Institute for
Public Safety
Crime and Justice

Clinical Lead Mental Health Treatment Requirement (MHTR) Manual

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Contents

1. Introduction

This resource is aimed at and has been developed in collaboration with Clinical Leads to support the development of Mental Health Treatment Requirement (MHTR) pathways, processes and protocols across England and Wales. Clinical Leads may wish to share this document with Primary Care MHTR Practitioners within the local site.

This document should be reviewed in conjunction with the MHTR Programme Operating Framework and is supplemented by Primary Care MHTR Practitioner Manual.

This document has been reviewed by the Programme Site Chairs, Clinical Leads and Primary Care MHTR Practitioners. It has been circulated to the National MHTR Oversight Group who have in turn shared it with partner agencies (inc. NHS England and NHS Improvement (NHSE/I), Her Majesty's Prison and Probation Service (HMPPS), Department for Health and Social Care (DHSC), and the Office for Health Improvement and Disparities (OHID) for review and wider comments.

Within the resource, you will find the following information with supporting template documentation being provided in the appendices:

- Overview of Mental Health Treatment Requirements;
- Information to inform the design and development of the MHTR intervention;
- Overview of the role of the Clinical Lead.

Acronyms:

A&E: Accident and Emergency	**HMPPS:** Her Majesty's Prison and Probation Service
ADHD: Attention Deficit Hyperactivity Disorder	**LASPO:** Legal Aid, Sentencing and Punishment of Offenders
ASC: Autism Spectrum Condition	**L&D:** Liaison and Diversion
AP: Assistant Psychologist	**MAPPA:** Multi-Agency Public Protection Arrangements
ATR: Alcohol Treatment Requirement	**MASH:** Multi- Agency Safeguarding Hub
CCG: Clinical Commissioning Group	**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
CSTR: Community Sentence Treatment Requirement	**OHID**: Office for Health Improvement and Disparities
DHSC: Department of Health and Social Care	**PCT:** Probation Court Team
DRR: Drug Rehabilitation Requirement	**RAR:** Rehabilitation Activity Requirement
GP: General Practitioner	**PSR:** Pre-Sentence Report
HMCTS: Her Majesty's Courts and Tribunals Service	**YOT:** Youth Offending Team

2. Mental Health Treatment Requirements

This section provides an overview of Mental Health Treatment Requirements. It is organised into the following sections: 2.1: Background and 2.2: MHTR Process

2.1 Background

Many offenders 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.

Since 2017 as outlined in the NHS Long Term Plan[1], five parts of England tested a new Mental Health Treatment Requirement Programme, this enabled courts to require people to participate in community treatment, instead of a custodial sentence. MHTR sites provided community treatment for people who may otherwise have been sentenced to short custodial sentences, alongside the other wider Community Sentence Treatment Requirement (CSTR). Following this, there were several national policy drivers that support the increased use of Treatment Requirements across England and Wales, including:

- **Female Offender Strategy** (2018[2]) – which highlights the complex and acute needs of female offenders and proposes that due to the offence profile of the majority of female offenders, managing them in the community is more effective than in prison. Increased use of CSTRs is identified in the strategy as one of the mechanisms by which more female offenders could be managed in the community to address the complex needs that drive their offending.
- **NHS Long Term Plan** (2019[1]) – which states how CSTR sites have provided community treatment for people who would otherwise have been sentenced inappropriately.
- **Smarter Approach to Sentencing** (2020[3]) – which 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.
- **Sentencing Guidelines for Offenders with Mental Disorders** (2020[4]) – a 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.

[1] https://www.longtermplan.nhs.uk/online-version/appendix/health-and-the-justice-system/
[2] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/719819/female-offender-strategy.pdf
[3] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/918187/a-smarter-approach-to-sentencing.pdf
[4] https://www.sentencingcouncil.org.uk/overarching-guides/magistrates-court/item/sentencing-offenders-with-mental-disorders-developmental-disorders-or-neurological-impairments/

- **Operating Framework for Probation** (2021[5]) – a new framework that outlines the new probation model, also referring to increasing the use of CSTR and MHTRs when providing recommendations to court.
- **Dame Carol Black Review of Drugs, Part 2** (2021[6]) – which recommends that DHSC and NHSE expand their CSTR programme to 100% of the country by the end of this Parliament, noting that 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. However, before 100% coverage is achieved many offenders will not benefit from this approach, and the high use of prison in the remaining uncovered areas will continue.

Mental Health Treatment Requirements (MHTRs) were introduced in the Criminal Justice Act in 2003 and is one of three possible treatment requirements which may be made part of a Community Order or Suspended Order sentence. The other two treatment requirements are Drug Rehabilitation Requirements (DRR) and Alcohol Treatment Requirements (ATR). An MHTR may be combined with DRR or ATR. ATRs/DRRs are provided through substance misuse services commissioned by the Local Authority. The term Community Sentence Treatment Requirement (CSTR) refers to one or combinations of MHTR, DRR and/or ATR as part of a Community Order or Suspended Order sentence.

'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 CJS should have access to treatment in the same way as anyone else via mental health services, commissioned by NHS 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, ensuring that services are integrated and providing interventions to all.

The other 10 possible requirements within Community Orders are:

- Unpaid work for up to 300 hours;
- Rehabilitation activity requirement (RAR) undertaking activities as instructed;
- Undertaking a particular programme to help change offending behaviour;
- Prohibition from doing particular activities;
- Adherence to a curfew, so the offender is required to be in a particular place at certain times;
- An exclusion requirement, so that the offender is not allowed to go to particular places;
- A residence requirement so that the offender is obliged to live at a particular address;
- A foreign travel prohibition requirement;
- An alcohol abstinence and monitoring requirement with the offender's consent; and

[5] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/959745/HMPPS_-_The_Target_Operating_Model_for_the_Future_of_Probation_Services_in_England___Wales_-__English__-_09-02-2021.pdf

[6] https://www.gov.uk/government/publications/review-of-drugs-phase-two-report/review-of-drugs-part-two-prevention-treatment-and-recovery

- Where offenders are under 25, they may be required to go to a centre at specific times over the course of their sentence.

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. The LASPO Act[7] sought to make it easier for courts to use the MHTR as part of a Community Order or Suspended Sentence Order by simplifying the assessment process and ensuring that those who require community-based treatment receive it as early as possible. The Act removed the requirement that evidence of an individual's need for mental health treatment is given to a court by a Section 12 registered medical practitioner.

This change means that 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 quicker, thus reducing the avoidable time delay leading to adjournments and unnecessary psychiatric court report costs of using the MHTR as part of a community sentence.

2.2. Guiding Principles, Aims and Objectives of MHTR Partnerships

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 are 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

The Primary Care MHTR Partnership services in any given area operate under six guiding principles. These are to:

1. 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)

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

2. Operate within the MHTR Framework /Commissioning and guidance.

3. Ensure inclusive approach, recognising mental health needs, associated vulnerabilities for those in contact with the CJS irrespective of any protected characteristics.

4. 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);

5. Signpost to social support to ensure that individuals engage with treatment until an appropriate discharge point is reached.

6. 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.

MHTR Programme Aims

- **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, 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 Framework and Commissioning Guidance and corresponding documents, and the sharing of good practice across the sites with support from the MHTR Programme team

A secondary aim is to raise awareness of the high numbers of individuals with mental health, personality disorder, neurodiverse 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.

How will this provision improve community integration?

More individuals will experience:

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.

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.

2.3. Eligibility for a Primary MHTR

The MHTR is intended for the sentencing of individuals convicted of an offence(s) which crosses the Community Order threshold and who have a mental health problem which does not require secure in-patient treatment.

Before sentencing an individual to a MHTR, the court must be satisfied that:

1. The mental condition of the individual requires treatment and may be helped by an intervention, but does not warrant making a hospital or guardianship order (within the meaning of the Mental Health Act 1983);
2. Arrangements have been or can be made for the individual to receive an intervention as specified in the order; and
3. The individual agrees and gives consent to receive an intervention for their mental health condition.

An individual is eligible for an MHTR if they meet the following criteria:

- 18 years old or above
- Consents to the requirement
- Charged with committing an offence which crosses the community order sentencing range
- For those with Mental Health, Personality Disorder problems and/or neurodivergence, reasonable adjustments will be made to accommodate individual needs 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 consideration of a MHTR.

- Individuals subject to these requirements may have several vulnerabilities, including mental health issues, substance misuse, autism, learning/communication difficulty, neurodivergence
- Adjustments will be made to ensure that the services are accessible to individuals subject to these requirements (e.g. accessible and easy read, information available in relevant languages

and formats, treatments offered in suitable and accessible locations (inc. telephone and virtual) taking into account sensory, 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

As with all clients coming through the courts, if they live and reside within the post code area that the MHTR 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 MHTR 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 before an MHTR intervention can begin. The 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.

Who is suitable for a MHTR?

The MHTR is intended as a sentencing option for individuals who suffer from a low to medium level mental health problem which is assessed as being suitable for a mental health intervention in the community. Specifically, this means those individuals who do not require secure in-patient treatment and whose offending behaviour may be positively affected by mental health intervention in the community. This will be dependent upon the recommendations of the mental health assessment.

Whilst individuals are assessed using different psychometric assessment tools (such as the CORE-10, CORE-34, PHQ-9, GAD-7 etc.) by the MHTR practitioner, the decision to recommend an individual for an MHTR is determined by the professional judgement of the Clinical Lead. The use of the psychometric tools, therefore, are to support the practitioner to identify mental health needs and their effects on the offending behaviour of the individual.

It is important that assessments consider each individual on a case-by-case basis, considering their full circumstances and demographic factors (such as gender, age, ethnicity etc.).

Neurodiversity

The term neurodiversity recognises the natural diversity in how individuals make sense of the world and is the umbrella term for both neurodivergent and neurotypical experiences. Neurodivergence may include several neurotypes: for the purposes of MHTRs the definition used in the 'Neurodiversity in the criminal justice system evidence review' is used. This recognises that neurodivergence includes "learning difficulties and disabilities (LDDs) which generally include: learning disability, dyslexia, dyscalculia, and developmental coordination disorder (DCD, also known as dyspraxia); other common

conditions, such as attention deficit hyperactivity disorder (ADHD), autism spectrum conditions, developmental language disorder (DLD, including speech and language difficulties), tic disorders (including Tourette's syndrome and chronic tic disorder); and cognitive impairments due to acquired brain injury (ABI)" (Criminal Justice Joint Inspection, 2021).

In 2020[8], HM Inspectorate of Prisons and HM Inspectorate of Probation were commissioned by the Lord Chancellor to review the evidence into neurodiversity in the criminal justice system. It was found that given the complexity of defining neurodiversity and associated comorbidities, it is difficult to be sure about the numbers or proportions of neurodivergent people within the criminal justice system, or to what extent they are over-represented. However, based on the evidence provided to this review, it seems that perhaps half of those entering prison could reasonably be expected to have some form of neurodivergent condition which impacts their ability to engage.

The suggested proportions of neurodivergent individuals in the criminal justice system is high:

- **Learning difficulties** - Between 30 and 50% of offenders are thought to have dyslexia, compared with 10% of the general population[9].
- **Learning disabilities** - Within a study of three prisons, the overall average for prisoners assessed either as learning disabled or borderline learning disabled for the three sites was 32%, with 6.7% assessed as learning disabled, and a further 25.4% as 'borderline'[10].
- **Attention Deficit Hyperactivity Disorder (ADHD) -** A meta-analysis showed that 25.5% of the prison population met the criteria for ADHD, a ten-fold increase in adults compared with the general population[11] and 59.4% of a sample of 69 women met the criteria for ADHD following screening[12].
- **Autism Spectrum Conditions** - The Neurodiversity in the criminal justice service review (Criminal Justice Joint Inspection, 2021) documents noted that "figures quoted in the call for evidence suggest that 5-7% of those referred to liaison and diversion services have an autistic spectrum condition (ASC). Within prisons the prevalence of autistic 'traits' or 'indicators' could be around three times as high (16% and 19% respectively)"[13].
- **Developmental Language Disorder (Previously known as Specific Language Impairment), including speech and language difficulties -** It is highlighted that 60% of young offenders in a community sample met the criteria for DLD, with this not previously having been diagnosed[14]. These individuals were more likely to reoffend. DLD may co-occur with other neurodiversities

[8] https://www.justiceinspectorates.gov.uk/cjji/wp-content/uploads/sites/2/2021/07/Neurodiversity-evidence-review-web-2021.pdf

[9] http://www.adders.org/dyslexia_and_youth_offending.pdf#:~:text=In%20recent%20years%20a%20number%20of%20projects%20and,offenders%20remains%20the%20exception%20rather%20than%20the%20rule.

[10] http://www.prisonreformtrust.org.uk/uploads/documents/NOKNL.pdf

[11] https://pubmed.ncbi.nlm.nih.gov/25066071/

[12] https://eprints.whiterose.ac.uk/93767/13/Farooq%20et%20al%202016.pdf

[13] https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/neurodiversity-in-the-criminal-justice-system/

[14] http://www.beyondyouthcustody.net/wp-content/uploads/Young-offenders-and-trauma-experience-and-impact-a-practitioners-guide.pdf

for example, autism and ADHD and research has suggested that young adults with DLD are more likely to experience anxiety and depression than their peers[15].

- **Acquired Brain Injury (ABI)/Traumatic Brain Injury (TBI) -** TBI is thought to affect around 8.5% of the population. Research has suggested that around 60% of prisoners have an ABI and it may increase the risk of offending (Williams, 2012). The leading cause of brain injury within a women's prison was shown to be domestic violence (McMillian et al., 2021).

Considering the available evidence, it is anticipated that a higher proportion of individuals with neurodivergent needs would be identified within the cohort sentenced to MHTRs. It is likely that some people will have these needs without this previously having been recognised.

Screening for neurodivergence, and then supporting neurodivergent individuals, is challenging, and it is not expected that frontline staff become experts. It is, however, expected that awareness, understanding and confidence in relation to neurodiversity is improved. To support health, probation and partner agency staff, a national lead has been appointed to support all MHTR sites, hosted by Barnet, Enfield and Haringey NHS Trust, to raise awareness of neurodiversity, improve screening and identification processes and establish guidance to support frontline practitioners.

Improvements to how neurodivergent individuals are supported within MHTR pathways will support the Ministry of Justice's (MoJ) objectives of 'Fair treatment, fair outcomes and equal access for all our service users'.

Difference between Primary and Secondary Mental Health Treatment Requirements

It is recognised that most individuals who are sentenced to an MHTR do not reach the clinical threshold for mental health treatment in secondary care. However, having a secondary care mental health issue does not necessarily exclude eligibility for a MHTR. For instance, if their offence was not related to their secondary mental health issue, they may still be eligible for a MHTR. Therefore, each individual should be assessed in accordance with the process outlined in Section 2.2.

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, 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.

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.

[15] https://pubmed.ncbi.nlm.nih.gov/18221347/

The following criteria (but not limited to) are used to identify individuals suitable for Secondary care mental health services:

- 18 years old or above
- Individual understands the requirement and consents to treatment
- Offence crosses the community or suspended sentence order range
- Meets the local criteria for being in the Care Programme Approach (CPA) (refer to CPA policy)
- 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 which exceeds what can be managed in primary care
- Requires active treatment
- Degree of mental health difficulties significantly impacts on daily functioning
- Individuals with low levels of symptoms (see 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 MHTR. If this proves insufficient a secondary care MHTR may be considered

Please refer to the *Guidance Paper to support access to Secondary Care Mental Health Treatment Requirements (MHTRs)* for a comprehensive overview.

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 CSTR process evaluation [16]. 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 CSTRs for individuals with associated vulnerabilities.

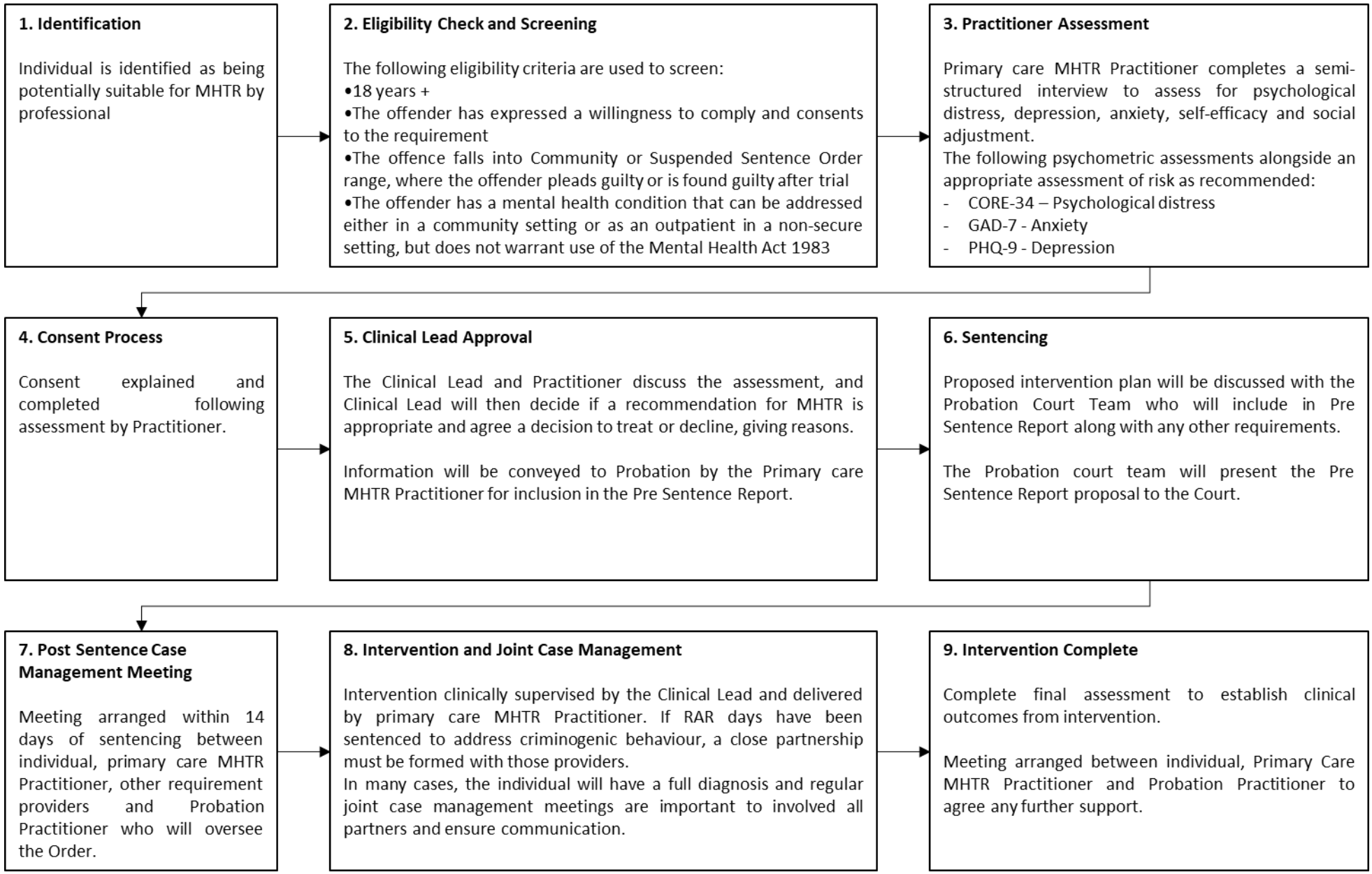
[16] https://www.gov.uk/government/news/lifeline-community-treatment-pilots-to-steer-offenders-away-from-crime

2.4: Overview of MHTR Process

This section details the MHTR process, providing information on each stage.

The MHTR process is illustrated in Figure 1.

Figure 1: MHTR Process



MHTR Process Stages

1. **Identification:**

Referrals can be made by different parties working across the criminal justice system including:

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

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.

2. **Initial Screening:**

The individual will be assessed using the agreed assessment tools either in police custody (typically undertaken by L&D team) and/or in court (could be undertaken by Probation, L&D, or dedicated MHTR worker or practitioner). The individual is assessed for: signs of mental ill health, substance misuse, social issues and other vulnerabilities (inc. housing, finance, relationship issues, work /education) and GP registration.

If screens do not indicate MHTR 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 Probation Court Team (PCT) 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 PCT.

As with all clients coming through the courts, if they live and reside within the post code area that the MHTR 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 MHTR 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 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

3. MHTR Practitioner Assessment:

Before providing an overview of the structure and content for Primary Care MHTR Practitioner assessments, it is critical to recognise and appreciate the guiding principles for referrals for MHTR.

These are:

1. **Offer hope with a recognition of need**
2. **To be offence blind, if considered suitable to be managed within the 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.**

The Primary Care MHTR Practitioner Assessment will be typically completed by the Primary Care MHTR Practitioner or other trained professional (inc. Nurses, Social Workers, or other relevant Primary care Practitioners). Where possible, it is preferable that the Practitioner who delivers the intervention completes the MHTR Practitioner Assessment.

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

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 Primary Care MHTR Practitioner based on needs and presentation of the individual.

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

- Speech, language and communication needs
- Neurodivergence and differences associated to this, for example memory, concentration, processing, time management, impulsivity and sensory 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 including 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 and/or suicide. If so, a more detailed assessment of this specific risk must be completed.
        - It should be determined whether or not the individual already has a suicide crisis plan, and which formal (e.g. service) and informal (family/friend support) structures are in place. Signs of safety should be recorded. If the individual does not have a plan in place, then a preliminary plan should be created linking into supports identified in the session. This should always include (at least) the most relevant local crisis service.
    - 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, executive functioning differences 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 will gain consent (see step 4) for the order to be proposed. All materials will be translatable and/or available in an easy read format.

The Practitioner should make careful note of any concerns related to suicide history, current thoughts or plans. These should be communicated to the clinical lead as part of the referral approval process. It is recommended that this information should be used by the clinical lead to determine whether or not proceeding with an MHTR is the safest option of the referred person.

The practitioner should make any note of psychiatric history particularly pertaining to psychosis. This should be combined with the practitioner's own qualitative judgement as to how feasible it is to work with the referred person (i.e. was communication successful to the point that therapy seems achievable). If there are barriers to successful therapy then it is recommended that the referred person by redirected to a medication review. If this can be undertaken before a court date and professional consensus suggests that treatment is likely to be successful following that review then proceeding with the MHTR is recommended. If a medication review is unlikely to be achieved before the referred person's court date, then it is recommended that an adjournment be sought in order to facilitate this. If neither case is possible then it is sometimes recommended that an MHTR not be sought in the individual's case, but that the key worker from probation recommend that if the case returns to court at a later date the case be reconsidered.

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

Recommendation from Practice:

The focus in the assessment process should be on inclusion criteria and the benefits of an MHTR for the individual rather than exclusionary factors.

Recommendation from Practice

Assessment where possible should be completed on the day of Court attendance, in a private room. A brief explanation of MHTR should be provided, with an appreciation of likely heightened anxiety due to the circumstances of being in Court. Where possible, the assessment should be completed by the practitioner that will be delivering the intervention if sentenced, but this cannot always be the case, so the person should be notified of this possibility.

4. Consent Process:

Consent explained and completed following assessment by MHTR assessor.

Assessor will fully explain the MHTR treatment including: What will be expected, and that 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**

Recommendation from Practice[17]

"An issue for obtaining consent for treatment from defendants arises out of stigma. Public acknowledgement of a mental health condition is still perceived to carry social stigma which may hinder the consensual uptake of an MHTR by offenders. To prevent the need for public acknowledgement of mental health problems which may lead to refusal to accept an MHTR, the court may choose to have the details of the MHTR agreed in private prior to the court hearing. The offender manager, health professional and the defendant can agree inclusion of a requirement and the court may then subsequently ratify this agreement without further details being disclosed in open court".

5. Clinical Lead Approval:

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

The Clinical Lead and Primary Care MHTR 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 Practitioner for inclusion in the Pre-Sentence Report (PSR).

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

Recommendation from Practice

The practitioner telephones the Clinical Lead and goes through the assessment and a brief formulation is developed about how the defendant's mental health issues may have contributed to the offence. Decision made as to suitability for treatment, and the practitioner reports the outcome back to probation, with reasons and brief explanation for or against a recommendation for an MHTR. Probation then feeds back to the Judge.

6. Sentencing:

The proposed treatment/intervention plan will be discussed with the Probation Court Team (PCT) who will include in the Pre-Sentence Report (PSR), along with any other community requirements. The PCT will present the PSR proposal to the court and if MHTR included, the recommendation will inform the judiciary that consent has been gained together with a named Clinical Lead if an MHTR (and provider agreement if an ATR/DRR).

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

7. Post Sentence Case Management Meeting:

A meeting will be arranged within 14 days of sentencing between the individual, requirement providers and Probation Practitioner who will be overseeing the order. The meeting will define appropriate delivery of the order, including communication, attendance and sequencing of treatment provision between mental health and substance misuse providers. Approximately 12 face-to-face MHTR sessions may be recommended by the mental health provider. If, during the MHTR delivery the individual withdraws consent for the requirement, the Order would then be returned to Court for re-sentence.

Recommendation from Practice – Clinical Lead Advice

"*Good partnership working is essential for successful orders. Having a prompt multi-agency meeting with the individual, probation officer, practitioner and the support worker helps to allay fears, explain what will be required and what support is needed for the individual as well as identifying challenges and barriers for progress in order to prevent breaches*".

8. Intervention and Joint Case Management Meetings

Once the intervention has commenced, regular meetings will be held throughout the Community Order, involving the Probation Practitioner and treatment requirement delivery partners. The meetings will enable effective communication of the individuals progress and engagement with treatment. Issues of non-compliance with the Community Order or specific requirements will be communicated, allowing for shared plans to re-engage an individual. In instances where breach procedures are initiated, the Joint Case Management Meetings will allow for the sharing of evidence and information to inform judicial decision-making.

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 and different formats, treatments offered in suitable and accessible locations taking into account sensory, physical and mental health requirements). Engagement should be supported 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.

9. Intervention Completion

At the end of the intervention, a meeting will be held between the individual, the Primary Care MHTR Practitioner and Probation Practitioner to discuss the treatment received, progress made and outline any ongoing needs. Further treatment or referrals into services will be agreed based on the individual's needs.

In the final session of treatment, an assessment will be completed to measure any change experienced by the individual.

Follow-up sessions may be required, depending on individual needs. In such instance, this should be communicated to the Probation Practitioner, with reasons provided in writing.

3. MHTR Intervention

This section provides an overview of the MHTR intervention and practice-related issues. It is organised into the following sections: 3.1: Structure and content and 3.2: Overseeing practice issues.

3.1: Structure and Content

The interventions will be individually tailored to the needs of each client and therefore will vary within and between sites. Critically, the content of each intervention should be determined in respect of issues and needs identified in the MHTR Practitioner Assessment as well as issues and needs that are identified through practice.

Clinical Leads, following feedback from Primary Care MHTR Practitioners, will determine:

- If individuals are suitable for the intervention;
- The structure and content of interventions; and
- When an individual has successfully completed an intervention.

The MHTR intervention is delivered within the bounds of the Community Order, involving close communication with Probation Practitioners who oversee the entire Community Order. The period of time to deliver an MHTR as part of a Community Order will be specified in the Pre-Sentence Report with agreement of the Clinical Lead.

The MHTR intervention involves on average 12 50-minute sessions across the Community Order. The number of sessions required may be less or more than 12, determined by clinical practice and judgment of the Clinical Lead. The decision to complete an intervention before 12 sessions, or extend an intervention, is made by the Clinical Lead, and it is expected that reasons for this are provided to the Probation Practitioner in writing.

The timing of sessions within the Community Order will be determined in the Post Sentence Case Management Meeting, considering other requirements and their interdependencies.

The intervention may typically involve skills and techniques from the following:

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

Noting variation between individuals and sites, the intervention is typically structured into 3 phases:

Phase 1 (Sessions 1-3): Structured introduction and formulation

The focus within the sessions in Phase 1 is to develop a good working relationship between the client and the Practitioner, making the client feel safe and listened to with no judgement and to develop goals of the 6-month order.

Within the introductory sessions, it will likely include:

- Review of needs identified in the MHTR Practitioner Assessment;
- Identification and discussion of values, lifestyle and coping mechanisms;
- Identification and discussion of any barriers to attending or engaging in the intervention and any reasonable adjustments; and
- Goal setting.

It is important that the client receives a positive experience in these sessions, and they are not just further information gathering. The client needs to feel listened to and to gain some appreciation that the intervention is one that they value or will come to value. Opportunities could be explored in this session for small pieces of psychoeducation or explanation, or an identification that there is something later in the programme that the individual may benefit from.

Recommendation from Practice – Clinical Lead Advice

"Sessions 1-3 are focussed on engagement, completion of full history, identification of key goals, lifestyle and values, and focus for therapy, with the development of a crisis plan if appropriate. This is also the time to focus on building a solid therapeutic relationship, based on empathy, genuineness and unconditional positive regard".

Recommendation from Practice – Clinical Lead Advice

"These are the assessment and formulation sessions; these may take only a single session or can take up to two if the individual requires further assessment or you think there is benefit in allowing them to discuss their difficulties in more length in session 1. Sessions 1 and 2 can also be considered 'buy-in' sessions for clients. By the end of session 2 there should be a completed formulation using the ACT model that should direct which interventions are likely to be best suited to the client's needs".

Phase 2 (Sessions 4-10): Individualised sessions to address needs

The focus within Phase 2 sessions is to deliver individually tailored sessions focused on the specific needs of the individual. These sessions are focused on completing psychoeducation (covering attachment, evolution and functions of emotions) and introducing strategies to manage emotions, such as attention training and mindfulness.

The specific content of sessions will be determined by the judgement of the Clinical Lead and the available resources within the local health trust. The following list is not exhaustive, but the intervention will likely draw upon established techniques from various psychotherapies such as:

- Cognitive Behavioural Therapy;
- Compassion Focussed Therapy;
- Dialectical Behaviour Therapy
- Mindfulness;
- Functional Analysis;
- Emotional Regulation;
- Worry Management;
- Problem Solving;
- Cognitive Diffusion;
- Sleep Hygiene;
- Assertiveness; and
- Self-esteem.

Recommendation from Practice – Clinical Lead Advice

"Within this service we are mainly using a Compassion Focused Therapy model to understand human distress but will use Cognitive Behavioural Therapy techniques such as exposure work and behavioural activation where indicated as interventions. We recognise that this can be difficult given the chaotic environments that some individuals live in, therefore it is important to be flexible in how material is covered to prevent disengagement. Individuals may also have struggled through education and have literacy deficits which must be considered. We try not to overload people with questionnaires and assessment tools, recognising they may need sensitively delivered help to complete these".

Recommendation from Practice – Clinical Lead Advice

"The IAPT MHTR treatment intervention has been designed in a modular fashion with set beginning and ending sessions and a range of discrete interventions appropriate to the client that may be used in between. Treatment should be delivered weekly, preferably at the same time. We are expected not to erect barriers to treatment for those who may be working, and this may require us to provide some input out of hours, within safe limits"

Phase 3 (Sessions 11-12): Consolidation and closure

The focus in Phase 3 is to consolidate any learning gained during the intervention especially in relation to positive coping strategies and signposting to available support within the community. It is important to summarise the individual's progress and achievements throughout the treatment requirement. For individuals who wish to or who would benefit, a small number of follow-up sessions are recommended.

Recommendation from Practice – Clinical Lead Advice

"The end of the order is focused on relapse prevention and having a good ending which they may not have had previously, for those requiring further support they will be referred to appropriate services".

Recommendation from Practice – Clinical Lead Advice

"Endings are mentioned throughout earlier sessions too, to try to avoid dependence issues and any surprises for the client!"

The following is an overview of different intervention models from across the sites:

Example 1:	
Session 1	Assessment and Engagement Sessions including SAPAS, Best hopes & Barriers to attending
Session 2	Emotional regulation – Breathing + sleep hygiene
Session 3	Functional Analysis – Home Tasks – Noticing work
Session 4	Values work – What matters? Life Balance?
Sessions 5-6	Thoughts work – Supercharging CBT with values work + Compassionate Other
Sessions 7- 12	New Wave Problem solving / Values led Behavioural Activation linking to Functional Analysis

Example 2:	
Session 1	Full biopsychosocial assessment
Sessions 2-3	Sleep work/emotional regulation – using "choosing sleep" manual. Introduce apps and core mindfulness concepts.
Sessions 4-5	Functional analysis
Session 6	Re-visit narrative and themes of F.A and work around importance of congruence with values
Session 7	Thoughts and thinking – noticing thoughts, mindful awareness
Session 8	B.O.L.D, compassionate other, importance of "holding" opposites
Session 9	"Choice point" – use B.O.L.D and compassionate other
Session 10	New wave problem solving
Session 11	Reconsolidate programme
Session 12	Final recap, follow up onward referral if necessary.

Example 3:	
Session 1	Background History, Build the therapeutic relationship
Session 2	Functional Analysis, Goals, barriers and coping
Session 3	Good Lives Model, Values and lifestyle
Session 4-9	Individualised Interventions (e.g. Behavioural activation, Worry management, sleep hygiene, Emotional regulation, Mindfulness, Problem solving etc.)
Session 10	Offence Chain
Session 11	Relapse Prevention
Session 12	Review and Goodbye letter.

Example 4:	
Session 1	Introduction
Session 2	Formulation
Session 3-4	Emotional regulation
Session 5-11	Individualised Interventions (e.g. Behavioural activation, Cognitive restructuring, Worry management, Problem Solving, Cognitive diffusion, Assertiveness, Compassion, Self-esteem etc.)
Session 12	Relapse prevention

The information provided above should act as a guide for Clinical Leads at developing a local intervention. It is crucial that developed interventions are founded on the principles of compassion, flexibility and personalisation.

3.2: Overseeing Practice Issues

This section provides information relating to overseeing and managing engagement and breach of MHTR and partnership working.

3.2.1. Waiting Lists

Depending on demand within sites, and progress of existing clients, some individuals may need to wait to start the intervention. This is colloquially referred to as waiting lists.

It is crucial that Clinical Leads recognise their responsibilities for individuals who have been sentenced to an MHTR but must wait to start the intervention. Such individuals are recognised as being under their clinical care, and therefore it is expected that communication (typically by the Primary Care MHTR Practitioner) is maintained with individuals on the waiting list, signposting to support as appropriate to manage their needs.

The frequency of contact will be determined by individual needs and presentation but may involve weekly/fortnightly communication. This is achieved in some sites through online platforms and/or text messages. Where sites experience a growth in waiting lists, steps should be taken to communicate this to the local site board to identify a solution to minimise the use of waiting lists.

3.2.2. Engagement / Breach

In instances when a MHTR client who has been sentenced does not engage with requirements set out in Community Order, they are to be returned to the courts for resentencing, this is known as a 'breach' or 'breaching'.

In MHTR treatment this would typically mean either non-attendance at treatment or attending but not engaging with the elements of treatment. Specialist advice should be sought to ensure vulnerable individuals are appropriately supported to engage with services. A client can also 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.

It is accepted that the MHTR client group is by nature one that may experience ambivalence or social disruptions that serve as an obstruction to regular attendance at sessions. Repeated lack of engagement – through attendance, lateness, cancellations or in session behaviour - should be communicated to the Probation Practitioner accounting for individual vulnerabilities. Evidence of non-attendance must be provided to Probation Service to allow them to present this evidence to the court should the consensus opinion be that the individual is not completing the MHTR order.

MHTRs are intended as supportive requirements which seek to support individuals 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 communicate with the Probation Practitioner regarding cases where breach may be a concern.

Missed appointments can be considered a breach of the MHTR. However, both missed appointments and non-compliance with treatment are contested as 'breaches' in cases where mental health problems impact upon the person's ability to comply with the order, for example some mental illnesses can make a person withdraw or have organisational difficulties and this could result in missed appointments.

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

- It is important that staff in Probation understand the interfaces between each organisation in order to ensure effective enforcement of Community Orders. It is also important for the Probation Service to continue to maintain contact, where possible, with offenders and encourage ongoing engagement with the court order;
- The final decision rests with the Probation Service 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 Probation Practitioner 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 Probation Practitioner 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.

Clients who are not engaging but not breached should not be offered further sessions and this should be communicated to the Probation Practitioner. A discussion on whether the client is placed back onto the waiting list or discharged should be held with the Clinical Lead.

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

It is the aim of the courts, probation and mental health services to give individuals a chance to complete their orders, with an understanding that this will possibly extend the amount of time it takes to deliver a set of treatment sessions. If the client is 'breached' and a warrant is out for their arrest, then the client should be considered as discontinued and discharged.

Maintaining contact between services and people with mental health illness and/or substance misuse is challenging. 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 considering the side effects the person may experience from medication may affect their attendance at appointments);
- inability to attend (for example, services are not local, transport links are poor, or services do not provide childcare);
- not being allowed to attend (for example, 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;

- services not considering and needs relating to neurodivergence;
- previous poor relationships with practitioners; and
- other personal, cultural, social, environmental (for example, gang affiliation) or economic reasons.

It is important to help those who may find it difficult to engage with services to get into and stay connected with services. There are specific populations who are more at risk, including:

- 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.

If a breach occurs, the MHTR provider will report non-attendance to the Probation Practitioner and a treatment plan will be provided to the Probation Practitioner 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 Probation Practitioner to ensure effective management of the Community Order as well as the mental health intervention.

Overall, while breach is important as a last resort where there is a need to provide a boundary for behaviour or if there has been persistent non-compliance, if the overall context within which the breach occurs is general improvement and progress then the professional should have the flexibility to take no action. Imposing a tougher sanction, including potentially a prison sentence, on people who breach a rehabilitative requirement such as the MHTR is problematic and undermines its potential to offer a robust community sentence. Further, there are ethical difficulties in deciding a breach for behaviours which may be the result of a person's illness.

Recommendation from Practice – Clinical Lead Advice

"Close communication with probation is vital. Clients are often seen in probation services. It is important to complete a regular brief summary of the individual's progress in the MHTR sessions and send an email to the Probation worker for input into their report for court. This provides an opportunity for the judge to address anything during the court review".

3.2.2. Partnership Working

MHTRs 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 key interdependencies are:

- Police
- General Practice
- Primary and Community Care
- 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

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

- Police and Crime Commissioners
- Judiciary and Court Staff
- Lived experience groups
- 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

The British Psychological Society (2017) Practice Guidelines set expectations for the practice of psychologists when working with other professionals, including:

- Work together with colleagues to develop a shared view of the aims and objectives of work at all levels. They should respect the professional standing and views of other colleagues and commit themselves to joint working.
- Make it clear to other professional colleagues what can be expected of them in collaborative work, the work that will be done, and the point at which the work will be terminated.
- Ensure that there are explicit agreements about information-sharing and confidentiality and its limits, and that these are adhered to.
- Practise and encourage in others full and open communication with colleagues/ agencies to support effective collaboration within the boundaries of the agreed limits on information-sharing and confidentiality,
- Demonstrate their commitment to involving clients in multi-agency work, finding ways to engage them and retaining the central principle of better outcomes for clients as the rationale for multi-professional and multi-agency work, as long as this is consistent with public safety; and
- Be sensitive to the effects of clients receiving contradictory advice from different professionals or agencies and should work towards a co-ordinated view wherever possible.

Recommendation from Practice – Clinical Lead Advice

"Good liaison with other stakeholders is essential as often there is a need to improvise therapy space and to ensure the safety of the practitioners. Appoint practitioners that are able to use initiative and work in bases away from the support of other MH workers, preferably with a range of experience of providing therapy. When setting up in services that are not familiar with MH basics, there can be considerable tensions and practicalities that need sorting out (privacy, storage, work space and IT, admin support, therapy space, car parking, GDPR and data sharing, limits of confidentiality etc)"

4. Role of the Clinical Lead

The MHTR intervention is typically delivered by a Primary Care MHTR Practitioner who is managed and overseen by a Clinical Lead. The Primary Care MHTR Practitioner is usually an Assistant Psychologist, though, depending on local configurations, other professionals with relevant professional experience and expertise may act as the Practitioner.

This chapter provides an overview of the role of the Clinical Lead and is organised in to the following sections: 4.1 Clinical Lead in Practice and 4.2 Managing and overseeing the Primary Care MHT Practitioner.

4.1 Clinical Lead in Practice

The Clinical Lead will be a registered and experienced psychologist or psychiatrist who will be the named clinician within the sentencing process. Whilst the Primary Care MHTR Practitioner in practice will screen individuals for suitability for the intervention, the Clinical Lead will ultimately determine which individuals are suitable to be recommended for an MHTR and will be personally responsible for their intervention. The Clinical Lead should also ensure that the Primary Care MHTR Practitioner receives an appropriate induction, ongoing training and supervision.

The Clinical Lead has a critical role at determining local procedures for the MHTR, including:

- locally agreed pre-sentence screening and assessment measures which will define guidance for the MHTR threshold, which is communicated in the PSRs;
- the consent process with the court (Probation Service);
- clinical care plans for individuals;
- determine the content of the intervention; and
- provide feedback to the MHTR steering group with the clinical progression of the requirements

Core functions of the Clinical Lead role include providing information to inform sentencing, ensuring robust oversight of the intervention and delivering successful clinical outcomes and MHTRs in practice. The Clinical Lead has several responsibilities pre- and post-sentence. The following outlines these responsibilities:

Pre-Sentence:

- Communicate and confirm suitability of individuals ('sign off') for Primary Care MHTR Practitioner Assessments; and
- Agree with the Probation Service the information required for inclusion within the PSR.

Post-Sentence:
If Clinical Lead is delivering the MHTR intervention:

- Ensure that the treatment will be recommended and provided within appropriate timescales in accordance with the community or suspended sentence order;
- Seek advice from the Probation Service for any compliance issues.

If Clinical Lead is supervising a Primary Care MHTR Practitioner who delivers the MHTR intervention:

- Define the evidence-based interventions, which will be provided within appropriate timescales in accordance with the community or suspended sentence order;
- Deliver high quality supervision following recommendations from the relevant professional body (e.g. British Psychological Society/ HCPC);
- Advise/support the effective sequencing of the requirements (if other treatment requirements have been ordered) to ensure maximum engagement and effectiveness; and
- Provide advice to the practitioner regarding any issues of compliance and support effective communication with the Probation Service and other agencies (e.g. social services).

Upon completion of intervention:

- Sign the order off and advise further treatment with statutory services and support from Third Sector organisations if appropriate; and
- Review clinical outcome (with Primary Care MHTR Practitioners), as specified pre-sentence to ensure assessments and treatments are effective and monitored as locally agreed.

The Clinical Lead position is typically a fractional post (0.2FTE). However, the Clinical Lead must take into account the fluctuations of individuals across Monday-Friday presenting within the judicial process who should be considered for a Community Order with a MHTR, thus, it is strongly recommended that the Clinical Lead schedules regular timeslots on each working day to sign off MHTR Practitioner Assessments and agree information to be included within the PSRs to inform the judicial process. Without such a working pattern, there is a significant risk that many individuals will not have the opportunity to be considered for an MHTR, presenting a key risk and inequity within service delivery.

Recommendation from Practice – Clinical Lead Advice

"Ensure weekly individual supervision of at least one hour. Iron out all the practical issues that arise as mentioned above (sometimes easier said than done). Make sure the Practitioner knows how to contact you. Make sure Practitioners manage boundaries professionally and safely."

4.2 Managing and overseeing the Primary Care MHTR Practitioner

Managing and overseeing the practice of the Primary Care MHTR Practitioner is a key role of the Clinical Lead, to ensure positive clinical outcomes for the individuals who receive the MHTR intervention. It is worth reiterating that the Clinical Lead is responsible for the treatment provided to individuals who are sentenced to an MHTR as the named Clinician.

The activities of a Primary Care MHTR Practitioner should align with the parameters as outlined by the British Psychological Society (2017), which include:

- research, audit and service evaluation;
- literature searches, developing and maintaining training packs, information leaflets, libraries of equipment, and other tasks necessary to the efficient running of the service;
- assessment of individuals and groups, for example, direct observations, formal psychometric testing, semi-structured interviews, and writing appropriate reports;
- delivery of interventions with individuals, groups and organisations;
- undertaking supportive work with carers, family members, employers, human resources professionals, team members, health staff and other professionals;
- delivering training for other professionals (if and when competent to do so); or
- promoting applied psychology services by providing relevant information to referrers, commissioners and others.

A Primary Care MHTR Practitioner should not be employed to:

- substitute for qualified applied psychologists; or
- undertake solely administrative or clerical duties for which a clerical assistant should be employed.

It is recommended that the Clinical Lead completes clinical supervision sessions with the Primary Care MHTR Practitioner on a weekly or fortnightly basis, dependent on local service arrangements. The British Psychological Society (2017) Practice Guidelines set expectations concerning the practice, supervision and oversight of Assistant Psychologists, which are relevant to Primary Care MHTR Practitioners. Below is a summary of key points:

- Appropriate mechanisms need to be in place to ensure that no practitioner is, for instance, put in a position where they have to design or decide on any materials or processes which could have a potential harmful impact on individuals or groups or to an organisation (such as potential loss of profit or revenue);
- A practitioner should carry out only prescribed interventions with individuals or in groups, and should write reports only when under close supervision of the primary, qualified psychologist. Any report should be signed as having been written 'under the supervision of' followed by the name, registration status and job title of the qualified psychologist;
- When a practitioner is called to give evidence in a legal setting, such as a tribunal, the qualified psychologist remains responsible for the professional quality of the practitioner's work. This means the qualified psychologist should attend the hearing also, as there may be questions which a practitioner cannot answer. Both should bear in mind that an Assistant Psychologist is not qualified to give evidence of opinion;
- A Practitioner should not undertake tasks in areas where there is not a competent supervisor;
- A Practitioner should not carry out the duties of a care assistant; and
- The managing or supervising psychologist has a responsibility to ensure that Practitioners are not given work to do that is over and above their level of competence.

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, relationships, leisure requirements, daily living, educational and occupational needs, employment/vocational needs, housing, finance)
- Identification of vulnerabilities including history of trauma and abuse
- Identification of safeguarding issues
- Assessment of self-harm/suicide risk
- Speech, language and communication needs
- Neurodivergence and differences associated to this, for example memory, concentration, processing, time management, impulsivity and sensory needs
- Physical health needs – management of physical health conditions
- Registered GP
- Drug and alcohol issues
- Identification of cultural and gender needs
- Medication – medication history
- Behaviours that have led to involvement with the Criminal Justice System?

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?

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 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	*Outcome of assessment / Plan:*
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	

Appendix 4: Example of PSR Recommendation for an MHTR

Mental Health Treatment Requirement. the defendant will be supervised and coordinated by a Probation worker, whom will ensure that the individual is supported in treatment and addresses issues linked to their offending behaviour

The MHTR will be provided by xxxx Treatment provider and will undertake a number of treatment and interventions sessions over xxx-time frame.

The individual has consented to treatment and the Clinical Lead overseeing the MHTR is Dr xxx

The Treatment will focus on the underlying mental health and social issues and how these may link to offending behaviour.

The Probation worker will be informed of the individual's compliance with their treatment plan, attendance at appointments and progress being made.

Whilst subject to this/these requirement(s), Mr/Ms XXXXX will be expected to comply with Probation Service National Standards and if they fail to do so enforcement action will be taken.

Appendix 5: Primary Care MHTR Decision Model

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

Referrals generation		
Main Referrers Probation Liaison and Diversion	**Secondary Referrers** Legal representatives Judiciary Court staff Self-Referrals Carers and family members Community MH Teams	**Note to action** Aim to increased referrals from L&D as this would enable improved communication and referral processes
Referral Criteria		
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	**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	**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
Screening		
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.		
Assessment		
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.	**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.	

Sentencing
1. PCP provide the court duty officer with the individuals information who is suitable for an MHTR 2. Consent and clinical lead approval provided 3. Potential first appointment date offered
Provider Informed of Sentencing Outcome
1. Court allocation team to include the MHTR provider in the email to the allocating Probation practitioner 2. Probation Practitioner, Providers, Individual, arrange court order planning meeting 3. Some sentences could be sentenced to a combined order i.e. MHTR with DRR/ATR in which case the sequencing of the requirements will need to be in partnership with the two providers. 4. Dependant on the needs of the individual these may also be run concurrently so the dual diagnosis could be supported/treated at the same time.
Post sentence: treatment commencement
1. Timescale for commencement agreed with the Probation practitioner, other CSTR providers and the individual 2. Must be provided in line with sentencing planning and within the timescale of the order 3. Breach: If an individual is failing to attend appointments, aim to understand the underlying reasons for the nonattendance. Has support been put inot place to address and provide adequate support? 4. Breach: keep the probation practitioner informed who will advise the provider on actions to take.
Notes • **Screen/Assessment resulting in treatment Ratio:** each site to monitor the assessment treatment ratio to ensure maximum time available to each sentenced individual otherwise we lose the frequency of the treatment options • **Secondary Care:** Individuals may be psychotic, actively suicidal requiring psychiatric reviews. Care requires a multidisciplinary approach

Appendix 6: Example of MHTR Information Leaflet

MHTR CRITERIA

An individual is eligible for an Primary Care MHTR if they meet the following criteria:

- Adults i8 years plus
- The individual has expressed a willingness to comply and consents to the requirement
- The offence crosses the Community Sentence Order range. The Individual pleads guilty or is found guilty after trial
- The individual has a mental health condition that would benefit from a psychological intervention but does not warrant use of the Mental Health Act 1983
- Inclusive of those with Mental Health, Personality Disorder problems (from depression/ anxiety through to secondary care mental health issues) neurodevelopmental disorders (e.g. ASD and ADHD) will not be excluded.

WHAT IS AN MHTR? It is a sentencing option for individuals who suffer from low to medium mental health problems who are assessed as suitable for a mental health

WHO CAN REFER?

- Probation
- Liaison and Diversion staff
- Legal representatives
- Court staff
- Judiciary
- Self-referrals
- Carers and family members
- Community Mental Health Team

Service address
Contact numbers
Website

If you require this leaflet in other formats or languages please contact PALS: 0800 917 8504

Dacă aveți nevoie de acest prospect în alte formate sau limbi, vă rugăm să contactați PALS: 0800 917 8504

এই লিফলেটটি যদি আপনার অন্য কোনো ফরম্যাটে বা ভাষায় প্রয়োজন হয়, তবে অনুগ্রহ করে 0800 917 8504 নম্বরে পালস এর সাথে যোগাযোগ করুন

Jeżeli są Państwo zainteresowani otrzymaniem tych informacji w innym formacie lub języku, prosimy o kontakt z PALS pod numerem telefonu 0800 917 8504.

Review date:

psychological intervention in the community

PRIMARY CARE MENTAL HEALTH TREATMENT REQUIREMENT

Primary Care MHTR service contact details

WHAT IS MHTR?

A Primary Care **Mental Health Treatment Requirement (MHTR)** is a **psychological intervention** (non-medicating) and is one of three possible treatment requirements which may be made part of a Community Order or Suspended Order sentence. The other two treatment requirements are Drug Rehabilitation Requirements (DRR) and Alcohol Treatment Requirements (ATR). An MHTR can be combined with DRR or ATR.

Individuals are assessed using different psychometric assessment tools by the MHTR practitioner. Suitability for the MHTR is determined by the professional opinion of the Clinical Lead.

A GP registration is required at the point of the first treatment.

Clients who are not engaging will be communicated to the Probation Practitioner who will determine the next steps.

An individual can withdraw their consent at any time, but this may result in a return to court for re-sentencing.

THE MHTR PROCESS STAGES

IDENTIFICATION

Individual is identified as potentially suitable for an MHTR. Referrals can be made by different parties working across the criminal justice system. The service will proactively work with partners to ensure that practitioners know who can be referred and the process for referral.

INITIAL SCREENING

The individual will be screened using the agreed tools.

If screens do not indicate MHTR 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.

MHTR PRACTITIONER ASSESSMENT

The MHTR Practitioner completes a semi-structured interview that assesses for signs of psychological distress, depression, anxiety and associated vulnerabilities.

CONSENT PROCESS

Consent is then explained and gained from the individual by the MHTR assessor. Assessor will fully explain the MHTR treatment.

CLINICAL LEAD APPROVAL

The Clinical Lead and Primary Care MHTR Practitioner agree on MHTR suitability, if not suitable reasons will be provided.

SENTENCING

Proposed treatment/intervention plan will be discussed with the Court Duty Officer (CDO) who will include details in the Pre-Sentence Report (PSR), along with any other community requirements. The CDO will present the PSR proposal to the court.

POST SENTENCING PLANNING MEETING

Meeting arranged within 14 days of sentencing between the individual, Primary Care MHTR Practitioner, other Requirement providers and Probation Practitioner who will be overseeing the order.

JOINT CASE MANAGEMENT:

Clinically supervised Interventions will be provided by the MHTR Practitioner overseen by the Clinical Lead. If Rehabilitation Activity Days (RAR) have been sentenced to address criminogenic behaviour a close partnership must be formed with those providing the RAR days and the MHTR provider.

The individual may have a dual diagnosis and regular joint case management meetings are important.

INTERVENTION COMPLETION

Complete final assessment to establish clinical outcomes following intervention.

MHTR BENEFIT

- Psychological interventions individually tailored to the needs of each client.
- The intervention typically involves 10-12, sessions, where the individual meets with the Primary Care MHTR Practitioner
- The intervention may typically involve a number of skills and techniques to address individual needs
- The MHTR providers work in partnership to provide a holistic rehabilitation support

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