DRUG & ALCOHOL FINDINGS Matrix cell

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Alcohol Treatment Matrix cell E5: Treatment systems; Safeguarding the community

K Probation struggling to cope with alcohol-misusing offenders ([UK] Ministry of Justice, 2009). National study in England and Wales describes a system creatively grappling with a huge drink problem among offenders, but undermined by lack of evidence and under-resourcing linked to a dispute over whether health or probation should be the core funders. See also similar report for Scotland (NHS Health Scotland, 2011). Discussion in bite's *Highlighted study* and *Issues* sections.

K "Unmet need" for alcohol services in Britain's prisons (HM Inspectorate of Prisons, 2010). Inspections and surveys of prisoners and staff in England reveal "very limited" services for problem-drinking inmates, leaving them with poor prospects on release. See also similar report for Scotland (NHS Health Scotland, 2011). Discussion in bite's *Issues* section.

K Challenges to collaboration between health and criminal justice (2010). Based on exhaustive consultations in south west England, investigates the blockages to providing alcohol-related services to offenders and recommends improvements in commissioning, coordination and practice. See also associated policy report (2011). Discussion in bite's *Issues* section.

K Systemic barriers to employing problem drinkers ([UK] Department for Work and Pensions, 2010). Clearest lesson from interviews with alcohol service clients in Britain and with staff working in or with treatment agencies is that interagency working can result in better support for problem drinkers and better access to training and employment opportunities.

K Networking facilitates evidence-based treatment practices (2008). Suggests that to improve uptake of evidence-based practices and quality improvements, commissioners should promote networking between several agencies providing criminal justice treatment rather than commission a single large organisation. Discussion in cell D5's bite

K Wales rolls out nationwide integrated support for children affected by substance use in the family (Welsh Government, 2014). Evaluation of the first three local schemes in a nationwide rollout of services based on the Option 2 crisis intervention service for families of parents with drug or alcohol problems. Documents how the schemes changed in response to experience and strategic and operational contexts.

K G Uncovering and responding to children's needs in relation to problem-drinking parents ([English] Office of the Children's Commissioner, 2014). On the basis of investigation of case study areas, aimed to identify and promote good practice. Key questions were how local areas can discover the extent of need and how services can best respond. Discussion in bite's *Issues* section.

K Treatment alone did not cut drink-drive deaths (2005). Multi-million dollar attempt to equip US communities to tackle substance misuse only succeeded in reducing alcohol-related traffic deaths when treatment initiatives were supplemented by measures to limit the availability of alcohol.

R Managing drink-drivers (Health Canada, 2004). Canadian report based on reviewing evidence and expert opinion; includes recommended ways of coordinating treatment, rehabilitation and enforcement approaches to alcohol/drug impaired driving.

R Melding disparate objectives and cultures is key to criminal justice treatment (Australian Government, 2005). Realistically acknowledges (section headed "Providing AOD treatment within the context of the criminal justice system") that criminal justice and treatment have different objectives and philosophies and don't naturally see eye to eye, but argues that education and training can underpin collaboration to achieve shared goals. Discussion in bite's *Where should I start?* and *Issues* sections (*Does Britain have the right partnership ingredients?*; *How far should collaboration go?*).

R Non-coerced treatment associated with greatest crime reductions (2008). Synthesis of 129 studies of offender treatment for problems including substance use finds treatment's crime-reducing impact increased to the degree to which the offender was free to choose treatment. Implication is that treatment systems should make it easy and attractive for problem drug users to enter treatment without legal coercion.

G Management of problem drinking offenders in England and Wales ([UK] National Offender Management Service, 2010). Official guidance on the commissioning, management and delivery of interventions for alcohol misusing offenders; predates changes in targets and performance indicators and commissioning and service provision structures introduced since May 2010. See also general health commissioning guidance ([UK] NHS Commissioning Board, 2013) issued after NHS England took responsibility for commissioning prison healthcare and local authorities for commissioning public health services for offenders under community supervision, in both cases including treatment of substance use problems.

G Alcohol and offenders guidance for Scotland (Scottish Government, 2012). Guidance and support for commissioners and planners who have a responsibility for developing strategic responses to alcohol problems among offenders.

G 'Whole-family' recovery advocated in Scotland (Scottish Government, 2013). Guidance specific to substance use intended for all child and adult services, including drug and alcohol services. What new patients should be asked about children and the role these services should play in a system which ("Getting our Priorities Right" is the title) prioritises child welfare. Discussion in bite's *Issues* section.

G Protocol for joint working between drug/alcohol services and children/family services ([UK] National Treatment Agency for Substance Misuse, 2011). Intended to help local areas develop agreements to strengthen the relationship between these services in order to safeguard the children of substance users. Includes identification, assessment and referral, sharing information, and staff competencies and training. Discussion in bite's *Issues* section.

G A model system for responding to problem-drinking prisoners (World Health Organization, 2012). Based on UK experience, offers an integrated model of best practice care for problem-drinking prisoners from screening through brief intervention and more intensive treatment, depending on need and feasibility.

G Working together to prevent domestic violence and abuse ([UK] National Institute for Health and Care Excellence, 2016). Planning and delivering multi-agency services for domestic violence and abuse.

G Lessons from drink-related domestic homicides (Alcohol Concern and Against Violence and Abuse, 2016). Messages for UK alcohol treatment services and their commissioners on preventing change-resistant drinkers from perpetrating domestic violence, abuse, and homicide, investigations of which informed the guidance. Discussion in bite's *Issues* section.

MORE This search retrieves all relevant analyses. See also hot topics on protecting children and on whether testing for and sanctioning substance use can displace treatment.
For subtopics go to the subject search page.

Close Matrix Bite

Links to other documents. Hover over for notes. Click to highlight passage referred to. Unfold extra text

What is this cell about? Constructing local, regional or national systems featuring treatment (usually along with criminal justice procedures) for offenders whose offending is related to their drinking. In these contexts, treatment is offered or imposed not because it has been sought by the client, but because it is thought that treating their substance use problems could reduce crime or otherwise benefit the community. Also includes treatment systems which benefit the community in other ways, including protecting the drinker's family and reducing the economic impacts of excessive consumption. As with commissioning in general, involves organising treatment provision to meet population needs in the context of resource constraints and national policy.

Research on treatment systems is rarely of the 'gold-standard', randomised controlled trial format. Whole areas and multiple coordinating agencies cannot easily be randomly assigned to implement new systems of care, while others must stand still or do the conventional thing to form a comparator; communities have their own lives, politics and event-driven diversions beyond the researcher's control. Instead, researchers usually look for patterns in what naturally happens rather than manipulating it to test the consequences. All this cell's key studies used variants on this methodology. Those patterns may reflect the presumed cause and effect mechanisms, but they may instead reflect unmeasured variables which randomisation would have evened up across intervention and comparison systems.

Treatment systems developed for criminal justice purposes are often derived from those centred on patient welfare and overcoming dependence; the impact of treatment in general on crime is the reason why it was adopted for criminal justice purposes. This means that for more research and ideas we can refer you back to cells dealing with brief interventions, treatment in general, medical treatments, and psychosocial therapies.

Where should I start? Try turning to the chapter starting page nine of the PDF version of a review commissioned by the Australian state of Victoria, published jointly with the Australian government. It explains that criminal justice and treatment systems must collaborate to treat offenders, but also that this is problematic due to radically different starting points: "Criminal justice systems are charged with carrying out justice and maintaining public safety; while … treatment systems assume responsibility for assisting individual clients to recover. As a result criminal justice systems … [require] the supervision and surveillance of offenders while treatment systems attempt to influence or modify clients' behaviour in the least restrictive manner possible". The consequence, says the report, is that each sector can see the other as ill-informed, unrealistic and undermining – not a good basis for joint working.

The remedy offered is education and training to foster mutual understanding and the recognition or forging of common or at least compatible goals. Turn to page 10 and you will see a bulleted list which distils US guidance down to nine ingredients for joint working between treatment and criminal justice systems. The following pages expand on those elements, explaining on page 12 that they come to a head in the case-management orchestration of services for the offender throughout their sentence/treatment. Doing this collaboratively "assumes that the criminal justice worker and the treatment provider view themselves as partners in a common effort to get the client-offender in recovery from [alcohol and other drug] abuse and living a crime-free life". One of the issues we will (below) invite you to consider is how far these ingredients have manifested themselves in Britain. Another is how far collaboration should go.

Highlighted study Commissioned by the Ministry of Justice, a report from a leading research centre on probation's alcohol-related work in England and Wales portrays a glass barely half full. Note the methodology: an *extensive* survey of all but one substance misuse lead in what were then 42 probation areas, allied with an *intensive* look at six case study areas. Such work can not only depict the general picture without bias due to sampling unrepresentative areas, but also dig deeper to see what produced this picture.

The resulting story was one of bottlenecks within probation and in accessing external services, and (perhaps as a result) a lack of priority given to identifying need. Among offenders who *were* identified and allocated to alcohol programmes, delays meant that by the end of their sentence, fewer than half were continuing in or had completed their treatments. A flagship national initiative – the Alcohol Treatment Requirement which enables courts to impose treatment – was massively under-used due to under-resourcing, itself partly due to a funding dispute between health and probation. Another theme was a lack of evidence on whether, even when adequately implemented, the interventions mounted by probation affect drinking or offending. Since the report we now know that the most common intervention has not been found to reduce offending.

In this report and in the corresponding report for Scotland there were bright spots of good practice, especially in the close integration of alcohol workers with probation, but overall this was a system not coping well under pressure, and often failing at the first step of identifying need.

Issues to consider and discuss

Does Britain have the right partnership ingredients? Look again at our starting point review and its ingredients for partnership working between treatment and criminal justice services. They start on page 10 of the PDF file, under the headings: Understanding the Intent of Sentencing; Understanding the Impact of Differing Goals; Understanding that Treatment Failure can Violate the Law; Communicating Clearly with a Common Language; Effective Case Management Strategies; Working with Indigenous AOD Clients (an issue more for Australia than the UK); Negotiating the Issue of Clinician Confidentiality in the Criminal Justice System.

Ask yourself some or all of the following questions. Are you convinced these are realistic objectives, the right ingredients, and sufficient to establish good partnership working? If you have experience of such working, to what degree were these ingredients present and what was their effect? Leaf through some of the British key studies in this cell (especially this report but also 1 2). Ask yourself whether these ingredients were identified as (or as not) characterising the investigated systems and whether they were seen as important to partnership working and ultimately to benefiting offenders and the community.

Why is drinking so prominent in sending thousands to prison, but not in prison services? In both England and Scotland there is a striking disparity between how commonly drinking precipitates imprisonment, and the attention paid to drinking by prison services – so striking that for England the prisons inspectorate subtitled their report, "An unmet need", while in Scotland researchers listed more gaps than fillings in the alcohol problem identification and treatment system.

If only because this could help cut their recidivist population, why aren't prisons doing more? Is it a case of 'see no evil'? Perhaps; the reports say that in England alcohol problems were not consistently or reliably identified, while in Scotland screening was generally limited to a yes or no question. Is it money? The English report highlighted a scarcity of resources dedicated to alcohol, meaning the national alcohol strategy was merely "an illusion of action". Is it that the authorities just don't know what to do? The English report comments that very few treatment or anti-offending programmes have been developed or accredited specifically for problem-drinking offenders, and the Scottish report that evidence is limited for most alcohol interventions in prisons.

There is a striking disparity between how commonly drinking precipitates imprisonment, and the attention paid it in prison

But even if all these and other factors are involved, that still begs the question of why eyes are half closed, resources lacking, and evidence uncollected. It's not that all such issues are so under-managed; more has been done for problems related to illegal drugs. Does the relative absence of alcohol in prisons permit the issue to be set aside? Is it because drinking is legal, so seen as 'not our business'? Does it simply reflect what is often seen as the relative lack of attention to alcohol (versus drug) problems in the broader society?

How far should collaboration go? Return again to the Australian starting point review and its argument that coordinating treatment in a criminal justice context "assumes that the criminal justice worker and the treatment provider view themselves as partners in a common effort to get the client-offender in recovery from [alcohol and other drug] abuse and living a crime-free life". From that starting point, says the review, these partners "can co-operate in setting goals for the client-offender, responding to undesirable or sentence-violating behaviour, and adjusting the terms of probation or parole and/or the type and intensity of treatment." Elsewhere the same document says collaborative working relationships mean responses to issues such as relapse will be "based on trying to achieve common goals for the client-offender". Establishing common goals in turn means that "the criminal justice system is much more likely to trust clinicians to make decisions and treatment personnel are more likely to base their decision on clinical grounds with full consideration of security and public safety".

Given that power lies mainly with the criminal justice system, do shared goals become in practice those of criminal justice?

"Full consideration" and "common goals" imply a collaboration so deep that what started out as the disparate goals identified in the review eventually become merged. Given that the power in this collaboration lies mainly with the criminal justice system – which must enforce the goals of the sentence, can require reports from the treatment service, and can revoke or change treatment – do 'shared goals' become in practice those of criminal justice?

That seems to be the view of a US expert whose manual on criminal justice supervision was listed in cell D5. More directly than in the Australian review cited above, Faye Taxman sees (p. 69) a good relationship between criminal justice staff and treatment services as enabling them to "work together toward the goal of maximum recidivism reduction". Treatment services "must address criminogenic needs" which may include substance use, but not concern themselves with "non-criminogenic factors, such as anxiety and low self-esteem" which "do not contribute to the mission of recidivism reduction".

Is this type of crime-centred collaboration desirable, or will it counterproductively deprive treatment of its focus on the patient's welfare, and with that its ability to engender crime-reducing change? After all, isn't it legitimate for treatment and criminal justice systems to have different priorities? Despite advocating integration, in the context of the treatment of drug-related offenders, another leading US expert has argued that "responsibility for ensuring offenders' adherence to treatment and avoidance of drug use and criminal activity is not, however, delegated to treatment personnel who may be unprepared or disinclined to deal with

such matters and who may have very limited power to intervene." It is, in other words, not the treatment service's job to prevent the offender returning to crime; for Professor Marlowe, that degree of sharing of goals is explicitly ruled out. Presumably, it is primarily their job to 'treat' their client or patient – though he says services should cooperate with the authority ordering the treatment, for example, by providing regular progress reports and testimony at hearings.

Where these issues come to a head is in rules about confidentiality – what the treatment service will/must disclose to criminal justice officials about the offender and what they have said or done during treatment. Our Australian starting point review dealt with this on page 14. A US review tackled the same issue in a panel headed "Confidentiality Guidelines for Integrated Approaches". Can you discern any substantive differences between the two?

The balance between client confidentiality and child protection Confidentiality is also a critical issue in the treatment of parents whose children may be at risk – an issue too big and too important for local service plans to fail to address. In England in 2014/15 an estimated 120,419 alcohol-dependent adults had 207,617 children living with them.

In 2013 a report from Australia's National Centre for Education and Training on Addiction investigated how alcohol and drug services can develop child and family sensitive practice. According to some treatment staff, a barrier to developing such practice was the requirements placed on them by local administrations to notify child protection services if they believed a client's children were at imminent risk. Concerns included loss of trust if child protection services approached the client, but also frustration when children who had been notified were not investigated and no feedback was provided. There was also the issue of when to notify – only when a serious event had happened or was looming, or in response to a developing pattern of less serious but perhaps cumulatively damaging behaviour?

Arrangements for treatment services to pass information to child protection services were addressed on page 4 of guidelines from England's National Treatment Agency for Substance Misuse and in chapter 3 of similar Scottish guidance. Both focused on explaining that overlapping legal considerations not only allow but in some circumstances require disclosure of risk, even if the patient withholds consent, and sometimes without seeking consent if to do so might aggravate risk or prejudice subsequent investigation. Both also acknowledged that local protocols may build on this foundation. Similar issues arise in relation to disclosure of domestic violence between adults (document listed above; Australian guidance).

What more would you like to see in your local arrangements, how would this help safeguard at-risk children, and what would the risk be of failing to safeguard them because parents react by not coming forward for treatment or withholding information? To help answer these questions, take a look at a report listed above from England's Office of the Children's Commissioner. On the basis of data and interviews in three local authority areas, an expert panel sought to identify and recommend good practice. Among other shortcomings, they noted that "Collaboration and liaison on information between adults' services, treatment services, children's services and wider family support services was not structured in a way which would enable better recognition of children's needs." In one area, "despite 'hundreds' of known parents being in treatment at any one time, just four referrals had actually been made over a period of six months" to a service offering help and support for children.

You might also consider what difference (if any) it makes if, as in Scotland, the child welfare system initiates legal proceedings only for the most serious cases. Scotland instead relies primarily on social work support and if warranted, (self-)referral to a Children's Hearing, where a panel of three elected and trained local volunteers coordinates support for the family and monitors progress, with the ultimate possibility of turning the case over to the enforcement system if progress is insufficient. It contrasts with the more legalistic systems in the rest of the UK and may facilitate joint working with families, but also enables some to disregard the panel.

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