

Managing the sentence

Alcohol misusing offenders subject to community orders or released from custody on licence should be case managed in accordance with the Offender Management Model (OMM), National Standards and other operational requirements and relevant probation circulars.

Core activities are:-

- To prepare and manage sentence and release plans with the purpose of reducing re-offending and alcohol misuse.
- To supervise and monitor offenders on the alcohol treatment requirement (ATR), other requirements involving the delivery of alcohol related interventions, and those on licence.
- To effectively manage the risk of harm (including self-harm).

Tiering

PC 08/2008: *National Rules for Tiering Cases and Associated Guidance* requires that:-

- Report writers should only make proposals for treatment requirements when the case has a risk/needs profile equivalent to tier 2 or above
- The treatment requirement should usually be accompanied by a supervision requirement
- All cases with a treatment requirement should be managed at tier 2 or above.

This amends Annex B to PC 57/2005 which stated that 'the ATR can be used as a stand alone requirement for those in the lowest band of the community sentence but an OM will still be needed for enforcement and general compliance with the order.'

Although an ATR should not usually be proposed without a supervision requirement, the court may impose a standalone ATR. As a minimum, these cases should still be managed at tier 2.

Offenders subject to an ATR assessed as posing a high or very high risk of serious harm or who are Prolific and other Priority Offenders (PPOs) should be managed in tier 4 regardless of the number, type or intensity of requirements.

Some probation areas/trusts have made arrangements so that the intervention provider e.g. external Alcohol Advisory and Treatment Service provides the whole ATR and the only expectation placed upon the offender manager (OM) is to make the arrangements for attendance (or ensure that those arrangements are made), monitor compliance and take enforcement action, if required. However, the expectation is that the ATR is embedded into a longer period of case management, in which work is undertaken with the offender to complement the core intervention. This should prepare the

offender, support, consolidate, assist with 'homework' etc. Therefore, whilst many of the weekly contacts will be carried out by the treatment provider(s), there should additionally be sufficient frequency of contact to maintain the offender's commitment to the ATR and to maximise the offender's chances of completing the order.

Irrespective of the offender tier the OM should have sufficient contact with the treatment provider (over and above receiving attendance sheets) so they are aware of how the offender is progressing. This is particularly important in a suspended sentence order (SSO) case subject to court reviews.

Sentence planning

Information obtained from the pre-sentence screening and assessment process will help the OM to produce a sentence plan of the work that will be done with the offender after the court has passed its sentence.

OMs should ensure that sentence plans specify how alcohol misuse will be addressed through the appropriate tier of alcohol provision under *Models of care for alcohol misusers (MoCAM)*, along with related offending e.g. substance misuse programme and wider needs, which may necessitate a more holistic assessment of the offender - both positives and negatives – post-sentence.

Careful consideration, within the sentence planning process, needs to be given to the sequencing of interventions (see section on sequencing).

Where the assessment flags up criminogenic needs without the capacity to meet those needs leaving OMs holding the risk e.g. limited alcohol treatment provision delaying the start of the ATR; capacity to start offending behaviour programmes; work can be done with the offender e.g. brief interventions, relating to other requirements, until the relevant components can begin within the timings of the community order. This will need to be reflected in the sentence plan.

In ATR cases the care plan should cover the entire period of the requirement and this should be reflected in the sentence plan.

Examples

1. Treatment should be spread over the length of the requirement however frequency may vary e.g. a 12 week treatment plan could be delivered fortnightly over a six month period (weekly contact is not necessary for the whole six month period of a supervision requirement running concurrently with an ATR apart from at Tier 4 to comply with National Standards).

or

2. Set weekly sessions for 12 weeks with relapse prevention or re-referral built into care plan for remainder of requirement period.

Sequencing

The sequencing of interventions e.g. ATR and programmes should primarily be determined by the use of the selection matrix. Waiting lists for treatment and programmes could also have an impact on the order interventions are undertaken.

For orders with a number of requirements consideration should be given to sequencing the interventions to maximise the impact of the order on the rehabilitation of the offender. This may be particularly relevant to offenders on ATRs who may need to have their alcohol problem addressed before being able to realistically comply with the other requirements.

It is particularly important for those leaving prison to ensure that there is the right kind of follow up to interventions begun in custody and that progress made is maintained upon release, although in prisons, as in the community, alcohol services have not developed as comprehensively as for illicit drugs. This is likely to require close links with CARAT teams and the Drug Interventions Programme (DIP) for those with polysubstance misuse (including alcohol) problems. Also, OMs should ensure that all alcohol interventions, whether delivered directly or brokered from other providers, should routinely be followed up to determine whether or not they have been effective and if further intervention will be needed.

Recording

It is crucial that the OM records all contacts (arranged and achieved) properly across all the requirements of the order.

Home visits

A home visit should be undertaken by the OM within 10 working days of sentence or release if the risk of harm posed by the offender is identified as high or very high. This should be subject to local guidance on health and safety/risk and home visiting. Particular attention should be paid to the potential effects of alcohol on the domestic situation especially in relation to any children of the household and or any victim issues.

Missed appointments

Where offenders are given acceptable absences, the number of appointments they are required to attend should only be extended to compensate for those they have missed where necessary to the integrity of the overall treatment episode i.e. where the composition of each session is such that it is essential that these are undertaken in a particular order and completed in entirety (programmes such as the Lower Intensity Alcohol Programme (LIAP) which have a modular structure). In such cases, it is reasonable to expect an offender to attend catch-up sessions or, if this is not possible, to start the whole course again.

Where it is not possible to re-arrange treatment sessions that have been missed so that the whole programme is completed within the duration of the original requirement, then it would be possible to extend the duration of the requirement (see below). Unless this is done, appointments scheduled outside the duration of the requirement (this should be specified in the order at point of sentence, although it does not necessarily have to start from the date the order is made, as long as it is completed before the order expires) would not be enforceable. Otherwise, if there is a continuing treatment need at the end of the requirement, whether all the planned sessions have been completed or not, then the offender should be encouraged to remain in treatment on a voluntary basis.

The solution is not to seek longer ATRs from the outset e.g. nine months instead of the usual six months duration if this cannot be justified by the specific treatment need within an overall package of requirements commensurate with offence seriousness, particularly as the option to seek an extension in length of the requirement is available if needed.

Post-sentence, under Schedule 8 Part 4 paragraph 18 of the Criminal Justice Act 2003 (CJA 2003), if the medical practitioner or other specified person by whom or under whose direction the offender is receiving treatment is of the opinion that:-

- **the treatment specified in the order should be continued beyond the period for which the requirement has effect;**
- the offender needs different treatment;
- the offender is not susceptible to treatment;
- the offender does not require further treatment; or
- if he/she is for any reason unwilling to continue to treat or direct the treatment of the offender

he/she **should** make a report in writing to that effect to the responsible officer i.e. an officer of a local probation board appointed for or assigned to the petty sessions area specified in the order and the officer **should** apply under paragraph 17 – *Amendment of requirements of community order* - to the court responsible for the order for variation or cancellation of the requirement. In response to such an application, the court may cancel the requirement or replace it with a requirement of the same kind which the court could include if it were then making the order e.g. a longer alcohol treatment requirement (ATR), with different treatment or delivered by a different provider, although in the case of a mental health requirement, drug rehabilitation requirement or ATR only with the prior consent of the offender to the proposed change. Should the offender fail to consent then the court may revoke the order and re-sentence for the original offence, including where appropriate, to custody.

As a last resort, the order could be taken back to court on the basis that the number of acceptable absences had made the requirement 'unworkable'. In these circumstances, the OM could make an application to the court for either the order to be revoked and/or the offender re-sentenced, if it appears to the court that 'having regard to circumstances which have arisen since the order

was made, it would be in the interests of justice' to do so (Schedule 8 Part 3 paragraphs 13 & 14 of the CJA 2003); or for the order to be amended by cancelling a requirement or replacing a requirement of the order (Schedule 8 Part 4 paragraph 17 of the CJA 2003). If the offender fails to agree to the ATR as proposed to be amended by the court, then the court can revoke the order and re-sentence.

Change of treatment provider

Where the treatment provider assesses that treatment can be better or more conveniently carried out by another suitably qualified provider not specified in the ATR e.g. in-patient or community based detoxification, then he may with the consent of the offender make arrangements for such treatment to be provided. The person making the arrangements should notify the supervising officer of the change, specifying where and by whom the treatment is now being carried out, and the officer apply to the appropriate court under paragraph 17 for variation of the requirement. For residential treatment, the guidance on case transfers set out in PC 25/2007 applies.

Transfer of cases

ATRs involving offenders in residential treatment should be transferred to the area where the residential facility is located as specified in PC 25/2007. Transfers should be properly planned. Formal planning for transfer should also include arrangements for planned or unplanned discharge from the residential treatment where the offender may return to the home area.

The referring probation area/trust should inform the new area of the impending transfer and discuss the case with them **prior** to the ATR being made. Similarly there should be discussion between the home area/trust and the area/trust to which the order is being transferred if an offender is being referred to an out of area rehabilitation facility after an ATR has been made. Prior liaison will help ensure that offenders are not placed in inappropriate residential treatment facilities, including those that the local area/trust would not use.

Revocation for good progress

The supervising officer or offender may apply for the ATR to be revoked early for good progress or for responding satisfactorily to supervision or treatment where this is applicable.

The whole order can be revoked on the grounds of good progress (Schedule 8 paragraph 13 (2)(3) of the CJA 2003). Alternatively, an ATR can be cancelled on the grounds of good progress even if other requirements of the order are still operational:-

'The appropriate court may, on the application of the offender or the responsible officer, by order amend a community order – (a) by cancelling any

of the requirements of the order' (Schedule 8, part 4, section 17 (1) (a)) of the CJA 2003).

Closing ATRs

Areas/trusts need to ensure that ATRs are closed on completion even if other requirements of the order e.g. supervision are still operational. Initially, ATRs should be recorded properly on case management systems so that OMs are aware of the end date of the ATR.

Responsibilities regarding notification of DVLA

In the interests of road safety, those who suffer from a medical condition likely to cause a sudden disabling event at the wheel or who are unable to safely control their vehicle from any other cause should not drive.

The Driver and Vehicle Licensing Agency (DVLA) has produced an *At a glance Guide to the current Medical Standards of Fitness to Drive*¹. The information in this booklet is intended to assist doctors in advising their patients whether or not they should inform DVLA of their medical condition and what the outcome is likely to be.

DVLA have advised that:-

- Anyone who has been in detoxification for alcohol use is classed as being 'alcohol dependent' and their licence is revoked for 12 months.
- Anyone who has received treatment only is classed as an alcohol misuser and their licence is revoked for 6 months.

As with any medical conditions which could impede a person's ability to drive, it is the licence holder's responsibility to contact the DVLA. However, OMs can do this by writing to the DVLA directly on an offender's behalf. Also, where the OM is aware that the offender intends to drive he/she has a responsibility to inform DVLA/Police.

This has clear implications for PSR writers recommending an ATR knowing the difficulty in accessing services other than by road in more rural areas.

¹ <http://www.dvla.gov.uk/medical/ataglance.aspx?keywords=fitness+to+drive>