



Institute for
**Public Safety
Crime and Justice**

**Primary Care Mental Health Treatment
Requirement (MHTR) Practitioner Manual**

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1 Introduction

This guidance manual has been produced to help Primary Care MHTR Practitioners in the delivery of Mental Health Treatment Requirements (MHTR) under a Community Order sentence or a Suspended Order sentence in England and Wales. It supplements the Clinical Leads Manual, which outlines further information about MHTRs, the intervention and the role of the Clinical Lead.

This document has been reviewed by the CSTR Chairs, Clinical Leads and Primary Care Practitioners. It has been circulated to the national CSTR programme board who has in turn shared it with partner agencies (inc. NHS England and NHS Improvement, and Her Majesty’s Prison and Probation Service) for review and wider comments. Finally, it has also been reviewed by the NHSE/I clinical reference group.

MHTRs sit alongside Drug Rehabilitation Requirement (DRR) and Alcohol Treatment Requirement (ATR) under the umbrella of ‘Community Sentence Treatment Requirements’ (CSTR). They were introduced in their current form in 2003 in England and Wales to enable Judges and Magistrates to tailor sentences according to the nature of the offence and the offender. It is recognised that CSTRs have been used in very few cases, despite evidence of high proportions of convicted offenders presenting with mental health conditions, and drug and alcohol misuse.

The guidance manual provides information about the background, key aims and objectives of the use of the MHTR, the roles of the Primary Care MHTR Practitioner and key partners in the delivery of the MHTR and how MHTRs work in practice in the criminal justice process.

Acronyms:

A&E: Accident and Emergency	HMCTS: Her Majesty’s Courts and Tribunals Service
ADHD: Attention Deficit Hyperactivity Disorder	HMPPS: Her Majesty’s Prison and Probation Service
ASC: Autism Spectrum Condition	LASPO: Legal Aid, Sentencing and Punishment of Offenders
AP: Assistant Psychologist	L&D: Liaison and Diversion
ATR: Alcohol Treatment Requirement	MAPPA: Multi-Agency Public Protection Arrangements
CCG: Clinical Commissioning Group	MASH: Multi- Agency Safeguarding Hub
CDO: Court Duty Officer	MHTR: Mental Health Treatment Requirement
CJS: Criminal Justice Services	MoJ: Ministry of Justice
CL: Clinical Lead	NHS: National Health Service
CPS: Crown Prosecution Service	NHSE/I: NHS England and NHS Improvement
CRC: Community Rehabilitation Company	NPS: National Probation Service
CSTR: Community Sentence Treatment Requirement	PHE: Public Health England
DoH: Department of Health	RAR: Rehabilitation Activity Requirement
DHSC: Department of Health and Social Care	RC: Responsible Clinician
DRR: Drug Rehabilitation Requirement	PSR: Pre-Sentence Report
GP: General Practitioner	YOT: Youth Offending Team

2 The CSTR Programme

The Community Sentence Treatment Requirement (CSTR) programme involves a partnership between the Ministry of Justice (MoJ), Department of Health and Social Care (DHSC), NHS England and NHS Improvement (NHSE/I)¹, Public Health England (PHE) and Her Majesty's Prison and Probation Service (HMPPS).

There are three types of CSTR, a Mental Health Treatment Requirement (MHTR), Drug Rehabilitation Requirement (DRR) or Alcohol Treatment Requirement (ATR), which enable courts to sentence people to participate in community treatment/interventions.

Since 2017, five testbed areas across England have been testing CSTRs to expand their use and to improve outcomes for those entering the criminal justice system. In time, provision will be expanded to more female offenders, short-term offenders, offenders with a learning disability and those with mental health and additional requirements (NHS Long-Term Plan, 2019:118).

These testbed areas were focussed on increasing the use of the Drug Rehabilitation Requirement (DRR), Alcohol Treatment Requirement (ATR) and Mental Health Treatment Requirement (MHTR). The five testbed areas were Plymouth, Milton Keynes, Northamptonshire, Birmingham and Sefton.

The overall aims and objective of the CSTR Programme are outlined below.

2.1 Guiding Principles, Aims and Objectives

Guiding principles

The CSTR Programme services in any given area will operate under six guiding principles. These are to:

1. Provide an exemplary assessment for all eligible referred adult offenders (18 years and over who consent to ATR/DRR/MHTR) ensuring the service is accessible to the most disadvantaged.
2. Operate within the CSTR Programme Operating Framework.
3. Take an inclusive approach, recognising the complex needs of all adults in contact with the CJS including mental health, neurodevelopmental disorders, acquired brain injury, personality disorder, substance misuse issues irrespective of their protected characteristics as defined under the Equality Act 2010.
4. Provide high quality information to key decision makers across the criminal justice pathway including the police, courts, probation, health, education, substance misuse and Youth Offending Teams (YOTs in transition to adult services).
5. Signpost to social support to ensure individuals engage with treatment until an appropriate discharge point is reached.
6. Ensure the CSTR workforce are adequately qualified to support all adults sentenced to a CSTR, are closely aligned, reflect and understand the needs of the local population.

¹ NHSE/I is the collective name for the National Health Service Commissioning Board, the National Health Service Development Authority and Monitor, acting together in respect of the statutory functions of commissioning services which rest with the National Health Service Commissioning Board (known as NHS England), part of the collective body.

CSTR Programme Aims

- Reduce offending/re-offending, by improving the health and social outcomes through rapid access to effective individualised treatment requirements (which if appropriate, and without up-tariffing², may include more than one treatment requirement).
- Provide alternatives to short custodial sentences for offenders by providing access to treatment which addresses the underlying cause(s) of the offending behaviours.
- Improve health and social care outcomes by providing evidence-based interventions, alongside GP registration and supported access to appropriate community services, as necessary.
- Providing accessible services which enable engagement for all eligible individuals irrespective of their protected characteristics as defined in the Equality Act 2010, including neurodevelopmental disorders and acquired brain injury.
- Strive for sentencing on the day where possible by providing assessment reports to inform pre-sentence reports.
- Enable access to community services through individualised support for individuals both during and after the community sentence irrespective of their protected characteristic.
- Ensure consistency of service provision within all new and existing CSTR Programme sites and develop to align to local services and population by the publication of the CSTR operating framework and corresponding documents, best practice sharing across the sites and support from the CSTR Programme team.

A secondary aim is to raise awareness for judges, magistrates, legal advisers and representatives, probation and the police of the high numbers of individuals with mental health and neurodevelopmental disorders, personality disorder and substance misuse conditions across the criminal justice pathway, including information on individuals with protected characteristics (as defined in the Equality Act 2010) who may be suitable for a CSTR.

Objectives

To achieve these aims CSTR sites will provide:

- Rapid access (where possible) to appropriate and effective assessment/interventions which may be integrated or sequenced alongside other community orders or treatment requirements.
- Services which meet the needs of all individuals irrespective of their protected characteristics as defined in the Equality Act 2010.
- Evidence based psychological interventions by skilled mental health practitioners to promote wellbeing and recovery who are cognisant and aligned to the needs of the local community.
- A local process map to ensure that all partners and stakeholders are clear of their roles and responsibilities for providing and accessing speedy CSTRs.
- A clinically led dedicated MHTR intervention service, following consent/agreement for the MHTR by the client. A case formulation will be completed along with practitioner supervision (see Clinical Leads Guidance). Clinical Leads will be appointed through the CSTR contracts to maintain clinical oversight (see Appendix 2 for more detail of the role of the Clinical Lead).
- A pathway/process for on the day DRR/ATR assessments, with clearly defined responsibilities for on-going management of any relevant requirement, including those combined with MHTRs.
- Timely access and referral into ongoing support after sentencing.

² Up-tariffing = increasing the sentence to accommodate the order requirements

- Local agreements must be in place to appropriately share information to include: Probation, HMCTS, Liaison and Diversion, Health and Substance Misuse Providers, and, where appropriate, Education. All information to be shared must be in accordance with data protection legislation and information sharing agreements need to be developed accordingly.
- A flexible service to maximise access taking into account the protected characteristics (as defined in the Equality Act 2010) which may previously have prevented access, also ensure flexibility around employment/education and family.
- Training to raise awareness of the mental health/substance misuse issues for magistrates, judges, legal advisers and representatives, police and probation providers. Sites should consider introducing feedback for courts regarding the effectiveness of the orders.

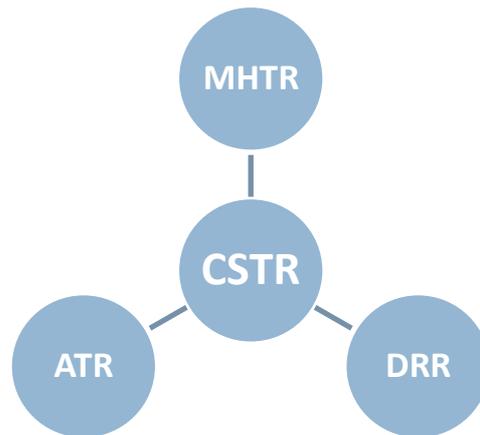
How will this provision improve community integration?

More individuals will experience:

- Improved access to mental health and substance misuse interventions: commissioning a CSTR service will increase the number of individuals over the age of 18 years who are assessed as suitable to receive individualised treatment/support to aid their recovery. Links with adult social care will help to ensure that those suspected of having social needs are assessed and, where appropriate, provided with support, or those with identified needs are considered.
- Improving access and outcomes to treatment for all individuals: supporting engagement for all adults taking into account their individualised requirements including protected characteristics as defined in the Equality Act 2010.
- Recovery and reduction in offending: appropriate treatment/interventions will address the individual's specific health, social and educational needs, identified through proactive engagement by appropriately qualified practitioners.
- Improved physical health: many individuals will not be registered with a GP, which can place an unnecessary burden on A&E, out of hours' and other emergency health services. The CSTR services would encourage GP registration, enabling improved physical health care and access to screening, continuity of prescribed medication etc.
- Effective care and support: individuals in contact with Criminal Justice Services (CJS) may have experienced years of trauma, abuse and victimisation with little care and support from appropriate services. They may have poor experiences of health, social services and may be reluctant to engage positively with staff. By addressing their mental health, substance misuse and social needs effectively and sensitively, individuals are more likely to engage in treatment and support.
- Reduced stigma and discrimination: CSTR services recognise that mental health, substance misuse and physical health are inseparable and inter-related. All vulnerabilities must be mainstreamed to remove all forms of stigma and discrimination to ensure all individuals are treated sensitively and enable access to mainstream services.
- Avoidable harm to themselves or others: assessment of risk is a key component of the CSTR services. Health and Justice staff will work closely together to develop a shared understanding of risk as it relates to mental health/substance misuse and criminogenic behaviors. Staff will be appropriately trained to provide support and interventions. Appropriate interventions will be put in place if levels of risk are raised.

2.2 Types of CSTR

The three rehabilitation requirements make up the options for service under a CSTR, and more than one set of requirements can be agreed:



Mental Health Treatment Requirement (MHTRs) may be used in relation to any mental health issue, including personality disorders and neurodevelopmental disorders such as ASC and ADHD. MHTRs can be provided by a broad range of Clinicians as long as the requirement is clinically supervised by or under the supervision of a suitably specialist registered medical practitioner or registered psychologist (CJA, 2003).

Drug Rehabilitation Requirements (DRR) are applicable where the offender is dependent on or has a propensity to misuse drugs; and that the dependency or propensity may be susceptible to treatment.

Alcohol Treatment Requirements (ATR) are applicable where the individual is dependent on alcohol, susceptible to treatment and arrangements can or have been made for treatment.

Many offenders experience mental health and substance misuse problems, but the use of treatment requirements as part of a community sentence remains low. The testbed sites have demonstrated that improved partnership working can increase the use of treatment requirements, particularly as an alternative to short term prison sentences.

All three treatment requirements were introduced as a sentencing option in the Criminal Justice Act 2003. 'Treatment' covers a broad range of interventions (for example talking therapies, medication or inpatient treatment). As members of the general population, offenders in the community should access treatment in the same way as anyone else via GP and mental health services, commissioned by NHS Clinical Commissioning Groups (CCGs) and drug and alcohol treatment services commissioned via Local Authorities. However, due to the multiple complexities of health and social needs affecting this cohort, there are few services in the community that are providing appropriate holistic treatment and care to support these orders, especially for those who don't reach the threshold of secondary care services.

ATRs and DRRs are provided through substance misuse services commissioned by the Local Authority.

MHTRs can be split into those provided by:

Primary care services: The majority of individuals sentenced to MHTRs don't reach the threshold of secondary care service. The testbed sites have demonstrated that the addition of clinically supervised mental health practitioners providing screening in court, followed by approximately 12 face-to-face individualised psychological interventions has been required to deliver primary care MHTRs.

Secondary care mental health services: When an individual's mental health condition reaches the threshold of secondary care services. This provision should already be provided through locally commissioned frameworks for secondary care.

The following criteria are used to identify individuals suitable for Secondary care mental health services:

- 18 years or over;
- Service user understands the requirement and consents to the treatment component;
- Sustained a conviction for any offence which falls into Community or Suspended Custodial Sentence range;
- Meets the local criteria for being in the Care Programme Approach (CPA) (refer to CPA policy or its proposed replacement the Community Mental Health Framework³);
- Severe and enduring mental health conditions /or a high degree of clinical complexity;
- Significant history of severe distress/instability;
- Longer term mental health problems characterised by unstable treatment adherence and requiring proactive follow up;
- Requires multiple service provisions from different agencies;
- Risk of harm to self or others and this risk exceeds what can be managed in primary care
- Requires active treatment;
- The degree of mental health difficulties significantly impacts on their daily functioning; and
- Individuals with low levels of symptoms (see Health of the Nations Outcome Scales (HoNOS) clusters 1,2 or 3) are, if a community health treatment requirement is thought necessary, probably more likely to benefit from a primary care order. If this proves insufficient a secondary care order may be considered.

Please refer to the *Secondary Care MHTR Guidance* for a comprehensive overview.

The requirements may be included in an order as either a single requirement or as part of a combination that includes other requirements (such as an MHTR/ATR or MHTR/DRR).

The following section explores the evidence from evaluations during this pilot period.

³ <https://www.england.nhs.uk/wp-content/uploads/2019/09/community-mental-health-framework-for-adults-and-older-adults.pdf>

2.3 Evidence from evaluations of MHTR

Key findings from the Process Evaluation Summary Report, published in June 2019 by the Department for Health and Social Care (with support from the National Institute for Health Research Mental Health Policy Research Unit), include:

- the MHTR pathway has filled a gap in service provision for offenders with lower level mental health problems;
- preliminary data suggests sites saw more MHTRs sentenced during the pilot than the previous year;
- in total, 441 CSTRs (ATRs, DRRs and MHTRs) were sentenced in the testbed sites over the course of the process evaluation; and
- a gap in services for those with more severe mental health problems has also been identified.

Key areas of learning from the testbed sites include:

- identification and assessment, including concerns about sufficient staff time and capacity;
- service user engagement, including concerns about breach and consent, as well as ways to facilitate this;
- the desire for central guidance around certain issues, such as funding and programme expectations; and
- the importance of multi-agency working, and factors that challenge and facilitate co-working between agencies.

Early research published in 2018 explored the perspectives of 25 offenders that received a MHTR (research by Manjunath *et al.*, 2018). It found that their core concern related to their risk of reoffending was 'instability' related to health issues and difficulties in relationships and their social support network. They recognised that the MHTR was designed to prevent their reoffending by becoming healthy, avoiding substance misuse and building a social life and support system. Most concluded that the MHTR helped their motivation to improve their lifestyles, health and relationships, but some pointed to challenges in MHTR delivery which led to increased stress under the order, including limited accessibility of their supervisor, confusion around the role of the supervisor and feeling a sense of stigma attached to the order.

Full article available at: <https://www.ncbi.nlm.nih.gov/pubmed/30402893>

2.4 Impact and Outcome Measurement

Nationally monitored via CSTR dataset (to be aggregated up from local monitoring data)

- Most of the information required (as set out below) can be collected by the treatment providers using the national CSTR National Minimum Data Set, supported by the CSTR Programme Team and local commissioning frameworks. Exceptions to this include breach information which will need to be provided by Probation and sentencer feedback forms which are completed by the judiciary/sentencer.
- In accordance with the data sharing legislation, anonymised data will be sent to the CSTR Steering Group Chair, within a format as agreed by the national CSTR Programme Board. The template will include separate tabs for MHTRs, ATRs and DRRs to allow for separate analysis of

each of the different types of treatment requirements. The data will be provided on a monthly basis and sent to the Chair by the second week of each month (or as locally agreed).

Pre-sentence

- Record and monitor the individuals assessed and in the services for the following characteristics, ensuring that the service is accessible and appropriate for all adults and in line with the Equality Impact form (EIF).
- Looked After Children/care leavers
- Number with Education, Health and Care Plans
- Source of CSTR referral
- Gender, Age and Ethnicity of individual
- Pregnancy and caring responsibilities
- Disabilities
- Armed Forces history
- Accommodation status (inc. change of accommodation status)
- Offence type
- Numbers assessed for MHTR/DRR/ATR/MHTR & DRR/MHTR & ATR
- Numbers consenting for CSTR following assessment
- Numbers of CSTRs obtaining provider approval for ATR/DRR
- Number of CSTRs obtaining MHTR Clinical Lead Approval

Sentence

- Number of CSTRs included within a Pre-Sentence Report
- Numbers of CSTRs accepted and declined by the judiciary (Accepted MHTR, DRR, ATR, MHTR & DRR, MHTR & ATR vs declined MHTR, DRR, ATR)
- Number of CSTRs sentenced on the day (within 24 hours)
- Number of sentencer feedback forms completed
- Additional data collected from the judiciary to highlight what the sentence may have been if the CSTR was not an available option (this data can help indicate instances where a short custodial sentence might otherwise have been ordered)

Post-Sentence

- Timing of multi-disciplinary review meeting post sentence
- Number of cases breached by the court (compiled by Probation) and information about how many were subsequently re-sentenced to a CSTR and how many were sentenced to custody
- Number of individuals registered with GP as a result of CSTR

Sentence completion

- Numbers completing CSTR requirements
- Current number of active requirements/numbers accessing and engaging with CSTRs
- Pre and post clinical outcomes (For MHTRs – CORE34, GAD7, PHQ9, SU/SH and for ATR/DRR relevant TOPS data as specified in the data template)
- E.g. Change in levels of psychological distress, accommodation status, coping skills with work/social adjustment, changes to health and social outcomes

In addition, we also expect local sites to collect the following information. Again, most of this information will be completed by treatment providers, however probation will also conduct independent assessments of risk (i.e. harm to self and others and risk of reoffending), breach reasoning and may also have key information needed to determine court adjournments. It would be

expected that the CSTR providers capture the additional data below which will be shared at each steering group meeting and provides detail to the NMDS with a view to local service development and improvement.

- Reasons given for Clinical Lead and/or Substance Misuse Provider accepting/declining an individual a CSTR and health/social support recommended
- Consent to be recorded by treatment providers, *as well as* by probation on n-delius
- Number of court adjournments and reasons (due to assessments not being available on the day or court led adjournment)
- If the court declines a CSTR, reasons to be recorded and detail of the health and social support recommended to be noted
- Whether an individual is registered with a GP (either before sentence or prior to treatment commencing)
- Reasons given for any instances of breach or individuals not completing the requirement
- Record if the breach directly related to the CSTR or another requirement within the court's order
- Levels of risk to self and others pre and post intervention
- Wider changes to health and social outcomes, changes in levels of psychological distress, coping skills with work/social adjustment, participation in constructive activities, NEET measures
- Monitor and record health outcomes, including 3, 6, 12-month post sentence completion (MHTR)
- Numbers referred to other relevant services post completion of sentence
- Experience and care outcomes
- Number of awareness sessions to include mental health, substance misuse and associated vulnerabilities for: judges, magistrates, legal representatives and other representatives, probation etc.

And to document/detail:

- Any improvements in CJS partnership/interdisciplinary relationships
- Relevant information agreements and data sharing agreements

The national team will also look to monitor reductions in re-offending outcomes for those who have completed a CSTR as part of the CSTR Programme.

3 Overview of Court

All criminal cases in England and Wales start in the magistrates' court, and the more serious cases are then sent to the Crown Court. Appeals and civil cases are dealt with differently, and tribunals have their own system (see <https://www.judiciary.uk/about-the-judiciary/the-justice-system/court-structure>).

3.1 The Magistrate's Court

In the magistrates' court, cases are heard by either 2 or 3 magistrates or a district judge. There is no jury in the magistrates' court. A magistrates' court normally handles 'summary offences', including most motoring offences, minor criminal damage, common assault (not causing significant injury) and can also deal with some of the more serious offences, such as burglary and drugs offences (these are called 'either way' offences and can be heard either in a magistrates' court or a Crown Court).

Magistrates always pass 'indictable offences' to the Crown Court, including robbery, rape and murder.

In some cases, the magistrates' court will decide if the individual should be kept in custody ('remanded') until their next court hearing or released on bail. This happens when another court hearing is needed, the court needs more information before passing sentence or the case is passed to the Crown Court for trial or sentencing.

Where individuals are released on bail, they generally have to follow strict conditions such as keeping away from certain people or places, staying indoors or wearing a tag.

Sentences⁴ a magistrates' court can give include:

- up to 6 months in prison (or up to 12 months in total for more than one offence);
- a fine;
- a community sentence, like doing unpaid work in the community;
- a ban, for example from driving or keeping an animal; and
- a combination of the above, for example a community sentence and a fine.

3.2 Sentencing and Community Orders

3.2.1 General principles

Community orders can fulfil the purposes of sentencing. In particular, they can have the effect of restricting the offender's liberty while providing punishment in the community, rehabilitation for the offender, and/or ensuring that the offender engages in reparative activities⁵.

⁴ Source: <https://www.gov.uk/courts>

⁵ Source: <https://www.sentencingcouncil.org.uk/offences/magistrates-court/item/sentencing-offenders-with-mental-health-conditions-or-disorders-for-consultation-only/>

A Community Order must not be imposed unless the offence is 'serious enough to warrant such a sentence'. Where an offender is being sentenced for a non-imprisonable offence, there is no power to make a community order. Sentencers must consider all available disposals at the time of sentence; even where the threshold for a community sentence has been passed, a fine or discharge may be an appropriate penalty. In particular, a Band D fine may be an appropriate alternative to a Community Order.

The court must ensure that the restriction on the offender's liberty is commensurate with the seriousness of the offence and that the requirements imposed are the most suitable for the offender. The Female Offender Strategy⁶ (2018) promotes the use of community sentences including MHTR for female offenders.

Sentences should not necessarily escalate from one community order range to the next on each sentencing occasion. The decision as to the appropriate range of community order should be based upon the seriousness of the new offence(s) (which will take into account any previous convictions). Save in exceptional circumstances at least one requirement must be imposed for the purpose of punishment and/or a fine imposed in addition to the community order. It is a matter for the court to decide which requirements amount to a punishment in each case.

Offenders can only be sentenced to a CSTR (as part of a community order) if a guilty plea has been entered or the individual has been found guilty after trial. The offence committed must have reached at least the threshold of a community order range as outlined in the Sentencing Council Guidelines. The offence and the sentencing range (as outlined in the Guidelines) will assist in determining the number and length of the requirements which may be attached to the order.

Generally, the use of combined treatment requirements can only be considered if the offence has reached at least the medium sentencing level of the community order range and above. However, these are sentencing guidelines and the courts may exercise discretion for each individual case. For those cases where the threshold for a community order has not been reached or the level of mental health/substance issues identified do not meet the criteria for a requirement, identify appropriate pathways to local support in partnership with Liaison and Diversion services.

3.2.2 Community Order Levels

The seriousness of the offence should be the initial factor in determining which requirements to include in a community order. Offence-specific guidelines refer to three sentencing levels within the community order band based on offence seriousness (low, medium and high). The culpability and harm present in the offence(s) should be considered to identify which of the three sentencing levels within the community order band (low, medium and high) is appropriate.

At least one requirement must be imposed for the purpose of punishment and/or a fine imposed in addition to the community order unless there are exceptional circumstances which relate to the offence or the offender that would make it unjust in all the circumstances to do so. A full list of requirements, including those aimed at offender rehabilitation, is given below.

⁶https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/719819/female-offender-strategy.pdf

Community Order bands, descriptions and suitable requirements (Sentencing Guidelines⁷)

Low	Offences only just cross community order threshold, where the seriousness of the offence or the nature of the offender's record means that a discharge or fine is inappropriate. In general, only one requirement will be appropriate and the length may be curtailed if additional requirements are necessary.	<ul style="list-style-type: none"> ▪ Any appropriate rehabilitative requirement(s) ▪ 40 – 80 hours of unpaid work ▪ Curfew requirement within the lowest range (for example up to 16 hours per day for a few weeks) ▪ Exclusion requirement, for a few months ▪ Prohibited activity requirement ▪ Attendance centre requirement (where available)
Medium	Offences that obviously fall within the community order band	<ul style="list-style-type: none"> ▪ Any appropriate rehabilitative requirement(s) ▪ Greater number of hours of unpaid work (for example 80 – 150 hours) ▪ Curfew requirement within the middle range (for example up to 16 hours for 2 – 3 months) ▪ Exclusion requirement lasting in the region of 6 months ▪ Prohibited activity requirement
High	Offences only just fall below the custody threshold or the custody threshold is crossed but a community order is more appropriate in the circumstances. More intensive sentences which combine two or more requirements may be appropriate.	<ul style="list-style-type: none"> ▪ Any appropriate rehabilitative requirement(s) ▪ 150 – 300 hours of unpaid work ▪ Curfew requirement for example up to 16 hours per day for 4 – 12 months ▪ Exclusion requirement lasting in the region of 12 months

Whilst the offence types do not map directly onto the matrix above, as the judiciary judges each case on its merits, the following list provides an overview of different offences typically captured across the existing sites:

- Public Order - Nuisance
- Harassment
- Drug offences
- Criminal Damage
- Arson
- Theft
- Burglary
- Robbery
- Fraud and Forgery
- Possession of an offensive weapon
- Possession of a firearm
- Violence against the person
- Murder - Manslaughter
- Sexual Offence
- Breach Court Order
- Vehicle Crime
- Motoring Offences

⁷ <https://www.sentencingcouncil.org.uk/offences/magistrates-court/item/sentencing-offenders-with-mental-health-conditions-or-disorders-for-consultation-only/>

3.2.3 Community Order Requirements

Community Orders consist of one or more of the following requirements⁸:

- **unpaid work requirement** (40 – 300 hours to be completed within 12 months)
- **rehabilitation activity requirement** (RAR's provide flexibility for responsible officers in managing an offender's rehabilitation post sentence. The court does not prescribe the activities to be included but will specify the maximum number of activity days the offender must complete. The responsible officer will decide the activities to be undertaken. Where appropriate this requirement should be made in addition to, and not in place of, other requirements. Sentencers should ensure the activity length of a RAR is suitable and proportionate).
- **programme requirement** (specify the number of days)
- **prohibited activity requirement** (must consult National Probation Service)
- **curfew requirement** (2 – 16 hours in any 24 hours; maximum term 12 months; must consider those likely to be affected; see note on electronic monitoring below)
- **exclusion requirement** (from a specified place/places; maximum period 2 years: may be continuous or only during specified periods; see note on electronic monitoring below)
- **residence requirement** (to reside at a place specified or as directed by the responsible officer)
- **foreign travel prohibition requirement** (not to exceed 12 months)
- **mental health treatment requirement** (may be residential/non-residential; must be by/under the direction of a registered medical practitioner or registered psychologist. The court must be satisfied: (a) that the mental condition of the offender is such as requires and may be susceptible to treatment but is not such as to warrant the making of a hospital or guardianship order (within the meaning of the Mental Health Act 1983 provided below); (b) that arrangements for treatment have been or can be made; (c) that the offender has expressed willingness to comply).
- **drug rehabilitation requirement** (the court must be satisfied that the offender is dependent on or has a propensity to misuse drugs and is such as requires and may be susceptible to treatment. The offender must consent to the order. Arrangements for treatment have been or can be made. Treatment can be residential or non-residential, and reviews must be attended by the offender (subject to application for amendment) at intervals of not less than a month (discretionary on requirements of up to 12 months, mandatory on requirements of over 12 months))
- **alcohol treatment requirement** (the court must be satisfied that the offender is dependent on alcohol and that the dependency is such as requires and may be susceptible to treatment. The offender must consent to the order. Arrangements for treatment have been or can be made. Treatment can be residential or non-residential, and reviews must be attended by the offender (subject to application for amendment) at intervals of not less than a month (discretionary on requirements of up to 12 months, mandatory on requirements of over 12 months))
- **alcohol abstinence and monitoring requirement** (where available)
- **attendance centre requirement** (12 – 36 hours. Only available for offenders under 25).

⁸ Source: Sentencing Council

3.2.4 Mental Health Treatment Requirements

The Sentencing Council states that if the court is considering making a Mental Health Treatment Requirement, sentencers should first seek assurance that the proposed treating psychiatrist or psychologist is aware of the duty to inform the court of any non-compliance with the order.

Referrals can be made by different parties including:

- Police custody officers
- Probation (both NPS/CRC)
- Legal representatives
- Liaison and Diversion staff
- Court staff
- Substance misuse services
- Community mental health services
- Self-referrals
- Carers and family members
- Appropriate adults

Mental Health Treatment Requirement⁹ (Sentencing Council¹⁰ – 01/10/2020)

Maybe made by:	A magistrates' court or Crown Court
In respect of an offender who is:	Convicted of an offence punishable with imprisonment
If the court is of the opinion:	That the mental condition of the offender is such as requires and may be susceptible to treatment but does not warrant detention under a hospital order. The treatment required must be such one of the following kinds of treatment as may be specified in the relevant order— (a) treatment as a resident patient in a care home an independent hospital or a hospital within the meaning of the Mental Health Act 1983, but not in hospital premises where high security psychiatric services within the meaning of that Act are provided; (b) treatment as a non-resident patient at such institution or place as may be specified in the order; (c) treatment by or under the direction of such registered medical practitioner or registered psychologist (or both) as may be so specified; but the nature of the treatment is not to be specified in the order except as mentioned in paragraph (a), (b) or (c).
And the court is satisfied:	That arrangements have been or can be made for the treatment to be specified in the order and that the offender has expressed a willingness to comply with the requirement.

⁹ Source: <http://www.legislation.gov.uk/ukpga/2003/44/section/207>

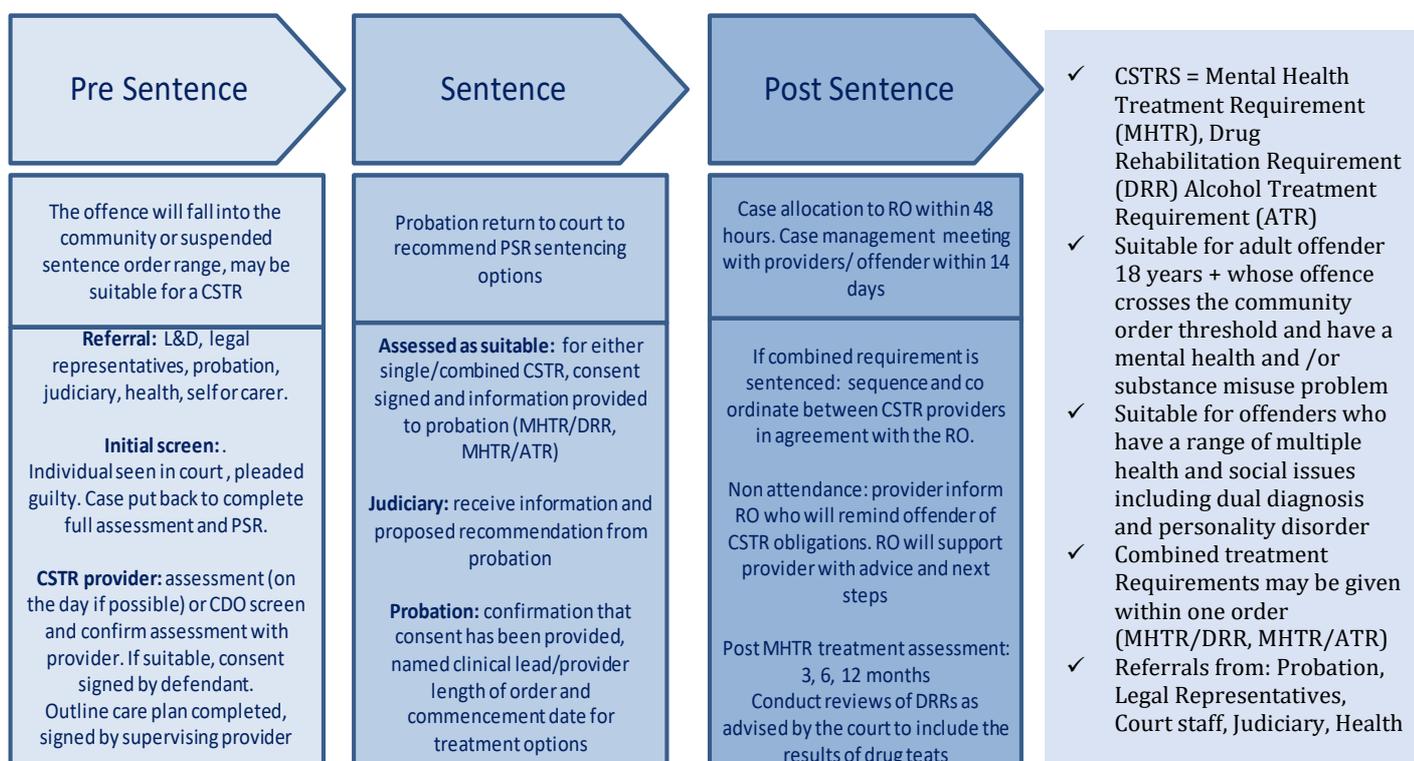
¹⁰ Source: <https://www.sentencingcouncil.org.uk/offences/magistrates-court/item/sentencing-offenders-with-mental-health-conditions-or-disorders-for-consultation-only>

In addition to these sentencing guidelines, the following guidance is provided¹¹:

- Where the defendant’s culpability is substantially reduced by their mental state at the time of the commission of the offence, and where the public interest is served by ensuring they continue to receive treatment, a MHTR may be more appropriate than custody;
- Even when the custody threshold is crossed, a Community Order with a MHTR may be a proper alternative to a short or moderate custodial sentence; and
- A MHTR is not suitable for an offender who is unlikely to comply with the treatment or who has a chaotic lifestyle.

3.3 CSTR in the sentencing process

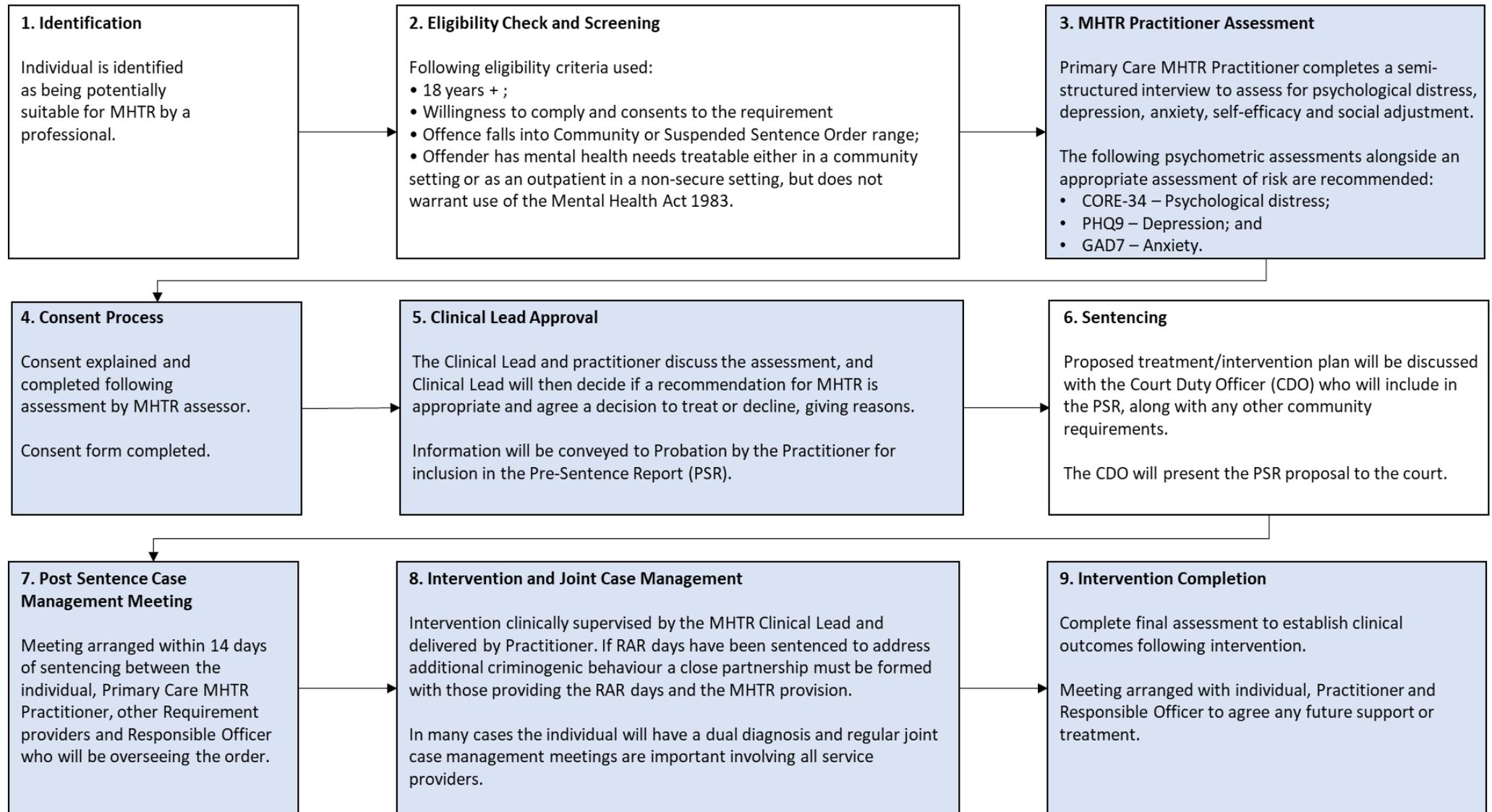
The table below summarises the key actions and decisions points that take place during the sentencing process to enable the implementation of a CSTR.



A typical step-by-step MHTR pathway is provided, with full guidance is provided in the Clinical Lead Manual, and each stage that typically involves the Primary Care MHTR Practitioner is shaded blue:

¹¹ Source: [http://www.mhldcc.org.uk/contents/14-sentencing/c-sentencing-options/ii-mental-health-treatment-requirement-\(mhtr\).aspx](http://www.mhldcc.org.uk/contents/14-sentencing/c-sentencing-options/ii-mental-health-treatment-requirement-(mhtr).aspx)

MHTR Process



4 Practicalities of Delivering the MHTR

This section seeks to provide some insight and helpful reminders about the practical aspects of identifying offenders for the MHTR, what the screening process entails, and advice related to delivering treatment and managing issues of safeguarding, breach of order and non-compliance.

Detailed information about the MHTR intervention is provided in the Clinical Lead Manual.

4.1 Eligibility check and screening

The initial identification and CSTR screen will typically be completed either in police custody or in court on the morning of the day of sentencing.

A probation single point of contact will be made available for all pre and post sentence queries along with telephone number/email to all relevant services. The service will proactively work with agencies to ensure that practitioners understand who can be referred and the process for referral.

The majority of cases identified for a mental health screening and potential MHTR are identified by Probation officers, Liaison and Diversion staff and police custody officers. However, referrals for Probation and the Courts to consider MHTR can be made by any party at the point of first hearing – for example by legal representatives, substance misuse or community mental health services that might know the individual, family members and carers.

In addition to the sentencing guidelines outlined above in Section 3.2, this is a brief reminder of the criteria that need to be met in order for Probation and the Courts to consider a MHTR:

- 18 years + ;
- The offender has expressed a willingness to comply and consents to the requirement (if someone does not consent then other sentencing options will be considered by Probation and Judiciary);
- The offence falls into Community or Suspended Sentence Order range, where the offender pleads guilty or is found guilty after trial;
- The offender has a mental health condition that can be addressed either in a community setting or as an outpatient in a non-secure setting, but does not warrant use of the Mental Health Act 1983;
 - This includes those with Mental Health (from depression/anxiety through to secondary care mental health issues), Personality Disorder difficulties, neurodevelopmental disorders (e.g. ASC and ADHD) and/or acquired brain injury will not be excluded;

Reasonable adjustments will be made to accommodate individual needs and no individual shall not be discriminated against based upon any protected characteristics in line with the Equality Act (2010). There is no need for a medical or psychiatric report evidencing that the person is suffering from a mental disorder prior to putting the person forward for consideration of a MHTR.

- Individuals subject to these requirements may have several vulnerabilities, including mental health, substance misuse, autism, learning/communication difficulty

- Adjustments will be made to ensure that the services are accessible to individuals subject to these requirements (e.g. easy read, information available in relevant languages, treatments offered in suitable and accessible locations (inc. telephone/virtual) taking into account physical/mental health requirements and individual circumstances)
- Childcare and general caring responsibilities will be taken into consideration.
- Supported engagement to ensure equality of service is provided irrespective of the presenting protected characteristic

In ideal circumstances, private rooms will be made available for the eligibility and screening check in the court building or in police custody. The initial screening can be undertaken by the Liaison and Diversion team, Probation officer or dedicated Link Worker.

The specific screening tools are agreed at the local level, but overall they are assessing the person for signs of:

- mental health needs;
- substance misuse;
- safeguarding;
- social and relationship issues;
- caring responsibilities;
- housing issues;
- financial issues;
- drug and alcohol use;
- challenges with daily living;
- work or education-related issues.

If screens do not indicate CSTR suitability but the individual requires support in other areas such as those outlined above, the individual can be further assessed by L&D and supported into appropriate local services.

If screened and the score indicates a likelihood of psychological distress, the Court Duty Officer (CDO) will be informed, and the mental health providers notified once a plea has been taken. Consideration to be given to support the people in court, depending on level of vulnerability, assessor to discuss with CDO. Consideration should also be given to support individuals with communication difficulties in court through, for example, easy read documentation or support from a Registered Intermediary.

As with all clients coming through the courts, if they live and reside within the post code area that the CSTR site is operating and there is a General Practitioner (GP) who is willing to register them before commencement of treatment/intervention, and they have been assessed as suitable and provided consent which has been approved by the CL; then there should be no reason why CSTR cannot be offered. It is expected, however, that individuals will be registered with a GP before commencement of the MHTR intervention.

As GP registration is a pre-requisite condition of an MHTR being used, the National Probation Service is responsible in pre-sentence reporting to ensure in advance that this condition is met and to advise the court on this matter.

The recommended screening tools which may act as a trigger for further assessment include:

- Kessler-10
- CORE-10
- CORE-34

During the screen/assessment processes, the assessor must ensure that material is available in appropriate language/easy read formats. If interpretation is required, the assessment may need to be put back to allow time to book an interpreter. In addition, the assessor must ensure that the assessor is skilled to engage effectively with all adults ensuring an equality of service is available and provided.

4.2 MHTR practitioner assessment

The MHTR Practitioner Assessment will be typically completed by an Assistant Psychologist or other trained professional. Where possible, it is preferable that the Practitioner who delivers the intervention completes the MHTR Practitioner Assessment.

The practitioner will use a semi-structured interview that focuses on engagement, motivation, fact-finding and captures a range of data including mental health and forensic history, current involvement in treatment, use of medication, and life problems.

Psychometric assessments will screen for psychological distress, depression, anxiety, self-efficacy and social adjustment. The outcome of the assessment interview would determine the appropriate psychological intervention or signposting to other services.

The recommended psychometric assessments alongside an appropriate assessment of risk include:

- CORE-34 – Psychological distress
- PHQ9 - Depression
- GAD7 – Anxiety

Other psychometric assessments may be completed on a case-by-case basis determined by the professional judgement of the Clinical Lead or Assistant Psychologist/Primary Care MHTR Practitioner based on needs and presentation of the individual.

Additional questions and information gathering through semi-structured interview may include:

- Speech and communication needs
- Identification of vulnerabilities including history of trauma and abuse
- Drug and alcohol issues
 - What is the impact of any drug and alcohol use on the ability to engage with psychological work?
- Social circumstances (including relationships inc. childcare, leisure requirements, daily living, educational and occupational needs, employment/vocational needs, housing, finance)
 - Briefly enquiry about: Childhood, Education, Family system, Employment, Relationships and Support networks
- Identification of cultural, age and gender needs
- Physical health needs – management of physical health conditions
- Medication – medication history inc. allergies

- Check current medication use
- Previous forensic history
 - Other agencies/ services currently helping you and your family with your problems?
 - What previous help/therapy have you had for your mental health and wellbeing? What helped?
 - Is there an existing diagnosis including co morbidity?
- Risk assessment
 - Any current or past thoughts of self-harm, suicide. If so, a more detailed assessment of this specific risk must be completed and result in a crisis plan being developed.
 - Any safeguarding concerns (inc. gang issues, exploitation, modern slavery)? If so, follow organisational policy.
- What are your MHTR goals?
- What is the main problem /difficulty affecting you?
- Have there been times when things have felt better? Enquire about helpful coping techniques?
- Are there any barriers to attendance? Consider childcare arrangements, COVID-19 restrictions; access to communication devices; gang affiliations etc.
- Is there anything you feel might be important or relevant that we haven't discussed?

The practitioner will then explain the MHTR process and if suitable will gain consent (see step 4) for the order to be proposed.

If any of these processes identify mental health and substance misuse issues the assessor will liaise with the substance misuse providers (if in court) or the Court Duty Officer to discuss appropriateness of assessment for a combined CSTR (MHTR/DRR or MHTR/ATR).

Please see **Appendix 1 for Example of MHTR Practitioner Assessment Template.**

4.2.1 Delays in assessment

Courts can adjourn to carry out assessments and to arrange treatment where necessary, for example where there is information required that cannot be obtained for preparation of the assessment and presentence report to assist the court in sentencing the offender at the first hearing.

Wherever possible, sentencing should take place on the same day to meet the current HMCTS target to complete 80% of cases at the first hearing and the expectation that 90% of pre-sentence reports are oral or fast delivery reports.

4.3 Consent process

Consent explained and completed following assessment by MHTR assessor.

Assessor will fully explain the MHTR treatment including: What will be expected, and it is their choice to engage. However, if they do not engage once MHTR is ordered then their case will be discussed with Probation who will contact the individual and explain next steps, which could include Breach and return to court.

Please see **Appendix 2 for Example of Combined Consent**

4.4 Clinical lead or responsible clinician approval

Once consent is provided, the practitioner will contact the MHTR Clinical Lead for primary care MHTR approval and sign off.

The Clinical Lead and practitioner discuss the assessment, and Clinical Lead will then decide if a recommendation for MHTR is appropriate and agree a decision to treat or decline, giving reasons. This information will be conveyed to Probation by the Primary Care MHTR Practitioner for inclusion in the Pre-Sentence Report (PSR).

Please see **Appendix 3 for Example of Information from Clinical Lead Approval for PSR**

4.5 Delivering the intervention

The treatment plans produced for clients on MHTRs usually entail approximately 12 one-to-one sessions with an Assistant Psychologist (AP). However, MHTR treatment can be provided by registered medical practitioner or a registered psychologist, which includes forensic psychologists, community psychiatric nurses, approved social workers or other similarly recognised and qualified practitioners.

The requirements are provided by or under the direction of a Responsible Clinician (RC), who is a suitably specialist registered medical practitioner or a registered psychologist (or both, for different periods). The local site CL will determine the structure and content of the intervention, and will provide bespoke training to the AP. An overview of example interventions and suggested content is provided in the Clinical Lead Manual.

The sessions are designed to provide guidance, support, tools and strategies using a broad range of therapeutic techniques to address the issues and problems identified through the assessment process.

They can also utilise value-based interventions, problem-solving and behavioural activation strategies alongside psychosocial education and skills development to help clients manage their emotions and reduce emotional distress.

Adjustments will be made to ensure that the services are accessible to individuals subject to these requirements (e.g. easy read, information available in relevant languages, treatments offered in suitable and accessible locations taking into account physical and mental health requirements). Supported engagement to ensure equality of service is provided irrespective of the presenting protected characteristic. Specialist advice should be sought to ensure vulnerable individuals are appropriately supported to engage with services.

4.5.1 *Timeframe for treatment delivery*

Locally commissioned services should include treatment that meets the specific needs of offenders on community sentences with MHTRs, DRRs and ATRs, and which can be accessed in a timely manner, in accordance with the order and as specified by the court. Waiting times (from the date of

sentence) should be in line with the general population. For mental health treatment, this is six weeks for psychological therapies and two weeks for those experiencing a first episode of psychosis but may be longer for those with ADHD/ASC.

The length of time over which the sessions are delivered should be recommended in the pre-sentence report (PSR) and would depend on the treatment needs identified, provided the overall restriction on liberty imposed by the Community Order or Suspended Sentence Order in its totality is commensurate with the seriousness of the offence(s).

A CSTR can last for a maximum of three years as part of a Community Order and two years as part of a Suspended Sentence Order. There is no longer a minimum length in law. In practice, however, CSTRs are usually much shorter as individuals won't need to spend two to three years in treatment.

Courts have the discretion to decide that a Suspended Sentence Order be subject to periodic review, including those with an MHTR. However, there is no power in law for MHTRs to be reviewed where part of a Community Order (unlike Drug Rehabilitation Requirements, which are reviewed).

In practice, APs will meet with a client on a weekly/fortnightly basis.

4.5.2 MHTR Completion

On completion of the MHTR, advice, signposting and, where necessary, appropriate referrals can be made if someone has any remaining mental health concerns. This could include the continuation of appropriate treatment after the end of the requirement.

It is recommended that local service provision, including threshold criteria and availability, is collated into a resource that can be shared with clients at the end of treatment. This resource might include the following:

- Mental health and crisis helplines (national and local);
- Local services and contact details;
- Recommended resources such as apps, books or online sites; and
- Publicly available information to improve health and wellbeing, such as Public Health England resources.

It is also recommended that MHTR providers consider 1 – 3 additional sessions with clients following completion based on individual needs.

4.6 Safeguarding

MHTR providers may identify safeguarding concerns. These concerns may relate directly to the individual or the welfare and safety of other adults or children. These adults or children may reside at the persons place of residence or may have regular contact with them.

MHTR practitioners, and all related partners and stakeholders, must follow the Adult & Child Safeguarding policies involving Multi-Agency Safeguarding Hubs (MASH) or Multi-Agency Public Protection Arrangement (MAPPA) as necessary and ensure they are appropriately trained and updated in line with these policies. All staff employed and engaged in working with individuals subject to a MHTR must have the appropriate level of Disclosure and Barring Service check which is regularly updated.

Sharing of information and confidentiality policies must be in place with the appropriate statutory authorities.

The MHTR providers must, on request, provide evidence to demonstrate compliance with all statutory requirements, including:

- NHS Constitution
- Mental Health Act 1983 and Care Act 2014
- NHS Community Care Act 1990 and associated guidance
- NHS Act 2006
- Health and safety requirements
- Healthy Children Safer Communities (DoH, 2009)
- Children Act 1989
- Children Act 2004
- Human Rights Act 1998
- Care Programme Approach
- Care Quality Commission Standards
- NHS complaints procedure
- Data protection legislation

4.7 Breach of order and non-compliance

A client can withdraw their consent for the MHTR at any time, which would be considered a breach and the order would then be returned to court for re-sentencing.

The Responsible Officer from the National Probation Service (NPS) will take overall responsibility for making any necessary arrangements in connection with the requirement, and in promoting the offender's compliance with the order. Therefore, NPS will make decisions regarding breach of the MHTR based on information given them by the MHTR practitioner and their own assessment.

MHTRs are intended as supportive requirements which seek to support offenders with their mental health issues in order to improve their prospects of reducing reoffending. As such, enforcement is concerned with breaching the conditions of the order but not the treatment itself. However, in practice this can be challenging to define, and MHTR practitioners are encouraged to keep communication with the Responsible Officer regarding cases where breach may be a concern.

Probation are provided the following instruction regarding the management of missed appointments for individuals on Community Orders:

- It is important that staff in the NPS understand the interfaces between each organisation in order to ensure effective enforcement of Community Orders. It is also important for probation service providers to continue to maintain contact, where possible, with offenders and encourage ongoing engagement with the court order;
- The final decision rests with the NPS on whether or not to proceed with presenting the breach based on the evidence presented in the enforcement information. In these circumstances, full consideration should be given by all providers via discussion as to the reasons for not proceeding to breach. Breach information must be of sufficient quality to enable the Enforcement Officer to present the case. The standard of sufficient quality

requires that the breach information meets the minimum standards of evidence and information required to present the breach in court and that this evidence and information is accurate, coherent and comprehensive; and

- The Responsible Officer must make a decision whether to refer the matter to the Enforcement Officer when an offender fails to comply with their order by the 6th working day after the alleged second unreasonable failure to comply. There are a number of reasons why offenders fail to comply and it is not the intention of this Instruction to provide an exhaustive list. Clearly, every effort must be made by the Responsible Officer to allow the offender to submit reasonable excuse for non-compliance; however, this process should not delay the timetable for the breach process. The decision to breach or not, should be clearly recorded within case records in order to ensure the decision-making process is documented.

If a breach occurs, the MHTR provider will report non-attendance to the Offender Manager and a treatment plan will be provided to the Offender Manager which may be presented in court. It is recognised that reporting a breach may damage the therapeutic relationship between the MHTR practitioner and the client, however, breach is important for establishing boundaries for specific behaviours or issues of persistent non-compliance. It is crucial effective communication is maintained between the MHTR practitioner/provider and the Responsible Officer to ensure effective management of the Community Order as well as the mental health intervention.

Maintaining contact between services and people with mental health illness and/or substance misuse is challenging. A brief summary of issues is outlined below:

It is important to recognise that even though building a relationship with the person and seeing even small improvements may take a long time, it is worth persevering. It involves:

- showing empathy and using a non-judgemental approach to listen, identify and be responsive to the person's needs and goals;
- providing consistent services, for example, if possible keeping the same staff member as their point of contact (especially for individuals with ASC) and the same lead for organising care; and
- staying in contact by using the person's chosen method of communication (for example, by letter, phone, text, emails or outreach work, if possible).

It is important to explore with the person why they may stop using services that can help them. This may include:

- fragmented care or services;
- inflexible services (for example, not taking into account that the side effects the person may experience from medication may affect their attendance at appointments);
- inability to attend because, for example, services are not local, transport links are poor, or services do not provide childcare;
- not being allowed to attend, for example because they have started misusing substances again;
- fear of stigma, prejudice or being labelled as having both mental health and substance misuse problems;
- feeling coerced into using treatments or services that do not reflect their preferences or their readiness to change;
- previous poor relationships with practitioners; and
- other personal, cultural, social, environmental (e.g. gang affiliation) or economic reasons.

It is important help those who may find it difficult to engage with services to get into and stay connected with services. In particular, people with coexisting severe mental illness and substance misuse are at higher risk of not using, or losing contact with, services. There are specific populations who are more at risk. These include men, young people, older people and women who are pregnant or have recently given birth. It also includes:

- people who are homeless;
- people who have experienced or witnessed abuse or violence;
- people with language difficulties;
- people who are parents or carers who may fear the consequences of contact with statutory services; and
- young adults.

It is important to ensure any loss of contact or non-attendance at any appointment or activity is viewed by all practitioners involved in the person's care as a matter of concern. Follow-up actions could include:

- contacting the person to rearrange an appointment;
- visiting the person at home;
- contacting any other practitioners involved in their care, or family or carers identified in the person's care plan; and
- contacting the person's care coordinator within mental health services in the community immediately if there is a risk of self-harm or suicide, or at least within 24 hours if there are existing concerns.

5 Partnerships

CSTRs can only be delivered through defined delivery partners who work closely together in partnership, have clarity of roles, responsibilities, share information and have clear lines of communication. The delivery partners include:

- National Probation Service (NPS)
- Judiciary (Magistrates and Judges)
- HM Courts & Tribunals Service (HMCTS)
- Liaison and Diversion service (L&D) provider(s)
- CSTR providers for: MHTR, DRR and ATR
- Community Rehabilitation Company (CRC)
- Third sector organisation
- Voluntary and Lived Experiencer groups

Stakeholders related to CSTRs do not play a role in the delivery or management of the CSTR, but play an important role in ensuring services are commissioned in ways that support CSTR provision and that colleagues across the criminal justice process support CSTRs in practice. Stakeholders often have influence over the performance and evaluation of CSTRs and therefore have a significant influence over their use. The stakeholders include:

- Police and Crime Commissioners
- Judiciary and Court Staff
- Lived experience groups (inc. victims of crime and/or those with lived experience of offending where appropriate)
- Local Health and Social care partners (including Local Authority)
- Police
- Legal Representatives
- Crown Prosecution Service (CPS)
- Clinical Commissioning Group (CCG)
- Health and Justice Commissioners (NHS England)
- Youth Offending Team (YOT) for those in transition to adult services

5.1 Key roles involved in the MHTR

The following is a list of key individuals involved in the MHTR process:

Primary Care MHTR Practitioner is central to the MHTR pathway, typically completing the practitioner assessment and agreeing suitability for an MHTR with the Clinical Lead, completing the treatment intervention with clients, communicating with the responsible officer and relevant partner services throughout the order, and attending the CSTR steering group and other locally appropriate governance structures.

Clinical Lead / Responsible Clinician will work directly with the Primary Care MHTR Practitioner to oversee the assessment process, determining suitability, providing information to complete the Pre-Sentence Report, managing and supporting the Primary Care MHTR Practitioner during treatment.

The Primary Care MHTR Practitioner will typically be trained by the Clinical Lead and receive regular supervision.

Responsible Officer (RO) from Probation will work directly with service users managing, supervising and enforcing Court Orders and post custody license periods. They assess the risk service users pose to the public, identify service user needs to achieve community reintegration, monitor their progress and help service users to achieve successful completion of court orders and post custodial supervision periods.

The Primary Care MHTR Practitioner will typically meet the RO for each client in the Post Sentence Case Management Meeting.

Liaison and Diversion Team members identify people who have mental health, learning disability, substance misuse or other vulnerabilities when they first come into contact with the criminal justice system as suspects, defendants or offenders. They support people through the early stages of criminal system pathway, refer them for appropriate health or social care or enable them to be diverted away from the criminal justice system into a more appropriate setting, if required.

The Primary Care MHTR Practitioner will typically meet members of the L&D team in court and will be a key point of contact for nominating individuals to undertake the MHTR Practitioner Assessment.

Court Duty Officers (CDOs) undertake a full range of offender management tasks with offenders under supervision including assessment, sentence implementation and producing reports; utilising service procedures and practice directions to underpin professional judgement.

The Primary Care MHTR Practitioner will typically meet CDOs in court and will be a key point of contact for communicating information to the Court.

Alcohol and Drug Service workers will complete assessments with clients to determine eligibility for ATR and DRR pathways respectively, and deliver treatment for clients where when sentenced to an ATR or DRR.

The Primary Care MHTR Practitioner will typically meet Alcohol and Drug Service workers in the Post Sentence Case Management meeting, when clients are sentenced to a ATR or DRR alongside the MHTR, where the timings of the respective treatments will be agreed.

5.2 Partnership in practice recommendations

The following are recommendations provided by existing Primary Care MHTR Practitioners:

“Close contact with organisations providing practical support and with the Responsible Officer is essential for positive outcomes”

“I find the initial 3 way meeting with the RO, client and myself helpful to engage the client in the MHTR, be clear and transparent about treatment and openly discuss expectations of attendance and engagement.”

“I found it helpful to go to Probation/Courts/Third Sector Organisations to introduce myself when I started in my post, knowing the person helped a lot in further communication”

“Copying all partners into emails regarding the delivery of the CSTR is helpful in keeping everyone in the loop. For example, I often have a 3 way meeting with myself, probation and the women’s centre”

“I have weekly catch up meetings with Probation at the women’s centre on what’s going on, changes in circumstances including gang-related violence that I need to be aware of when booking service users in, as some cannot be at the centre at the same time”

“We outline the partner roles and responsibilities with the clients, as well as align the Service needs to the benefit of the client”

“It’s vital to have all partners direct contact details”

“For example, I have a client who I thought might benefit from some goal setting work. I asked his Prison Advice and Care Trust mentor if she would be able to help with this. She did and it enabled the client and I to focus on mental health issues, while he learned practical skills in her sessions. This meant that we did not duplicate our work and we were able to maximise the benefits to the client.”

“Transparency and sharing information with partners, with the client’s consent”

“Clients can often be working with Education, Training and Employment workers, substance misuse teams, group providers, education providers etc. as well as the RO and myself. I find it really helpful to joint work with all of the different agencies to support clients effectively. Taking a holistic approach with forensic clients is essential”.

“Develop good working relationships with all partners to ensure meaningful outcomes across the partnership, including the women’s centre and third sector organisations”.

5.3 Administration

This administration checklist was put together by the Cambridgeshire and Peterborough testbed for their MHTR pilot. It provides a useful template for Assistant Psychologists and MHTR practitioners to build a local ‘checklist’ to ensure all information and administrative tasks are undertaken at the correct points in the justice and treatment process.

Offender at court:

- Liaise with Probation Officers and/or Liaison a Diversion Team – does this person need screening for mental health needs?
- If based in court, offer joint assessment with L&D practitioner, if not based in court consider adjourning
- If eligible – complete consent form and assessment
- Complete CORE34/K10 and/or other assessment tools
- If applicable – capture details of those not eligible for MHTR on a spreadsheet

Following an assessment:

- Score the CORE34/K10/other assessment tools and produce the result
- Discuss the result with the Clinical Lead (CL) or Responsible Clinician (RC) in the MHTR provider service
- Health System entry
- Complete court report with assessment result
- Send court report to National Probation Service contact
- Send/save assessment, consent form and questionnaires to CL/RC/admin support
- Follow up any referrals/liase with other partners as appropriate (e.g. DRR/ATR/housing services)
- Complete data capture in spreadsheets: e.g. rolling monthly data and MHTR caseload data (defined by local partnership)
- If applicable - capture details of those not eligible for MHTR on a spreadsheet

Following court outcome:

- Produce letter to GP (for both accepted and declined)
- Health System entry
- Update appropriate care teams and probation
- Find out risk status score from probation for caseload spreadsheet
- Complete data capture in spreadsheets: e.g. rolling monthly data and MHTR caseload data (defined by local partnership)

Following a treatment session:

- Save/send any documents to CL/RC/admin support to upload (e.g. questionnaires, treatment plan)
- Health System entry (risk, summary, plan)
- Complete data capture in spreadsheets: e.g. rolling monthly data and MHTR caseload data (defined by local partnership)
- Share information as appropriate with probation (e.g. daily contact form)
- Update caseload spreadsheet for final session

Weekly:

- Manage appointments diary with clients and share information as appropriate with probation

Monthly:

- Send collated data at the end of the month to agreed partners/steering group etc.

Appendix 1: Example of MHTR Practitioner Assessment Template

Action: Introduce yourself and the MHTR Practitioner Assessment

Action: Complete Psychometric Assessment:

Psychometric Assessment Outcomes

CORE-34	
PHQ-9	
GAD-7	

Action: Look at CORE assessment results

Where are the areas of difficulty and distress:

Functioning:

Symptoms:

Wellbeing:

Risk:

Semi-Structured Interview Topic Guide

About the individual:

Topics to discuss:

- Social circumstances (including safeguarding, relationships, leisure requirements, daily living, educational and occupational needs, employment/vocational needs, housing, finance)
- Identification of vulnerabilities including history of trauma and abuse
- Speech and communication needs
- Physical health needs – management of physical health conditions
- Drug and alcohol issues
- Identification of cultural and gender needs
- Medication – medication history
- Behaviours that have led to involvement with the Criminal Justice System?

Risk

Complete local service Risk Assessment

About mental health:

Topics to discuss:

- Previous engagements with therapy/mental health support
 - Helpful/ Not so helpful?
- Impact of mental health on daily living
 - Have there been times when things have felt better? Enquire about helpful coping techniques?

About the intervention:

Topics to discuss:

- MHTR goals
- Main problem /difficulties
- Barriers to attendance?

Interview Close:

- Is there anything you feel might be important or relevant that we haven't discussed?

Appendix 2: Example of Combined Consent (Easy read will be provided within the CSTR site)

Personal information /data

Your personal information may be shared to, gain:

- An improved assessment of your treatment needs
- An assessment of health needs
- Information regarding safeguarding and child protection (where applicable)
- Information around assessing risk
- Statistical analysis for service delivery and future funding
- Information from partner agencies
- Collate anonymised data to monitor the quality of service delivery
- Contractual obligations

What is meant by data sharing?

Sharing of personal information is strictly controlled by law and anyone receiving information is under legal duty to keep all information confidential.

There may be occasions where staff are duty bound to disclose personal information without your consent. This will only happen if there are any concerns around threats being made to self or others, safeguarding issues around adults or children or any serious criminal offence you inform us you are going to commit.

Collecting data: We collect and store your data in a specific way:

- Consent: we always seek your consent to store and share your information and ask that you sign our consent form.
- Contractual obligations: as part of the funding we receive we are required to share information with our funders.
- Legal compliance: In some circumstances, we are required to collect and process your information
- Legitimate interest: in some situations, we require your information to send you and or your GP specific details about your treatment

Retention of information

We retain your information on our active case management system from assessment to last treatment closure. Your information will then be encrypted and stored electronically and securely indefinitely.

Your rights to withdraw consent

You have the right to withdraw your consent at any time. You will be asked to renew your consent on the above principles every year if still in treatment.

Changes to your information

We want to make sure that your personal information is accurate and up to date. You may ask us to correct or remove information you think is inaccurate.

Assessing the information, we hold on you

You have the right to request a copy of the information that we hold about you. If you would like a copy of some or all of the information, please use the contact details below

Consent

Reasonable care is taken to ensure that discussions, conversations, and telephone calls relating to confidential matters cannot be overheard. Wherever possible identifying details are not shared.

Issues relating to harming themselves or others or to the safety and well-being of children must be reported to external agencies.

I have been provided with information regarding the assessment process and treatment requirements, and understand and consent to the assessment and specific requirements for treatment should one or more of the following be granted (highlight requirement assessed and granted):

- Mental Health Treatment Requirement (MHTR)
- Drug Rehabilitation Requirement (DRR)
- Alcohol Treatment Requirements (ATR)

This will include assessment for suitability (delete as required) for MHTR, DRR, ATR. If the:

1. Mental Health Treatment Requirement be granted:
 - Attendance of the 12-week programme, consisting of one hour sessions weekly
 - Engagement in therapeutic activities required for successful completion of programme
2. Drug Rehabilitation Requirement is granted
 - Engagement in therapeutic activities required for successful completion of programme
3. Alcohol Treatment Requirement is granted
 - Engagement in therapeutic activities required for successful completion of programme

Confidentiality Agreement

I have read or had read to me the confidentiality statement and consent to assessment and treatment. I understand that information about me may be shared as outlined above. I understand that confidentiality may be breached if there is a risk of harm to myself or others.

Name..... **Date of Birth**.....

Signature..... **Date**.....

GP surgery.....

Appendix 3: Example of Information from Clinical Lead Approval for PSR

Mental Health Treatment Requirement	
Responsible Clinician's Report	
Name	
Date	
Initial Assessment Completed by	
Consent of defendant to assessment and treatment gained?	
Presenting problem and formulation	<i>Outcome of assessment / Plan:</i>
Screening tool assessment information is attached	
Recommendations to court from Responsible Clinician	
Treatment Plan, including details of treatment provider	
Risk Information	.
When and where initial therapy will be available	