Community Sentence Treatment Requirement (CSTR) Programme MHTR Service Description

Primary Care Mental Health Treatment Requirements (MHTRs)

A partnership between the Ministry of Justice (MoJ), Department of Health and Social Care (DHSC), NHS England and NHS Improvement (NHSE/I), Her Majesty's Prison and Probation Service (HMPPS) and Public Health England (PHE)

NHS England and NHS Improvement

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Executive Summary

This Service Description is to be used in conjunction with the Community Sentence Treatment Requirements (CSTR) Operating Framework for the purpose of commissioning Primary Care MHTR services. As stated in the CSTR Operating Framework, the term Primary Care is used in this context to indicate the need for mental health support which doesn't meet the threshold for referral into secondary care services.

These documents will support the commissioning of Mental Health Treatment Requirements (MHTRs) along with providing a framework to increase both Drug Rehabilitation Requirements (DRRs) and Alcohol Treatment Requirements (ATRs).

An increase in these requirements can only be achieved through a consistent approach across all new and developing sites, along with an integrated, inclusive and formalised partnership with the relevant criminal justice/health/substance misuse and social support partners in each site.

These documents have been developed through the CSTR Programme (the Programme) testbed and developing sites during year one of the Programme development.

Definition of CSTR services

The provision of assessment and treatment through a process relating to offences which fall into the category of a community or suspended sentence order. Assessments determine whether they reach the criteria for CSTR and what additional social support they may require which will enable integrated engagement for all adults.

The CSTR delivery partners work together to ensure that consistent processes, services and pathways are in place to enable information, assessment and consent on the day of the court hearing wherever possible. This ensures that sentencing courts are provided with informed and effective community treatment order recommendations, and that appropriate and accessible treatment for all offenders (including those with multiple and complex health and social care needs, ethnicity, communication and accessibility needs) is made available taking into account all protected characteristics as defined in the Equality Act 2010.

National CSTR

The Programme is a partnership between the Ministry of Justice (MoJ), Department of Health and Social Care (DHSC), NHS England and NHS Improvement (NHSE/I)[1], Her Majesty's Prison and Probation Service (HMPPS) and Public Health England (PHE).

During 2017/18 five testbed areas were selected to test the recommendations within a protocol developed between the programme partners, with a view to increasing the use of the DRRs, ATRs, and MHTRs.

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. The testbed sites have demonstrated that improved partnership working and effective engagement with all adults can increase the use of treatment requirements, particularly as an alternative to short custodial sentences.

All three treatment requirements were introduced as a sentencing option in the Criminal Justice Act 2003. 'Treatment' covers a broad range of interventions (for example talking therapies, psychosocial support, a course of medication or inpatient treatment). As members

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

of the general population, offenders in the community should access treatment in the same way as anyone else via GP and mental health services, commissioned by NHS Clinical Commissioning Groups (CCGs) and substance misuse services commissioned via Local Authorities. However, due to the multiple complexities of health and social needs affecting this cohort, there are few services in the community that are providing appropriate holistic treatment and care to support these orders, especially for those who don't reach the threshold of secondary care services. In developing this service, a priority is given to ensuring that services are integrated and provide interventions to all individuals.

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

MHTRs can be split into those provided by:

Secondary care mental health services: When an individual's mental health condition reaches the threshold of secondary care services. The individual may, at the time of the offence, already be referred or accepted for treatment but may have failed to attend. This provision should already be provided through locally commissioned frameworks for secondary care. The provision of Secondary Care MHTR services falls outside the scope of this specification.

Primary care mental health services: When an individual has undiagnosed mental health needs and/or mental health needs that may be treated in primary care, an MHTR may be appropriate. The majority of MHTRs don't reach the clinical threshold for treatment in secondary care. The testbed sites have demonstrated that the addition of clinically supervised mental health practitioners providing assessment in court and 1:1 short, individualised psychological interventions has been appropriate and effective in delivering primary care MHTRs. In many areas no such service currently exists. Primary care mental health services will be commissioned or co commissioned by NHS E/I. The description of these primary care MHTRs is to distinguish them from MHTRs provided under the standard mental health contract. It does not refer to services provided by GPs under GMS, PMS or APMS contracts.

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

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

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

[2]A study published by the MoJ 2018 provided the first evidence to show that including an MHTR or ATR into a community order or suspended sentence order can have a positive impact on reducing reoffending.

The study found that for those with identified mental health issues, MHTRs attached to community orders or suspended sentence orders were associated with significant reductions in re-offending where they were used, compared with similar cases where they were not. Over a one-year follow-up period, there was a reduction of around 3.5 percentage points in the incidence of re-offending where such requirements were used as part of a community order, and of around 5 percentage points when used as part of a suspended sentence order. In the

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

case of ATRs, for those with identified alcohol misuse issues, ATRs were associated with similar or slightly lower re-offending where they were used compared with similar cases where they were not.

[3]Additionally, the year one process evaluation of the five testbed sites has been published, shows promising results and indicates that by strengthening partnerships, processes and governance pathways, the increased use of treatments is achievable.

The Legal Aid, Sentencing and Punishment of Offenders (LASPO) Act 2012 made changes to the administration of the MHTR by amending provisions linked to the Criminal Justice Act 2003 and the Mental Health Act 1983:

> [4]*"The LASPO Act 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 offender's need for mental health treatment is given to a court by a Section 12 registered medical practitioner."*

This change means that the courts may seek views and assessments from a broader range of appropriately trained mental health professionals. The intention is 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, if using the MHTR as part of a community sentence.

1.1 National Drivers

NHS Long Term Plan: "Since 2017, five parts of England have been testing a new Community Sentence Treatment Requirement (CSTR) Programme. This enables courts to require people to participate in community treatment, instead of a custodial sentence. CSTR sites have provided community treatment for people who would otherwise have been sentenced to short custodial sentences. We will build on this by expanding provision to more women offenders, short-term offenders, offenders with a learning disability and those with mental health and additional requirements."

[5]**The Proposed Future Model for Probation: A Draft Operating Blueprint 2019** provides a blueprint for the newly developing probation service. The document supports the increased use of the three-treatment requirements by improving the range and quality of rehabilitative interventions, targeted to address the needs of vulnerable offenders.

Female Offender Strategy: Published in June 2018 by the MoJ. The strategy 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. The strategy seeks to reduce the number of women coming into contact with the CJS through early intervention and effective support in the community, and in turn reducing the number of women on short custodial sentences. 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.

Five Year Forward View for Mental Health taskforce 2016: In January 2016 the Five-Year Forward View for Mental Health strategy was published by the Mental Health Taskforce. Several of the recommendations relate to this group including one which recommends the increased use of MHTRs where appropriate. Additionally, there were recommendations for

[3] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/810011/cstr-process-evaluation-summary-report.pdf
[4] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/655971/LASPO-Act-2012-post-legislative-memorandum.pdf
[5] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/810334/The_Proposed_Future_Model_for_Probation_-_A_Draft_Operating_Blueprint_-_HMPPS_-_19-06-2019.pdf

co-morbid mental health and substance misuse problems to be provided through joint assessment and provision.

Guiding Principles, Aims and Objectives

1.2 Guiding principles

The CSTR services will operate under six guiding principles. These are to:

1. Provide an exemplary assessment for all eligible referred adult offenders (18 years and over who consent to ATR/DRR/MHTR) ensuring the service is accessible to the most disadvantaged including e.g. BME, women, individuals with learning/communication difficulties, physical/mental disability, ethnicity, sexuality, religion and veterans.
2. Operate within the CSTR Operating Framework.
3. Take an inclusive approach, recognising the mental health needs, substance misuse and personality disorder of adults in contact with the CJS irrespective of any protected characteristics (as defined in the Equality Act 2010).
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 CSTR workforce are adequately qualified to support all adults sentenced to a CSTR, are closely aligned, reflect and understand the needs of the local population.

1.3 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[6], may include more than one treatment requirement).
- **Provide alternatives to short custodial sentences for offenders** by providing access to treatment which addresses the underlying cause 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 sentencing on the day where possible** by providing assessment report to inform pre-sentence reports (PSRs).
- **Enable access to statutory community services** through individualised support for individuals 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 CSTR sites** and develop to align to local services and population by the publication of the CSTR Operating Framework and corresponding documents, best practice sharing across the sites and support from the CSTR Programme team.

A secondary aim is to raise awareness of the high numbers of individuals with mental health, personality disorder and substance misuse conditions across the criminal justice pathway, including information on individuals with protective characteristics who may be suitable for a CSTR for: judges, magistrates, legal representatives, probation and the police. This increased awareness enables greater confidence to be placed in the CSTR process which, in turn, may lead to CSTRs being used more often in sentencing.

[6] Up tariffing = Increasing the sentence to accommodate the order requirements

1.4 Objectives

- **Rapid access to appropriate and effective assessment/interventions** which may be integrated or sequenced alongside other community orders or treatment requirements.
- **Providing services which meet the needs of all individuals** irrespective of any protected characteristics the individual may have (as defined in the Equality Act 2010).
- **Evidence based psychological interventions** by skilled mental health practitioners to promote wellbeing and recovery who are cognisant and aligned to the needs of the local community.
- **A local process map** to ensure that all partners and stakeholders are aware of their roles and responsibilities for providing and accessing speedy CSTRs.
- **A clinically led dedicated MHTR intervention service,** following consent/agreement. An individualised case formulation plan will be completed along with practitioner supervision (see Clinical Leads Guidance attached).
- **A pathway/process for on the day DRR/ATR assessments,** with clearly defined responsibilities for on-going management of any relevant requirement, including those combined with MHTRs.
- **Timely referral and access to ongoing support** after sentencing.
- **Local agreements must be in place to appropriately share information** to include; Probation, HM Courts & Tribunal Service (HMCTS), Liaison and Diversion, Health and Substance Misuse Providers.
- **A flexible service** to maximise access i.e. around employment/education and family.
- **Education and training** to raise awareness of the mental health issues for magistrates, judges, legal representatives, police and probation. Sites should consider introducing feedback for sentencing courts regarding the effectiveness of CSTRs.

Commissioning MHTR provision

The NHS Long Term Plan has enabled increased provision of MHTRs by providing some funding to scale up across England. The funding for the MHTR provision will be channelled via the seven NHS Health and Justice (H&J) commissioning teams within NHSE/I supported by the centrally funded CSTR Programme Manager.

The CSTR testbeds have demonstrated that successful sites are provided through integrated multi-partnership funding and utilisation of shared resources. When a site is identified it is suggested that the H&J commissioner will liaise with the National CSTR Programme Manager to explore information around the proposed site, this will include:

1. Local partnership arrangements already in place;
2. Proposed courts along with L&D coverage;
3. If a steering group and Chair has been identified;
4. If a proposed model been developed and costed;
5. Identification of local project management/coordination of mobilisation phase.

1.5 Commissioning a CSTR site

As an example, see below:

Commissioning model:	NHSE/I commissioned (from additional allocation)	NHSE/I commissioned (from existing regional allocation)	Commissioned by local partners - may include regional NHSE/I contribution
Accessible service delivery location	Location agreed with partners, ensuring that Liaison and Diversion remains central to assessment for CSTR.	Location agreed with partners, ensuring that Liaison and Diversion remains central to assessment for CSTR.	Location agreed with partners, ensuring that Liaison and Diversion remains central to assessment for CSTR.
Application of Operational Framework	Local model based on CSTR Operational framework. Mobilisation costs to be considered and covered.	Local model based on CSTR Operational framework. Mobilisation costs to be considered and covered.	Local model based on CSTR Operational framework. Mobilisation costs to be considered and covered.
Commissioning	NHSE/I(regional commissioning) and partners will agree contract management responsibilities.	NHSE/I (regional commissioning) and partners will agree contract management responsibilities.	NHSE/I (regional commissioning) and partners will agree contract management responsibilities, and NHSE/I regional team will remain fully engaged in understanding and influencing performance.
Contract and data management	All sites submit the national minimum data (NMD) set on a monthly basis.	All sites submit the national minimum data (NMD) set on a monthly basis.	NHSE/I regional commissioning will encourage use of minimum data set but cannot mandate this if not contributing to site funding.

CSTR activities

The activities undertaken by the commissioned service are outlined below:

1.6 Commissioned MHTR activities

In line with the national CSTR Operating Framework the service commissioned to support the MHTR process will:

- Source/provide or negotiate access to accommodation for the service where treatment can be provided. This may require negotiation with the court regarding assessment space within the court building. When considering accommodation ensure that access is suitable to accommodate disabilities.
- Provide a Clinical Lead (CL) (Clinical/Counselling Psychologist) to define the assessments/interventions. They will oversee the requirements and supervise mental health practitioners (*see Appendix 1 CSTR Operating Framework*).
- Provide mental health practitioners to provide the MHTR provision for assessment in court/consent/intervention delivery and follow up ensuring the practitioners reflect and align to the local community.
- Engage with CSTR delivery partners (Probation, HMCTS, Substance Misuse, L&D) to develop an integrated service and agree process and governance pathways to maximise the benefit of MHTRs, along with working alongside substance misuse providers to co-ordinate combined orders with ATR/DRRs.
- Aim for on the day assessments where possible for MHTR suitability at court.
- Develop information/data sharing agreements across the relevant partner organisations to enable joined up working across the sectors.

- Ensure consent has been fully explained and received from the individual prior to sentencing and provide information in a range of languages and easy read.
- Agree daily access times for the CL to review the case and agree or not to the requirement so that the recommendation for MHTR may be included in the PSR (written or verbal) to enable 'on the day' sentencing where possible.
- Post sentence three/four-way meeting with probation Offender Manager (OM), MHTR and/or substance misuse providers, and individual to discuss sequencing of the order, goals and expectations.
- Establish clearly defined and agreed joint case management protocols in consultation with partner agencies.
- Ensure the individual is registered with a GP prior to treatment commencement.
- Provision of evidence based psychological interventions which may be individualised to the needs of the individual.
- Retain records and provide pre-agreed data to CSTR Project Group on a monthly basis, or as agreed.
- Establish an effective relationship with RO to manage non-attendance, breach and completion of orders including information flow across Probation and CSTR provider. Work jointly with RO to manage non-attendance at appointments, breaching and completion of orders.
- Provide timely access and referral into ongoing services for appropriate support post sentence.
- Contribute to the ongoing development of the service through engagement in the CSTR Project Group, national CSTR Programme team and other relevant networks.
- Seek feedback which informs the development of the service and engage people with lived experience in decisions regarding service development.
- Monitor and evaluate the effectiveness of the service through qualitative feedback from those who have used the service.
- Make reasonable adjustments to accommodate individual needs and protected characteristics in line with the Equality Act (2010).
    - Individuals subject to these requirements may have several vulnerabilities, including mental health, substance misuse, autism, learning/communication/physical difficulty.
    - Adjustments will be made to ensure that the services are accessible to individuals subject to these requirements (e.g. easy read, information available in relevant languages, treatments offered in suitable and accessible locations taking into account physical and mental health requirements).
    - Supported engagement to ensure equality of service is provided irrespective of any presenting protected characteristic as defined in the Equality Act 2010.
- Respond to complaints and FOI requests within agreed timeframes.

1.7 Outcomes and Key performance indicators include:

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

In accordance with the data sharing legislation, anonymised data will be sent to the CSTR Steering Group Chair, within a format as agreed by the national CSTR Programme Board. The template will include separate tabs for MHTRs, ATRs and DRRs to allow for separate analysis of each of the different types of treatment requirements. The data will be provided on a monthly basis and sent to the Chair by the second week of each month (or as locally agreed).

Pre-sentence:

Record and monitor the individuals assessed and in the services for the following characteristics, ensuring that the service is accessible and appropriate for all adults and in line with the Equality Impact form (EIF).

- Source of CSTR referral
- Gender, Age and Ethnicity of individual
- Pregnancy and caring responsibilities
- Disabilities
- Armed Forces history
- Offence type
- Numbers assessed for MHTR/DRR/ATR/MHTR & DRR/MHTR & ATR
- Numbers consenting for CSTR following assessment
- Numbers of CSTRs obtaining provider approval for ATR/DRR
- Number of CSTRs obtaining MHTR Clinical Lead Approval

Sentence:

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

Post-Sentence:

- Number of orders managed by probation
- Timing of multi-disciplinary review meeting post sentence
- The number of DRR court reviews conducted
- Number of cases breached by the court (compiled by Probation) and information about how many were subsequently re-sentenced to a CSTR and how many were sentenced to custody
- Unplanned discharge reasons
- Number of individuals registered with GP as a result of CSTR

Sentence Completion:

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

In addition, we also ask local sites to collect the following information. Again, most of this information can be completed by treatment providers, but probation will need to provide information on risk, breach reasoning and may also have key information needed to determine court adjournments. It would be expected that the CSTR providers capture the additional data below which will be shared at each steering group meeting and provides detail to the NMDS with a view to local service development and improvement.

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

And to document/detail:

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

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

Eligibility and scope

1.8 Eligibility

- 18 years +
- Consents to the requirement
- Charged with committing an offence which falls into community or suspended sentence order range
- For MHTR: 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

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

1.9 Operational scope

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

Court	Address	Number of court rooms (operational)

Times of operation:

The CSTR service will be delivered from the following sites/times (MHTR/DRR/ATR)

Location	Mon	Tues	Wed	Thurs	Fri

Services will operate between the hours of 9am to 5pm Monday to Friday. It may however be necessary to consider evening sessions to accommodate individuals who are working or to facilitate childcare or caring arrangements.

Cases that appear on Saturday morning will be identified by NPS, and, if appropriate, a recommendation made to adjourn for a PSR to include MHTR assessment for the following week so all cases appearing in the court have equal access to CSTRs.

Service Delivery Model

The service delivery model set out below is based on the CSTR Operating Framework and the learning from the five testbed sites.

Based on the CSTR testbed data, the number of MHTRs sentenced to (within a population size of 300,000) is in the region of 85 per annum. This figure is dependent on CSTR site funding, population and levels of deprivation and other factors.

The entire pathway is managed by probation. The OM is responsible for managing compliance with the order, which includes overseeing the MHTR. Therefore, the provider and RO will have close contact and communication during the delivery of the MHTR.

Referrals can be from a number of sources including:

- Police custody
- Probation
- Liaison and Diversion
- Court Staff
- Legal Representatives
- Substance Misuse services
- Community mental health services
- Self-referrals
- Carers and family members
- Appropriate adults

A single point of contact within probation will be made available for all pre and post sentence queries along with telephone numbers/email addresses 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.

1.10 CSTR Processes, Clinical Guidance, Consent:

Details of the following can be found in the CSTR Operating Framework:

- Example process flow
- MHTR clinical model, from screen to treatment
- MHTR Clinical Leads guidance
- ATR/DRR initial screen
- Court consent for all CSTRs
- Court report templates

Space must be made available for morning screen and assessment in the court building.

1.10.1 CSTR process:

Initial screen/assessment and consent: It will be locally agreed who completes the initial screen for MHTR/ATR/DRR.

This could include: Probation Court Duty Officer (CDO), Liaison and Diversion services or the MHTR provider. For screen tools see *Operating Framework.* The screening would also assess for: social issues (housing, finance, relationship issues, work/education) and GP registration along with ensuring that the individual clearly understands the reason for the screen and interpreters/advocates are available to support if necessary.

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

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

1.10.2 Sentencing:

The report and proposed programme will be discussed with the CDO who will input details into the PSR, along with any other community requirements. The CDO will recommend the proposal to the sentencing court, including that the individual has consented to the requirements, that the providers have agreed to provide interventions for the MHTR, and that there is a named clinician to oversee the requirement.

If sentenced to a CSTR the judiciary will be asked to complete a short form which indicates the sentence which might have been imposed had the CSTR not been available.

An appointment will then be made with the relevant providers.

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

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

1.10.3 Joint Case Management:

The MHTR provider will work with the allocated RO and individual to sequence treatments in order to maximise the benefit of the requirements. If an individual is sentenced to a combined

CSTR, the providers will be expected to work in partnership to appropriately deliver the court order.

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

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

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

1.10.4 The MHTR Intervention:

See the MHTR clinical intervention manual for recommended psychosocial interventions and substance misuse treatment.

1.10.5 MHTR Delivery:

The MHTR provider will work closely with the RO allocated to oversee the court order. The providers will be guided by the RO with regard to compliance and any breach proceedings. The providers must ensure that they keep in regular contact with the RO.

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

Consideration to be given to ensure accessibility for the interventions along with intervention delivery.

1.10.6 Sentence Completion:

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

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

1.10.7 Service Providers to Deliver Vulnerabilities Awareness Sessions to Partners:

The local CSTR steering group will drive forward awareness sessions across the CJS pathway, ensuring that all partners are adequately briefed and provided with information needed to support decisions regarding the appropriate use of CSTRs.

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

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

1.11 Lived Experience Engagement

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

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

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

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

MHTR workforce

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

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

Experience from the five testbed sites indicates that additional resources are required to provide primary care MHTRs. As an example, based on a population of 300,000, this resource may include:

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

CSTRs: Additional consideration could be given to social support, post sentencing. If sentencers have been recommended to include Rehabilitation Activity Requirements (RAR) days into the sentence some of the testbed sites have been able to direct these to support the social issues via dedicated Link Workers. This would require pre-agreement with RO who would indicate who their commissioned providers are for RAR days.

1.12 Staffing

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

1.12.1 Clinical Lead:

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

Pre-sentence screening and assessment measures.

The CL will: *(see Appendix 2 of the Operating Framework)*

- Define the pre-sentence screening and assessment process and the consent process with the court (NPS);
- Agree the information required within the assessment that NPS require for the PSR;
- Agree the clinical care plan;
- Agree with NPS the sign off process if the Clinical Lead is not personally gaining consent (via telephone or email);
- Oversee and agree to the requirement both pre-sentence and post sentence.

The CL or allocated deputy will be available Monday – Friday between locally agreed times. The testbeds have generally requested CL availability between 12.00 to 13.00 (as a minimum) to consider the suitability for an MHTR and make the recommendation to be included in the PSR at court. The CL may work remotely from court.

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

1.12.2 Primary Care Mental Health Practitioner:

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

Following assessments, the practitioner, following discussion with the CL, will determine the appropriateness of the MHTR intervention, which may also include a recommendation for assessment for medication or psychiatric screening.

1.12.3 Consent:

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

The mental health practitioner will complete the consent template.

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

1.12.4 Clinical Lead Sign Off

: The mental health practitioner will contact the CL following the assessment in order to agree or to decline with reasons for electing this option to be provided. The mental health practitioner will inform NPS for inclusion in the PSR.

1.12.5 Recommendation to Court:

The mental health practitioner will inform the probation duty officer of the outcome of the assessment. Where the Clinical Lead has recommended an MHTR order, probation will include these details in the PSR.

1.12.6 Post Sentence:

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

1.12.7 Delivery of Interventions

The mental health practitioner will deliver interventions in line with formulations agreed with the CL and attend supervision sessions. It is recommended that a Band 7 mental health professional or the CL be available to provide treatment for more complex cases.

Providers to ensure that interventions are individualised and appropriate to meet the needs of the individuals social circumstances and that any information provided is in a suitable language/easy read format or available through a suitable information platform.

It is anticipated that between 10 – 12 x 50 min MHTR sessions will be provided for an MHTR intervention under a sentence. The location of the treatment will take into account required appointments with RO and, where appropriate, take place at the same location.

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

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

Where appropriate the CL will advise/support the effective sequencing of the requirements (where other treatment requirements have been ordered) to ensure maximum engagement and effectiveness.

The CL will be informed of any non-compliance with the requirement and advice would be obtained from Probation.

1.13 Interdependence with other Services/Providers

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

- Police
- General Practice
- Primary and Community Care
- 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

1.13.1 Safeguarding:

CSTR providers/partners may identify safeguarding concerns, which relate directly to the individual or to the welfare and safety of other adults or children.

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

Sharing of Information and Confidentiality Policies must be in place with the appropriate statutory authorities before the MHTR service goes live.

All staff employed and engaged in working with the individual must have the appropriate level of disclosure and barring service check that is updated annually. The service must, on request, provide evidence to demonstrate compliance with all statutory requirements.

Particularly relevant to the service include:

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

1.13.2 Engagement with Mainstream Services:

The provider will make referrals into mainstream services during and post treatment to ensure continued support is provided where required. The MHTR providers will demonstrate how they will ensure engagement with services and how they will make arrangements for appropriate communication of operational data.

1.14 Reporting expectations

The service will be expected to have in place:

- Information sharing protocols to enable sharing of clinical information with other agencies when appropriate, which is underpinned by Caldicott Principles and information governance structures.
- Operational and joint working protocols in place – agreed with relevant agencies e.g. sharing confidential information/risk assessment.
- Risk Register.
- Quarterly Incident and workforce report (including safeguarding incidents).
- Regular structured review of referrals.

Governance and Reporting

1.15 Governance

The local CSTR steering group will be responsible for monitoring the progress of the CSTR service to ensure it enables effective multidisciplinary working.

The performance and effectiveness of the site (including cost effectiveness) is a key commissioning responsibility and therefore if the MHTR service is commissioned by the regional NHSE/I team, under its Liaison and Diversion commissioning framework, it will be reviewed by the regional commissioner and also shared with the CSTR steering group. The membership of the CSTR steering group will ideally include:

Chair (determined locally), H&J NHSE/I, CCG, local authority commissioners, probation, HMCTS, judiciary, service users, CSTR provider, third sector providers. The CSTR steering group will provide updates to the local stakeholders according to the local arrangements and to the national CSTR Programme Board.

1.15.1 Reporting:

The steering group will oversee the delivery of the CSTR site. Local commissioners will conduct regular contract review meetings which will include review of the CSTR site.

Data will be collected from all partners to support the data requirements as outlined above. It may be possible that once CSTR delivery is fully embedded as business as usual, the steering group may be stepped down, or amalgamated with another group with similar objectives.

1.15.2 Information Sharing:

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

1.15.3 Diversity Monitoring:

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

- Given due regard to eliminate all forms of discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as defined in the Equality Act 2010) and those who do not share it; and
- Given regard to reduce inequalities between individuals in access to, and outcomes from this CSTR services and to ensure the providers are integrated with other services in order to reduce health inequalities.

All individuals who engage with the treatment process will be asked to provide equal opportunities/diversity information. This will be monitored to ensure that no groups are disadvantaged.

The provider will record diversity information.

1.15.4 Information Governance

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

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

1.15.5 Health and Safety:

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

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

Abbreviations

CSTRs	Community Sentence Treatment Requirements (DRR/ATR/MHTR)
MHTR	Mental Health Treatment Requirement
DRR	Drug Rehabilitation Requirement
ATR	Alcohol Treatment Requirement
NPS	National Probation Service
CL	Clinical Lead
CDO	Court Duty Officer
OM	Offender Manager (Probation)
RP	Responsible Practitioner (Dr)
L&D	Liaison and Diversion Service
PCC	Police and Crime Commissioner
HMCTS	Her Majesty's 's Court and Tribunal Service
MoJ	Ministry of Justice
PHE	Public Health England
NHSE/I	NHS England and NHS Improvement

This MHTR service description has been written on behalf of the CSTR Project Board by Mignon French CSTR Programme Manager.

In Consultation with the: The CSTR sites:

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- Sean Russell: West Midlands Combined Authority, Birmingham and Solihull Testbed Chair
- Mark Knight: Strategic Lead for Substance Misuse, Manchester Testbed Chair
- Paul Bullen: PCC office and Chair of the Northamptonshire CSTR site
- Kate North: Sodexo CRC, Deputy Chair Northampton CSTR site
- Felicity Sparshott: Senior Probation Officer, Milton Keynes Testbed
- Claire Weston: Head of Health and Justice (East of England), Chair of the Bedfordshire CSTR site
- Zoe Hickman: Programme Manager, MOPAC CSTR Testbed
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- Andy Hunt: NHS England and NHS Improvement
- Nino Magdalena: Public Health England
- Rita Parmar: Ministry of Justice
- Lizzie Renard: Ministry of Justice
- Vince Treece: NHS England and NHS Improvement
- Sue Whitaker: Her Majesty's Prison and Probation Service

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