Mental Health Treatment Requirement (MHTR) Operating and Commissioning Framework

In consultation with Ministry of Justice (MoJ), Department of Health and Social Care (DHSC), NHS England and NHS Improvement (NHSE/I), Her Majesty's Prison and Probation Service (HMPPS) and Office of Health Improvement and Disparities (OHID)

NHS England and NHS Improvement

Version 2: 2022

Contents

.

Introduction

This Operating and Commissioning Guidance for the Mental Health Treatment Requirement (MHTR) Programme is designed to assist new sites to develop pathways to enable and facilitate the increased use of Mental Health Treatment Requirement (MHTRs) which may be sentenced alongside Drug Rehabilitation Requirements (DRRs) or Alcohol Treatment Requirements (ATRs) if appropriate.

This programme is led by NHS England and NHS Improvement (NHSE/I) but is written in consultation with Ministry of Justice (MoJ), Department of Health and Social Care (DHSC), Office of Health Improvement and Disparities (OHID) and Her Majesty's Prison and Probation Service (HMPPS).

This document aims to support consistency of service provision within new sites by increasing the use of MHTRs through the introduction of new pathways and additional primary care services. This relates to the provision of planned and co-ordinated services with a focus on primary/secondary care MHTRs as part of a community or suspended sentence order. This document should be read in conjunction with the MHTR secondary care guidance papers.

[1] Learnings from the early and developing sites have informed this Framework which supports the ambitions of the programme. It describes how health, social care and justice services should work together to ensure vulnerable offenders (particularly those with mental health and substance misuse needs) receive the health and social support they require.

The Programme aims to increase the use of all MHTRs with a view to reducing reoffending through effective and coordinated health and social care treatment requirements and to offer an alternative to custodial sentences and provide the courts with information and confidence to sentence to these requirements.

The Programme ensures that the promotion of equality and reduction of health inequalities at the heart of the services and NHSE/I's values. Throughout the development of this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as defined in the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between individuals in access to, and outcomes from, healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

It is important to ensure that partnerships, processes, services and pathways are in place that can provide appropriate and accessible treatment for individuals with multiple and complex health and social care needs, many of whom don't reach the threshold for access to secondary care mental health services**.**

[1]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/810011/cstr-process-evaluation-summary-report.pdf

Background

Many Individuals in the criminal justice system experience mental health and substance misuse problems, but the use of treatment requirements as part of a community sentence remains low and has been declining over recent years. This may be due to a range of issues including the need to improve partnerships between health and justice providers. Improved partnership working can increase the use of treatment requirements, particularly as an alternative to short custodial sentences. There are three types of treatment requirement:

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

[2]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 psychological therapies, a course of medication or inpatient treatment). As members of the general population, Individuals in the criminal justice system should have access to mental health treatment in the same way as the general population, commissioned by Clinical Commissioning Groups (CCGs) and drug and alcohol treatment services commissioned by Local Authorities. However, there are few services in the community that provide appropriate holistic treatment and care to support the health needs of this specific cohort of individuals.

The Legal Aid, Sentencing and Punishment of Offenders Act 2012 (the LASPO Act) made changes to the administration of the MHTR by amending provisions linked to the Criminal Justice Act 2003 and the Mental Health Act 1983:
[3]"The LASPO Act sought to make it easier for courts to use the MHTR as part of a community order by simplifying the assessment process with a view to ensuring that those who require community-based treatment receive it as early as possible. The Act removed the requirement that evidence of an offender's need for mental health treatment is given to a court by a Section 12 registered medical practitioner."

This change means that the courts may seek views and assessments from a broader range of appropriately trained mental health professionals. The intention was to ensure that courts receive appropriate advice based on mental health assessments, thus reducing the avoidable time delay leading to adjournments and unnecessary psychiatric court report costs.

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

Assessments/treatment for MHTRs are commissioned or co commissioned by NHSE/I and/or Clinical Commissioning Groups (CCGs) and may be split into:

- **Secondary care mental health services:** when an individual's mental health condition meets the criteria for secondary care services. The individual may, at the time of the offence, have already been referred or accepted for treatment but may have failed to attend. This provision should be provided through locally commissioned frameworks for secondary care mental health service provision.

- **Primary care services**: many individuals with mental health issues don't reach the criteria for treatment in secondary care. The addition of clinically supervised mental health practitioners providing assessment in court and short, individualised,

[2] www.gov.uk/government/uploads/system/uploads/attachment_data/file/391162/Mental_Health_Treatment_Requirement_-_A_Guide_to_Integrated_Delivery.pdf
[3]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/391162/Mental_Health_Treatment_Requirement_-_A_Guide_to_Integrated_Delivery.pdf

psychological interventions have been shown to be effective in providing primary care MHTRs. These new services will be commissioned or co commissioned by NHSE/I. The description of these Primary care MHTRs is to distinguish them from MHTRs provided under standard secondary care mental health contracts.

[4]Between Jan-Dec 2017 there were 554 MHTRs given (on average 0.40% of COs/SSOs given that year). The latest 12-month cumulative figure shows that 1,257 MHTRs were given between Oct-20 and Sept-21 (1.36% of COs/SSOs given in Sept-21).

[5] A year one process evaluation of the early sites shows promising results and indicates that by strengthening partnerships, processes and governance pathways, the increased use of treatment requirements, particularly MHTR, is achievable. The process evaluation also provides feedback from the site workforce and individuals who collectively agree that increased use of Treatment Requirements is beneficial in addressing some of the underlying causes of the offending behaviours, providing alternatives to short custodial sentences and enabling rehabilitation within the community.

[6]A study published by the MoJ in 2018 provided the first evidence to show that including an MHTR or ATR into a community order can have a positive impact on reducing reoffending. The study found that for individuals with identified mental health issues, MHTRs attached to community orders or suspended sentence orders were associated with significant reductions in reoffending where they were used, compared with similar cases where they were not. Over a one-year follow-up period, there was a reduction of around 3.5 percentage points in the incidence of re-offending where such requirements were used as part of a community order, and of around 5 percentage points when used as part of a suspended sentence order.

Barriers

A number of barriers have been identified which may contribute to the low uptake of the treatment requirements, these are also highlighted in the year one process evaluation[7]. Further information is included in the myth buster / Q&A document which is available to all Programme sites. Some barriers to developing MHTR provision include:

- The clinical criteria regarding suitability haven't been clear, especially for those with lower-level mental health and complex social issues.
- Availability of suitable treatment/intervention provision that effectively engages adults taking into consideration e.g., sexuality, gender, religion, ethnicity, BAME, physical/mental disability, veterans.
- Lack of availability and access to community services that can provide wrap-around services for individuals with multiple complexities including dual diagnosis.
- Low awareness and confidence among both criminal justice, health professionals and judiciary around the effectiveness of mental health/substance misuse for individuals with associated vulnerabilities.

[4] MoJ Data 2022

[5] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/810011/cstr-process-evaluation-summary-report.pdf

[6] www.gov.uk/government/publications/do-offender-characteristics-affect-the-impact-of-short-custodial-sentences-and-court-orders-on-reoffending

[7] https://www.gov.uk/government/news/lifeline-community-treatment-pilots-to-steer-offenders-away-from-crime

Definition of Primary Care MHTR Services

The provision of screening, assessment and treatment through a defined process for individuals whose offence crosses the community sentencing threshold. The initial assessments determine whether individuals would meet the criteria for a primary care MHTR along with any additional social support they may require enabling effective integrated engagement for all adults.

Delivery partners work together to ensure that processes, services and pathways are in place to enable information, assessment and consent in line with the court's requirements and timescales. This ensures that the courts are provided with informed and effective recommendations, and that appropriate and accessible mental health treatment for individuals with multiple and complex health, social, communication and accessibility needs is available taking into account physical/mental disability, neurodivergence, ethnicity, sexuality and gender.

Guiding principles

- Provide an exemplary assessment for all eligible referred and consenting individuals (18+ years) ensuring the service is accessible to the most disadvantaged, taking into account protected characteristics as defined in the Equality Act 2010);
- Operate within the MHTR Framework /Commissioning and guidance.
- Ensure inclusive approach, recognising mental health needs, associated vulnerabilities for those in contact with the CJS irrespective of any protected characteristics.
- Provide high quality information to key decision makers across the criminal justice pathway including the police, courts, probation, health, substance misuse and Youth Offending Teams (YOTs in transition to adult services);
- Signpost to social support to ensure that individuals engage with treatment until an appropriate discharge point is reached.
- Ensure the workforce are adequately qualified to support adults sentenced to an MHTR and that they are closely aligned, reflect and understand the needs of the local population.

National Drivers

NHS Long Term Plan
"Since 2017, we have been testing a new Community Sentence Treatment Requirement (CSTR) Programme… We will build on this by expanding provision to more women offenders, short-term offenders, offenders with a learning disability and those with mental health and additional requirements."

[8]**Smarter Approach to Sentencing** (2020)
This paper sets out the government's proposals for important changes to the sentencing and release framework in England and Wales. The framework outlines the need to increase the use of CSTRs including the new MHTR programme.

[8] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/918187/a-smarter-approach-to-sentencing.pdf

[9]**Dame Carol Black Review of Drugs, Part 2** (2021)
"NHSE's programme to rebuild community treatment sentences is making progress. The programme covers mental health treatment requirements (MHTRs), DRRs, ATRs and combined orders, and now covers 20% of the country. Funding has been committed in the NHS Long Term Plan to expand coverage to 50% of England by 2023.

[10]**Sentencing Guidelines for Offenders with Mental Disorders** (2020)
New guideline for sentencing offenders with mental disorders, developmental disorders published by the Sentencing Council including the need to increase the use of community orders including MHTRs.

[11]**Operating Framework for Probation** (2021)
This framework outlines the new probation model, also referring to increasing the use of ATR/DRRs and MHTRs when providing recommendations to court.

[12]**Female Offender Strategy** (June 2018)
The strategy highlights the complex and acute needs of women within the justice system, including profile offences and alternatives to custody .

Aims and Objectives

Aim	How
Reduce offending/reoffending by improving the health and social outcomes	through rapid access to effective individualised treatment requirements (which, if appropriate, and without up tariffing[13], may include more than one treatment requirement).
Provide alternatives to short custodial sentences	by providing access to mental health treatment which addresses the underlying cause of the offending behaviours.
Improve health 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 any protected characteristics the individual may have as defined in the Equality Act 2010.
Strive for early sentencing, or as advised by the court	by providing rapid assessment reports to inform pre-sentence reports (PSRs).
Enable access to statutory community services	through individualised support both during and after completion of their community sentence irrespective of any protected characteristics the individual may have as defined in the Equality Act 2010.
Ensure consistency of service provision within all new and existing sites	developed to align to local services and population by the publication of the MHTR Operating, Guidance Framework and corresponding documents, and the sharing of good practice across the sites with support from the MHTR Programme team

[9] Review of drugs part two: prevention, treatment, and recovery - GOV.UK (www.gov.uk)
[10] New guideline for sentencing offenders with mental disorders published – Sentencing (sentencingcouncil.org.uk)
[11] HMPPS_-_The_Target_Operating_Model_for_the_Future_of_Probation_Services_in_England___Wales_-__English__-_09-02-2021.pdf (publishing.service.gov.uk)
[12] Female Offender Strategy (publishing.service.gov.uk)
[13] Up tariffing = Increasing the sentence to accommodate the order requirements

A secondary aim is to raise awareness of the high numbers of individuals with mental health, personality disorder and substance misuse conditions across the criminal justice pathway, including information on how to identify individuals with protected characteristics and neurodivergence who may be suitable for an MHTR, for the Judiciary, Court Staff, legal representatives, probation and the police. This increased awareness enables greater confidence to be placed in the sentencing process which, in turn, may lead to an increase in the number of MHTRs being sentenced.

Objectives

Objectives	How
Rapid access to appropriate and effective assessment/interventions	Supported access by integrated or sequenced alongside other community orders or treatment requirements.
Services which meet the needs of individuals	irrespective of any protected characteristics the individual may have (as defined in the Equality Act 2010).
Evidence based psychological interventions	to promote wellbeing and recovery, provided by skilled mental health practitioners who are cognisant and aligned to the needs of the local community **process mapping** to ensure that all partners and stakeholders are aware of their roles and responsibilities for providing and accessing rapid MHTRs and for substance misuse providers when a combined order is sentenced (MHTR/DRR, MHTR/ATR)
Clinically led dedicated MHTR interventions	An individualised case formulation plan will be completed along with practitioner supervision (CL Guidance).
Local agreements in place to share information with partners	including Probation, HM Courts & Tribunal Service (HMCTS), Liaison and Diversion, Health and Substance Misuse Providers.
A flexible service	maximising opportunity for access to social support i.e. around employment/education and family
Raising awareness of mental health issues	for Judiciary, legal representatives, Court Staff, police and probation. Sites should consider introducing feedback for sentencing courts regarding the effectiveness of MHTRs.

How will this provision improve community integration?

- ✓ **Improved access to mental health and substance misuse interventions:** commissioning an MHTR service will increase the number of adults 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.
- ✓ **Improving access and outcomes to treatment for all individuals:** supporting engagement for all adults taking into account their individual 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 and social 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 MHTR services would encourage GP registration, enabling improved physical health care and access to screening 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.

- ✓ [14]**Reduced stigma and discrimination:** MHTR 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 and enable access to mainstream services.
- ✓ **Avoidable harm to themselves or others:** assessment of risk is a key component of the MHTR service. 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 reflect the needs of the local community and to provide support and interventions. Appropriate interventions will be put in place if levels of risk are raised.

Outcomes and Key Performance Indicators

Nationally monitored via MHTR dataset

Most of the information required (as set out below) can be collected by the treatment providers using the MHTR National Minimum Data Set, supported by the MHTR Programme Team.
In accordance with the data sharing legislation, anonymised data will be sent to the Steering Group Chair/Commissioner. The template includes two tabs for MHTR data and outcomes. The data will be provided on a monthly basis and sent to the Chair/Commissioner by the second week of each month (or as locally agreed) then forwarded to: england.cstr@nhs.net.
Data collected includes:

Pre-sentence	• Source of referral • Gender, Age and Ethnicity of individual • Pregnancy and caring responsibilities • Disabilities • Neuro divergence • Armed Forces history • Offence type • Numbers assessed for MHTR, MHTR/DRR, MHTR/ ATR • Numbers consenting • Number of obtaining MHTR Clinical Lead Approval
Sentence	• Numbers included within a Pre-Sentence Report • Numbers of accepted and declined by the judiciary • Numbers of sentenced on the day (within 24 hours)
Post-Sentence	• Number of orders managed by probation • 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 an MHTR and how many were sentenced to custody • Unplanned discharge reasons • Number of individuals registered with GP • Monitor and record health outcomes, post sentence completion
Sentence completion	• Numbers completing the MHTR • Current number of active requirements • Pre and post clinical outcomes: CORE34, GAD7, PHQ9

14 ttps://pure.northampton.ac.uk/ws/portalfiles/portal/30740786/Practice_and_Ethical_Guidance_for_Clinical_Staff_Supporting_Trans_Clients_Sentenced_to_Mental_Health_Treatment_Requirements.pdf

In addition, we ask sites to ensure the following:

- Consent recorded by treatment providers, *as well as* by probation on n-delius
- Numbers referred to other relevant services post-completion of sentence
- Number of awareness sessions to include mental health, substance misuse and associated vulnerabilities for: judges, magistrates, legal representatives and other representatives, probation etc.
- Improvements in CJS partnership/interdisciplinary relationships
- Relevant information agreements and data sharing agreements

Nationally, we will also look to monitor reductions in re-offending outcomes for those who have completed an MHTR.

Sentencing

Individuals can only be sentenced to an MHTR (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 defined in the [15]Sentencing Council Guidelines. The offence and the sentencing range (as outlined in the Sentencing Council Guidelines) will assist in determining the length of the requirements which may be attached to the order.

[16]Generally, the use of combined treatment (MHTR/DRR, MHTR/ATR) requirements can only be considered if the offence has reached at least the medium sentencing level of the community order range and above.
Consideration must be given to ensure that up tariffing does not occur. 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.

[15] https://www.sentencingcouncil.org.uk/the-magistrates-court-sentencing-guidelines/
[16] https://www.sentencingcouncil.org.uk/wp-content/uploads/Imposition-definitive-guideline-Web.pdf

Commissioning Primary Care MHTRs

The NHS Long Term Plan has enabled increased provision of MHTRs by providing some funding to scale up across England. The funding for the MHTR provision will be provided via the seven NHS Health and Justice (H&J) commissioning teams within NHSE/I supported by the MHTR Programme team.
The early adopter sites have demonstrated that a multi-disciplinary oversight partnership and utilisation of shared resources leads to improved outcomes and success of a site. When a site is identified the H&J commissioner may wish to liaise with the national MHTR Programme team who will be happy to offer support during the set-up phase.

As an example, see below:

Commissioning model:	NHSE/I commissioned (from additional allocation)	NHSE/I commissioned (from regional allocation)	Commissioned by local partners - may include regional NHSE/I contribution
Accessible service delivery location	Demographic coverage/courts/cohort agreed with partners.	Location/cohorts determined by the commissioners, followed by consultation with justice partners regarding court coverage	Location/courts agreed with partners
Application of MHTR operational framework	Local model based on MHTR Operational framework. Mobilisation costs to be considered and agreed with partners.	Local model based on MHTR Operational framework	Local model based on MHTR Operational framework. Mobilisation costs to be agreed between partners
Commissioning	NHSE/I(regional commissioning) and partners will agree contract management responsibilities.	NHSE/I (regional commissioning) will contract manage the new service	The Partnership will agree contract management responsibilities, NHSE/I regional team will remain fully engaged influencing, advising performance.
Contract and data management	All sites submit the national minimum data (NMD) set monthly.	All sites submit the national minimum data (NMD) set monthly.	NHSE/I regional commissioning will request the use of minimum data set but cannot mandate this if not contributing to site funding.

1.1 Eligibility and scope

Eligibility

- 18 years old or above
- Consents to the requirement
- Guilty of committing an offence which crosses the community order sentencing range
- For those with lower-level Mental Health, Personality Disorder problems, neurodevelopmental disorders and Neuro divergence (e.g. ASD and ADHD) reasonable adjustments will be made to accommodate individual needs in line with the Equality Act 2010.

Operational scope: Example chart: The following courts will be included in delivery:

Court	Address	Number of court rooms (operational)

Times of operation: The MHTR service will be delivered from the following sites/times

Location	Mon	Tues	Wed	Thurs	Fri

Services will operate between the hours of 9am to 5pm Monday to Friday. It may however be necessary to consider evening sessions to accommodate individuals who are working or to facilitate childcare or caring arrangements.
Cases that appear on Saturday morning will be identified by the Courts and, if appropriate, a recommendation made to adjourn for a PSR to include MHTR assessment for the following week so all cases appearing in the court have equal access to this service.

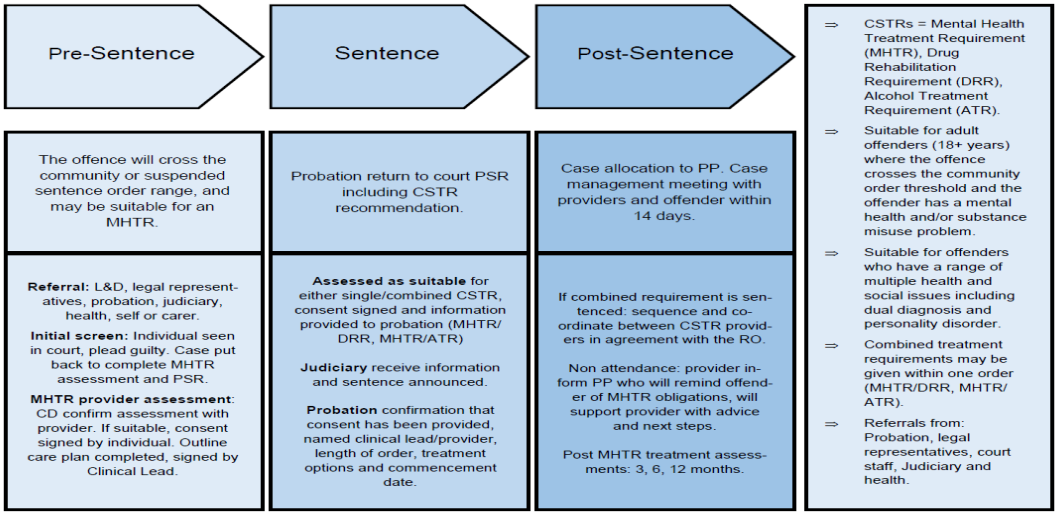
1.2 Processes, Clinical Guidance and Consent

The following documents may be helpful when considering processes, guidance and consent:

- Example Court Process (Appendix 1)
- Example Process Map (Appendix 2)
- PC Example MHTR Model, from screen to treatment (*Appendix 3*)
- PC MHTR Clinical Leads Guidance (*Appendix 4)*
- Combined Court Consent for MHTR/DRR/ATR (*Appendix 5)*
- PC MHTR Example Decision Model (*Appendix 6)*

1.3 Example MHTR Pathway and Process

Probation is responsible for managing all aspects of sentence including the requirements attached to the order. The Probation Practitioners will be in regular communication with the providers. During the initial engagement, pre-sentence, Probation Court Team will be the point of contact. Post-sentencing the individual would be allocated to a Probation Practitioner (PP) for continued support. The pathway below and provides an overview of the MHTR process



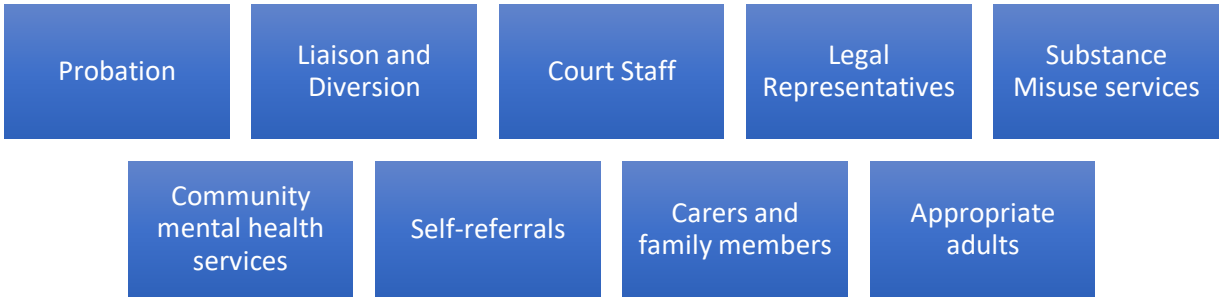
1.4 Delivery Partners and Stakeholder Group

PC MHTRs can only be provided through defined delivery partners who work closely together in partnership through a local Steering Group.
The Steering Group members will have clarity of roles, responsibilities, share information and have clear lines of communication. In most instances a Chair will be appointed who will take the lead and oversight of the local service delivery.
Additionally, there are wider stakeholders that will require information and communication to enable awareness of the services and referral pathways.

The delivery partners	The stakeholders
• Probation Service • Judiciary (Magistrates and Judges) • HM Courts and Tribunal Service (HMCTS) • Liaison and Diversion service (L&D) provider(s) • Providers for MHTR and Substance Misuse • Third sector organisations • Voluntary and Lived Experience groups • Commissioners: Health and Justice, Local Authority, Police and Crime Commissioners	• Senior Presiding Judge • Police and Crime Commissioners • Judiciary and Court Staff • Lived experience groups • Local Health and Social Care partners (including Local Authority) • Police • Legal Representatives and other representatives • Crown Prosecution Service (CPS) • Clinical Commissioning Group (CCG) • Health and Justice Commissioners (NHSE/I) • Youth Offending Team (YOT) for those in transition to adult services. • Women's centres or specialist support centres • Sentencing Council

Service Delivery Model

The Probation Practitioner (PP) is responsible for overseeing and managing compliance with the order, which includes the MHTR. Therefore, the provider and PP will have close contact and communication during the delivery of the MHTR. Referrals can be from a number of sources including:



The service will proactively work with agencies to ensure that practitioners understand who can be referred and the process for referral. Space must be made available for morning screen and assessment in the court building. [17]All up to date documentation will be found on the NHSE/I Futures platform within the "New and Developing Site" file.

[17] Community Sentence Treatment Requirement (CSTR) - FutureNHS Collaboration Platform

1.5 MHTR process

Points of Engagement: The initial identification and MHTR screen may occur via the Liaison and Diversion team in police custody but will mostly take place in court.
Wherever possible, space will be made available for morning screen and assessment in the court building. The commissioned MHTR providers will determine where the treatments/interventions are provided.
A recommendation is that the location of the treatment facilities is within reasonable geographical proximity for the individuals, with the treatment rooms accessible to accommodate any disabilities.

Initial screen/assessment and consent: It will be locally agreed who completes the initial screen for MHTR this could include: Probation Court Team, Liaison and Diversion services or the MHTR provider.

For screening tools see *Framework and Clinical Manuals.* The screening would also assess for: social issues (housing, finance, relationship issues, work/education) GP registration along with ensuring that the individual clearly understands the reason for the screen and interpreters/advocates are available to support if necessary.

If screened and score indicates a likelihood of mental health vulnerabilities and/or psychological distress/substance misuse the relevant MHTR providers would be contacted and will be requested to come to the court to complete a more thorough assessment.

If the screen does not indicate issues suitable for an MHTR but the individual requires support in other areas such as those outlined above, the individual may be further assessed by Liaison and Diversion and supported into appropriate local services.

Assessment: the MHTR provider will assess the individual, within the timeframe outlined by the court. (for details on the proposed assessment refer to the[18] clinical manuals) if the individual is deemed suitable for the MHTR, a full explanation of the programme and treatment will be provided. The outcome of the assessment will be sent immediately to the clinical lead for agreement/decline to oversee the requirement. If the individual is deemed not suitable, this will be raised with the Liaison and Diversion service and the individual will be supported into appropriate local services.

Consent: if the individual is deemed suitable and agrees to the MHTR, consent must be gained prior to sentencing and the Probation Court Team informed and included within the Pre-Sentence Report (see example consent forms within the Futures "new and Developing Site" file

Sentencing: The report and proposed programme will be discussed with the Probation Court Team and will be incorporated into the PSR, along with any other community requirements. If appropriate the Probation Court Team will recommend and notify the court of agreed consent, including that the individual has consented to the requirement, that the providers have agreed to provide interventions for the MHTR, and that there is a named clinician to oversee the requirement.

An MHTR combined with either a DRR or ATR may only be recommended if the offence is serious enough i.e, a court order that includes two treatments will only be available to individuals whose offence reaches the medium level community order threshold, or higher.

[1818] Callender_Matthew_IPSCJ_2020_Clinical_Lead_Mental_Health_Treatment_Requirement_MHTR_Manual.pdf (northampton.ac.uk)

Whilst the individual is being sentenced Probation and Judiciary must ensure that the person understands the sentence and is provided with an MHTR leaflet (language appropriate/easy read if necessary) along with the date/time of the next appointment.

It is requested that if an individual is sentenced to an MHTR, the HMCTS Court Admin team are asked to inform the provider at the same time as the allocated Probation Practitioner, this will ensure swift information sharing to enable adequate support for the individual.

Joint Case Management: The MHTR provider will work with the allocated Probation Practitioner and individual to sequence treatments in order to maximise the benefit of the requirements. If an individual is sentenced to a combined treatment requirement the providers will be expected to work in partnership to appropriately deliver the court order.

The MHTR interventions will be provided by the MHTR mental health practitioners and clinically supervised by the Clinical Lead.

Link work support considered to support social issues whilst individuals are receiving their MHTR. This support may be provided before, during and after the requirement has been completed.

In many cases the individuals may have a dual diagnosis therefore requiring combined orders (MHTR/DRR, MHTR/ATR). It is important therefore the service providers must hold regular joint case management meetings.

Primary Care MHTR Intervention: See the MHTR [19]clinical intervention manual for recommended psychosocial interventions and substance misuse treatment.

Primary Care MHTR Delivery: The provider will work closely with the Probation Practitioner allocated to oversee the court order and guide the providers regarding compliance and any breach proceedings. The providers must ensure that they keep in regular contact with the Probation Practitioner.

It is the Probation Practitioner's responsibility to support the providers if engagement is proving difficult or if the requirements aren't meeting the individual's needs and requires adjustment, or if the individual has responded well and doesn't require the entire duration of interventions or treatment.

Consideration is to be given to ensure physical accessibility to the interventions along with intervention delivery and any suitable adjustments are made.

Sentence Completion: Upon completion of the requirements, the service providers will sign the completion documents along with ensuring that advice and further treatment/interventions have been arranged for the purposes of providing ongoing support.

The providers must ensure that the individual has all the information required for the pre-arranged and agreed ongoing health and social support.

Service Providers to Deliver Vulnerabilities Awareness Sessions to Partners: The local MHTR steering group will drive forward awareness sessions across the CJS pathway, ensuring that all partners are adequately briefed and provided with information needed to support decisions regarding the appropriate use of MHTRs.

[19] Callender_Matthew_IPSCJ_2020_Clinical_Lead_Mental_Health_Treatment_Requirement_MHTR_Manual.pdf (northampton.ac.uk)

It is expected the MHTR providers will play a key role in raising awareness across the CJS pathway, ensuring that all partners are confident regarding mental health and associated vulnerabilities. Wherever possible providers will include lived experience either within the session or within case studies, both of which have proved to be valuable for all concerned.

Partners include probation, court staff and judiciary, legal representatives, health providers, commissioners, and police.

Lived Experience Engagement: It is expected that engagement with lived experience colleagues is evident throughout the development and delivery of the MHTR site.

It is vital to ensure that individuals with lived experience are embedded within the local steering groups and that questionnaires and satisfaction statements or concerns are captured/acted upon and fed into the service improvement plan.

It is vital that this service becomes integrated within the local community services and is reflective and understands the needs of the local community, this information is vital and will be developed with the support of lived experience engagement.

Commissioners and stakeholders will monitor the appropriate engagement of service users in all decision making, ensuring that this is not limited to prescribed activities, but is a genuine opportunity to influence services.

1.6 Primary Care MHTR workforce

The MHTR workforce will reflect the local population and have a good understanding of the diverse needs of the local community. They will demonstrate a proactive approach to delivering services to all adults assessed as suitable for the requirement, ensuring that engagement and accessibility is suitable and relevant.

MHTR: to provide primary care psychologically led individualised interventions, delivered through mental health practitioners. As a minimum.

- Based on a population of 350,000
- A minimum of 1 x whole time equivalent (WTE) band 4/5/6 MH practitioner: Monday-Friday. Each carrying an approximate case load of 15-20 cases at any one time.
- 0.2 Clinical Lead (Psychologist) to provide clinical oversight and supervision of the MH practitioners. The Lead may also carry a small case load of more complex cases

Staffing: The provider will employ staff who will work within the relevant professional standards/ guidance and will develop the partnerships required for a successful MHTR site participating within the governance provided by the Programme Steering Group. There may be some flexibility to adjust the staffing arrangements depending on local needs to manage the workload (see statement above, under MHTR workforce).

Clinical Lead: The provider will ensure that a Clinical Lead is available with suitably recognised and qualified support from within the provider service when the appointed Clinical Lead is not available.

Pre-sentence screening and assessment measures.

The Clinical Lead will: *(see Appendix 2 of the Framework and Clinical Manual)*

- Define the pre-sentence screening, assessment, and consent process
- Support the Primary Care Practitioner with delivery
- Agree with probation information required for the PSR.
- Agree the clinical care plan
- Work with probation around the sign off/consent process
- Oversee and agree to the requirement both pre-sentence and post-sentence.
- Provide clinical supervision and support to the practitioners, providing advice and guidance to those subject to an MHTR.

The Clinical Lead or allocated deputy will be available Monday – Friday between locally agreed times. It would be expected that as a minimum the Leads will be available between 12.00 to 13.00 to consider the suitability/agreement for an MHTR and make the recommendation to be included in the PSR at court. The Lead may work remotely from court.

The Clinical Lead will develop a formulation of delivery interventions, please see *Clinical Manual Framework.*

Clinical Lead Agreement: The mental health practitioner will contact the Clinical Lead following the assessment to agree or to decline with reasons. The mental health practitioner will inform probation for inclusion in the PSR.

Primary Care Mental Health Practitioner: The MHTR Provider will employ mental health practitioners who will work with partner organisations to identify offenders that are suitable for MHTR (see statement under MHTR workforce).

Following assessments, the practitioner, with guidance from the Clinical Lead, will determine the appropriateness for the primary care MHTR intervention. If not suitable for MHTR, the practitioner will discuss with Liaison and Diversion other suitable referral options.

During the clinical assessment, the clinician may also assess:

- Speech, Language and communication needs.
- Neurodivergence including Autism, ADHD, Learning Disability, Tic Disorders, Specific Learning Difficulties (Dyslexia, Dyspraxia, Dyscalculia) and Brain Injury
- Identification of vulnerabilities including history of trauma and abuse.
- Drug and alcohol issues.
- Identification of cultural and gender needs.
- Social circumstances (including safeguarding, relationships, , daily living, educational and occupational needs, employment/vocational needs, housing, finance);
- Physical health needs – management of physical health conditions.
- Current medication and medication history.

The practitioner will then explain the MHTR process and if suitable will gain consent for the requirement to be proposed. The practitioner will contact the MHTR Clinical Lead for primary care MHTR approval and sign-off 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 Probation Court Team to discuss appropriateness of assessment for a combined MHTR (MHTR/DRR or MHTR/ATR).

Consent: The mental health practitioner will fully explain to the individual details of consent, including what will be expected and that it is their choice whether to engage or not. However, if they do not engage after an MHTR is ordered by the court then their case will be discussed with probation, who will contact the individual and explain next steps, which could include breach proceedings and a return to court.

It is important to ensure that consent is fully understood by the individual and information will be made available in the appropriate language/easy read format. Interpretation services will be made available if necessary.

The mental health practitioner will complete the consent form ready for the individual to sign.

Recommendation to Court: The mental health practitioner will inform Probation Court Teams of the outcome of the assessment. Where the Clinical Lead has recommended an MHTR order, probation will include the details in the PSR.

Post Sentence: The mental health practitioner will hold a three/four-way meeting with the allocated Probation Practitioner, substance misuse provider where appropriate, and the individual to discuss expectations and goals of the order.

Delivery of Interventions: The mental health practitioner will deliver interventions in line with formulations agreed with the Clinical Lead. It is recommended that a Band 6/7 mental health professional or the Clinical Lead be available to provide treatment for more complex cases. Providers will ensure that interventions are individualised and appropriate to meet the needs of the individual's circumstances and that any information provided is in a suitable language/easy-read format or available through a suitable information platform where necessary.

It is anticipated that between 10-12, 50-minute sessions will be provided for an MHTR intervention under a sentence (although the number of sessions will be determined based on clinical need). The location of the treatment will be considered in line with appointments with the Probation Practitioner and if possible, take place at the same location.

If the Clinical Lead is personally providing the psychological therapy or interventions, then treatment will be recommended and provided within appropriate timescales, in accordance with the community or suspended sentence order.

For cases where the Clinical Lead is not providing the interventions but is acting as supervisor and overseeing the requirement, they will define the interventions which may include, for example, psychoeducational and compassion focused therapy, ensuring the interventions will be provided within appropriate timescales. The frequency of supervision will follow recommendations from the relevant professional body (e.g., British Psychological Society/ Health and Care Professional Council (HCPC)).

Where appropriate the Clinical Lead will advise/support the effective sequencing of the requirements (where other treatment requirements have been ordered) to ensure maximum engagement and effectiveness. The Clinical Lead will be informed of any non-compliance with the requirement and advice would be obtained from Probation.

Commissioned activities

The activities undertaken by the commissioned service are outlined below:

- Source/provide or negotiate access to accommodation for the service where treatment may be provided. This will require negotiation with the court regarding assessment space within the court building. When considering accommodation ensure that access is suitable to accommodate individuals with disabilities and neurodivergence.
- Provide a Clinical Lead (CL) (Clinical/Counselling Psychologist) to define the assessments/interventions. They will oversee the requirements and supervise mental health practitioners (*see Appendix 1*).
- Provide Mental Health Practitioners, to assess suitability in court/consent/intervention delivery and follow up ensuring the practitioners reflect and align to the local community.
- Engage with delivery partners (Probation, HMCTS, Substance Misuse, L&D) to develop an integrated service and agree processes and governance pathways to maximise the benefit of MHTRs, along with working alongside substance misuse providers to co-ordinate combined orders with ATR/DRRs.
- Aim for swift assessments working alongside the courts timetable.
- Where appropriate, develop information/data sharing agreements across the relevant partner organisations to enable joined up working across the sectors.
- Consent pre-Sentence ensure processes are in place for consent to be fully explained and received from the individual and provide accessible information in a range of languages and easy read.
- Agree daily access times for the CL to review the case and agree/disagree to the requirement so that the recommendation for MHTR may be included in the PSR (written or verbal) to enable a swift sentencing process.
- Conduct a post-sentence three/four-way meeting with Probation Practitioners (PP), MHTR and/or substance misuse providers, and individual to discuss sequencing of the order, goals, and expectations and any reasonable adjustments required.
- Establish clearly defined and agreed joint case management protocols in consultation with partner agencies.
- Ensure the individual is registered with a GP prior to commencement of treatment (to note, an individual may be sentenced without a GP but MUST be registered prior to treatment commencing)
- Provision of evidence based psychological interventions which may be individualised to meet the needs of the individual.
- Retain records and provide pre-agreed (anonymised) data to Steering Group monthly, or as agreed.
- Establish an effective relationship with PP to manage non-attendance, breach and completion of orders including information flow across Probation and MHTR provider.
- Provide timely access, referral to ongoing services for appropriate support post-sentence.
- Contribute to the ongoing development of the service through engagement in the Steering Group, national MHTR Programme team and other relevant networks.
- Seek feedback which informs the development of the service and engage people with lived experience in decisions regarding service development (such as Peer Support networks).
- Monitor and evaluate the effectiveness of the service through qualitative feedback
- Make reasonable adjustments to accommodate individual needs and protected characteristics in line with the Equality Act (2010).
    - Individuals subject to these requirements may have several vulnerabilities, including mental health, substance misuse, autism, learning difficulties, ADHD brain injury, speech, language and communication needs and physical difficulty.
    - Adjustments will be made to ensure that the services are accessible to individuals subject to these requirements (e.g. accessible and easy-read documents, information available in alternative languages, treatments offered in suitable and

accessible locations taking into account sensory, physical and mental health requirements and strengthening treatment around neurodivergent needs).
    - Supported engagement to ensure equality of service is provided irrespective of any presenting protected characteristic as defined in the Equality Act 2010.
- Respond to complaints and FOI requests within agreed timeframes.
- Record the reasons given for Clinical Lead declining an individual
- Consent to be recorded by treatment providers, *as well as* by Probation on n-delius
- If the court declines an MHTR, reasons to be recorded and detail of the health and social support recommended to be noted
- Reasons given for any instances of breach or individuals not completing the requirement
- Record if the breach is directly related to the MHTR
- Levels of risk to self and others pre and post intervention
- Monitor, record health outcomes, including 3, 6, 12-month post sentence completion
- Numbers referred to other relevant services post completion of sentence
- Number of awareness sessions to include for: judges, magistrates, legal representatives and other representatives, probation etc.

Nationally, we will also look to monitor reductions in re-offending outcomes for those who have completed an MHTR as a result of this service.

Governance and Reporting

Governance: The local steering group will oversee the progress of the MHTR service to ensure it enables effective multidisciplinary working with the contract management held by the lead commissioner.

The Steering group will ensure process mapping and clear pathways are in place to provide effective local delivery across the partnerships of this service.

The Steering Group consists of a Chair, and partners (determined locally), H&J NHSE/I, CCG, local authority commissioners, probation, HMCTS, judiciary, service users, Providers and third sector providers. The steering group will provide communication and updates to the local stakeholders according to the local arrangements and in response to the national MHTR Programme.

Reporting: The steering group will oversee the delivery of the MHTR site. Local commissioners will conduct regular contract review meetings which will include review of MHTRs

Data will be collected monthly and provided to the national programme using the following email: england.cstr@nhs.net

The service provider will ensure that appropriate data sharing agreements are in place with local partners. If agreement to share data cannot be obtained, the steering group will discuss how to resolve this issue.

Diversity Monitoring: The promotion of equality and health inequalities are at the heart of this service. Throughout the development of the MHTR service we have:

- Given due regard to eliminate all forms of discrimination, harassment, and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as defined in the Equality Act 2010) and those who do not share it; and

- Given regard to reduce inequalities between individuals in access to, and outcomes from this MHTR service and to ensure the providers are integrated with other services to reduce health inequalities.

[20]Ensuring equality across the Trans community within this programme is vital and can be refed to within the referenced document.
All individuals who engage with the treatment process will be asked to provide equal opportunities/diversity information. This will be monitored to ensure that no groups are disadvantaged. The provider will record diversity information.

Information Governance: The provider will ensure the policy and practice meets the relevant NHS information governance standards regarding:

- GDPR.
- Information sharing protocols to enable sharing of clinical information with other agencies when appropriate, which is underpinned by Caldicott Principles and information governance structures.
- Operational and joint working protocols in place – jointly agreed with relevant agencies e.g. sharing confidential information/risk assessment.

Health and Safety: The provider will ensure the health and safety policies and procedures relating to both the service provision and as an employer meet the statutory requirements and good practice as stated within the NHS standard contract.

The provider will work with probation to ensure that safe sentencing is carried out.

Interdependence with other Services/Providers

Services must work in partnership to ensure safe, planned and joined-up care. There must be smooth transitions between services to avoid individuals slipping through the net. Information must be shared with the relevant professionals when consent has been agreed and risk considered in line with local policy.

The key interdependencies are:

- Police
- General Practice
- Primary and community care
- Liaison and Diversion
- Specialist Mental Health Crisis Resolution and Home Treatment services
- Specialist Mental Health accommodation and support providers
- Third sector information, advice, support and advocacy providers including those for carers
- Housing services
- Substance misuse services
- Learning disability services
- Employment services
- Health and social care locality teams
- Tertiary health providers – forensic and independent
- Out of Hours Urgent Care services.

[20] Trans Guidance for the MHTR Programme

Reasonable adjustments
Reasonable adjustments will be made to accommodate individual needs and protected characteristics in line with the Equality Act 2010.

- 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
- Supported engagement to ensure equality of service is provided irrespective of the presenting protected characteristic.

It is recognised that there is a higher proportion of neurodivergence within the criminal justice system and so it would be expected that there would be a higher proportion of individuals with neurodivergent needs within the cohort sentenced to MHTRs. It is likely that some people will have neurodivergent needs without this having previously been recognised or assessed. It is expected that reasonable adjustments will be in place across the MHTR process to enable the identification of neurodivergence and that processes are accessible and supportive with these needs in mind.

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 person's place of residence or may have regular contact with them.

The staff group must follow the Adult & Child Safeguarding policies involving Multi-Agency Safeguarding Hubs (MASH) or Multi-Agency Public Protection Arrangements (MAPPA) as necessary and ensure they are appropriately trained and updated in line with these policies.

Sharing of information and confidentiality policies must be in place with the appropriate statutory authorities before the MHTR service becomes operational.

All staff employed and engaged in working with individuals subject to an MHTR must have the appropriate level of disclosure and barring service (DBS) check which should be regularly updated. The service must, on request, provide evidence to demonstrate compliance with all statutory requirements.

Particularly relevant to the service include:

- 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
- Children Act 1989
- Children Act 2004
- Human Rights Act 1998
- Care Programme Approach
- Care Quality Commission Standards
- NHS complaints procedure
- Data protection legislation

Engagement with mainstream services

MHTR Providers will make referrals into mainstream services both during and post treatment to ensure continued support, where required. It is expected that secondary care services will continue to provide care when the MHTR has completed in order to support ongoing engagement. The providers will demonstrate how they will ensure engagement with services and how they will arrange for appropriate communication of operational data.

Information Schedule for the Primary Care MHTR service to include:

- Information sharing protocols to enable sharing of clinical information with other agencies when appropriate, which is underpinned by Caldicott principles and up to date NHS information governance structures and is compliant with the requirements of data protection legislation.
- Operational and joint working protocols in place – jointly agreed with relevant agencies e.g. sharing confidential information/risk assessment and management/obtaining assessments under the Mental Health Act 1983 etc.
- Written complaints procedure.
- Risk Register.
- Quarterly Incident Report (including safeguarding incidents) and compliance with NHS E/I's serious incidents policy and procedures.
- Quarterly Workforce Report.
- Review of referrals.

Final considerations when developing local service

1. Assessing locally whether there is a gap in sentencing options for individuals who may require treatment requirements as an alternative to short custodial sentences.
2. Engagement with probation, Liaison and Diversion, HMCTS, Health (NHSE/I and CCG commissioner), local authority, Office of police and crime commissioners.
3. Appointment of a local steering group, with a chair who has the ability and capacity to lead and coordinate across local services.
4. Assess what provision is already available, such as:
    a. Liaison and Diversion service or other health provision
    b. Engagement/willingness of local MH /SM services
    c. Social provision, either statutory or 3rd sector support, what are they providing?
    d. Is there a health provider who could provide this service?
5. What sentencing options are being offered? Who are they commissioning to provide the RAR days?
6. Consider if the court and Probation have adequate on-site accommodation for on the day assessments?
7. Funding requirements and availability.
8. Clinical Lead (Psychologist) who can agree/supervise the primary care MHTR order. Consult with the Liaison and Diversion commissioner to see if funding may be made available to commission additional capacity to undertake assessment/treatment and supervision of these staff.
9. Feedback is built in across the programme which is vital to develop, and information delivery includes: Lived Experience, Probation, Judiciary

[21]NHS Futures Platform

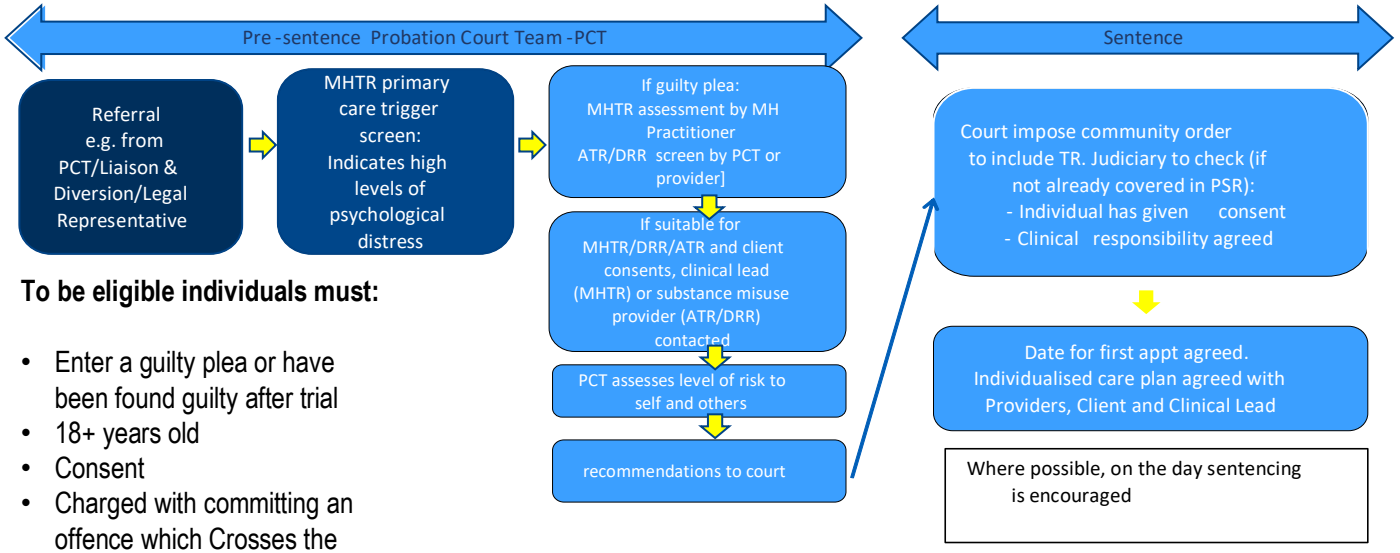
Includes information required to develop a local site. For access to the platform please contact the MHTR Programme team.

[21] Community Sentence Treatment Requirement (CSTR) - FutureNHS Collaboration Platform

Abbreviations

CSTRs	Community Sentence Treatment Requirements (DRR/ATR/MHTR)
MHTR	Mental Health Treatment Requirement
DRR	Drug Rehabilitation Requirement
ATR	Alcohol Treatment Requirement
PS	Probation Service
CL	Clinical Lead
PP	Probation Practitioner
RP	Responsible Practitioner (Dr)
L&D	Liaison and Diversion Service
PCC	Police and Crime Commissioner
HMCTS	HM Courts and Tribunals Service
MoJ	Ministry of Justice
OHID	Office for Health and Disparities
NHSE/I	NHS England and NHS Improvement

Appendix 1: MHTR screening and court process



To be eligible individuals must:

- Enter a guilty plea or have been found guilty after trial
- 18+ years old
- Consent
- Charged with committing an offence which Crosses the Community order Sentencing Range

Mental Health Treatment requirements (MHTR):

- Primary care and secondary care
- Any MH issues and personality disorder problems
- Range of evidence -based screening tools and assessments used throughout the process, depending on the specific site and individual in question.

- DRR= Drug Rehabilitation Requirement
- ATR= Alcohol Treatment Requirements

Appendix 2: Example Process Map

Police Custody		
Where and When	**Process**	**Responsibility**
Custody screen	Standard Liaison and Diversion screen for all vulnerabilities including treatment requirements. Liaison and Diversion practitioner will profile the individual on: Offence type, MH/SM/ASD and any other associated vulnerability, disability, substance misuse issues, if already known and presenting behaviours.	**Those identified who may be suitable for an MHTR :** Liaison and Diversion practitioner will pass information to Court Liaison and Diversion team, Court Probation Team **Consider intermediary support for court appearance.**
Court		
Day before/on the day	Probation Court Team screen the list the day before for: Offence type and for those whose offence may fall into the Community Order (CO) range likely plea, already known to probation and screen for MHTR suitability. Liaison and Diversion screen daily court listing for MHTR suitability and those identified via police custody.	Liaison and Diversion**/** Court Probation Team: compile and compare the list of Defendants who may be suitable to be screened for MHTRs List defined for MHTR screens in agreement with Court Probation Team. *depending on court process the morning meeting may include legal advisors, defence, prosecution and Liaison and Diversion *consider if intermediaries may be required for people who may require support during court process
On the day	Probation Court Team **discuss potential suitability with Defence** who may wish to discuss with their Client. Also inform potential suitability with Court legal representative.	**Court Probation Team:** inform Treatment provider of the number of potential assessments.
On the day (MHTR eligibility screen)	Liaison and Diversion **or MHTR Provider** complete initial screen for MHTR suitability (K10/Core 10)	Liaison and Diversion**/MHTR Provider inform** Probation Court Team **of suitability before plea is taken:** if criteria for Treatment Requirement assessment is passed, Probation Court Team to request the possibility of bringing forward in the morning court list.

		Liaison and Diversion**/or MHTR Provider** inform MHTR provider of outcome who will await outcome of plea..
On the day (Plea)	**Enter Plea:** Guilty or Not guilty. If guilty plea, Sentencers request Pre-Sentence Report (PSR) and case put back until later in the day.	Probation Court Team **inform Treatment providers of Plea:** if Guilty plea, request on the day (morning) assessment.
Pre-Sentencing (Plea outcome)	**Guilty**: and offence crosses the CO sentencing range, MHTR provider/ informed of plea outcome by Court Probation Team/ Liaison and Diversion. **Not Guilty:** note trial date and inform provider/s.	**Guilty: MHTR/Substance misuse provider/s** are informed of plea. **Not Guilty**: Court Probation Team/L&D Treatment provider discusses support requirements pre-trial.
Pre-Sentencing (assessment/suitability and consent)	**Suitable***:* Provider to assess, gain consent and contact clinical lead for review and sign off, **Not suitable***:* following assessment or as decided by the clinical lead, give reasons and inform Court Probation Team. Provider discuss with Liaison and Diversion for follow up and support to suitable services.	**Assessor:** assess as directed by Clinical Lead, if criteria met gain consent, assessor contact clinical lead for approval and sign off. If not suitable inform Probation Court Team with reasons. Liaison and Diversion for post sentence support.
Pre-Sentencing (Court Probation Team; PSR preparation)	**Assessment outcomes passed to** Probation Court Team along with confirmation of consent and date of 1st meeting with provider, plus outline plan for treatment.	**Providers:** inform Probation Court Team of assessment outcomes Probation Court Team**:** include MHTR recommendations into PSR
Sentencing (Sentencing, within 14 days if not possible on the day)	Probation Court Team outlines PSR recommendations to the sentencer and answers any questions. Sentence given. **MHTR sentenced:** Providers informed, and case allocated to Probation Practitioners, Provider informed. **MHTR not sentenced:** Liaison and Diversion informed for follow up and support into suitable services.	**Sentencer**: *if sentenced* to MHTR ensure consent has been secured (signed), record length of requirements and date of 1st meeting. Probation Court Team meet with individual post sentence to ensure understanding of order and provide initial appointment date. Probation Court Team to inform treatment provider of outcome Liaison and Diversion. *If not sentenced,* Liaison and Diversion informed in order to support into appropriate support services.

Probation/MHTR delivery		
Allocation to Probation Practitioner	**Probation will allocate the case**. When allocated and assigned to a practitioner a meeting will be held with the individual	**Probation Practitioner** to meet individual after sentencing to explain the sentence. Agree date for multidisciplinary meeting.

Probation/MHTR delivery		
Post sentence Multidisciplinary meeting to agree sentence planning	**Meet with: Probation** and **MHTR provider** to agree and maximise the benefit of the treatment requirement. Appointments agreed at the meeting Consideration and support to be given to provide appropriate accessibility to treatment ensuring equality of access is available to all adults sentenced to an MHTR	**Probation Practitioner:** coordinates a sentence planning meeting, which includes all partners and individual. Sequencing of treatments and any other requirements is agreed, recorded in the sentence plan.
Delivery	**Review** MHTR clinical progress throughout the order. DRR/ATR as agreed with provider and PP **Non-attendance:** process around non-attendance and enforcement will be discussed and agreed at the multidisciplinary meeting.	**PP/MHTR provider:** review throughout via electronic /telephone/email communication**.** **Non-attendance**: Provider communication with PP who will make any decision regarding enforcement. PP will communicate with the individual and providers.
Completion	**Provider**: refer to longer term support and treatment if necessary. Clinical final assessment to establish clinical outcomes following treatment.	**PP/ MHTR provider:** arrange a meeting with the individual and provider at the end of the treatment, any future support or treatment will be agreed together with the decision regarding whose responsibility it will be to contact services. **Provider** offers a certificate of completion along with feedback questionnaire.

Appendix 3: MHTR Primary Care Clinical Model

Initial screen
Recommended screening tools which may act as a trigger for further assessment: [22]Kessler 10, [23]CORE 10
MHTR assessment
Recommended interview assessments could include: CORE -34 Psychological distress PHQ9 Depression GAD7 Anxiety Appropriate assessment of Risk **Additional questions and information gathering through semi structured interview**: 1. Other agencies/services currently helping you and your family with your problems? 2. Check current medication use 3. What is the impact of any drug and alcohol use on the ability to engage with psychological work? 4. What are your MHTR goals? 5. Physical Health issues 6. What is the main problem/difficulty affecting you? 7. Briefly enquire about: Childhood, Education, Family system, Employment, Relationships and Support networks 8. Have there been times when things have felt better? Enquire about helpful coping techniques 9. What previous help/therapy have you had for your mental health and wellbeing? What helped? 10. Is there anything you feel might be important or relevant that we haven't discussed? 11. Is there an existing diagnosis including co morbidity? 12. Are there any barriers to attendance? 13. Neurodivergence- including Autism, ADHD, LD, Specific Learning Difficulties (Dyslexia, Dyspraxia, Dyscalculia), Tic Disorders, Developmental Language Disorder (including speech, language and communication needs) and Brain Injury. This might include thinking about memory, processing, time management, concentration and sensory needs 14. Primary Formulation
Consent process
Consent explained and completed following assessment by MHTR assessor (consent template, Appendix 1). **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 Court Team who will contact the individual and explain next steps, which could include Breach and return to court.
Clinical Lead sign off
The Clinical Lead is contacted by the primary care practitioner to discuss the assessment, CL will then decide if a recommendation for MHTR is appropriate and agree a decision to treat or decline, giving reasons. **MHTR assessor:** Conveys information to Probation Court Team for inclusion in the Pre-Sentence Report (PSR).
Case management
Post sentence:

[22] https://www.tac.vic.gov.au/files-to-move/media/upload/k10_english.pdf
[23] http://www.coreims.co.uk/About_Measurement_CORE_Tools.html

Hold a multi-disciplinary meeting with the allocated PP MHTR, Substance misuse provider and other relevant agencies with the individual to discuss goals and expectations.

Clinical engagement

This will be agreed at the case management meeting but may be weekly or fortnightly and depending on other community order commitments.

MHTR treatment interventions

This is not a homogenised group and interventions will vary depending on clinical needs and individualised formulation.
The following has been developed though practice-based evidence.

A formulation of delivery interventions, drawn from best practice, for example:

- Psycho education, breathing, mindfulness
- Compassion focused therapy
- DBT, CBT, behavioural activation
- Acceptance and commitment therapy (ACT)
- Mindful practices
- Value based solution focused therapy

Please refer to the Clinical Guidance Manual for more detailed information on the psychosocial interventions.
On average, each MHTR consists of approximately 10-12, 50-minute sessions over the duration of the order as specified by the court (although this will be determined locally)

Clinical supervision of MHTR provider

Weekly or fortnightly clinical supervision sessions with MHTR provider, depending on local arrangements.

Review

Individuals are reviewed as part of the supervision sessions outlined above, but always at 6 months. For those cases sentenced in the Community Justice Courts the individuals may be subject to 4 weekly court reviews where the case and progress is reviewed.

End of treatment review

Outcome measures are scored: (CORE, GAD, SAPAS, dealing with feelings, TOSCA and WSAS).
End of treatment: where appropriate referral letter is prepared to ensure engagements with local service provision to continue treatment.

End of MHTR review with PP and MHTR provider: along with a questionnaire which aids with follow up 3,6,12 months following treatment.
Consideration of treatment completion/goodbye letter.

The Clinical Leads have collectively written the text below to provide a summary of an MHTR site: *"MHTR sites employ suitably qualified mental health trained staff to provide psychological interventions for individuals referred through the court, for people who have been identified as suitable to benefit from a therapeutic intervention as part of their community sentence. Sessions are designed to provide guidance, support, tools and strategies using a broad range of cognitive-behavioural therapy techniques.*
These are provided through value-based interventions, problem solving and behavioural activation strategies alongside psychosocial education and skills to help people manage their emotions, reduce emotional distress and lead meaningful lives. The sessions also function as an initial introduction to mental health, support and therapy services where individuals may be referred onwards to formal psychological treatment should the need become apparent either during or at the termination of MHTR sessions."

Appendix 4: MHTR Clinical Leads Guidance

Clinical Lead (CL) Guidance for Primary Care MHTRs
(CLs will be registered with a professional statutory body e.g. HCPC)

Pre-sentence:

1. **The CL will define** the locally agreed pre-sentence screening and assessment measures which will define guidance for the MHTR threshold. The CL **will agree the consent process** with the court probation team
2. The **CL will agree the information required within the assessment** that Probation Court Team will require for the PSR
3. The **CL will agree the clinical care plan** including the desired outcomes from the interventions to be provided
4. Court Probation Team and the CL will **agree a sign off process if the CL isn't personally gaining consent**
5. The **CL will be the named clinician** for the purpose of sentencing

Post sentence treatment delivery:

1. If the **CL is personally** providing the psychological therapy or interventions, the treatment will be recommended and provided within appropriate timescales in accordance with the community order
2. If the **CL isn't providing** the psychological therapy or interventions but is acting as supervisor and overseeing the requirement the CL will define the evidence-based interventions, which will be provided within appropriate timescales
3. If the **CL is acting as a supervisor,** the frequency of supervision will follow recommendations from the relevant professional body (e.g. British Psychological Society/HCPC)
4. Where appropriate the **CL will advise/support the effective sequencing of the requirements** (if other treatment requirements have been ordered) to ensure maximum engagement and effectiveness

The **CL will be informed of any non-compliance** with the requirement and advice would be gained from the PP

Sentence completion:

1. On completion, the **CL will sign the order off and advise further treatment** with statutory services if appropriate
2. The **CL (and treatment provider) will review clinical outcome**, as specified pre-sentence to ensure assessments and treatments are effective and monitored as locally agreed
3. The **CL will feed back to the steering group** with the clinical progression of the requirements

Appendix 5: Example consent

Confidentiality Statement and Consent to Treatment and Assessment.

Information you tell anyone in the MHTR service may be shared with people from other services ONLY if they 'need to know' the information

Mental Health Treatment Requirement
Client Confidentiality Statement and Consent to Treatment and Assessment.

Information you tell anyone in the MHTR service may be shared with people from other services ONLY if they 'need to know' the information

These other services include: xxxxxx

Personal information /data

Your personal information will be shared to gain:

- Information to help with your treatment
- Information to understand your health needs
- Information about safeguarding and child protection (where needed)
- Information around assessing risk
- Data to help us understand how the service is doing and help fund it
- Information from the other services we work with
- Information that we must get because of our contracts.

What is meant by data sharing?

There are laws around sharing personal information and any staff getting information must keep all information confidential.
There may be times where staff must share personal information without your consent. This will only happen if there are any worries around threats being made to self or others, safeguarding issues around adults or children or any serious crimes you tell us you are going to do.

How we keep your information

We keep your information on our active case management system from assessment to when you finish treatment. Your information will then be encrypted. This means only some people will be able to see it. It will then be stored electronically and securely indefinitely.

Consent

Your consent or agreement with this is needed.

We will make sure that discussions, conversations, and telephone calls about confidential information cannot be overheard. We will not share information that tells people who you are unless this is needed.
Information about hurting yourself or another person, or to the safety and well-being of children must be reported to external agencies.

You have been given information about the assessment and treatment requirements. You understand and consent to the assessment and treatment if you are given a Mental Health Treatment Requirement (MHTR)

If you are sentenced to a Mental Health Treatment Requirement you must go to all the treatment sessions and do what is agreed in your treatment plan

Agreement to receive treatment/interventions for (MHTR)

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

Name…….

Date of Birth……..

Signature…… Date……..

GP surgery……

Appendix 6: MHTR Decision Model

Primary Care Mental Health Treatment Requirement **Decision Model**

<table>
<tr><th colspan="3">Referrals generation</th></tr>
<tr>
<td>Main Referrers
Probation
Liaison and Diversion</td>
<td>Secondary Referrers
Legal representatives
Judiciary
Court staff
Self-Referrals
Carers and family members
Community MH Teams</td>
<td>Note to action
Aim to increased referrals from L&D as this would enable improved communication and referral processes</td>
</tr>
<tr><th colspan="3">Referral Criteria</th></tr>
<tr>
<td>Principles
1. Offer Hope with a recognition of need
2. To be offence blind, if considered suitable to be managed in community by probation
3. Engagement with secondary care should not be a reason to exclude if interventions may be helpful. Discussion with secondary care to determine suitability.
4. Screen in and be as inclusive as possible</td>
<td>All may be considered if
1. The Offence crosses the community Order threshold
2. Presenting with a range of mental illnesses from mild/moderate to Neurodiversity, personality disorder issues, presenting with psychological distress, dual diagnosis histories of trauma and abuse</td>
<td>Not suitable but will require immediate support
1. Not suitable if the needs and risks cannot be managed in the current MHTR service model and partner agencies
2. Actively suicidal
3. Presenting with Psychosis, that would not enable therapeutic engagement</td>
</tr>
<tr><th colspan="3">Screening</th></tr>
<tr><td colspan="3">1. Ensure earlier screening and referral by L&D from arrest and first court appearance.
2. Ensure the processes are in place to screen prior to plea: K10, CORE 10.</td></tr>
<tr><th colspan="3">Assessment</th></tr>
<tr>
<td colspan="2">PC Practitioner
1. Generally, 45 min assessment
2. Assess suitability using CORE 34
3. If PCP has assessed as potentially suitable for MHTR, discuss a possible treatment plan.
4. Gain consent
5. PCPs will be supported via regular supervision by CL’s on suitability the expectation is that only a small number may be turned down by CL.</td>
<td>Clinical Leads
1. Receive information same day from the PCP
2. Review, discuss with PCP, respond back with acceptance, or otherwise.
3. If turned down, state why along with suitable referral options.</td>
</tr>
</table>

This MHTR Operating and Commissioning Guidance Framework has been written to support the MHTR new and developing MHTR service by Mignon French MHTR Programme Manager.
In Consultation with the NHSE/I Health and Justice Commissioners, Programme Steering Group and Partner Agencies:

:
With thanks to the Revolving Doors Lived Experience Panel for their combined feedback.

Version 2 :2022:
This is a live document and will be reviewed at regular intervals