, the clients reported that there was considerable cross-over as Alcohol Treatment workers assisted them with matters such as education, employment/skills and legal issues which according to clients' sentence plans come under the role of Probation.

Recommendation: Such flexibility at this stage is not necessarily a negative so long as the joint working is good. However if client numbers increase and time pressures potentially become greater, communication may reduce, leading to a problem of duplication of effort or contradictory messages being passed over. This was an issue during the first pilot of the ATR.

Relationships

Clients were usually seen fortnightly by their Alcohol Treatment workers for a one-to-one treatment session which followed clients' appointments with their Probation Offender Managers. The commitment and consistent support provided by the Alcohol Treatment workers during and outside of the one-to-one sessions came across strongly as the fundamental factor in clients' contentment with the service they received. Alcohol Treatment workers were praised for being dependable and available at all times.

While some clients received consistent support from their Probation Offender Manager with whom they spent time discussing offending and related matters, others felt they had no relationship with their Probation Offender Manager after seeing different members of staff and their appointments consisting of little more than signing an attendance sheet. It also doesn't seem that all clients saw their Probation Offender Manager every week for the first 16 weeks as stipulated by the National Standard. This is despite all members of Probation staff being assigned cases for this pilot, rather than a selected few, with the aim of preventing this problem of discontinuity.

Recommendation: In the interests of building positive and productive relationships between clients and their Probation Offender Managers it is recommended that in future the Probation Service strives to ensure clients have regular contact with the same officer. Where staff changes are unavoidable, clients would benefit from spending sufficient time with their new officer each time they attend so that rapport can be quickly re-established and the clients' needs can be fully addressed.

Outcomes

Measures of alcohol use including the AUDIT, LDQ, Drink Diary, Behavioural Questions and TOP forms together show clear improvements in clients' drinking behaviour. After just three months in treatment clients were less alcohol dependent, were consuming fewer units, were not drinking mid-week and in the mornings as frequently and were experiencing fewer negative consequences of drinking. Therefore there is substantial evidence that the pilot has achieved its objective of giving individuals insight into their alcohol intake and has resulted in positive changes to their drinking behaviour, thereby minimising the risks of potential harm to them. The most notable improvements in alcohol related attitudes and behaviours had occurred during the first half of clients' treatment period and for the majority of those who remained engaged these changes were maintained through to the end of their order.

Clients' readiness to change at assessment may be associated with better outcomes. Specifically, higher levels of readiness to change (usually relating to how important clients perceived change to be) were associated with greater reductions in AUDIT, AUDIT-C and LDQ scores. However there was no consistency across readiness to change scales or outcome measures. Findings here may not be indicative of the relationship between readiness to change and treatment success among the wider client group due to the sample size being small and the scale not being validated.

Reports of other substance misuse suggested the drug advice provided by the Alcohol Treatment workers led to a reduction in the overall numbers using crack and/or opiates, however those who continued to use these drugs became more frequent users.

Recommendation: The drug advice was clearly necessary for a substantial minority of alcohol treatment clients therefore any future alcohol intervention should continue to offer such information alongside the alcohol-specific support.

Data showed the order was not effective in preventing the offending of four of the ATR clients who were re-convicted at some point during their six-month order, two of whom were given a custodial sentence (one for four months and the other for one year).

Recommendation: Clients' re-offending patterns should be examined over a longer period of time in order to get an accurate impression of the impact of the ATR on offending behaviour, especially as these are not prolific offenders according to their criminal histories as recorded on PNC. This could not be done within the time allowed for delivery of this report.

When asked about the effectiveness of their ATR and any recent significant changes in their lives, the majority of clients gave examples of positive outcomes that related more to physical and mental health following a reduction in their drinking rather than to their offending behaviour or impacts on others. This suggested that a clear association between their alcohol problems and offending was not made, despite the onset of the order being at the point of sentencing and there being an immediate assessment and referral into treatment. It would seem therefore that while the ATR has been successful in providing a route into treatment for people who have an alcohol need linked to their offending, its impact on the risk of repeat offending remains to be seen. Conclusions around the success of the scheme so far would have to be limited to its health benefits rather than criminal justice benefits. Whilst there may benefits in terms of client offending the information gathered for this study is not sufficient to confirm these.

GHQ and TOP data provided evidence that psychological wellbeing had increased for this group of clients throughout the duration of their orders, a finding supported by the confidence and optimism shown by clients who were determined to make changes and complete their orders. Meanwhile self-report measures of physical health and quality of life increased but not significantly. All three TOP measures of health and social functioning were highest at the

time of clients' three-month reviews, perhaps signifying a stage at which many clients had come to realise the extent of their problems and were taking action to address them.

Recommendation: The scheme needs to continue to work with clients to promote their health to levels that clients feel are good, rather than acceptable, and to equip them with the tools to sustain a desirable level of wellbeing once they are no longer engaged on the order.

While outcomes for the ATR clients who completed their orders appear positive in terms of their drinking behaviour, health and perceived quality of life, such outcomes may have been less positive for the more chaotic clients who could not be followed-up by interview, including those who breached their ATR or were re-convicted.

Attendance

Despite clients being identified well and the scheme targeting the right individuals not all complied with their order. Further, almost all clients had missed appointments with their Alcohol Treatment worker and/or Probation Offender Managers even though they knew this could potentially result in them breaching their order and going to prison.

Recommendation: The breach process needs to be flexible to a point to take into account clients' individual circumstances but inconsistencies in the application of the breach procedure by Probation Offender Managers could cause problems, especially if the scheme is expanded. Clients should therefore be reminded of what constitutes an unacceptable absence and the breach procedure should be followed where appropriate – a response to compliance that according to stakeholders is motivating for the offender.

Aftercare

While clients felt optimistic about their future and confident that they could continue to tackle their problems with alcohol, there was no formal procedure for onward referrals following treatment to ensure clients had further support readily available to them if they required it in future, particularly for those whose supervision element did not exceed the six-month ATR contact. Interviews with stakeholders revealed they felt it necessary to develop a framework to ensure sufficient aftercare is provided to those completing their order and who require continued support.

Recommendation: Exit strategies from the scheme need to be put in place to ensure the positive impacts that can be seen among the clients are lasting, as currently ATR clients

inevitably form a group at risk of relapse. This might involve the creation of a support group solely for this purpose.

Conclusion

This second attempt at piloting the ATR in Liverpool has proved to be more successful than the first. Processes and working relationships have embedded well aside from some minor concerns. Communication across the scheme is excellent and this has no doubt assisted in its smooth delivery. The short time period for the pilot limited numbers and therefore makes conclusions around the potential success of the scheme on a wider scale difficult to draw. However, for the clients involved in the evaluation there were significant improvements in a number of areas, most notably alcohol consumption. The improvements are no doubt in a large part attributable to clients' positive relationships with alcohol treatment workers and in many cases, their Probation Offender Managers. Assessment of re-conviction over a substantially larger period than attempted here would be necessary in order to form any concrete conclusions on the schemes effectiveness in tackling offending.

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