

**POLICY**

Centre for  
Mental Health



**Criminal  
Justice  
Alliance**

# The Mental Health Treatment Requirement

Realising a better future

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## Executive Summary

The Mental Health Treatment Requirement (MHTR) is one of twelve options available to magistrates and judges when they make a Community Order - a sentence served by an offender in the community. Given the prevalence of mental health problems within the criminal justice system, there has been a surprisingly low uptake of the MHTR to date - it represents fewer than 1% of all requirements made as part of Community Orders.

The MHTR has unfulfilled potential to offer offenders with mental health problems the option of a sentence in the community which will enable them to engage with appropriate treatment and support. Wider use of the MHTR could result in improved health outcomes and reduced reoffending, cutting the costs of crime for the wider community.

There have been a number of barriers to its effective use, including uncertainty as to who should receive an MHTR, how breaches of the order are managed and the need for a formal psychiatric report. Recent changes to the legal framework for the MHTR offer hope that it will become more flexible and therefore more effective as a form of diversion and rehabilitation. But there are concerns that the impact of other changes in policy and the current pressures on public spending may create further barriers to the effective use of the MHTR.

This briefing examines these barriers and how they can be overcome. At a time where both the criminal justice and health systems are undergoing reform against a backdrop of significant cuts to public spending, the Criminal Justice Alliance and Centre for Mental Health believe now is an opportune time to raise the profile of the MHTR and consider how professionals can be supported to use the requirement effectively.

This paper makes seven key recommendations to achieve this transition in the light of recent changes to health and criminal justice services.

- The Government should develop clear guidance on the MHTR.
- More training and information on mental health, including the MHTR, should be made available to criminal justice staff. Health professionals should also have more information on the MHTR and their role in delivering it.
- For each local area, Her Majesty's Court Service should work with the relevant mental health commissioners and service providers to establish an agreed protocol on the provision of mental health assessments and advice to the courts.
- The Government should monitor levels of uptake of the MHTR.
- Liaison and diversion schemes in courts should provide information to the courts for sentencing and support criminal justice professionals in responding appropriately to individuals with mental health problems.
- Health and Wellbeing Boards and Clinical Commissioning Groups must consider how local commissioning plans will meet the mental health and other related needs of offenders.
- There should be investment in research focusing on the mental health needs of offenders serving community sentences and how such individuals can be supported to reduce offending and improve their mental health.

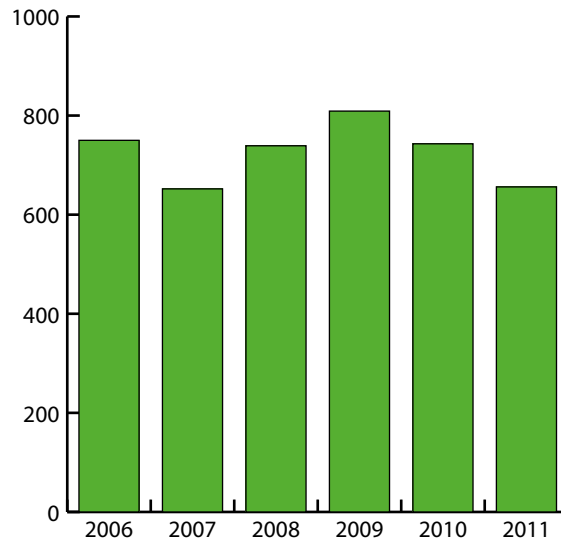
## Introduction

Under the Criminal Justice Act 2003, when someone is to serve their sentence in the community, magistrates or judges can give them a Community Order and are able to choose from one or more of twelve requirements to make up this Order. This allows for flexibility to ensure that a sentence is appropriate and proportionate to the offence and the needs of the offender.

The Mental Health Treatment Requirement (MHTR) is one of the twelve options available to magistrates and judges. Introduced in 2005, the MHTR provides a mechanism to ensure that certain offenders with mental health problems who are given a Community Order are able to access appropriate treatment. However, despite efforts to increase its uptake, the number of MHTRs issued as part of Community Orders remains startlingly low.

In 2006, the first full year in which the requirement was available, 725 MHTRs were issued as part of a Community Order. This rose slightly to 809 issued in 2009 (Ministry of Justice, 2010a). But this still only represented just under 0.035% of the total number of requirements issued as part of a Community Order, far lower than the number of Drug Treatment Requirements and Alcohol Treatment Requirements – 6% and 3% respectively. These figures demonstrate the infrequent and underuse of the requirement, a fact acknowledged in the Government’s Green Paper on punishment, rehabilitation and sentencing, “Breaking the Cycle” (Ministry of Justice, 2010b). Disappointingly, the most recent figures suggest that the number of MHTRs has further declined with only 656 MHTRs issued as part of a community order in 2011 (Ministry of Justice, 2011a) (See Figure 1).

This low level of uptake is perhaps surprising given research which suggests that a significant number of offenders carrying out their sentence in the community have mental health problems: some estimates show that at least 39% of



**Figure 1: Use of MHTRs between 2006 and 2011**  
**Source:** Ministry of Justice, 2011a

offenders supervised by probation services have mental health problems (Brooker *et al.*, 2012). There is therefore a potentially significant minority of offenders who might benefit from some form of mental health treatment as part of their community sentence.

Yet the low numbers of offenders who receive an MHTR suggests that it has not delivered its full potential in assisting sentencers to tailor the Community Order to the needs of people with mental health problems, nor as a means of diverting people from custodial sentences. This briefing considers how existing barriers to using the MHTR could be overcome and suggests ways to promote its effective use in community sentencing.

The Criminal Justice Alliance and Centre for Mental Health believe now is an opportune time to again raise the issue and profile of the MHTR.

The Government is:

- Making improved efforts to divert people with mental health problems towards treatment and support;
- Showing support for increased use of the MHTR by passing legislation which removes what has been a significant barrier to the use of the MHTR – the requirement for a formal psychiatric report;
- Introducing changes to community sentences and reviewing the role of probation and other agencies in managing these sentences

When the relevant provisions come into force on 3 December 2012, the Legal Aid, Sentencing and Punishment of Offenders Act 2012 will broaden the range of health professionals who can assess a person's mental health needs in relation to the MHTR. The Act will also give the courts greater flexibility in responding to breach of a Community Order. The Government has also recently introduced amendments to the Crime and Courts Bill to implement reforms to community sentencing, including a mandatory punitive requirement for all Community Orders except in exceptional circumstances.

## The high prison population

Over the last two decades, the number of people in contact with the criminal justice system has steadily increased. Particular concern has been voiced over the considerable growth in the prison population: towards the end of 2012 around 86,000 people within England and Wales found themselves in custody up from 41,000 in 1992 (Ministry of Justice, 2012a).

The reasons for this rapid expansion of the prison population are numerous: more activities being labelled as criminal behaviour, an increase in the average sentence length, and incarcerating more individuals for a wider range of low level offences are just some of the factors which have undoubtedly contributed to the rise in prison numbers.

Many if not most people in prison have a range of complex and multiple needs including poor mental and physical health, substance misuse, homelessness, unemployment and histories of family breakdown and trauma. Too often their needs remain unidentified and unsupported so that they become trapped in a cycle of crisis and crime. The overcrowded prison estate, which is currently far exceeding its Certified Normal Accommodation levels (Berman, 2012), is an unfortunate symbol of the failure of services in the community to identify and support vulnerable people to prevent or break this cycle.

Of particular concern is the high number of people in prison with mental health problems: an estimated 90% of prisoners have a mental health problem, substance misuse problem or personality disorder; 70% have two or more of these problems and approximately 1 in 10 will be affected by severe mental illness (i.e. psychosis). Being in prison may in itself damage mental health, for example because of separation from family, bullying and a lack of someone to trust (Durcan, 2008). Despite some improvements as a result of the introduction of prison mental health inreach teams, prisons struggle to deal with the high levels and complexity of need. Overall, prison remains a high-cost intervention which is inappropriate as a setting for mental health care and is ineffective in reducing subsequent offending.

## Probation services

In parallel with the upsurge in the prison population, the number of people being supervised by probation has increased over the last few decades: the annual total probation caseload increased by 39% between 2000 and 2008; in 2011 over 230,000 offenders were under probation supervision (Ministry of Justice, 2012b).

For many offenders community sentences can be a proportionate response to their offending behaviour while allowing them to maintain links and access support in the community, which can help them to positively address this behaviour. Particularly when compared to short prison sentences (those less than 12 months),

community sentences have proven to be more effective at reducing reoffending, by between 5-9% according to Ministry of Justice statistics (Ministry of Justice, 2011b).

Although there is limited evidence on the mental health needs of those on the probation caseload, recent research into the caseload of Lincolnshire Probation Trust found that 39% had a current mental illness (Brooker *et al.*, 2012). A previous study by Brooker *et al.* (2011) also found that a large proportion of those with a current mental illness were not receiving treatment: for example, 60% of those with a mood or anxiety disorder were not receiving any treatment, and only half of those with a current psychosis were receiving any support from mental health services. Moreover, the research suggests that mental health problems are under-identified by probation staff: only 33% of individuals identified as having a psychotic disorder by the study's researchers were subsequently recorded in probation files as having such a disorder.

This under-identification could be partly explained by the limited opportunities available to probation staff to receive any form of mental health awareness training, with many grades of probation staff receiving no formal training in this area. In their report, Brooker *et al.* (2011) concluded that probation staff require at least a 'basic' level of mental health awareness in order to effectively perform tasks such as writing pre-sentence reports to advise on the disposal of offenders within the criminal justice or health systems, assessing risk, and liaising with health services in both community and prison settings on behalf of offenders.

## The Development of the Mental Health Treatment Requirement

The previous Government introduced various reforms to sentencing in England and Wales. In particular, provisions of the Criminal Justice Act 2003 were introduced to provide greater clarity to sentencing in England and Wales, to reserve prison for the most dangerous offenders and to move lower level offenders away from short prison sentences into robust and rehabilitative community punishments (Home Office, 2006).

Implemented as part of the 2003 Act, the Community Order amalgamated a range of orders and requirements; it is now what a magistrate or judge hands down when giving an adult a community sentence. Originally made up of ten different requirements, the Community Order gives judges and magistrates the flexibility to choose from a range of options when determining a sentence.

In 2005, a further two requirements were introduced, the Alcohol Treatment Requirement and the Mental Health Treatment Requirement, in recognition that sentencers needed to have options available to them to address those particular issues. (See Table 1.)

The MHTR provides sentencers with an option to deal with the situation where individuals with mental health problems have committed relatively minor offences but the court is of the view that it is not appropriate to divert them from a criminal justice sanction altogether. An MHTR allows an individual to engage with treatment while still receiving a sentence: a form of diversion within rather than away from the criminal justice system, but outside custody.

The MHTR as part of the Community Order is not the first attempt to address the mental health problems of offenders through community sentences: the Probation Order with Psychiatric Treatment was introduced in 1948 and later replaced with the Community Rehabilitation Order with a requirement for psychiatric treatment in 2001. Both of these requirements were also little used by sentencers.

The introduction of the MHTR can therefore be seen as an attempt to recreate a way of engaging offenders with mental health problems with appropriate treatment, improving their wellbeing and increasing their likelihood of desistance. By giving magistrates and judges the option of giving an offender a sentence which facilitates treatment in the community, the MHTR in principle has the potential to reduce unnecessary reliance on custody. This is particularly important given that prisons are not designed to be therapeutic regimes and struggle to meet the high level and complexity of need of many individuals.

### Liaison and diversion

A key development which could have an impact on the use of the MHTR is the Government's commitment, subject to business case approval, to roll out a national network of liaison and diversion services in police stations and courts across England and Wales by 2014 (HM Treasury, 2010).

At present, the mental health needs of those in contact with, or at risk of entering, the criminal justice system are often not identified or addressed. Mental health liaison and diversion schemes operate at the interface between criminal justice and mental health services. The concept of "diversion" can be loosely defined as a way to ensure that people with mental health problems who enter the criminal justice system are identified and directed towards appropriate mental health care (Sainsbury Centre, 2009). Where appropriate, this can be as an alternative to the formal criminal justice system and/ or as an alternative to imprisonment. Liaison and diversion services can also identify and support people with other vulnerabilities such as learning difficulties.

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

Requirement	Time demanded	Details
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'.

In 2008, the Women's Institute began its Care not Custody campaign, calling for an end to the inappropriate detention of people with mental health problems. The campaign highlights that too many prisoners with mental health problems receive inadequate care instead of being diverted to hospitals or community mental health alternatives.

Lord Bradley's Report in 2009 threw the issue of mental health and offenders into the spotlight, reinvigorating political desire to better address the increasingly overlapping issues of mental health and criminal justice. Emphasising the growing number of people with mental health problems in custody, the report demonstrated how imprisoning these individuals can exacerbate their problems, heighten vulnerability and increase the risk of self-harm and suicide (Bradley, 2009).

Similarly, in January 2009, a joint report from the Prison Reform Trust and the National Council for the Independent Monitoring Boards in England and Wales concluded that a failure to identify people in need of mental health care was leading to avoidable and damaging incarceration. It suggested that too often the courts were using prisons as "a default option" for people who should have been diverted into the mental health system, placing "intolerable strains" on prisons (Edgar & Rickford, 2009).

Diversion can take place within or outside the justice system; increasing attention has been given to diverting vulnerable offenders from custodial sentences to sentences which allow mental health treatment and other appropriate support to be provided in the community. There is a growing body of evidence which supports the effectiveness of properly designed liaison and diversion schemes, both in terms of improving outcomes for individuals and their value for money. Diverting people towards effective community-based services can improve their mental health and wellbeing, reduce the prevalence of other risks factors, and improve the effectiveness of interventions aimed at other influences on offending (Sainsbury Centre, 2009).

In the 2010 Comprehensive Spending Review (HM Treasury, 2010), the Government committed to invest £50 million in mental health liaison and diversion services at police stations and courts. So far, £5 million has been invested in children and adult services in 2011/12 with a further £19.4 million of funding set aside for 2012/13 to develop and expand provision. The Care not Custody campaign is focusing on ensuring that the Government lives up to these commitments.

This investment in liaison and diversion services could play an important part in facilitating greater use of the MHTR. The absence of any national policy framework for liaison and diversion has meant that services have developed in a piecemeal fashion. Previous research by the Centre (2009) found that some areas have no arrangements at all and others only have minimal coverage; overall, it was estimated that just one-fifth of the potential national caseload was seen by diversion services. This can often mean that individuals are processed through court without their mental health and other needs being identified, drawn into custody and thereafter fail to access the support and treatment they need.

With increased resources liaison and diversion services should be able to deal with more cases and ensure that the mental health needs and other vulnerabilities of those in contact with the criminal justice system no longer go unidentified and unsupported. However, the design and development of these schemes will be crucial. It is of course equally imperative that local commissioning bodies and authorities ensure that there are adequate and appropriate services available in local areas that offenders can be diverted to.



## Integrated Offender Management

As well as investing in liaison and diversion services, the Government has continued to support the roll out of Integrated Offender Management (IOM) with the aim of reducing prolific offending and preventing groups of individuals coming into repeat contact with the criminal justice system.

Although the cohort group varies across the country, reflecting local risks and priorities, the focus has tended to be offenders who receive short term prison sentences. This group receives no statutory support on release from prison but often includes those with the most multiple and complex needs.

IOM seeks to provide a framework to ensure coordinated and holistic support for individuals at high risk of causing serious harm or of reoffending. It aims to increase the amount of partnership work and level of collaboration between different agencies, which can help to:

- open up relationships between mental health services and criminal justice agencies;
- highlight the mutual benefits of cooperating to address the needs of individuals; and
- establish both formal and informal lines of communication.

In focusing local commissioners and agencies on addressing multiple needs, including mental health problems, IOM could help to encourage greater use of the MHTR as a way to address an offender's mental health needs. Greater understanding and communication between criminal justice and mental health services could also facilitate the joint working that is necessary for successful use of the MHTR.

## Is the MHTR a viable component of a community sentence?

Previous research by the Centre concluded that the MHTR was yet to fulfil its potential as an option for magistrates and judges when constructing a Community Order (Khanom *et al.*, 2009).

Under section 207 of the Criminal Justice Act 2003, an MHTR can be made when the following criteria are met:

- The court is satisfied that the offender's mental condition requires and is susceptible to treatment but does not warrant making a hospital order or guardianship order under the Mental Health Act 1983. Currently this decision must be made on the basis of evidence from a registered medical practitioner approved under section 12 of the Mental Health Act 1983 as having special expertise in the diagnosis and treatment of mental disorder. However, this requirement is set to be abolished when the relevant provision of the Legal Aid, Sentencing and Punishment of Offenders Act 2012 comes into force on 3 December 2012.
- The court is satisfied that arrangements have been or can be made for treatment.
- The offender expresses willingness to comply with the MHTR.

If these criteria are met and an MHTR is made, the offender is required to receive treatment by or under the direction of a registered medical practitioner or a registered psychologist for a specified period. Treatment can be based on medication, psychological therapy or a combination of the two. The nature and frequency of the treatment depends on the diagnosis and severity of the offender's mental illness and the perceived risk of future offending. An MHTR is usually made alongside a Supervision Requirement so that probation can monitor compliance with the Community Order.

It is clear from the criteria set out above that, while people requiring compulsory admission to hospital or a guardianship order under the Mental Health Act 1983 are ineligible for an MHTR, there is no minimum threshold of severity of mental illness that an individual must meet before they can receive an MHTR. It is therefore open to the courts to use the MHTR for a wide range of individuals with varying levels of mental health needs. This could benefit a considerable number of people coming into contact with the criminal justice system who have a diagnosable mental health problem but presently do not have access to adequate mental health assessment and treatment.

### Unfulfilled potential

The MHTR will not be the appropriate solution for every individual with a mental health need who comes into contact with the criminal justice system. However, it has unfulfilled potential to offer offenders with mental health problems the option of a sentence in the community which will enable them to engage with appropriate treatment and support. In doing so, wider use of the MHTR could result in improved health outcomes and reduced reoffending, cutting the costs of crime for the wider community.

Emerging findings from interviews conducted with health professionals, offenders and probation officers involved in the MHTR (Taylor 2012) suggest that the core concern of all parties involved (offender, health professional and offender manager) is the need to resolve chaos and disorder in a service user's life. The MHTR, if done well, can provide the vehicle to facilitate the transition from chaos to stability.

According to research commissioned by the National Offender Management Service (NOMS), the incorrect targeting of requirements for offenders with a lower risk of serious harm can increase rather than reduce the likelihood of reoffending (NOMS, 2007). Ensuring, therefore, that an individual's Community Order is appropriate to their needs and circumstances is crucial. If used appropriately, the support and treatment provided through the MHTR may also help offenders to comply with their Community Order and therefore could help reduce the rate of breach of Community Orders, which has tended to be high (Mair & Mills, 2009). This is particularly important given that there has been an almost 500% increase in imprisonment for breach of non-custodial sentences between 1995 and 2009 (Ministry of Justice, 2009).

The MHTR could also be a useful option for sentencers when dealing with offenders with mental health problems who are on the cusp of custody – i.e. where the sentencer is undecided as to whether or not the individual should receive a custodial or community sentence. Taking a broad perspective, use of the MHTR acknowledges that punishment is only one of the five aims of sentencing. When the other four – reduction of crime, reform and rehabilitation of offenders, protection of the public and making reparation – are considered, using the MHTR as part of a Community Order for offenders with mental health problems could in many cases better fulfil the legislative aims of sentencing than a custodial sentence.

## What have been the barriers to using MHTR?

There are a number of barriers which have contributed to the low uptake of the MHTR.

### Uncertainty as to who should receive an MHTR

There is evidence that professionals vary in their view as to who should receive an MHTR. In practice, professionals have tended to exclude certain groups including those with personality disorders or those with depression or anxiety (Khanom *et al.*, 2009). In reality, the use of the MHTR is likely to be limited by the requirement that there must be available treatment and the generally high thresholds set by mental health services for access to treatment.

The Centre has found that some psychiatrists would not recommend an MHTR for those who may only require talking therapy or psychological treatment. It was felt that those with mild to moderate mental health problems such as anxiety and depression would be better supported by primary care (Khanom *et al.*, 2009). Some also thought that the MHTR would not be appropriate for some psychological treatments as the effectiveness of such treatments depends on voluntary engagement.

There appears to be some confusion about the role of compulsion in an MHTR. It must be made clear that the MHTR is not a way of delivering forced treatment: an offender must consent to an MHTR before it can be made and they cannot be forced to comply with any treatment by clinical staff while on an MHTR. The issue of enforcement only arises once consent has been given and the person breaches the terms of their Community Order.

There is, however, still a limited amount of published literature on how the MHTR works in practice and it remains difficult to get a clear idea of when and for whom an MHTR would be most beneficial (Khanom *et al.*, 2009). This may not always be determined by severity of illness alone: mild to moderate mental health problems can have a highly harmful impact on someone's quality of life and, for example, NICE guidelines indicate that some psychological therapies are appropriate for moderate depression. There is therefore scope to use the MHTR for a wider range of mental health needs rather than focusing only on those with severe and enduring mental illness. However, the issue of diagnosis is still one that needs to be resolved if the MHTR is to fulfil its potential as robust option for sentencers when constructing a Community Order.

Further, many offenders who could potentially be eligible for the requirement may have multiple problems and complex needs which may preclude them from accessing certain services. A particular issue is where an individual has a dual diagnosis of mental health and substance misuse problems. Both mental health and substance misuse services often struggle to deal with such clients. Unless services are available in the community to support clients with a dual diagnosis, it is likely that there will be cases where a person's mental health needs continue to go unaddressed and where it would be difficult to identify available treatment in order to make an MHTR.

There is a strong argument that the MHTR should be an option for children and young people with mild to moderate mental health problems such as depression who wish to access this support (an MHTR is an option for sentencers when constructing a Youth Rehabilitation Order). This would reflect the approach taken by Child and Adolescent Mental Health Services, many of which include mild to moderate mental health problems within their remit.

## Low awareness and confidence among professionals

Following interviews with professionals working in the courts, probation and health services, the Centre found that many lacked direct experience of the MHTR and some were not aware of it at all (Khanom *et al.*, 2009). Awareness of the MHTR and understanding of the processes involved was particularly low among health care staff. Court and probation professionals, meanwhile, vary in their awareness of mental health and their confidence in dealing with mental health issues. Magistrates and judges are reluctant to use requirements that they have little knowledge of, and even more so when they are unfamiliar with the specific local services that are used to carry out such requirements (Mair & Mills, 2009). These problems are likely to be particularly acute for sentencers in relation to the MHTR. Sentencers also tend to use the same Community Order requirements consistently, often where they have built up confidence in them and what probation officers can provide through them. Hence just five of the twelve possible requirements for Community Orders account for 90% of all such sentences (Supervision, Unpaid work, Accredited programmes, Drug rehabilitation, Curfew) (National Audit Office, 2008).

The Chairman of the Magistrates' Association has stated that magistrates want to get out in the community to see first-hand the services that are available to the courts (see Speech given to the Criminal Justice Alliance by John Fassenfelt, Chairman of the Magistrates' Association, 12 January 2012). The Magistrates' Association's position is that they want to use custody as a last resort, but in order to do so they must have confidence in the alternatives available locally. Therefore, magistrates should be given the opportunity to view mental health services to see what is involved if offenders undertake their programmes and to gain an insight into the sort of outcomes that can be expected. Magistrates and judges also need information, training and assistance when it comes to mental health issues. Support in this area is currently insufficient and has undoubtedly contributed to low use of the MHTR. Further, magistrates and judges are often

only made aware of the mental health issues of an offender late in court process, if at all; they struggle to detect such issues on their own. In their own admission this can lead to individuals receiving custodial sentences when, had more information available to the courts, Community Orders would have been more appropriate (Magistrates' Association, 2010).

Probation officers also have a significant role to play in the use of the MHTR. They are often responsible for recommending sentences to magistrates and judges. Where there are no liaison and diversion services in place at the court or other mental health experts available, it often falls on probation staff to recognise the mental health issues of an offender and to make appropriate recommendations to the court. For this reason the Bradley Report (2009) recommended that all probation staff should receive mental health awareness training, having found that existing provision was often non-existent or wholly inappropriate.

## Different professional cultures and views

The professionals who need to be involved in the MHTR process come from different professional cultures and often hold differing views on their roles in that process. In interviewing court and probation professionals, the Centre found a general reluctance to engage with offenders about their mental health (Khanom *et al.*, 2009). There is a sense that, other than for those who require compulsory admission to hospital, mental health needs should not be managed through the criminal justice system. Health professionals, on the other hand, saw their role as providing treatment to improve health and were less likely to consider their role in reducing reoffending. Overall, all parties seem unclear about what is required of them under the MHTR, including offenders themselves.

Emerging findings from research by Taylor (2012) illustrate that the different philosophies of the parties to the MHTR can act as a barrier to its effective use. A particular point of contention is whether the enforcement mechanisms of a Community Order are a positive or negative aspect of using the MHTR. For some health care professionals it appears that such enforcement is useful as it provides an extra lever for ensuring offenders comply with the treatment required. For others, however, enforcement is seen as potentially damaging in that it blurs the boundaries between a therapeutic and coercive relationship.

A persistent issue that can cause tension between sentencers and mental health providers is the pressure that the former are under to produce 'swift justice'. For example, courts want to avoid adjournments as much as possible and so cannot always wait for more accurate assessments of individuals (particularly when, as discussed below, formal psychiatric reports can be difficult to obtain). This often runs contrary to the goals and attitudes of health professionals. There is the potential this tension will be exacerbated by the Government's current emphasis on speeding up the criminal justice process (Ministry of Justice, 2012c). It is therefore essential that sufficient safeguards are put in place to ensure that the needs of vulnerable defendants are identified and addressed.

## Managing breach

There is widespread uncertainty among professionals about how to determine when an offender has breached an MHTR and how this should be managed. In particular, some health care professionals appear concerned that reporting breach could damage the therapeutic relationship with the person they are treating.

Probation relies on health professionals to report non-compliance but there is no formal guidance on, for example, the information that needs to be shared or frequency of contact. Some probation staff feel that health care professionals are reluctant to share information. Conversely, some health care professionals

have expressed concern over delays by probation in responding to breach; they see this as problematic as non-compliance can be associated with increasing risk (Khanom *et al.*, 2009).

There is no specific guidance on how an offender can breach an MHTR and professionals vary in how they interpret non-compliance with the requirement. It seems that missed appointments are generally accepted to constitute a breach of the MHTR; non-compliance with treatment is more contested (Khanom *et al.*, 2009). Uncertainty about breach can also be linked to inadequacies with the initial psychiatric report. For example, if the report is not specific about the treatment to be received or does not include a treatment plan then it can be more difficult to enforce the requirement.

Where a person breaches the requirements of their Community Order, they can be taken back to court and could be given a more onerous requirement or even a prison sentence. Court professionals have expressed concern about the impact of making an MHTR more onerous as a result of breach. For probation staff, however, breach proceedings are generally seen as a crucial way of encouraging compliance, particularly for those who are high risk.

However, it must be recognised that offenders given Community Orders often have multiple needs and lead chaotic lives. While breach is important as a last resort where there is a need to provide a boundary for behaviour or if there has been persistent non-compliance, if the overall context within which the breach occurs is general improvement and progress then the professional should have the flexibility to take no action.

Imposing a tougher sanction, including potentially a prison sentence, on people who breach a rehabilitative requirement such as the MHTR is problematic and undermines its potential to offer a robust community sentence. Further, there are ethical difficulties in deciding a breach for behaviours which may be the result of a person's illness.

There needs to be greater understanding about the causes of breach. Some mental illnesses, for example, can make a person withdraw and this could result in missed appointments. However, there is no data currently available on breaches of the MHTR or actions taken as a result; it is therefore difficult to get an overall picture of how breach is being managed.

### Need for a formal psychiatric report

Perhaps the biggest practical barrier to the effective use of the MHTR up to this point has been the requirement for a formal psychiatric report (Khanom *et al.*, 2009). This has been addressed in recent legislation, which is discussed below. Obtaining such a report has proven to be a lengthy and burdensome task leading to considerable delays, costs and, in some instances, offenders spending disproportionate lengths of time on remand awaiting sentence. There appear to have been a number of reasons for these delays, including difficulties in finding a suitable psychiatrist and some psychiatrists being unwilling to write a report for someone who is not already known to them. As the NHS is not under any responsibility to provide information to the courts, the majority of psychiatrists who prepare the reports do so in a private capacity and it can be difficult to find a psychiatrist willing to do so for a fixed fee. Further, some psychiatrists feel that the requests they receive from probation are vague and do not specify the purpose for which the report is being sought (Khanom *et al.*, 2009).

Another problem has been that some of the reports obtained do not provide the offer of treatment from local mental health services which is necessary for an MHTR to be made. This is particularly the case where a report is prepared by an independent psychiatrist who cannot make an offer of treatment from the offender's local mental health provider. In these circumstances, even if an MHTR is proposed it cannot be implemented until probation or the psychiatrist liaise with the local provider and gain their agreement to treat the person. Further reports then have to be carried out by the local provider before they will accept the person. The difficulties in finding a psychiatrist willing to write a report and offer treatment are often greater where the offender does not reside in the area served by the court where he or she is sentenced. Even where protocols have been agreed between the courts and the local NHS mental health trust to provide psychiatric reports, these will normally exclude those who are from a different area (Khanom *et al.*, 2009).

## Overcoming the barriers

### Removal of the requirement for a formal psychiatric report

When it comes into force in December 2012, section 73 of the Legal Aid, Sentencing and Punishment of Offenders Act 2012 will remove the requirement for a report by a section 12 approved registered medical practitioner before a court can issue an MHTR. Section 82 makes a similar amendment in relation to an MHTR made as part of a Youth Rehabilitation Order. These measures do not change the criteria for issuing an MHTR. The court will still need to be satisfied that the offender has a mental health condition susceptible to treatment but not so as to require compulsory admission to hospital or a guardianship order. Treatment still needs to be available and an offender still has to consent to an MHTR. It is important to highlight, therefore, that these changes do not mean that the court will be able to make an MHTR without any form of expert assistance in identifying the offender's mental health needs and appropriate treatment. What the amendments do is to offer more flexibility by broadening the scope of the professionals who could undertake the initial assessment of a person's mental health needs. The Government's aim in introducing this amendment was to ensure that a broader range of mental health specialists can carry out the initial health assessment to reduce delays in obtaining the necessary information (Hansard, 2011).

This additional flexibility around medical evidence could reduce delays and remove what has been a significant practical barrier to the effective use of the MHTR. Concerns, however, have been expressed that removing the requirement for a section 12 report could result in an MHTR being made when it is medically inappropriate. The Act itself does not make it clear how the relevant medical evidence is to be obtained. It is crucial that the court does not make an MHTR without a proper assessment of a person's mental health needs and input from relevant experts to ensure that any treatment offered is appropriate, proportionate and available.

Valuable lessons could be learned from pilot schemes which have improved the provision of mental health information to the courts. For example, through the South West Courts Mental Health Assessment and Advice Pilot (HMCS & NHS South West, 2009), service level agreements resulted in the mental health provider offering a 'triage' system in court which operated as follows:

- On the day or within one working day of a request from the court, a mental health professional (usually a Community Psychiatric Nurse) would provide an initial screening report based on a face-to-face assessment with the offender and information about any current or previous contact with mental health services.
- If it was not possible to provide enough information through this initial screening report, the mental health service would recommend a further report. This could be either a Health and Social Circumstances report produced by a mental health professional or a full psychiatric report prepared by a general adult psychiatrist. The Health and Social Circumstances report would be produced within 2-3 weeks and an adult psychiatrist report within 3-6 weeks depending on whether the person was on remand or had no previous contact with the provider.
- A forensic psychiatric report was only prepared for defendants committing more serious offences and appearing in the Crown Court. If required, this was facilitated by the mental health professionals at the court and it was agreed that the court would allow 12 weeks for the report to be completed.
- It was agreed that the courts would not request a further report without having first seen a screening report.



The psychiatrist employed by the mental health service provider completed the reports requested by the courts. Although the reports were provided privately by the psychiatrist, they were paid for by the mental health service provider from funds provided by Her Majesty's Court Service.

The results from this pilot suggest that in most cases an initial screening report provided sufficient information to the court and the number of psychiatric reports requested was reduced by 55%. The final evaluation of the pilot (Hean *et al.*, 2009) suggests that it led to an increase in the number of cases dealt with without adjournment and a reduction in the time from initial hearing to disposal. It also found that criminal justice professionals had increased confidence in working with defendants with mental health conditions and mental health professionals noted a decrease in inappropriate requests for psychiatric reports.

### Flexibility in responding to breach

As highlighted above, a widespread source of confusion about the MHTR is how to manage breach of the requirement. It is thought a more flexible approach to breach could help to raise the confidence of sentencers in MHTRs and reduce tensions between health, probation and court professionals. Currently the court must respond to a breach by either varying the Community Order to make the requirements more onerous or revoking the Order and re-sentencing as if the offender had been reconvicted. Where the offender has wilfully and persistently failed to comply with a Community Order, the court can impose a sentence of imprisonment even if the original offence was not serious enough to justify imprisonment. Section 67 of the Legal Aid, Sentencing and Punishment of Offenders Act 2012 should give courts more flexibility in responding to breaches of Community Orders, including the possibility of issuing fines as a response to breach.

### Practical guidance and training

Increased flexibility both in terms of the initial assessment of mental health needs and in responding to breach could, however, exacerbate the uncertainty which to date has surrounded the MHTR. If the MHTR is to be a viable option for sentencers, there must be practical guidance available for criminal justice and health professionals on how to construct and manage MHTRs as part of a Community Order. Attempts by the previous Government to provide guidance to the courts and probation services on the use of the MHTR have not succeeded in increasing uptake. However, the new legislation provides an opportunity to re-engage with justice and health services more effectively and ensure that the new legislative provisions reduce rather than increase levels of uncertainty.

There also needs to be training and support to ensure that professionals conduct accurate assessments and produce adequate reports for the court and probation that provide the necessary information to issue and effectively manage an MHTR. Both criminal justice and health professionals need to have greater understanding of each other's work and culture. Moreover, there needs to be adequate provision of mental health awareness training for sentencers and for probation staff to build confidence in working with offenders with mental health problems. Sentencers should have access to training on the MHTR and efforts should be made to link local courts with their communities so that magistrates and judges are able to see first-hand the services that are available.

## Diversion

Liaison and diversion services can facilitate information sharing between courts, probation and health services and therefore promote more effective inter-agency working. They have considerable untapped potential to fulfil a vital bridging function between these very different services and professional cultures.

Even where liaison and diversion services are already operating within the courts, few take any part in the process of issuing an MHTR (Sainsbury Centre, 2009). Most existing liaison and diversion services tend to see their role as focusing on screening, assessment and referral at an early stage in the criminal justice process and not to make recommendations as to sentencing.

However, there is no reason why liaison and diversion services should not take a wider role, ensuring that the courts have access to timely assessments and making sentencing recommendations including whether or not an MHTR should be made. For example, the Camberwell Green Forensic Mental Health Practitioner Service run by Together works with London Probation and Camberwell Green Magistrates' Court to screen people with mental health needs and provide recommendations to the court based on their assessments. This has resulted in increased diversion of offenders to community sentences and a 30% reduction in the number of unnecessary court requests for psychiatric reports (Make Justice Work, 2011).

Liaison and diversion services can also play a key role in providing mental health awareness training to criminal justice professionals, increasing knowledge and confidence in dealing with offenders with mental health problems which could also increase confidence in using MHTRs.

## Ensure services are in place

It is vital that the courts have the confidence that health services are available to support offenders with mental health problems on Community Orders. The Bradley Report (2009) recommended that a service level agreement should be drawn up between Her Majesty's Court Service, the Probation Service and the NHS in each locality to ensure that the necessary mental health provisions are in place to deliver MHTRs.

Particularly with the current restraints on public spending, mental health services may not currently have the resources to provide the treatment required if the number of MHTRs increases. Health and Wellbeing Boards, which will be fully functioning from April 2013, will be a key forum for bringing local partners together to address the public health needs of local populations. Providing mental health services and support for offenders in the community should be a key focus for these boards and for local commissioning plans.

## Conclusion

The Criminal Justice Alliance has campaigned for a reduced prison population, and believes custody to be a punishment of last resort for those who have committed serious offences and pose a risk to others. The membership of the alliance involves a diverse group of organisations working across the justice system, who support the goal of achieving a substantially smaller and more appropriate custodial population which has the potential to lead to a safer and more just society.

Centre for Mental Health works to improve the life chances of people with mental health problems and has focused much of its work on criminal justice since 2006. The Centre has identified effective methods of supporting and diverting people with mental health problems coming into contact with the criminal justice system.

Both the Criminal Justice Alliance and Centre for Mental Health believe that the prison estate should not be used as the fall back place to deal with vulnerable individuals who have fallen through the gaps in community services, often as a result of a complex mix of needs, including mental health problems, which individual services struggle to manage. An absence of better alternatives should never be the determining factor when deciding where a person with mental health problems ends up.

The Mental Health Treatment Requirement is one of a number of means by which some offenders can be better managed in the community. It is now widely recognised that addressing the mental health needs of offenders is crucial for their recovery and rehabilitation and can improve outcomes for society as a whole.

The MHTR has the potential to improve the outcomes of community sentences: by ensuring access to appropriate treatment and support, it can help offenders make the transition from chaos to stability, encourage their desistance and help them to make a positive contribution.

Recent changes to the legal framework for the MHTR offer hope that it will become more flexible and therefore more effective as a form of diversion and rehabilitation. But there are concerns about the impact of other changes in policy and the current pressures on public spending on the use of the MHTR. Recent amendments to the Crime and Courts Bill to require sentencers to include a ‘punitive element’ in all community sentences, for example, could undermine the use of the MHTR as a rehabilitative measure. Although the Bill provides that sentencers do not need to include a punitive requirement in exceptional circumstances where it would be unjust to do so, it is unlikely that this will capture the significant proportion of offenders who have mental health problems particularly as many do not have their needs recognised by the time they are sentenced.

Community sentences have at times rightly been criticised for ‘up-tariffing’ and net widening (Justice Select Committee, 2011; Mills, 2011). It is therefore imperative that any increased use of the MHTR is not due to individuals receiving them who have committed minor offences which would usually be dealt with through informal mechanisms.

There is also a concern that as the NHS seeks cost reductions of at least £15 billion over the course of this decade, services for offenders and those going through the criminal justice system will be seen as a low priority. This could reduce the options available to sentencers and ultimately force them to issue custodial sentences.

However, when viewing public spending as a whole and given the sheer economic and social costs of custody, there is a strong mandate for the more effective use of the MHTR.

## Recommendations

Earlier in the paper we identified a number of reasons as to why the MHTR has not yet achieved its potential as an option for community sentences which assists the criminal justice system to deal effectively, appropriately and proportionately with offenders with mental health problems. We also identified a number of ways that existing barriers to using the MHTR could be overcome.

The Criminal Justice Alliance and Centre for Mental Health believe that now is the opportune time to attempt to alter this position by adopting the following recommendations.

### **1. The Government should develop clear guidance on the MHTR.**

To date there has been little useful guidance for criminal justice or health professionals on how to construct and manage an MHTR as part of a Community Order. If the MHTR is to be used more often, it is essential that appropriate guidance should be developed jointly by the Ministry of Justice and Department of Health. This guidance does not need to be overly prescriptive but should address some key issues.

For example, there is still a degree of uncertainty among professionals as to which offenders the MHTR is or should be aimed at. Guidance should set out in clear and simple terms those individuals for whom it would be appropriate for sentencers to choose an MHTR as part of their Community Order. This should be supported by further research considering the appropriateness of the MHTR for different groups of offenders and its potential to improve outcomes for individuals.

This guidance should also provide support and information to allow professionals to manage breach of the MHTR. For example, the Government may wish to consider the circumstances in which an MHTR would be breached and what response would be appropriate. We would call on the Government to allow a flexible approach which considers the reasons for breach and whether support can be

given to ensure compliance with a Community Order, rather than simply returning an individual to court.

### **2. More training and information on mental health, including the MHTR, should be made available to criminal justice staff. Health professionals should also have more information on the MHTR and their role in delivering it.**

Mental health awareness training and information need to be available to judges, magistrates, legal advisers, solicitors and probation officers. Criminal justice professionals do not need to become experts in mental health but they should be able to assist in identifying individuals with mental health issues and feel confident in dealing with them during the court process. This was recommended in the Bradley Report (2009) but there is limited evidence of its implementation. If the mental health needs of offenders are to be effectively identified and addressed, it must be a priority to ensure that people working in the criminal justice system receive mental health awareness training appropriate to their role.

Sentencers, particularly magistrates, are more inclined to use requirements that they feel comfortable with and which they can see are effective. Mental health services and courts should develop mutual ties that enable sentencers to visit community services to see for themselves that they make a difference and that help mental health professionals to understand the needs of the justice system.

### **3. For each local area, Her Majesty's Court Service should work with the relevant mental health commissioners and service providers to establish an agreed protocol on the provision of mental health assessments and advice to the courts.**

The Legal Aid, Sentencing and Punishment of Offenders Act 2012 has opened up the opportunity for a more flexible approach

to providing the necessary mental health assessments to the court for the purpose of making an MHTR. However, for this to result in improved uptake of the MHTR it is crucial that local courts have in place an agreed protocol with local mental health services which sets out how and by whom such information would be provided. We therefore strongly encourage Clinical Commissioning Groups to develop protocols with their local court and probation services which support the use of the MHTR. Lessons can be learned from pilots such as the South West pilot discussed above.

#### **4. The Government should monitor levels of uptake of the MHTR.**

Recent figures have suggested a fall in the use of the MHTR. It is crucial that the Government monitors the impact of changes brought into force by the Legal Aid, Sentencing and Punishment of Offenders Act 2012 to assess whether they are assisting in the uptake of the MHTR and improving access to treatment for offenders. The Government should also monitor the impact of the provisions relating to community sentencing in the Crime and Courts Bill, particularly the proposed mandatory punitive element, if and when such provisions are implemented.

#### **5. Liaison and diversion schemes in courts should provide information to the courts for sentencing and support criminal justice professionals in responding appropriately to individuals with mental health problems.**

As the Government continues to invest in the development of liaison and diversion services, these services should recognise the important role they can play in supporting the court to make appropriate sentencing decisions. They should work to ensure that the court has access to timely and adequate information on an offender's mental health and make sentencing recommendations. Liaison and diversion services should also be willing to provide mental health awareness training and information to criminal justice professionals to increase their confidence in working with individuals with mental health problems. Liaison and diversion services should also work

with local health and social services to build their capacity to support people who are given an MHTR.

#### **6. Health and Wellbeing Boards and Clinical Commissioning Groups must consider how local commissioning plans will meet the mental health and other related needs of offenders.**

If the MHTR is to be a viable option for sentencers, then sentencers must have confidence that the necessary services and treatment to allow an offender to fulfil an MHTR are available in the community. These services need to be able to address the complex needs that offenders often have, particularly those with a dual diagnosis of mental health problems and substance misuse. It is crucial, therefore, that criminal justice professionals are involved in local decision-making structures – for example, we recommend that they are represented on local Health and Wellbeing Boards.

#### **7. There should be investment in research focusing on the mental health needs of offenders serving community sentences and how such individuals can be supported to reduce offending and improve their mental health.**

At present there is limited knowledge and research available on the level of mental health need among those on community sentences, and under the supervision of probation more generally. There is also limited research and evidence on how the MHTR works in practice and its impact on outcomes for individual offenders. Investing in more research to accurately determine the prevalence and nature of mental health needs among this group, as well as on the appropriateness and effectiveness of different sentences, will greatly assist in the development of future successful policies to prevent these individuals returning to the criminal justice system.

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