

REPORT

SAINSBURY CENTRE  
for MENTAL HEALTH  
removing barriers achieving change



# A Missed Opportunity?

Community sentences and the  
Mental Health Treatment Requirement

Husnara Khanom, Chiara Samele  
and Max Rutherford

a **better** way



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## Community Sentences and the Mental Health Treatment Requirement

**Husnara Khanom, Chiara Samele and Max Rutherford**

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### **A research report**

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# Contents

	Acknowledgements	<b>4</b>
	Executive summary	<b>5</b>
1:	Introduction	<b>7</b>
2:	The research	<b>10</b>
3:	Professionals' views of the MHTR	<b>12</b>
4:	Criteria for the MHTR	<b>17</b>
5:	Psychiatric reports	<b>21</b>
6:	Breach of the MHTR	<b>26</b>
7:	Relationships between agencies	<b>29</b>
8:	The Drug Rehabilitation Requirement	<b>31</b>
9:	Discussion	<b>35</b>
10:	Conclusions	<b>37</b>
11:	Recommendations	<b>40</b>
	References	<b>43</b>



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# Executive summary

The Mental Health Treatment Requirement (MHTR) is one of 12 options ('requirements') available to sentencers when constructing a Community Order or a Suspended Sentence Order.

The MHTR can be given to an offender with mental health problems who does not require immediate compulsory hospital admission under the Mental Health Act. If they give their consent, the MHTR requires them to receive mental health treatment for a specified period.

At least 40% of offenders on Community Orders are thought to have a diagnosable mental health problem. Yet there has been very little uptake of the MHTR in England and Wales since its introduction in 2005. Only 686 MHTRs commenced in the year to 30 June 2008 out of a total of 221,700 requirements issued with Community Orders across the country. This compares with 12,347 requirements for drug rehabilitation and 3,846 for alcohol treatment.

This report is based on an exploratory research project; the first to examine the way in which the Mental Health Treatment Requirement is issued and the processes involved. We interviewed 56 professionals working in the courts, in probation and in health services about their experiences and knowledge of the MHTR.

Appropriate use of the MHTR depends on probation officers, defence solicitors and psychiatrists all being both familiar with and confident in using it. Our interviews have indicated that this is far from being the case in practice. Many professionals lacked direct experience of the MHTR, and some were not aware of it at all.

Court and probation professionals varied widely in their knowledge of mental health issues and their confidence in dealing with them. Many did not feel the courts should get involved in mental health issues.

Professionals had varied views about the purpose of the MHTR. Some felt it should help offenders who had fallen out of touch with mental health services to get back into contact. Others thought this was inappropriate, or that the MHTR should only be considered where mental illness had led the person to commit the offence of which they had been convicted.

The criteria for who should receive an MHTR were not clear to the professionals we interviewed. Many felt that the MHTR was not suitable for people with personality disorders or those with depression or anxiety.

The biggest barrier to the creation of an MHTR is the need for a formal psychiatric report. These are subject to lengthy delays as well as difficulties with costs. Some psychiatric reports do not provide the offer of treatment from local mental health services that is vital for the creation of an MHTR.

Once an MHTR has begun, the main concern among professionals is about how to determine when an offender has breached the requirement and how to manage this. Missed appointments were widely held to constitute a breach of the MHTR, but non-compliance with treatment was more contested.

Many court professionals were concerned about the impact of making an MHTR more onerous if it was breached.

The MHTR relies on good communication between the courts, probation and health services. Poor communication between health and probation services can hinder its effectiveness. Yet the court diversion and liaison teams that we encountered rarely played an active role in the operation of the MHTR.

For offenders with a dual diagnosis of drug misuse and mental health problems, the courts were much more likely to make a Drug Rehabilitation Requirement (DRR) than an MHTR. This is because they are more familiar with the DRR, it has a dedicated staff team and the process for making and managing a DRR is clearer.

Despite the challenges presented by the MHTR, we conclude that it has unfulfilled potential to offer offenders with mental health problems a robust alternative to a short prison sentence. That potential can be harnessed through practical improvements to the way the MHTR works on the ground and through improved communication between health and criminal justice agencies.

Our recommendations include:

- Central government should provide practical guidance for criminal justice and health professionals on how to construct and manage MHTRs.
- Primary care trusts should commission services that enable the courts to issue MHTRs.
- The National Offender Management Service should provide detailed information for probation officers on how to manage the MHTR.
- Protocols need to be developed between the courts, probation and health services to enable the appropriate use of the MHTR.
- Diversion and liaison schemes should be involved in the MHTR to organise timely psychiatric reports and make sentencing recommendations.



# Introduction

The Mental Health Treatment Requirement (MHTR) is one of 12 options ('requirements') available to sentencers when constructing a community sentence. The MHTR is available with both the 'Community Order' and the 'Suspended Sentence Order' (SSO), and was introduced as part of the Criminal Justice Act 2003.

The Community Order replaced all previous community sentence options in 2005. It gives judges and magistrates a choice of options to issue to offenders as an alternative to prison. The Suspended Sentence Order, by contrast, is effectively a prison sentence suspended on the condition of complying with community based requirements, aimed at more serious offenders and offences.

Sentencers are able to tailor a community sentence to the individual, with the ability to combine punishment, rehabilitation, reparation and public protection. An offender may be given a single requirement or a combination of several, although in practice this is usually no more than three.

The Criminal Justice Act of 2003 specifies that courts can issue an MHTR where an offender agrees to undergo medical treatment for their mental health condition. The courts must be satisfied that the individual is 'susceptible to treatment' but does not need to be admitted compulsorily to hospital under the Mental Health Act, and that arrangements have been, or can be, made for treatment to which the offender has given their consent. The MHTR could, therefore, potentially serve a significant proportion of offenders on community sentences. Yet, since its implementation in 2005, there has been very little uptake of the MHTR in England and Wales.

## Use of the MHTR

The most frequently used requirements under the Community Order are supervision and unpaid work. These account for two thirds of community sentence requirements. This has remained consistent since 2005.

There are three types of treatment requirement in the list of 12 options: drug treatment, alcohol treatment and mental health treatment. The Drug Rehabilitation Requirement is the most frequently and consistently used of the three. Between 1 July 2007 and 30 June 2008, 12,347 DRRs were issued by the courts, compared with 3,846 Alcohol Treatment Requirements (Ministry of Justice, 2008a).

The MHTR is one of the least used of the 12 requirements available under the Criminal Justice Act 2003. For example, only 686 MHTRs commenced in the year to 30 June 2008 out of a total of 221,700 requirements issued with Community Orders across the country (Ministry of Justice, 2008a).

This raises significant concerns in view of the large numbers of people on community sentences who have mental health problems. Some estimates show that at least 42% of offenders supervised by probation services have mental health problems (Solomon & Silvestri, 2008). This suggests that the majority of offenders on community sentences who may theoretically benefit from the MHTR are not receiving it.

## The process for issuing an MHTR

A court can issue an MHTR where it is satisfied that the mental condition of the offender is susceptible to treatment, but the condition is not so serious as to require compulsory hospital admission under the Mental Health Act. Arrangements for treatment must be in place, together with the offender's consent, before the court can make an MHTR.

Prior to sentencing, any concerns about an offender's mental health will need to be brought to the attention of the sentencer. This is usually done by the defence solicitor or the probation officer. Concerns about mental illness may also be raised by the jailors, court diversion and liaison schemes or by the sentencer themselves.

Depending on what stage in the court process these concerns are raised, a psychiatric report may be organised by either the defence solicitor or by a probation officer. This can assist with decisions about fitness to plead or stand trial, or sentencing. Where concerns are raised prior to plea, the onus falls on the defence advocate to organise a psychiatric report. Where the case reaches sentencing and a Pre-Sentence Report (PSR) is requested by the court, the probation officer may raise mental health concerns and organise a report on behalf of the court to assist with sentencing decisions.

In either case, where a psychiatric report highlights that there is a mental health issue that is susceptible to treatment, and where there is an offer of treatment, the courts may issue an MHTR as part of a sentence. This decision will also be guided by the recommendations in the PSR.

The MHTR cannot be imposed unless the offender gives their consent. There is no specific time when this is sought, though it is usually done by a defence advocate or a probation officer before they seek a psychiatric report.

Although sentencers can issue as many or as few options of the 12 requirements as they consider appropriate, the MHTR will seldom be used in isolation and it will often require the oversight of probation to enforce the order through the use of a Supervision Requirement.

Once an offender has been made subject to an MHTR with a Supervision Requirement, the supervising probation officer will initiate contact with the mental health care provider, who will seek to carry out the treatment. This can be based on medication, psychological therapy or a combination of the two. The nature and frequency of treatment will be determined by the diagnosis and severity of the illness and the risk of offending the individual is thought to pose.

Theoretically, probation and the health care provider will need to liaise throughout the course of the order for probation to monitor compliance. MHTRs can last for three years as part of a Community Order or for two years as part of a Suspended Sentence Order.

Where an offender fails to meet the conditions of the MHTR on a community sentence this will be regarded as a breach. The offender will be taken back to court where they may be faced with a more onerous requirement, or a prison sentence as the ultimate penalty.

Given the very little published literature on how the MHTR is issued and works in practice we sought to shed light on the processes involved and the challenges faced by court, probation and mental health service professionals.

**Table 1: The 12 requirements of the Community Order**

(Adapted from Seymour &amp; Rutherford, 2008)

<b>Requirement</b>	<b>Time demanded</b>	<b>Details</b>
1. Unpaid work	40-300 hours	Includes activities such as cleaning up graffiti, making public areas safer or conservation work.
2. Supervision	Up to 36 months	An offender will be required to attend appointments with an offender manager or probation officer.
3. Accredited programme	Combined with a Supervision Requirement	These are aimed at changing offenders' thinking and behaviour, for example to enable offenders to understand the consequences of their offence, and to make them less impulsive in their decision making.
4. Drug rehabilitation	6-36 months	People whose crime is linked to drug misuse may be required to go on a Drug Rehabilitation Programme. The offender's consent is required for this requirement.
5. Alcohol treatment	6-36 months	This requirement is intended for offenders whose crime is linked to alcohol abuse. The offender's consent is required for this requirement.
6. Mental health treatment	Up to 36 months	After taking professional advice, the court may decide that the offender's sentence should include mental health treatment under the direction of a doctor or psychologist. The offender's consent is required for this requirement.
7. Residence	Up to 36 months	An offender may be required to live in a specified place, such as in a probation hostel or other approved accommodation.
8. Specified activity	Up to 60 days	Including community drug centre attendance, education and basic skills or reparation to victims.
9. Prohibited activity	Up to 36 months	Offenders may be ordered not to take part in certain activities at specified times, like attending football matches.
10. Exclusion	Up to 24 months	An offender may be prohibited from certain areas and will normally have to wear an electronic tag during that time.
11. Curfew	Up to 6 months for between 2-12 hours in any one day	An offender may be ordered to stay at a particular location for certain hours of the day or night. Offenders will normally wear an electronic tag during this part of their sentence.
12. Attendance	12-36 hours with up to 3 hours per attendance	The court can direct offenders under 25 to spend between 12 and 36 hours at an attendance centre over a set period of time. This requirement is designed to offer 'a structured opportunity for offenders to address their offending behaviour in a group environment while imposing a restriction on their leisure time'.



## The research

This report is based on an exploratory qualitative research project; the first to examine the operation of the Mental Health Treatment Requirement in practice. It aimed to understand:

1. How an offender is issued with an MHTR and the decision making behind sentencing.
2. How the MHTR works in practice by describing what it entails, the key professionals and agencies involved in conducting it, and the processes and procedures by which it is carried out.

It also had a number of secondary aims:

- To explore the views of sentencers and identify the main problems that have prevented them from issuing the MHTR at the point of sentencing.
- To examine the Drug Rehabilitation Requirement for any lessons its operation may provide for improving the MHTR.
- To consider whether the MHTR is an effective, suitable and therapeutic form of diversion for offenders with mental health problems.
- To explore inter-agency working.

### Interviews with professionals

The research for this report took place in nine London boroughs, two of which shared one magistrate's court. The boroughs were selected to provide a mix of areas where the MHTR had and had not been used at the time of the study.

We conducted a total of 56 interviews with professionals from the courts, probation and health services, including voluntary sector agencies and court diversion and liaison services. In addition, we conducted interviews with staff from drug services providing the Drug Rehabilitation Requirement in order to compare it with the MHTR. Table 2 lists the types of people we interviewed.

We approached 67 professionals and 56 agreed to participate. Some professionals declined as they felt unqualified to discuss the MHTR due to their lack of experience of it. Delays in gaining approval from NHS research governance bodies meant that we could not approach as many health care staff as we required. There is thus an under-representation of the views of health care staff. However, since our research is primarily focused on exploring the processes involved in issuing an MHTR and the decision making behind sentencing, this under-representation is not a serious limitation.

Interviews with court staff focused on the decision making behind sentencing and explored the barriers. With probation staff we looked at the decision making behind recommendations to courts, issues surrounding inter-agency working with health services and how they manage offenders on an MHTR. The health staff interviews focused on identifying what types of treatments are available for those on an MHTR and issues about treating people who are on a Community Order and working with probation services.

**Table 2: Interview participants**

<b>Courts</b>		<b>Drug rehabilitation</b>	
Judges	8	Probation officer	1
Magistrates	6	Psychiatrist	1
Legal advisors	7	<b>Voluntary sector</b>	
Solicitors	6	Forensic mental	
<b>Probation</b>		health practitioners	4
Senior probation officers	6	Manager	1
Probation officers	6	<b>Court diversion and</b>	
Senior probation staff	2	liaison schemes	2
<b>Health</b>		<b>TOTAL PARTICIPANTS</b>	
Psychiatrists	3		56
Approved social workers	2		
Community psychiatric nurse	1		

Most of the professionals we interviewed had no direct experience of either issuing the MHTR or of supervising or treating someone on this requirement. Where professionals had no direct experience of the MHTR or had never heard about it, they were asked to talk more generally about this requirement and to discuss what difficulties or issues might be presented by the MHTR.

## Documentation

In order to understand more about the decision making behind sentencing, we viewed several anonymised pre-sentence reports for offenders with mental health problems. We were able to access 10 reports from three different boroughs, which we analysed to see how probation officers respond to mental health issues prior to or at the time of writing pre-sentence reports.



## Professionals' views of the MHTR

Appropriate use of the MHTR depends crucially on probation officers, defence solicitors and psychiatrists all being both familiar with and confident in using it. Our interviews have indicated that this is far from being the case in practice.

### Awareness of the MHTR

It was evident from the professionals we interviewed that there was a striking lack of awareness of the MHTR. Few had any direct involvement in it, or understood the processes involved such as when and how it should be used.

For some of the professionals we approached, our research prompted them to look at the MHTR in detail for the first time.

Of all the professionals we interviewed, those working in the courts were the most likely to have heard of the MHTR. All of the 27 court professionals were aware that the MHTR was one of the 12 requirements under the Community Order. Only four, however, had any direct experience of the MHTR that they could recall.

“The problem with those sentences [is that] I have barely heard of them and I’m a very experienced criminal lawyer.” (Solicitor)

Similarly, most of the probation officers had heard of the MHTR by name but only a few had any direct experience, either of recommending the MHTR in a pre-sentence report or of supervising someone on an order.

Awareness of the MHTR was notably lower among health care staff. Only three of the health care professionals we interviewed were aware of the MHTR. During the course of our interviews, some confused the MHTR with the recently introduced provisions for supervised community treatment under the 2007 Mental Health Act.

Without a psychiatrist’s explicit recommendation in a report for the MHTR, with an offer of treatment, probation services cannot recommend it and sentencers are therefore unable to issue it.

This lack of awareness of the MHTR could be contributing to professionals’ hesitancy in using it. We were told that court and probation professionals feared making errors in using unfamiliar legislation.

“It’s all, ‘I’m not familiar with that, better not consider it because I might do something wrong’.” (Solicitor)

“It’s still relatively new [MHTR]. I think many professionals in probation don’t fully understand what is required of an MHTR, in [terms of] what we have to give the court.”

(Probation officer)

Others blamed a lack of clarity in the legislation itself for the infrequent use of the MHTR.

“Some of [the legislation is] really badly drafted and, if we don't know about it, we don't use it. There are huge bits of legislation that basically get passed and are barely used. It does fall to us. It's got to be picked up. If somebody is up for sentencing, unless the probation officers know about it and they are suggesting it, unless we know about it, it doesn't get suggested to the bench.” (Solicitor)

Clearly, the lack of awareness and understanding of the process of the MHTR present some formidable challenges to its use.

## Knowledge of mental health

Court and probation professionals varied widely in their knowledge of mental health issues and their confidence in dealing with them.

Judges were the most likely to say they had sufficient knowledge of mental health for their job. Magistrates, in contrast, felt that the training they received was minimal and that they did not know enough.

“I don't think we know as much as we should or we could. I believe we could benefit from lectures and seminars. I believe magistrates would welcome this.” (Magistrate)

Magistrates were particularly keen to receive training to increase their knowledge about mental health and to undertake additional training on how and when to make use of requirements such as the MHTR.

“It would be an extremely good thing if we have more training on [the MHTR]. I think we are wary of anything new.” (Magistrate)

One magistrate we interviewed argued that their lack of knowledge of mental health and the MHTR was partly because this issue rarely comes up.

Probation officers gave less of a clear picture of their understanding of mental health issues. Some probation officers, however, said they were not so confident in managing cases where offenders have mental health problems and that there is not enough training on mental health.

## Responsibility for mental health

Many of the court professionals we interviewed felt that mental health was not the business of the criminal justice system.

“We are supposed to be hitting figures and targets and get cases disposed of quickly... we are supposed to be working on a simple, speedy, swift summary justice.” (Legal advisor)

The courts want to resolve cases as quickly as possible. Requirements such as the MHTR cause delays and cases may remain ‘unfinished’ for a long time.

“The most vulnerable defendants are going to be badly hit by speedy summary justice, it's because courts just want to know whether the client's pleading guilty or not guilty.”

(Solicitor)

“We have a system that is all about speed. All about getting things done quickly, all about budgets, targets and [mental health] messes it all up. And that’s far too complicated, nobody gets paid ... the defence lawyers don’t get paid to do any extra work, the courts are being told to process as quickly as possible. The whole system is going in that direction ... [mental health] is not going to be looked into.” (Solicitor)

Each of the agencies we interviewed had a very clear view of its role and responsibilities. Sentencers said their role was not to respond to mental health problems; that there were services outside the criminal justice system to do this.

“At the end of the day you have got to consider what our role is, you know if we were to take on every case that had this mental health aspect to it, which we could and go on and on and on with it, we lose sight of what our job is.” (Judge)

“I think mental health problems shouldn’t be left to the criminal justice system.” (Judge)

In turn, one psychiatrist told us that it was not the role of mental health services to ‘police’ offenders on an MHTR and indicated that offenders were not within their community mental health team’s remit.

## The purpose of the MHTR

Interviews with professionals from court, probation and health services reveal a large disparity in the perceived purpose of the MHTR and its inclusion and exclusion criteria.

A significant number of people who come into contact with the criminal justice system were said to be known already to secondary mental health services. There were very mixed views among court and probation staff about whether the MHTR should be used to encourage people to get back into services when they have lost touch or whether it should be used to engage people for the first time. A few felt it should be used for both.

Some court and probation staff told us they would not consider the MHTR for those who were currently known to mental health services. They said that making an MHTR in such cases would be ‘duplicating’ treatment already in place, for those who are currently engaging with services.

Others, however, said that the MHTR could be used for those who are known but have disengaged with services, to serve the purpose of re-engagement.

“The fact that they are already linked in [to mental health services], I would have thought that would be an advantageous reason for going for this treatment, because if they breach the order then it lays open the chance to re-sentence them for that crime.” (Legal advisor)

Using the MHTR in this way could be a useful means of ensuring that an offender attends appointments and receives treatment. Both of these could reduce the likelihood of reoffending, especially if there was a link between the offence and the illness (Sainsbury Centre, 2009).

One interviewee felt that the MHTR could be used for a range of clients.

“For those that have fallen out of the routine to get them back on the horse, as it were, and for newcomers to get the treatment they hadn’t realised they wanted or needed.” (Solicitor)

There was some contention about this view. A few sentencers felt that it was not the court's role to link people back into services. They believed that there were more appropriate ways of doing this.

Courts that had access to a court diversion and liaison scheme felt less inclined to use the MHTR for the purposes of engagement. These schemes were thought to provide assistance to the offender and to link them back to their mental health teams.

“Most of the linking people back with their services, if they have fallen out with them, is done by the duty psychiatrist.” (Solicitor)

Others suggested that probation services are able to link people back in with services through the use of the Supervision Requirement.

One judge we interviewed said that they would not issue an MHTR for a person who was currently engaging with services due to the consequences if they breach the MHTR.

“If they are already getting treatment it's not worth making an order because, of course, the consequences of breaching a Community Order are severe now. And sometimes you are setting people up to fail by imposing too many conditions in a Community Order.” (Judge)

Many probation officers also suggested to us that an MHTR would only be suitable if the person's mental illness was directly linked to their offence.

“[the mental illness has] got to be a factor that has led the offender into offending.”  
(Senior probation officer)

One senior probation officer held strong views about using the MHTR where the illness was not directly linked to the offence.

“I think it's illegitimate to use criminal law for a matter which is not related to offending.”  
(Senior probation officer)

Court and probation professionals had different interpretations of what the MHTR was intended for and how it should be applied.

## The usefulness of the MHTR

Finally, we asked professionals whether they perceived the MHTR to be a useful component of the Community Order. Some court professionals responded by expressing their uncertainty about what outcome an MHTR might achieve.

“One of the frustrations of being a magistrate is that so rarely do we discover the outcomes of anything that we have dealt with ... we don't know what works.” (Magistrate)

“The only time that we get an inkling, at all, is on a very narrow anecdotal basis as to whether we see the same person back again.” (Judge)

Others said that, while the MHTR might be useful, the difficulties they had experienced in putting it together made it impractical.

“It's extremely difficult ... This is the sort of sentence that appears awfully good on paper but in practice it's much, much more difficult.” (Judge)

## A MISSED OPPORTUNITY?

Probation staff also expressed mixed views about the usefulness of the MHTR. We were told that it can potentially be useful but that it needs more resources, and more willingness from mental health services, to offer better access to treatment.

Health professionals told us that the MHTR was useful, but only for the 'right person'. Voluntary sector agency staff also indicated that the MHTR would be suitable for some, but that it was difficult to gain a clear, meaningful idea of when and for whom it would be most beneficial.



## Criteria for the MHTR

The first stage of the process of issuing an MHTR is for probation or a defence solicitor to identify a mental health problem and to communicate this to the court. This initial identification is critical and it is often highly dependent on the experience of probation officers.

### Severity of mental illness

While the legislation excludes people who require an immediate compulsory hospital admission, there is no lower limit on the level of mental ill health that qualifies a person for an MHTR. And the legislation does not specify what types of mental illness would lead to an MHTR disposal other than to state that it must be ‘susceptible to treatment’.

The lack of clarity of the legislation has led to a variety of interpretations as to what mental health conditions meet the criteria for the MHTR. The courts, probation and health services have different views about where and when the MHTR would and should be used.

Some of the court professionals we interviewed said they had difficulty in identifying which people would qualify for the MHTR because of uncertainties about how severe a mental health problem should be to make the requirement appropriate.

“*They are in that tiny piece of middle ground, so these are people who will respond to some sanctions but a sanction short of absolute compulsion ... it’s quite a narrowly defined community that you are aiming at and I’m not sure I will recognise them.*” (Legal advisor)

The category for those who would be suitable for the MHTR was said to be a ‘very narrow niche’. The majority of court staff said they found it easier to recognise and identify those who were severely ill and may require a formal hospital admission. Some believed that most offenders with severe mental health problems would need to be compulsorily admitted under the Mental Health Act, while those with less severe problems would not have their mental health needs addressed in court at all.

“*There are very few that are in need of punishment and treatment at the same time ... I just don’t tend to see many people that fit with the sentence effectively.*” (Legal advisor)

“*[If a] person is a diagnosed schizophrenic and they haven’t got previous convictions or maybe they have got one or two, or maybe they are just a nuisance ... there is a very strong case of sheer practicality, of getting on with a case and getting rid of it, because in theory, for someone with mental health problems, there are these services outside the criminal justice system.*” (Judge)

Other court professionals felt that an offender with severe mental health problems would be unable to cope with the demands of an MHTR or that severe mental illness should not be managed in the criminal justice system anyway.

“The whole idea of a criminal sanction on somebody who is mentally ill, who isn’t complying with their treatment is to me barmy, completely barmy.” (Judge)

Judging the level of mental health problems and whether treatment should be sanctioned legally thus posed great difficulties for court professionals, who clearly struggled with making appropriate decisions about what to do.

## Mental health diagnosis

Although the legislation does not set any clear exclusion in terms of diagnoses that would include or exclude a person from receiving an MHTR, many professionals have identified illnesses that they consider not to meet the threshold. Personality disorders, depression and anxiety were commonly mentioned by professionals from several different agencies as not meeting the criteria for an MHTR.

“When I enquired to probation, I was told that being depressed does not meet the criteria [for MHTR].” (Magistrate)

“One of the difficulties it seems is the definition of the mental health problems because there is a tendency, I think, to say if it’s personality disorder there is nothing you can do.” (Judge)

All of the psychiatrists we interviewed agreed that the MHTR would only be suitable for those with severe and enduring mental health problems such as schizophrenia and bipolar disorder. It would not be recommended for those who may only require talking therapy or psychological treatment. The psychiatrists interviewed felt that those with mild to moderate mental health problems such as anxiety and depression were not within their remit and would be better supported by primary care.

The justification for excluding illnesses that would only require psychological therapy was linked to the perceived effectiveness of treatment.

“[For] people with milder disorders and where the main treatment will be talking treatment like psychotherapy... I think that if there is a degree of compulsion it will reduce the effectiveness of the treatment.” (Psychiatrist)

It was felt that the effectiveness of such treatment relies upon voluntary engagement. This view was shared by most of the health care professionals we interviewed.

There appears to be some confusion over compulsion and the MHTR. The MHTR is not a way of delivering forced treatment. While there are enforcement issues if someone is placed on an order, the MHTR requires the offender’s consent before it can be imposed.

Personality disorder was said to be a particularly problematic diagnosis. Many sentencers, both magistrates and judges, indicated that offenders with personality disorder would be excluded from the MHTR as their condition was not thought to be amenable to treatment. Some sentencers said that personality disorders were among the most prevalent mental health conditions in those coming before the court.

## Assessing mental health needs

In most cases, it appears to be the role of probation to raise any concerns about an individual's mental health. We were told that the courts rarely consider mental health issues of their own accord. Their time with the offender is limited and they do not have the expertise to identify mental illness.

“We are reliant on the probation service telling us whether the person has mental health problems when they do the report.” (Magistrate)

The most widely used system for assessing the needs of offenders is the Offender Assessment System (OASys). This is a tool used by probation officers to assess an offender's likelihood of reconviction and their risk of harm to themselves or to others. It is used to identify offending-related needs which include personality characteristics and social issues. There is no specific section on OASys that looks at mental health problems. However, one probation officer indicated that some sections of OASys, such as 'Emotional Wellbeing' and 'Thinking and Behaviour', could be used to highlight mental health concerns. Where these sections were seen as the main risk factors to offending, a disposal such as the MHTR may be considered.

Most probation staff said that the Offender Assessment System was just a means through which issues relating to mental illness might be raised, and that probation services were not solely reliant on this. Many said they would pick up issues around mental illness from speaking to the offender and through their body language.

“OASys cannot diagnose anything, it's a tool, it isn't the answer.” (Probation officer)

“The most experienced probation officer would not need OASys to tell them that, a lot of it comes out of the presentation.” (Senior probation officer)

Many probation professionals agreed that the identification of mental health issues relied on the individual probation officer writing the report, on their ability to recognise signs and symptoms and on their knowledge of what questions to ask. This is likely to lead to inconsistencies in identification.

In addition to interviewing court, probation and health care professionals, we analysed a small sample of ten anonymised pre-sentence reports, from three different boroughs, in which mental health concerns were raised. They are not a representative sample of all pre-sentence reports but they do provide some insight into how an offender is issued with an MHTR, what the treatment entails and the decision making behind sentencing.

We found that most offenders whose mental health was raised as a concern in pre-sentence reports had an established history of mental illness. Most were either previously or currently known to mental health services. In the two cases where the MHTR was recommended by the probation officer, a clear link between the mental illness and the offence was apparent throughout the report. In both reports, there was reference to a psychiatric report still in progress. In both, the probation officer stated that the MHTR could be considered by the bench but could not be implemented without a recommendation in the psychiatric report. As we were not able to follow the case, because of the confidentiality of psychiatric reports, we do not know whether these resulted in the disposal of an MHTR.

We also found that decision making is heavily directed by the OASys risk assessment. Where 'Emotional Wellbeing' and 'Thinking and Behaviour' were particularly high on the risk assessment scale, and they were perceived as the main factors contributing to the offence, mental health concerns were discussed in greater depth.

## Alternatives to the MHTR

While there is no specific alternative sentence to the MHTR, it has been reported that in many cases a Supervision Requirement is used to encourage people to get back into services and to gain access to treatment. Some sentencers have viewed this as a preferable alternative.

“The vast majority of them are in touch with the community psychiatric team because they have had periods of being in- and out-patients. I would just make a straightforward supervision order and leave it up to the probation officer to encourage them on the supervision to continue cooperating rather than force them with the legislation to cooperate.” (Judge)

Our interviews also suggested that, where court diversion and liaison schemes screen and refer people to services, courts are less likely to pursue the MHTR.

“I think that works better. Because I think that if they are in real need of treatment then the psychiatric team at the court can arrange for the treatment.” (Judge)

“We might say, ‘ok, give him a Community Order with a Supervision Requirement to come and see us’. So we might facilitate supporting the mental health needs through that route, rather than the MHTR.” (Voluntary sector agency manager)

Using supervision in such creative ways would avoid the need for a psychiatric report, reduce the time spent on remand or bail and avoid the problem of breach.

While it is possible that supervision is used to respond to mental health issues, probation statistics do not provide insight into how frequently this happens.



# Psychiatric reports

Once a suitable candidate for an MHTR has been identified, there can be practical difficulties in gathering the relevant information needed in a timely manner. The most notable difficulty is in obtaining a formal psychiatric report.

“It’s such a long shot to get to the point where you can have an MHTR. You could be talking about adjournments for 16 weeks.” (Legal advisor)

Gathering the required information is one of the main stumbling blocks for the MHTR. It creates delays in sentencing, adds to the workload of both defence advocates and probation, and it causes difficulties for the offender. The two key stages of this process are the pre-sentence report (PSR, produced by probation officers) and a formal psychiatric report, produced by a psychiatrist who is approved to give assessments under the 1983 Mental Health Act.

## Pre-sentence reports

Most court professionals did not indicate any problems with obtaining pre-sentence reports from probation services.

“The quality of the reports that we receive here has improved enormously.” (Magistrate)

However, a few court professionals did mention concerns about the quality and timeliness of pre-sentence reports. Some said they had experienced occasions where probation services were not able to allocate a report writer to a case because of a lack of resources.

“The problem is probation’s lack of resources in being able to deal with as many reports as the court asks for. We frequently adjourn a case for reports and often the case will come back to court and they will produce a resources letter saying they have been unable to allocate a probation officer for that person and then they ask for another three weeks.” (Legal advisor)

## Arranging psychiatric reports

The most frequently cited barrier to issuing the MHTR was the organisation of psychiatric reports. This was the biggest single issue in many interviews with court and probation staff.

“We have quite a bit of difficulty in getting reports from psychiatrists, which is why it’s quite rare that we make these orders.” (Legal advisor)

Difficulties have been encountered with the organisation of reports, with costs, with time delays and, in particular, with offenders who do not reside in the area served by the court where the offence was committed.

Psychiatric reports can be requested to assess a person's fitness to plead, their ability to stand trial or for sentencing purposes. Reports are usually organised by the defence solicitor or by probation services, depending on what stage in the court proceedings they will be used and when the issue of mental health problems was raised.

Regardless of which agency is pursuing the reports, it is a lengthy and burdensome task.

Solicitors are required to gain prior authority from the Legal Services Commission before they can begin organising a report and they must justify the reasons for their request. Often, according to our interviews, this takes several weeks.

Probation might be asked to organise a psychiatric report on behalf of the court where concerns about the mental health of a person on bail have been raised. Alternatively, probation staff may themselves identify mental health problems when doing the pre-sentence report and may ask the court to adjourn for a full psychiatric report.

Where mental illness is picked up at this latter stage, there are usually more delays, particularly as probation staff will often wait for the completed psychiatric report to inform the recommendations they make to the court.

For people on remand, the prison service organises psychiatric reports. This process is equally difficult. Such delays in the production of psychiatric reports can cause people to spend disproportionate lengths of time on remand awaiting sentence. In some cases we were told the defendant themselves will give up waiting for a report and ask to be sentenced to an alternative punishment.

### Causes of delays

The most commonly cited reasons for delays in the completion of psychiatric reports were difficulties in finding a suitable psychiatrist.

“*Psychiatrists are either increasingly overworked or alternatively they have no respect for the court's time deadlines. It is not unusual that a psychiatric report requested by the court sometimes takes up to three months.*” (Senior probation officer)

Solicitors and probation officers have expressed difficulties in finding a psychiatrist willing to write a report. They told us that psychiatrists would refuse to write a report for a number of reasons, including payment, whether the person is known to them and time factors. Some psychiatrists do not see it as part of their job to write reports for the court but will do it in their own time.

We were told that it was easier to get a psychiatric report for somebody who is already known to mental health services.

“*If they know somebody, and they are currently under their care, they are more likely to do the report. If somebody is not currently under their care, then they are very averse to the idea of doing it.*” (Legal advisor)

The psychiatrists we interviewed confirmed this. They expressed an unwillingness to write a report for people who were unknown to them. This was primarily due to time constraints.

Once a psychiatrist has agreed to write a report, court and probation staff told us that it can also take considerable time before the report is ready and made available to court.

“There is an extreme delay in getting a [psychiatric] report; that person might well be in custody and can have served their sentence.” (Judge)

The judges we interviewed said these delays were “very, very frequent”. Some sentencers told us that it is not uncommon for defendants to spend more time on remand than they would on any prison sentence issued at the magistrate’s court.

“If they [offender] have been in custody for 12 weeks waiting for a report, when our maximum sentence is six months, they have served their time. So there is an argument which says that they have done it.” (Judge)

## Fitness for purpose

In the vast majority of cases, a psychiatric report must identify a mental health problem with an offer of treatment from local mental health services before a court can issue an MHTR. Some probation staff, however, have told us that reports can lack the information that is necessary to issue an MHTR. While psychiatric reports do not have to provide detailed treatment plans, some psychiatrists do offer care plans while others do not. This can leave probation and court staff without sufficient information about what is required of them.

Probation professionals were particularly critical of defence solicitors for obtaining psychiatric reports from independent psychiatrists and not those from the offender’s local area or the mental health team where they belong.

“Defence get random psychiatrists who make a diagnosis but cannot offer treatment because they are acting in a private capacity... you have got to have treatment from a local provider.” (Senior probation officer)

“There are people [psychiatrists] that we use reasonably often, people we have used before. We usually resort to them.” (Solicitor)

Such reports cannot make an offer of treatment for the MHTR. Even if an MHTR is proposed, it cannot be implemented unless the probation service or psychiatrist liaises with the local treatment provider to gain their agreement to treat the person. On the rare occasions in which this has been achieved, we were told that further reports then had to be carried out by the local treatment provider.

Most of the court professionals we interviewed blamed health services for incomplete or inappropriate psychiatric reports. Others, however, saw it as a reflection of the poor quality of service by probation.

“Probation don’t seem to realise what is required [to arrange an MHTR]. The number of times we get a report saying MHTR but they haven’t spoken to a psychiatrist and that means another adjournment.” (Legal advisor)

“Probation have a lot to answer for in terms of what they are proposing, because we can get a psychiatric report, but the MHTR is very specific, so they don’t get the named supervisor, they don’t say what the treatment is [or] where it is going to be. They don’t do any of that. All that [information] is required [for an MHTR], so a psychiatric report by itself is just step one.” (Judge)

Two of the psychiatrists we interviewed told us that the requests they received from probation and from defence solicitors were vague. They seldom directed the report writer by stating neither why the report was requested nor its purpose.

“*The requests [for psychiatric reports] from probation officers I think are quite problematic. They are not very well formulated, or say what is required. I even get requests from solicitors where they don't put down the index offence. You know it takes two weeks to find out what the offence is and I feel that I can't begin to write a report until I have got some basic information, even if I know the patient really well. Because if it's a parking offence it's ridiculous to put down what the effect might be of going to prison.*” (Psychiatrist)

One of the psychiatrists had direct experience of recommending the MHTR in a report and then treating someone on the requirement. The request from the probation service asking for a psychiatric assessment had simply asked for a report to be conducted and did not specify whether the purpose of the report was for fitness to plead or to stand trial or for sentencing; nor did it contain the person's criminal history, nor the details of the offence.

## Who pays for reports?

One of the main difficulties in obtaining psychiatric reports was said to be in finding a psychiatrist who is willing to write a report for a fixed fee. Some court professionals and probation officers have indicated that psychiatrists charged more for reports than the courts have the capacity to pay. This leaves the probation service and defence solicitor in a difficult position where they must find someone who is willing to write the report for a certain fee.

Most judges were aware of the processes involved in arranging psychiatric reports and of concerns about costs. Many magistrates, by contrast, were not aware of any issues around costs, and it was something they said they did not think about.

“*I don't know what the mechanics of it are. I don't know whether the court directly orders it or whether the court asks for the probation service to get it.*” (Magistrate)

Probation officers highlighted more concerns over costs. Although the probation service is not responsible for funding psychiatric reports, there is still confusion about who pays and what the costs are.

“*Officially it's about £250 but we usually pay them £500 because we usually work it on the basis that it's two lots of work.*” (Legal advisor)

Where psychiatric reports are being prepared for a person on remand, the prison's visiting psychiatrist will write the report. Some probation officers have indicated that there are problems in liaising with prison psychiatrists, who are often difficult to contact.

In some cases we were told that it was easier to get reports for those who are seriously ill and require hospital admission.

“*Where I have found it has been very easy is where they are so ill, so seriously ill that they are transferred from prison to a secure unit, and then the secure unit immediately prepare a report because they are asking for a hospital order or they want them to stay in a secure unit. So then they are very forthcoming with the report and nobody pays for that as far as I'm aware.*”  
(Solicitor)

Difficulties in finding a psychiatrist willing to write a psychiatric report and offer treatment are often greater where the person is not local to the court where they are being tried. Where protocols have been agreed between the courts and the local NHS mental health trust to provide psychiatric reports, for example, this will normally exclude those who are from a different area.

### Incomplete psychiatric reports

We were told that, in some instances, MHTRs had been issued without complete psychiatric reports. In some cases, we were told that psychiatric reports had not been written by a doctor approved under Section 12 of the Mental Health Act. We were also told about occasions where offenders had been given an MHTR without a treatment provider being agreed.

Probation officers told us of cases in which they had been informed by an offender that an MHTR was part of their sentence but that they were not receiving any treatment. Other probation officers said they had discovered the existence of an MHTR when they looked back at the requirements on an offender's order.

These incomplete reports were attributed by our interviewees to expediency or a lack of expertise in the finer details of the process.

“*To my knowledge it has happened more than once. It's just because courts want things to be expedient ... they just want the case over with and out of their list and gone.*”

(Senior probation officer)

### Speeding up psychiatric reports

Delays in the provision of psychiatric reports for court purposes have led to the development of two major pilots in England, one in the South West and one in London, to improve access to psychiatric reports. Service level agreements have been formed between the courts and the local mental health trust to improve access to psychiatric court reports.

Since the South West project began in April 2008, use of the MHTR in the region has increased. Seven MHTRs were issued by the courts in as many months. Instead of obtaining a full psychiatric report, an assessment was carried out by a probation officer and agreement to treat the person was gained from a psychiatrist. This approach may help to cut the costs of obtaining psychiatric reports to the court and any unnecessary time spent on remand or on bail (Hean *et al.*, 2008; Staddon, 2008).

Some of the MHTRs issued in the South West have been issued without an accompanying Supervision Requirement, and some have no other requirements at all. These have been given to people who were already known to mental health services. Although the probation services are not involved in providing 'supervision' as an additional requirement, there is a named probation officer who will take responsibility if breach proceedings become necessary.

Currently these pilots are still in their initial stages and it is not yet clear what impact they will have on the ease of acquiring reports and on sentencing decisions (Hean *et al.*, 2008). Only one of the courts in London that we visited was involved in this pilot and had a protocol in place. In all other courts, issues surrounding psychiatric reports were paramount.



## Breach of the MHTR

Once an MHTR has begun, the biggest concern raised in our interviews was with how to manage instances in which a person breaches the terms of their MHTR, and with what constitutes a breach of this requirement.

The Centre for Crime and Justice Studies found that breach of Community Orders and Suspended Sentence Orders in general was a serious concern among sentencers (Solomon & Rutherford, 2007). Many sentencers believed that making the conditions of an order more onerous once an offender had breached the initial order was setting them up to fail.

Similar concerns were raised in our interviews with court professionals, but not by most probation staff. They found that breach proceedings were a useful way of encouraging compliance, particularly for those who are high risk.

We have been unable to obtain information about the number of occasions on which an MHTR has been breached, or on the actions that were taken as a result.

### How can an MHTR be breached?

There are no specific guidelines on how an offender can breach an MHTR. By and large, we were told breach occurs due to 'non-compliance'. But this has been interpreted in different ways by different probation officers and their actions have thus varied widely.

The majority of people we interviewed said that missed appointments would be as regarded as a breach of the MHTR. But there was no agreement about whether 'non-compliance' included medication.

“I suppose if someone consistently refused to take their medication that might cause breach.” (Magistrate)

“You could breach it by not cooperating with the requirement. I guess the requirement would be to cooperate with treatment [medication].” (Senior probation officer)

Probation officers attributed increased risk as a justification for breaching someone on an MHTR for missed medication.

“Your risk is increased [if you miss medication], in terms of risk of harm, not only to the self but also the public.” (Senior probation officer)

Others argued that an MHTR could be breached by missing appointments without good reason or committing a further offence, but not by missing medication.

“*[Breach] is all appointment based, not medication based. If they are not taking their medication it would be for the mental health teams to address that. If they are attending their appointments then they are meeting our national standards.*” (Probation officer)

One senior probation officer attributed uncertainty about what constitutes breach of an order to the lack of information contained in psychiatric reports at the outset of the process. If these were not specific about treatment and did not include a treatment plan, probation services may lack the information they need to enforce breach proceedings.

“*I think the biggest thing we struggle with is to get information backwards and forwards between ourselves and the CMHTs. I often say what constitutes treatment. They often don't give us a full treatment plan. You get a psychiatric report, it won't say how often they are going to see them, it won't say who else is going to treat them, you never really get much of a sense of what the psychiatrist is actually doing with this person.*” (Senior probation officer)

This state of affairs may well be a reflection of the underdeveloped nature of inter-agency working between mainstream mental health and probation services. It was evident from our interviews, for example, that some probation officers were unfamiliar with the way mental health services function and how they engage with their clients.

## The outcome of breach

Many of the court professionals we interviewed were unclear about what the outcome of a breach would be for a person on an MHTR. Legislatively, in the event of a breach, courts are required to make the order more onerous or to impose a prison sentence.

Other requirements, such as unpaid work or drug rehabilitation, provide a relatively straightforward means of responding to a breach such as increasing the length of a sentence or extending the number of hours for unpaid work. For mental health treatment, the response is much less obvious.

Some court professionals seemed troubled by the possibility of such a case and felt that it would be counter-productive to the purpose of the order.

“*All they have got to say is that they are ill and the court is going to be in a dreadful state and what does it do? Send them to prison, stick a curfew requirement to make their life more unpleasant or revoke and resentence to a different disposal altogether?*” (Legal advisor)

“*It's absolutely ridiculous for us to impose an order with a sanction which will involve custody if they don't comply with it. How can you do that for someone if they are genuinely mentally ill?*” (Judge)

“*If a mental health problem was causing them not to keep appointments ... there would be less inclination to breach. But if someone is not prepared to cooperate then they could be breached and then a more onerous requirement ... well it would almost be ludicrous ... and you might even remove the requirement and you might substitute another requirement. You might revoke and resentence in another way.*” (Legal advisor)

A senior probation officer said that, in practice, courts are unlikely to impose a penalty on a first breach.

“Most magistrate’s courts will not sentence a breach of an order especially if it is first time, or even the second time ... if you have someone who is labouring under a lot of other difficulties, to make an order more onerous flies in the face of common sense in many respects. The courts have got to do something but they don’t know what to do, so they tend to revoke the sentence and make another alternative or lengthen the requirement.” (Senior probation officer)

Some probation officers who have been involved in breach proceedings have told us that, from their experience of the cases they have managed, courts will often allow the order to continue or will revoke the requirement without imposing a penalty.

## The role of health professionals

In order to enforce breach proceedings, probation services rely on the health care provider to inform them of missed appointments and non-compliance. There is no formal guidance on how to liaise, on what information should be shared, or on the frequency of contact.

Many probation staff felt that health care professionals were not forthcoming to share information on compliance which made it difficult for them to carry out their responsibilities.

“I think it’s some time before they tell us that [the offender] is not complying.” (Senior probation officer)

Probation staff who have supervised offenders on an MHTR told us that on occasions they became aware of non-compliance only when the offender started to miss the supervision appointments. Lack of timely information sharing makes it difficult for probation services to enforce breach proceedings.

Interviews with health care staff gave a different picture. One psychiatrist felt that probation services were slow to respond to a breach and that this was problematic as non-compliance was said to be associated with increasing risk. Psychiatrists said they were familiar with and comfortable about using compulsion as a means of engaging someone into treatment. They described compulsion as a ‘double edged sword’. While there were clear benefits to having the element of compulsion, particularly for those with more serious mental health problems, it could potentially have a negative impact on the relationship formed with the offender. This may make it unsuitable for treatments such as psychological therapies, where voluntary engagement is fundamental to the success of the intervention.

Social workers and community psychiatric nurses (CPNs), who have a greater frequency of contact with those on an MHTR than most, said they would try to manage a breach initially before reporting it to the probation services. There was greater understanding with regards to the causes of the breach.

“Some illnesses make the person lethargic, socially isolated and they withdraw from people. If they have a programme where they have to attend group meetings for instance, when someone becomes so ill they don’t want to engage, it’s difficult to report them for breaching without understanding why they are actually breaching, which is why you have to understand the illness and the person ... Sometimes it is the illness itself that makes them breach not because they want to breach.” (Social worker)



## Relationships between agencies

The MHTR relies on the cooperation of three different agencies: the courts, probation and health services. This presents one of the most significant obstacles to the application of the requirement.

*“There’s a lack of interface between the three. I think there is a mutual respect but there is this idea that we don’t talk to each other, we wouldn’t understand each other.”* (Solicitor)

The majority of court and probation staff we interviewed indicated a strong working relationship between their two agencies. Courts were particularly sympathetic to the constraints of probation and were largely satisfied with the assistance they received.

In one borough, links between courts and probation services were particularly strong. Quarterly meetings were held between the courts and probation services through a Probation Liaison Committee. This committee gave magistrates and probation services the opportunity to voice concerns, share information and work together at improving the relationship and efficiency of court proceedings.

*“It’s helpful for us to have a close working relationship so we understand, for example, manpower issues that may arise from time to time. We can’t sentence in a vacuum, what we can do and should do must be dictated by the environment in which we are working.”*  
(Magistrate)

The relationship with health services was more problematic for both the courts and probation services. Other than the operation of diversion and liaison schemes within the courts, there was usually no other direct link between courts and health services. Most of the court professionals we interviewed felt that the input they received from diversion teams was sufficient. Yet some of the professionals from courts that had access to a court diversion and liaison scheme were not aware of its existence.

More concerns were raised about the relationship between probation and health services, primarily about information sharing and maintaining contact. Probation staff told us that it was often difficult to get hold of health professionals or to gain access to information. Concerns about patient confidentiality may make psychiatrists unwilling to share psychiatric reports with probation services or discuss a patient’s compliance or details of treatment.

By contrast, most of the health professionals said they did not have any difficulties in liaising with probation services. It also appeared from our interviews that inter-agency working was better in the cases of individuals whose risk to the public was seen to be higher, for example those subject to multi-agency public protection arrangements (MAPPA).

## Diversion and liaison schemes

Many courts have access to a diversion and liaison scheme. The primary function of these teams is to identify people with mental health problems and to link them to health services within or outside the criminal justice system to receive treatment and care. Schemes typically consist of mental health professionals, community psychiatric nurses (CPNs), social workers and at times psychiatrists. There is no single model for a diversion and liaison scheme. As a result schemes tend to vary considerably in their size, function and coverage (Sainsbury Centre, 2009).

Six of the eight courts we visited had a court diversion and liaison scheme. Four of these schemes were provided by the local mental health trust and the remaining two were provided by a voluntary sector agency.

Interviews with courts and probation services have revealed that, in most areas where there are criminal justice diversion and liaison schemes operating within the courts, they take no part in the process of issuing an MHTR. While diversion and liaison schemes carry out assessments of people who are thought to have mental health problems, they do not normally make recommendations for sentencing purposes, and their involvement is usually quite early on in court processes.

Court professionals suggested to us that, if court diversion and liaison schemes are striving to get people back into services, there is no need to use the MHTR.

“I think why it hasn't happened so much is because a lot of mental health teams are intervening a lot earlier in the process, before conviction even, and so quite a lot of people are actually diverted away from the criminal process a lot earlier.” (Legal advisor)

The staff we interviewed from diversion and liaison schemes had little awareness of the MHTR. Some schemes did not see it as their role to make recommendations about sentencing or to be involved with the MHTR. They felt their primary role was to screen for mental health problems and refer the person onto appropriate services. The diversion scheme workers we interviewed did not appear to be very familiar with either the MHTR or any of the other requirements under the Community Order.

The voluntary sector agency that provides a diversion and liaison service to two of the courts we visited also has the capacity to supervise offenders on an MHTR. This agency employed forensic mental health practitioners (FMHPs), mental health professionals who work specifically with offenders, who spend half of their time in court and the other half in probation. Their role in the court is primarily to screen referrals to determine whether there are mental health concerns, and to facilitate requests for psychiatric reports. In probation, their role is to provide assistance to probation officers to manage offenders with mental health problems and in some cases take on the supervision element of community sentences, particularly for those on an MHTR.

This is the only example that we found of a diversion and liaison scheme being involved in the MHTR. But even this arrangement does not always work smoothly:

“I think [probation] struggle because of their workload. They are carrying huge caseloads and sometimes what we find is someone has been on a Community Order for a length of time and then we get a referral for our services even though there might have been mental health concerns earlier ... There is an increasing number of unqualified staff compared to qualified staff and we are spending an awful lot of time with the unqualified staff who have much less experience of offender management and complex issues, not just mental health but drugs and alcohol.” (Voluntary sector agency manager)



# The Drug Rehabilitation Requirement

The Drug Rehabilitation Requirement (DRR) is used far more widely than the MHTR, in approximately one Community Order in 20. The DRR is normally issued to offenders with substance misuse problems, mainly class A drug users. This chapter examines the DRR, both to identify any lessons for improving the effectiveness of the MHTR and to understand why it is used so much more often.

Under the Drug Rehabilitation Requirement, offenders are given treatment for their drug use with regular testing. Unlike any other requirement, the courts may in some cases have the option of reviewing the DRR throughout the course of the order.

Similar to the MHTR, the offender must also give their consent in order for the requirement to be made part of the sentence. Consent was not said to be an issue as it was generally perceived by probation and court staff that offenders will by and large be willing to undergo this treatment. It is less stigmatising than mental health treatment and the courts were said to take a sympathetic approach to those on the requirement.

The majority of sentencers, legal advisors and probation staff we interviewed had direct experience of the DRR. There was notable familiarity with this requirement, of the processes, what it involves and the treatments.

## Dual diagnosis

We asked court and probation staff how individuals with a dual diagnosis of mental health problems co-occurring with substance misuse are typically dealt with and what disposals they are likely to receive. An overwhelming majority of probation and court staff said they would be more likely to recommend and sentence to the DRR than to the MHTR. Familiarity, ease of use, accessibility and a tendency to perceive the drug problem as the underlying issue were cited as the main reasons for this decision.

“ I think it’s partly because that’s a more practical approach [the DRR]. I think there’s the feeling that if the person is getting into trouble because of their drug difficulties, and their drug difficulty is exacerbating their psychiatric health, then get them off the drugs first.” (Judge)

It would appear from our interviews that offenders with dual diagnosis are more likely to be diverted via the DRR route than through an MHTR.

“ We tend to focus on that [the DRR]: there are more resources, there is more money for drug rehabilitation in this area than there is for anything else.” (Judge)

“ They are probably more likely to get something under their drugs... There’s a lot out there for them, absolute backing, even voluntary services.” (Legal advisor)

Probation staff were specific about their decision to recommend the DRR over the MHTR. Many said that the decision to advance on the DRR would be determined on an individual basis. They believed that low level mental health problems would be dealt with by drug services.

“It depends on the underlying problem. We expect low key mental health problems to be dealt with in substance misuse. It’s the judgement of the individual, sometimes you will find that they go one way when they should go the other.” (Senior probation officer)

By and large probation staff expressed greater confidence in the DRR, with what it involves and with their role in its management. The strength of the DRR and the heightened confidence of probation staff could partly be due to the greater and more established links with drug services.

“We have more communication with the drug agency. They are just across the road, so it’s easier to liaise.” (Probation officer)

Sentencers expressed a similar confidence in probation services managing these orders.

“Probation take responsibility for it and are familiar with it. They know it and feel at home with it.” (Judge)

In addition, drug issues are given particular focus and priority by the probation service. Many probation offices have staff whose primary responsibility is to supervise offenders on DRRs. This specialist group of probation officers will be equipped with the knowledge, skills and experience to manage offenders on a DRR.

Offenders with dual diagnosis could potentially receive both a DRR and an MHTR to run in parallel. There were mixed views about whether this would be a suitable or a workable option.

Some expressed the view that the two requirements together would be far too onerous an order.

“[The DRR] is a very onerous requirement. They have to turn up on time, they have probation meetings, drugs meetings, it’s almost a full time job.” (Magistrate)

We were told by some court professionals and probation staff that an MHTR could be given with a DRR if there was a need.

“It could be both because it could be the drugs that trigger the mental health problems. It should be both.” (Senior probation officer)

None of the professionals we interviewed had ever heard of an MHTR being used in conjunction with a DRR. Exploring both mental health and drug problems would create practical difficulties as well as timing issues for probation services. Reports would need to be gathered from specialists in each area, which take differing lengths of time, and this may create difficulties for probation officers.

## Initiating a DRR

There was variation between localities in terms of who conducts the DRR assessments and in the extent of probation’s involvement. Nonetheless, the processes and procedures involved in the DRR were familiar to all probation staff and easy to follow.

Local agreements have been formed with the NHS to provide DRR services. These teams are specifically designed to treat offenders on this requirement. This ensures there are no problems in finding treatment. Since these teams are built for purpose, there was said to be no issue with capacity:

DRR teams were able to take on anyone referred to the service and to carry out assessments following a three-week adjournment for this to take place. We were not made aware of any specific difficulties with people being subject to a DRR outside their normal area of residence.

With the MHTR, by contrast, local mental health providers are expected to treat offenders on an MHTR as part of their normal caseload. There is no service level agreement or additional funding to provide the MHTR for health services.

## Reviewing a DRR

Unlike any other requirement under the Community Order, the DRR may subject some offenders to regular monitoring of treatment through testing and reviews at the court. It was reported by probation staff that those on a DRR for six to nine months may not have a DRR review. Initially, reviews tend to be more frequent: as often as once a month. The frequency of reviews may remain consistent or decrease depending on the progress of the order. Supervising probation officers will be required to provide reports for each review.

For sentencers, DRR reviews provide a valuable insight into what the requirement entails, as well as giving an indication of its effectiveness. Some sentencers and other court professionals have expressed discontent over the lack of information about what works with regard to Community Orders in general. The only indication sentencers have of how successful or unsuccessful Community Orders are will be whether the person reoffends or through such reviews.

“ I think they are a good idea because I think it does mean that the defendant knows that someone is keeping a beady eye on them. And also I think it’s good when defendants come and can prove that they have been making good progress.” (Judge)

Although reviews have clear potential benefits, some probation officers felt they were unnecessary, as they were already monitoring progress and encouraging compliance on a regular basis through supervision, and that all the reviews were doing was adding another layer of formality.

“ To be honest it feels like a waste of everyone’s afternoon.” (Probation officer)

We asked whether the MHTR would benefit from the inclusion of reviews. Some indicated that it may be helpful but would create additional problems such as difficulties in acquiring reports which will require input from psychiatrists. This may not be appropriate for the MHTR given the difficulties in gaining psychiatric reports.

“ The only thing that would worry me is if you have monthly reviews - it’s actually getting the reports done - because another issue for us is when you want a psychiatric report, either there is nobody to do it or it takes forever and a day to get one done.” (Judge)

Another judge told us that sentencers may not be ‘qualified’ to review MHTR cases:

“ I think we have got a lot of experience of drug addicts but we don’t have much experience of mental health, I’m not sure I would feel confident to assist that [with MHTR reviews].” (Judge)

## Breach of DRR

From our interviews it appears that professionals generally take a sympathetic approach to breach of the DRR. Offenders could be breached for missed appointments, but positive drug tests were not considered breach of the order. Professionals felt and recognised that overcoming drug habits was a gradual process and offenders needed to be supported and monitored along the way.

“If they have one or two urine tests that have come up positive for drugs, it doesn't matter as long as they are trying.” (Magistrate)

## Lessons for the MHTR

Our interviews show that, while there are significant differences between the DRR and the MHTR, the former's operation provides a number of lessons about why and how it appears to be more effective.

The DRR is clearly very familiar to all of the professionals concerned with it. The DRR has a good infrastructure and is well resourced. There are good relationships between drug and probation services, with clear service level agreements, which makes it much easier for court professionals to make decisions. Attitudes to breach of the DRR also appear to be more consistent and more understanding of the difficulties involved in undergoing drug rehabilitation.

But the DRR also has clear advantages over the MHTR. The outcomes of drug rehabilitation are relatively easy to measure, through drug testing, for example. This will always be harder to achieve for mental health treatment.



## Discussion

This research project aimed primarily to uncover and describe how an offender is issued with an MHTR, the decision making behind sentencing, and how it works in practice. Its secondary aims were to explore the views of sentencers and identify the main problems that have prevented them from issuing the MHTR at the point of sentencing; to consider the MHTR as a viable means of diversion for offenders with mental health problems; to examine inter-agency working between the courts, probation and health services; and to attempt to identify lessons from the Drug Rehabilitation Requirement that might be applicable to the MHTR.

What was immediately clear in the analysis of the interviews with professionals was that few had direct experience of using the requirement. Moreover, most professionals expressed a reluctance to engage with the group for whom the MHTR could be applied – offenders with mental health problems. Criminal justice professionals were in general uncomfortable or reluctant to become involved in mental health issues, and were not greatly concerned with the health benefits of mental health interventions. Some said that mental health was simply ‘not their business’. Health care professionals, conversely, were interested in providing input that would improve health but were less interested in reducing reoffending.

Health care professionals were divided as to the value of the MHTR as a means of first engagement or re-engagement in services. Some viewed the MHTR as a way to link their clients back to their service and thought that probation supervision would ensure better engagement, while others viewed a criminal justice sanction as a poor starting point for delivering treatment.

In addition, there was considerable confusion about the purpose of the MHTR, most significantly in terms of inclusion and exclusion criteria. Sentencers and probation staff believed that the requirement could only be used to address significant mental illness, when the legislation in fact states that there is no lower seriousness threshold.

The issue of diagnosis in relation to the MHTR is clearly one that needs to be resolved. The legislation makes it clear that the requirement is specifically not available to offenders who need to be treated under the Mental Health Act. But it is incorrect to view the MHTR as only for those with severe mental illnesses. In fact the MHTR could be used to provide services for offenders with even moderate depression where, for example, NICE guidelines (NICE, 2004) indicate that some psychological therapies are appropriate.

Diagnosis is attained by psychiatric reports, which can take a long time to be delivered to the courts, with the damaging result that offenders with mental health problems can be on remand in custody longer than would otherwise be the case. It is also significant that psychiatric reports are of limited practical use in MHTR planning if they are obtained from an independent psychiatrist who cannot make a commitment on behalf of local mental health services to provide treatment. In addition, the high cost and disparate quality of psychiatric reports makes them of inconsistent usefulness to the courts.

Linked to the challenges presented by diagnosis and thresholds is the finding that professionals have radically divergent views on compulsion. There is clearly a significant debate to be had on whether the court environment imposes mental health treatment on offenders, even though it would appear that the alternative for some, of custody in prison, involves a far greater degree of compulsion overall. In addition, the damage caused by a short prison sentence is far greater than the imposition of a community sentence (discussed further in the Conclusions, chapter 10).

Responding to breach of the MHTR is particularly contentious. A sound understanding of the consequence of a breach and the flexibility that is available in how professionals can react is essential. Confusion and differing interpretations of the breach process were very apparent in the interviews with professionals.

What is strikingly clear from the findings is that the appropriate use of the MHTR requires substantial and adaptable inter-agency and inter-professional working. Inter-agency working is important in the planning and delivery of the MHTR. The requirement is presently hamstrung by differing professional views between agencies. But there is potential for diversion and liaison schemes to become much more actively involved as ‘bridge-builders’, particularly between health and criminal justice services. Greater awareness of the MHTR and willingness to take on offenders with mental health problems among health care professionals is key to increasing its use, and making this requirement a much more viable alternative to custody.

Finally, there are lessons that can be learned from the experiences of the DRR. It has been relatively successful despite also being a health intervention with breach implications, and that also requires the offender’s consent. As the use of the DRR has shown, the MHTR could work well, but it requires a shared understanding between professionals and agencies, pooled resourcing and robust outcome measurements.



# Conclusions

Community sentences provide a robust alternative to short custodial sentences. Short prison sentences are often just long enough for a prisoner to lose their home, their job, their family, their benefits, their health and their mental health. Yet they are rarely long enough to establish robust resettlement plans, and they rarely achieve positive health, housing or employment outcomes (Sainsbury Centre, 2009; Sainsbury Centre, 2008).

Short prison sentences can be particularly damaging to the mental health of offenders, and they cause significant disruption in care, making continuity of treatment very difficult (Sainsbury Centre, 2008).

Community sentences have proven to be more effective both economically and at reducing reoffending (Sainsbury Centre, 2009; Ministry of Justice, 2008b). For offenders with mental health problems who cannot be entirely diverted away from a criminal justice sanction, a community sentence with an MHTR is a potentially viable diversion tool, which can link or re-engage offenders with mental health problems to services as part of a community sentence. There are, however, a multitude of barriers that have prevented its wider use.

If looked at as a whole, these difficulties could paint a bleak picture of the current situation. They raise the thorny question of whether this requirement is worth pursuing at all.

The answer, we conclude, is that *it is*; but that the MHTR needs substantial reinvigoration and reinvention as a widely recognised and utilised non-custodial option for people who would otherwise be imprisoned on short sentences.

Where the MHTR has been used well it has indicated its unfulfilled potential as a means of diverting offenders from custody. That potential can be harnessed more widely through practical improvements to the way the requirement works on the ground.

The majority of people who receive a criminal justice sentence have not had access to adequate mental health assessment and treatment. A substantial proportion of those involved in the criminal justice system require mental health care of some sort (Sainsbury Centre, 2009). The few offenders who have been given an MHTR represent a miniscule proportion of the offenders who would benefit from mental health treatment alongside other interventions to help them to improve their lives and reduce their risk of further offending.

One reason that the MHTR has been used infrequently, as our findings suggest, is that mental health is rarely considered a priority by the courts or probation services. In most cases, unless an offender's mental health problems are so severe or noticeable that they suggest compulsory admission to a psychiatric hospital is required, the courts will generally view mental health as 'someone else's business'.

At the same time, our interviews revealed that mental health professionals were reluctant to become involved with people going through the criminal justice system and often did not see providing

services for offenders as their business. Yet it is vital that mental health professionals work with court and probation staff if diversion, and more specifically the MHTR, is to be effective.

Some professionals were concerned about the 'compulsion' element of providing treatment as part of a criminal sentence, despite the need for the offender's consent prior to sentencing. Professionals need to be given much clearer guidance about compulsion. Much more could be done to ensure that professionals adopt the principles of assertive outreach, such as encouragement, engagement and re-engagement, that have been used in mainstream mental health services, to the MHTR.

Since its introduction in 2005, few individuals have been seen to meet the criteria for the MHTR. This, in our view, is a missed opportunity. The law says that the MHTR is available for offenders with a mental health problem of any nature, as long as their condition is not so acute that it requires the use of the Mental Health Act. This is potentially a huge group of offenders. Most people with a severe mental illness rarely require compulsory admission and could be eligible for an MHTR at times they do not need to be detained in hospital. Yet this is clearly not being considered in the majority of cases.

Either the legislation needs to be reworked to take account of the professional misinterpretation that has occurred thus far, or professionals need a much clearer definition of the broad range of offenders who could qualify for an MHTR. This could be achieved through clear guidance or operational policies that could be developed and implemented across courts, mental health services and probation, or through local service agreements.

There is also a risk, borne out in our interviews, that the MHTR becomes confused with the recently adopted new regime of Supervised Community Treatment (SCT) for people discharged from hospital but still under the compulsory powers of the Mental Health Act through a Community Treatment Order (CTO). With growing numbers of people likely to be subject to SCT, it is vital that mental health practitioners are aware of the differences between these quite distinct provisions and are able to support those on an MHTR as comprehensively as those on SCT.

The MHTR's first four years have shown that the process of initiating the requirement is far too arduous and slow. Speed is of the essence in a court room, and attempting to arrange sentences that will delay a whole day's proceedings is never going to be popular. We firmly believe that justice should not be unnecessarily delayed to construct an MHTR. It would be unjustified and damaging for people with mental health problems to be kept longer in custody because of delays to procedure, or because agencies and professionals cannot agree on how to proceed.

Currently, one of the slowest elements of the MHTR process is the production of psychiatric reports. This must, therefore, be a high priority area for resolution. These reports are frequently a major cause of tensions between health services, probation and the courts. Efficient and timely delivery of high quality mental health reports from local service providers is vital to the effective use of the MHTR as a form of diversion from custody. Criminal justice diversion and liaison schemes could help to remove these barriers and to speed up the provision of reports. While few take any active role in the MHTR process, we would strongly recommend that this function be included as part of these schemes' reconfigured role (see Sainsbury Centre, 2009).

Almost all of the professionals in our study were uncertain, or otherwise had very different views, about how an offender given an MHTR should be managed. If the MHTR is to meet its unfulfilled potential, a shift in attitudes and understanding of how both mental health and criminal justice agencies work is essential. This should start with a greater commitment by all agencies to recognise that there is a high prevalence of mental health problems within the offender population, and that without effective treatment, offending problems are likely to be harder to tackle.

Taking the initiative more frequently and more boldly with joint and strategic commissioning, and working in partnership across agencies, are likely to be the most promising ways of reversing the missed opportunity that the MHTR has represented to date. Our recommendations suggest how this opportunity can be seized, and how the MHTR could become one of the viable tools for mainstream diversion.



# Recommendations

## Policy and guidance

**1. Central government should provide practical guidance for criminal justice and health professionals on how to construct and manage an MHTR.**

The purpose and process of the MHTR needs to be described by central government, with directions that state who is eligible for the requirement and how it should be used. The departments best placed to do this, in collaboration, are the Ministry of Justice and the Department of Health. They should communicate the guidance jointly to criminal justice agencies and relevant mental health professionals.

**2. Primary care trusts should ensure that they engage with criminal justice agencies and commission services that enable the courts to issue MHTRs.**

Primary care trusts should recognise that supporting services to offenders with mental health problems is part of their core business. They should resource services to courts, sentencers and probation to do their job too by commissioning diversion and support for implementing the MHTR.

## Training and information

**3. The National Offender Management Service should provide detailed information for probation officers on how to manage the MHTR.**

The National Standards for the Management of Offenders contain virtually no guidance on the MHTR (Ministry of Justice, 2007). By contrast, specific information was provided in the National Standards for the Drug Rehabilitation Requirement regarding issues such as frequency of contact, drug testing and implementation. The next National Standards should include similarly detailed information on the MHTR, with specific guidance to probation services.

**4. Judges, magistrates, legal advisors, solicitors and probation officers require training and information on mental health awareness and sentencing options.**

Training should be offered to criminal justice professionals to increase their knowledge of mental health. All would benefit from gaining insight into different types of mental health problems and how they might be addressed to improve health and reduce reoffending. Information is also required on sentencing options for people with mental health problems such as the provisions in the Mental Health Act, community sentences, and less formal interventions that may be available locally.

Information for defence solicitors, who can have a significant influence on the consideration of an MHTR, would be valuable. They are involved early on in the court process. If the solicitor raises

mental health issues at an early stage and an MHTR is considered, the process of organising the information required for the MHTR can be done more efficiently, reducing delays and unnecessary time on remand or on bail.

## MHTR arrangement and management

### **5. Protocols at a local level need to be developed between the courts, probation and health services to enable the appropriate use of the MHTR.**

A protocol is needed at a local level between courts and mental health providers to clarify the roles and responsibilities of each agency, and to understand what information needs to be shared to enable and manage an MHTR. Building on the experience of the current pilot schemes in London and the South West, this would detail the information that criminal justice and health agencies need to share, with timeframes for delivery, and agreements related to treatment provision as part of the MHTR. Health services would require clearly defined briefs of what information the courts want in psychiatric reports, and the courts would need an outline of a possible treatment plan.

A protocol is also needed between probation and health services about the management of people on the MHTR. It should detail the roles and responsibilities of each agency in the management of the order, in enforcement and on breach. Service level agreements can ensure regulated and agreed systems of payment.

### **6. A request for a psychiatric report should detail the information that is required by criminal justice agencies, and make clear the report's purpose.**

Psychiatrists need information such as the basic details of the offender, the offence they committed and any other reports on the offender including screening reports conducted by diversion and liaison schemes. They may also be asked to consider the efficacy of particular sentencing options, such as the MHTR. Ideally the report should be conducted by a locally based practitioner to ensure that there is an awareness of the services available locally.

### **7. Diversion and liaison schemes should be involved in the MHTR process.**

National coverage of proactive court diversion and liaison schemes would help to identify who might benefit from an MHTR, to organise timely and appropriate psychiatric reports and to make recommendations about sentencing. Every PCT should have a scheme that operates across police and courts (Sainsbury Centre, 2009).

Diversion and liaison schemes that operate throughout all stages of the criminal justice system could also play a significant role in the implementation of the MHTR. Schemes could act as an interface between probation and health while the requirement is in place or by providing information and assistance to probation on how to manage it.

Diversion and liaison schemes would need specific training on the MHTR, and they could then train other agencies, such as probation or sentencers, to help them to make best use of the requirement.

## Responding to breach

### **8. The National Offender Management Service should provide greater clarity on what constitutes a breach of an MHTR, and on how agencies should respond to breach.**

The next National Standards for the Management of Offenders should include clear instructions on what constitutes a breach for each requirement, including the MHTR. This should acknowledge that health based requirements like the MHTR or DRR require a degree of flexibility. Where a breach is caused by the illness itself, and not by unwillingness to comply with the requirement, guidance should allow for professional discretion in managing breach.

Mental health professionals will be able to provide further insight into the nature of the breach, and may be best placed to decide on the most appropriate outcome. They should therefore be engaged by probation as part of the decision making process and the management of a breach.

## Monitoring use and measuring outcomes

### **9. Use of the MHTR should be consistent nationally, and outcomes should be measured.**

The MHTR should be monitored for operational procedures to help to reduce unacceptable geographical variations in its use. Outcomes, such as engagement or reoffending rates, as well as people's own experiences and views of the MHTR, should be measured routinely. The Care Quality Commission might be well placed to facilitate this to ensure that people subject to the MHTR receive care of the same standard as other users of health and social care services and that the use of compulsion does not extend beyond the limits set by the legislation.

### **10. The Government should commission an extensive survey of psychiatric morbidity among offenders serving sentences in the community.**

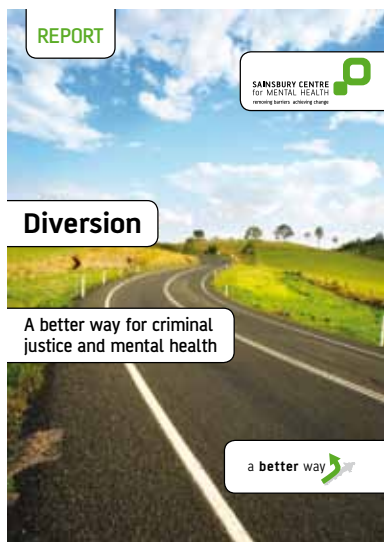
This is necessary to identify what proportion of people on community sentences have what kind of mental health problems to assist local commissioners to plan to meet their needs.



# References

- Hean, S., Warr, J. & Staddon, S. (2008) *Interim Report on Phase 1 Baseline of the Evaluation of the South West Mental Health Assessment and Advice Pilot, May 2008*. Bournemouth: School of Health and Social Care, Bournemouth University. Unpublished.
- The Mental Health and Criminal Justice Third Sector Forum (2008) *Improving Health, Supporting Justice: A consultation response*. ([http://www.scmh.org.uk/pdfs/Improving\\_health\\_supporting\\_justice\\_response.pdf](http://www.scmh.org.uk/pdfs/Improving_health_supporting_justice_response.pdf))
- Ministry of Justice (2007) *National Standards for the Management of Offenders: Standards and Implementation Guidance*. London: Ministry of Justice.
- Ministry of Justice (2008a) *Probation Statistics Quarterly Brief. April to June 2008 England and Wales*. London: Ministry of Justice.
- Ministry of Justice (2008b) *Reoffending of Adults: Results from the 2006 Cohort, England and Wales. Statistics Bulletin*. London: Ministry of Justice.
- NICE (2004) *Depression: Management of depression in primary and secondary care*. London: National Institute for Health and Clinical Excellence (NICE).
- Sainsbury Centre (2008) *On the Outside: Continuity of care for people leaving prison*. London: Sainsbury Centre for Mental Health.
- Sainsbury Centre (2009) *Diversion: A better way for criminal justice and mental health*. London: Sainsbury Centre for Mental Health.
- Seymour, L. & Rutherford, M. (2008) *The Community Order and the Mental Health Treatment Requirement*. London: Sainsbury Centre for Mental Health
- Solomon, E. & Rutherford, M. (2007) *Community Sentences Digest*. London: Centre for Crime and Justice Studies, King's College, London.
- Solomon, E. & Silvestri, A. (2008) *Community Sentences Digest*. London: Centre for Criminal Justice Studies, King's College, London.
- Staddon, S. (2008) *South West Court Mental Health Assessment and Advice Pilot. Appendices to the Interim Report to the Steering Group, June 2008*. HMCS & CSIP South West. Unpublished.





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