

# Preston Nightsafe Conditional Caution Alcohol Awareness Pilot Project

Outcome Evaluation Final Report  
September 2008



Central Lancashire   
Primary Care Trust



**Lancashire  
Constabulary**  
police and communities together

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# Preston Nightsafe Conditional Caution Pilot Project: Outcome Evaluation Report

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## 1.0 Introduction

### 1.1 Health and Crime

Excessive alcohol consumption and its impact on health and society are areas of increasing concern. In 2002 the World Health Organisation identified alcohol as the third highest risk to health in developed countries and established a direct link between alcohol and 5.2% of the chronic disease burden in the UK (WHO, 2005). Figures recently released by the Office of National Statistics demonstrate that the number of alcohol related deaths in the UK has more than doubled from 4,144 in 1991 to 8,396 in 2005 (ONS, 2006a). However, the charity Alcohol Concern has argued that this number does not fully capture the scale of the problems associated with alcohol consumption in the UK. Its recent report 'Wasted: Lives Lost to Alcohol', investigates the wider ramifications of alcohol misuse to reveal that 22,000 people die each year from alcohol-related causes. This number included deaths due to cirrhosis of the liver, cancer, cerebro-vascular diseases, as well as accidents, suicide and violent crime (Alcohol Concern, 2006).

The social impact of alcohol-related crime has also become an increasing cause for public concern. Crimes associated with alcohol are wide-ranging, including driving offences, assault, criminal damage offences, drunk and disorderly and other public order offences. A survey of arrestees between October 2003 and September 2004 in England and Wales found 57% of arrestees to be harmful or dependent drinkers (Boreham et al, 2006). The most recent release of the British Crime Survey disclosed that alcohol related violence had remained high since 1995, with the 2006/7 survey finding that in nearly half (46%) of all violence related incidents, victims believed the offender to be under the influence of alcohol. This figure rose to 58% in cases of 'stranger violence' (Nicholas et al, 2007).

Much alcohol-related crime is connected with the night-time economy, particularly in and around clubs and bars in town and city centres (Institute of Alcohol Studies, 2006, Finney, 2004). A high level of binge drinking has been identified as a contributory factor to alcohol-related crime. A survey in 2003 found that binge drinkers were more likely to offend than other regular drinkers, with almost a fifth (19%) of adult binge drinkers (aged 18 to 65 years) admitting they had committed an offence in the past twelve months, compared to 6% of other regular drinkers. Binge drinkers were found to account for a disproportionate volume of crime. Whilst they made up only 16% of the total sample, they were responsible for 55% of the total crimes reported by adults in the past twelve months. Binge drinking was found to be particularly prevalent amongst younger age groups, with 44% of 18 to 24 year olds qualifying as binge drinkers. Over a quarter of these (27%) admitted to committing an offence in the past year compared to only 13% of regular drinkers. Young, male binge drinkers were most likely to be involved in violent crime and were over twice as likely to be involved in a violent incident in the past twelve months compared to other male drinkers (16% compared to 7%) (Matthews and Richardson, 2005). Moreover, a study of young adults' drinking patterns and offending behaviour found that binge drinkers in the 18 to 24 year old age group were five times more likely to admit being in a fight than regular drinkers

(15% compared to 3%) (Richardson and Budd, 2003). Research has also shown that young males presenting to Accident and Emergency with facial injuries sustained through falls or assault are often heavy binge drinkers, manifesting the early signs of chronic alcohol misuse (Smith et al, 2003).

The Strategy Unit Alcohol Harm Reduction Project calculated that annual costs for alcohol-related harm in England could amount to £20 billion. Of this, harms to health accounted for £1.7bn, harms to society and family accounted for £4.6bn and loss of productivity and profitability in the workplace accounted for £6.4bn, whilst alcohol-related crime incurred the largest cost of £7.3bn. To address and reduce these costs, the Government's Alcohol Harm Reduction Strategy aims to improve education and communication about alcohol, improve the identification and treatment of alcohol problems, encourage relevant industries to promote responsible drinking and help tackle levels of crime, public disorder and anti-social behaviour associated with alcohol. Particular areas of concern around alcohol-related crime are the public disorder and anti-social behaviour in town and city centres as a result of the night-time economy and underage drinking. Less visible areas of concern to be addressed include driving offences, domestic violence and alcohol-related crime caused by repeat offenders. The need for a range of interventions to deal with heterogeneous groups of alcohol-related offenders has been recognised. Treatment can be provided for dependent, pre-dependent, binge or non-serious drinkers, including brief interventions, counselling and referral to self-help groups or alcohol treatment agencies. Proposed rehabilitative measures could be incorporated into Community Orders and through the introduction of Conditional Cautions (Cabinet Office, 2004).

## 1.2 Conditional Cautioning

Conditional Cautioning was introduced as part of the Criminal Justice Act 2003, where a Conditional Caution was defined as 'a caution which is given in respect of an offence committed by the offender and which has conditions attached to it' (Home Office, 2004). It represents a statutory development of the non-statutory 'simple caution' used previously by Police and the CPS. Conditional Cautioning provides offenders with an alternative disposal without channelling them through the usual court processes. Conditional Cautions are applicable where the offender is over 18, where an admission of the offence has been given and where there is sufficient evidence to prosecute. Offenders must be notified at the time the Conditional Caution is issued that should they fail to comply with the conditions imposed, they will be prosecuted for the original offence. Sufficient evidence for charge is therefore needed to ensure that should the Conditional Caution be breached without valid reason, the caution can be cancelled and the offender then prosecuted through the courts. The offender signs an official document (MG14) providing the details of their offence, their admission, their consent to being issued with a Conditional Caution, their agreement to comply with the conditions imposed and their acknowledgement of the consequences should they breach these conditions (Home Office, 2004).

Conditional Cautions may be used as an alternative to charge when the Crown Prosecutor considers that, though the public interest justifies prosecution, the offender and victim would be better served through the offender's compliance with restorative justice conditions. These conditions must be proportionate and relevant to the offence and achievable within a realistic time period. Conditions attached to a caution should have reparative, rehabilitative or restrictive aims (Home Office, 2004, Director of Public Prosecutions, 2006).

- Reparative conditions might involve paying compensation to the victim or community, repairing any damage to property or replacing stolen goods, and will often accompany a letter of apology to the victim (Home Office, 2004).
- Rehabilitative conditions might include participating in drug or alcohol treatment through attendance at awareness sessions, including perhaps some form of assessment and appropriate referral to further services (Home Office, 2004).
- Restrictive conditions might include prohibiting the offender from entering a certain area or premises. Less commonly used, restrictive conditions are intended to reinforce other reparative or rehabilitative elements (Director of Public Prosecutions, 2006), where appropriate.

To address alcohol-related harms, reduce future re-offending and reduce health and criminal justice costs incurred by alcohol-misuse there have been strong recommendations for the wider availability and delivery of alcohol brief interventions (Alcohol Concern, 2006). The Conditional Caution presents the possibility of integrating a brief-intervention session as part of the rehabilitative condition in order to address problematic alcohol consumption and its related health, social and criminal consequences.

### 1.3 Alcohol Brief Interventions

A brief intervention is not clearly defined in form or structure and may range from a single five-minute information and advice meeting to two or three sessions of motivational interviewing or counselling. It is designed as an early intervention for those drinking excessively but not for dependent drinkers. Brief interventions commonly include information about the adverse effects of alcohol, how the recipient's levels of consumption compare to national averages and recommended levels, in addition to information and encouragement on reducing consumption. Despite the accepted benefits of brief intervention sessions, research has raised the need to distinguish between different types of brief intervention in order to properly appraise effectiveness and long-term impact. This might include the distinction between very brief interventions of five to ten minutes' advice as opposed to brief interventions involving behavioural therapy, self-help manuals and follow-up visits (Anderson, 1994).

Studies in Britain, the United States and Australia have demonstrated the beneficial impact of the brief intervention session on reducing excessive alcohol consumption amongst both sexes, particularly in primary care settings (Heather and Wallace, 2003, Alcohol Concern, 2001, Wutzke et al, 2002, Moyer and Finney, 2004). Research has also shown brief interventions to be effective in reducing mortality amongst problem drinker populations by between 23% and 36%, providing further evidence of their psychosocial benefit and for their routine application in medical settings (Cuijpers et al, 2004). The value of brief interventions as a low cost and early intervention for non-dependent drinkers has been recognised (Department of Health, 2005).

A meta-analysis examining randomised control trials, involving short motivational and counselling sessions ranging from ten to 60 minutes, found that heavy alcohol drinkers were twice as likely to moderate their alcohol consumption as a result of the brief intervention for up to twelve months (Wilk et al, 1997). However, the long-term effectiveness of brief interventions has been questioned since they were found to be insufficient to sustain reduced alcohol consumption at ten-year follow-up (Wutzke et al, 2002). Research has demonstrated success with some forms of brief intervention for alcohol in a primary care setting (Wallace et al, 1988, Poikolainen, 1999, Ballesteros et al, 2004). However, there is a need for research into the wider applicability and effectiveness of the brief intervention session in non-medical settings, including its use within social care, the workplace and the criminal justice system (Heather and Wallace, 2003). Preston's alcohol Conditional Caution scheme is one example of how the intervention session can be incorporated into the criminal justice system.

#### 1.4 Preston Alcohol Conditional Cautioning Pilot Project

Since the early twentieth-century Preston has been an important administrative centre for Lancashire. The docks, rail network and road links have made the city an important hub for marketing and distribution. Industrial closures of Courtaulds and British Leyland brought job losses in the 1980s but the Riversway redevelopment of the dockland in the 1990s has contributed to the area's economic regeneration (Preston City Council, 2006). Preston's total population is estimated at 131,300 (ONS, 2006b). Approximately 6.5% of this population are unemployed, a higher level than the North West and UK averages of 5.2% and 5.4% respectively (Nomis, 2008). Crime rates in Preston are also higher than the national average. Between January and March 2006, there were 38.6 offences per 1000 of the population in Preston compared to 24.9 offences per 1000 in England and Wales (Home Office, 2006). Crime statistics indicate that over this period, levels of criminal damage in Preston were over twice the national average (11.0 per 1000 compared to 5.5 per 1000). Levels of violence against the person in Preston also exceed the national average (6.6 per 1000 compared to 4.5 per 1000) (Home Office, 2006).

Alcohol misuse has been identified as a prominent cause of health inequalities, crime and social disorder in Preston. Between 2001 and 2003, Preston was reported to have the fifth highest male death-rate from alcohol in England and Wales of 29.5 per thousand of the

population, compared to the national average of 15.9 per thousand (ONS, 2005). The rate of alcohol-related deaths is estimated to be increasing faster in the North West than in other parts of England and Wales (from 12.8 per 1000 in 1995 to 19.2 per 1000 in 2002). In Preston, 42% of men and 27% of women drink more than the recommended daily limit, whilst 24% of men and 11% of women drink more than double their recommended daily limit (Hughes et al, 2004). In 2000-2002, over a fifth (21.9%) of people over 16 within the Preston Local Authority area were categorized as binge drinkers. This rate was higher than the English average, which stood at 18.1%, though lower than the average for the North West (25.1%) (Morleo et al, 2006).

These high levels of binge-drinking are coincident with high levels of alcohol-related crime. In 2005/6, 1,799 incidents of recorded crime in Preston were attributed to alcohol. These included crimes such as robbery, burglary, theft of a motor vehicle and theft from a motor vehicle, as well as sexual offences. However, violence against the person accounted for the largest proportion of alcohol-related crimes in Preston, comprising 1,373 (76%) of the total alcohol related crimes. In 2004/5, Preston had the fourth highest rate of violent crime related to alcohol in the North West (11.76 per 1000 of the population). Between 2002 and 2003 Preston had the highest increase in more serious violent alcohol related crime in the North West (0.16 per 1000 of the population) (Morleo et al, 2006).

To combat alcohol misuse and its associated crimes, the Preston Alcohol Harm Reduction and Prevention Strategy Action Plan has been developed by the agencies represented at Preston Crime and Disorder Reduction Partnership (CDRP) Alcohol Subgroup. This operates through a network of stakeholders from the criminal justice system, drug and alcohol treatment services, emergency services, health services, local industry and charities. The strategy is directed towards the four aims specified in the Cabinet Office Alcohol Harm Reduction Strategy mentioned above. As part of the objective to improve health and treatment services, the Preston Alcohol Harm Reduction Strategy seeks to evaluate the effectiveness and cost-effectiveness of alcohol brief interventions in criminal justice settings and has set up the Nightsafe Conditional Caution Alcohol Awareness Scheme (Preston Community Safety Partnership, 2006).

The Conditional Cautioning scheme utilises a rehabilitative condition that seeks to divert alcohol-related offenders from 'more serious alcohol related crime' including, amongst others, murder, attempted murder, manslaughter, infanticide and death caused by dangerous driving (Strategy Unit, 2003; cited in Hughes et al, 2004). The scheme operates as a partnership between Central Lancashire PCT, Lancashire Constabulary, Criminal Justice Support (CJS), Alcohol and Drug Services (ADS) and the Crown Prosecution Service (CPS) in Preston. Conditional Cautioning as a whole started in Preston in August 2005 and Alcohol Conditional Cautioning began in September 2005 (Department of Health, 2005). To date the scheme has been self-funded through the payment of a £30 fee by offenders attending the alcohol brief intervention session.

The alcohol rehabilitation element has been organised and facilitated by Preston ADS through monthly alcohol awareness sessions. They currently take place at ADS' Fox Street site and are scheduled to last two hours. During this time, the administrative process of registration and fee payment is carried out in addition to the delivery of the alcohol awareness package. The brief intervention is delivered through a Microsoft Power Point presentation giving statistical and descriptive information about the social and physiological consequences of excessive alcohol consumption, as well as providing advice on unit intake. Offenders are invited to participate in a quiz, which facilitates education and discussion about alcohol consumption and the associated risks. At the end of the session, offenders are offered the opportunity to give feedback about the session and are directed to further services provided by Preston ADS. They are also provided with alcohol unit calculators, self-help literature on alcohol and drugs, in addition to service contact details for use at a later date. Failure to attend the session without a valid reason constitutes a breach of the Conditional Caution and without extenuating circumstances leads to prosecution for the original offence.

### 1.5 Evaluation Aims

The Centre for Public Health at Liverpool John Moores University has been commissioned to conduct an evaluation of Preston's Nightsafe Conditional Caution Alcohol Awareness Pilot Project. Preston is one of a small number of chosen pilot areas around the country where alcohol Conditional Cautioning has been implemented and, at least temporarily, made part of standard practice. Preston has been running this alcohol Conditional Caution scheme since September 2005 and this evaluation has been commissioned to provide evidence on the scheme's progress and potential for future development and sustainability.

The study is comprised of a process evaluation and an outcome evaluation. The process evaluation findings were reported in an interim report, where data were collected from interviews with key-stakeholders at the outset of the evaluation, a progress report and a final report, incorporating a second round of key stakeholder interviews which took place in February and March 2008. The outcome evaluation aims to analyse empirical data in order to evaluate the effectiveness of the alcohol brief intervention and therefore the Alcohol Conditional Caution as a whole, primarily in terms of client rehabilitation and re-offending rates. Data were collected through questionnaires completed with offenders, before the session, immediately after the session and at three month follow-up.

The key aim of the outcome evaluation is to analyse the effectiveness of the alcohol brief intervention and Conditional Caution as a whole in eliciting positive behavioural changes among individuals both in terms of alcohol use and its associated health, social and criminal justice consequences.

## 2.0 Methodology

### 2.1 Outcome Evaluation Methodology

The outcome evaluation was conducted in three stages.

Stage one - All clients put forward for the intervention, and who agreed to participate, were sent a questionnaire by post in addition to the standard contact letter sent out by ADS. Clients were expected to self-complete this questionnaire and return it by post in a pre-paid envelope or bring it with them to the alcohol awareness session. Any clients not returning the questionnaire by post or bringing it with them to the session were given the questionnaire to complete whilst they were waiting for the alcohol awareness session to begin. The questionnaire examined topics such as the clients' alcohol consumption profile, their perception of their drinking and its consequences, health and well being, offending and its relationship to their drinking and their pre-conceptions and motivation regarding the brief intervention. Participant contact details were collected by the researcher present prior to the alcohol awareness session. To encourage responses from participants, including those who did not eventually attend the session, and to recompense participants for their time, an incentive in the form of a £5 high street shopping voucher was given at this stage. This voucher was posted out to participants following receipt of their questionnaire either by post or at the alcohol awareness session.

Stage two - Immediately after clients had attended the brief intervention, a session feedback form was subsequently administered to ascertain individuals' immediate perceptions of the intervention, such as the usefulness of information given and the usefulness of other aspects of the session. The questionnaire was appended onto the course evaluation questions administered by ADS at the end of the session. This feedback mechanism has the potential to create a further tool that ADS could utilise for future self-evaluation. No incentive was given for participation at this stage to avoid rewarding the rehabilitative condition.

Stage three – Clients were asked to complete a follow-up questionnaire three months after participating in the brief intervention session, which addressed the same topics as those examined in the initial questionnaire at Stage one. In addition, individuals' revised perceptions of the intervention and its impact were also recorded at this stage. Initially it was proposed that face-to-face interviews would be conducted at a neutral PCT or community venue at follow-up stage but owing to the geographical diversity and nature of the sample group postal questionnaires were utilised in order to maximise participant numbers at follow-up. In order to encourage participation at follow-up stage and in an attempt to secure a sufficiently robust sample size, a further incentive of a £10 gift voucher was sent to participants on receipt of the follow-up questionnaire.

To supplement data obtained through participant questionnaires, information was also collected via observational grids, completed during six of the brief intervention sessions between 18<sup>th</sup> September 2007 and 15<sup>th</sup> January 2008. These sought to evaluate the content

and method of delivery of the alcohol awareness training, with a view to determining clients' responses to it and providing insight into issues of attendance, capacity and optimum group size.

## 2.2 Sample Targets & Final Numbers

At the outset of the evaluation the police performance indicator set the target for recruited clients at 20 per month. It was estimated that attendance at the alcohol awareness sessions would average around 50%, meaning that the study expected to recruit around 10 individuals per month. Initially the time interval between arrest and attendance at the session had the potential to take up to three-months, depending on whether the client attended at the first, second or third opportunity, if at all. The process was, however, modified so clients were allocated just one opportunity to attend a session within a month of being arrested and failure to attend would immediately result in a breach of conditions. The proposed time-period for recruitment of a sample of approximately 40 clients was estimated at seven months, however, owing to the relatively small sample size, the study period was extended by two months, making February 2008 the final month for recruitment for the study. While attendance at the alcohol awareness session was accurately estimated to be about 50%, the total recruitment estimate, targeted by the police as 20 individuals per month, appears to have been an over estimation. While these numbers were successfully generated in the early stages of the scheme, it appeared they could not be maintained for the duration of the study period, with numbers gradually depleting with the continuation of the scheme. In the last month for recruitment, February 2008, only one client was recruited onto the scheme and this client failed to participate in the evaluation. The reasons for and implications of these low numbers are discussed in more depth in the Process Evaluation Final Report. The final sample group was comprised of 23 individuals, all of whom completed the initial questionnaire, 21 of whom completed the session feedback form and 15 of whom completed the follow-up questionnaire.

## 2.3 Analysis

In most analyses, comparisons were within subjects and depended on individuals answering the relevant sections in both the initial and follow-up questionnaires and in some cases the session feedback forms. Despite 15 individuals participating in each stage of the research, clients did not always successfully complete the relevant sections of each questionnaire. Therefore, despite 15 of 23 clients completing all three questionnaires, subject comparisons were typically less than 15. Data from the initial questionnaires, the session feedback forms and the follow-up questionnaires were collated and analysed in the statistical programme SPSS (SPSS Ltd, 1999).

Alcohol related knowledge, including recommended daily limits, alcohol processing time and alcohol by volume (ABV) for various drinks, was quantitatively compared at all three stages. In addition, qualitative questions regarding the negative health impacts of alcohol were also examined. Alcohol consumption was quantitatively compared both initially and at follow-up

stage and was derived from the Alcohol Use Disorders Identification Test (AUDIT) as created by the World Health Organisation (1992), an edited version of which was validated by Piccinelli et al (1997). This AUDIT related to the three months prior to the initial and follow-up questionnaire. A drinking diary section was also used to calculate the total number of units consumed in the last seven days for each client and to identify clients' drink preferences. The questions from the AUDIT were used to examine the number of occasions on which clients drink, the quantity of alcohol consumed on a given occasion and the frequency of occasions that men consumed more than eight drinks and women more than six. General client well being was examined using the standardised General Health Questionnaire (GHQ) , created by Goldberg in 1978, with a shortened version validated by Goldberg et al in 1997. The GHQ examines aspects of self-perceived mental and physical well being. Alcohol related behaviour was analysed using a combination of quantitatively recorded frequencies of behaviours associated with drinking alcohol. Drinking and offending patterns were also recorded in the three months prior and post the brief intervention, including details of the frequencies of arrests and nature of offending. The session feedback forms also provided information regarding the usefulness of different aspects of the brief intervention session.

Statistical analyses were performed on all data where appropriate to determine significance among results. For not normally distributed, within subject, before and after trial linear data, the Wilcoxon Signed Rank Test. For ordinal within subject data, before and after a trial, the McNemar Change Test was used. For normally distributed, within subject, before and after trial data, the Paired or Matched Samples T-Test was used. To determine the strength of not normally distributed correlations, the Spearman-Rank Correlation Test was used. To determine the strength of derived models, such as the linear relationship between the amount of client drinking (AUDIT) and client well being (GHQ), Backwards Stepwise Linear Regression and ANOVA Tests were used.

#### 2.4 Ethics

This research was reviewed and passed as ethical in its design and proposed implementation by Liverpool John Moores University Ethics Committee. Participants were assured of confidentiality and advised of their right to withdraw at any time.

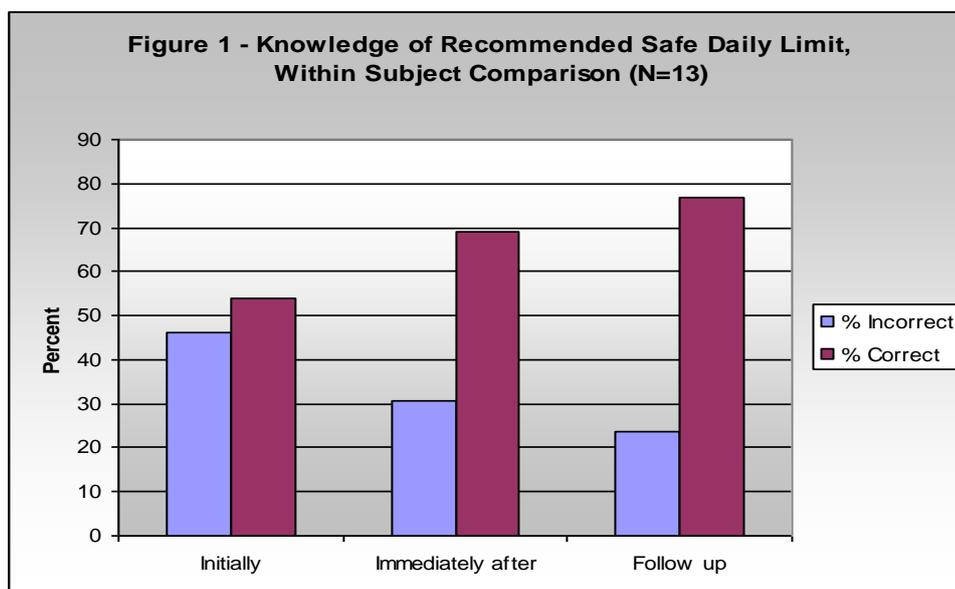
## 3.0 Results

### 3.1 Participant Profile

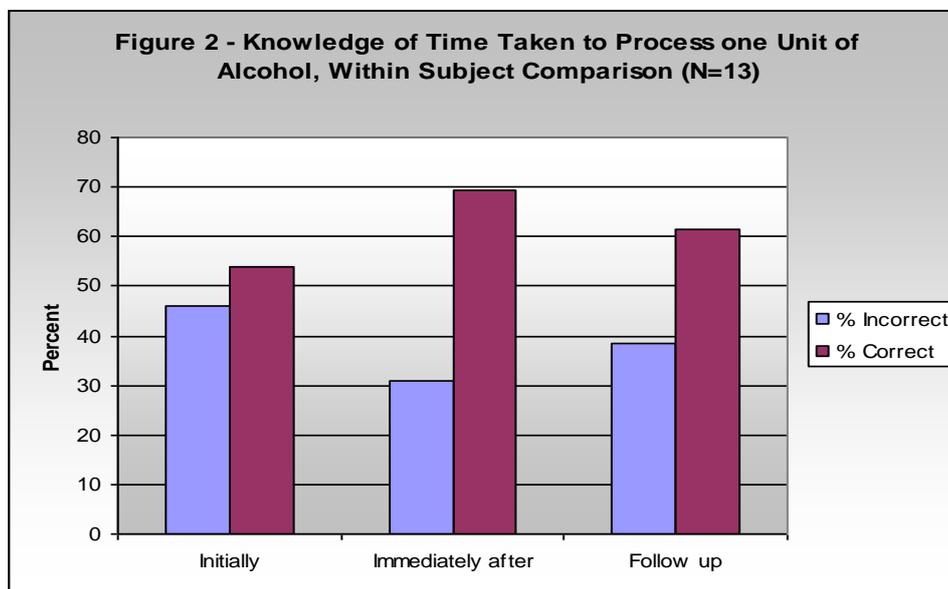
There were 21 males and two females in this sample group. The mean age of participants was 32.5 and the age range across participants was 19-69. Of the participants, 19 were White British, one was White Irish and two were White European. In occupational terms, 10 participants were working full time, nine participants were unemployed, one of which was receiving incapacity benefit, one participant was a student and working part time and one participant was a single parent and was not working. In terms of seeking alcohol related help, four participants claimed to have accessed an alcohol intervention previously, two of whom had received counselling, one had sought advice and one did not specify the type of intervention sought or accessed. Finally, five participants expressed that they thought they needed help or an alcohol intervention, one of whom expressed a need for alcohol related knowledge, one of whom expressed a need for one to one counselling and one of whom expressed that they had failed in cutting down the amount they drank.

### 3.2 Alcohol Related Knowledge

Figures 1 to 6 describe clients' knowledge relating to alcohol, namely the recommended safe daily limits, alcohol processing time and the alcoholic units contained in various alcoholic drinks. As demonstrated in Figures 1 and 2, knowledge, relating to the recommended safe daily limit and alcohol processing time, improved from the pre-session initial questionnaire to the post session and follow-up questionnaire. In both cases the percentage of individuals who were correct in their estimates of recommended limits and alcohol processing times improved from just fewer than 50% before the session to just fewer than 70% immediately after the session. The McNemar change test showed the change between the percentage of correct and incorrect scores for knowledge of recommended safe daily limits between 'initially' and 'follow-up' stages not to be significant ( $p > 0.05$ ).



However, in Figure 2 there is a decrease in the percentage of correct scores between immediately after the session and at follow-up stage, while in Figure 1 an increase is observed between the same periods. The McNemar change test showed the change between the percentage of correct and incorrect scores for knowledge of alcohol processing times between 'initially' and 'follow-up' stages not to be significant ( $p > 0.05$ ).



Figures 3 to 5 demonstrate clients' estimates of the units contained in one pint of premium lager, one small glass of wine and one shot of a standard spirit, such as vodka. It appears in all cases that the majority of clients before and immediately after the session estimated units incorrectly, although estimates appear to improve from immediately after the session to the follow-up stage. Figure 3 demonstrates estimates for premium lager and shows a slight improvement in client estimates from before the session to immediately after the session, followed by a more substantial improvement from immediately after to follow-up stage. The McNemar change test showed the change between the percentages of correct and incorrect estimates of unitary values between 'initially' and 'follow-up' stages not to be significant ( $p > 0.05$ )

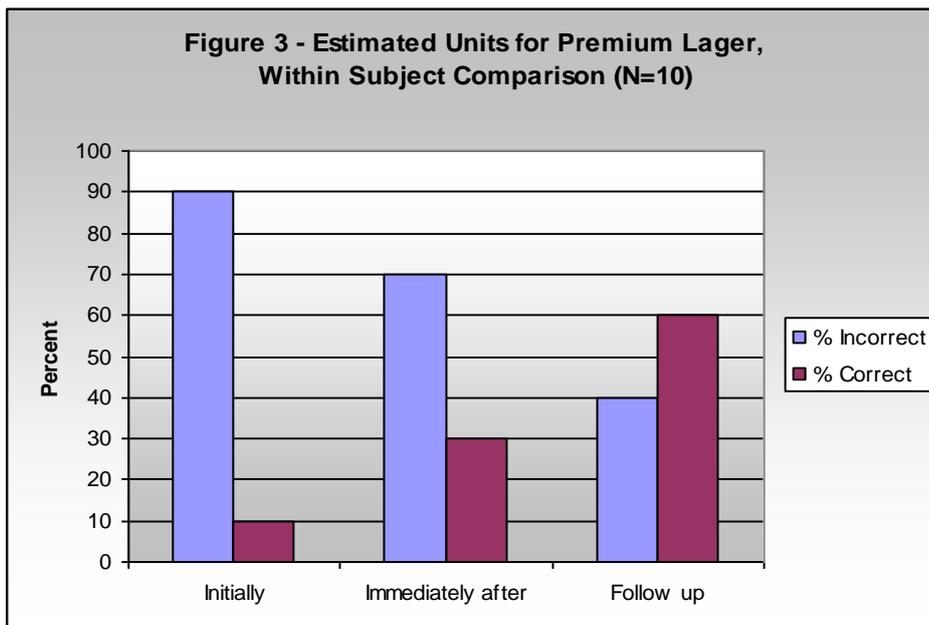


Figure 4 demonstrates estimates for wine and shows that 90% of participants were incorrect with their unitary estimates of wine both before the session and immediately after the session. An improvement is observed at follow-up stage but 60% of participants remained incorrect in their unitary estimates of one small glass of wine. The McNemar change test showed the change between the percentages of correct and incorrect scores between 'initially' and 'follow-up' stages not to be significant ( $p > 0.05$ ).

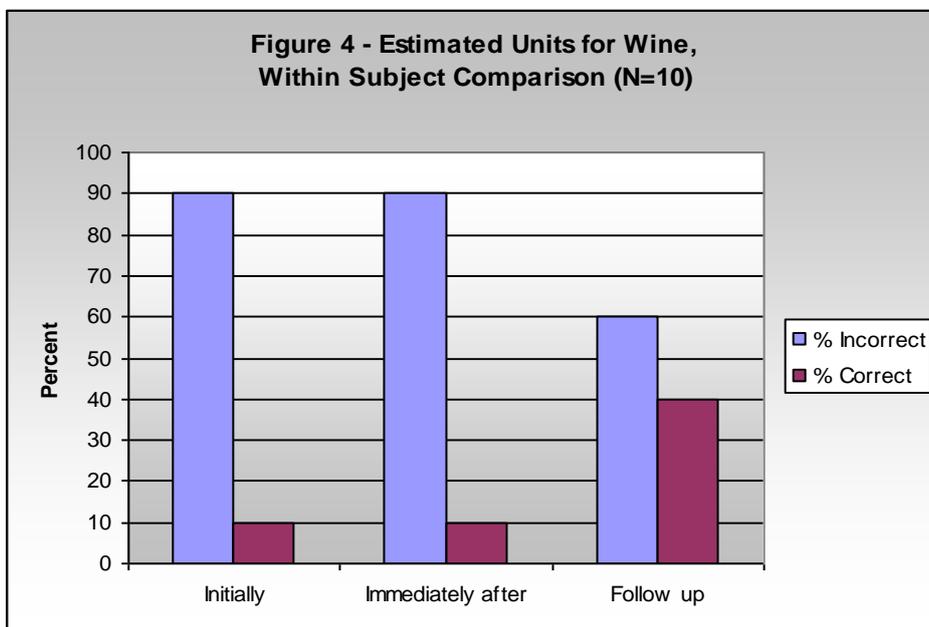


Figure 5 demonstrates more consistent estimates for standard spirit measures and shows a slight improvement in estimates between initially and immediately after the session, which subsequently decreased again by follow-up stage. The majority of clients at all stages incorrectly estimated units for standard spirit measures. The McNemar change test showed the change between the percentages of correct and incorrect scores between 'initially' and 'follow-up' stages not to be significant ( $p > 0.05$ ).

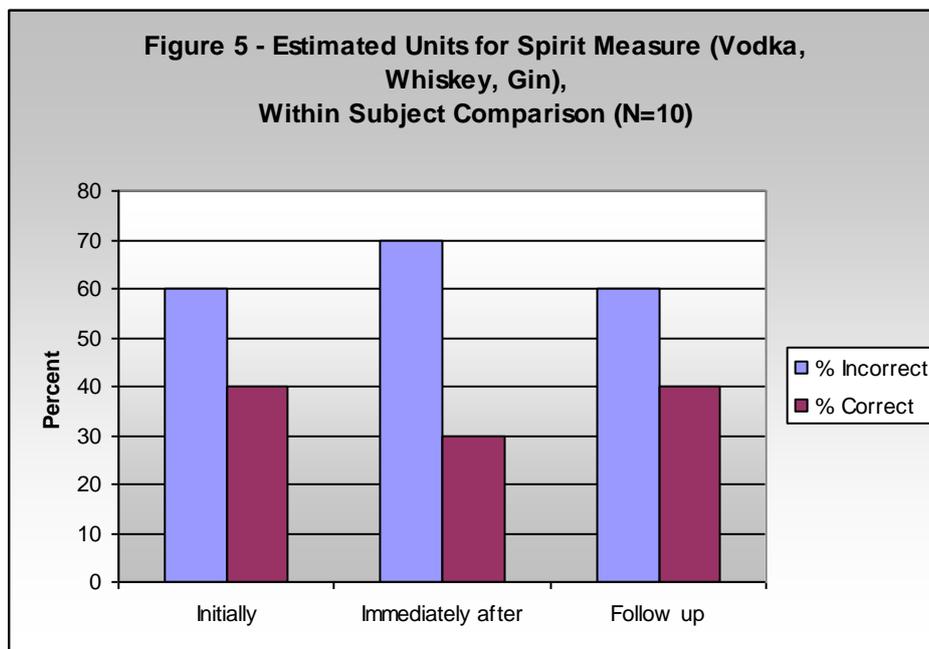


Figure 6 demonstrates a summary of these findings with the actual unitary values for each drink type also indicated. As demonstrated client estimates improved after the initial questionnaire in all cases except with estimates of spirit measures, in this case vodka. The group mean estimates are an indicator of the direction of participant misconceptions surrounding the unitary values of standard drinks, with the least accurate estimates being for standard spirit measures, which typically were substantially over-estimated by the client group.

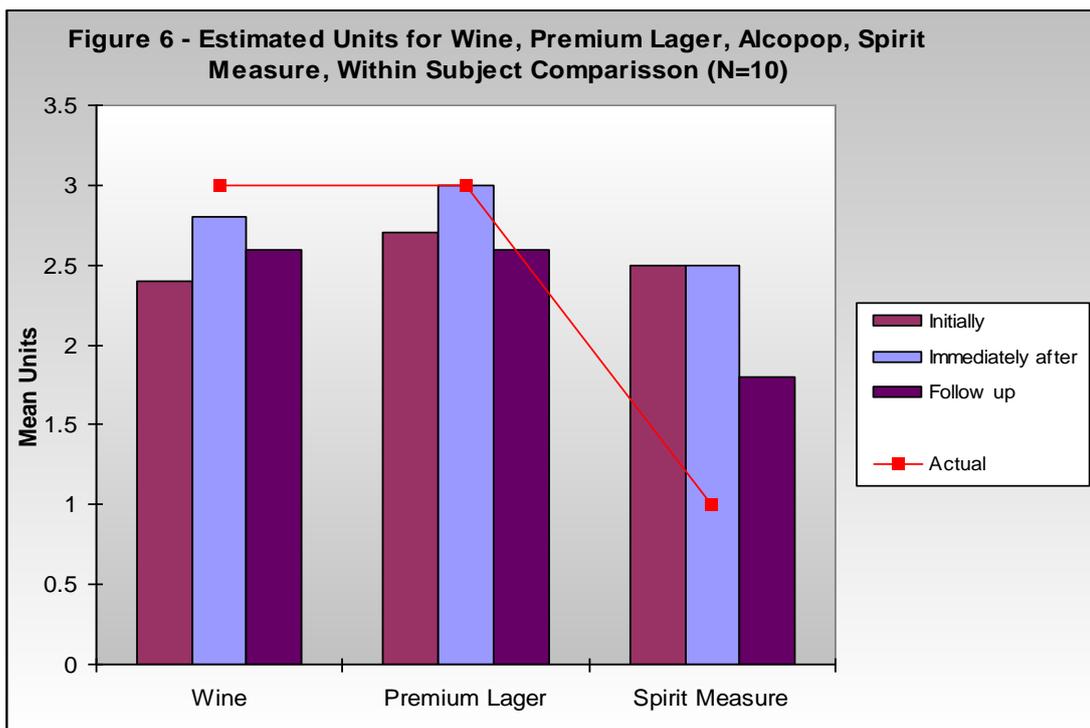
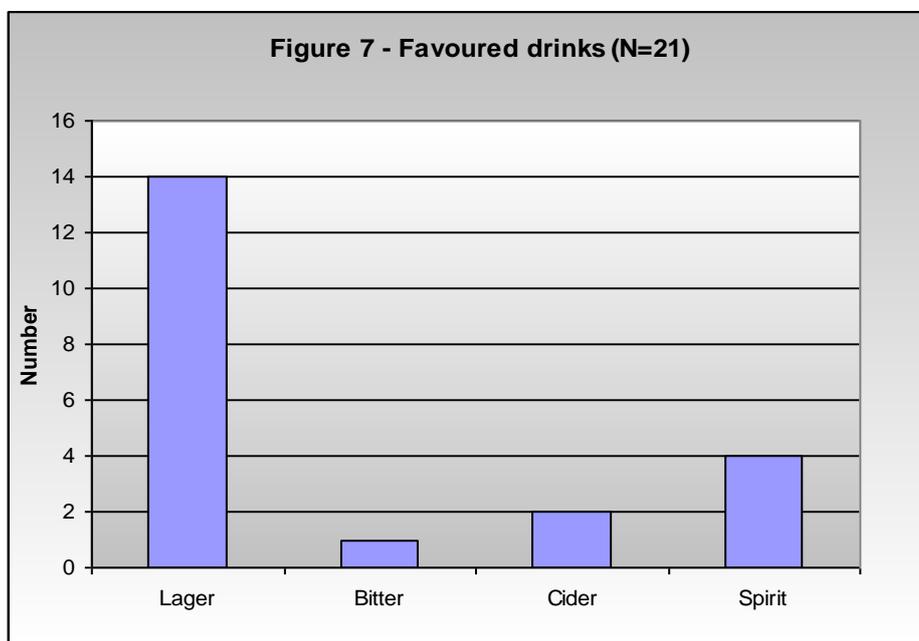


Figure 7 demonstrates the favoured drinks of the participant group and shows lager to be by far the most popular. Of the 19 participants who specified one or more preferred drinks, 14 chose lager, four chose spirits, two chose cider and one chose bitter.



Finally, in terms of alcohol related knowledge, participants were asked to ‘name three ways in which alcohol can damage your health’, with most participants correctly identifying physical, mental or social consequences. Table 1 displays the percentages of correct answers at the varying stages of the evaluation. As displayed, progressively fewer individuals

participated in this section of analyses and progressively fewer individuals correctly identified negative consequences of health induced by alcohol consumption as the study period progressed. This suggests that understanding of alcohol related harms reduced over time.

**Table 1**

	Initially	Immediately after	Follow-up
Total participants	23	23	23
Participated in this section	18	16	15
Percentage correct	78.3	69.6	65.2
Percentage incorrect	21.7	30.4	34.8

Of the 105 answers volunteered, 63 were correct physical consequences, such as damage to the liver, kidney and heart, 21 were correct psychological consequences, such as loss of memory, brain damage and depression, and 2 were correct social consequences. Of the 19 'incorrect' answers volunteered most were vague or potentially indirect consequences of harmful drinking, such as 'head' or 'legs'.

### 3.3 Alcohol Consumption

Figures 8 to 10 demonstrate aspects of alcohol consumption at initial and follow-up stages using the drinking AUDIT. Figure 8 displays how often clients estimate they have a drink containing alcohol. As displayed those participants who were drinking '2 to 4 times a month' more than doubled from before the session to follow-up stages. This was offset by a slight reduction in clients drinking '2 to 3 times a week' and '4 or more times a week'. There was an absolute decrease in clients drinking monthly or less from four to zero. It also appears that from before the session to follow-up stages one client moved to abstinence, when initially there were none.

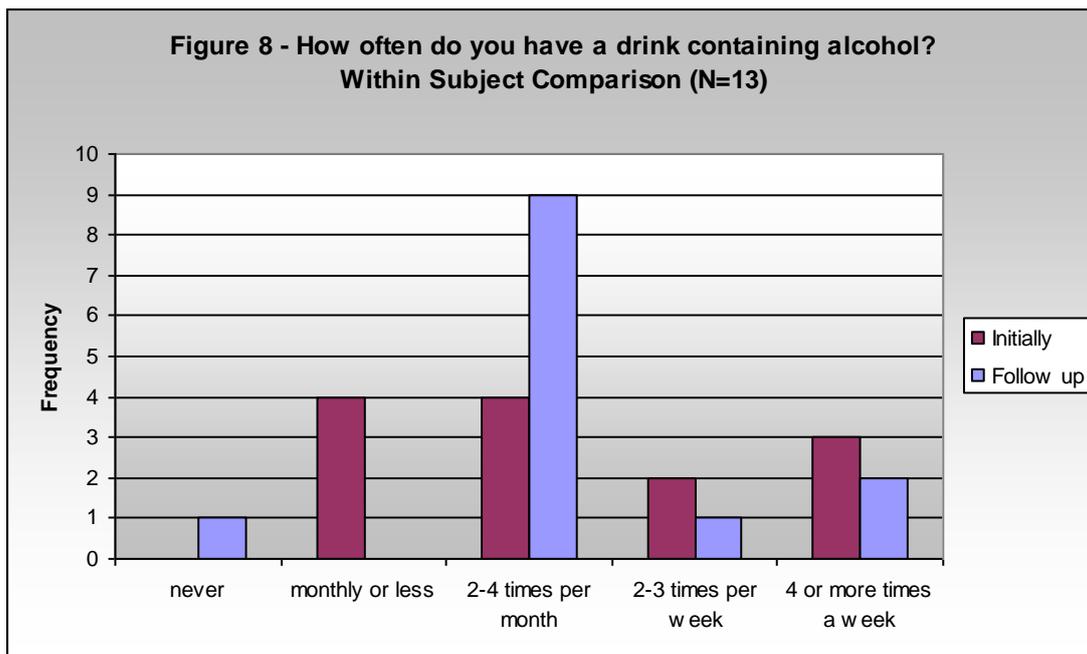


Figure 9 displays how many drinks clients estimate they have on a typical day when they are drinking. Substantial decreases are observed for clients drinking '1 or 2' and '10 or more' drinks on a given occasion but an increase can be seen in clients drinking '5 or 6' and a substantial increase in clients drinking '7, 8 or 9' drinks on any one occasion.

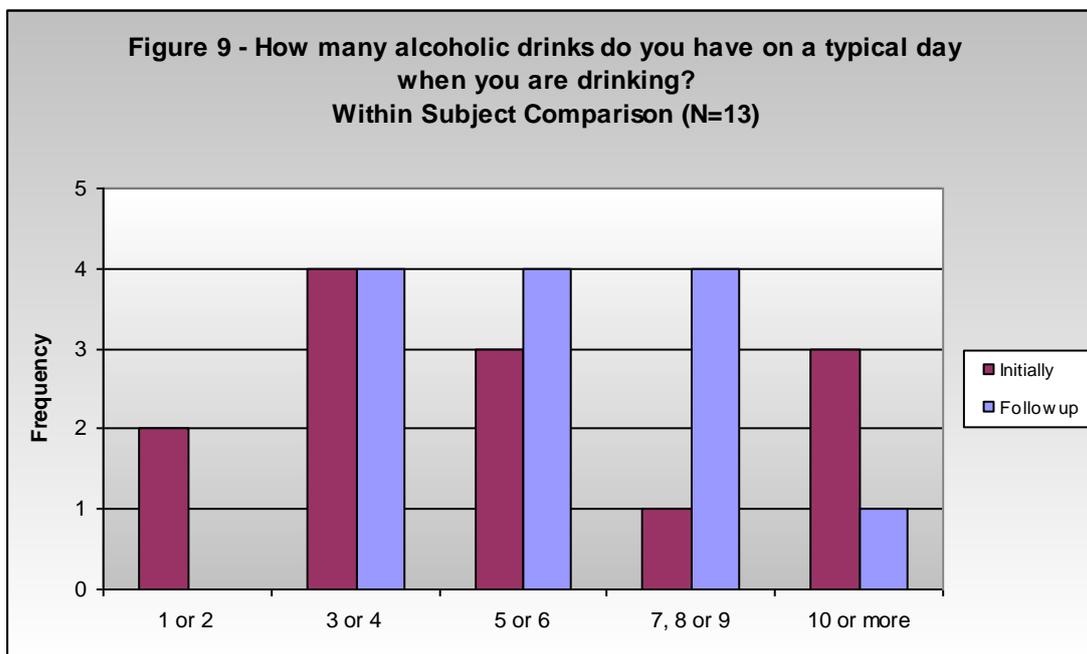
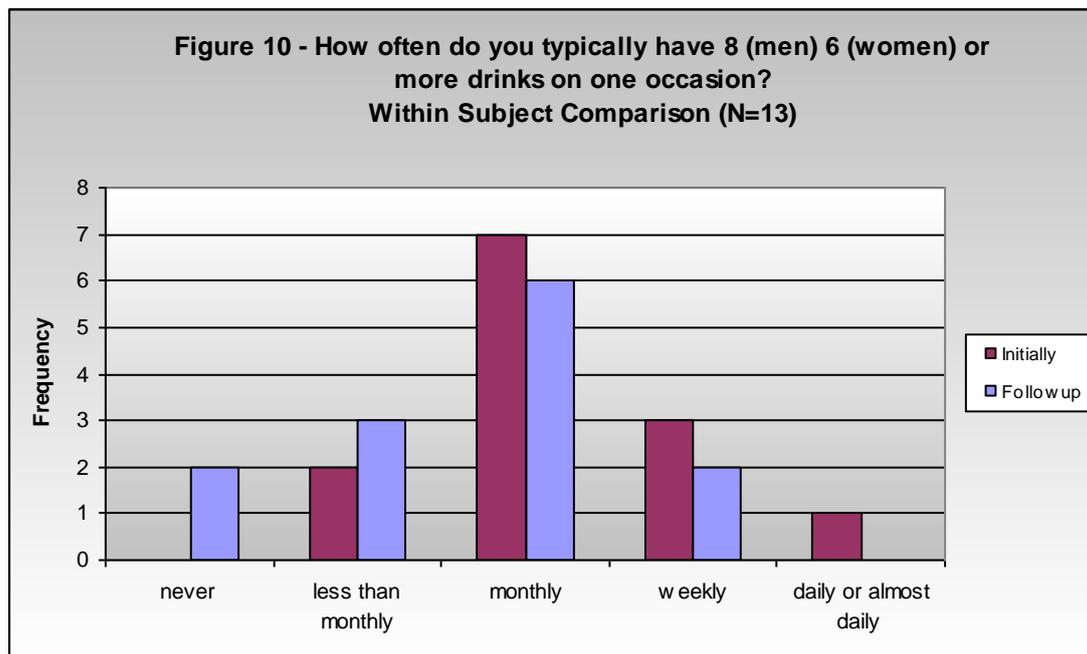


Figure 10 displays how often clients estimate they drink more than 8 drinks, if male, and more than 6 drinks, if female, on any one occasion. There are observed decreases in clients' drinking 8 or more drinks, for men, and 6 or more drinks, for women, on a daily, weekly and

monthly basis. This is offset by a slight increase in clients' adopting this pattern of excessive drinking 'less than monthly' and 'never'.



Statistical analyses for Figures 8, 9 and 10 were combined and compared in terms of total individual AUDIT scores. A matched samples t-test showed the moderation of drinking levels before treatment and at follow-up stage, not to be significant ( $p > 0.05$ ).

Figure 11 displays the total units consumed by the collective participants seven days prior to the initial and follow-up questionnaires, indicated as a weekly pattern of drinking. Analyses, in this case, are for a particularly small sample of the eight participants who successfully completed the weekly unit count both before the session and at the follow-up stage. The mean units consumed per day are also displayed. As demonstrated there is a strong suggestion of binge drinking at the weekend but since this sub group is comprised only of eight individuals the data is easily skewed, as demonstrated by an individual who consumed over 60 units on a Monday. A Wilcoxon Signed Rank Test showed the change in mean units consumed per day before and after treatment, at follow-up stage, not to be significant ( $p > 0.05$ ).

Clients were also asked to estimate their typical spending on alcohol on a night out. In the three months before the intervention clients spent an average of £39.70 from a range of £15 to £90. This decreased slightly by follow-up to £37.90 from a range of £10 to £115.

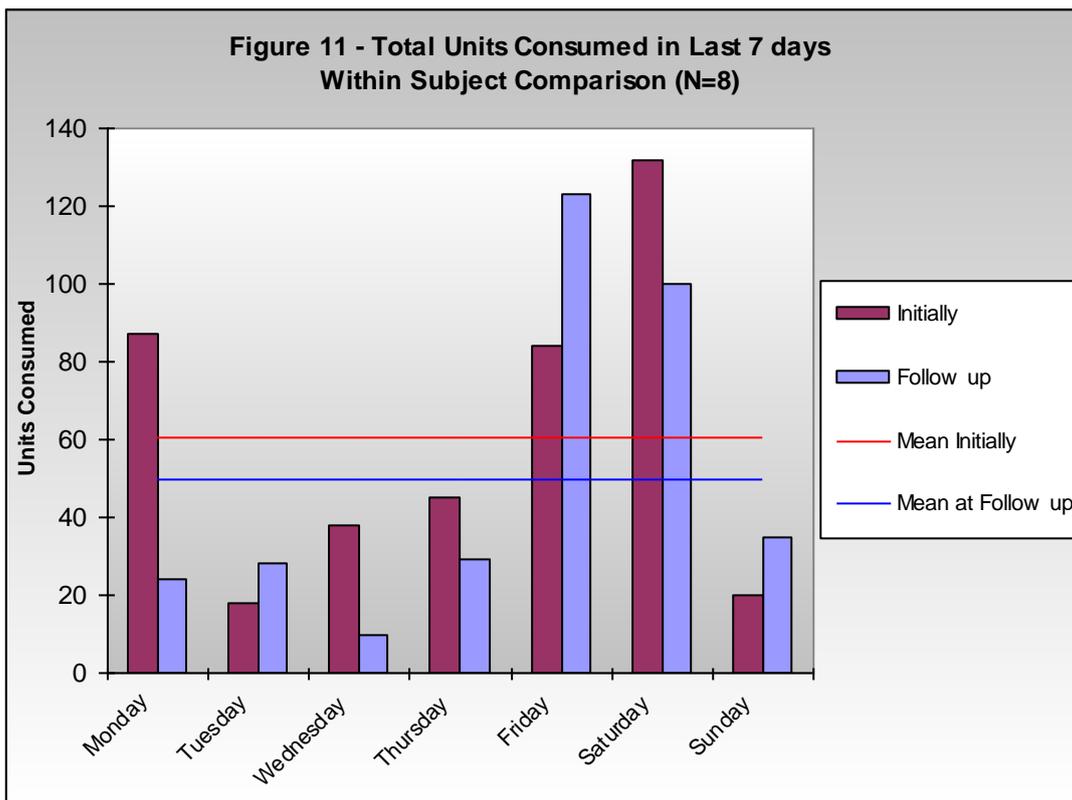
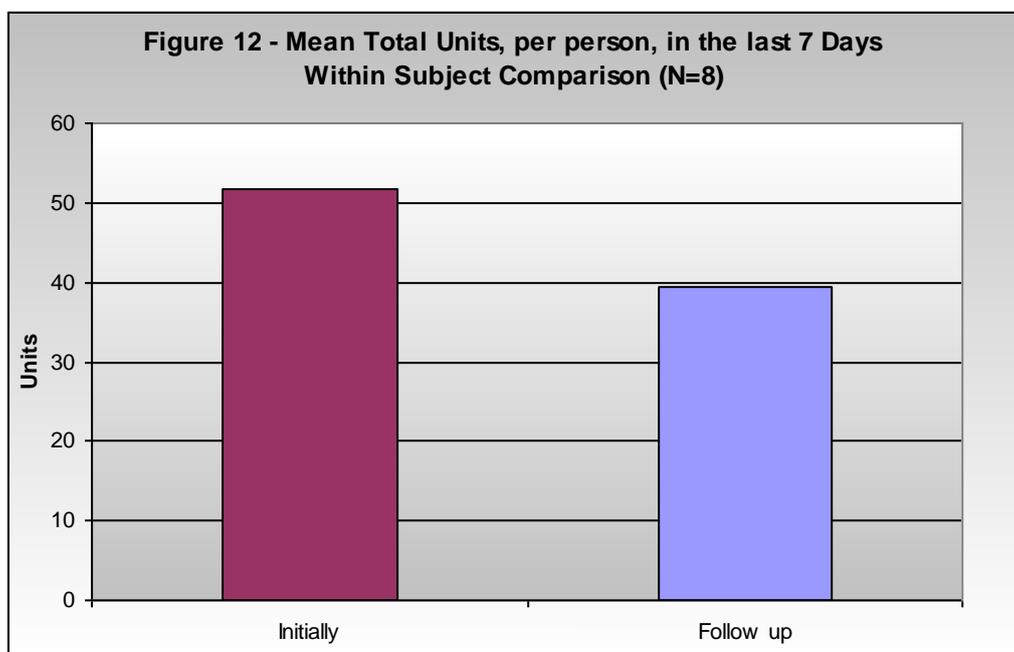


Figure 12 displays the within subject comparison of mean units consumed per person per week. Despite the small sub group, a decrease of over 20% is demonstrated, which in this context is a positive result. A matched samples t-test showed the change in units per person per week not to be significant ( $p > 0.05$ ).



3.4 Well Being

Figures 13 and 14 display changes in clients' psychological well being, as derived from the GHQ, where higher scores represent higher psychiatric morbidity (Cohen et al, 1995). Figure 13 expresses changes in total GHQ scores for each of the 13 aspects of well being. Substantial decreases in total GHQ scores and therefore improvements in well being are observed for each of the 13 aspects of general health. The Wilcoxon Signed Rank Test showed the change in mean scores per category before the session and at follow-up stage, to be significant ( $T = 2.832, p < 0.05$ ).

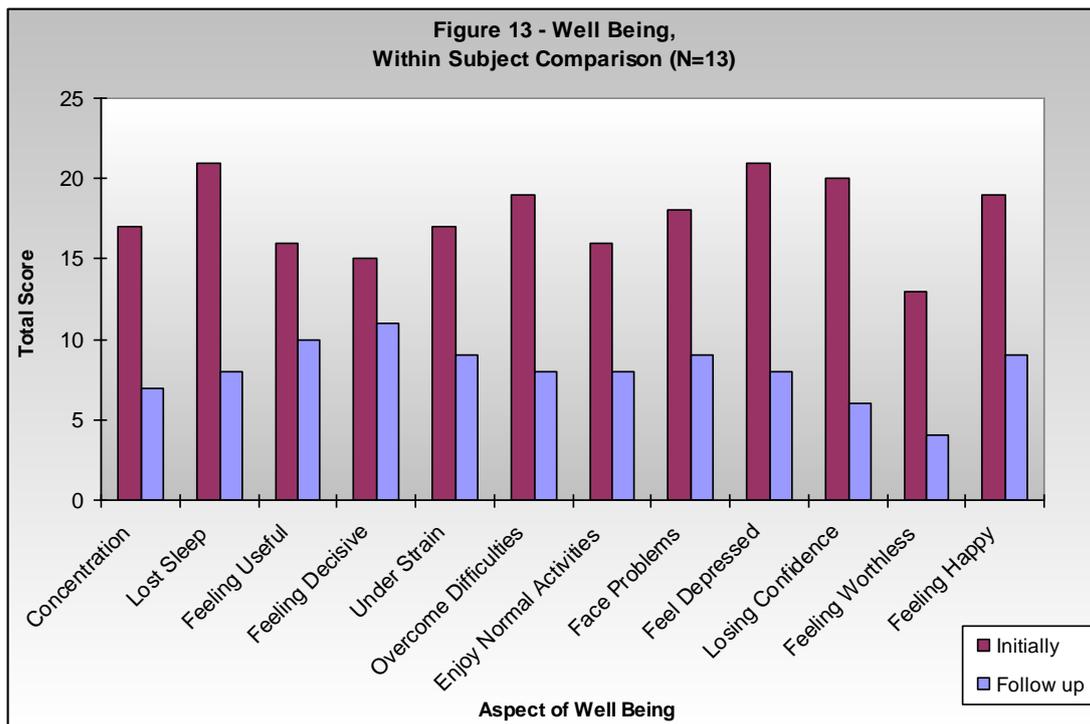
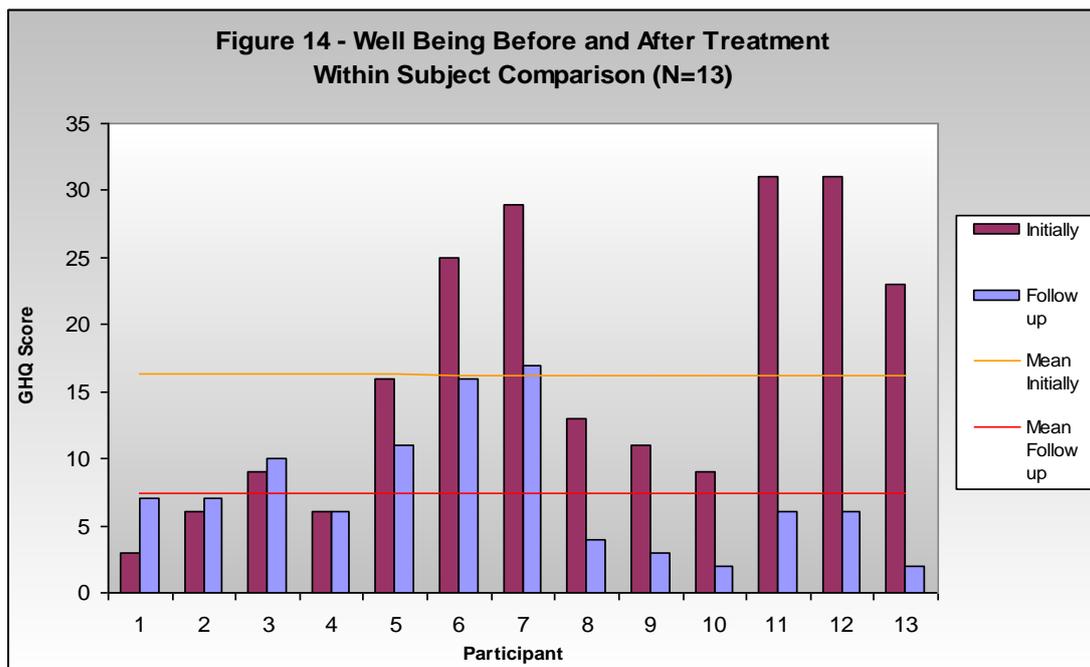


Figure 14 expresses the changes in total GHQ scores for each of the 13 individual participants, with the mean score of the group of participants included from initial and follow-up stages. A matched samples t-test shows the change in mean score per person is not significantly different between initial and follow-up stages ( $p > 0.05$ ). When the total scores for all clients are summed, there is a total decrease in scores of over 54% between initial and follow-up stages. However, this overall reduction is comprised of wide variety among individual participants.



Figures 15a & 15b demonstrate the relationship between the AUDIT and GHQ scores. Figure 15 displays a plot of AUDIT scores on the primary Y axis and GHQ scores on the alternate Y axis for all individuals at both initial and follow-up stage. This plot does not seek to express or account for the effect of the alcohol brief intervention but demonstrate a relationship, if any, between alcohol consumption and psychological well being. As demonstrated there is greater variation among GHQ scores than AUDIT scores but once trend lines are fit to the data points there appears to be a positive linear relationship between the scores. This implies a negative linear relationship between increasing levels of drinking and client well being since higher GHQ scores represent higher psychiatric morbidity. The Spearman-Rank Correlation Test was used to statistically analyse the correlation between drinking and well being, in this case the correlation was found to be significant ( $r_s(32)=-.438, p < 0.05$ ).

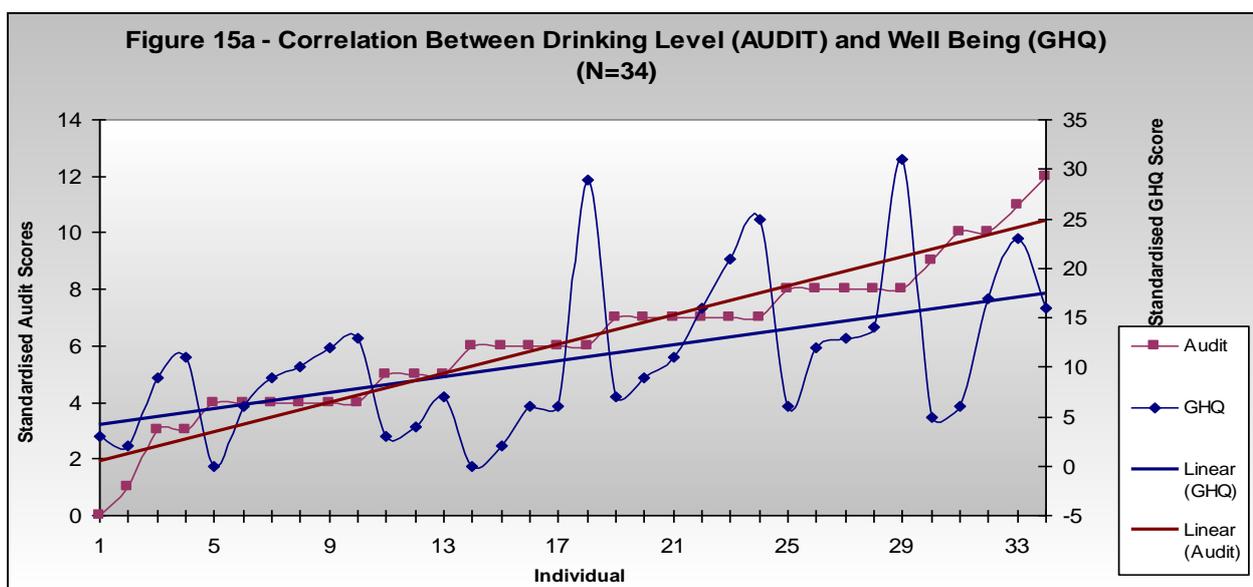
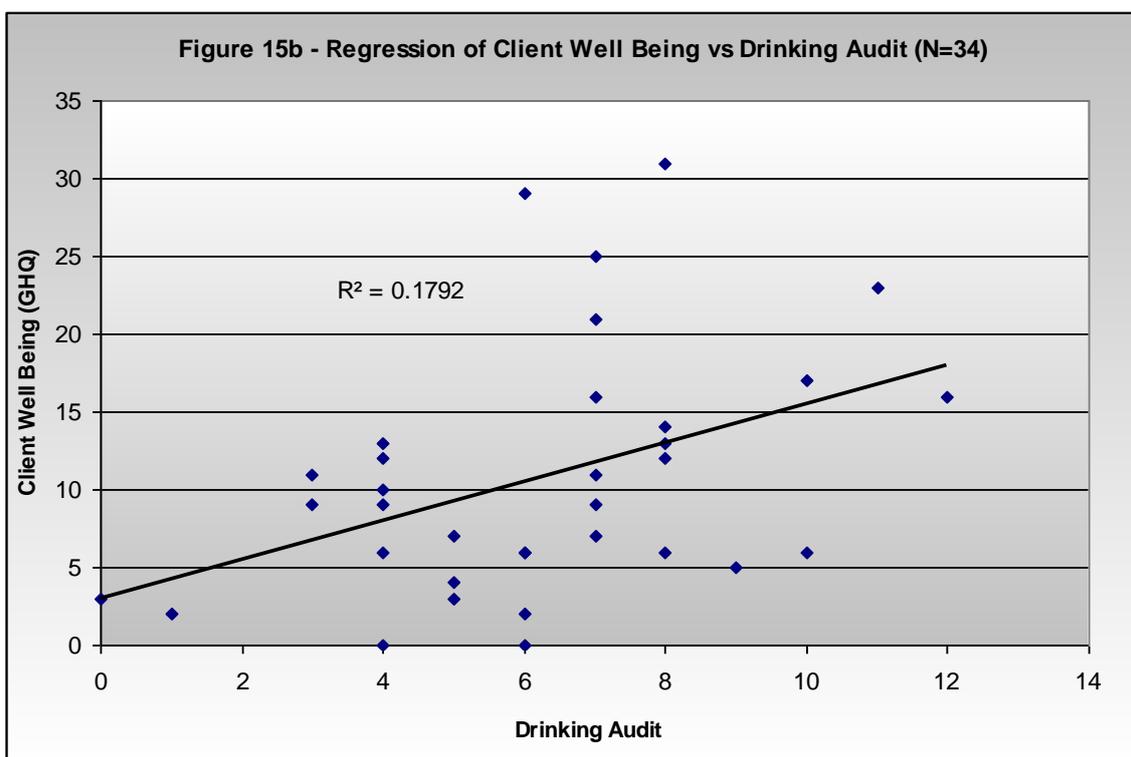


Figure 15b expresses this relationship as a scatter plot with the dependent variable of well being (GHQ) plotted on the Y axis and the independent variable of drinking levels (AUDIT) plotted against it on the X axis. Backwards Stepwise Linear Regression and ANOVA Tests were used to determine the predictive strength of this model: the linear relationship between clients well being (GHQ) and the amount of client drinking (AUDIT). In this case clients drinking (AUDIT) was found to be a significant correlate of client well being (GHQ) ( $p < 0.05$ ), despite explaining just under 18% of the variance of the data points as indicated by the value for  $R^2$  ( $R^2 = 0.1792$ ). This suggests that there are a large number of potential factors, in addition to alcohol use, that may be influence a client's well-being.



### 3.5 Alcohol Related Behaviour

Figures 16 and 17 display changes in self reported negative alcohol related behaviours, both initially and at follow-up stage. Figure 16 demonstrates these self reported changes across 14 identified negative behaviours associated with drinking. All but four of these aspects show a decrease in reported behaviours and the change in one of those four that show an increase, 'having drunk and driven', is very small. The most substantial decreases were in 'losing the ability to walk', 'having a fight', 'being regretful' and 'being unable to remember the night before', all of which adds evidence to the argument that there has been a shift in drinking behaviour in this sample group to consuming less alcohol on a given occasion. The Wilcoxon Signed Rank Test showed the change in mean scores per category, from before the session to follow-up stage, was significant ( $T=3.1$ ,  $p < 0.05$ ).

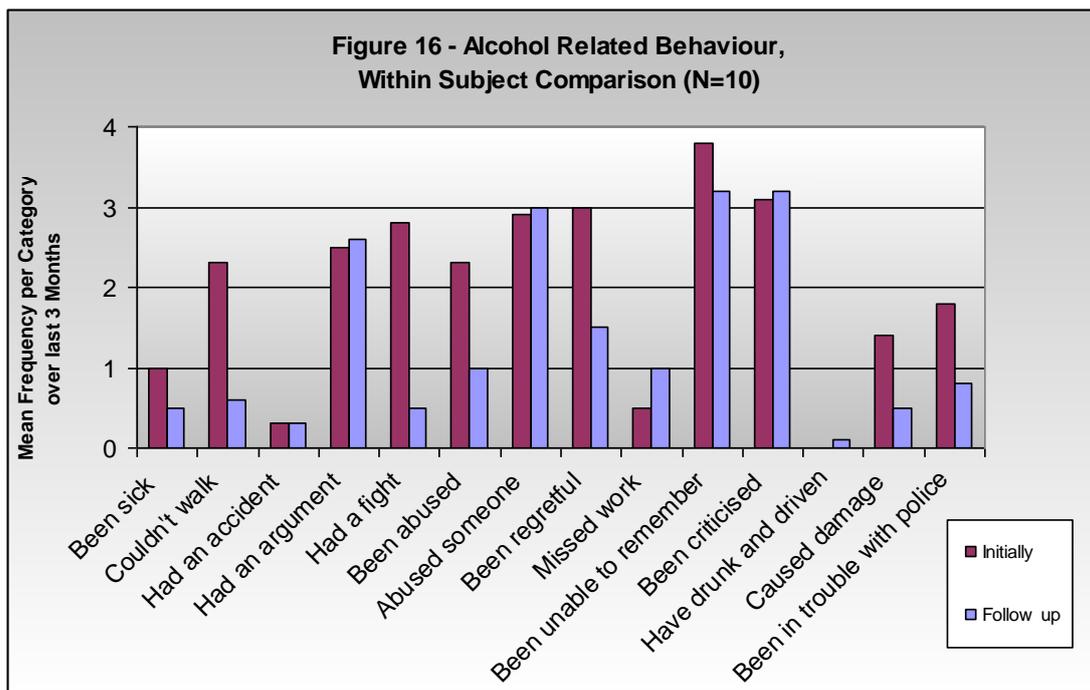
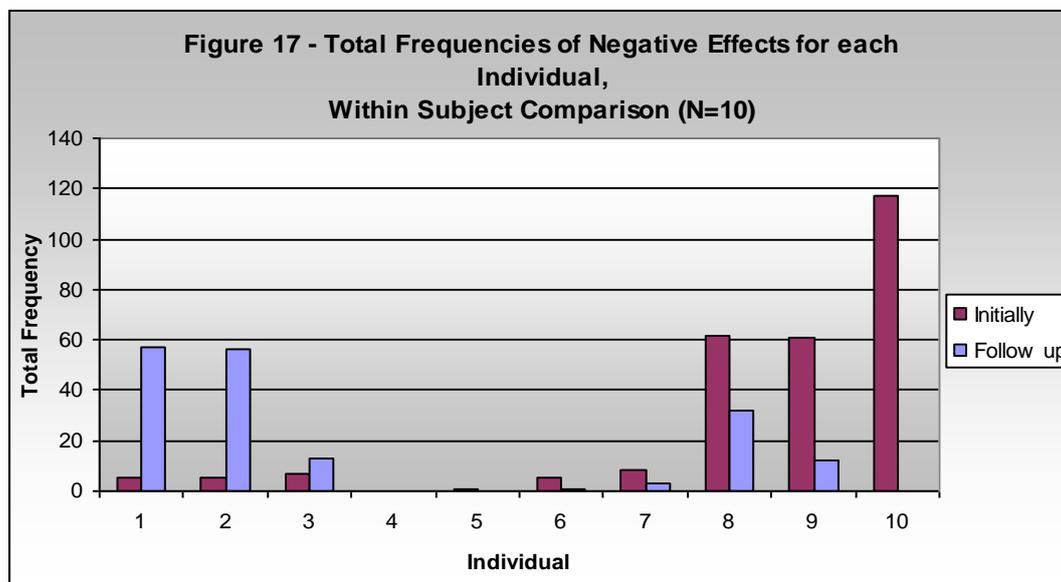


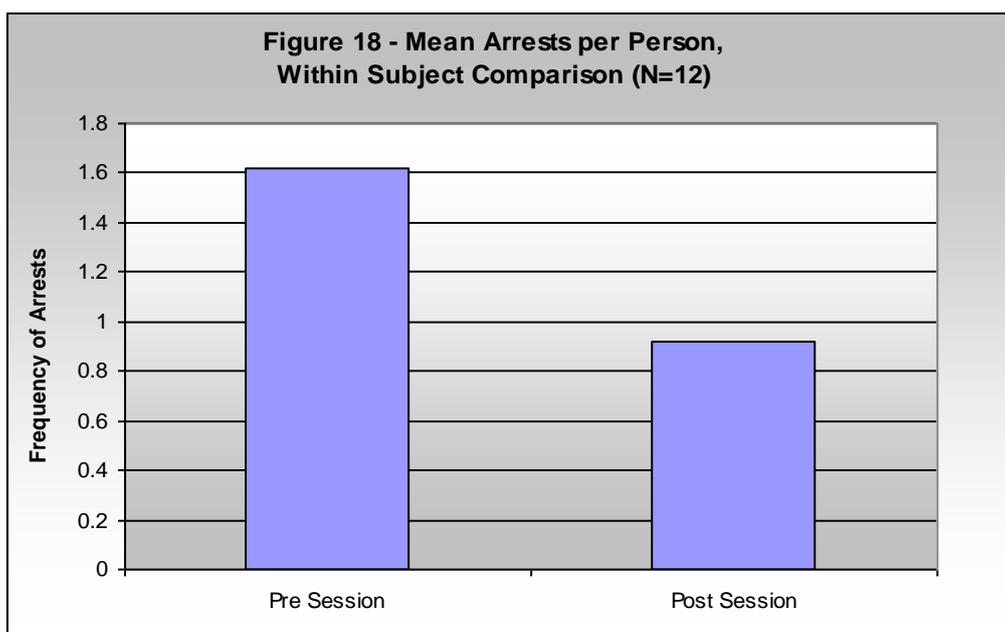
Figure 17 displays these effects for each of the 10 individuals who successfully completed the relevant sections at both stages. As can be observed, there is a great deal of variation between each individual with some reporting substantial increases while others report substantial decreases in negative behaviours associated with drinking. The Wilcoxon Signed Rank Test showed the change in scores per person, from before the session to follow-up stage, was not significant ( $p > 0.05$ ).



Participants were also asked to specify reasons and circumstances that would encourage them to stop drinking. These questions were asked only at the initial stage. Participants indicated the most likely reasons for stopping drinking were: 'I have run out of money', 'I am

going to do other activities', 'the drinking place closes', 'there is no more alcohol available' and 'I have to work the next day'. The most unlikely reasons for participants in this group to stop drinking were 'I have taken mind altering drugs before I started drinking', 'I am getting depressed', 'I plan on using mind altering drugs after I drink alcohol', 'I don't like the place I am drinking in' and 'I don't want to damage my brain'. These results are useful in highlighting that none of the top five reasons for this sample group to stop drinking were related to potential physical, mental or social harms that may be induced by consuming alcohol.

Figure 18 demonstrates self reported frequencies of arrests in the three months before and three months after the brief intervention treatment. As can be observed a substantial and significant decrease in the mean arrest per person of around 57% is evidenced. This is a key finding and a particularly positive one in the context of this study. This importance is reinforced by the fact that 27 out of 28 arrests at the initial stage and 11 out of 12 at follow-up stage were due to drinking, in the opinion of participants. A matched samples t-test showed the arrests per person for the three months prior to the treatment was significantly different from the three months after treatment ( $t(11) = 2.42, p < 0.05$ ).



### 3.6 Session & Participant feedback

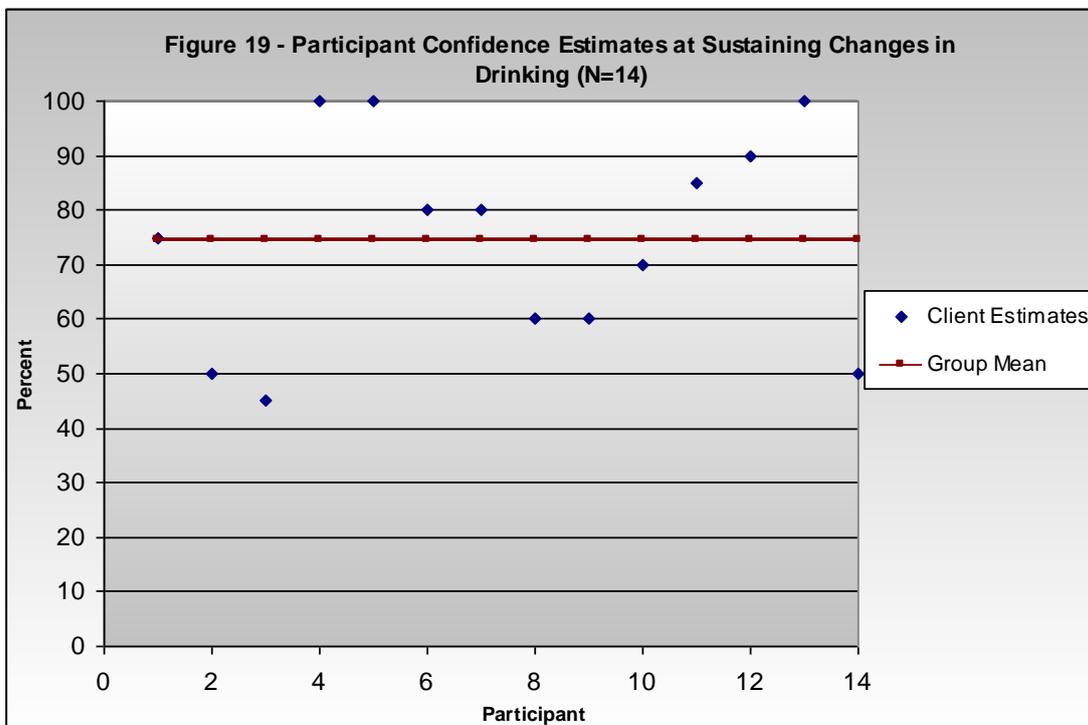
At the end of the follow-up stage clients were given an opportunity give feedback or make comments on the brief intervention session and the alcohol conditional cautioning process as a whole. Given below are the comments of all participants who chose to complete this final qualitative section of the questionnaire.

- 'I realised that I am better person when I'm not drinking'
- 'It's the best £30 I have ever spent'

- ‘Now I see how consuming different units of alcohol can affect my judgement’
- ‘It (the session) makes you see how bad you were’
- ‘I don’t go out and drink as much as I used to’
- ‘I cut down on drinking and found it (the session) interesting’
- ‘Information was useful and I have cut down on drinking’
- ‘It (the session) showed I had a problem, I was putting myself and others in danger’
- ‘I no longer mix drinks and I try to drink soft drinks in between alcoholic ones’
- ‘The session has affected the amount I drink’
- ‘It (the session) showed me the damage it can cause’
- ‘For me nothing has changed, I am not a binge drinker’
- ‘I am not a drinker. It was the whiskey. I will not drink that again’
- ‘I was not drunk when I was arrested and I was still put on this course’

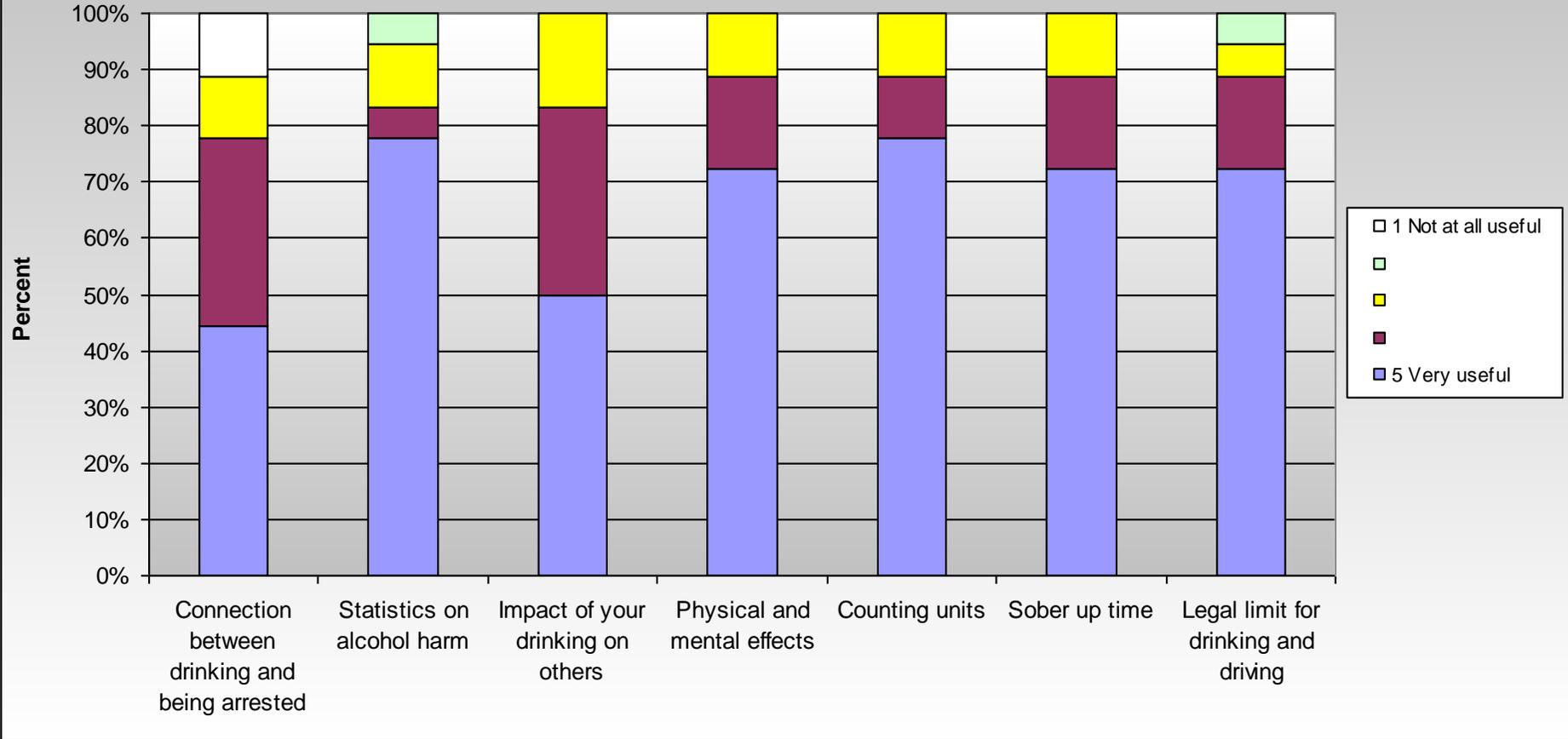
As can be seen most are positive outcomes either from a personal perspective or from a treatment effectiveness point of view. As can be seen there remains some clients who do not feel this disposal was correct for them or was not effective in tackling harmful drinking, although these comments are in the minority.

Figure 19 displays how confident clients were that they would be able to maintain changes induced or encouraged by the alcohol brief intervention. Each client’s estimate is displayed as a scatter point with the group mean indicated as a solid line. The mean group estimate was around 75% and the range of client estimates was 45-100%, which for a varied group such as this is a positive result, in the context of the scheme.

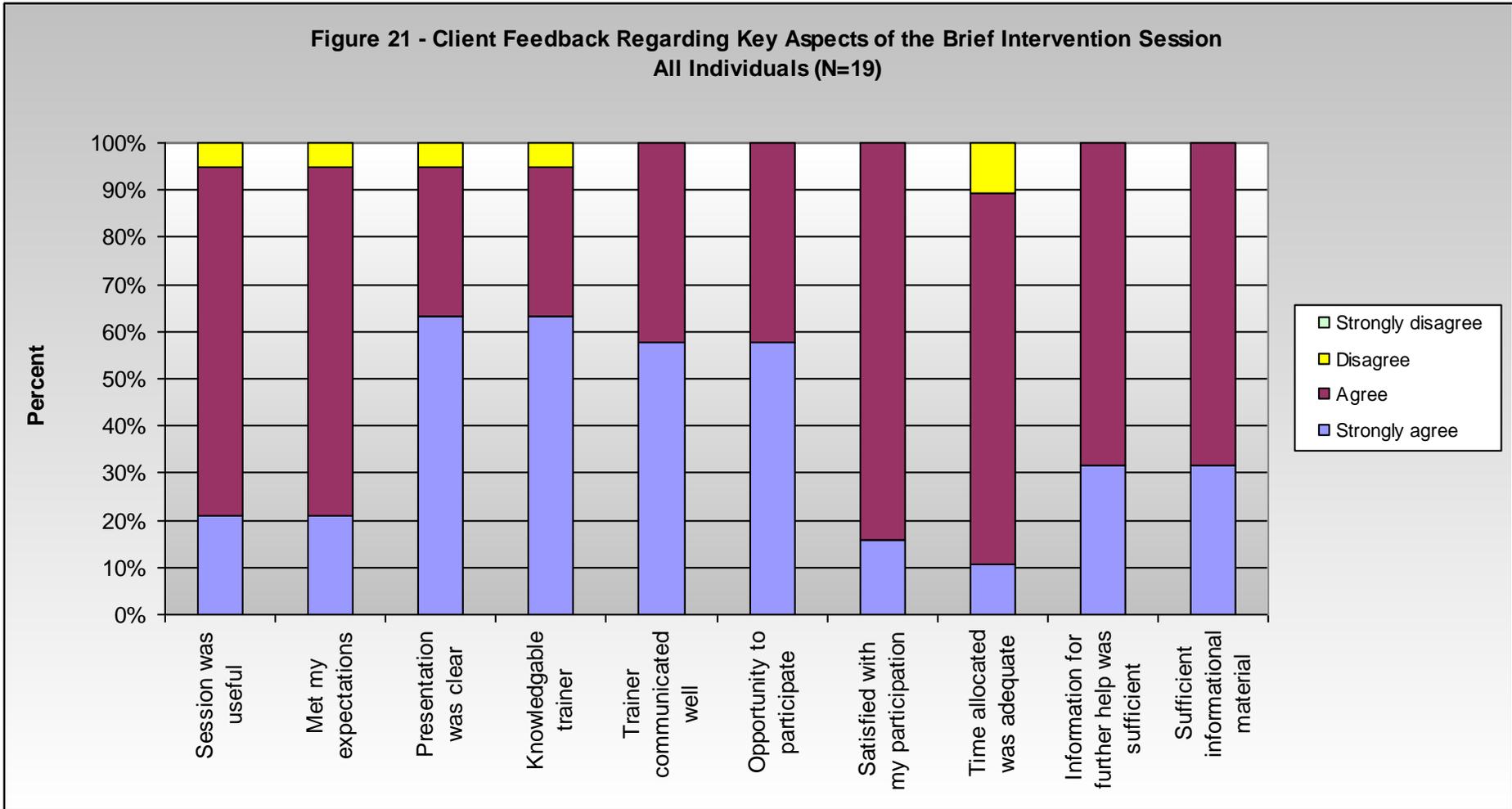


Figures 20 and 21 demonstrate participant feedback relating to all aspects of the alcohol brief intervention session. Figure 20 displays the usefulness of key information given out at the alcohol awareness session while Figure 21 displays feedback for a variety of other key aspects of the session. Figure 20 demonstrates highly positive feedback with over 75% of participants reporting that every aspect of information was 'very useful' or 'useful'. In four cases 100% of participants found the information to be 'very useful' or 'useful' and in all but one case over 90% of individuals reported information to be 'very useful' or 'useful'. In only one case, 'making the connection between your drinking and being arrested' did over 10% of participants find the information to be 'not at all useful'. Figure 21 demonstrates similarly successful feedback with five out of ten positive statements relating to the session being agreed with by 100% of participants. Of remaining statements, only one, 'the time allocated for the session was adequate', was disagreed with by more than 5% of participants.

**Figure 20 - Usefulness of Key Information Given  
All Individuals (N=19)**



**Figure 21 - Client Feedback Regarding Key Aspects of the Brief Intervention Session  
All Individuals (N=19)**



## 4.0 Discussion

### 4.1 Alcohol Related Knowledge

Significant improvements in clients' knowledge are observed for the recommended safe daily limits and alcohol processing times between the pre-session and immediately after-session questionnaires. Different effects are subsequently observed between the immediately after-session and follow-up questionnaires, where knowledge in recommended safe daily limits again improves, while knowledge of safe alcohol processing times worsens. A slight decrease in correct estimates might be expected between these stages since the brief alcohol intervention may not be effective at eliciting long lasting changes for all clients. Interventions have been shown to manifest longer term changes when delivered over a longer time frame (Wutzke et al, 2002). One might expect a one-off brief intervention for alcohol to have limitations in sustaining long term changes but would undoubtedly benefit from reinforcement, be it from the national media or local support groups. In the case of estimates of recommended safe daily limits, clients' correct scores show improvement between immediately after the intervention and the follow-up stage, which may be a reflection of such marketing campaigns, for example by the Home Office, The Department of Health and the NHS to promote safer drinking. Such campaigns may help to reinforce the information given at the intervention session and could be helping to maintain changes made in clients' alcohol related behaviour.

The closest estimates and biggest improvements among clients' unitary estimates were for premium lager, where just 10% of clients estimated units correctly before the session compared to 60% by follow-up stage. This trend may reflect the drinking preferences of a male dominated sample group, as demonstrated by clients' preferences, which show the favoured drinks for the majority of the group to be lager. The least accurate estimates were for standard spirit measures, such as vodka, which appeared to be consistently over estimated by clients, with no improvement observed between pre-session and follow-up stage. Wine was also inaccurately estimated in the most part but did show some improvement by follow-up stage. Significance was not derived for any of the changes in client estimates in this section of analyses, chiefly owing to the small sample group who successfully completed the appropriate sections at all stages.

From the alcohol related knowledge section it appears that participants had a better existing and learnt knowledge of recommended safe daily limits and alcohol processing times than unitary values of various alcoholic drinks. It appears, when summarised, that client mean estimates were not substantially inaccurate. Despite being incorrect in many instances estimates showed a reasonable understanding of differences between drinks. Participants demonstrated a more accurate understanding of qualitative aspects of alcohol related knowledge, specifically negative consequences of harmful drinking. However, despite the majority of participants showing a reasonable understanding of the detrimental consequences of heavy drinking many of the responses were often general, vague or indirect consequences.

## 4.2 Alcohol Consumption

Analyses of alcohol consumption display an overall moderation in extreme drinking behaviour from both the lowest and highest AUDIT values. The interpretation of these findings is particularly positive since more frequent but less heavy drinking is observed, which is often encouraged as safer drinking practice. However, as demonstrated, while there is an absolute reduction of those consuming 10 or more drinks on any one occasion, there is also a reduction in individuals drinking 1 or 2 drinks on any one occasion, the lowest option in this case. Despite this stabilising effect and overall reduction, most clients report drinking levels substantially higher than the recommended daily limits, assuming an average drink contains more than one unit. There is a positive effect of reduced excessive drinking as demonstrated by participants less frequently consuming '8 or more' drinks, for men, and '6 or more' drinks, for women, on any one occasion. There appears to be a whole-scale shift down in the frequencies of excessive binge drinking behaviour and this is arguably the most positive result from this section of analyses.

The alcohol consumption section demonstrates most of the sample group could be considered as heavy weekend binge drinkers and not dependent drinkers, the weekly pattern of drinking displays this trend. Such drinkers were targeted by the Alcohol Conditional Cautioning scheme as they would be most likely to respond positively to an alcohol brief intervention. Ultimately, responses evidenced a decrease in mean units consumed per person per week although the decrease was not significant and largely shaped by one individual. However, this is a positive outcome of the scheme and meets one of the principle aims of the alcohol awareness course. However, if client drinking remains substantially above the recommended limits questions remain as to whether this treatment be considered sufficiently efficacious to warrant continuing investment.

## 4.3 Well Being

The overall mean GHQ scores per category reflect a substantial and significant improvement in client well being from the initial to follow-up stage, where an average decrease of over 50% is observed for this sample group of 13 individuals. Similar improvements are reflected at individual level with only three individuals reporting a slight increase in GHQ scores while nine individuals report, often substantial, decreases, which equate to substantial improvements in general health and well being. When the total scores for all clients are summed, there is a total decrease in scores of over 54% between initial and follow-up stages. This difference is an extremely positive outcome for the scheme. It has been shown that a diversity of socioeconomic factors effect psychological well being, including marital status, denomination, income, class and qualifications (Cohen, 1995). It is possible, that some clients experienced major life changes in these areas in the three months between questionnaires. However, it is more likely that modifications made to alcohol consumption have created such perceived improvement. Despite this it is important to note that the regression analysis conducted suggested that there were indeed other factors influencing well being outside of alcohol consumption for this client group.

The potential relationship between drinking levels and well being is not easily demonstrated but in this case the correlation between client drinking and well being is explored and is demonstrated to be statistically significant. Correlation does not always imply causation and while it would be tempting to make linear predictions from this model it remains clear that general health and psychological well being are influenced by a great diversity of variables. For example, in this case clients engaging in heavy or harmful drinking may have temporary and distorted views of their general health or well being. However, if participants achieved some stability with their drinking and maintained a positive attitude towards changing their drinking behaviour, general health could directly correlate with drinking levels and be a prominent causal factor. Since higher GHQ scores are related to higher psychiatric morbidity, we can conclude that client well being, in this case, is negatively correlated with increasing alcohol consumption. The data here can be interpreted as an example of this trend, albeit with the aforementioned potential limitations.

#### 4.4 Alcohol Related Behaviour

The mean frequency of negative alcohol related behaviours per person in the three months prior the brief intervention session was 27.1 compared to 17.4 in the three months after the intervention. However, these means are disproportionately derived; since one individual in the three months prior to the intervention reported 117 negative alcohol related behaviours. Generally the decreases in self reported alcohol related negative behaviours are a particularly positive outcome for this section but, unlike general health and well being, great variation is found among the categories. Substantial decreases are observed in behaviours related to excessive binge drinking, which is a positive stand alone outcome. The substantial decrease in clients reporting having 'been in trouble with the police' is also positive. The categories that marginally decreased or increased might not be interpreted as entirely negative outcomes in terms of the scheme since many of them could be consequences of moderations in client drinking. Such categories as 'had an argument' or 'been criticised' are more subjective experiences and potentially experiences that may be reported less, even if the occurrence was the same, if the individual was drinking more heavily. 'Being unable to remember the night before', for example, could perhaps include occasions when a participant had an argument or was criticised, which were not subsequently remembered and reported.

Individually, a mixed picture of outcomes is demonstrated for the client group. While three clients show substantial decreases in negative behaviours, two clients show substantial increases and five show little change. This demonstrates a great deal of variation among the clients. It is also indicative of some individuals being more or less appropriate than others for this type of intervention and the difficulty in tailoring an intervention to apply to all people. Despite this, there are some positive effects. The reduction in the mean frequency of arrests per person in the three months after the session compared to the three months prior is encouraging, as it successfully meets one of the scheme's principle aims of reducing offending. However, one cannot reliably conclude that this reduction is more or less

significant for this disposal method compared to another, such as a charge or a simple caution, without re-offending data from a control group of alternately disposed individuals.

#### 4.5 Session Feedback

While results in this section demonstrate highly positive client feedback for information distributed and extremely positive client feedback for various aspects of the session, the qualitative comments volunteered show a more balanced cross section of views. Most participants expressed positive changes and reflections of the session but others maintained that the treatment was not suitable for them and one maintained that they had been sober on arrest. While feedback here is very encouraging on the whole, questions remain as to the ideal nature of clients and the recruitment procedure to ensure the recruitment of the most appropriate individuals.

#### 4.6 Limitations

The main limitations to analyses and the further application of this evaluation are the sample size, the veracity of the data and the omission of a control group. The sample size obtained was below that of the targets agreed at the outset of the evaluation. The reasons for this are discussed in the process evaluation. While sufficient to yield significant data for certain aspects of the study, a larger sample size would have allowed more robust statistical analyses and potentially extended the application of the data. A larger sample may also have highlighted the variation among clients further, which would have helped in re-defining the recruitment criteria. Future work would undoubtedly benefit from setting realistic targets and a realistic time frame in which to meet those targets. While any evaluation must consider limitations in the experimental procedure, the veracity of responses in an evaluation such as this is likely to have some effect that is worth considering. Clients may have felt inclined to respond in a certain way, especially at follow-up stage, where an improvement in drinking and harmful behaviour has been encouraged. Within the design of this study it is impossible to confirm whether this has been a factor, but it is correct to acknowledge its potential existence. Finally, the lack of a control group has also placed limitations on the data. A control group would have enabled all outcomes to be compared with alternate disposal options, such as a fixed penalty or a simple caution, in order to derive the relative efficacy. As it stands it is not possible to disentangle the effect of the arrest alone from the effect of the arrest and intervention session combined. Future work would undoubtedly benefit from such a comparison.

## 5.0 Conclusions and Recommendations

### 5.1 Conclusions

In summation this evaluation has demonstrated both the potential for schemes such as this as well as highlighting some of the limitations. In spite of a small total sample size and smaller sub-group samples, results demonstrate trends of varied nature and have reached significance in multiple cases. Among the most positive and encouraging findings are the decrease in AUDIT scores, the decrease in mean units consumed per individual in the seven days prior to questioning, the improvements made in individual general health scores, the improvements in self reported negative behaviours or effects of alcohol and the decrease in mean arrests per person. While all of the positive outcomes are encouraging in terms of this and future applications of schemes such as this, there remain limitations in the interpretation and reliability of conclusions. While all the outcome findings undoubtedly are of interest and imply something of the efficacy of the conditional cautioning disposal, applying these findings in modifying or creating future processes must be conducted with care.

Some results were less encouraging. Improvements in clients' knowledge and understanding were not observed with significant effect, in the most part, and some clients continued to feel that the conditional caution was not the right output for them. Perhaps the least encouraging aspect was the fact that such great variation among the client group was observed, implying that the intervention appears to be more effective for some clients when compared to others. This re-emphasises questions arising from the Process Evaluation relating to recruitment of the "right" client. The nature of the intervention and the nature of the offender are key determinants of the success of this disposal and if, for whatever reason, the clients' attitude is not positive towards the treatment, harmful drinking and associated behaviour will be very difficult to modify. The responsibility of stakeholders of the scheme are, not only to ensure that clients of the right nature are recruited, but that once recruited clients are made aware of the opportunities and benefits that may be taken advantage of. As discussed in the Process Evaluation some of these potential inefficiencies might be reduced by streamlining the process. One suggested idea, for example, was recruiting an alcohol and drugs specialist to administer brief interventions directly from the custody suite. Pilot projects are currently in place around the UK with this particular adaptation in place and the evaluations of these projects will help to redefine the best practice boundaries of future schemes.

Despite variation among individuals within the sample population, the overall positive and, on occasion, significant changes in group means for various aspects of harmful drinking are a particularly positive outcome for this evaluation. Such aspects, including substantial decreases in alcohol consumption, associated negative behaviours and arrests between initial and follow-up stage, imply something of the treatment efficacy but in no case can the brief intervention be said to be unequivocally responsible for these changes. Recent media campaigns, individual motivation or personal reasons such as poor health could all affect

one's drinking and the consequences of it. However, outcomes in this case are certainly sufficiently balanced and positive to warrant further administration, evaluation and perhaps, in time, common practice of the alcohol conditional caution. The biggest limitation to the interpretation and application of these findings is the number of participants recruited. This difficulty, despite stakeholder effort and investment, continued and in fact worsened as the study period progressed. Future work would have to rectify the identified problems encountered in the process of alcohol conditional cautioning if a level of robustness can be achieved to evoke widespread changes. It seems likely however that disposing of low level alcohol fuelled offenders in this way has great potential to reduce harm not only to the individual but also to the community.

## 5.2 Recommendations & Future Application

While it would seem logical to recommend further work, subsequent evaluations would be well served by attending to the problems and potential solutions discussed throughout this evaluation. Future evaluations that capture data but incur similar restrictions to that of the Preston pilot project may not serve to facilitate the evolution of this disposal option. From an empirical perspective subsequent evaluations could help to clarify and disentangle the variables affecting the relationships and correlations suggested here. For example, the negative correlation between drinking and well being could have potential worth in re-defining the priorities of alcohol brief interventions. In addition, communication and information transfer between researchers, stakeholders, commissioners, government representatives and the media is of paramount importance in deriving an ethos and working practice that all parties can understand and share the objectives of. If the process can be modified and incorporated into mainstream disposal options, there is some evidence that it can become an innovative strategy for rehabilitating offenders in the medium term. Some consideration of longer terms outcomes would also be useful in considering the future use of this disposal option. A self-evaluation by the schemes stakeholders, potentially using some of the materials designed for this project, could allow the continued monitoring of existing and future clients and help to redefine both the parameters of the scheme and the nature of clients best suited to this type of disposal.

As discussed in the Process Evaluation, finances also have the potential to be a significant blocker and, ultimately, schemes such as this might require an initial investment or mainstream funding before being incorporated into normal practice. This scheme has demonstrated wide variation in clients in terms of drinking and offending profiles and this presents a substantial barrier to designing an appropriate group intervention. The number of individuals recruited onto the scheme has partly prevented the identification of which clients are 'right' for this type of disposal. However, increasing numbers could result in clients with a mindset less well suited to this intervention being referred, therefore negatively affecting outcomes and potentially participation in any evaluation. Investment would not only have to be put into creating the mechanisms of the scheme but also in continuing to evaluate and redefine the nature of clients for which the intervention will be most efficient. Once accomplished to a satisfactory level, involved parties would have to create a process in which these clients with the attitude most suited to this intervention

could be recruited without incurring justification or discriminatory problems. From here successful practice could surely ensue.

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