Alcohol Abstinence Monitoring Requirement The pan London roll out: A review of process and performance from year 1.

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MOPAC Evidence & Insight

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Executive Summary

In 2011 the Mayor's office secured legislation to allow for the introduction of a new sentencing power, the Alcohol Abstinence Monitoring Requirement (AAMR) to tackle the significant problem of alcohol related offending in London. The AAMR gives the Judiciary the statutory power to stop an offender drinking alcohol (Compulsory Sobriety), where their offence is alcohol related. The AAMR involves fitting a tag to the offender's ankle and monitoring their alcohol consumption for up to 120 days. When this is not complied with, the offender will be breached and punished further.

Following the positive learning from the pilot rollout of the innovation, during 16-17 the AAMR has now been rolled out across London. This programme continues to monitor the technology and generate learning. This report provides learning from the first year of the pan London AAMR focussing upon process and performance evaluation.

Key Findings:

Performance learning

- A total of 367[1] AAMRs have been imposed between April 2016 and March 2017, with an average length of 67 days tagged.
- The vast majority of offenders who completed the AAMR did so successfully, indicating a 92% (*n*=235) compliance rate with this requirement[2].
- AAMRs were usually given for a Community Order (74%, *n*=270), and standalone AAMRs accounted for 28% (*n*=100) of all Orders. Multiple requirement Orders usually consisted of AAMR and Unpaid Work (19%, *n*=69).
- AAMRs were given for a variety of crime types, most commonly in relation to violence (31%, *n*=115) or drink driving offences (22%, *n*=82), which is similar to the pilot (63%, *n*=80 – both offences).
- AAMRs have been imposed across London, most frequently from Magistrates Courts (93%, *n*=342), specifically Croydon Magistrates (17%, *n*=58) and Uxbridge Magistrates (14%, *n*=49). However, other courts such as Thames and Barkingside who were last to roll-out AAMR in January 2017 have also performed well and have awarded 16 and 17 AAMRS respectively.
- The technology continues to work as intended, taking on average 48 readings per day, providing effectiveness and certainty to stakeholders.
- Findings are generally comparable with the AAMR pilot in terms of usage and offences the AAMR was imposed for, although some differences were observed around the use of AAMR as a standalone requirement (28% vs 40% standalone requirements in pilot). It is encouraging to see that the compliance rate of 92% has remained consistent with the pilot.

Process learning

[1] A total of 378 orders were issued but due to data quality issues on NPS systems MOPAC was not able to include all of the cases in the analysis.

[2] For the purpose of measuring compliance we have recorded an unsuccessful completion when alerts about violations on the tag led to enforcement action being taken by the Offender Manager that led to a breach conviction at Court.

- Overall the AAMR has been accepted well across London by all delivery stakeholders as an additional tool that is tailored and specific to addressing alcohol related offending; a tool that has not been available to them previously.
- Training was well attended and received. Stakeholders who attended the training were more supportive and aware of the programme than those who did not.
- Stakeholders are trusting of the AAMR technology and recognised it's capacity to facilitate engagement with other services, to target underlying issues, and allow offenders a 'break' in their drinking so to reflect.
- Stakeholders reported that they expected more cases to be suitable however individuals had to be excluded largely due to alcohol dependency.
- Stakeholders remain positive about the potential impact of the AAMR on offenders; however practitioners expressed a desire to see the longer term evidence around potential impacts.
- While most offenders were relatively optimistic about the AAMR and had confidence in completing it successfully, as reported in the pilot research, the size and weight of the tag emerged as issues. A number of offenders (23/56) reported some discomfort; that it influenced their general well-being (7/56); some raised the issue of stigmatisation and negative influence on financial situations wearing the AAMR.
- The strongest theme to emerge around learning related to the scale up challenges:
    - Delays in tagging offenders (52%, *n*=160, of offenders were tagged within 24 hours during the full roll-out compared to 82%, *n*=83, in the pilot) possibly reflecting issues with the taggers covering wider geographical areas.
    - More awareness raising and improved communication around the AAMR: Less respondents in the pan-London roll-out felt satisfied with the awareness raising information provided by MOPAC (69%, *n*=37/54 vs 78%, *n*=31/40) and many of the promotional guidance items had not been seen by many stakeholders in the Pan London cohort compared to the pilot (for example, the leaflet was seen by 57%, *n*=30/53, in the roll-out cohort compared to 80%, *n*=35/44, in the pilot). If further training or information is rolled-out it may be preferable to ensure all relevant organisations are represented. Additionally, stakeholders would like to be kept informed of performance of the programme on a regular basis.
    - The majority of stakeholders reported positively about the usefulness of the AAMR, however this was 15% less than the pilot cohort (78%, *n*=40/51 vs 93%, *n*=38/41). Interestingly little difference was seen between these cohorts when stakeholders attended training (92%, *n*=480/524). This highlights the positive impact that training by MOPAC and AMS has had but also the importance of continual awareness raising outside of formal training events by MOPAC.
    - Significantly fewer stakeholders from the pan-London cohort said that the AAMR has allowed them to develop better working practices with partners (49% decrease compared to the pilot cohort).
    - Some of the above differences in stakeholder perceptions about the AAMR could be due, at least in part, to the different respondent characteristics between the pilot and the pan-London roll-out stakeholder survey. For example in the pilot stakeholder survey 58 respondents answered the survey and were mainly probation

officers (58%) whilst in the pan-London survey 60 respondents answered the survey and over half were from the courts (magistrates, legal advisors and court staff).

Much of the learning encountered in the current pan London evaluation report reflects that of the initial pilot research, indicating the importance of effective implementation - something that was always going to be a challenge in scaling up to a London level. It is also important to remember that it is always challenging trying to embed an innovative programme of work into a complex landscape with changing external pressures both politically and within individual organisations. Despite this, uptake and use of the AAMR has been positive to date.

This report sits as part of a wider, holistic evaluation around the roll out of the AAMR across London. As we enter year 2, additional research is currently being conducted around performance and process analysis, proven reoffending analysis to explore the impact of AAMR on offending behaviour and a full cost benefit analysis. These elements will be reported on in the second interim report in late spring 2018 (at the end of the two year roll out) and the final report in winter 2018.

Introduction

It is widely understood that alcohol use contributes to criminal behaviour, particularly around violent crime and public disorder in the UK. It was last estimated that the total cost of alcohol related harm was £21 billion, with alcohol recognised as a major cause of attendance at Accident and Emergency departments and hospital admissions (Public Health England, 2014a).

Historically, as measured by the CSEW approximately half of violent incidents are related to the influence of alcohol. Whilst there has been a slight decline (from 53% in 13/14 to 40% 15/16) - it remains clear that there is a longstanding resistant association between alcohol and violence. Recent trends suggest that alcohol is present among violent incidents that are likely to occur in a pub or club (83%), at the weekend (49%), during the evening/night time (48%) (ONS, 2017), with victims also more likely to receive greater injuries (ONS, 2015). Wider data also contributes to the picture - around a fifth (21%) of Londoners think that people being drunk or rowdy in public places is a problem (MOPAC Public Attitude Survey (PAS), Financial Year 2016/17), a trend that has remained stable over the previous year[3]. Similar views are held by London businesses who perceive people being drunk / rowdy in their local area to a problem (26%) (MOPAC Business Attitude Survey, 2014 – 2016).

Aside from violence, it is clear that other crime types (e.g., see McSweeney, 2015) such as driving offences, can also contribute to cause considerable harm. In 2015 for example, 37,578 defendants were convicted 'Driving / attempting to drive with excess alcohol', the majority of whom received a fine (76%) and a further 16% received a Community Order. Offences of this type have the potential to cause considerable harm; the total number of casualties of all severities in drink drive accidents in Great Britain in 2014 was 8,270. Of these, 1,310 were killed or seriously injured (Department for Transport, 2015a).

The links between criminal behaviour and alcohol are intrinsically linked, with large costs to both the public purse and public health and wellbeing. Many attempts have been made to address alcohol use over the years from both a criminal and health related perspective. This report will review relevant interventions and further discuss the introduction of a compulsory sobriety programme introduced across London to address alcohol related offending.

Sobriety Programmes and Interventions:

Following a number of popular drug and alcohol sobriety programmes (e.g. 12-step Programme, Alcoholics Anonymous), the focus within sobriety interventions has shifted from addressing addiction, towards specific behavioural implications such as offending. The primary approach has been the monitoring of alcohol-use through various methods; from random sobriety check-points and ignition interlocks in addressing driving under the influence (DUI) (Roth, Marques & Voas, 2009; Bergen, Pitan, Shults & Sleet, 2012; Blais & Dupont, 2005) to continuous monitoring via transdermal tags, urine and blood testing to reduce alcohol-fuelled offending (Dougherty, Charles, Acheson,

[3] The PAS explores the views of the residents across London around crime, ASB and policing issues via a face to face interview with over 12,800 respondents per year. In quarter 3 2015/16 20% of Londoners thought that people being drunk or rowdy in public places was a problem.

John, Furr & Hill-Kapturczak, 2012). The focus of many of these programmes has been around assessing the efficacy of the equipment and compliance with the programmes' ethos.

While few studies have explored the impact of such interventions, those that have, have published promising results; most notably, the South Dakota 24/7 Sobriety Programme (Kilmer, Nicosia, Heaton & Midgette, 2013). This programme sought to reduce DUI offences using transdermal tags and/or twice-daily breathalyser tests to encourage complete abstinence from alcohol. Primarily targeting repeat offenders, the programme combines constant alcohol monitoring with 'swift' and 'modest' sanctions - those who breach are immediately taken into custody or court (Kilmer, Nicosia, Heaton & Midgette, 2013). Compared to counties where a 24/7 sobriety programme was not implemented, results suggested a 12% reduction in DUI repeat-arrests and a 9% reduction in arrests related to domestic abuse across the 5 years following the intervention.

A similar project assessing the use of Secure Continuous Remote Alcohol Monitor (SCRAM) tags (Flango & Cheesman, 2009) had mixed results but provided vital learning. Within this study a small difference, albeit not significant, (2.8%) in recidivism across two years was seen between those who wore a SCRAM tag and matched controls, increasing by over 10% when restricted to prolific offenders with at least two prior convictions (12.9%). While unable to infer impact from these results, the data provided learning in terms of the timeliness of the order. Those who wore the tag reoffended more quickly than controls and often to a greater extent following tag-removal. Investigating this trend further, Flango and Cheesman (2009) found this effect was mediated by the length of the order; those who wore the tag for at least 90 days reoffended at around half the rate of those who did not wear the tag (10.3% vs. 21.2% respectively) whereas recidivism for those who wore the tag for less than 90 days being almost equal to controls.

It is unclear at this time what the longer term behaviour effects are from participating in a programme of enforced sobriety and Axdahl (2013) suggested that behavioural effects beyond tag removal may be short-lived. Comprehensive evidence around the efficacy of enforced sobriety is both lacking and mixed. Despite this, an intervention of this kind has been well-implemented across a number of US counties and states (Kilmer et al, 2013) and the Alcohol Abstinence Monitoring Requirement (AAMR), inspired by the approach in South Dakota, provides an opportunity to address alcohol related offending under UK criminal justice legislation.

Alcohol Abstinence Monitoring Requirement:

In 2012 a new sentencing power was introduced as part of the then Mayor's manifesto pledge to address the significant problem of alcohol related offending in London. Under the Legal Aid, Sentencing and Punishment of Offenders (LASPO) Act 2012, the Judiciary are allowed to impose the punitive Alcohol Abstinence Monitoring Requirement (AAMR); a requirement that necessitates offenders abstain from alcohol for a fixed time period of up to 120 days. Compulsory sobriety is measured via regular testing via a transdermal alcohol monitoring devise (a tag around the offenders ankle) as part of a Community or Suspended Sentence Order[4], and when this is not complied with, the offender will be prosecuted under breach proceedings and punished further.

[4] Providing the offender is deemed both suitable and eligible (see Appendix A for criteria).

The 2014/2015 Pilot:

An initial 12 month pilot of the AAMR was commissioned in south London by the Mayor's Office for Policing And Crime (MOPAC) commencing in July 2014. This was subject to a process and performance evaluation[5]. Over this time, 113 AAMR Orders were imposed by the Courts. The AAMR pilot had a final compliance rate[6] of 92%[7] which compares favourably with other orders - analysis by the NPS in 2014 estimated a compliance rate of 61% for other community based Orders it managed with the Community Rehabilitation Company (CRC)[8]. Variation was also seen with different requirements - 82% of offenders completed Unpaid Work Orders successfully[9] in London compared to Alcohol Treatment requirements (80%) and Drug Rehabilitation requirements (67%) (Ministry of Justice, 2015).

The research indicated the AAMR was received well, particularly by the judiciary and professionals, who recognised the AAMR as an important '*tool in the box'*. This can in part be attributed to the strength of the design and implementation of the programme. There were clear toolkits and training provided, effective partnership working and a project management team in place with relevant experience in this area. The effectiveness and certainty provided by the technology, as well as a strong understanding of the aims of the pilot and how the AAMR works in practice amongst both offenders receiving the order and stakeholders involved in its delivery also helped. In addition, there were a number of associated positive consequences of the pilot, including but not limited to; the period of abstinence gave offenders a 'pause' in their drinking; it also provided time for reflection of their alcohol consumption and the impact it has on offending behaviour, work and relationships; and an opportunity was provided for offenders to break their cycle of routine drinking. The AAMR was also used as a 'teachable moment' in some instances, with products such as tailored advice and relevant literature supplied by the service providers to support offenders further. The report also stressed the potential challenge in sustainability and the scale up challenge in moving from a small scale pilot to a pan London approach. This initial pilot research was not able to explore robust impact on reoffending due to sample size and follow-up time limitations.

[5] https://www.london.gov.uk/sites/default/files/aamr_final.pdf

[6] Caution needs to be applied when interpreting the completion and compliance rate of AAMR – this was a pilot study with a small sample size enabling the project manager to provide some assurances that the large majority of the AAMRs were enforced when failures to comply arose. This may not necessarily be the case with other Orders and requirements.

[7] The AAMR pilot had a compliance rate of 92%, based on the number of cases (n=9) who were returned to court and convicted on breaching their AAMR as a proportion of all cases imposed. Of these nine, five had their AAMR revoked and failed to complete, and the remaining 4 completed their AAMR following their return to court. This gives a final completion/compliance rate of 95% (Pepper, & Dawson, 2016).

[8] However there are caveats to be considered such as a direct 'like for like' comparison is not possible due to different offence types, offender characteristics, breach processes and the length of the orders themselves.

[9] These figures should be caveated however as the AAMR project manager recently reviewed other requirements on Orders (i.e. UPW), finding there were numerous occasions when breaches were not enforced and cases were simply closed, which may distort the actual compliance rate.

Pan London Roll Out:

The pilot was considered to be a success and following the Conservative's government's manifesto commitment to make sobriety tags available across England and Wales, MOPAC and the Ministry of Justice agreed to joint fund the roll out of the AAMR pan London from the 1 April 2016 until the 31 March 2017. The pan London Roll out provides the opportunity to test the effectiveness of the South London pilot on a much larger, more complex scale. To achieve this we will ensure that the core elements of the South London proof of concept pilot are maintained, including the use of transdermal tags enabling a full and comparative evaluation to be completed.

The London Sobriety Project will aim to test:

- Learning from the original pilot;
- Take up the AAMR requirement by the Judiciary;
- Compliance with the AAMR;
- Completion rates of the AAMR;
- Re-offending rates

Building upon the findings from the MOPAC pilot study, this report outlines initial findings from the first year of the Pan London roll out of the AAMR. It details the implementation process of the AAMR through the views and experiences of stakeholders involved in delivery and offenders sentenced to wear the alcohol tag and analysis of performance metrics. These findings sit as part of a wider holistic evaluation around the roll out of the AAMR across London, which also includes continued performance and process analysis, proven reoffending analysis to explore the impact of AAMR on offending behaviour and a full cost benefit analysis. These elements will be reported on in the second interim report in late spring 2018 (at the end of the two year roll out) and the final report in winter 2018.

Methodology

Both quantitative and qualitative research methods were employed to triangulate learning and gain an understanding of the AAMR working processes, how the AAMR is performing and experiences of offenders and stakeholders. A variety of methodologies were used to collect data[10], including:

- *Training feedback surveys:*
  Training sessions were held throughout London for AAMR practitioners such as probation staff and the judiciary. At each training event surveys were distributed to gather information around training delivery, understanding the AAMR technology, understanding eligibility criteria, levels of confidence in using the technology and motivation for using the technology. 546 stakeholders completed this brief survey after attending a training event. No differences across training feedback findings from different LJA's were identified so findings reported here are across all LJA's.

- *Stakeholder surveys:*
  An online survey was completed by 64 stakeholders to explore their understanding and experiences of AAMR (see Appendix B). Distribution was completed in waves, to reflect the staggered approach of AAMR roll out across the 9 Local Justice Areas (LJAs)[11] in London, with survey's 'going live' approximately one month after each LJA started to use AAMR's. A follow up email was sent four weeks later to encourage stakeholders to respond. Respondents were largely based at Magistrates courts (46%, *n*=31/67), within the National Probation Service (NPS) (19%, *n*=13/67) and Her Majesty Courts and Tribunal Service (HMCTS) (13%, *n*=9/67) more widely, with Magistrates, Legal Advisors and Probation Service Officers being the most common responders.

- *Stakeholder interviews:*
  To gain a more in-depth understanding of stakeholder's views, face-to-face and telephone interviews were conducted. A total of 19 semi-structured interviews were conducted with a variety of stakeholders including practitioner and strategic levels across London[12] (see Appendix C). Topics included: understanding the rationale, partnership working, training, implementation, usage, time taken for different aspects of the AAMR, decision making, suitability, perceived impacts, good practice, lessons learned, challenges, and broader attitudes to the equipment.

- *Offender surveys:*
  Offenders who received an AAMR were asked to complete a survey at the time the electronic tag was fitted, and when it was subsequently removed. The two surveys sought to understand their first impressions of the tag, perceptions of what life maybe like whilst wearing the tag and once it has been removed. Surveys were given to the offender by the

[10] Given the size of the research cohort (e.g. the number of respondents to the stakeholder survey/offender surveys), caution should be used when considering the results. Response base size is provided, however this varies as not all respondents answered every question.
[11] London Local Justice Areas (LJAs) include: Central, South, South East, South West, West, North West, North, North East and East.
[12] Potential interviewees were identified with the AAMR project manager and contacted via email by the researchers. There was no obligation to participate, therefore participants were self-selecting. Interviews were both face-to-face and conducted over the telephone, depending on the wishes of the interviewee. Where possible, interviews were audio-recorded and detailed notes were taken in all interviews, and analysed to draw out themes.

Electronic Monitoring Services (EMS) tag fitter[13]. Completing the survey was not compulsory, and some offenders chose not to participate. In total, 169 (out of a possible 356, 47%) completed the survey at the time when the tag was initially fitted, and 115 (out of a possible 297[14], 39%) completed it during tag removal[15].

- *Performance monitoring data:*
  A range of performance data was gathered from both the NPS/CRC and EMS - the company which conduct the field delivery and assist in data collection of performance metrics about the tag. Performance metrics included: numbers of AAMR given, types of offences, court details, demographics on who received the tag, number of breaches and compliance with tag.

[13] Whilst this method of distribution has its limitations, this was the most practical approach available for obtaining insightful data on offender perceptions and experiences.
[14] This accounts for offenders who have completed their AAMR requirement and are no longer an 'active' case.
[15] Due to the way the data was anonymously collected, it is not possible to link survey responses to know whether offenders who completed the initial survey also completed the removal survey

Results

Using the AAMR: Performance Learning.

Imposing the Requirement:

A total of 367 AAMR's were imposed during the initial year of the pan London rollout (April 2016 and March 2017)[16] and 17% of these (*n*=59) remain active cases, in that the offender is still subject to the requirement.

Following the initial pilot, the AAMR was introduced across London in a phased approach and therefore some LJAs have had the opportunity to impose AAMR for considerably longer than others. In fact, the AAMR has been used five times as much from the first quarter (FY 2016/17 Q1: average AAMR sentences/month = 13) to the last quarter (FY 2016/17 Q4: average AAMR sentences/month = 52), with AAMRs being imposed most frequently from Magistrates Courts (93%, *n*=342/356) (see full breakdown of AAMRs issued by Courts in Appendix D).

Use of the AAMR has also varied across court and LJA. Following the South London LJA hosting the yearlong pilot (and continuation immediately after pilot period), it is unsurprising this area had already gained momentum and had the confidence to use the AAMR in comparison to other LJAs where roll out has been phased throughout the past year. Whilst Croydon Magistrates Court (17%, *n*=58/342) continues to be the court that imposes the most AAMRs, it would appear that without the 'focus' of a specific pilot project, there has been a slight decline in the use of AAMR in what was initially classified as the most 'active' borough in the pilot – with 82 sentences including an AAMR in the pilot compared to 63 AAMRs in the past year in Croydon[17]. However, other courts such as Thames and Barkingside which were last to roll-out AAMR in January 2017 have performed well and have awarded 16 and 17 AAMRS over three months.

To be considered for an AAMR, the offence must be alcohol related, however this leaves a broad scope of the type of offences committed. In total, the 367 AAMRs were ordered in relation to 63 differently classified offences (see breakdown of offences in Appendix E). In light of the literature (for example McSweeney, 2015) it is unsurprising that the majority of AAMR's were imposed for offences of violence (31%, *n*=115) or drink drive related offences (22%, *n*=82). Although the eligibility criteria meant domestic abuse offenders were excluded from an AAMR recommendation, data suggests that 10% (*n*=38) of the offenders had been highlighted as such[18].

Overall, compulsory sobriety was usually imposed as a requirement of Community Orders (74%, *n*=270), with nearly a third being given as a standalone requirement (28%, *n*=100/357)[19]. This is significantly fewer ($p<.05$) standalone AAMR's than used during the pilot programme where nearly 40% of Orders used AAMR alone. This may indicate that those sentencing in court may feel that the AAMR requires the support of additional requirements, or that the AAMR only addresses a specific element of their offending behaviour (alcohol use). When the AAMR was used in conjunction with other requirements there appears to be a large variation in the types of requirements it was paired with. Table 1 details the most frequently combined requirements with a AAMR.

[16] In fact NPS data records indicate that 376 AAMR's were imposed in this time period, however data from the NPS and EMS was only available for 95% (n=356) of cases that will be used as the total base size throughout this report.
[17] Magistrates and Crown court combined.
[18] This domestic abuse flag indicates that at some point in their lives they have been a domestic abuse perpetrator, however it is not necessarily relevant to the current offence. NPS advised that caution needs to be applied around the reliability and robustness of this flag.
[19] Requirements data not provided by NPS for 11 offenders.

Table 1: Additional requirements paired with AAMR.

Requirement	Number of Order's	Percentage
AAMR Standalone	100	28%
AAMR + UPW	69	19%
AAMR + Rehabilitation Activity Requirement (RAR)	57	16%
AAMR + Prohibited Activity	24	7%
AAMR + UPW + Prohibited Activity	19	5%
AAMR + RAR + UPW	16	5%
AAMR + RAR + Accredited Programme	10	3%
Other requirements[20]	62	17%

The AAMR Tag:

A requirement dictating compulsory abstinence from alcohol is initiated immediately when the Order is given in Court. Where possible, EMS should aim to fit the tag within 24 hours of an offender receiving the sentence, and in 90% (*n*=332) of cases EMS received notification from the court on the same day (*n*=279) or the following day (*n*=53). Despite speedy notification to the tagging company, only 50% (*n*=167/332) of offenders (where EMS were notified the same or next day) were tagged on the same day (*n*=65) or within one day of notification (*n*=102)[21]. This is a significant reduction ($p<.05$) from the pilot study (82%), which may reflect a resource issue deriving from the scaling up of the project and the EMS tag fitters ability to cover a much larger geographical area.

This finding supports the potential changes to the operational model that will be piloted in year 2 in two courts (Westminster and Bromley). There are plans to introduce 'tagging at source' where offenders are tagged immediately after sentence either at the court house or nearby Probation office by a probation officer, with AMS supplying the equipment and EMS monitoring performance metrics only. This may prevent the delay in offenders receiving the tag and thus also ensure that the Order can be monitored and enforced from the earliest opportunity.

In total over this reporting period 367 Orders were imposed. Of those offenders who have completed the AAMR, 92% (*n*=235) did so successfully[22]. During this period there were 75 offenders who were issued warning letters for non-compliance and discretion was applied in 32 of cases This provides a compliance rate that matches the pilot (92%).

Of the 270 successfully completed Orders, offenders were subject to the tag for an average of 67 days (range 7 days – 120 days). This reflects an 8 day reduction in average length the AAMR compared to this requirement in the pilot (average = 75 days). In total, over 825,000 transdermal readings were taken by the tags in the initial year, an average of 48 readings a day, indicating that the technology underpinning the tag is working as intended.

[20] This includes cases where there was no match n=15

[21] EMS must attend on the day for all orders issued before 3pm, or within 24 hours for orders received after 3pm

[22] For the purpose of measuring compliance we have recorded an unsuccessful completion when alerts about violations on the tag led to enforcement action being taken by the Offender Manager that led to a breach conviction at Court.

Offender Demographics:

In terms of basic demographics, the majority of offenders who were sentenced to an AAMR were male (86%, *n*=314) and white (47%, *n*=171)[23]. Whilst this follows the trend of the pilot's findings, there is a significant decrease ($p<.05$) in the proportion of white offenders receiving this Order (pilot: 66%). Additionally, across London the average age of offenders who received the AAMR matched the pilot cohort, averaging 33 years old (range 18 years – 74 years), with nearly two thirds (63%, *n*=226) aged between 18 and 34 years.

The CRC and NPS conduct risk of harm assessments on all offenders who receive either a Community Order or Suspended Sentence Order. Nearly two thirds of those sentenced to an AAMR were assessed as medium risk of harm (61%, n=225). A mere four offenders were considered to be high risk of harm. On the whole this reflects that the AAMR is being used correctly.

The Offender Group Reconviction Scale version 3 (OGRS3) scores for the AAMR pan London cohort were calculated at the point of receiving a Court Order by the NPS or CRC. OGRS uses static factors such as age at sentence, gender, offence committed and criminal history to predict the likelihood of proven reoffending within either one or two years after starting their Court Order. Offenders with a high OGRS score are at greater risk of reoffending. As a group (*n*=317[24]), the OGRS 2 year score was 37% (ranging from 5 to 97) – indicating that just over one third of offenders would be predicted to reoffend within two years (see Appendix F). This is comparable to the OGRS score of the pilot AAMR cohort (OGRS Year 2 = 35%). This shows that those receiving the AAMR are broadly identified as low and align to the general offending population in the UK, particularly those who receive community sentences (Farrington, 2005, Ministry of Justice, 2015b).

Key Learning:

367 AAMRs were imposed over the first year of the pan London roll out programme. The majority of AAMRs were given as part of a Community Order, with an average length of 62 days. The tag technology appears to be working as intended, taking on average 48 readings per day. Standalone AAMRs accounted for 28% of all Orders and multiple requirement Orders usually consisted of AAMR and Unpaid Work (19%).

Offenders receiving the AAMR were largely white males with an average age of 33 years. Tags were given for a variety of crime types, most commonly in relation to violence or drink driving offences. As expected the AAMR cohort did not have an extensive criminal background, with an average two year OGRS score of 37%.

In total over this reporting period 367 Orders were imposed. Of those offenders who have completed the AAMR, 92% (*n*=235) did so successfully[1]. During this period there were 75 offenders who were issued warning letters for non-compliance and discretion was applied in 32 of cases This provides a compliance rate that matches the pilot (92%).

Findings are generally comparable with the AAMR pilot in terms of usage and offences the AAMR was imposed for and the continued high compliance rate, although some differences were observed around the use of AAMR as a standalone requirement (28% vs 40% standalone requirements in pilot).

Using the AAMR: Process Learning from Stakeholders.

Throughout the AAMR pan-London roll-out, stakeholders were surveyed to gain an understanding of the wider London perspective around the Order and to detect any changes in understanding or use, given its expansion from the initial pilot. This section details the views and experiences of stakeholders (including staff at the NPS, Magistrates Courts and HMCTS) around the training and awareness raising, working practices, using the AAMR and their views on the impact the AAMR has had on offenders.

Training and Awareness:

MOPAC and AMS delivered training to more than 1,250 London Magistrates, 50 District Judges, over 130 Legal Advisors and to all National Probation Service Court Teams. Overall, the training sessions have been well attended and received, with attendees' finding it a positive and useful experience (97%, *n*=238/245[25]) (see Appendix G for a breakdown of all responses) and willing to use the AAMR in future (95%, *n*=499/526). In particular the training helped them to understand how to use the AAMR in their job role (93%, *n*=509/545) and understand the aims and objectives of the project (97%, *n*=528/545); a finding reflected in the wider stakeholder survey (93%, *n*=53/57). Whilst those who attended the training strongly indicated that they knew how to apply the eligibility criteria (97*%, n*=516/545), this was not so clear from respondents to the wider survey (who may not have attended the training course). Compared to the pilot, here stakeholders felt they had less understanding of the criteria (77%, *n*=44/57, *p*<.05) than those in the pilot cohort (95%[26], *n*=38/40) despite more respondents using AAMR in their role (61% roll-out *n*=31/51 vs. 48% pilot *n*=19/40).

It was felt that training would have benefitted from more 'case study' type information to demonstrate instances where a AAMR had been given and how it had worked in practice, as well as the opportunity to see the tag working 'in action' to really understand its implications. Interviewees also raised an issue around inconsistency in understanding of the AAMR across different organisations.

> "*Even though we [probation officers] try our best to make sure that the magistrates, benches, justices etc. know about the AAMR, they just aren't on board; they really do take some persuading...they do not have enough training to make them feel more open to it*."

A variety of awareness raising paraphernalia (i.e. AAMR poster, website and toolkit) around the AAMR have been produced, with the AAMR leaflet noted by respondent's as the most useful method of information and communication, however this document has still been seen by less stakeholders than in the pilot (57%, *n*=30/53 vs. 80%, *n*=35/44). Indeed, many of the promotional/guidance items had not been viewed by stakeholders who responded to the survey[27]. In comparison, interviewee's detailed their use of the professional documentation/toolkit, which they have found to be *"very easy to read and straightforward"*. The reasons for the decline in

[25] Note that not all attendee's to the training completed every question of the survey feedback; therefore base sizes vary for each question.

[26] Pilot results are based on the collation of data from 3 surveys administered throughout the pilot project, due to low response rate (n=58). Eighteen respondents completed more than one survey throughout the pilot period, where possible, base sizes have been adjusted to reflect this. Survey respondents who had responded to previous surveys were not required to answer all questions in later surveys therefore response numbers differ depending on question.

[27] AAMR documentation not seen by respondents: poster = 72%, website = 83% and toolkit = 59%.

awareness are complex and could relate to the larger size and scope of the pilot, i.e., more staff, more areas, the challenges in implementing and overseeing a pan London innovation. As noted in the pilot evaluation report, the level of involvement from the project manager was not necessarily sustainable as the project has been expanded more widely. This has impacted the evaluation in particular, especially around accessing relevant stakeholders and data, thus impeding the robustness of the conclusions that can be derived. This has been reflected in the struggle to recruit stakeholders to participate in research interviews and complete the survey.

There was a desire for additional awareness raising and improved communication around the AAMR gleaned from stakeholder interviews and also less stakeholders were satisfied with the awareness raising information provided by MOPAC (stakeholder survey: 69%, *n*=37/54); a figure that has declined from the pilot cohort as the project has expanded across London (pilot cohort: 78%, *n*=31/40). Specifically there was a lack of information available in the Courts to other staff members, solicitors, or offenders, with a number of interviewee's noting that *"more awareness raising is needed"* outside of the immediate people involved. Awareness raising was also raised by those at training - only half of stakeholders who attended the training (53%, *n*=28/53) reported being satisfied[28] with communication from MOPAC, the project commissioners, compared to 85% in the pilot study. However it is apparent that satisfaction with the awareness raising and communication is improved if stakeholders have attended the training, rather than relying on their own self learning or gathering information from a colleague or documentation.

"I didn't even know that MOPAC were involved with the AAMR!"

If further training or information is rolled out, it may be preferable to ensure all relevant organisations are represented or focus on information sessions specifically for court staff. Additionally, respondents from both the surveys and interviews with stakeholders raised that they would like to be kept informed of AAMR performance, in terms of compliance rates, and uptake of the requirement on a regular basis so they could understand the trends and usage across London.

Working practices:

The AAMR directly addresses low level and non-dependant alcohol related offending behaviour - a requirement that, until now, has not been at the courts disposal. This has previously been an area of frustration to both sentencers and report writers, who felt there was very little they could do to directly affect specific underlying factors (e.g. non-dependant drinking) of someone's offending. The AAMR has also been welcomed due to its "*easy to understand and self-explanatory nature*", with an appreciation that "*it's useful to have another requirement*" than the long-standing options previously available.

"[AAMR is] the cherry on the cake"

In general the AAMR has been accepted positively by all stakeholders. However, the survey data suggests the roll out of the AAMR programme pan-London may have dampened appreciation or acceptance of the requirement. While the majority of respondents felt the AAMR was a useful additional tool for their role (78%, *n*=40/51), this did see a significant decrease (-14%, *p*<.05) compared to the pilot cohort (93%, *n*=38). Though, a different picture is seen in those who have attended training, where support for the order is comparable to that seen in the pilot (92%,

[28] Categorised from where respondents have responded with 'very satisfied' or 'fairly satisfied'.

n=480/524), highlighting one of the benefits of attending training and the importance of continued awareness raising of the programme as it moves forward.

One of the aims of the evaluation was to explore the effect that AAMR has on offender management processes and possibility of reducing staff workloads. Although the pilot report only briefly explored this theme, there was no firm evidence of this from the pan-London stakeholder surveys, where less than 10% of stakeholders agreed the AAMR speeds up their workloads[29]. However, AAMR is not considered to be particularly onerous. Significantly fewer stakeholders (17%, $p<0.05$) felt the AAMR had increased their workload, compared to the pilot cohort. However, this may be explained by the demographics of the pilot survey respondents who tended to be probation staff who would be more engaged in the delivery process (both at the pre-sentence report stage and managing offenders who receive the requirement) than magistrates, more of whom responded to the pan-London survey.

A key element of AAMR, particularly around implementation of the new initiative, is the need for good partnership working between agencies such as CRC, NPS and the judiciary. However since rolling out the programme across London, significantly fewer stakeholders felt that the AAMR allowed them to develop new relationships with partners (49% decrease, $p<.05$) or improve their relationships with existing partners (55% decrease, $p<.05$). The stark differences observed in the pilot may be due to the smaller scale of the scheme, located in a small geographical area with high political and media interest. The dedicated pilot AAMR project manager pro-actively encouraged team working and delivered cross-agency training which likely facilitated communication between partners, however this may not have been possible as the programme rolled out across London. In particular MOPAC had to stop the Local Implementation Group sue to the size of roll-out and resources available.

Using the AAMR:

There are many factors that can influence the decision making process of whether to recommend/sentence an offender to a period of compulsory sobriety. Findings indicate that for many delivery stakeholders this process most commonly focuses on the facts of the case and a pattern of behaviour that emerges from alcohol use.

> "*the AAMR is…ideal for people who have maybe had too much to drink on a Saturday night and become a nuisance and committed criminal damage etc.*"

However, stakeholders also suggested that 'preventing people from committing alcohol-related crime' was the most important goal of the AAMR, as well as 'improving public confidence in the ability of the criminal justice system to tackle alcohol-related crime'. Stakeholders stated that they also took these factors into consideration when considering an AAMR.

> "*if it [AAMR] can open the door to other things such as counselling, talking to their GP, taking medication, talking to family and friends I am more likely to recommend it*".

[29] 74% disagreed with the statement "Offenders on the AAMR are dealt with more quickly than those on other orders".

The importance of identifying whether there are additional underlying issues that could also be addressed in a rehabilitative way, in addition to its punitive impetus was also highlighted by stakeholders. In particular, many stakeholders reported that they would consider the AAMR if they felt it would help offenders with their alcohol use as:

> "*it also has the parallel benefit of giving people the chance to stop drinking and have some time to reflect on the impact that alcohol has on their life*",

and a period of compulsory sobriety provides an opportunity to:

> "a*ssess whether … it will help them identify that alcohol is causing them problems*".

However, challenges have arisen around the usability of the requirement which have affected decision making. It was identified that the strict eligibility criteria for the requirement meant it was often difficult to recommend, as many offenders did not meet the criteria set out using the AUDIT screening tool or had perpetrated domestic abuse, which was something that was also found in the pilot evaluation. Additionally, issues of practicality and suitability such as nickel allergies, having no fixed abode or the nature of employment, were cited. Interviewees also referred to the issue of alcohol dependency, which meant they were unable to recommend the AAMR even if they wanted to.

> "*AAMR is unrealistic for the majority of alcohol-related offending… we see a lot of dependent drinkers, and even the 'binge' drinkers often require more in depth treatment to address the psychological reasons underlying their alcohol abuse*".

It is clear that there are many factors to consider in the decision making process that have influenced the usage and uptake of AAMR, but it is important to remember that it is often difficult to introduce new initiatives into already complex situations involving a multitude of agencies (Stanko & Dawson, 2015). Interviewees commented that the courts, at the beginning, did not have confidence in the requirement and were reluctant to impose it. However:

> "*the tide might be turning but we've still got a long way to go in terms of it being something that the courts think of really quickly and take on as a sentence*".

This has been compounded further by the pan-London roll out coming at a time when London CRC is experiencing wider disruptions and transformations. Challenges have arisen due to internal changes in terms of policies, new ICT and staffing structures, which have meant that the "*new senior team … don't have as much knowledge about the AAMR*". This hampers progress as there is not the senior level support to champion new initiatives, and one interviewee described that such disruptions "*do not support the imbedding of good practice*".

Potential effects on offenders:

When complied with – the AAMR requires abstinence from alcohol, which could have an impact upon the individuals offending as well as other areas (i.e., health, education, wellbeing etc.). The current report does not cover offending at this stage; however, some insights around impact can be sought from other sources, such as staff and the offenders themselves. With the roll-out of AAMR across London, stakeholders' and offenders perceptions around its potential impact have been sought. Overall, interviewees were generally positive about the potential effect this requirement may have in terms of reducing offending behaviour and alcohol intake, although the majority of those surveyed were unsure about the longer term effects; a change from the pilot cohort. Now we see slight reductions across the board in the perceptions on impact from the pilot, but small sample sizes preclude firm statements here. Stakeholders stated they did not know if AAMR will stop people committing crime in the long term (63%, *n*=32/51; pilot: 55%, *n*=22/40), help people to drink less alcohol in the long term (55%, *n*=28/51; pilot: 40%, *n*=16/40) or help people to play a more positive role in society (53%, *n*=27/51, pilot: 40%, *n*=16/40).

The wider applications of the AAMR in terms of rehabilitation have been acknowledged, as it provides opportunities for reflection and further intervention. When explored through interviews, a frequent suggestion was additional health benefits may also stem from this period of compulsory abstinence, providing a pause in their drinking to "*evaluate whether they think they need to cut back or stop completely going forward*"; a message strongly identified during the pilot. The learning, around the wider rehabilitative application of AAMR, has been reiterated through the pan London AAMR training, which may explain the frequency at which it has been reported during the current evaluation.

> "*the only thing we're told anecdotally during training was that offenders had addressed their drinking because of being on the AAMR" and "more updates on how successful the AAMR cases have been would be really useful...my inspiration for recommending the AAMR is that it will make a difference, and it would be good to have the evidence to back it up."*

Domestic abuse perpetrators:

One theme to emerge from the interviews was the use of AAMR with DA perpetrators. This was excluded in the pilot but, within the Pan London approach, there has been a plan to conduct a

feasibility study exploring the use of AAMR with DA perpetrators. Overall, practitioners broadly supported the concept of AAMR with DA, 70% (*n*=35/50) would support rollout to DA perpetrators and two thirds of respondents (66%, *n*=33/55) felt AAMR could be a useful and effective tool for cases of domestic abuse. Although it should be noted that some concern around this issue was raised, with the need for additional measures to be put in place for these cases emphasised:

"*If AAMR is to be used in DA cases it should only be after very careful and thorough assessment…Prohibiting alcohol consumption when it is a coping strategy for someone could actually raise the risk unless other protective factors and supports are put in place…*"

Such concerns should be explored within the feasibility study and associated evaluation and will be reported on in year two.

Looking forward:

"I wanted to recommend someone for the AAMR…but they were from Middlesex and committed the offence in London. This is a common issue"

This programme has another year to run and given its popularity, the majority of stakeholders would support the roll out of AAMR nationally (86%, *n*=43/50), with hopes that a wider roll-out would overcome difficulties where offences were committed in London by those residing elsewhere, which are linked to the night time economy. In terms of learning, there have been suggestions for using the AAMR in a more creative manner. For example, respondents recognise that compulsory abstinence may not be the most suitable requirement for an offender immediately, but an AAMR could be used in a staggered approached with other requirements, thus providing the offender with treatment and support to reduce their alcohol intake and ensure they are better able to cope with sobriety. A period of enforced monitored abstinence may then as motivation to continue, especially considering that producing negative drugs tests can boosts people motivation and self-esteem.

Despite some minor scale up challenges, it is an exciting time for the AAMR programme, with new innovative ways of using AAMR being tested as the project moves forward into its second year pan London, such as the DA feasibility study and tagging at source. Overall, this requirement has been well received by delivery stakeholders, who appear to have sufficient knowledge and understanding of the AAMR to conduct their work effectively, but would appreciate more performance information around the AAMR and evidence of long term impact. The offenders, who are subjected to wearing the tag, have also been given the opportunity to express their views about this innovative programme - their views are heard next.

Key Learning:

The AAMR has generally been received well across London by all delivery stakeholders, and training has been well attended, although there is still a need for more awareness raising and communication around AAMR, especially from MOPAC. Better facilitation of partnership working at these events and outside of training would also prove advantageous.

Stakeholders have welcomed the additional tool that is tailored and specific to addressing alcohol related offending – a tool not previously available. But there have been barriers to uptake during the pan-London roll-out namely, reorganisation of the CRC and cases not meeting the eligibility criteria, which has led to fewer cases being recommended than expected, largely due to issues around alcohol dependency and offences of domestic abuse. Also issues of practicality and suitability have reduced the use of the AAMR.

Whilst the AAMR is thought to have wider application than just to reduce offending and alcohol intake, such as having a rehabilitative effect, providing the offender the opportunity for reflection and further intervention, it is worth noting that significantly fewer stakeholders thought this compared to the pilot cohort.

Using the AAMR: Process learning from offenders.

To gain a better understanding of the impact of the AAMR tag on offenders, EMS tag fitters delivered surveys to 169 offenders at tag fitting and a further 115 offenders at tag removal (see Appendix H for full breakdown of responses). This is a far larger number than was able to be delivered in the pilot research and brings a unique voice to the discussion.

Entry Survey - Expectations and concerns:

In general, the majority of those surveyed appeared to have relatively good relationships with family (90%[30], *n*=120/133) and friends (92%, *n*=122/133), somewhere suitable to live (86%, *n*=111/129) and a relatively good sense of well-being[31] (75%, *n*=95/127). However, over a third of respondents suggested they were currently experiencing financial difficulty (38%, *n*=46/122) despite the majority being in an enjoyable job (77%, *n*=83/108), possibly reflecting the experiences of many in the current economic climate.

At the start of their Orders however, offenders were broadly optimistic, although with clear subsets that were more mixed, with many feeling the AAMR would improve all aspects of their lives ('*life in general':* 65%, *n*=79/122) (see Appendix H) including family relationships (50%, n=60/119), current financial situation (62%, n=75/121), offending behaviour (67%, n=77/115), physical health (70%, n=87/127) and mental wellbeing (60%, n=71/119). This may be indicative of the recognition of AAMR's ability to infiltrate other aspects of people's lives, beyond their offending behaviour.

Despite having received a AAMR order, when asked to reflect on their alcohol use, just under half felt that drinking alcohol had a negative effect on their lives (43%, *n*= 54/126) and 60% (*n*= 76/127) felt that going out and socialising with their friends did not cause them any problems. However, nearly all offenders (93% *n*=116/125) felt they understood why they had received the tag and felt confident[32] they would successfully complete the order (99%, *n*= 113/132). Which is reflective of the high compliance rate with this requirement (92%)

While the potential benefits of the requirement were understood by offenders, as demonstrated in the pilot findings, practical concerns were raised about the tag itself. Offenders commented on the size and weight of the tag. Additionally, concerns were raised around health and well-being implications, such as bathing restrictions, exercise and sleep. All of these are consistent with views from the pilot research.

"*the tag is too big and is uncomfortable to wear*"

"*I am unable to exercise, which I love doing, because the tag hurts my ankle"*

The pilot also highlighted that the size of the tag could lead to issues around stigmatisation ("*People assume you are dangerous*"[33]). This was reiterated through the roll-out entry surveys, where 41% (*n*=46/112) of offenders were worried about what their friends and families would think, with some expressing concern that the tag would make these relationships worse ("*Relationships with family*" 5%, *n*=6/50, "*Relationships with friends*" 7%, *n*=8/60). Concerns around stigmatisation also extended to work and education; while more respondents felt the tag would have no impact on their

[30] Based on collated 'Strongly Agree' and 'Agree' responses.
[31] Measured by those who stated they 'are happy most of the time'.
[32] Based on collated 'Fairly Confident' and 'Very Confident' responses.
[33] Pepper, M. & Dawson, P. (2016). *Alcohol Abstinence Monitoring Requirement: A process review of the proof of concept pilot*. MOPAC

employment or education, (44% (*n*=52/117) and 49% (*n*=56/114), respectively), a small proportion (14%, *n*=16/117) felt the tag would make their employment situation worse:

> "*I work as a project manager consultant for various blue chip companies, having to be dressed smartly all the time, this tag is very big and can easily be noticed… I'm very worried about this…it will be very hard to hide."*

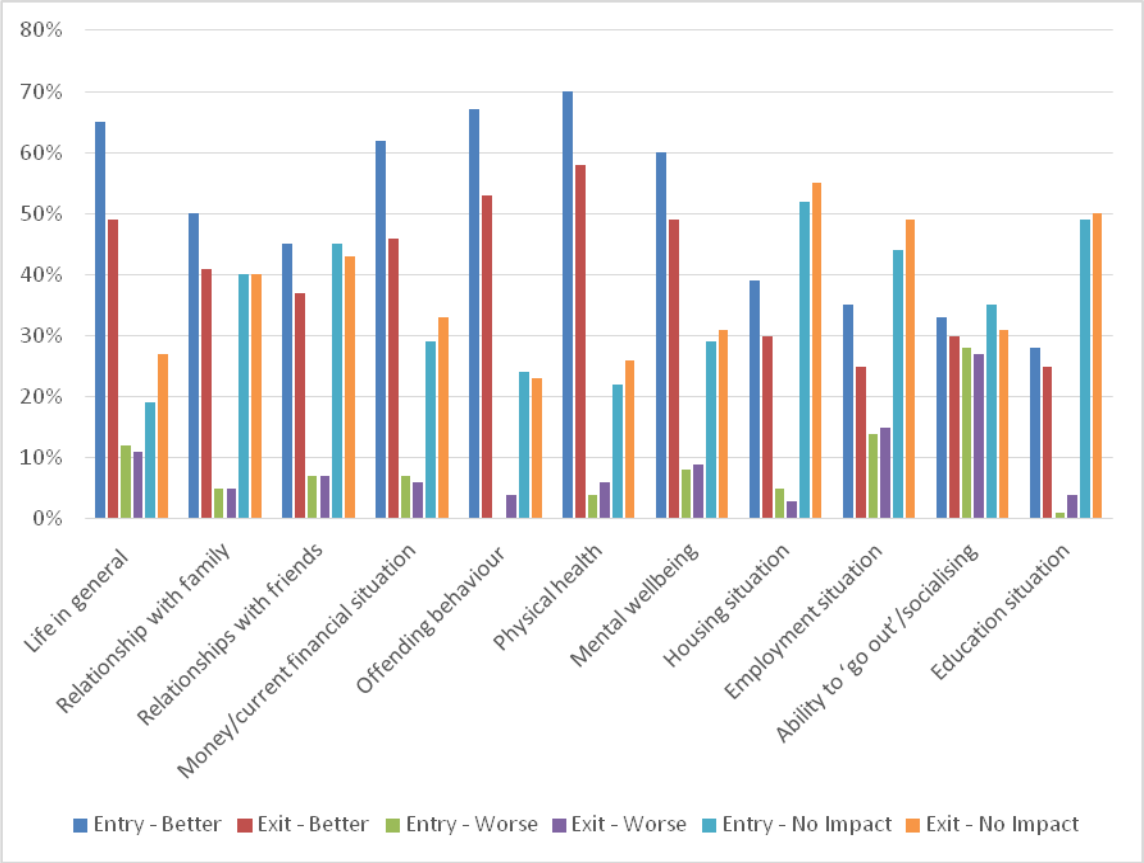
Exiting the AAMR order - were concerns realised?

Once an offender had completed the AAMR Order, the tag was removed and offenders were asked to complete another survey. Overall, offenders continued to report living a stable life with good relationships with friends (89%, n=93) and family (86%, n=90), health (83%, n=87), happiness (75%, n=78) and accommodation (80%, n=84). Small changes were observed in some of the feedback, for example, some evidence of perceived stigmatisation being realised; 4% more respondents were worried about what friends and family thought about the tag, after finishing the order (45%, n=47) than before it had commenced (41%, n=46), however, these are very small scale changes. Overall, when asked whether they felt the AAMR had made things better, worse or had no impact, the trend in the data suggests that by and large, offenders felt the AAMR had made their lives better. (over 40% of offenders across 6 of the areas) or had no impact on them (over 30% of offenders across 7 of the areas) (see Figure 1).

> "*This has put pressure on my already tight finical situation; I work in a corporate environment and have had to buy all new clothes to cover the Tag*".

When considering these results, caution needs to be applied due to the small percentage changes and it should be noted that the survey methodology relied on a between-subjects design. At the time of writing, it was not possible to link responses from the entry survey to those at the exit survey; this means that these changes cannot be directly attributed to the tag itself. Furthermore, participants responded to this question on a 5-point Likert scale from Strongly Agree - Strongly Disagree, with little opportunity to expand on why they have given the answers they have.

Figure 1: Offender Entry and Exit survey responses



Key Learning:

Offenders reported generally being satisfied with their lives when they initially received the Order, maintain good relationships with friends and family, accommodation and well-being, which continued post tag removal. However, offenders did raise practical concerns about the tag itself citing concerns about financial implications due to having to buy new clothes to cover the tag, health and wellbeing concerns, as well as concerns about the size and weight of wearing the tag that may lead to stigmatisation.

Using the AAMR: Cost implications

Implementing a new innovative programme comes with associated costs, however it is important to understand whether these costs have been beneficial, whether that is through a reduction in reoffending or a speedier course through the criminal justice system, requiring fewer resources.

Throughout the evaluation attempts were made through surveys to collect data around the time taken to assess, prepare, induct, enforce and manage AAMRs in comparisons to other requirements. However these attempts were not successful either because respondents found it difficult to quantify due to the varying nature of cases and workload, or more commonly, because their job role did not provide the opportunity to work directly with AAMRs 'on the front-line'. For example, a number of Magistrates completed the survey, and whilst they are the individuals who impose the requirement and hear the breach cases, the AAMR would not be a factor that would affect the time they spent dealing with the case. By contrast, Probation Officers or Probation Service Officers, who had responsibility for managing the cases, and thus would have a good indication of the time required to deal with an AAMR case, were not well represented in the survey responses. Therefore limited conclusions can be drawn around whether AAMR affects the amount of time required to deal with a case, however the general feeling was that in most cases, the AAMR was largely similar to other requirements.

In order to fully understand the benefits that may be gained from the AAMR, throughout year 2 a full cost benefit analysis will be conducted, providing the opportunity to consider implications for reoffending and wider impact on health and other partners.

Discussion

The AAMR was introduced as a pilot concept in 2014 to address the significant problem of alcohol related offending in London. This new sentencing power enabled courts to impose, as part of a Community Order or Suspended Sentence Order, a requirement that compelled an offender to abstain from alcohol for a fixed time period and be regularly tested via electronic monitoring. The AAMR is now a pan London programme that has been generally welcomed by delivery stakeholders as an additional option to specifically address alcohol related offending behaviour. Following the success of the initial south London pilot in 2014, this programme provided the opportunity to test the effectiveness of AAMR on a larger, more complex scale. This report helps to build the evidence base around compulsory sobriety electronic monitoring, detailing a process evaluation generating learning through the views and experiences of stakeholders involved and offenders who were sentenced to this requirement.

In many respects, the roll out of AAMR has been viewed positively by both the judiciary and Probation staff, often reflecting the views and experiences highlighted in the pilot evaluation report (Pepper & Dawson, 2015). There appears to be continued confidence in the electronic monitoring equipment which is reflected in the steady uptake of the AAMR and now that all LJAs are 'live', year 2 will provide a clearer landscape of the overall uptake. Whilst there has been overall acceptance of the project across London, it appears that the impact of this requirement has been minimal for those that work in the field. It is now another "tool in their toolbox" that equips them to do their job better. It has been incorporated easily into everyday working, which may in fact be a testament to the ease of application of this innovative programme. However, there have been some concerns about cases not meeting the eligibility criteria due to alcohol dependency, allergies and other issues, which has meant that the judiciary have not been able to recommend the AAMR as much as they would have liked to. This would indicate that although the eligibility criteria is restrictive, the AAMR is actually being used appropriately by the judiciary.

The main goal of the AAMR was, stakeholders suggested, to prevent people from committing further alcohol related crime. Although a greater number of stakeholders in the pan London roll-out did not know if the AAMR would have long lasting effects in stopping people committing crime, or drink less alcohol,. Indeed, previous research would suggest that although offending may reduce whilst subject to this type of requirement, behavioural effects beyond tag removal may be short-lived (Axdahl, 2013). Despite this there was still a general perception that the AAMR would provide offenders with a pause in their drinking behaviour and the opportunity to reflect on their lives.

When implementing a large scale programme of work across London, it is expected that challenges and difficulties may arise (Dawson & Stanko, 2013). Indeed, the AAMR pilot was considered a success due to the positive implementation, mainly down to clear communication and consistent engagement with stakeholders from the outset, and a dedicated programme manager with 'on the ground' experience and established contacts. As noted in the pilot evaluation report, this level of involvement from the project manager was not necessarily sustainable as the project has been expanded more widely. This has impacted the evaluation in particular, especially around accessing relevant stakeholders and data, thus impeding the robustness of the conclusions that can be derived. This is reflected in the struggle to recruit stakeholders to participate in research interviews and complete the survey. Despite many efforts to engage stakeholders in the research, there has

been a definite reluctance, evidenced by the considerable decline in participation since the pilot study. Reports are, particularly from the CRC, that staff members do not have the time or inclination to participate, due to substantial restructuring and organisational changes that are currently taking place. It appears that they are in unstable times and understandably not prioritising the AAMR.

Further challenges have arisen since the scale up around both the practicalities of tagging the offenders, and stakeholders and staff working with the AAMR. For example, since the pilot there has been delays in getting offenders fitted with the tag within one day of receiving their court Order, which may reflect a resource issue from the tagging company now that the 'taggers' are expected to travel across London. For those working with AAMR, the new initiative has not provided as many opportunities to build partnership relations that had previously been available during the pilot. Again, this may not be reflective of the implementation of AAMR itself, but more a reflection of the current offender management landscape.

Looking forward, since the start of the pan London roll out, MOPAC were successful in a bid to the Home Office's Police Innovation Fund to undertake development work. This includes the testing of AAMR for domestic abuse perpetrators and designing efficiencies within the current model to enable sustainability. One way to do this is through 'Tagging at Source' which aims to administer the electronic monitoring tag to the offender at the Court or probation office rather than their home address. These elements are still in development, however as they progress forward, MOPAC's Evidence and Insight team will include these in the overall evaluation.

Finally, this report is just one element of the evaluation taking place around the roll out of AAMR across London. A holistic approach is being taken overall, including continued process evaluation (focusing on large scale implementation, stakeholder views, offender experience), cost benefit analysis, performance metrics and the impact of AAMR on proven reoffending. In late spring 2018, at the end of the second year, an update report will be produced focusing upon performance and process, and early impact on the pan London cohort (e.g. 6 + 3 months reoffending). A final impact report, focusing on proven reoffending and cost analysis will be produced in winter 2018.

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Appendix A: Eligibility and Suitability Criteria

In order to be eligible for an AAMR, the following conditions must be met:

- Consumption of alcohol must be an element of the offence or an associated offence, or the court must be satisfied that consumption of alcohol was a factor that contributed to the offender committing the offence or an associated offence;
- The offender must not be dependent on alcohol;
- The court must not include an alcohol treatment requirement (ATR) in the order (ATRs are for dependent drinkers only);
- The offender must live in London;
- The offence must not have involved domestic abuse (at the present time).

The Probation Court Team officer will assess "suitability" with alcohol AUDIT Tool. This assessment is used to determine the offender's alcohol dependency levels.

Appendix B: Survey Respondents

Organisation	Job Role	Local Justice Areas represented	No. of respondents
NPS	Probation Officer / Probation Service Officer /Court Based Officers	Central, South West, South, South East, East	10
CRC	Probation Officer / Probation Service Officer	North West, South, South East	3
	Strategic Leads / Administrators		4
HMCTS / Courts	Legal Advisors	North West, South, South East, South West, West	10
	Court Staff		6
	Magistrates		21
MPS	Police Officer	South East	1
EMS/AMS	Project Team	South, South East, West	5
		Overall Total	**60**

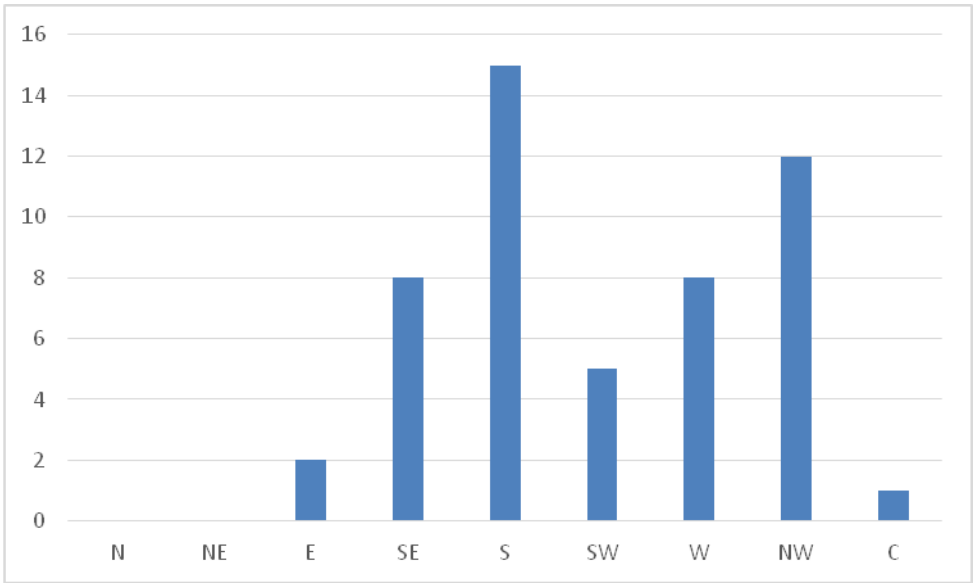

Figure 2: London Justice Areas represented in the stakeholder survey.

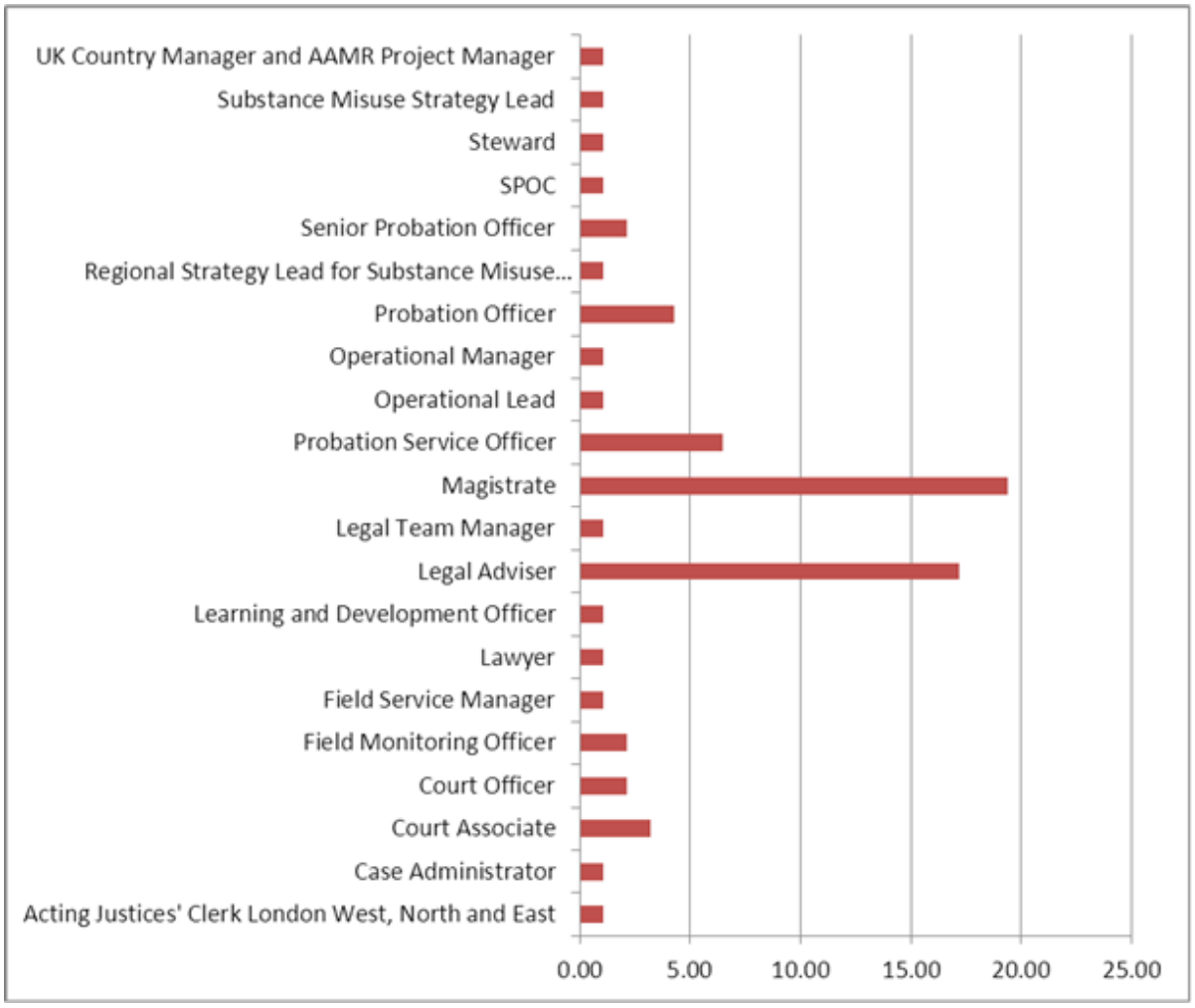

Figure 3: Job titles of stakeholders who responded to the stakeholder survey.

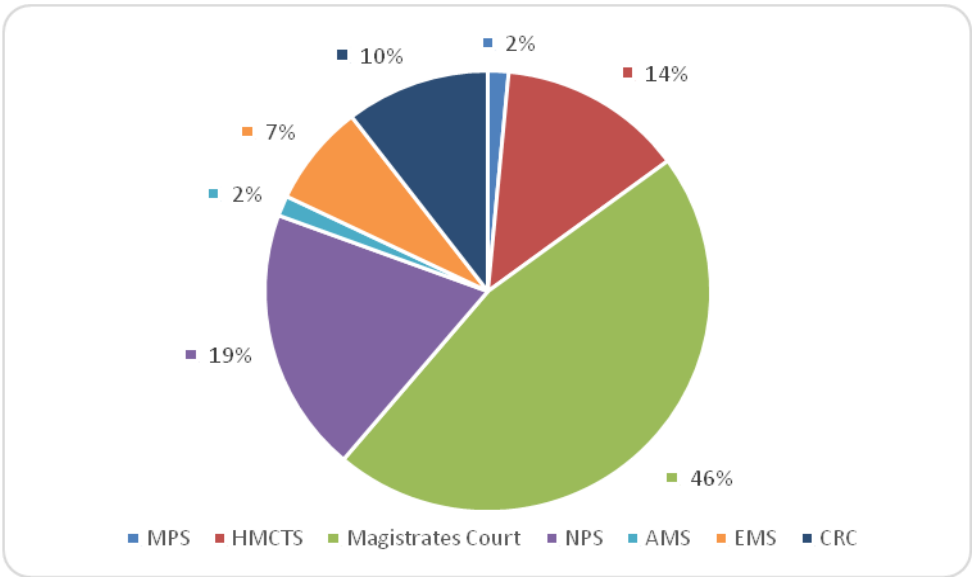

Figure 4: The organisation breakdown of all stakeholders who responded to the stakeholder survey.

Appendix C: Interviewee Respondents

Full breakdown of those who agreed to be interviewed.

Organisation	Job Role	Local Justice Area	No. of interviewees
NPS	Probation Officer - Court Based	Central	3
		North	3
		South	1
		South East	3
	Probation Officer / Probation Service Officer	North	2
		North West	1
	Probation Prosecutor	South	1
CRC	Probation Officer / Substance Misuse	South	1
		West	2
Courts	Deputy Justice Clark	South West & West	1
	Legal Advisor	South East	1
		Overall Total	**19**

Appendix D: Breakdown of Courts that have imposed AAMR.

Magistrates Court	No. of AAMR imposed	Roll-out date
Croydon MC	58	Apr-16
Camberwell Green MC	29	Apr-16
Wimbledon MC	27	Apr-16
Bromley MC	20	Apr-16
Bexley MC	11	Apr-16
City of London MC	3	Jul-16
Ealing MC	8	Jul-16
Hammersmith MC	19	Jul-16
Feltham MC	3	Jul-16
Uxbridge MC	49	Jul-16
Westminster MC	29	Jul-16
Willesden MC	4	Oct-16
Hendon MC	21	Oct-16
Highbury Corner MC	28	Oct-16
Thames MC	16	Jan-17
Barkingside MC	17	Jan-17
Total	**342**	

Crown Court	No. of AAMR imposed	Roll-out date
Woolwich CC	4	Apr-16
Inner London CC	2	Apr-16
Croydon CC	5	Apr-16
Central Criminal Court	6	Jul-16
Isleworth CC	3	Jul-16
Kingston Crown Court	2	Jul-16
Harrow CC	2	Oct-16
Wood Green CC	1	Oct-16
Total	**25**	

Appendix E: Offence type

This table describes the offence type for which an AAMR was ordered, 01 April 2016 to 31 March 2017.

	Offence Type	No. of offences	%
Damage/Theft	Burglary	4	1%
	Criminal Damage	22	6%
	Theft	4	1%
	Unauthorised taking of a motor vehicle	4	1%
Driving	Driving or attempting to drive whilst unfit through drink/drugs	82	22%
	Failing to provide specimen	12	3%
	Other driving	8	2%
Drugs	Failure to cooperate (drugs)	1	0%
	Supply/Possession of drugs	5	1%
Harassment	Harassment	7	2%
	Racially aggravated harassment	14	3%
	Threatening words or behaviours	21	6%
Public Order	Drunk and disorderly conduct	7	2%
	Offences against Public Order	1	0%
	Other offences	3	1%
Sexual	Exposure	5	1%
	Sexual Assault	9	3%
Violence	Assault (beating, common assault, ABH, GBH)	115	31%
	Assault on Police Officer	29	8%
	Possession of a weapon	12	3%
	Resisting/Obstructing a Police Officer	2	1%
	Total	**367**	100%

Appendix F: OGRS3 scores for offenders who received an AAMR.

OGRS score	No. of AAMR offenders	%
Very low (0 - 24%)	105	33%
Low (25% - 49%)	107	34%
Medium (50% - 74%)	77	24%
High (75% - 89%)	20	6%
Very high (90% +)	7	2%
Total	**316**	**100%**

Appendix G: Stakeholder training survey

The table below indicates both the feedback questions and responses[34] provided by stakeholders who attended the AAMR training.

Question	Agree		Neutral		Disagree		Total
The trainers did a good job delivering the training event	525	96%	2	0.4%	18	3%	545
I was given enough time to ask questions	464	85%	4	1%	78	14%	546
The training was delivered at the right pace	481	88%	16	3%	48	9%	545
I understand the aims and objectives of the AAMR	528	97%	3	1%	14	3%	545
I understand how to use the AAMR in my role	509	93%	1	0.2%	35	6%	545
I understand the offender eligibility criteria for the AAMR	516	95%	4	1%	22	4%	542
I understand how the AAMR equipment works	512	94%	3	1%	31	6%	546
I know where to get more information/support around the AAMR	415	82%	36	7%	55	11%	506
I see the AAMR is a useful way to tackle alcohol related offending	480	92%	24	5%	20	4%	524
I will use the AAMR	499	95%	6	1%	21	4%	526
The first session was useful	238	97%	2	1%	5	2%	245
The second session was useful	164	96%	4	2%	3	2%	171
The third session was useful	119	94%	3	2%	5	4%	127
Overall this training has provided me with enough information to confidently use the AAMR	495	96%	4	1%	18	3%	517
Overall I was satisfied with this training event	505	97%	0	0%	15	3%	520

[34] Responses were on a 7 point Likert Scale from 1 = Strongly Agree to 7 = Strongly Disagree. Scores '1', '2', and '3' have been combined into one output 'Agree' and scores '5', '6', and '7' have been combined into 'Disagree' category.

Appendix H: Offender Survey Questions

Entry Survey: Total number of respondents = 169

Question	Strongly Agree/ Agree		Neither agree nor disagree		Disagree/Strongly Disagree		Total Responses[35]
I have a good relationship with my close family	90%	120	5%	7	5%	6	133
I have a good relationship with my friends	92%	122	5%	7	2%	3	133
I have good physical health	86%	114	8%	11	5%	7	132
I have a nice place to live	86%	111	8%	10	6%	8	129
I have a job which I enjoy	77%	83	9%	10	12%	13	108
Going out and socialising with my friends causes me problems	18%	23	21%	26	60%	76	127
My current financial situation is difficult	38%	46	30%	37	30%	37	122
My offending behaviour causes me problems	46%	57	18%	23	32%	40	125
Drinking alcohol has a negative effect on my life in general	43%	54	21%	27	34%	43	126
I am happy most of the time	75%	95	17%	21	9%	11	127
I understand why I received the Alcohol tag	93%	116	0%	0	7%	9	125
I understand what I must do to comply with the Alcohol tag order	99%	124	0%	0	1%	1	125
I am worried about what my friends and family will think of the Alcohol tag	41%	46	0%	0	59%	66	112

[35] Total Responses includes 'Don't Know' responses and missing data, therefore data shown does not necessarily sum to the data shown in Total Responses. Not every respondent answered every question so there is variation to the total number of respondents overall (n=169).

Entry Survey

Question	Better		Worse		No impact		Total
Life in general	65%	79	12%	15	19%	23	122
Relationship with family	50%	60	5%	6	40%	48	119
Relationships with friends	45%	54	7%	8	45%	54	121
Money/current financial situation	62%	75	7%	8	29%	35	121
Offending behaviour[36]	67%	77	0%	0	24%	28	115
Physical health	70%	87	4%	5	22%	27	124
Mental wellbeing	60%	71	8%	10	29%	34	119
Housing situation	39%	47	5%	6	52%	62	120
Employment situation	35%	41	14%	16	44%	52	117
Ability to 'go out'/socialising	33%	39	28%	33	35%	42	119
Education situation	28%	32	1%	1	19%	56	114

[36] Offending behaviour - 'Better' may refer to less offending and 'Worse' may refer to more offending.

***Exit Survey*: Total number of respondents = 115**

Questions	Strongly Agree - Agree		Neither agree nor disagree		Disagree-Strongly Disagree		Total Responses[37]
I have a good relationship with my close family	86%	90	2%	2	4%	4	105
I have a good relationship with my friends	89%	93	1%	1	2%	2	105
I have good physical health	83%	87	5%	5	4%	4	105
I have a nice place to live	80%	84	5%	5	5%	5	105
I have a job which I enjoy	66%	69	12%	13	7%	7	105
Going out and socialising with my friends causes me problems	10%	11	27%	28	52%	55	105
My current financial situation is difficult	31%	33	22%	23	37%	39	105
My offending behaviour causes me problems	33%	35	18%	19	38%	40	105
Drinking alcohol has a negative effect on my life in general	35%	37	17%	18	36%	38	105
I am happy most of the time	74%	78	11%	12	7%	7	105
I was worried what my friends and family thought of the alcohol tag	45%	47	0	0	55%	58	105
The alcohol tag felt comfortable to wear	27%	28	0	0	73%	77	105
The AAMR guidance document I received was useful	71%	75	0	0	29%	30	105

[37] Total Responses includes 'Don't Know' responses and missing data, therefore data shown does not necessarily sum to the data shown in Total Responses. Not every respondent answered every question so there is variation to the total number of respondents overall (n=115).

Exit Survey

Questions	Better		Worse		No impact		Total
Life in general	49%	51	11%	12	27%	28	105
Relationship with family	41%	43	5%	5	40%	42	105
Relationships with friends	37%	39	7%	7	43%	45	105
Money/current financial situation	46%	48	6%	6	33%	35	105
Offending behaviour[38]	53%	56	4%	4	23%	24	105
Physical health	58%	61	6%	6	26%	27	105
Mental wellbeing	49%	51	9%	9	31%	33	105
Housing situation	30%	31	3%	3	55%	58	105
Employment situation	25%	26	15%	16	49%	51	105
Ability to 'go out'/socialising	30%	32	27%	28	31%	33	105
Education situation	25%	26	4%	4	50%	53	105

[38] Offending behaviour - 'Better' may refer to less offending and 'Worse' may refer to more offending.