Introduction

Purpose

Best practice guidance for probation staff, in particular Assistant Chief Officers (ACOs), Senior Probation Officers (SPOs), Offender Managers (OMs), Offender Supervisors and interventions staff who work with substance misusers, on the effective commissioning, management and delivery of a range of interventions for alcohol misusing offenders. This includes updated advice on the implementation of alcohol treatment requirements (ATRs).

The guidance:

- defines requirements for managing offenders with alcohol related needs and in matching evidence based interventions to need
- provides more detailed advice on the appropriate targeting, delivery and enforcement of ATRs to contribute towards greater standardisation of the probation service's work with alcohol misusing offenders
- clarifies the distinction between offence seriousness and treatment need in developing pre-sentence report (PSR) proposals and updates guidance on tiering
- includes further advice on working with women offenders with alcohol misuse issues, in line with the *Offender Management Guide to Working with Women Offenders*[1]

This guidance updates Annex B to PC 57/2005[2], *Managing the Alcohol Treatment Requirement (ATR)*, to better reflect *Models of care for alcohol misusers (MoCAM)*[3] and the *Review of the Effectiveness of Treatment for Alcohol Problems*[4], which the existing guidance pre-dated. It also addresses specific queries raised by probation areas/trusts and issues that NOMS has identified centrally.

The focus of the revised guidance is on improving provision within existing resources based upon evidence of what has been found to be effective and, most importantly, cost-effective. Improved targeting of interventions; swifter and more accurate identification of alcohol and offending needs; more timely and appropriate advice and information and referral into structured treatment, where indicated; increased availability and accessibility of a wide range of evidence based interventions and greater continuity between what is delivered in prison and the community should all lead to cost savings.

1 http://noms.justice.gov.uk/news-publications-events/publications/guidance/OM-Guide-Women

2 http://npsintranet.probation.gsi.gov.uk/index/pc57-2005.htm

3http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4136806

4 http://www.nta.nhs.uk/publications/publications.aspx?CategoryID=6

The guidance was informed by: -

- *Evidence based practice? The National Probation Service's work with alcohol misusing offenders*[5] published on 28th October 2009
- implementation guidance developed locally by probation areas/trusts
- work undertaken as part of NOMS Alcohol Best Practice Projects Initiative[6]
- ATR workshops held at two national alcohol conferences[7]
- analysis of responses to ATR questionnaires issued to all probation areas
- feedback from, *Improving local alcohol provision for offenders under probation supervision*, an Alcohol Treatment Providers Consultation Event held jointly with Alcohol Concern[8]

It is not expected that staff will read the entire document but rather use it as a reference guide to assist with specific problems.

Typology of drinking

Sensible drinking

Sensible drinking is defined as regularly consuming less than the recommended daily limits.

The government advises[9] adult women not to drink more than 2–3 units (1 unit is 10 ml of pure alcohol) and adult men not more than 3–4 units of alcohol a day on a regular basis, to reduce their risk of alcohol-related harm.

At least one day a week should be alcohol-free and two days should be alcohol-free following a heavy drinking session.

Women who are pregnant or trying to conceive should avoid drinking alcohol but if they choose to drink should not drink more than 1 -2 units once or twice a week and should not get drunk.

The risk of harm from drinking above sensible levels increases the more alcohol that you drink and the more often you drink over these levels.

5 http://www.justice.gov.uk/publications/alcohol-misusing-offenders-research-report.htm

6http://npsintranet.probation.gsi.gov.uk/index/service_delivery/interventions/drugs__alcohol/alcohol_best_practice_projects.htm

7 NPS Alcohol Strategy Implementation Events held in Bath and Sheffield in October 2006.

8http://npsintranet.probation.gsi.gov.uk/document_library/index/alcohol_treatment_provider_event_report_7th_december_2006.htm

9 *Safe. Sensible. Social. The next steps in the National Alcohol Strategy* (2007)

Categorisation of alcohol misuse

There is no single or scientific method of categorising individuals requiring intervention or treatment for alcohol misuse.

World Health Organisation (WHO)

The World Health Organisation (WHO)'s tenth revision of the *International classification of diseases* (ICD-10)[10] defines:-

- ***hazardous*** use of a psychoactive substance, such as alcohol, as an 'occasional, repeated or persistent pattern of use…which carries with it a high risk of causing future damage to the medical or mental health of the user but which has not yet resulted in significant medical or psychological ill effects.'[11]

- ***harmful*** use of a psychoactive substance, such as alcohol, as 'a pattern of use which is already causing damage to health. The damage may be physical or mental.'[12]

- ***dependence***[13] as 'a cluster of physiological, behavioural, and cognitive phenomena in which the use of a substance or a class of substances takes on a much higher priority for a given individual than other behaviours that once had greater value. A central descriptive characteristic of the dependence syndrome is the desire (often strong, sometimes overpowering) to take psychoactive drugs (which may or may not have been medically prescribed), alcohol, or tobacco. There may be evidence that return to substance use after a period of abstinence leads to a more rapid reappearance of other features of the syndrome than occurs with nondependent individuals.'

Drinkers falling into the later category can be further classified as having mild, moderate and severe levels of dependence.

10 http://www.who.int/classifications/icd/en/

11 Hazardous drinking is defined as consuming more than 14 or 21 units per week (women and men respectively) but not yet experiencing harm.

12 Harmful drinking is defined as consuming more than 35 or 50 units per week (women and men respectively) and/or experiencing the harmful effects of alcohol consumption but not alcohol dependence (Examples of harmful effects include an alcohol-related accident, acute alcohol poisoning, hypertension or cirrhosis).

13 Dependence is difficult to define, as it is not a single entity, but a constellation of behaviours and internal processes that combine to cause a chronic problem.

Models of care for alcohol misusers (MoCAM)

MoCAM (using the WHO classification) identifies four main categories of alcohol misusers: hazardous drinkers; harmful drinkers; moderately dependent drinkers; and severely dependent drinkers.

Hazardous drinkers – drink 'at levels over the sensible drinking limits, either in terms of regular excessive consumption or less frequent sessions of heavy drinking. However, they have so far avoided significant alcohol-related problems.'

Harmful drinkers – usually drink 'at levels above those recommended for sensible drinking, typically at higher levels than most hazardous drinkers', however they show clear evidence of some alcohol-related harm.

Moderately dependent drinkers – have a level of psychological dependence 'with an increased drive to use alcohol and difficulty controlling its use, despite negative consequences.'

***Severely dependent* drinkers** – have a severe level of psychological dependence and often have physical withdrawal upon cessation. They may have formed the habit of drinking to stop withdrawal symptoms. Their drinking is likely to comprise 'habitual significant daily alcohol use or heavy use over long periods or bouts of drinking.'

Department of Health

In 2008, the Department of Health (DH) consulted with experts to agree a new description of categories of drinking based on risk. This resonated better with the public and non-specialist health professionals than the terms hazardous and harmful used in the WHO classification.

WHO	DH	MEN	WOMEN
Sensible levels	Lower Risk	No more than 3-4 units per day on a regular basis	No more than 2-3 units per day on a regular basis
Hazardous levels	Increasing Risk	More than 4 units per day on a regular basis	More than 3 units per day on a regular basis
Harmful levels	Higher Risk (this category includes all dependent drinkers)	More than 8 units per day on a regular basis or more than 50 units per week	More than 6 units per day on a regular basis or more than 35 units per week

Binge drinking

Safe. Sensible. Social. The next steps in the National Alcohol Strategy[14] defines ***binge drinking*** as 'drinking too much alcohol over a short period of time, e.g. over the course of an evening, and it is typically drinking that leads to drunkenness. It has immediate and short-term risks to the drinker and to those around them.'

Trends in binge drinking are usually identified in surveys as consuming **more than twice** the Government's recommended daily limit **in a single session** (i.e. 8 units for men and 6 units for women) but many binge drinkers consume substantially more than this level or drink this amount more rapidly.
Binge drinking cuts across the 'Lower Risk', 'Increasing Risk' and 'Higher Risk' categories.

The WHO classification is used in this document, whenever appropriate, for reasons of historical accuracy e.g. reference to past research studies. The NHS is being guided to use the new DH terminology and therefore, to facilitate partnership working, probation staff are encouraged to adopt these definitions rather than continue to refer to WHO categories such as hazardous and harmful.

14 http://www.homeoffice.gov.uk/documents/alcohol-strategy-2007

Drinking Categories

Drinking Category	Definitions
Abstainers	Men and women who have not drunk alcohol in the past year
Lower risk	For men: not regularly drinking > 3-4 units per day For women: not regularly drinking > 2-3 units per day
Increasing risk	For men: regularly exceeding > 3-4 units per day > – but not drinking at levels incurring the highest risk For women: regularly exceeding > 2-3 units per day >– but not drinking at levels incurring the highest risk
Higher risk	For men: regularly drinking > 50 units per week or regularly drinking > 8 units per day For women regularly drinking greater than 35 units per week or regularly drinking > 6 units per day
Binge drinking	Drinking too much alcohol over a short period of time, e.g. over the course of an evening and it is typically drinking that leads to drunkenness. The Office for National Statistics (ONS) uses the measure of consuming more than twice the lower-risk levels in one day (>6 units for women and > 8 units for men). **(Sub-set of Lower, Increasing and Higher risk groups)**
Dependence	Dependence is characterised by: • A **strong desire** or **sense of compulsion** to drink alcohol • **Difficulty in controlling** drinking (stop/start) • A physiological **withdrawal state** (e.g. tremor, sweating, anxiety, seizures, disorientation, hallucinations) when drinking has ceased or reduced • Drinking to relieve or **avoid** such withdrawal states • Evidence of **tolerance** • **Persisting** with alcohol use **despite harmful consequences** (ICD-10, WHO) **(Sub-set of Higher risk drinking group)**

Models of care for alcohol misusers (MoCAM)

In 2005, the Department of Health commissioned the National Treatment Agency for Substance Misuse (NTA) to develop and publish *Models of care for alcohol misusers* (MoCAM). This document provides best practice guidance on a framework for commissioning and providing interventions and treatment for adults affected by alcohol misuse.

Alcohol treatment services are categorised into 4 tiers of intervention in MoCAM. The tiers represent a stepped approach to alcohol problems (starting with a very brief intervention and intensifying efforts in case of no success), and range from low-intensity interventions for modest alcohol problems (Tier 1) to intensive specialist treatment for severe alcohol dependence (Tier 4).

- **Tier 1: Alcohol-related information and advice; screening; simple brief interventions; and referral**. This is defined as the identification of hazardous, harmful and dependent drinkers; the provision of information on sensible drinking; simple brief interventions to reduce alcohol-related harm; and referral of those with alcohol dependence or harm for more intensive interventions. Tier 1 interventions include alcohol advice and information; targeted screening and assessment for those drinking in excess of DH guidelines on sensible drinking; provision of simple brief interventions to hazardous and harmful drinkers; and referral of those requiring more than simple brief interventions for specialised alcohol treatment. These are delivered in health settings (e.g. in primary care, A&E departments) and in generic settings by offender managers and other non-specialists with the necessary Drugs and Alcohol National Occupational Standards (DANOS) competences.[15]

- **Tier 2: Open access, non-care-planned, alcohol specific interventions.** This is defined as provision of open access facilities and outreach delivering alcohol-specific advice, information and support; extended brief interventions to reduce alcohol-related harm; and assessment and referral of those with more serious alcohol-related problems for care-planned treatment. Interventions provided include triage assessment; brief treatment and mutual aid groups e.g. Alcoholics Anonymous. Tier 2 provision may be offered in a probation setting where staff have the required DANOS competences or through referral to specialist alcohol services and are generally appropriate for hazardous and harmful drinkers who have not responded to simple brief interventions.

- **Tier 3: Community-based, structured, care-planned treatment.** This is defined as specialised alcohol misuse assessment, and alcohol treatment that is care co-ordinated and care-planned. Interventions include comprehensive substance misuse assessment; evidence based prescribing interventions, including for medically assisted alcohol

15 Available at www.skillsforhealth.org.uk

withdrawal (detoxification)[16] and to reduce risk of relapse; structured evidence based psychosocial therapies and support; and structured day programmes and care-planned day care. These interventions are usually provided within specialised alcohol treatment services and are generally appropriate for moderately dependent drinkers.

- **Tier 4: Alcohol specialist inpatient treatment and residential rehabilitation.** This is defined as residential, specialised alcohol treatments which are care-planned and co-ordinated to ensure continuity of care and aftercare. Tier 4 includes in-patient assisted withdrawal – typically a relatively brief intervention lasting 7-10 days (and sometimes less if treatment starts as an in-patient and is completed in the community). In-patient assisted withdrawal is indicated when service users would be at risk if treatment was provided in the community. Assisted withdrawal can also be provided at the start of a residential treatment placement. Tier 4 interventions are likely to be suitable for those who have severe dependence or alcohol dependence with other problems, and may be provided in specialised statutory, independent or voluntary sector inpatient facilities or residential rehabilitation units by medical staff with specialist competences.

MoCAM Tiers

Tier	Interventions	Target Drinking Category	Who can provide these interventions?
1	Alcohol-related information, identification and brief advice; and referral to specialist services	Increasing-risk Binge drinking	GPs, EDs, other health and social care professionals, arrest referral schemes, probation, prisons
2	Open access, non-care-planned, alcohol-specific advice and counselling	Increasing-risk Binge drinking	Drop-in centres, homelessness services, domestic violence services, criminal justice settings
3	Community-based (outpatient), structured, care-planned alcohol treatment • counselling services • day treatment programmes	Higher-risk Dependence	NHS Mental Health Trusts/Health Boards and third-sector alcohol treatment community organisations
4	Alcohol specialist inpatient treatment and residential rehabilitation	Dependence	NHS Mental Health Trusts/Health Boards and third-sector alcohol treatment residential providers

16 Otherwise known as 'prescribed medication.'

Offender Management Model Tiers

The NOMS Offender Management Model (OMM)[17] defines a four tier classification structure for the management of offenders under supervision. The tiered approach coupled with systematic assessment of offenders is designed to ensure that the level of probation resources and services applied to the supervision of individual offenders is commensurate with the assessed levels of risk of serious harm to the public and assessed likelihood of re-offending behaviour. The OMM is designed to be progressive – subsequent tiers building on the preceding tier. The primary purpose and approaches required at each tier are:

Tier	**Primary Purpose**	**Offender Management Approach**
Mode Label	**Description of Mode**	
1. PUNISH	The primary purpose of ***Offender Management*** at Tier 1 is to ensure that the sentence requirements imposed by the Court or prison licence are carried out as intended and to ensure that the ***Offender*** complies with them.	
	Arrangements made for the implementation of the sentence requirements, with due regard for decency, health and safety and the preservation of citizenship; monitor risk factors; 'signpost' to helping resources.	Hands-off; administrative; organising; monitoring; signposting to resources.
2. HELP	The primary purpose of ***Offender Management*** at Tier 2 in addition to ensuring that sentence requirements are carried out as intended is to motivate and refer ***Offenders*** to resources providing practical help to address particular circumstances or situations linked to offending, to reduce the likelihood of re-offending.	
	Motivation; referral to resources providing practical help addressing circumstances, or situation – typically employment, accommodation, basic and life skills; support and encouragement of participation.	Hands-on; motivating; encouraging; referring; supporting; problem solving.
3. CHANGE	The primary purpose of ***Offender Management*** at Tier 3 is to extend the Tier 2 arrangements by motivating ***Offenders*** to take advantage of specialist resources providing treatments and interventions designed to produce behavioural change which will lead to reduction in frequency and/or seriousness of re-offending.	
	Implementation of carefully planned programme designed to achieve personal change, typically including Offending Behaviour Programmes, drug and alcohol treatment, some social skills.	Hands-on; treatment (usually) to complement or as part of a specialist treatment programme; co-ordination of all inputs to complement one another.

17 http://noms.justice.gov.uk/news-publications-events/publications/strategy/offender-management-model-1.1

		Sometimes referred to as 'therapeutic'.
4. CONTROL	The primary purpose of ***Offender Management*** at Tier 4, and in particular those ***Offenders*** classified as ***Prolific and other Priority Offenders*** (*PPOs)*, is for the Area/Trust to use best endeavours to ensure that these ***Offenders*** are managed safely within prisons and the community and, where appropriate, to take all necessary actions in partnership with ***MAPPA*** partners and other agencies to: • minimise risk of serious harm to ***Offenders*** and the public at large • respond expeditiously to any developing threats • work with ***Offenders*** to radically reduce the frequency and seriousness of re-offending • ensure that breaches of sentence and/or licence result in appropriately swift return to court or recall to custody	
	Intensive, inter-agency, multi-faceted programmes to control and monitor behaviour, including surveillance and intelligence work. Typically, Prolific Offender Schemes and dangerous offender MAPPA 'packages'.	Hands-on; risk management; inter-agency co-ordination; high level of teamwork.

Alcohol related offending and the sentencing framework

Offenders with identified alcohol misuse needs sentenced to either a community order or suspended sentence of imprisonment can receive alcohol related interventions in a number of different ways dependent upon their assessed level of drinking problem, seriousness of offence and risk of re-offending/harm.

The ***Alcohol Treatment Requirement*** (ATR) is one of the 12 requirements which can be included in a community sentence for adult offenders (offenders aged 18 or above) for offences committed on or after 4th April 2005. The ATR is targeted at those offenders assessed as alcohol dependent and provides access to intensive, specialist, care-planned treatment (Tiers 3 and 4 of MoCAM), with the aim of reducing or eliminating the offender's dependency on alcohol. An ATR can be made part of a community order for a minimum of six months and maximum of three years and a suspended sentence of imprisonment for a minimum of six months and maximum of two years. The court has discretion to decide that a suspended sentence order be subject to periodic review, including those with an ATR.

Alcohol-specific information, advice and support (a.k.a. brief interventions)

- Extended brief interventions or brief motivational counselling typically takes between 20-30 minutes to deliver and can involve a small number of repeat sessions (Tier 2 of MoCAM). This is delivered to higher risk (excluding those assessed as dependent) or less persistent

binge drinkers who do not meet the dependency test of the ATR, either in-house by probation areas/trusts or in partnership with the voluntary sector, through an ***activity requirement*** or as part of a ***supervision requirement***. Some areas/trusts have 'marketed' the former to courts as an Alcohol Specified Activity Requirement (ASAR).

- Simple brief interventions (generally around 5 minutes of structured brief advice) (Tier 1 of MoCAM) are targeted at increasing risk drinkers and usually delivered by Offender Managers or Offender Supervisors competent to the relevant Drugs & Alcohol National Occupational Standards (DANOS) immediately following screening at the pre-sentence report (PSR) stage or during supervision.

Alcohol related offending behaviour is addressed through substance misuse accredited programmes and delivered through a ***programme requirement*****.**

- ***Addressing Substance Related Offending (ASRO)*** or the ***Offender Substance Abuse Programme (OSAP)***, targeted at offenders recognised as having a significant (higher risk or dependent) alcohol problem with a medium to high risk of re-offending or for whom the misuse of alcohol has been assessed as a significant factor in their offending behaviour, are available in nearly all probation areas/trusts.

- The ***Lower Intensity Alcohol Programme (LIAP)*** aimed at those whose alcohol misuse and offending needs are not sufficient to lead to a referral to ASRO/OSAP or whose primary need requires referral to an accredited programme e.g. violence but where there is still a need for alcohol related offending to be addressed. LIAP has been piloted in eight areas, provisionally accredited by the Correctional Services Accreditation Panel (CSAP) and is now available for all probation areas/trusts to use as part of their suite of programme provision.

- The ***Drink Impaired Drivers (DID)*** scheme aimed at those who have committed a drink drive offence but have not otherwise been involved with crime.

Where offenders with identified alcohol misuse needs are due to be released from prison and will be subject to statutory supervision on licence (sentenced to 12 months and over), their offender managers are responsible for ensuring there is an appropriate licence condition which requires those offenders to address their problems with alcohol. This condition may, for instance, require the offender to attend a substance misuse accredited programme.

Offenders can also access community alcohol services under general licence conditions or be referred on a voluntary basis.

Alcohol and Wales

MoCAM and the NTA have no direct influence or bearing on operational practice in Wales.

The Welsh Assembly Government Substance Misuse Strategy, *Working Together to Reduce Harm*[18], launched in November 2008, includes the misuse of alcohol alongside the misuse of illegal drugs. Community Safety Partnerships (CSPs) have responsibility for the delivery of the Strategy. This focuses attention on the community safety and crime and disorder aspects of alcohol misuse.

As part of the changes being made as a result of the reconfiguration of the NHS in Wales, the new Local Health Boards (LHBs) are a 'responsible authority' within the CSPs. This will mean that the new LHBs will share the statutory responsibilities for tackling substance misuse in their area with the CSPs. The new NHS Trust, Public Health Wales, will become a 'body with whom the responsible authorities should co-operate' at the same time. It is also intended that the Probation Service will become a 'responsible authority' within CSPs early next year. These changes will ensure that all bodies responsible for planning and commissioning substance misuse services will be formal members of CSPs.

Guidance on relevant alcohol provision is generated by the Welsh Assembly Government and its existing Substance Misuse Treatment Framework (SMTF)[19]. The Framework is being published in modular form as guidance of good practice; those already published include Alcohol Treatment and Managing Alcohol Misuse in the Workplace. The Planning and Provision of Substance Misuse Services to Children and Young People in the Care of Youth Offending Services and Treatment of Offenders with substance misuse problems have also been published and include guidance on treatment for both drug and alcohol misuse. An Alcohol Education and Prevention in Further and Higher Education Organisations module is currently being developed and will be published in spring 2010.

18http://wales.gov.uk/about/programmeforgovernment/strategy/publications/socialjustice/substancemisuse/?lang=en

19http://wales.gov.uk/topics/housingandcommunity/safety/substancemisuse/treatmentframework/?lang=en