Evaluation of the AAMR tagging pilot

Year 2 process evaluation findings

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Introduction and background

The report presents findings of the independent process evaluation of the Humberside, Lincolnshire and North Yorkshire (HLNY) Alcohol Abstinence Monitoring Requirement (AAMR) pilot, which was used as part of a multi-requirement order in cases where alcohol contributed to the offence. The pilot was delivered across three local justice areas for a period of two years. It utilised new sentencing powers in England and Wales which allow courts to impose a requirement as part of a Community Order or a Suspended Sentence Order that an offender abstain from alcohol for a fixed period of up to 120 days. The offender is then monitored, via a transdermal alcohol monitoring device in the form of a 'tag' fitted around the ankle which detects consumption of alcohol through sweat.

The HLNY partnership included the Offices of the Police and Crime Commissioners for Humberside, Lincolnshire and North Yorkshire; Humberside, Lincolnshire & North Yorkshire Community Rehabilitation Company (HLNY CRC) Ltd, with representation from Her Majesty's Courts and Tribunals Service, the Crown Prosecution Service, Her Majesty's Prison and Probation Service (HMPPS) and the Ministry of Justice (MoJ). With funding in place, the Project Board implemented the pilot on 5 June 2017 for two years. In the first year, this enabled seven courts covered by the three local justice areas to issue AAMR orders monitored through a tag using the SCRAM Continuous Alcohol Monitoring (SCRAM CAM) technology. The coverage of the pilot was expanded in Year 2 to include another seven courts.

The National Centre for Social Research (NatCen) was commissioned by North Yorkshire Police and Crime Commissioner (PCC) to undertake a process and outcomes evaluation of the HLNY AAMR pilot. This report focuses on the process evaluation, the aim of which was to learn from the experiences of setting up and using AAMR and offender management to support positive outcomes, with a focus on domestic violence cases. The outcomes evaluation of the HLNY AAMR began in March 2019 and aims to report in February 2020. Its aim is to assess whether and to what extent the pilot positively affects offenders' behaviour, including reduced reoffending rates.

Methodology

A qualitative design was used to obtain a comprehensive picture of the pilot across the three case study areas in Year 1. The scoping phase of the process evaluation aimed to explore AAMR pilot set-up and early views on delivery through a document review and in-depth interviews with key staff and stakeholders. Main stage qualitative case study fieldwork took place between November 2018 and May 2019 and involved in-depth interviews with a range of stakeholders across the criminal justice system (CJS). Participant groups included: the police and probation services (the HLNY CRC and National Probation Service (NPS)); the courts including the judiciary; support

organisation staff and tag wearers. In total, 31 interviews were conducted with 25 staff and six tag wearers.

Pilot set-up

Setting up the AAMR pilot involved laying the necessary legislation, recruiting staff to deliver the pilot, getting contracts and processes in place with the range of partners involved in delivery, developing a range of briefings, guidance and training, and setting up the necessary equipment and software to fit and monitor the tags. The HLNY AAMR pilot was set-up with a different operating model to the previous alcohol monitoring tagging pilot trialled by MOPAC. Key differences of the HLNY model included the CRC having responsibility for fitting and maintaining the AAMR tags and the inclusion of domestic violence offenders.

Staff and stakeholders valued the high-quality provisions that were put in place to support the set-up of the pilot. Many reported that they felt well-informed, trained and supported on how the pilot was intended to be used and delivered. This was facilitated through briefings across local CJS partners, practical training on tag fitting and maintenance, and flexible, responsive support from the pilot project manager. Ensuring adequate resources were available to deliver the pilot was also important and while provisions had been made to ensure the range of equipment was available for use, problems were highlighted with internet access and connectivity both in staff offices and wearers' homes, especially in more rural areas. This was, on occasion, perceived to have impacted on the timeliness of fittings and automatic download of data for the purpose of offender management.

Early perceptions of AAMR

Staff and stakeholders were enthusiastic about AAMR and keen to be involved in a pilot that might create opportunities for people to change their relationship with alcohol and deal with other issues in their lives. However, concerns were also flagged which related to how individuals would respond to the tag, the appropriateness of the order for the crimes it aimed to address and the level of wider CJS engagement, which was considered pivotal to the smooth running of the pilot.

Wearers generally understood why they had been given the AAMR order and anticipated that it might help them change their drinking habits. However, the survey which was carried out when tags were initially fitted, highlighted a degree of nervousness in relation to other people knowing about the tag. Half of survey respondents reported that they did not think it would be easy to forget about the tag, linking to later findings related to the size, comfort and practicalities of wearing the tag.

Overview of pilot activity

An overview of the profile of wearers and the nature of the requirement for the pilot is provided in the Management Information (MI). Key findings from the MI include:

- Over the course of the pilot, 226 individuals were issued the AAMR order. Some individuals were tagged more than once, resulting in 231 total AAMR orders. These

- individuals were predominantly white (98%) and male (88%). Almost all (96%) wearers were under 50 years old.

- Half (52%) of wearers were sentenced in Lincolnshire, one-third (33%) in Humberside and 13% in Yorkshire at the time of receiving the AAMR order.

- Alcohol is a significant factor in offending in the pilot areas, particularly in domestic violence cases and 31% of wearers were convicted of a domestic violence offence.

- The volume of individuals sentenced to the requirement increased in the second year of the pilot. In the first year, approximately 20 people were tagged every three months, increasing to 40 people in the second year of the pilot. This increase in uptake reflects the extension of the pilot to the entire CRC in the second year.

- Overall, compliance with the AAMR was high, with 94% successfully completing the requirement.[1] The final sober days rate was 97.4% sober days.[2]

- In all but one case the AAMR was ordered alongside other requirements. Three-quarters (74%) of wearers had a single additional requirement, a quarter (24%) had two additional requirements and a very small minority (2%) had three additional requirements.

Identification of eligible individuals

The use of discretion and professional judgement were important factors in identifying appropriate individuals to recommend for the AAMR. Participants valued the discursive nature of the assessment process which included the pre-sentence interview as it enabled a range of circumstances and needs to be considered. Effective partnership working and use of assessment tools, such as AUDIT[3] were considered critical in informing sentencing decisions.[4]

Judges and magistrates took time to understand how individuals might manage an AAMR order and the role it could potentially play in their rehabilitation, weighing it against other options to select the most appropriate sentence for each person. Factors such as an offender's ability and willingness to comply with the order and the potential benefits of other sentencing options, such as the 'Building Better Relationships' programme, (which is used regularly across the sector with domestic violence offenders) were taken into consideration.

As highlighted, take-up of the AAMR was slow initially. Barriers to using AAMR included a lack of knowledge about the order and some resistance to using it with specific cohorts, (including domestic violence offenders) and among certain stakeholder groups, including

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[1] A successful completion was defined as reaching the end of the requirement without being breached or revoked and resentenced.

[2] A sober day is defined as 'when no drinking or tamper alerts are detected'.

[3] The Alcohol Use Disorders Identification Test (AUDIT) is a 10-item screening tool developed by the World Health Organisation (WHO) to assess alcohol consumption, drinking behaviours, and alcohol-related problems. A score of 8 or more is considered to indicate hazardous or harmful alcohol use. Use of AUDIT is part of the pre-sentence report process.

[4] To be eligible for the order, individuals were supposed to have an AUDIT score of between eight and nineteen. Most wearers (71%) had an AUDIT score within this range, though some individuals with AUDIT scores outside of this range were issued the order.

defence solicitors, some of whom believed the order to be too punitive. Participants felt that these barriers were addressed over time as partners became more familiar with AAMR. Reported facilitators included awareness raising activities and communication about the pilot which was targeted at different groups. For example, AAMR project leads visited courts to explain the softer benefits of using the order to judges and magistrates.

Tag fitting

Regular and effective communication between NPS court staff and the CRC was thought to facilitate the smooth fitting of AAMR tags. Examples of good practice included ensuring staff with fitting experience were available and had private office space booked on days when people would typically be given an AAMR order. Wearers valued the approach taken by CRC staff to reassure them and explain the requirements of the order. However, some challenges were identified with the time taken to fit tags (which was intended to be within 48 hours of sentencing). Wearers' proximity to a CRC office and the time of day sentences were given had an impact on how quickly this could happen.

Offender management

Participants involved in monitoring and supporting wearers spoke positively about having access to regular data on alcohol consumption as it helped to facilitate honest and productive conversations about drinking habits and any lapses wearers might have experienced so that appropriate support could be put in place.

Compliance with AAMR was high and wearers explained that the tag acted as a reminder to abstain from alcohol. However, some reported that they had found it hard to modify their drinking behaviour and identified times when they felt they might be at greater risk of relapsing, for example when things 'go wrong' in their lives such as a break-up with a partner.

Using the data available to them, staff participants welcomed the possibility for a staged approach to infractions, which could increase in line with the seriousness of the breach, guidance from the project manager and an element of professional judgement enabled offender managers to tailor support as they saw fit.

Support

The combination of monitoring alcohol consumption via the tag with tailored offender management and Rehabilitative Activity Requirement days was thought to be appropriate as it offered a chance to 'break the pattern' of offending behaviour. Most support was delivered via the CRC or NPS, which was considered to be appropriate given the experience and level of contact offender managers had with wearers. However, views on this support were mixed. Practical barriers to delivering probation support included a lack of time to support wearers alongside busy workloads and a lack of resources (such as appropriate meeting room space).

Support was also offered to wearers through external organisations to help with more specialist issues such as employment, housing, domestic violence and substance

misuse needs. Such provision had filled important gaps, however, there was evidence to suggest that it was not always accessed in cases where it may have been helpful. Furthermore, though specific accredited domestic violence programmes such as Building Better Relationships were valued and viewed positively, barriers to accessing this provision were also highlighted. This raised concerns among staff that wearers (and victims) were not receiving support for domestic violence behaviours quickly enough.

Perceived impacts of the AAMR pilot

Reported impacts of the AAMR pilot on wearers included:

- **Alcohol consumption**: over three-quarters of 'tag-off' survey respondents reported that they thought they would drink less alcohol or no alcohol at all when the tag was removed, a finding which was echoed in the qualitative data collected with staff and wearers. However, some wearers worried about whether they would be able to maintain abstinence once the tag was removed.

- **Resettlement:** wearers and staff reported the tag had positive impacts on relationships with family. They also described home environments as more 'calm' as much of the previous tension, and sometimes violence, had stemmed from the wearers' drinking.

- **Health and wellbeing:** wearers described feeling healthier and happier for achieving a period of abstinence. However, concerns with the size and comfort of the tag were also raised and wearers were worried that it would be noticeable to others.

Mixed impacts on CRC and probation staff capacity were reported by staff participants. Some felt that workloads had increased in areas where there was high demand while others reported very little impact. Support agencies also felt their role was unaffected by the pilot in that they still provided the same services to wearers regardless. However, staff highlighted that if the pilot were to be rolled out more widely, impacts on staff workloads should be properly considered and the necessary resources put in place.

Learning from the AAMR pilot

Overall, staff and wearer participants were positive about the potential for AAMR to support effective community sentencing. It was felt to be an important 'tool' available to decision-makers which could be used to support the rehabilitation of a specific offender group, where drinking had contributed to their offending behaviour.

Two key overarching recommendations were raised by participants. Firstly, staff participants highlighted the importance of the necessary resources being in place if the programme was scaled up. This includes adequate time for probation staff to fulfil all programme responsibilities, (e.g. fitting tags, monitoring wearers and delivering effective offender management) as well as dedicated administrative support to enable the smooth delivery of the programme. Secondly, participants were keen to understand what worked well and challenges related to the delivery of AAMR, to ensure that partners across the CJS continued to use it effectively, and, give confidence to the judiciary in making sentencing decisions.

Other learning points to be considered if the pilot were to be rolled out more widely included the need for:

- **Clear and consistent communication** about the pilot to help increase awareness, knowledge and embed provision across the CJS. Strong and effective partnerships where stakeholders are clear on their roles and responsibilities was also highlighted as important. This would help support more effective identification and sentencing of eligible offenders and confidence in using the order to achieve rehabilitative aims.

- **Equipment (e.g. laptops) that is accessible and well connected**. Challenges included a lack of access to essential equipment, including laptops, especially when the pilot was extended to the entire CRC. The connectivity of some devices and wi-fi in wearers' homes also made it hard to manage the fitting and monitoring processes in some areas.

- **Tailored and accessible offender management and support**. For the AAMR to be effective, participants were clear that support should wrap-around the period of abstinence and help the wearer to make positive changes while sober. Appropriate time and resources should be allocated to support provision to ensure wearers are given the best possible chance to maintain sobriety and deal with issues that may impact on their offending behaviour beyond the period of wearing the tag.

1   Introduction

This report presents the findings of the independent evaluation of the Alcohol Abstinence Monitoring Requirement which was piloted across three local justice areas in England; Humber, Lincoln and North Yorkshire. This section briefly sets out the policy context and background to the pilot, the aims and objectives of the evaluation and the methodology used.

1.1   Policy background

In March 2018, victims of violent crimes perceived the offender to have been under the influence of alcohol in 39% of incidents recorded (Elkin, 2018). The Crime Survey for England and Wales further shows that in 2016/17, over 20% of criminal damage incidents and hate crimes were alcohol-related (Office for National Statistics, 2018).

Electronic Monitoring is a way of remotely monitoring and recording information on an individual's whereabouts or behaviour, using an electronic tag which is normally fitted to a subject's ankle (Mair and Nellis, 2013). Included as part of the Legal Aid, Sentencing and Punishment of Offenders (LASPO) Act 2012,[5] the Alcohol Abstinence Monitoring Requirement (AAMR) is a new sentencing power in England and Wales which allows courts to impose a requirement as part of a Community Order or a Suspended Sentence Order that an offender abstain from alcohol for a fixed period of up to 120 days. For the purposes of the pilot, compliance was monitored via a transdermal alcohol monitoring device in the form of a 'tag' fitted around the ankle which detects consumption of alcohol through sweat. The tags can determine the difference between alcohol that has been consumed and that which is environmental.

The London Mayor's Office for Policing and Crime (MOPAC) conducted a 12-month pilot of the AAMR in four London boroughs to test use, compliance and perceived effectiveness from February 2016 (Pepper and Dawson, 2016). This was the first compulsory sobriety scheme in Europe and part of MOPAC's response to tackling and reducing the volume of alcohol-related crime within London. MOPAC excluded offences linked to domestic violence due to concerns that abstaining from alcohol may create additional risks for the victim and divert attention away from specific interventions designed to tackle domestic violence. However, a small number were included in the latter stages of the pilot following stakeholder consultation. A key recommendation of MOPAC's proof of concept report was that wider roll-out of AAMR and further evaluation would give opportunities to properly explore impacts on offending behaviour and wider possible benefits. As a result, MOPAC extended and expanded their pilot, which achieved a 94% compliance rate with the requirement and a 98% sober day rate in its second year (Hobson et al., 2018). The MOPAC model differed from the pilot evaluated in this report with the monitoring and field services carried out by Electronic Monitoring Services (EMS) in a direct contractual relationship with MOPAC.[6]

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[5] Inserted as Section 212A of the Criminal Justice Act 2003.
[6] EMS are the providers of electronic monitoring for curfew and location monitoring to the Ministry of Justice.

1.2   Description of the AAMR pilot

1.2.1 Pilot aims and overview

In June 2017, the Humberside, Lincolnshire and North Yorkshire (HLNY) AAMR pilot was rolled out across the three local justice areas for a period of two years, building on and extending the approach trialled by MOPAC.[7] Within Humberside, Lincolnshire and North Yorkshire, alcohol is a significant factor in offending, particularly in domestic violence cases, where reoffending is higher for people who commit offences under the influence of alcohol[8] (though this is not unique to HLNY). The HLNY pilot had a focus on domestic violence cases from the outset to explore wider potential benefits of the order. The AAMR was also intended to be used as part of a multi-requirement Order, alongside a Rehabilitation Activity Requirement[9] or an Accredited Programme Requirement, as opposed to a standalone order. [10] In accordance with legislation,[11] an AAMR can be imposed in cases where alcohol contributed to the offence, but it cannot be used with offenders who are dependent on alcohol or alongside an Alcohol Treatment Requirement.[12]

The HLNY partnership included the Offices of the Police and Crime Commissioners for Humberside, Lincolnshire and North Yorkshire; Humberside, Lincolnshire & North Yorkshire Community Rehabilitation Company (HLNY CRC) Ltd, with representation from Her Majesty's Courts and Tribunals Service, the Crown Prosecution Service (CPS), Her Majesty's Prison and Probation Service and the Ministry of Justice (MoJ). With funding in place, the Project Board implemented the pilot on 5 June 2017 for two years. This enabled courts in the pilot areas to issue AAMR orders monitored through a transdermal alcohol monitoring device using the SCRAM Continuous Alcohol Monitoring (SCRAM CAM) technology.

1.2.2 Pilot areas

In Year 1 the pilot was live in seven courts across the three pilot sites within the HLNY area. The number of people given an AAMR order was lower than anticipated in the first year,[13] so the coverage of the pilot was expanded in Year 2 to include another seven

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[7] A partnership was formed between the Humberside, Lincolnshire and North Yorkshire Police and Crime Commissioners and the Humberside, Lincolnshire and North Yorkshire Community Rehabilitation Company to run the pilot.

[8] HLNY Community Rehabilitation Company (internal document) *Operational AAMR Guidance and Information.*

[9] The RAR is one of the requirements that can be included within a Community Order or Suspended Sentence Order. The main purpose is to secure someone's rehabilitation, so that service users can live a purposeful life.

[10] An accredited programme is a systematic series of activities aimed at supporting rehabilitation which have been accredited by the Correctional Services Accreditation Panel. Programmes vary in length and complexity and are targeted according to risk and need.

[11] Section 76 of the LASPO Act 2012 sets out conditions around the AAMR.

[12] The Alcohol Treatment Requirement is targeted at offenders assessed as alcohol dependent, who will often have complex coexisting needs e.g. mental health, social and housing problems, and require intensive, specialist, care-planned treatment e.g. day programmes, detoxification, residential rehabilitation and integrated care involving a range of agencies.

[13] As highlighted in chapter 3, the MI shows that referrals to the pilot were low initially. However, overall, the numbers achieved were close to what was expected.

courts. This was intended to increase the number of AAMR orders, which would make better use of the funding available for the pilot and ensure as much learning and value were gained as possible.

The Year 1 pilot areas were used as case study areas for the evaluation. These were York (York Magistrates' Court and York Crown Court), Grimsby (Grimsby Magistrates' Court and Grimsby Crown Court) and Boston (Boston Magistrates' Court, Lincoln Magistrates' Court and Lincoln Crown Court). The locations were chosen for the pilot because they had a high concentration of alcohol related crime; and high numbers of domestic violence cases where alcohol was a contributing factor. These areas are also characterised by significant alcohol problems in the local community.

1.2.3 Eligibility criteria

The pilot guidance stated that an offender would be eligible for the AAMR pilot, if:

- Alcohol was a feature or factor in the offending behaviour.[14]

- The individual is not dependent on alcohol. This is assessed using the AUDIT (Alcohol Use Disorders Identification Test) tool. AUDIT scores from 8-19 indicate the offender is suitable for the order.[15] Scores above 19 indicate a dependence and scores of lower than 8 may suggest that alcohol is not a big enough factor for the individual to benefit from the intervention.

- The individual lives in either Grimsby, Boston, Spalding, Skegness, Louth or York & Selby, and is sentenced in one of the pilot courts.[16]

The guidance further advises that AAMR should be used as part of a multi-requirement order with a Rehabilitative Activity Requirement or Accredited Programme Requirement (but not an Alcohol Treatment Requirement).

1.2.4 Pilot set-up

The key activities involved in setting up the pilot included:

- Securing the necessary funding;

- The selection of pilot areas, guided by alcohol-related offending rates including domestic violence;

- Laying the necessary legislation and getting contracts and processes in place with the range of partners involved in delivery, including the tagging technology provider;

- Recruiting staff, including a project manager;

- Developing and delivering a range of briefings, guidance and training to partners and staff across the pilot areas, including the courts, National Probation Service (NPS) teams and Community Safety Partnerships;

- Acquiring and setting up the necessary equipment and software to fit and monitor the tags; and

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[14] AAMR 4. Guidance for sentencers as per the law
[15] AAMR 2. Operational guidance
[16] This guidance was given before the addition of the extra courts in Year 2.

- Putting in place the alcohol interventions to be used alongside the tag.

The range of partners involved in the set-up of the pilot included PCC leads, probation services (NPS and the CRC), the courts, local domestic violence stakeholders, the police and other support services including mental health, substance misuse and safeguarding services. These partners carried out the following roles and responsibilities to support the set-up and delivery of the pilot:

- Police: to ensure a flag is recorded on MG5 forms[17] to indicate if an offence was linked to the offender's use of alcohol, and as such, if the offender could be eligible for AAMR.

- NPS court staff: to assess the offender's suitability and eligibility for AAMR and recommend rehabilitative activities.

- Judiciary and legal advisers: to impose the AAMR order as part of a multi-requirement order, where appropriate.

- CRC case managers: to fit and remove AAMR tags and liaise with the monitoring centre, manage offenders allocated to case management by NPS court staff and provide rehabilitative activities.

- NPS probation officers: to manage offenders allocated to case management by NPS court staff and provide rehabilitative activities.

- Alcohol Monitoring Systems (AMS): to provide the hardware and SCRAM software[18] and give training and guidance to staff.

- MoJ: to lay necessary legislation, amend Magistrates' and Crown Courts notification procedures, notify courts and advise on policy to help develop guidance and deliver briefings.

These key stakeholders reported a range of views and expectations of the pilot, which are discussed in more detail in section 2.5.

1.3   Evaluation aims and objectives

The National Centre for Social Research (NatCen) was commissioned by North Yorkshire Police and Crime Commissioner (PCC) to undertake a process and outcomes evaluation of the HLNY AAMR pilot. This report focuses on the process evaluation.

The aim of the process evaluation was to learn from the experiences of setting up and using AAMR and offender management to support positive outcomes, with a focus on domestic violence cases and the different operational model used in HLNY compared to the MOPAC pilot. It was designed to increase understanding of the processes involved in alcohol monitoring using the continuous alcohol monitoring tags, explore factors affecting take-up, changes to pilot delivery, any challenges and how these may have been overcome. Consideration was also given to perceived impacts of the pilot, including whether the availability and use of alcohol monitoring tags had affected the behaviour of local justice decision-makers and wearers. The process evaluation also explored the

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[17] The MG5 is a police document used to provide details of a case for a first hearing at court.
[18] Alcohol Monitoring Systems is based in the US and owns and delivers the SCRAM software used for continuous alcohol monitoring.

CRC's experiences of delivering the Field and Monitoring Service[19] and views of organisations involved in delivering support both to offenders, including for example substance misuse services and victim support services. Best practice has been identified to inform potential future roll-out of an AAMR order across England and Wales.

The outcomes evaluation of the HLNY AAMR began in March 2019 and aims to report in February 2020. Its aim is to assess whether and to what extent the pilot positively affects offenders' behaviour, including reduced reoffending rates. It will provide a causal estimate of the impact of participating in the pilot on re-offending, within 12 months of tag fitting, using a propensity score matching (PSM) approach. The report's conclusion contains more detail about the outcomes evaluation.

1.4 Methodology

1.4.1 Scoping phase

The scoping phase of the process evaluation was carried out between May to October 2018 to inform understanding of the AAMR pilot set-up, early views on delivery and any early reported impacts. This stage involved a high-level review of key pilot documents relevant to set-up and delivery, followed by in-depth interviews with eight members of staff across stakeholder groups, including: members of the AAMR project board; the MoJ; staff from probation services and the police. Findings from the scoping phase were used to inform the design of the main stage fieldwork and confirmed the range of potential participant groups to be included in the evaluation.

1.4.2 Main stage fieldwork

Ethical approvals were required before mainstage fieldwork could commence. More detail on these approvals is included in Appendix A.

Sampling and recruitment of participants
Main stage qualitative case study fieldwork took place between November 2018 and May 2019 and involved in-depth interviews with a range of stakeholders across the criminal justice system (CJS). Participant groups included: the police and probation services (NPS and the CRC); the courts including the judiciary; support staff; and tag wearers. In total, interviews were conducted with 25 staff and six tag wearers (see Appendix A for a breakdown of interviews by participant group).

Case study data collection focused on the Year 1 pilot locations: Grimsby in North East Lincolnshire, York in North Yorkshire and Boston in Lincolnshire. The AAMR pilot was expanded to an additional seven courts in Year 2, but it was decided that interviews in Year 1 locations would sufficiently capture experiences and views around the roll-out of the pilot into other areas.

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[19] A new role of AAMR Case Manager or Senior Case Manager was created to reflect these responsibilities for the pilot.

Purposive sampling was used to ensure a range of individuals were invited to take part in the evaluation. A designated CRC lead in each case study area provided the research team with contact details of staff members across participant groups who had consented to be contacted by NatCen. In addition, the research team used the networks of staff that had participated in the evaluation by asking whether they could speak to their colleagues about the research and share the contact details of those interested in taking part (with their consent). Prior to contacting any potential participants about the research, gatekeepers (CRC leads or other staff participants) were clearly briefed by the NatCen team about the evaluation and the data-sharing process.

For tag wearers, a two-pronged recruitment approach was used to maximise the range and diversity of participants taking part. This involved the research team:

1. Drawing on the sample of wearers who had given permission to be re-contacted by NatCen as part of a separate CRC tagging survey completed by wearers when the tag was fitted and removed. All offenders sentenced to AAMR were asked at 'tag on' and 'tag off' if they consented to being contacted by NatCen.
2. Liaising with gatekeepers to explore opportunities to approach wearers about the evaluation and pass the contact details of those interested in taking part to NatCen. This built on the first step, as only individuals who indicated a willingness to participate through the surveys were contacted at this point. Gatekeepers were briefed about the evaluation and the process of consent and sharing personal information, prior to contacting any potential participants.[20]

The achieved sample of staff participants was closely monitored to ensure diversity across participant groups, geographical locations and type of court (Crown or Magistrates'). The wearer sample was also monitored across the following characteristics: geographic location, age, gender, ethnicity, type of sentence and offending history. However, due to challenges with recruitment (outlined in section 1.5 and discussed in Appendix A) we were not able to recruit the anticipated number of participants. This may have impacted the diversity in the wearer sample in particular. Achieved quotas are provided in Appendix A.

Individuals were contacted by the NatCen research team to arrange a suitable time and date for the interview. Information leaflets about the evaluation and what participation involved were sent to each person at this stage. Participants were offered a choice of having a telephone or face-to-face interview; all opted for telephone.

Fieldwork conduct
Topic guides were used to ensure a consistent approach across encounters and between members of the research team. Separate topic guides were developed for staff and tag wearers. They were used flexibly, with open and non-leading phrasing to allow researchers to respond to participants' individual accounts. Staff interviews focused on views and experiences of pilot set-up and delivery, as well as any impacts over the life of the pilot. Wearer interviews focused on views, experiences and impacts of wearing

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[20] Gatekeepers had to get the consent of potential participants before passing their contact details to the NatCen research team. The details of wearers were transferred securely, either via the Criminal Justice Secure Mail service or over the phone.

the tag, and recommendations for improvement. More information on the topic guides and an overview of key themes covered is included at Appendix B. Interviews ranged from 30 to 90 minutes.

Analysis and reporting

With participants' permission, the interviews were audio recorded and transcribed verbatim. Interview data was managed and analysed using the Framework approach developed by NatCen. This matrix-based analytic method facilitates rigorous and transparent qualitative data management, with a thematic framework used to classify and organise data according to key themes, concepts and emergent categories.

As this is qualitative research, the number of people who hold a particular view is not reported as it offers no indication of the extent to which these views are held in the wider population. Any numerical inference is likely to be misleading or inaccurate as qualitative samples are not designed for this purpose, but instead to capture a range and diversity of views and experiences. The report distinguishes between different types of participants where this helps to illuminate findings and does not breach anonymity.

Responsible officers in charge of monitoring wearers are either case managers or offender managers, depending on whether they are NPS or CRC staff. For the sake of brevity we will use the term 'offender manager' to refer to both roles.

Interview quotations are used to illustrate themes and findings where appropriate. They are labelled according to staff group or as a wearer participant. Staff groups include police and probation staff, court staff and support staff.

Wearer survey

Findings from two surveys conducted by HLNY CRC with wearers when tags were fitted and removed are also included in this report where relevant. Surveys asked wearers about their expectations for wearing the tag, drinking behaviour, impacts of alcohol on day-to-day life and experiences and impacts of wearing the tag. 101 wearers completed the 'tag-on' survey and 70 wearers completed the 'tag-off' survey (Management Information (MI) shows that 231 AAMRs were issued in total).[21] Given response rates, it is possible that the views of those who completed the surveys are not representative of all tag wearers.

Management information

Key pilot data and MI was produced for the HLNY pilot in the form of a 'dashboard' and disseminated to partners on a regular basis. It was analysed to provide important context for this report. This data set included demographic information about wearers and details of their AAMR orders, including where and when they were sentenced, what they were sentenced for, additional requirements and details on compliance and completion.

It is important to note that this data has been extracted from MI systems which, as with any administrative recording system, are subject to possible error with data entry and processing.

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[21] This gives a response rate of 44% for the 'tag-on' survey and 30% for the 'tag-off' survey.

1.5 Methodological challenges and limitations

As with all research, the evaluation methodology had limitations and it is a marker of high-quality research to acknowledge them. The main methodological challenge for this study involved the recruitment of staff and wearer participants. These were largely overcome for staff participants, but wearer recruitment remained challenging and as a result only six wearers were interviewed. As such, staff and wearers' perspectives are unlikely to be representative of all those involved in the HLNY pilot. More detail about these challenges and strategies to overcome them is given in Appendix A.

1.6 Report overview

The rest of the report is structured as follows:

- **Chapter 2** explores how the AAMR pilot was set-up and managed from the perspective of strategic and operational staff.

- **Chapter 3** explores the profile of wearers and the nature of the requirement for the pilot. This draws predominantly upon MI collected by HLNY as part of the pilot and the wearer data from the 'tag on' surveys.

- **Chapter 4** details views and experiences of identifying eligible wearers and imposing an AAMR order, tag fitting and monitoring of wearers, and the delivery of offender management and rehabilitative support.

- **Chapter 5** describes the reported impacts of AAMR on wearers, staff involved in delivery and wider impacts on related sectors.

- **Chapter 6** sets out the report's conclusions.

2 Pilot set-up

This chapter explores how the AAMR pilot was set-up and managed from the perspective of strategic and operational staff. It considers communications and training, resources, governance and staff and wearers' early perceptions of the pilot.

2.1 The HLNY AAMR model

As outlined in chapter 1, the HLNY AAMR pilot was set-up with a different operating model to the MOPAC alcohol monitoring tagging pilot. One of the key differences was that the CRC was given responsibility for fitting and maintaining the AAMR tags, which was a new area of practice for CRC case managers, who had previously not been expected to fit tags as part of their role.[22] In addition, for the first time in the use of an electronically monitored condition, the monitoring was carried out by probation staff, which meant that the CRC had direct access to MI, without it being mediated by a third party.

In the first instance the AAMR semi-specialist role was advertised internally as an opportunity for CRC case managers and senior case managers.[23] The voluntary nature of the role was viewed as an indication of staff enthusiasm to be involved in the pilot.

A unique aim of the pilot was to fit tags as soon as possible after the AAMR order had been given. For the AAMR model, this was viewed as 'tagging at source' and the intention was for individuals to attend the nearest CRC probation office for tag fitting immediately following sentence, where possible. The aim was also for the person fitting the tag to be the 'responsible officer' or offender manager, where possible, to provide a holistic response to managing the AAMR as part of a wider community sentence and to ensure rehabilitative activities could begin quickly. More information on the views and experiences of tag fitting activities and rehabilitative support is detailed in chapter 4.

A further key difference to previous pilots was that domestic violence perpetrators were in scope. As detailed in chapter 1, a key aim of the pilot and evaluation was to explore how AAMR could be used effectively and safely with this cohort. In the early stages of pilot delivery, local domestic violence stakeholders, including the police and support services, were consulted to ensure the requirement could be utilised appropriately and not put victims at risk, particularly after the tag was removed – an initial concern for some stakeholders. Despite these concerns, participants could see the potential value of AAMR for people convicted of domestic violence offences, due to the 'logical link' between domestic violence and alcohol use. Their sense was that AAMR may help to reduce victims' risk, and they were keen to see whether it had this impact.

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[22] CRC case managers were required to undergo a health and safety risk assessment in respect of this new area of responsibility.

[23] Senior Case Manager is the equivalent of the Probation Officer grade (i.e. those who have completed the Diploma in Probation Studies or equivalent qualification). Case Manager is the equivalent of the Probation Service Officer role.

'I was really interested to see whether or not the sobriety tag imposed […] would have the desired effect; increasing compliance and motivation, leading to real safe outcomes with regards to domestic abuse.' (Probation staff)

2.2 Communication, training and guidance

2.2.1 Communication

A key aspect of pilot set-up was informing staff and stakeholders about the nature of the pilot and key delivery partners' roles and responsibilities. Early communication about the pilot included the dissemination of written information such as leaflets and emails, and face-to-face briefings provided by the CRC to the courts, NPS teams and Community Safety Partnerships.

Two main types of briefing were conducted, covering practical and strategic information. Practical briefings demonstrated how the tags worked and were provided to staff that were directly involved in the pilot, including probation (CRC and NPS court staff), for example. Staff found these briefings informative and reported that this helped them to understand the data produced by the tags. The CRC also conducted strategic briefings disseminating top-level information on the scope and aims of the pilot and explaining how the hardware worked. These were provided to groups that were less involved in the day-to-day delivery of the pilot, such as local strategic boards. Briefings were also carried out during pilot delivery on an ad-hoc basis to maintain awareness of the pilot among stakeholders and delivery partners.

Participants who viewed early communication positively described it as useful and comprehensive, or felt it gave them sufficient information to carry out their role. Being able to ask questions during briefing sessions was particularly welcomed.

In contrast, some staff and stakeholders felt they were not provided with enough information during pilot set-up. For example, some court staff felt that more information could have been delivered face-to-face rather than in writing, which may have made them more likely to engage with the pilot and use it effectively. Further detail on judicial engagement in the pilot is discussed in section 2.5.

2.2.2 Training and guidance

Training staff in how to set-up and use the alcohol monitoring equipment, including the tag, was another important element of pilot set-up. Formal training was delivered to CRC staff by AMS, the company that provided the monitoring technology for the pilot. AMS provided a two-day training course at the beginning of the pilot as well as refresher sessions to train new staff and to mitigate for delays between the training and staff fitting tags. The training included how the technology works and practical skills. This included how to fit and remove tags; perform maintenance on the tags; use the software to monitor wearers; and interpret the data produced by the tag. Participants also reported trainees having the opportunity to wear the tags overnight so that they could experience what it felt like and review the data generated.

Staff generally welcomed this formal training as it gave them a thorough understanding of how the tag worked as well as familiarity with the equipment and software. Staff particularly valued the positivity of the trainers. However, delays between receiving the formal training and using the tags meant some valuable learning was lost. Staff also suggested training that allowed them to apply the skills learnt may have been useful in some cases, and that more support could have been given to help staff interpret the data (discussed further in chapter 4).

In addition to formal training on using the equipment, NPS and CRC staff had access to a range of guidance during the set-up and delivery of the pilot. A key source of valued support was through the pilot project manager who was available to help resolve issues quickly.

> *'I was told that any problems I could just ring the project manager who had a really good understanding of everything. She just said any issues or problems that come up just give me a call and we'll try and solve it […] It's been brilliant. It's been a really big help.'* (Probation staff)

Support was also offered by the AMS team who provided this outside of formal training sessions, particularly to senior staff during the set-up phase. This support was perceived to be important in familiarising staff with the monitoring equipment and data interpretation as the pilot was rolled out.

> *'It's been fantastic. It's been absolutely vital in terms of me understanding all aspects of the tagging.'* (Probation staff)

However, ad-hoc phone support provided by AMS was not always viewed positively by frontline staff responsible for monitoring wearers and managing alerts. One reason for this was that some staff felt the US team were not familiar with the context within which AAMR was being delivered in England, which made it difficult to always interpret information and resolve issues quickly.

Guidance and best practice were also disseminated through regular practitioner Skype meetings between NPS and CRC staff. These were viewed positively by staff as a forum to discuss ongoing 'teething problems' and share learning. To enhance this, staff suggested it might have been useful to connect with the London team who already had experience of tagging and managing wearers through the MOPAC pilot (though differences in the two delivery models were highlighted). To this end, participants would have welcomed either a briefing session or the opportunity to shadow staff in London in the pilot's early stages.

2.3   Resources and logistics

Key components of the AAMR pilot were the fitting kits and tags themselves and the trained staff to fit and monitor them. Participants felt staff resources and the necessary specialist equipment such as tags, base units and breathalysers had been adequately

sourced and provided to sites. Laptops were also purchased for each of the pilot sites specifically for AAMR and available wi-fi connections were used in offices where possible. Where this was not possible, wi-fi dongles were purchased.[24]

While provisions had been made to facilitate the set-up of the pilot, some participants felt that the realities of delivering the pilot and the work environment, especially in more rural areas, were not fully considered when equipment was provided. For example, case managers in some pilot areas initially struggled to fit tags due to a lack of internet access. Even when provided with dongles they experienced difficulties with signal and switching between networks which meant that they could not use direct connect to set up the tag.[25] Delays in fitting tags caused by these technological issues was perceived to have had an impact on both offender managers and wearers. For example, some wearers reported having to take additional time off work to attend a second fitting appointment, when it had been unsuccessful the first time. Poor wi-fi connections in wearers' homes also meant that tags could sometimes not download information twice in 24 hours as directed. More information on tag fittings and offender management is provided in chapter 4.

Ensuring resources were in the right place was also highlighted as key to successful set-up and delivery of the pilot, as some equipment such as laptops, breathalysers and fitting kits were shared across areas and CRC offices. As the pilot expanded geographically, sharing resources became challenging, especially in more rural areas.[26] Participants reported that in some instances, fittings were delayed for several days after sentencing because the necessary equipment was in the wrong location. In addition, there were instances where there was not enough equipment (for example, tags) available. Participants recommended that dedicated resources and teams for fitting tags would be necessary if the pilot were to be extended nationally.

2.4   Governance and partnership working

The HLNY AAMR Project Board provided oversight and contract management of the pilot. The CRC acted as the day-to-day managers. Within the CRC the pilot was overseen by strategic and operational leads, as well as local leads who provided more specific knowledge in each of the pilot areas. The relationship between the Project Board and the CRC was seen as a positive one. Staff from the CRC felt the Project Board provided clear leadership and gave helpful advice and guidance. There was also clear communication between the two.

In addition to the Project Board and CRC, there were a number of steering groups related to specific issues (such as domestic violence, specifically safeguarding) and local implementation boards which fed into the Project Board. Local implementation boards were viewed as a constructive way to share information and feedback issues.

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[24] More information on resources allocated to the pilot is included in Appendix D.

[25] Direct Connect allows frontline staff to connect directly to the secure, web-based SCRAMNET application. The direct connection facilitates streamlines installations, removals, data uploads and downloads and other client management functions.

[26] The steering group highlighted the Project Manager had responsibility for ensuring that kit was transferred between sites in order to meet demand across areas. For example, more tags were brought from North Yorkshire into Hull to respond to the different demand locally.

Involvement in local implementation boards also gave stakeholders perspective on how the pilot was operating across different agencies and the opportunity to share learning and resolve challenges together. However, there were concerns that the steering groups and local implementation boards were sometimes poorly attended, cancelled, or not properly planned. For example, the domestic violence steering group initially met bi-monthly with attendees invited from across pilot areas and partner agencies. However, it was moved to once a quarter as the pilot progressed due to poor attendance, with some staff participants unaware if the group was still running or not. These views may have contributed to the perception among some staff that some stakeholders were not fully engaged in or committed to the pilot.

NPS court staff and offender managers were key stakeholders in the pilot and there were mixed views on the effectiveness of relationships between CRC and NPS staff initially and as the pilot progressed. Early views on training and communications provided by the CRC were positive, and NPS staff valued the time given to explain how the HLNY model would work (as outlined earlier in the chapter). However, participants expressed concerns about certain aspects of ongoing partnership working between the CRC and NPS, highlighting instances of poor communication, particularly when NPS court staff were attempting to book in appointments for tags to be fitted by the CRC. Differences of opinion between the CRC and NPS about the correct approach for managing wearers were also reported, especially in the early stages as the pilot was bedding down and staff worked out how to interpret and implement guidance. Among those who suggested there was a difference in opinion, CRC staff reported feeling that NPS offender managers did not always reinforce the requirements of the tag. On the other hand, NPS staff reported being frustrated by differences in opinion about whether to breach a wearer. A suggested solution for dealing with these types of issues and to clear up confusion from the outset was an initial three-way meeting with the CRC, NPS and wearer when an AAMR order is given.[27]

2.5 Early perceptions of AAMR

2.5.1 Staff expectations

In reflecting on their early perceptions of the pilot and expectations for delivery, staff and stakeholders reported that they were interested in AAMR as a concept and keen to see how it would work in practice. Some staff expressed excitement about being involved in a pilot that could have a positive impact on a specific group of offenders and support staff in their efforts to effectively manage these individuals in the community. Several specific anticipated benefits were reported:

- That AAMR could be a useful tool in dealing with **alcohol-related offending**, including domestic violence which some participants felt was particularly relevant for their local areas.

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[27] Government guidance published in May 2019 sets out plans for NPS to manage all offenders on a Community Order or licence from 2021 (HMPPS, 2019). Therefore, the suggested early meeting could instead include the NPS offender manager, tagging provider and wearer, instead of CRC staff.

'For people just going out […] getting hammered and having a fight, I thought it was an ideal thing.' (Court staff)

- That a period of **enforced abstinence might create opportunities** for people to change their relationship with alcohol and deal with other issues in their lives. It was hoped that this would not only reduce reoffending, but benefit wearers more broadly, improving their health, wellbeing and employment prospects, for example.

  'Like all of us, if we can get that first kick-start and think actually I feel much better for not drinking and my relationships are better and I feel more like getting a job.' (Support staff)

Alongside the potential benefits, early concerns were also raised:

- **How wearers would respond to the tag**. The size of the tag was perceived as off-putting for wearers, especially in comparison to other technology, such as curfew tags, which are much smaller. Participants also suggested AAMR would only be effective if a wearer was willing and motivated to address their offending and drinking behaviours, which some may not be (see chapter 4 for further discussion). Participants were particularly apprehensive about this if they did not think that wearers were fully engaged and on board with the pilot.

  'People need to want to do something; otherwise their motivation to change won't be there if it's imposed on them.' (Court staff)

- Support organisation staff expressed concerns that an AAMR order may not have the desired long-term impact on a wearer's behaviour due to **the short length of time it is worn for**. This could mean the wearer reverts to previous or even increased levels of drinking, and possibly reoffending, once the tag has been removed.

- **The appropriateness of the order** for the crimes it aimed to address, with some court staff describing the order as too punitive and onerous for wearers. Concerns here related to giving additional Rehabilitative Activity Requirements alongside AAMR. For example, some judges and magistrates felt that imposing other accredited programmes such as Building Better Relationships, in addition to AAMR, felt excessive. This is discussed further in chapter 4.

2.5.2 CJS engagement

There was appetite for and interest in the pilot which was particularly evident among NPS and CRC staff. However, some participants felt that certain stakeholder groups, for example, the police and defence solicitors, may not have been fully engaged in AAMR. For the police, this may have been partly because their role in identifying potential eligible individuals had not been as active as initially anticipated, due to changes to police systems in some areas. This was particularly concerning to those who felt that the lack of police engagement may have caused eligible individuals to be missed, though as detailed in chapter 4, NPS colleagues played a greater role in identifying when alcohol had been a contributory factor to the offence.

Judges and magistrates were also described as hesitant to engage with the pilot initially. Participants suggested that this may have been because AAMR was a new community sentencing option, which, like other pilots and interventions, would take time to embed. As a result, some judges and magistrates may not have felt confident about using it, especially early on and if they were unsure about the kinds of results and impacts AAMR might have. As with senior police buy-in, participants worried that this may have led to eligible offenders not receiving AAMR as part of their sentence, who may have benefited.

> *'Judges and magistrates […] aren't always that amenable to change […] so it was quite difficult, I think, to try and sell it, to start with.'* (Probation staff)

2.5.3 Wearer expectations

The qualitative data suggests that wearers generally seemed to understand that they had been given an AAMR tag because their offending behaviour related to alcohol consumption in some way. Some explained that they thought the purpose of the tag was to curb or stop them from drinking, though not every wearer perceived their drinking habits to be problematic. This highlights a potential disconnect between wearer perceptions and the AUDIT assessment tool used to identify eligible offenders before sentencing. [28]

As part of the survey that was carried out when tags were fitted, wearers were asked a series of statements related to how they felt about wearing the tag. Positive views related to the fact that three quarters of survey respondents (75%) agreed strongly or agreed that the tag would help them make positive changes in their life. This could relate to spending less money or arguing less with family and friends; behaviours most commonly reported in the survey in relation to drinking. Nearly all wearer participants also reported that they understood what was expected of them when wearing the tag (99% agreed or agreed strongly).

Less positive views related to a nervousness about people seeing wearers with a tag; 64% said that they did not want people to see them wearing a tag, other than family and friends. There were also mixed views about whether it would be easy to forget about wearing the tag. Half of survey respondents did not think this would be the case, which suggests that people may have felt worried about the size, comfort and practicalities of wearing the tag, issues which are explored in more detail in chapter 3.

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[28] More information on the AUDIT assessment tool is included at 4.1.

Figure 1 Wearer perceptions of wearing the tag
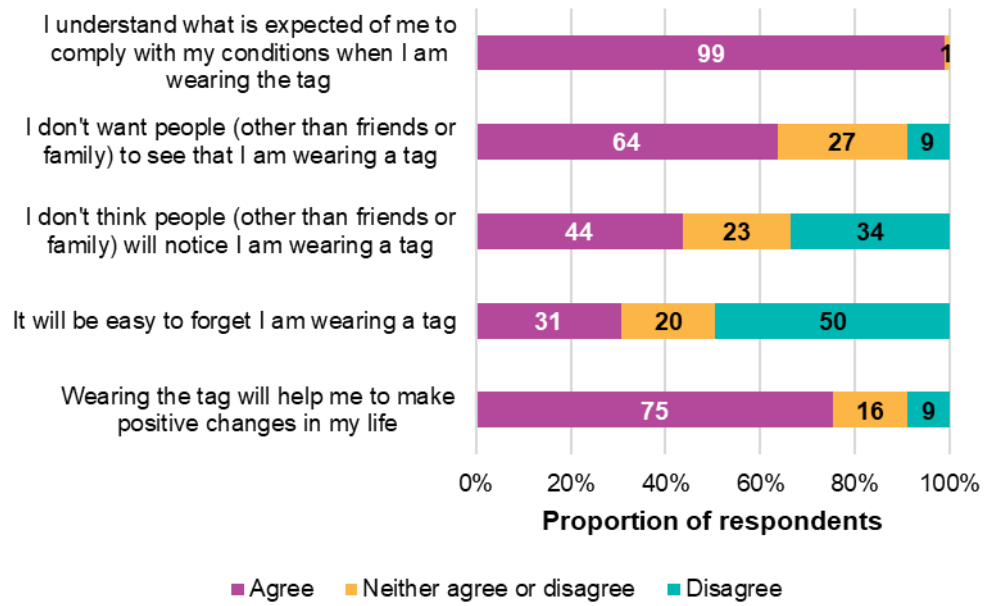
Source: Tag on survey
Base: All respondents to 'tag-on' survey (n=101)

3 Overview of pilot activity

This chapter explores the profile of wearers and the nature of the pilot requirement. This draws upon MI collected by HLNY as part of the pilot, the wearer data from the 'tag on' surveys and the qualitative interviews with staff and wearers.

3.1 Wearer profiles

This section explores the characteristics of wearers, including their demographics, their alcohol consumption, the types of offences wearers typically commit and their risk of reoffending at the start of the pilot.

3.1.1 Demographics

Over the course of the pilot, 226 individuals were issued the AAMR order. Some individuals were tagged more than once, with 231 orders being issued in total. These individuals were predominantly White (98%) and male (88%). Almost all (96%) wearers were under 50 years old (see Figure 2).

Figure 2 Age profile of wearers
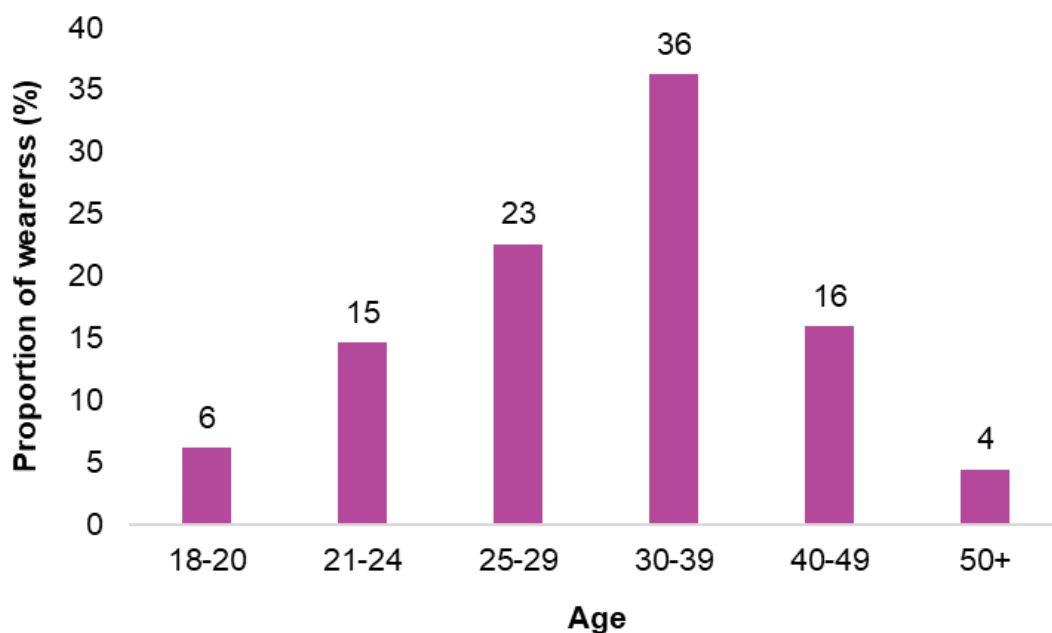
Source: Management information
Base: All wearers (n=226)

Half (52%) of wearers were sentenced in Lincolnshire, one-third (33%) in Humberside and 13% in Yorkshire at the time of receiving the AAMR order.

3.1.2 Alcohol use

To be eligible for the order, individuals were supposed to have an AUDIT score of between eight and nineteen.[29] Any score over 19 should have been considered for an Alcohol Treatment Requirement prior to AAMR, though guidance stated that scores of 20 and above could be considered if drinking behaviour was deemed as 'binging'. As shown in Figure 3, most wearers (71%) had an AUDIT score within this range, though some individuals with AUDIT scores outside of this range were issued the order too. As outlined in chapter 4, this indicates that the NPS court team, judges and magistrates may have been using discretion in the application of AUDIT when identifying eligible individuals for AAMR.[30]

Figure 3 AUDIT distribution of wearers

Source: Management information
Base: All wearers with a recorded AUDIT score (n=204)

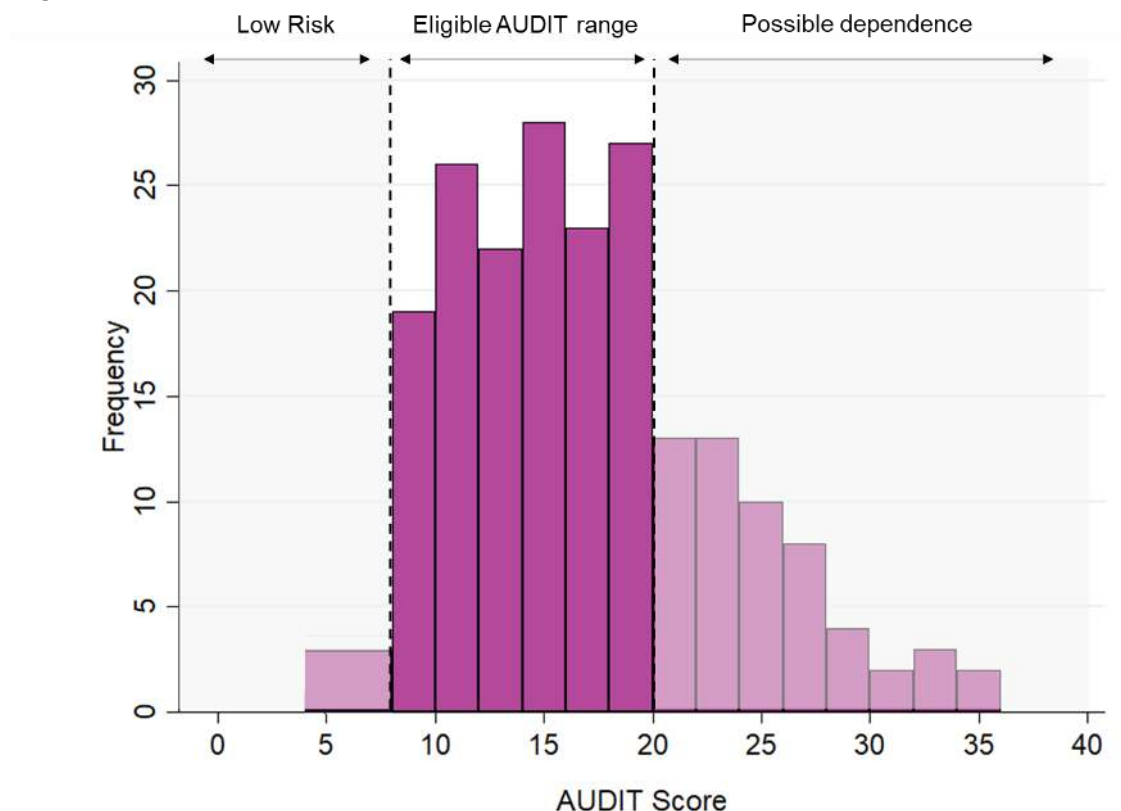As highlighted in 2.5.3, the 'tag on' survey included questions about wearers' alcohol use and the influence of alcohol on their behaviour. The frequency with which participants reported that they drank alcohol varied with some saying they had not drunk at all in the last 12 months and 5% of participants reporting they drank almost every day. Most participants (52%) reported that they drank between once or twice a month and once or

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[29] The Alcohol Use Disorders Identification Test (AUDIT) is a 10-item screening tool developed by the World Health Organisation (WHO) to assess alcohol consumption, drinking behaviours, and alcohol-related problems. A score of 8 or more is considered to indicate hazardous or harmful alcohol use. Use of AUDIT is part of the pre-sentence report process. This measure is self-reported by individuals, not independently assessed.

[30] More information on the use and application of AUDIT is explained in 4.1.

twice a week. Participants were also asked how often in the last year alcohol had led them to do something they later regretted. Spending more money than planned was one of the more common behaviours reported with almost half of participants (49%) reporting that this had happened weekly or once or twice a month. Having an argument or fight with a friend/family member was also reported more frequently than other behaviours, with 41% reporting that this had happened between weekly and once every couple of months. Less frequent behaviours included driving under the influence of alcohol (7% reported this happening more than once every couple of months), whilst one-in-five (20%) had argued or fought with a stranger in the same period.

Wearers also reflected on the role alcohol had played in their offending behaviour during the qualitative interviews. One participant described how they had been arrested on several occasions when consuming alcohol, and another reported how drinking could lead them to be in confrontational situations.

3.1.3 Offending behaviour

Wearers offences varied, though assault and other forms of violence were most commonly recorded. Other offences included drink driving, criminal damage, public order offences and driving offences (excluding drink driving).

As noted in section 1.2.1 alcohol is a significant factor in offending in the pilot areas, particularly in domestic violence cases. Three-in-ten (31%) wearers were convicted of a domestic violence offence. Some staff reflected on how they might have expected to see more of these cases included in the pilot, though this may reflect the different levels of uptake across the pilot areas.

Wearers involved in the pilot were mostly considered at low or medium risk of reoffending. Three-fifths (62%) of wearers had a 'low' OGRS score[31] (1-40), one-third (32%) had a 'medium' score (40-75) and a small minority (6%) were at a high or very high risk of reoffending (75+). Conversely, one-third (35%) were assessed as being at low risk of serious harm, three-fifths (61%) at medium risk and a small proportion (4%) at high risk of serious harm.

3.1.4 Previous experience of wearing a tag

Most respondents of the 'tag on' survey (61%) had no experience of wearing an electronic tag before being given an AAMR. Just over one-third (37%) had worn a tag between one and three times, while a small minority (2%) had worn a tag more than four times. Respondents reported previous experience of Curfew, Home Detention Curfew (HDC) and AAMR tags (when given an AAMR more than once during the pilot).

3.2   Pilot overview

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[31] The Offender Group Reconviction Scale (OGRS) is a predictor of proven re-offending based on static risks - age, gender, current offence and criminal history, which are risk factors known to be associated with the likelihood of re-offending. Lower scores represent a lower likelihood of reoffending.

This section explores how the requirement has been implemented in practice, including the number of wearers, the length of the requirement, the time taken to tag individuals and requirements imposed alongside AAMR.

3.2.1 Volumes of wearers

Over the course of the pilot, 226 individuals received the order. Some individuals received the order more than once, totalling 231 orders. Overall, compliance with the pilot was high, with over nine-in-ten (94%) successfully completing the requirement.[32] The final sober days rate recorded by AMS was 97.4% sober days.[33]

A third (33%) of wearers who did not complete the requirement were non-compliant, which meant that they breached the conditions of the order in some way (for example, by consuming alcohol). In the MI, a range of reasons were recorded as contributing to non-completion for the remaining wearers. They included health issues, issues with the equipment, and resentencing to Alcohol Treatment Requirements, where it was deemed more appropriate.

As shown in Figure 4, the volume of individuals sentenced to the requirement increased in the second year of the pilot. In the first year, approximately 20 people were tagged every three months, increasing to 40 people in the second year. This increase in uptake reflects the extension of the pilot to the entire HLNY CRC area in the second year.

Figure 4 Volumes of wearers tagged over time

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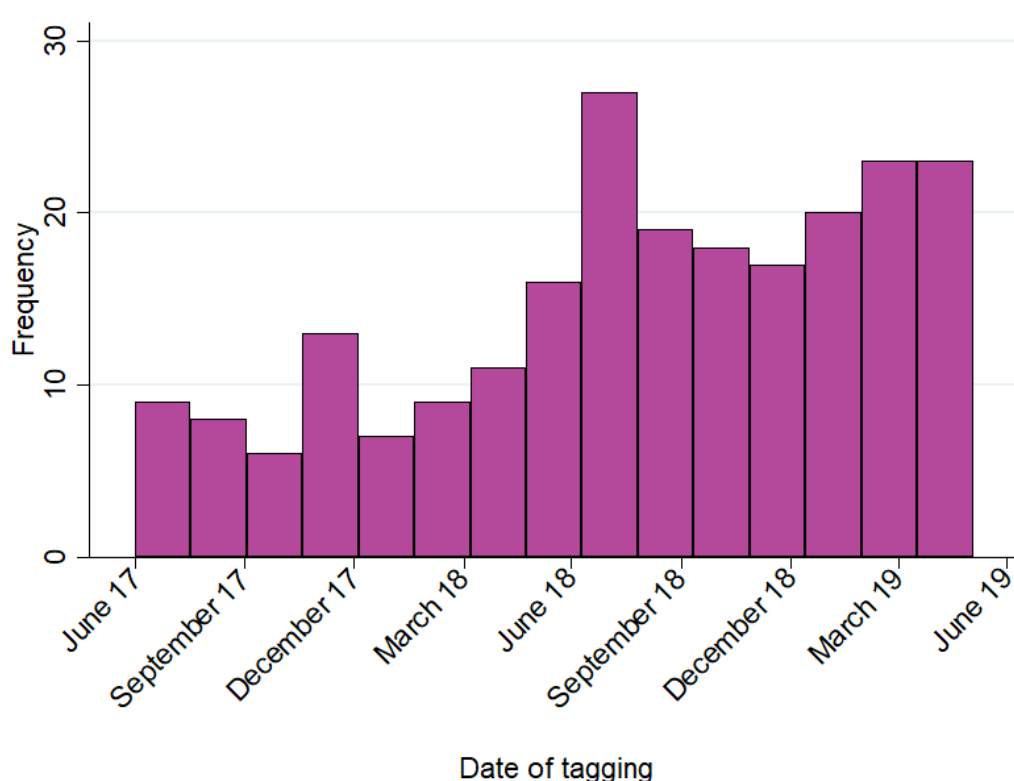
[32] A successful completion was defined as reaching the end of the requirement without being breached or revoked and resentenced.

[33] A sober day is defined as 'when no drinking or tamper alerts are detected'.

Almost all (98%) wearers received the order once, though a small number of wearers (2%) received the order twice[34] over the course of the two-year pilot (no individuals received the order more than twice).

During the first year of the pilot, a median of 13 individuals were wearing a tag on any given day, which increased to 34 individuals in the second year of the pilot. The number of live cases peaked in the autumn of 2018, when 44 individuals were wearing a tag at the same time.

Figure 5 Live caseload during the pilot
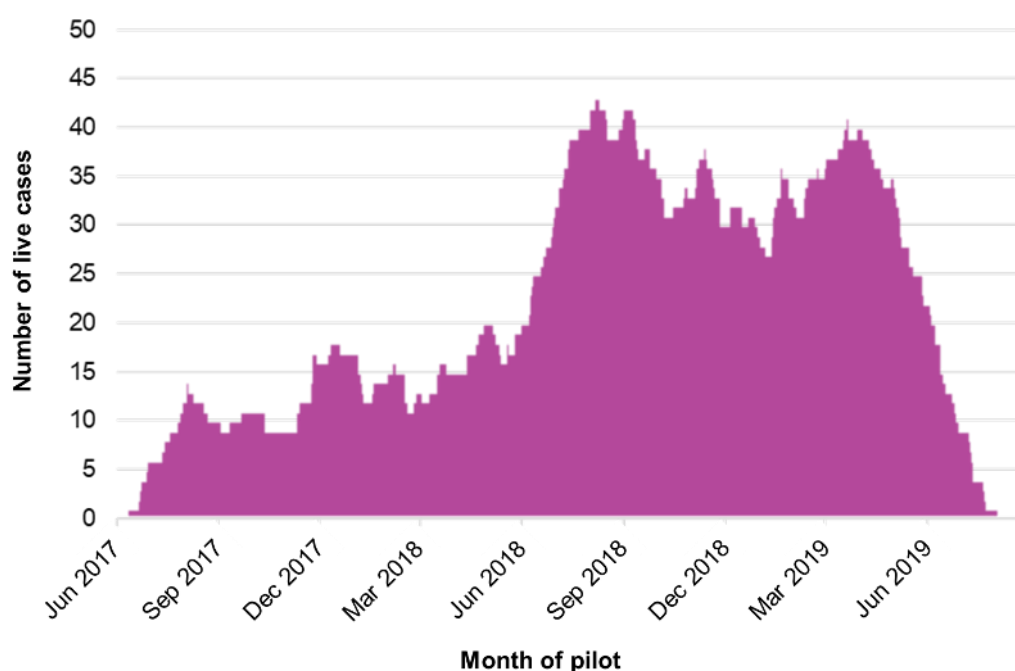
3.2.2 Length of the requirement

The length of the requirement ranged from 28 days to 120 days (the maximum allowed by the order) with the median requirement lasting 90 days. As indicated in Table 3:1, less than one-in-ten (8%) of wearers were sentenced to a requirement of less than 60 days, with three-fifths (57%) receiving an order of at least 90 days but less than 120 days.

Table 3:1 Length of the requirement as sentenced		
Length of requirement	**Frequency**	**Proportion (%)**
Less than 60 days	17	8
At least 60 days, but less than 90 days	48	21

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[34] The analysis of the MI presented in this report only explores the first instance of tagging to avoid double counting.

Table 3:1	Length of the requirement as sentenced	
At least 90 days, but less than 120 days	129	57
120 days	32	14

Source: Management information
Base: All wearers (n=226)

The actual duration of tagging was similar, though in some cases individuals were wearing tags for more than 120 days.[35]

Table 3:2	Actual duration of wearing a tag	
Length of requirement	**Frequency**	**Proportion (%)**
Less than 60 days	57	25
At least 60 days, but less than 90 days	108	48
At least 90 days, but less than 120 days	57	25
120 days or more[36]	4	2

Source: Management information
Base: All wearers (n=226)

3.2.3 Time taken to tag wearers

On being sentenced to the requirement, it is intended that most wearers would be fitted with a tag within 48 hours. As indicated in Table 3:3, two-thirds (67%) of wearers were tagged within two days of being sentenced and 14% of wearers were tagged in three to four days. The remaining fifth (19%) were tagged five or more days after sentencing. In rare cases it took much longer to tag wearers after sentencing. The longest delay between sentencing and tagging was 28 days.[37] Reasons for delays to tagging are explored in greater depth in section 4.3.

Table 3:3	Time taken to tag wearers in days	
Time taken to tag wearers	**Frequency**	**Proportion (%)**
Within two days	151	67
Three to four days	32	14
Five or more days	43	19

Source: Management information
Base: All wearers (n=226)

The timeframe in which tags were intended to be fitted was considered challenging depending on where people were sentenced and their proximity to a CRC office. In addition, the model used by HLNY meant that tags could only be fitted within working

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[35] Where the tag was in place beyond the 120 days maximum legal period for monitoring, due to a missed appointment for example. Any data collected by default beyond 120 days would not be used for management or enforcement purposes.

[36] Ibid 37.

[37] In this instance the case was not communicated to the case co-ordinator, leading to a delay in fitting.

hours. As a result, the fitting process was perceived to work less well in more rural areas and in cases where people were sentenced towards the end of the day. Other reasons cited for the delay in tagging wearers were the availability of equipment and wearer employment, as discussed further in chapter 4.

3.2.4 Number and type of additional requirements

The AAMR was typically issued alongside other requirements. Three-quarters (74%) of wearers had a single additional requirement, a quarter (24%) had two additional requirements and a very small minority (2%) had three additional requirements. In a single case, the AAMR was issued as a standalone order.

Almost all (95%) wearers had a Rehabilitative Activity Requirement, just under one-fifth (17%) had to undertake unpaid work and just under one-in-ten (7%) were involved in Building Better Relationships, the accredited programme for domestic violence offenders (more detail on which is included in chapter 4). One-in-twenty (6%) were sentenced to a range of other requirements, such as curfews, the Thinking Skills Programme, and Drunk Impaired Driving.

4 Delivery of the AAMR pilot

This chapter explores the delivery of the AAMR pilot across the three areas. It draws on qualitative data from stakeholders, staff and wearers. The chapter explores views and experiences about identifying eligible wearers and imposing an AAMR order, tag fitting and monitoring of wearers and the delivery of offender management and rehabilitative support. Facilitators and barriers to effective delivery are highlighted throughout the chapter.

4.1 Identification of eligible wearers

Partners who worked with defendants and courts had a role to play in considering the suitability of an AAMR tag in supporting the monitoring of offenders in the community. There were several stages at which eligibility for an AAMR order was flagged (listed below); these fed into the production of Pre-Sentence Reports which supported the judge or magistrate in sentencing.

- **Police referral to court**: The MG5 can be used by the police to identify that alcohol was a factor in a defendant's offence and alert the courts that AAMR may be a suitable sentencing option.

- **Pre-sentence interview**: Before a court appearance, NPS court staff interview defendants to understand the details of the case and the individuals' needs. Eligibility for AAMR was considered at this point and a proposal made to the magistrate or judge in the PSR.

- **AUDIT assessment**: As part of the pre-sentence interview, individuals are assessed by NPS court staff using the alcohol screening tool, AUDIT, before they appear in court to understand their alcohol consumption. As discussed, the guidance for the pilot states that scores from 8 to 19 indicate the offender is suitable for the order. Any lower and the order may be disproportionate and those who score 20 and over should not be placed on the order due it being considered unsafe because of alcohol dependency (though guidance stated that scores of over 20 and above could be considered if drinking behaviour was deemed as binging).[38] Staff participants explained that discretion was used alongside the questionnaire as the score generated was sometimes felt to be inaccurate or misrepresentative.

4.1.1 Facilitators and barriers to effective identification

The use of discretion and professional judgement across these stages was viewed as an important factor in identifying appropriate individuals to recommend for the AAMR. Participants valued the discursive nature of the assessment process as it enabled a range of circumstances and needs to be considered, such as health and housing issues, offending history and the potential for a successful period of sobriety.

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[38] AAMR 2. Operational guidance.

Two other factors were reported as critical to identifying suitable individuals for an AAMR:

- Firstly, effective partnership working ensured detailed and accurate information was transferred and considered. Partnership working was also thought to facilitate and sustain awareness of AAMR as a sentencing option. However, some participants did not always think this had worked as intended. For example, and as noted in chapter 2, the extent to which police forces flagged potential cases using the MG5 form was thought to be limited. However, it is important to note that the pre-sentence interview carried out by NPS court staff analyses information from the CPS case summary and the offender's account to determine where an offence was linked to use of alcohol. It also includes the AUDIT assessment, all of which pick up on alcohol use as a matter of course, rendering the MG5 form potentially less important.

- The second factor was the effective use of AUDIT in relaying accurate information about a defendant's drinking habits. NPS and CRC staff identified three challenges with AUDIT which were thought to have undermined the process in some instances. These included a lack of clarity among professionals about how AUDIT scores should be interpreted, a lack of trust in the scores produced through the tool (i.e. that they are misrepresentative) and the opportunity for offenders to answer questions to suit their own purposes. In relation to the latter point, NPS and CRC staff reported that some offenders knew how to answer AUDIT questionnaires in a way that would render them ineligible for the intervention, by for example inflating or downplaying aspects of their drinking, a finding that was also picked up in early research undertaken by MoJ.[39] Staff participants expected that this may have reduced the number of eligible individuals identified.

4.2 Imposing the AAMR order

Judges and magistrates used information collated in PSRs to aid sentencing decisions, including AUDIT scores and their index offence, and this was also the case for people convicted of domestic violence offences. Staff reported other guiding principles that supported them in considering the appropriateness of AAMR, which included:

- **Alcohol must be a contributing factor** in the offending behaviour. However, the defendant must not be 'alcohol dependent'.
- **The proportionality of the sentence and inclusion of AAMR should be considered.** Again, this was raised in early scoping work carried out by MoJ and discussed specifically in relation to domestic violence cases. In such cases it was felt that sentencers were sometimes opting for the Building Better Relationships (BBR) programme on its own, rather than in conjunction with AAMR so as not to be overly punitive. This is discussed further below.

> 'Domestic abuse is a really difficult nut to crack because of sentencing proportionality. We've really struggled so I think court report writers, when they were faced with entrenched domestic abuse, I think they were going to BBR,

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[39] MoJ undertook focus groups with staff in pilot areas early in pilot delivery to explore views of the operation and implementation of the AAMR pilot.

preferring other outcomes rather than imposing sobriety tags in a number of cases.' (Probation staff)

- AAMR **should not be used as an alternative to custody**. If the correct thresholds are met to necessitate a custodial sentence, these cannot be bypassed by imposing an AAMR order, though it can be used as a requirement of a Suspended Sentence Order (SSO).

- A consideration of the **individual's ability to manage the requirements** of the AAMR order; for example, their physical and mental health.

    'They [wearers] need to have the capacity to understand that they can't drink, so there's that aspect to it. I think if mental health is their main issue, then that's what we look at addressing rather than putting an alcohol tag on […]. Obviously, we've got the guidelines, the criteria that people have to meet but I think it does fall down to your judgement.' (Probation staff)

Staff participants with experience or knowledge of the court process reported that judges and magistrates generally took time and care considering how individuals might manage an AAMR order and the role it could play in their rehabilitation. There was a sense that decision-makers viewed AAMR as one option available to them during sentencing to help offenders change their behaviour, particularly around alcohol consumption as well as deal with other issues that may contribute to their offending. However, this would be weighed against other factors such as an offender's ability and willingness to comply with the order and the potential benefits of other sentencing options, such as the BBR programme. In domestic violence cases, the individual might be given both an AAMR and the BBR programme; for example, if they are living with their partner who is abusive towards them when they drink. However, judges and magistrates sometimes decided which option was most suitable, due to concerns that both requirements might be too punitive.

In addition to the principles mentioned, magistrates and judges considered how support, including the use of Rehabilitative Activity Requirement days (RARs), could be most effectively used alongside the AAMR. While some participants felt court staff understood the value of sentences that incorporated targeted, mandated support, others were concerned by instances where individuals had received AAMR and the BBR programme as part of their sentence, without the support of RAR days. Participants believed there to be a clear rationale for deciding on rehabilitative activities to ensure that these would help people implement positive changes in their lives while remaining abstinent.

    'The tag is fitted long enough for them [wearers] to at least make decent headway with what other requirements have been imposed.' (Probation staff)

The AAMR could be imposed for up to 120 days. While some participants thought this was appropriate, others would have preferred the option to impose an AAMR for longer. This was because they thought it might be hard for some individuals to embed long-term positive behaviour change in a short timeframe.

4.2.1 Facilitators and barriers to imposing AAMR order

Several barriers to imposing an AAMR order were identified:

- **Lack of knowledge about AAMR** among some partners which included a lack of understanding of the potential benefits of combining rehabilitative activities with a period of abstinence.

- **Reluctance to use AAMR with the domestic violence cohort**. For example, though thresholds for a custodial sentence cannot be bypassed, some participants raised concerns about whether AAMR could be used to effectively and safely manage risk within the community, particularly with those convicted of domestic violence offences. One concern here related to the lack of restrictive requirements given to offenders alongside AAMR. For example, GPS location monitoring was not available during the pilot period which meant that offenders could be given community sentences without monitoring their whereabouts or contact with victims. Magistrates were also concerned about the risk of retaliation against victims, for example if the wearer blamed the victim for them being given AAMR.

- **Resistance to using an AAMR order** among specific partners. For example, some participants reported that defence solicitors thought AAMR could violate human rights as it is not illegal to consume alcohol. Their view was that it therefore should not be possible to impose abstinence, and it is possible this group may have discouraged its use as a result.

- **Perceptions of a lack of resources** were thought to have impacted on the extent to which judges and magistrates felt confident to issue an AAMR order. There was a sense that decision-makers may have been reluctant to use the intervention if they thought there was a risk the tag would not be fitted within the required 48-hour timeframe. Instances where offenders were not tagged within the timeframe may have contributed to these views (33% of wearers were tagged at three days or more after sentencing). More detail is provided on the tag fitting process in 4.3.3.

- **The number of defendants residing outside of a pilot area** limited the extent to which AAMR orders could be issued. This was particularly the case in tourist areas, such as York where participants reported high levels of alcohol-related crime committed by individuals who did not live in the area.

While these challenges were felt to have impacted on the number of people considered for and given an AAMR tag, participants also discussed ways in which these barriers had been addressed as partners became more familiar with the processes involved. For example, partners had worked effectively together to raise awareness and sustain buy-in which is likely to have contributed to the increased take-up over time. A key part of this was the ongoing training and communication about the pilot which was perceived to have been helpful when awareness was low early on and in courts where the order had been utilised less. A range of activities aimed at improving knowledge of AAMR were discussed, such as AAMR project leads visiting courts to explain the 'softer' benefits of using the order to judges and magistrates. This included the home environment feeling

more 'calm', particularly in domestic violence cases (see chapter 5). As highlighted in chapter 2, local implementation boards were also identified as a key forum for awareness-raising work between partners.

4.3 Tag fitting

4.3.1 Fitting process

Where possible, NPS court staff liaised with the AAMR administrator to alert them that an AAMR order had been recommended. The administrator would then speak to the field team to set up a fitting appointment and inform NPS staff. A proportion of sentences were imposed on the day without pre-sentence adjournment, which meant that staff had to be more responsive to AAMR orders being recommended and given within a short period of time. After sentencing, the case was allocated to either the NPS or CRC to carry out all offender management and supervision activities with the individual. Regular and effective communication between court staff and the CRC was thought to facilitate this process and help to ensure fitting activities could happen immediately

After sentencing, offenders were typically required to attend a local CRC office as soon as possible (within 48 hours) for the tag to be fitted. While in most cases participants reported this happened, the timeframe in which tags were intended to be fitted was considered challenging depending on where people were sentenced and their proximity to a CRC office. In addition, the model used by HLNY meant that tags could only be fitted within working hours. As a result, the fitting process was perceived to work less well in more rural or isolated areas. Similarly, in cases where people were sentenced towards the end of the day, it was thought to be more challenging to meet the 48-hour fitting window. More detail on timings for tag fittings is given below in section 4.3.3.

The relative speed with which it was expected tags to be fitted after sentencing was also thought to have impacted on levels of awareness among wearers. CRC staff reported that some wearers had very little understanding of the tag and associated conditions at the fitting appointments and were 'shocked' by certain aspects of it, including its size. Some wearers felt frustrated by the lack of information given before the fitting and were disappointed that they did not have a chance to discuss the tag in advance. One suggestion was to give some additional easily accessible information at court about the tag, which might help with overall engagement.

At fitting appointments, CRC staff checked that wearers had a working internet connection and asked them to sign a 'terms and conditions' form which included details on the pilot and evaluation. They also explained how the tag worked and the requirements of complying with the AAMR order (for example, plugging in the base station and ensuring the tag is always in contact with skin). To aid understanding, wearers were given an 'induction pack' containing guidance about how the tag worked. Initially these resources were not suitable for people who did not speak English as a first language. However, materials were made available in other languages and communication about the tag to wearers was thought to have improved over the course of the pilot as a result.

Where resources allowed, two members of staff were assigned to fit a tag. This helped ensure appointments were timely and did not over-run as one staff member could focus on discussing the tag with the wearer and the other on fitting and testing the equipment.

The number of wearers deemed at high risk of serious harm was low.[40] Attempts were however made to ensure that any individuals who were deemed 'high risk' (due to the nature of their offence) were assigned two staff members to fit the tag. A range of other organisational policies including health and safety and home visit risk assessments, and 'people safe' devices[41] were available to help manage risks related to fitting tags. However, some participants still expressed concern about the fitting process when working with higher-risk clients.

Though home visits are an established part of probation practice, some safety issues were also raised in relation to home fittings which happened for several reasons, including when somebody was sentenced late in the day or to accommodate staff work commitments. Though this happened infrequently and seemed to be avoided where possible, some participants felt it should not have happened at all. This was because even with the safety policies outlined above (e.g. home visit risk assessments), they did not always feel they had enough detailed information about individuals and their offences before entering wearers' homes.[42]

4.3.2 Wearer experiences of tag fittings

Overall wearers reported positive experiences of tag fitting appointments and valued the friendly and approachable nature of staff. Wearers particularly appreciated the reassurance given by staff around the size and weight of the tag and felt comforted in the knowledge that people became used to wearing the equipment.

> *'They were really polite, really nice. In a way, they were trying to cheer me up because obviously, I was a bit gobsmacked by the size of it and stuff […] They said, you'll be fine, it will help you. No, they were really kind actually.'* (Wearer)

The information given by staff at this stage was also key in helping wearers to properly understand the requirements of the order and the practicalities of wearing the tag. For example, how to wash with it and limit the use of deodorants and other solvents. However, another view was that having more detailed information about the specifics of the tag, particularly actions that may lead to a breach, could raise anxiety around accidentally causing alerts.

Another key issue raised by wearers related to the lack of detailed information received after leaving court was about where to go for the fitting. Participants explained that they

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[40] The MI showed that a small proportion (4%) were assessed as at high risk of serious harm.

[41] People safe devices were supplied to home workers within the CRC to support them when lone working or undertaking home visits.

[42] One explanation suggested by the steering group as to why staff may have felt concerned about home visits was that usually initial assessment visits take place in the probation office environment. Staff therefore may have found it unusual for the first contact with a wearer to be at their home, before the supervisory relationship had been established.

felt the process happened quickly and some experienced difficulties finding CRC offices. It is likely that this could be particularly disorienting for those released from a period of remand in custody which could lead to a risk of people missing appointments.

> *'I had to go to this place to go and get the tag on. I've not even come from the area. I didn't even know where the hell I was going. Took me about 40 minutes to find this building. I had to ask loads of people and I was mortified really because my head was everywhere. I'd just come out of prison and I'm just like, this is doing my head in.'* (Wearer)

4.3.3 Barriers and facilitators to the fitting process

58% of all AAMR tags were fitted on the day of sentencing or the day following sentencing and 81% were fitted within five days of sentence. 19 cases did not have their tag fitted within five days due to AAMR staff or equipment availability, or to accommodate the needs of wearers (for example, in relation to employment commitments).[43] Key factors thought to have either supported or hindered the process of fitting tags included effective planning, resource management and communication, as detailed below. These factors were perceived to be interrelated and fundamental to effective offender management in the community.

Effective planning and resource management was perceived to be key to ensuring tag fittings took place within the intended 48-hour period. Participants described processes they had put in place to support this. For example, one area ensured staff with fitting experience were available and had private office space booked for fittings on days when people would typically be given an AAMR order. Another valued source of support was the pilot administrator who helped facilitate the process of fitting tags and ensured that the correct staff were available to meet wearers.

However, other participants reported difficulties with staff availability and access to the right equipment and facilities, for example private rooms. It was also acknowledged that any unexpected staff absences were difficult to overcome within the intended time-frame for fittings. One consequence of these reported challenges was that on a small number of occasions, courts were told they could not give AAMR orders because there was nobody to fit the tags.[44]

> *'I don't think we were as responsive to the courts as we should've been because, crudely, we didn't always have the people available that could drop everything*

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[43] While the time it took to fit tags varied, it is worth noting that all AAMRs were active and enforceable from the date of sentence whether their tag was fitted or not and clear guidance was given to all AAMR cases regarding alcohol consumption and enforcement.

[44] Two occasions were described by the steering group when it was not possible for courts to use AAMR. One related to a significant increase in AAMRs and staff leave during a specific period of time. In this case the Court was informed that the CRC did not have anyone available to fit the tag immediately and so the order was not made. A contingency process was put in place following this incident which involved the Project Manager having oversight of all proposals where no one was identified to fit the tag. There was also another occasion where a court was requested not to propose AAMRs for a short period of time (one week) whilst additional resources were sought. The decision was made to ensure sentencers remained confident that all AAMR sentences would be fitted and managed appropriately.

and fit a tag because their job descriptions and caseloads are so generic and large, and have increased, they haven't really had the capacity.' (Probation staff)

Effective communication was also thought to be a key factor in ensuring tags were fitted in a timely way. Due to the different agencies involved in the process, it was necessary for partners to be in regular communication and participants reported that they found it helpful to discuss specific cases in advance of sentencing to plan for potential fittings. For example, discussions over the phone with courts in the morning helped identify individuals who might receive an AAMR order. If possible, these cases were then held earlier in the day to enable CRC staff to swiftly follow up with fitting appointments.

> *'What works well is communicating with people from the off. As soon as we hear about a requirement we make sure we communicate that to people, so people have a plan in place and we are doing what we can to make that process as easy as possible from our end in terms of a bit of preplanning regarding equipment. So we would keep a check on for example, in [name of area] I've only got two tags left, so we would be very aware of that and we would be physically moving those tags around our area in preparation for an upcoming order.'* (Probation staff)

Conversely, some participants highlighted instances where communication did not work as well and where CRC staff were not informed in advance of when AAMR orders may be given. In cases where there was less proactive communication with the courts, CRC staff reported that they found it harder to accommodate unexpected fittings and appointments may have been missed or delayed as a result.

> *'Sometimes the courts were imposing the AAMR at 4pm that day so by the time they got out of court the office was closed. We share our office with the local council so the doors are locked at 5pm and we weren't able to accommodate them. Then that person would be at work the next day. So, whilst we always aimed to have them fitted on the day of sentencing, sometimes it's been up to a week later or two weeks later until they've been fitted if I'm honest.'* (Probation staff)

4.4 Monitoring wearers

Following the fitting process, wearers had regular contact with offender managers as required. This ranged from once a week to monthly and participants explained the frequency of appointments was decided based on a risk and need assessment.

> *'An offender would attend the office for planned appointments in line with their level of risk, in line with their plan, their current situation, relationship and motivation.'* (Probation staff)

Ongoing monitoring of alcohol abstinence was facilitated through the data provided by SCRAMNET (as detailed in chapter 2). The CRC case coordinator had responsibility for checking the monitoring system and informing the necessary offender managers of any alerts that needed addressing so that they could investigate and arrange to speak to wearers quickly. For NPS cases it was intended that the CRC semi-specialist would join

three-way appointments where relevant and keep in close contact with the NPS offender manager to ensure compliance.[45]

As outlined in other sections, effective partnership work and communication between NPS and CRC teams was necessary to ensure data was shared by the CRC in a timely way to support effective offender management.

Participants involved in monitoring and supporting wearers spoke positively about having access to regular data on alcohol consumption. They explained that the SCRAMNET data helped to facilitate honest and productive conversations about drinking habits and any lapses wearers might have experienced. Following this, appropriate support (such as additional meetings or referrals to other agencies) could be put in place to help address issues that may have impacted on a wearer's decision to drink.

However, several barriers which related to the practicalities of using the data generated by the tags (including the Daily Action Plans (DAP)[46]) were highlighted. These included:

- **Poor wi-fi connectivity at wearers' home addresses**, which affected the transmission of timely data and information about alerts, especially in rural areas.[47] Where this was an issue, workarounds were put into place whereby the service user could download data when they attended their probation appointment.

- **Difficulties understanding and interpreting monitoring data**. Participants reported that they did not always feel confident about interpreting the alert data which made it hard to have meaningful conversations with wearers about their drinking behaviour in some cases. This impacted on wearers who reported anxiety about alerts generated by the tag, especially in circumstances where they understood that a breach might lead to a custodial sentence. Challenges in interpreting the data were raised with the project board where appropriate. Drawing on earlier findings, participants valued the ad-hoc support offered by the AMS team and their responsiveness in resolving any issues with the data.

- **Difficulties accessing the data**. Daily action plans which included information on alcohol alerts, tampers and download failures were generated by SCRAMNET and reviewed by the case coordinator daily. However, some participants highlighted the lack of real-time data on alerts as a limitation of the pilot and felt this could be a barrier to effective monitoring in the future if the pilot were to be expanded. Linked to this, the case coordinator's role in supporting the collection and dissemination of data was viewed as vital and participants felt strongly that this provision should be factored in to any future roll-out to ensure data is accessible.

- **Partnership working** in relation to communicating alert information was thought to be essential, especially between the CRC and NPS. There had been occasional

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[45] More information on staff roles and responsibilities is outlined in Appendix D.
[46] DAPs were sent by SCRAMNET to agreed recipients and included high level information about breaches. More detailed reports and data could also be accessed by some staff.
[47] Multi-connect devices were supplied to wearers to address this issue, which worked in some cases.

delays in receiving information as well as some disagreements about how alerts should be managed. Supporting wearers and dealing with potential breaches is discussed in the next section.

4.5 Compliance

Overall, compliance with the pilot was high, with 94% successfully completing the requirement.[48] Staff thought the tag helped individuals modify their drinking and offending behaviour and work towards sustainable rehabilitation in the community. Early qualitative data collected by MoJ echoes this, stating a range of reasons for high compliance, including for example the threat of a sanction, high probability of detection and changing habits.[49]

Wearers also discussed their intentions to comply with the AAMR order and explained that the tag acted as a reminder to abstain from alcohol or risk being given a custodial sentence, or lose access to their homes or families, which participants were keen to avoid.

> *'Because I knew that I'd go to jail if I don't [comply], so you either be responsible or be an idiot and drink. Obviously I had my house, my job and everything on the line, because my sister said if I drank on it she'd kick me out so I'd have nowhere to go and obviously I lose my job if I go to jail. So it's like stick to it.' (Wearer)*

Some reported that they had found it hard to modify their drinking behaviour, especially around others. They also reported times when they felt they might be at greater risk of relapsing, for example when things 'go wrong' in their lives such as losing their home, breaking up with a partner or losing contact with children. However, as described in more detail in the following chapter, wearer participants were keen to use the opportunity of an enforced period of abstinence to try and change their relationship with alcohol and improve their lives.

4.5.1 Non-compliance and breach

Issues of non-compliance ranged in severity. Minor non-compliances were raised for tampering alerts and were sometimes due to wearers not fully understanding the conditions of the requirement. For example, one staff participant explained that some wearers did not know they could not wear socks underneath the tag. More serious non-compliance included heavy drinking episodes, but these appeared infrequent.[50]

Participants explained that when staff were alerted to non-compliance they contacted the wearer first to discuss what had happened. If offender managers were confident that a deliberate breach had occurred following this discussion, a warning would typically be

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[48] A successful completion was defined as reaching the end of the requirement without being breached or revoked and resentenced.

[49] Ibid 34.

[50] A third (33%) of wearers who did not complete the requirement (7% of the total wearer population) were non-compliant, which meant that they breached the conditions of the order in some way (for example, by consuming alcohol).

given. For second offences, staff explained that wearers would usually be sent back to court, and a decision would then be taken about the appropriate course of action.

If an individual disclosed that they were drinking regularly (which happened in a small number of cases), it would indicate they were not suitable for the order due to alcohol dependency. These cases were returned to court for amendment and removal of AAMR as abstinence was not considered possible or clinically safe to achieve.

Staff participants welcomed the clear boundaries around how to deal with issues of non-compliance and perceived the staged approach of the response, which increased in line with the seriousness of the breach, to be appropriate. They also valued the guidance offered by the project manager and element of professional judgement involved in making decisions around non-compliance and breaches. Participants thought that it was important to retain an element of discretion to enable offender managers to tailor support and monitoring of wearers as they saw fit.

4.6 Support and offender management

Support and rehabilitative programmes formed part of wearers' sentence plans with the aim of tackling issues assessed to contribute to offending behaviour. Support was tailored to wearers' needs, with an acknowledgement that some required more intensive or targeted support than others. For example, one staff participant explained that somebody convicted of a domestic violence offence might need more or different support than somebody convicted of a drink driving offence. Regardless, there was an expectation that support offered through offender management and RAR was comprehensive and tailored.

> *'They are supported with welfare needs, anything that service user wants to address or change about their lives should all be part of a rehabilitative package, whether that's around employment or training or education or housing, or any aspect of their life.'* (Probation staff)

The model of combining tag and support was viewed positively as it was perceived to be an important opportunity to work with wearers while they abstained from alcohol. One staff participant described this as a chance to have a real impact and 'break the pattern' of offending behaviour.

> *'It's work that we can implement and put in whilst they're abstaining from alcohol […] It gives you the opportunity to really get in and make the work mean something.'* (Probation staff)

Support was delivered as part of wearers' RAR days through probation or external agencies, depending on need. An overview of both forms of support is provided below. The section finishes by focusing on support provided to people convicted of domestic violence offences.

4.6.1 Probation support

A significant amount of the support given to wearers was delivered via the CRC or NPS as part of a wearer's offender management. This was considered appropriate given the level of contact offender managers had with wearers and their vast experience of supporting offenders with a range of needs. The programmes and support provided by the CRC/NPS were focused on setting goals, problem-solving, dealing with alcohol issues and behaviour management; considerations that would be taken into account as part of routine sentence planning with offenders. Staff used a range of tools to facilitate discussions with wearers, with the alcohol awareness and AAMR activity packs highlighted as key resources.

Wearers' views on the support delivered through offender managers were mixed. Some reported positive experiences. For example, one wearer described how they had been given a range of different materials and help in relation to issues such as low confidence and poor mental health. There was a sense that wearers who were ready and willing to make positive changes in their lives may have benefited more from this kind of supervision.

Others however, felt the support they received was too light-touch and were disappointed by the limited amount of time they were able to spend with staff to address their needs. Linked to this, there was a feeling among some that they would have liked more positive and proactive contact with staff. These participants felt that they had most contact when difficulties were experienced, or alerts generated rather than on a regular, structured basis. The dual role that staff had in supporting positive behaviour change alongside monitoring compliance (which included breaching wearers) was also raised as problematic, though this is arguably an issue in all probation practice.

Several practical barriers were also acknowledged by staff, which may have impacted on the effectiveness of support given. These included:

- **A lack of time to deliver comprehensive support** to wearers alongside very busy workloads.
- **A lack of resources including materials and space**. For example, one staff participant explained that support had on occasions been provided in unsuitable places due to the lack of private office space.
- **Challenges related to communicating with wearers** who did not have English as a first language.

4.6.2 Support from external organisations

There were mixed views about the extent to which external support organisations had been used to support wearers with more specialist issues, such as employment, housing, domestic violence and substance misuse needs. Some offender/case managers felt confident that specialist support was accessed regularly and when needed, whereas others felt links with support organisations could be improved. However, there was agreement that in theory, accessing support from local partners complimented CRC/NPS provision.

'So, we work very closely with [a mentoring service] working with the alcohol and drug treatment service providers. We have a choice of links with them and there's a lot of referrals to their agencies, linked with training and education providers and job search agencies. We work closely with the Jobcentre and housing, the local authority as well.' (Probation staff)

Some offender managers proactively accessed specialist support and helped facilitate referrals to other agencies by setting up meetings or attending initial appointments with wearers. This was thought to encourage engagement with more specialist services, especially among those who felt nervous about speaking about their tag and offending behaviour. Linked to this, some participants explained that being able to mandate wearers to attend support services encouraged engagement.

'Even if there's no kind of court order requirement to [refer to particular support organisations], the case manager could still make a decision that this case needed to go and see them and ideally you'd want them to go - you'd want a case to go from their own motivation and their desire. But sometimes you can have an element of compulsion and you can say, 'Well, actually this is going to be part of your national standards appointment, you need to go and if you don't go, we'll enforce it.' (Probation staff)

While external organisations were perceived to have filled some important gaps in support provision, there was evidence to suggest that offender managers did not always use or seek additional support in cases where it may have been helpful. Participants suggested this may have been due to a lack of knowledge about the services on offer, variation in services across different areas or reluctance to request valuable resources from other organisations. Another view from staff was that referrals to specialist organisations may not have been necessary as needs should be met through CRC or NPS offender management alone.

In addition to this, both staff and wearers reported that they had encountered some challenges with eligibility in accessing specialist services. For example, one wearer who had been referred to a specialist alcohol service was told they could not receive help because their drinking habits were not 'bad enough', which the wearer found disappointing.

4.6.3 Support for domestic violence perpetrators and victims

Wearers could be sentenced to an accredited HMPPS domestic violence programme alongside AAMR, such as BBR (discussed earlier in the chapter). Staff participants felt that BBR had generally been well received by wearers. For example, one spoke of a wearer that realised he used alcohol as a controlling mechanism to induce fear in his partner after having received support through the programme. However, barriers to effectiveness included delays with delivery, with BBR often starting after AAMR tags had been removed. This raised concerns among staff that wearers (and victims) were not receiving support for domestic violence behaviours quickly enough.

Support from a partner link worker was offered to victims whose (ex-)partners received BBR or Help alongside AAMR. Once the wearer was sentenced to BBR, the partner link worker wrote to the victim explaining their (ex-)partner's sentence and that they will be their point of contact until six months after the programme ends. The victim can decide whether to contact the partner link worker or not. If they do, the partner link worker provides support and can make referrals to local domestic violence services following a comprehensive risk assessment. A partner link worker described how they had not been contacted by any (ex-)partners of wearers at the time of the interview, but they had received informal feedback that victims valued knowing their situation was being monitored and they could seek help if they needed to. That the partner link worker cannot proactively contact victims was seen as a barrier to the effectiveness of this support mechanism.

5 Reported impacts of the AAMR pilot

This chapter explores the reported impacts of AAMR, on wearers, staff involved in delivery and wider impacts on the CJS and related sectors. It draws on findings from the qualitative interviews and the 'tag-off' wearer survey. There are three points to consider when interpreting these findings:

- This report details the findings of the process evaluation. As such, the impacts presented here are those reported by participants and are *indicative* of change. However, impacts cannot be attributed directly to the AAMR pilot; this would involve using a quasi-experimental or experimental design like a randomised control trial (the outcomes evaluation, concluding in 2020, involves a quasi-experimental design in the form of PSM). Delivery staff stressed the importance of an outcomes study, as they believed it would demonstrate the pilot's success.

- Due to the small number of interviews with wearers (six), and relatively low number of responses to the tag-off survey, the reported impacts on wearers may not be representative of all wearers in the HLNY pilot.

- The impacts described here are all short-term. The wearers who were interviewed were either still wearing the tag or had had it removed relatively recently. Some staff participants expressed their concern that the length of time the tag is worn is too short to change behaviour in the longer-term. The outcomes evaluation will explore longer-term impact in more detail.

Before we discuss the reported impacts of the pilot, we briefly reflect on what outcomes participants considered to denote 'success'. For wearers, this meant complying with their order, not reoffending and improved health outcomes. At a societal level, long-term success would be demonstrated by reduced reoffending, resulting in less pressure on criminal justice agencies; and healthier communities which would lead to less demand on health and social care and third sector support services.

5.1 Impacts on wearers

Reported impacts on wearers centred on alcohol consumption, resettlement, and health and wellbeing, discussed further below. This section concludes with discussion of the factors underpinning these impacts.

5.1.1 Alcohol consumption

Over three-quarters of 'tag-off' survey respondents reported that they thought they would drink less alcohol or no alcohol at all when the tag was removed (81%).[51]

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[51] The total percentage adds up to more than 81 percent due to rounding.

Figure 6 Wearer perceptions of future change in drinking behaviour
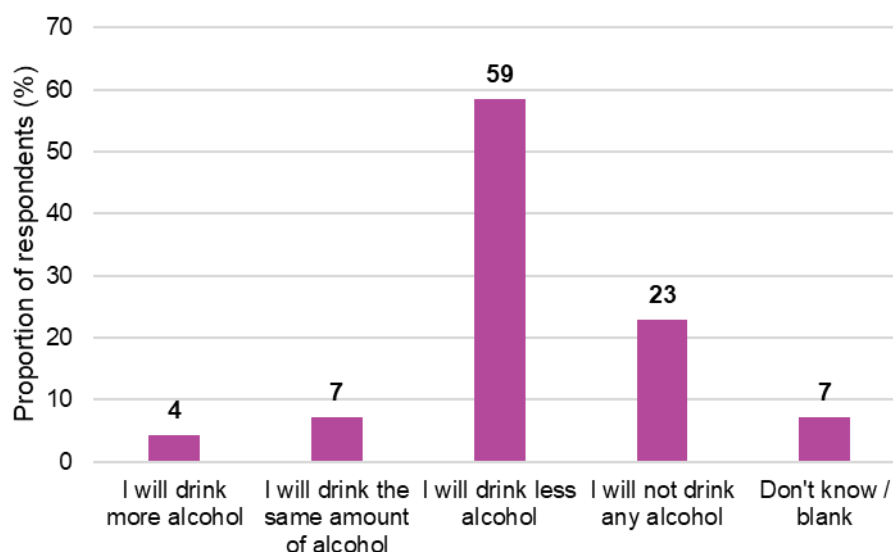
Source: 'Tag-off' survey
Numbers are percentages. Base = 70.

This range of responses was broadly reflected in the qualitative interviews with wearers. Participants who were still wearing the tag were all complying with their order and not drinking at the time of their interview. They credited the tag with their abstinence, describing how they would have 'definitely drunk' without it and so would have received a custodial sentence.

> *'I'd just say that I've been quite surprised how it has worked really because I didn't think I would actually be like this today. I didn't think I'd ever change [...] and I have, and I think completely different to what I did six months ago. You know what I mean? It's mad really.'* (Wearer)

Probation staff and delivery partners echoed these accounts and also described how having an 'enforced period of sobriety' motivated wearers to address some of the wider issues in their lives (discussed further below). However, despite evident pride with their progress, some wearers worried about whether they would be able to maintain it once the tag was removed and were considering seeking additional support as they approached this milestone.

Wearers that took part in the interviews whose tags had been removed reported a range of outcomes. One spoke of having the 'odd drink' when the tag was first removed but had been abstinent for three months at the time of the interview. Less successful outcomes were described by probation staff who said that some wearers had soon started drinking again once the tag had been removed. One wearer interviewed had replaced alcohol with a Class A drug while he was wearing the tag, after being introduced to it by someone he was doing unpaid work with as part of his Community Order. His tag had since been removed and he described enjoying continuing to drink and using drugs.

'I've met a drug dealer and when you have a tag and you can't drink, you find other alternatives […] He said to me, 'Look, if you can't drink, maybe try this. This is good.' […] I think I like [it] even better than alcohol […] [The tag] didn't help me at all, it just made me worse.' (Wearer)

5.1.2 Resettlement

It is widely acknowledged that family ties and being in paid employment are protective factors against reoffending (Bruton-Smith and Hopkins, 2014). Wearers and staff echoed this and impacts on relationships, employment and financial management are discussed below.

Relationships and home life

Wearers and staff reported that wearing the tag had positive impacts on relationships with family, such as living in stable accommodation with a sibling (who would not have lived with the wearer had they still been drinking), and being able to see their children again, who wearers and staff described had been taken into care following wearers' imprisonment on remand. More widely, staff described home environments as more 'calm', 'stable' and 'harmonious', as much of the previous tension, and sometimes violence, had stemmed from the wearers' drinking. Delivery staff and partners described this as a particularly positive impact in households where there had been domestic violence.

> *'So to be on a tag [and] to not be drinking, it positively impacts on the other things in their lives and on their relationships. I think of a guy in a domestic violence case, who has reduced his drinking and had her [his partner] reduce her drinking, and together they drink less and don't have the same altercations that they would have done when they both would drink. So it's a good impact.'*
> (Probation staff)

Other wearers spoke of how they had become more involved in household tasks like cooking, cleaning and gardening since wearing the tag, and that they took pride in these activities.

Employment

The wearers interviewed either had a job or felt reasonably positive about the prospect of finding one. One wearer described how a particular job application was looking promising at the time of the interview. Another wearer said he felt confident about finding work but wanted to wait until his supervision appointments had stopped, so that he would not have to request time off to attend them (though such appointments happen irrespective of AAMR).

There were also examples of the tag creating barriers to work, with one wearer explaining how the size of the tag prevented them from wearing boots that were required for factory jobs. Staff participants echoed this and recommended that the tags be made smaller to facilitate such work. One gave an example of a wearer giving up a job in catering because it involved being around alcohol. While this is a negative impact in terms of employment,

it shows self-awareness and risk management on behalf of the wearer, which is a positive outcome. Two 'tag-off' survey respondents revealed in open-text responses that they had lost their job because of the tag; one because their employer was aware of their offending, the other because of the tag interfering with footwear on a construction site.

Financial management

Probation staff highlighted that not drinking meant that wearers had saved money. This was also raised by a wearer in the open text responses to the 'tag-off' survey.

5.1.3 Health and wellbeing

Another positive impact related to wearers' physical and mental health. They described feeling healthier and some wearers were pleased to report that they had lost weight due to drinking less. Other's weight had increased which they also saw as positive as they saw themselves as unhealthy and underweight before being tagged. Some probation staff described a marked improvement in wearers' appearances when removing their tag.

More generally, wearers spoke of feeling good in themselves for their ongoing abstinence and a sense of pride for what they had achieved. This had not been without challenges; one wearer described moments when he had 'wanted a can' but had kept a positive attitude and refrained from drinking.

Despite these positive impacts, wearers variously described the tag as 'massive', heavy and uncomfortable, and this came as a shock to some when they were fitted for their tag, as discussed in chapter 4. A female wearer suggested the tag should come in a different size for women, as she had to buy trousers with a different fit to accommodate the tag's bulkiness. Concerns about size were echoed by probation staff and support providers and, as discussed above, they recommended that the tags be made smaller to facilitate employment opportunities.

The size of the tag also meant that wearers felt it was very noticeable to others and so were concerned around being judged or stigmatised for wearing the tag. Some wearers were worried about being asked questions and having to explain why they were wearing it. Reassurance from loved ones that the tag was not visible, and their support more broadly, appeased some wearers' concerns. Echoing the qualitative findings, 51% of 'tag-off' survey respondents did not want others to see they were wearing a tag.

Open text responses to the survey revealed other impacts on health and wellbeing such as the tag interfering with exercise, problems with sleep due to the 'buzzing' noise emitted by the tag, and difficulty bathing properly as the tags cannot be immersed in water.

5.2 Factors underpinning impacts on wearers

A key factor underpinning abstinence and identified by wearers and staff participants was being **ready to change**. These findings link to Maruna's concept of a 'turning

point' as being central to the process of desistance (Maruna, 2001), as well as desistance relating to age, maturity and changing personal identities (McNeill, 2009).

> *'I suppose it [the tag] is a good thing to have. […] I know [someone] that's had it where I live and [they] just keeps drinking on it and still fighting on it. So for [them] it hasn't worked. For me it worked. […] If you don't want to change you aren't going to change are you? Obviously it was my time in life to change. [Theirs] still hasn't come.'* (Wearer)

By contrast, some wearers did not believe they had a problem with alcohol and rationalised that their offence was minor compared to others, and that they had been unlucky getting caught.

> *'But why do I need to stop drinking? What did I do? I know I got caught drink driving […] I know I committed a crime and I am paying for it [… but] I have met people a lot worse than me in Community Service.'* (Wearer)

The **influence of others** had a bearing on impacts on wearers, in a range of ways. Consistent support from partners, family or friends had been instrumental to some wearers staying sober. For example, one wearer's sister and friend would call her daily when they knew she was alone and at risk of drinking. At the other end of the spectrum, actions perceived as unsupportive, such as a partner who continued to drink while the wearer was tagged, could make sobriety challenging.

For some wearers, **breaking contact with associates** they would have previously drunk or offended with was identified as an important protective factor. Others maintained these links and found that going out with friends that were drinking encouraged them to continue to abstain, because they could see their friends enact their old behaviours.

> *'I did still go out on the tag, just not drink on it and I'd seen men just literally fighting over just spilling a drink over people and it's like mad. […] It's a proper eye-opener, because before I would have been stuck straight in the middle of that, but when you go out sober and to watch it, it's totally different.'* (Wearer)

Wearers and staff identified the **possibility of being given a custodial sentence** as a strong incentive to comply with their order (particularly for those subject to an SSO), and some wearers were adamant they would have breached the restrictions or requirements of their sentence had it not been for AAMR, which seemed to support compliance in such cases. Staff noted however that the deterrent of prison was true of many orders or programmes and not unique to the AAMR pilot.

Finally, staff participants suggested that **a lack of information about what the tag would involve** (discussed in chapter 4) could have a negative impact on wearers' compliance with their order, although this was not directly raised by the wearers interviewed.

5.3 Impacts on staff

Reported impacts on staff centred on capacity and workload, discussed further below.

5.3.1 Capacity and workload

Some participants noted that involvement in AAMR could lead to increased workloads among CRC staff. They described how staff felt pressure to accommodate AAMR fitting activities around already busy caseloads and sometimes at short notice. Staff gave examples of needing to fit a tag on a given day and not being able to. In such instances staff either arranged the fitting for the next day, fitted the tag in the evening after their normal working hours, or found someone else to do it (who the wearer might not have met before). However sometimes the latter was not an option, in offices where only one or two people had been trained. Having a small number of people who were trained to fit tags was described as stressful by some. As discussed in chapter 4, several factors were felt to exacerbate this, such as small teams covering large geographical areas and signal issues in remote areas (both of which meant a long time out of the office to fit and/or check tags) as well as accommodating staff annual leave and sickness.

> *'For a certain number of staff it did cause quite a lot of stress because of the extra additional workload and especially when one or two staff members weren't available. I think in whole of [three areas] there might've been one person that could do a fit. I had to, one time, drive up to [place] because once somebody got a tag there who was a risk for female staff. So it had to be fitted by a male staff member […] So then there's a whole lot of issues around having an appropriately-trained and mobile team.'* (Probation staff)

CRC staff were concerned about the potential impact of these issues on both the quality of their work and their safety and wellbeing, particularly if they were fitting or checking tags alone in a wearer's home.

However, not all CRC and NPS staff were concerned about capacity and workload. Some reflected that uptake of the pilot had been low and more could be done around raising awareness and encouraging support for it. There was also felt to be an insufficient number of tags issued for the pilot, which may have impacted on the number of AAMR orders given. As such, these participants reported little impact in terms of their role and workload but were mindful that their workload could increase if the pilot was rolled out and/or taken up more widely. For other CRC staff, the impact on their workload varied due to fluctuations in use of the tag, with one participant describing how the pilot sometimes 'takes over [their] life' and at other times they 'forget it's still running'.

Beyond probation, the pilot was found to have relatively minimal impact on other services' workloads. It was found to have had little effect on court staff, apart from administrators who had to log an extra resulting code onto Libra.[52] Support agencies also felt their role was unaffected by the pilot in that they still provided the same services to wearers regardless, and as such the rehabilitative aspect of the order remained unchanged. They did however flag the importance of knowing which of their service

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[52] Case management IT system used in Magistrates' Courts.

users was tagged, so they could communicate with the wearer's offender manager if any issues or risks arose.

5.3.2 Motivation

As discussed in chapter 2, there was a sense of excitement and expectation around AAMR. Staff were largely enthusiastic about the intervention and saw it as an opportunity to work with a specific group of individuals to help them succeed in addressing their offending behaviour. The innovative technology and its capacity to closely monitor alcohol consumption was thought to be particularly motivating for staff.

> *'I think it's been exciting for staff to be involved in something at this level […] They love having something innovative and some technology that supports them in their role. So I think it's rejuvenated some of them into their roles and how they deliver these services to service users.'* (Probation staff)

5.4 Wider impacts

Some participants highlighted that the pilot had been well received by children's social care services, as the tags gave social workers added confidence that their service users were not drinking. Staff described how this had helped when wearers were building relationships with their children who had been taken into care due to their offending and/or drinking.

6   Key learning from the pilot

Studies have shown that in certain circumstances reoffending rates are lower for 'court orders' (Community Orders and Suspended Sentence Orders) than for short-term custody (Eaton and Mews, 2019; Mews et al., 2015). Recently, ministers have said that they want to reduce or end the use of short prison sentences to reduce reoffending (Beard et al., 2019). In July 2019, figures were cited which showed that there would be around 32,000 fewer offences per year if all current custodial sentences of less than six months were replaced with community alternatives (MoJ, 2019). Other research has shown that electronic monitoring could support this ambition (Kerr et al., 2019).

Data collected for this study highlights the potential for AAMR to contribute to safe and effective sentencing in the community and, from the perspective of some staff participants, support reductions in reoffending rates (the ongoing outcomes evaluation will assess long-term impacts, more detail on which is given at the end of this chapter).

Findings have important implications for policymakers and staff across the CJS and should be taken into consideration in the planning of any future roll-out.

6.1 Key benefits and challenges of the AAMR

Overall, staff and wearer participants were positive about the potential for AAMR to support effective community sentencing. It was felt to be an important 'tool' available to decision-makers which could be used to support the rehabilitation of a specific offender group, where drinking had contributed to their offending behaviour. The key factor perceived to facilitate the success of the intervention was its potential to motivate individuals and change behaviour through an 'enforced period of sobriety'. The tailored approach of the order, including the length of the tag requirement and use of RAR days was also thought to be important.

> *'It's good to have a range of options post court and we're quite limited really in what we can propose and this is just another thing to propose. That in itself is valuable […] It stops people doing something but it's also encouraging a change in behaviour so it's something which people have liked.'* (Probation staff)

Other research acknowledges the importance of resettlement factors in supporting effective rehabilitation, including family ties and employment (Brunton-Smith and Hopkins, 2014). Key benefits of the AAMR for wearers included opportunities to live or spend time with family and friends, maintain a more 'harmonious' home life (especially in domestic violence cases), find or maintain employment, and a range of perceived health and wellbeing outcomes. Conversely, there were instances where AAMR impacted more negatively on wearers' rehabilitation, including for example the tag creating barriers to employment and being uncomfortable to wear.

Other challenges were also highlighted, which related to awareness of the intervention in identifying individuals who might benefit from the AAMR as well as the complex processes involved with fitting the tags, ongoing monitoring, and supervision. However, it was expected that, over time, knowledge and processes surrounding AAMR as an

option to support community sentencing would improve as delivery became embedded within the wider CJS.

6.2 Learning points

The following learning points bring together findings from the report in addition to participants' reflections of overall pilot delivery and impact. It is important that these points are taken into consideration in any future planning to roll-out AAMR to ensure that the intervention targets and supports the most suitable individuals. Two overarching recommendations were discussed across participant groups in the three pilot areas; these related to the appropriate allocation and management of resources and the demand for ongoing learning about the impact of AAMR, discussed below.

In the context of busy and increasing workloads, staff participants highlighted the importance of **the necessary resources being in place** if the programme was scaled up. This includes probation staff having enough time to fit tags, monitor wearers and deliver effective offender management. Participants agreed that consideration would need to be given to the division of responsibilities (e.g. tag fitting and monitoring) to ensure that resources are allocated in the most effective way. Finally, dedicated administrative support was thought to be vital in supporting the organisation of the pilot, and would need to be in place for any future roll-out.

The second overarching point related to an appetite to know more about the pilot's success; participants were keen to understand **what worked well and any challenges**. It was hoped that knowing more about the impacts and efficacy of AAMR would ensure that partners across the CJS continued to use it effectively, and, give confidence to the judiciary in making sentencing decisions. The outcomes evaluation, which this process evaluation precedes, was welcomed and participants were keen to understand more about the extent to which AAMR supports positive outcomes in the longer-term. An overview of progress and plans for the impact evaluation is provided in the section below.

Other learning points highlighted the need for:

- **Clear and consistent communication** about the pilot across the CJS. Participants thought that better knowledge of the processes and perceived benefits of AAMR would support more effective identification and sentencing of eligible offenders. While there was evidence that information about the pilot had been communicated widely, including in courts, there was a sense that in some areas, certain groups, (for example, the judiciary) may have benefited from more details about the pilot, including information about the range of softer benefits. There was however, an acceptance that understanding would naturally improve over time as awareness and use of the order increased.

- **Strong and effective partnerships**. Effective joint-working was viewed as a particular strength as it facilitated the smooth running of the pilot in certain ways, for example, managing the fitting of tags. However, some challenges between the NPS and CRC were also highlighted early in the pilot. Participants explained that effective delivery hinges on partners being clear on their roles and responsibilities and how

they fit together. More frequent meetings and consistent communication was thought to be important. This was especially the case post-sentence, when offenders were being supported in the community to comply with the varied requirements of their sentence, including the AAMR order.

- **A reconsideration and strengthening of the assessment processes** involved in identifying eligible wearers, especially in relation to AUDIT. Participants highlighted the need for accurate tools to enable a more sophisticated understanding of alcohol consumption, offending behaviours and motivations to change. The continued ability to use discretion and professional judgement in this process was highly valued and should be retained.

- **Equipment (e.g. laptops) that is accessible and well connected**. Challenges included a lack of access to essential equipment, including laptops, especially when the pilot was extended to the entire CRC. The connectivity of some devices and wi-fi in wearers' homes also made it hard to manage the fitting and monitoring processes. Linked to this, participants highlighted the need for more accessible information about alerts and training to interpret the data generated by the tag accurately.

- **Smaller and more discrete tags**. The size and weight of tags was thought to have raised anxiety among wearers. If the intervention were to be scaled up, it was hoped that consideration would be given to using smaller, more comfortable tags if possible. This might help wearers to feel less nervous about the associated stigma of people noticing them wearing a tag and engage more positively in their rehabilitation.

- **Tailored and accessible offender management and support**. A range of challenges were highlighted in relation to the delivery of CRC/NPS support, for example the time and resources staff could offer wearers. For AAMR to be effective, participants were clear that support should wrap-around the period of abstinence and help the wearer to make positive changes while sober. It is worth noting that for most wearers, probation supervision would continue beyond the tagging period and this time should be used to continue to engage and support individuals to maintain personal objectives, (such as sobriety) with the overall aim of reducing recidivism.

- **Flexibility over how AAMR is used**. For example, some participants were keen to explore how the tag might work if longer orders of over 120 days, which is what the current legislation supports, could be given to wearers or used for lower level offences instead of a fine or conditional discharge. However, the range of potential benefits and challenges with these options would need to be carefully considered as they may be viewed as too punitive.

6.3 Plans for the outcomes evaluation

The outcomes evaluation will explore whether and to what extent the pilot positively affects offenders' behaviour, including reduced reoffending rates. It will seek to produce a causal estimate of the impact of participating in the pilot on re-offending, within 12

months of tag fitting. This estimate will be produced using Propensity Score Matching (PSM), to compare the reoffending of those tagged with those who have not been tagged who match on observed characteristics.

This will draw on data from the Police National Computer (PNC) and Offender Assessment System (OASys) to match tagged individuals with similar individuals outside of the AAMR pilot areas. The indicators included in the matching model will incorporate a wide range of characteristics, such as offending history, socio-economic characteristics and drinking behaviours.

The PSM analysis will involve several stages:

- Tagging areas will be matched with similar areas based on local area characteristics, using publicly available data.
- PNC and OASys data on tagged individuals and a random sample of individuals from matched areas will be provided to NatCen.[53]
- Individuals within matched areas will be matched to tagged individuals using the individual level data from PNC and OASys.

The area-level matching and PSM analysis will be conducted as soon as the data is supplied to NatCen.

A more detailed proposal setting out the rationale for the data sources, indicators and analysis planned was included in the Year 1 report.

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[53] This is all done in line with a Data Sharing agreement between the listed organisations.

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Appendix A: Methodology

This appendix gives further information about the qualitative methodology used for the process evaluation, as well as the methodological challenges encountered and how these were overcome.

Sampling and recruitment of staff and wearers

A range of staff and wearers were interviewed in each case study area, as presented below.

Table A.1 Staff participants interviewed

Number of staff interviews per case study area	Participant groups			
	Police and probation services	Courts including the judiciary	Support and victim support organisations	Total interviews (by area)
Boston (Lincolnshire)	8	3	-	11
Grimsby (North East Lincolnshire)	5	1	2	8
York (North Yorkshire)	3	2	-	5
Total interviews (by participant group)	**17***	**6**	**2**	**25**

*Includes a participant whose role is based across case study areas.

Across the three case study areas, 25 staff interviews were completed across participant groups. Interviews were carried out with nine CRC staff, seven NPS staff, one member of police staff, six staff from the courts and judiciary and two staff from external support and victim organisations.

Across the tagging survey and gatekeeper recruitment, interviews were conducted with 6 wearers. The research team contacted or attempted to contact 72 wearers from the tagging survey sample, outlined in more detail in Table A.2 below.

Table A.2 Wearer contact details from tagging survey

Contacts from tagging survey	Number of wearers

Interviews scheduled: • Interviews conducted from sample – 4 • Interview no shows – 4 • Opted out after scheduling interview – 2	10
Wearers who opted out when reached by phone	5
Not able to pursue due to language difficulties	2
Contact exhausted — Wearer was uncontactable via the details provided	17
Contact attempted via phone three times (and text or email once, if information available)	18
Contact attempted via letter and/or email only (where no phone number was provided)	20
Total number of wearers contacted or contact attempted	**72**

Contact details for tag wearers were also shared with the research team by a gatekeeper (either a CRC case study lead or a staff participant). Of the 14 wearers whose contact details were passed on, 7 were not included in the tagging survey sample (their details were provided solely by gatekeepers) and 7 were listed in the survey sample, but their details were also provided by a gatekeeper (See Table A.3).

Table A.3 Wearer contact details provided by gatekeepers

Contacts provided by gatekeepers	Number of wearers
Interviews scheduled: • Interviews conducted – 4 (2 not included in survey) • Interview no shows – 2 • Unable to reschedule – 1	7
Abandoned after multiple attempts to schedule interview after opt-in	5
Uncontactable	2
Total number of wearers contacted or contact attempted	**14**

Out of the 7 interviews initially scheduled with wearers, 4 were successfully conducted, 2 interviews resulted in respondent 'no shows' and 1 interview could not be rescheduled after the participant asked to move the interview date. In addition, 5 wearers opted in to

taking part in the research, however, these contacts were exhausted after multiple attempts to confirm an interview time with them. This was due to ethical concerns around the limits to consent and whether these wearers were indirectly opting out of taking part.

Methodological challenges and limitations

As with all research, the evaluation faced challenges and had methodological limitations and it is a marker of high-quality research to acknowledge them. The main methodological challenge for this study involved the recruitment of staff and wearers:

Staff recruitment challenges

- **Difficulty engaging staff groups across the CJS**: Recruiting staff across the CJS took longer than anticipated. Participating may also have been difficult for some staff alongside their workloads. Limited involvement in or awareness of the pilot meant that some staff declined to take part.

- ➢ **Solutions**: The research team built up a network of potential contacts by asking interview participants whether they knew other staff members that might be willing to take part. We also offered to conduct interviews at a time and date that suited participants, and the option of a shorter interview if the time commitment was a barrier to participation. Participation was also encouraged by explaining that having limited involvement in the pilot was itself a helpful finding.

- **AAMR delivery differed from expectations**: The intention was to interview support staff working with tag wearers and/or victims of those wearing the tag. However, external support organisations were often not involved in providing this support in practice (the CRC or NPS delivered most of this rehabilitative work), which meant potential participants often did not feel able to comment on the pilot due to a lack of cases. There was also variation in terms of the number of AAMRs imposed in different geographical locations and by different courts (e.g. between the Crown and Magistrates' Court), which was reflected in lower participation by some members of the courts and judiciary.

- ➢ **Solutions**: The research team were able to interview staff in these groups by being flexible with coverage of the topic guide. For example, asking hypothetically about whether they felt this type of sentence would be effective. Initial interview quotas were also revised accordingly.

- **Ethical approvals**: Waiting for ethical approvals to be granted prior to starting fieldwork with certain participant groups caused delays in recruitment, particularly in relation to court staff and the judiciary:
  - **HMPPS NRC approval**: Submitted by the NatCen research team in April 2018, approval granted in May 2018.
  - **HM Courts and Tribunals Service Data Access Panel approval**: Required to interview court staff. Submitted by the NatCen research team in July 2018, approval granted August 2018.
  - **Judicial Office approval**: To interview members of the judiciary. Submitted by the NatCen research team in June 2018, approval granted March 2019.

➤ **Solutions**: The research team planned fieldwork to ensure interviews could be arranged as soon as possible after ethical approvals were granted.

Wearer recruitment challenges

- **Wearer contact details**: Due to time passing since wearers had completed the tagging survey, the contact details provided were often not up to date and so it was not always possible to recruit using the survey database.

- **Difficulty encouraging wearers to take part**: We were not able to offer a 'thank you' payment to wearers, which may have discouraged some from taking part.

- **Availability**: Wearers' working patterns made it difficult for the research team to contact them at a convenient time. Many wearers also had busy or changing schedules. For example, some people were willing to be interviewed but were then not available to talk at the time arranged due to an unpredictable work schedule or having to attend appointments. All participants were given the option to rearrange.

- **Concerns around confidentiality and anonymity**: While the research team reassured participants about confidentiality and anonymity in information leaflets and at the start of their interview, some did not feel entirely comfortable with participating due to a mistrust in authority.

- **Variation in number of tags ordered in different locations** resulted in variation in the number of potential wearers that could be interviewed across pilot locations.

A number of strategies were employed by the NatCen research team to increase the number of wearers able to take part in the research:

- Using a mobile phone to contact wearers for more accessibility and flexibility;
- Calling and texting at different times of the day to ensure that potential participants who work or have other commitments were not excluded;
- Exhausting all possible modes of contact available, including postal addresses, email addresses or phone numbers where available[54];
- Accommodating specific needs, such as language requirements. For example, we were able to interview a non-English speaking participant by using a NatCen researcher to interview this individual in their native language; and
- Flexibility in interview timings. The research team worked together to ensure availability whenever suited participants, including before/after usual working hours.

Another key methodological limitation was that due to the small number of interviews with wearers (six), wearers' perspectives are unlikely to be representative of all wearers in the HLNY pilot. Despite this, wearer participants had different experiences of wearing

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[54] A mode of contact was exhausted when contact was attempted three consecutive times via that method. Postal addresses were exhausted after sending a letter to the address.

the tag, and came from a range of backgrounds across the three case study areas. This provided useful insight into the perceived benefits and challenges of AAMRs.

Appendix B: Topic guides

Tailored topic guides were used to ensure a consistent approach across all the interviews and between members of the research team. The guides were used flexibly to allow researchers to respond to the nature and content of each discussion, so the topics covered and their order varied between interviews. Researchers used open, non-leading questions, and answers were fully probed to elicit greater depth and detail where necessary.

The main headings and subheadings from the topic guides used for interviews with staff and wearers are provided below.

Staff topic guide

1. Introduction
- Introduce self and NatCen
- Introduce research, aims of study and interview
- Brief overview of topics to be covered in interview
- Length (about 60 minutes)
- Voluntary participation
- Confidentiality, anonymity and potential caveats
- Audio recording (including encryption, data storage and deletion)
- Questions
- Verbal consent audio recorded

2. Background
- Current position or professional role
- Involvement in AAMR pilot
- Nature and profile of local area

3. Early awareness and expectations
- Awareness and understanding of AAMR
- Initial views on AAMR
- Early expectations and hopes for AAMR

4. Set-up and implementation
- Role in set-up and implementation
- Funding and resources available for AAMR implementation
- Training and guidance received/delivered
- Governance – overview of how pilot is managed strategically and locally
- Key facilitators/barriers to set-up
- Roll-out to additional courts in Year 2

5. Delivery
- Identifying cases for an AAMR order
- Imposing an AAMR order

- Decision-making around order requirements, Rehabilitative activities and other elements
- Process of tag fitting
- Supervision and monitoring of wearers on the order
- Process of communicating decision and requirements of AAMR order
- Process of tag removal/de-installing equipment
- Profile of wearers on AAMR order
- Infrastructure and operational issues

6. Outcomes and Impacts
- Key outcomes the pilot aims to achieve
- Perceived impact of pilot to date
- Alternatives and added value

7. Recommendations

8. Next steps and close

Wearer topic guide

1. Introduction
- Introduce self and NatCen
- Introduce research, aims of study and interview
- Brief overview of topics to be covered in interview
- Voluntary participation
- Confidentiality, anonymity and potential caveats
- Reporting process
- Audio recording (including encryption, data storage and deletion)
- Disclosure policy
- Questions
- Verbal consent audio recorded on tape

2. Background
- Participant background
- Education and employment history
- Offending and court history
- Most recent court experience (leading to AAMR order)

3. Initial understanding and expectations of AAMR order
- Initial information on AAMR
- Perceived reason for receiving an AAMR order
- Understanding of how a tag works
- Understanding of requirement to engage with rehabilitative intervention (Rehabilitative Activity Requirement or Accredited Programme Requirement)
- Initial views of AAMR

- Any previous experiences of tagging

4. Experience of wearing a tag
- Process of fitting a tag
- Experience of rehabilitative intervention
- Other supervision and support
- Experience of complying with alcohol-related tag conditions (abstinence)
- Experience of complying with rehabilitative conditions
- Any experience of breach or non-compliance of conditions
- Practicalities of wearing a tag
- Process of removing a tag (if relevant)

5. Impact of AAMR order
- Influence of AAMR tag on compliance
- Influence of rehabilitative requirement
- Other impacts of tag and rehabilitative requirement
- Extent of other influences on impacts discussed
- Views on tag and rehabilitative initiative compared to other forms of sentence
- Behaviours once tag was removed (hypothetically if still wearing tag)
- What would have happened if tag was not in place

6. Overall experience and recommendations
- Overall experience of wearing tag and rehabilitative initiative
- Whether wearing tag met expectations
- Views on how tag and rehabilitative requirement can be improved

Appendix C: Glossary

Alcohol Abstinence Monitoring Requirement (AAMR): A new sentencing power in England and Wales which allows courts to impose a requirement as part of a Community Order or a Suspended Sentence Order that an offender abstain from alcohol for a fixed period of up to 120 days. The offender is regularly tested, via a transdermal alcohol monitoring device in the form of a 'tag' fitted around the ankle which detects consumption of alcohol through sweat.

Accredited programme: An accredited programme is a systematic series of activities aimed at supporting rehabilitation which have been accredited by the Correctional Services Accreditation Panel. Programmes vary in length and complexity and are targeted according to risk and need.

Alcohol Treatment Requirement: Targeted at offenders assessed as alcohol dependent, who will often have complex coexisting needs e.g. mental health, social and housing problems and require intensive, specialist, care-planned treatment e.g. day programmes, detoxification, residential rehabilitation and integrated care involving a range of agencies.

Alcohol Monitoring Systems (AMS): Alcohol Monitoring Systems, Inc is based in the US and owns and delivers the SCRAM software and hardware used for continuous alcohol monitoring used for the AAMR pilot.

Breach: A confirmed violation of a wearer's order requirement not to drink alcohol, as monitored by the AAMR tag.

Community Rehabilitation Company (CRC) Case Manager: Responsible officers in charge of monitoring wearers were either case managers or offender managers, depending on whether they are supervised by the CRC or NPS. CRC case managers fitted and removed AAMR tags, liaised with the AMS monitoring centre, managed low to medium risk offenders and provided rehabilitative activities.

Community Order: A Community Order is a sentence given by a court that combines punishment with activities carried out in the community. These can include multiple requirements such as unpaid work, curfew, rehabilitative activities, and offender behaviour programmes. Courts were able to impose alcohol abstinence monitoring as one of these requirements in the pilot.

Community Rehabilitation Company (CRC): Community Rehabilitation Companies are private sector suppliers of probation services. They supervise low to medium risk offenders in the community.

National Probation Service (NPS): The National Probation Service is a public sector criminal justice service that supervises high-risk offenders in the community. The NPS are also responsible for the provision of pre-sentence reports within courts, which provide guidance on suitable sentencing options.

National Probation Service (NPS) Offender Manager: Responsible officers in charge of monitoring wearers were called either case managers or offender managers, depending on whether they are supervised by the CRC or NPS. NPS probation officers managed higher-risk offenders on the AAMR tag and provided some rehabilitative activities.

Rehabilitative Activity Requirement: The Rehabilitative Activity Requirement is one of the requirements that can be included within a Community Order or Suspended Sentence Order. The main purpose is to secure someone's rehabilitation, enabling service users to live a purposeful life.

SCRAM Software: Secure Continuous Remote Alcohol Monitor (SCRAM) Software delivered by AMS to assist probation with the continuous transdermal alcohol monitoring for the AAMR tag.

Suspended Sentence Order: A Suspended Sentence Order is a custodial sentence of between 14 days and two years (or six months in the Magistrates' Court), the court may choose to suspend the sentence for up to two years. The Suspended Sentence Order consists of an 'operational period' (the time for which the custodial sentence is suspended) and a 'supervision period' (the time during which any requirements take effect). If the Suspended Sentence Order is breached, the court must activate the suspended sentence unless there are strong reasons for not doing so.

Wearer: An individual who had experience of wearing an AAMR tag on the pilot.

Appendix D: HLNY AAMR model

This appendix provides additional detail about the HLNY model, including information about the resources allocated to the pilot, staff roles and the technology used.

Resources

The hardware required to deliver the pilot was provided by ScramSystems UK and included the tag bracelets, multi-connects and base stations which supported connectivity to ensure continuous alcohol monitoring could take place. Hardware was divided between the three pilot sites and there was agreement at project board level that tags could be moved between the three areas in accordance with demand.

In year 1, each site was also allocated the following equipment to deliver the pilot:
- A laptop specifically for use for AAMR tag fitting
- Wi-fi dongle to support fitting outside of the office or for use where wi-fi connection was not available
- Two fitting kits including tools to fit tags, protective gloves and direct connect device
- Breathalyser
- Cleansing wipes
- Bags for waste generated during fitting

In year 2, additional materials were provided by the CRC to support fitting over a wider area. These included additional fitting kits, multi-connects, breathalysers and laptops.

Job roles

A number of AMMR-specific roles were important in the set-up and delivery of the pilot. They included:

Project Manager: responsible for operational oversight of the AAMR project including:

- Support to operational staff including practice forums

- Oversight of AAMR order management across the pilot, liaison with Interchange Manager leads where appropriate

- Advice to operational staff and courts regarding AAMR requirement management and recommendations

- Stakeholder engagement – chair of the DA steering group and Humberside Local Implementation Group, also responsible for delivery of presentation and updates to relevant community forums e.g. Community Safety Partnerships, Courts.

- Liaison with AMS

- Updates to the Project Board including compilation of CRC highlight reports, updating risk log, collating lessons learned.

- Responding to information requests from media and external agencies in consultation with Project Board.

Case coordinator role: responsible for administration of the pilot and liaison with SCRAMNET which included responding to the daily action plan.[55] The case coordinator passed this information on to the relevant case manager to action either within the CRC or NPS. The case coordinator was also responsible for:

- Inventory oversight, including return of faulty equipment to AMS,
- Responding to court requests for fitting appointments and setting these up with the semi-specialists,
- Management of the AAMR mailbox.
- Tracking when tags were due for removal and prompt case managers accordingly.
- Collating management information to inform performance reports to the Project Board.

Case manager role: AAMR semi-specialists had overall management of the CRC service users sentenced to AAMR including management and maintenance of the tag, risk management of the service user including liaison with partnership services where appropriate, delivery of rehabilitative interventions and enforcement of the order in incidents of non-compliance.

All case managers were trained in accessing and using SCRAMNET. For NPS cases the CRC semi-specialist would join three-way appointments where relevant and keep in close contact with the NPS offender manager. They were also trained in and responsible for fitting and removing tags; and delivering the brief alcohol intervention work.

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[55] The daily action plan generated by SCRAMNET detailed any alcohol alerts, tampers, download failures or maintenance alerts.