Institute for
Public Safety
Crime and Justice

Clinical Lead Mental Health Treatment Requirement (MHTR) Manual

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Contents

1. Introduction

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

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

This document has been reviewed by the CSTR Chairs, Clinical Leads and Primary Care Practitioners. It has been circulated to the national CSTR programme board who has in turn shared it with partner agencies (inc. NHS England and NHS Improvement, and Her Majesty's Prison and Probation Service) for review and wider comments. Finally, it has also been reviewed by the NHSE/I clinical reference group.

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

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

Acronyms:

A&E: Accident and Emergency	**HMCTS:** Her Majesty's Courts and Tribunals Service
ADHD: Attention Deficit Hyperactivity Disorder	**HMPPS:** Her Majesty's Prison and Probation Service
ASC: Autism Spectrum Condition	**LASPO:** Legal Aid, Sentencing and Punishment of Offenders
AP: Assistant Psychologist	**L&D:** Liaison and Diversion
ATR: Alcohol Treatment Requirement	**MAPPA:** Multi-Agency Public Protection Arrangements
CCG: Clinical Commissioning Group	**MASH:** Multi- Agency Safeguarding Hub
CDO: Court Duty Officer	**MHTR:** Mental Health Treatment Requirement
CJS: Criminal Justice Services	**MoJ:** Ministry of Justice
CL: Clinical Lead	**NHS:** National Health Service
CPS: Crown Prosecution Service	**NHSE/I:** NHS England and NHS Improvement
CRC: Community Rehabilitation Company	**NPS:** National Probation Service
CSTR: Community Sentence Treatment Requirement	**PHE:** Public Health England
DoH: Department of Health	**RAR:** Rehabilitation Activity Requirement
DHSC: Department of Health and Social Care	**PSR:** Pre-Sentence Report
DRR: Drug Rehabilitation Requirement	**YOT:** Youth Offending Team
GP: General Practitioner	

2. Mental Health Treatment Requirements

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

2.1 Defining MHTRs

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

The other 10 possible requirements within Community Orders are:

- Unpaid work for up to 300 hours;
- Rehabilitation activity requirement (RAR) undertaking activities as instructed;
- Undertaking a particular programme to help change offending behaviour;
- Prohibition from doing particular activities;
- Adherence to a curfew, so the offender is required to be in a particular place at certain times;
- An exclusion requirement, so that the offender is not allowed to go to particular places;
- A residence requirement so that the offender is obliged to live at a particular address;
- A foreign travel prohibition requirement;
- An alcohol abstinence and monitoring requirement with the offender's consent; and
- Where offenders are under 25, they may be required to go to a centre at specific times over the course of their sentence.

All three treatment requirements were introduced as a sentencing option in the Criminal Justice Act in 2003. The term Community Sentence Treatment Requirement (CSTR) refers to one or combinations of MHTR, DRR and/or ATR as part of a Community Order or Suspended Order sentence.

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

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

Guiding Principles, Aims and Objectives

Guiding principles

The CSTR Programme services in any given area will operate under six guiding principles. These are to:

1. Provide an exemplary assessment for all eligible referred adult offenders (18 years and over who consent to ATR/DRR/MHTR) ensuring the service is accessible to the most disadvantaged.

2. Operate within the CSTR Operating Framework.

3. Take an inclusive approach, recognising the complex needs of all adults in contact with the CJS including mental health, neurodevelopmental disorders, acquired brain injury, personality disorder, substance misuse issues irrespective of their protected characteristics as defined under the Equality Act 2010.

4. Provide high quality information to key decision makers across the criminal justice pathway including the police, courts, probation, health, education, substance misuse and Youth Offending Teams (YOTs in transition to adult services).

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

6. Ensure the CSTR workforce are adequately qualified to support all adults sentenced to a CSTR, are closely aligned, reflect and understand the needs of the local population.

CSTR Programme Aims

- Reduce offending/re-offending, by improving the health and social outcomes through rapid access to effective individualised treatment requirements (which if appropriate, and without up tariffing[1], may include more than one treatment requirement).

- Provide alternatives to short custodial sentences for offenders by providing access to treatment which addresses the underlying cause(s) of the offending behaviours.

- Improve health and social care outcomes by providing evidence-based interventions, alongside GP registration and supported access to appropriate community services, as necessary.

[1] Up tariffing = increasing the sentence to accommodate the order requirements

- Providing accessible services which enable engagement for all eligible individuals irrespective of their protected characteristics as defined in the Equality Act 2010, including neurodevelopmental disorders and acquired brain injury[2].

- Strive for sentencing on the day where possible by providing assessment reports to inform pre-sentence reports.

- Enable access to community services through individualised support for individuals both during and after the community sentence irrespective of their protected characteristic.

- Ensure consistency of service provision within all new and existing CSTR Programme sites and develop to align to local services and population by the publication of the CSTR operating framework and corresponding documents, best practice sharing across the sites and support from the CSTR Programme team.

A secondary aim is to raise awareness for judges, magistrates, legal advisers and representatives, probation and the police of the high numbers of individuals with mental health and neurodevelopmental disorders, personality disorder and substance misuse conditions across the criminal justice pathway, including information on individuals with protected characteristics (as defined in the Equality Act 2010) who may be suitable for a CSTR.

Objectives

To achieve these aims CSTR sites will provide:

- Rapid access (where possible) to appropriate and effective assessment/interventions which may be integrated or sequenced alongside other community orders or treatment requirements.

- Services which meet the needs of all individuals irrespective of their protected characteristics as defined in the Equality Act 2010.

- Evidence based psychological interventions by skilled mental health practitioners to promote wellbeing and recovery who are cognisant and aligned to the needs of the local community.

- A local process map to ensure that all partners and stakeholders are clear of their roles and responsibilities for providing and accessing speedy CSTRs.

- A clinically led dedicated MHTR intervention service, following consent/agreement for the MHTR by the client. A case formulation will be completed along with practitioner supervision (see Clinical

[2] There is increasing awareness of neuroscience findings that indicate brain development continues into early adulthood resulting in young adults having different thinking styles and needs compared with older adults. To be effective, CSTR programmes need to be aware of this difference and able to adapt to meet the different needs of young adults.
https://www.barrowcadbury.org.uk/wp-content/uploads/2018/04/Young-adult-courts-CJI.pdf
http://www.revolving-doors.org.uk/file/2451/download?token=XT3bl7VL

Leads Guidance). Clinical Leads will be appointed through the CSTR contracts to maintain clinical oversight (see Appendix 2 for more detail of the role of the Clinical Lead).

- A pathway/process for on the day DRR/ATR assessments, with clearly defined responsibilities for on-going management of any relevant requirement, including those combined with MHTRs.

- Timely access and referral into ongoing support after sentencing.

- Local agreements must be in place to appropriately share information to include: Probation, HMCTS, Liaison and Diversion, Health and Substance Misuse Providers and, where appropriate, Education. All information to be shared must be in accordance with data protection legislation and information sharing agreements need to be developed accordingly.

- A flexible service to maximise access taking into account the protected characteristics (as defined in the Equality Act 2010) which may previously have prevented access, also ensure flexibility around employment/education and family.

- Training to raise awareness of the mental health/substance misuse issues for magistrates, judges, legal advisers and representatives, police and probation providers. Sites should consider introducing feedback for courts regarding the effectiveness of the orders.

How will this provision improve community integration?

More individuals will experience:

- Improved access to mental health and substance misuse interventions: commissioning a CSTR service will increase the number of individuals over the age of 18 years who are assessed as suitable to receive individualised treatment/support to aid their recovery. Links with adult social care will help to ensure that those suspected of having social needs are assessed and, where appropriate, provided with support, and those with identified needs are considered.

- Improving access and outcomes to treatment for all individuals: supporting engagement for all adults taking into account their individualised requirements including protected characteristics as defined in the Equality Act 2010.

- Recovery and reduction in offending: appropriate treatment/interventions will address the individual's specific health, social and educational needs, identified through proactive engagement by appropriately qualified practitioners.

- Improved physical health: many individuals will not be registered with a GP, which can place an unnecessary burden on A&E, out of hours' and other emergency health services. The CSTR services would encourage GP registration, enabling improved physical health care and access to screening, continuity of prescribed medication etc.

- Effective care and support: individuals in contact with Criminal Justice Services (CJS) may have experienced years of trauma, abuse and victimisation with little care and support from

appropriate services. They may have poor experiences of health, social services and may be reluctant to engage positively with staff. By addressing their mental health, substance misuse and social needs effectively and sensitively, individuals are more likely to engage in treatment and support.

- Development of a trusting relationship with shared goals is an essential step that needs to occur before mental health/substance misuse and social needs can be addressed.

- Reduced stigma and discrimination: ongoing awareness and training is a key element in reducing stigma and discrimination. CSTR services recognise that mental health, substance misuse and physical health are inseparable and inter-related. All vulnerabilities must be mainstreamed to remove all forms of stigma and discrimination to ensure all individuals are treated sensitively and enable access to mainstream services.

- Avoidable harm to themselves or others: assessment of risk is a key component of the CSTR services. Health and Justice staff will work closely together to develop a shared understanding of risk as it relates to mental health/substance misuse and criminogenic behaviors. Staff will be appropriately trained to provide support and interventions. Appropriate interventions will be put in place if levels of risk are raised.

Eligibility for an MHTR

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

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

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

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

- 18 years + ;
- The offender has expressed a willingness to comply and consents to the requirement (if someone does not consent then other sentencing options will be considered by Probation and Judiciary);
- The offence falls into Community or Suspended Sentence Order range, where the offender pleads guilty or is found guilty after trial;

- The offender has a mental health condition that can be addressed either in a community setting or as an outpatient in a non-secure setting, but does not warrant use of the Mental Health Act 1983;
    - This includes those with Mental Health (from depression/anxiety through to secondary care mental health issues), Personality Disorder difficulties neurodevelopmental disorders (e.g. ASC and ADHD) and/or acquired brain injury will not be excluded.

Reasonable adjustments will be made to accommodate individual needs and no individual shall not be discriminated against based upon any protected characteristics in line with the Equality Act (2010). There is no need for a medical or psychiatric report evidencing that the person is suffering from a mental disorder prior to putting the person forward for consideration of a MHTR.

- Individuals subject to these requirements may have several vulnerabilities, including mental health, substance misuse, autism, learning/communication difficulty
- Adjustments will be made to ensure that the services are accessible to individuals subject to these requirements (e.g. easy read, information available in relevant languages, treatments offered in suitable and accessible locations (inc. telephone and virtual) taking into account physical/mental health requirements and individual circumstances)
- Childcare and general caring responsibilities will be taken into consideration.
- Supported engagement to ensure equality of service is provided irrespective of the presenting protected characteristic.

As with all clients coming through the courts, if they live and reside within the post code area that the CSTR site is operating and there is a General Practitioner (GP) who is willing to register them before commencement of treatment/intervention, and they have been assessed as suitable and provided consent which has been approved by the CL; then there should be no reason why CSTR cannot be offered. It is expected, however, that individuals will be registered with a GP before commencement of the MHTR intervention.

As GP registration is a pre-requisite condition of an MHTR being used, the National Probation Service is responsible in pre-sentence reporting to ensure in advance that this condition is met and to advise the court on this matter.

Who is suitable for an MHTR?

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

Whilst offenders are assessed using different psychometric assessment tools (such as the CORE-10, CORE-34, PHQ-9, GAD-7 etc.) by the MHTR practitioner, the decision to recommend an offender for an MHTR is determined by the professional judgement of the Clinical Lead. The use of the

psychometric tools, therefore, are to support the practitioner to identify mental health needs and their effects on the offending behaviour of the individual.

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

Difference between Primary and Secondary Mental Health Treatment Requirements

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

Primary care mental health services: The majority of individuals sentenced to an MHTR do not reach the clinical threshold for mental health treatment in secondary care, but experience high levels of stress, anxiety and depression. The testbed sites have demonstrated that the addition of clinically supervised mental health practitioners providing assessment in court and 1:1 short, individualised psychological interventions has been appropriate and effective in delivering primary care MHTRs. In many areas no such service currently exists.

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

The following criteria are used to identify individuals suitable for Secondary care mental health services:

- 18 years or over;
- Service user understands the requirement and consents to the treatment component;
- Sustained a conviction for any offence which falls into Community or Suspended Custodial Sentence range;
- Meets the local criteria for being in the Care Programme Approach (CPA) (refer to CPA policy or its proposed replacement the Community Mental Health Framework[3]);
- Severe and enduring mental health conditions /or a high degree of clinical complexity;
- Significant history of severe distress/instability;
- Longer term mental health problems characterised by unstable treatment adherence and requiring proactive follow up;
- Requires multiple service provisions from different agencies;

[3] https://www.england.nhs.uk/wp-content/uploads/2019/09/community-mental-health-framework-for-adults-and-older-adults.pdf

- Risk of harm to self or others and this risk exceeds what can be managed in primary care
- Requires active treatment;
- The degree of mental health difficulties significantly impacts on their daily functioning; and
- Individuals with low levels of symptoms (see HONOS clusters 1,2 or 3) are, if a community health treatment requirement is thought necessary, probably more likely to benefit from a primary care order. If this proves insufficient a secondary care order may be considered.

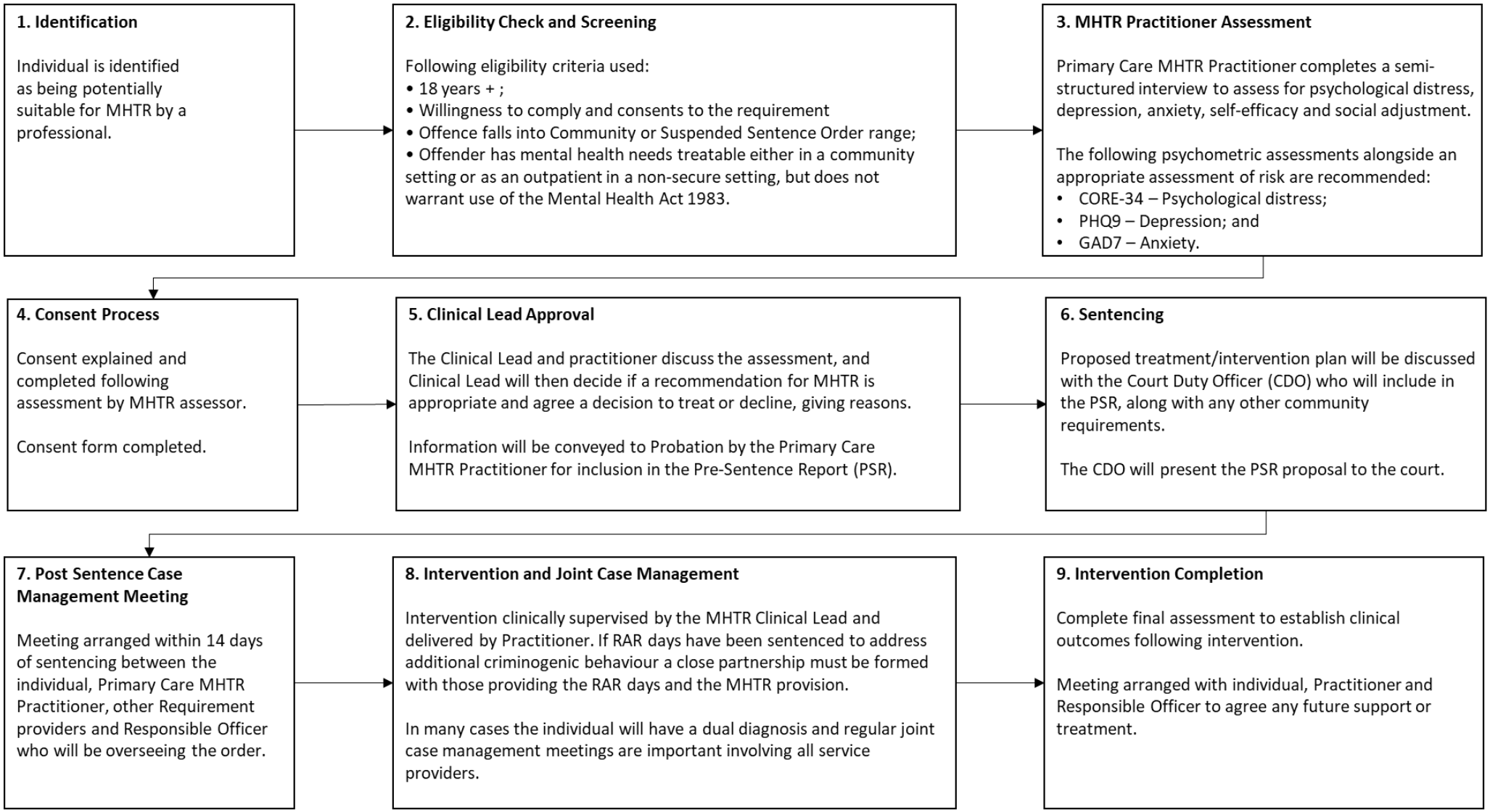
Please refer to the *Secondary Care MHTR Guidance* for a comprehensive overview.

2.2: Overview of MHTR Process

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

The MHTR process is illustrated in Figure 1.

Figure 1: MHTR Process



MHTR Process Stages

1. **Identification:**

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

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

A probation single point of contact will be made available for all pre and post sentence queries along with telephone number/email to all relevant services. The service will proactively work with agencies to ensure that practitioners understand who can be referred and the process for referral.

2. **Initial Screening:**

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

If screens do not indicate CSTR suitability but the individual requires support in other areas such as those outlined above, the individual can be further assessed by L&D and supported into appropriate local services.

If screened and the score indicates a likelihood of psychological distress, the Court Duty Officer (CDO) will be informed, and the mental health providers notified once a plea has been taken. Consideration to be given to support the people in court, depending on level of vulnerability, assessor to discuss with CDO.

As with all clients coming through the courts, if they live and reside within the post code area that the CSTR site is operating and there is a General Practitioner (GP) who is willing to register them before commencement of treatment/intervention, and they have been assessed as suitable and provided consent which has been approved by the CL; then there should be no reason why CSTR cannot be offered. It is expected, however, that individuals will be registered with a GP before commencement of the MHTR intervention.

As GP registration is a pre-requisite condition of an MHTR being used, the National Probation Service is responsible in pre-sentence reporting to ensure in advance that this condition is met and to advise the court on this matter. The recommended screening tools which may act as a trigger for further assessment include:

- Kessler-10
- CORE-10
- CORE-34

3. MHTR Practitioner Assessment:

The MHTR Practitioner Assessment will be typically completed by an Assistant Psychologist or other trained professional. Where possible, it is preferable that the Practitioner who delivers the intervention completes the MHTR Practitioner Assessment.

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

The practitioner will use a semi-structured interview that focuses on engagement, motivation, fact-finding and captures a range of data including mental health and forensic history, current involvement in treatment, use of medication, and life problems.

Psychometric assessments will screen for psychological distress, depression, anxiety, self-efficacy and social adjustment. The outcome of the assessment interview would determine the appropriate psychological intervention or signposting to other services.

The recommended psychometric assessments alongside an appropriate assessment of risk include:

- CORE-34 – Psychological distress
- PHQ9 - Depression
- GAD7 – Anxiety

Other psychometric assessments may be completed on a case-by-case basis determined by the professional judgement of the Clinical Lead or Primary Care MHTR Practitioner based on needs and presentation of the individual.

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

- Speech and communication needs
- Identification of vulnerabilities including history of trauma and abuse
- Drug and alcohol issues
    - What is the impact of any drug and alcohol use on the ability to engage with psychological work?
- Social circumstances (including relationships inc. childcare, leisure requirements, daily living, educational and occupational needs, employment/vocational needs, housing, finance)
    - Briefly enquiry about: Childhood, Education, Family system, Employment, Relationships and Support networks
- Identification of cultural, age and gender needs
- Physical health needs – management of physical health conditions

- Medication – medication history including allergies
    - Check current medication use
- Previous forensic history
    - Other agencies/ services currently helping you and your family with your problems?
    - What previous help/therapy have you had for your mental health and wellbeing? What helped?
    - Is there an existing diagnosis including co morbidity?
- Risk assessment
    - Any current or past thoughts of self-harm, suicide. If so, a more detailed assessment of this specific risk must be completed and result in a crisis plan being developed.
    - Any safeguarding concerns (inc. gang issues, exploitation, modern slavery)? If so, follow organisational policy.
- What are your MHTR goals?
- What is the main problem /difficulty affecting you?
- Have there been times when things have felt better? Enquire about helpful coping techniques?
- Are there any barriers to attendance? Consider childcare arrangements, COVID-19 restrictions; access to communication devices; gang affiliations etc.
- Is there anything you feel might be important or relevant that we haven't discussed?

The Practitioner will then explain the MHTR process and if suitable will gain consent (see step 4) for the order to be proposed. All materials will be translatable and/or available in an easy read format.

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

Recommendation from Practice:

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

Recommendation from Practice

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

4. **Consent Process:**

Consent explained and completed following assessment by MHTR assessor.

Assessor will fully explain the MHTR treatment including: What will be expected, and it is their choice to engage. However, if they do not engage once MHTR is ordered then their case will be discussed with Probation who will contact the individual and explain next steps, which could include Breach and return to court.

Please see **Appendix 2 for Example of Combined Consent**

Recommendation from Practice[4]

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

5. **Clinical Lead Approval:**

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

The Clinical Lead and Primary Care MHTR Practitioner discuss the assessment, and Clinical Lead will then decide if a recommendation for MHTR is appropriate and agree a decision to treat or decline, giving reasons.

This information will be conveyed to Probation by the Practitioner for inclusion in the Pre-Sentence Report (PSR).

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

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

Recommendation from Practice

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

6. Sentencing:

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

7. Post Sentence Case Management Meeting:

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

Recommendation from Practice – Clinical Lead Advice

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

8. Intervention and Joint Case Management Meetings

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

Adjustments will be made to ensure that the services are accessible to individuals subject to these requirements (e.g. easy read, information available in relevant languages, treatments offered in suitable and accessible locations taking into account physical and mental health requirements). Supported engagement to ensure equality of service is provided irrespective of the presenting protected characteristic. Specialist advice should be sought to ensure vulnerable individuals are appropriately supported to engage with services.

9. Intervention Completion

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

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

3. MHTR Intervention

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

3.1: Structure and Content

The MHTR intervention involves 10-12, 50 minute sessions across the Community Order as specified by the Court, where the individual meets with the Primary Care MHTR Practitioner overseen by the Clinical Lead. The timing of sessions within the Community Order will be determined in the Post Sentence Case Management Meeting, considering other requirements and their interdependencies.

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

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

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

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

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

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

Within the introductory sessions, it will likely include:

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

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

Recommendation from Practice – Clinical Lead Advice

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

Recommendation from Practice – Clinical Lead Advice

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

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

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

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

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

Recommendation from Practice – Clinical Lead Advice

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

Recommendation from Practice – Clinical Lead Advice

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

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

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

Recommendation from Practice – Clinical Lead Advice

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

Recommendation from Practice – Clinical Lead Advice

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

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

Example 1:

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

Example 2:

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

Example 3:

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

Example 4:

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

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

3.2: Overseeing Practice Issues

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

3.2.1. Engagement / Breach

In instances when a MHTR client has been sentenced to a Community Order that they are required to complete; if they do not they are to be returned to the courts for resentencing, this is known as a 'breach' or 'breaching'.

In MHTR treatment this would mean either non-attendance at treatment or attending but not engaging with the elements of treatment. Specialist advice should be sought to ensure vulnerable individuals are appropriately supported to engage with services. A client can also withdraw their consent for the MHTR at any time, which would be considered a breach and the order would then be returned to court for re-sentencing.

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

MHTRs are intended as supportive requirements which seek to support offenders with their mental health issues in order to improve their prospects of reducing reoffending. As such, enforcement is concerned with breaching the conditions of the order but not the treatment itself. However, in practice this can be challenging to define, and MHTR practitioners are encouraged to communicate with the Responsible Officer regarding cases where breach may be a concern.
Missed appointments can be considered a breach of the MHTR. However, both missed appointments and non-compliance with treatment are contested as 'breaches' in cases where mental health problems impact upon the person's ability to comply with the order, for example some mental illnesses can make a person withdraw or have organisational difficulties and this could result in missed appointments.

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

- It is important that staff in Probation understand the interfaces between each organisation in order to ensure effective enforcement of Community Orders. It is also important for probation service providers to continue to maintain contact, where possible, with offenders and encourage ongoing engagement with the court order;
- The final decision rests with the NPS on whether or not to proceed with presenting the breach based on the evidence presented in the enforcement information. In these circumstances, full consideration should be given by all providers via discussion as to the reasons for not proceeding to breach. Breach information must be of sufficient quality to enable the Enforcement Officer to present the case. The standard of sufficient quality requires that the breach information meets the minimum standards of evidence and information required to present the breach in court and that this evidence and information is accurate, coherent and comprehensive; and
- The Responsible Officer must make a decision whether to refer the matter to the Enforcement Officer when an offender fails to comply with their order by the 6th working day after the alleged second unreasonable failure to comply. There are a number of reasons why offenders fail to comply and it is not the intention of this Instruction to provide an exhaustive list. Clearly, every effort must be made by the Responsible Officer to allow the offender to submit reasonable excuse for non-compliance; however, this process should not delay the timetable for the breach process. The decision to breach or not, should be clearly recorded within case records in order to ensure the decision-making process is documented.

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

The Responsible Officer from the National Probation Service (NPS) (for offenders assessed as posing a high risk of serious harm to the public and all those subject to Multi-Agency Public Protection Arrangements (MAPPA) regardless of their level of risk) or Community Rehabilitation Company (CRC) (for low to medium risk offenders) will take overall responsibility for making any necessary arrangements in connection with the requirement, and in promoting the offender's compliance with the order. Therefore, the NPS or CRC will make decisions regarding breach of the MHTR based on information given them by the MHTR practitioner and their own assessment.

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

Maintaining contact between services and people with mental health illness and/or substance misuse is challenging. A brief summary of issues is outlined below:

It is important to recognise that even though building a relationship with the person and seeing even small improvements may take a long time, it is worth persevering. It involves:

- showing empathy and using a non-judgemental approach to listen, identify and be responsive to the person's needs and goals;
- providing consistent services, for example, if possible keeping the same staff member as their point of contact (especially for individuals with ASC) and the same lead for organising care; and
- staying in contact by using the person's chosen method of communication (for example, by letter, phone, text, emails or outreach work, if possible).

It is important to explore with the person why they may stop using services that can help them. This may include:

- fragmented care or services;
- inflexible services (for example, not taking into account that the side effects the person may experience from medication may affect their attendance at appointments);
- inability to attend because, for example, services are not local, transport links are poor, or services do not provide childcare;
- not being allowed to attend, for example because they have started misusing substances again;
- fear of stigma, prejudice or being labelled as having both mental health and substance misuse problems;
- feeling coerced into using treatments or services that do not reflect their preferences or their readiness to change;
- previous poor relationships with practitioners; and
- other personal, cultural, social, environmental (e.g. gang affiliation) or economic reasons.

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

- people who are homeless;
- people who have experienced or witnessed abuse or violence;
- people with language difficulties;
- people who are parents or carers who may fear the consequences of contact with statutory services; and
- young adults.

It is important to ensure any loss of contact or non-attendance at any appointment or activity is viewed by all practitioners involved in the person's care as a matter of concern. Follow-up actions could include:

- contacting the person to rearrange an appointment;
- visiting the person at home;
- contacting any other practitioners involved in their care, or family or carers identified in the person's care plan; and
- contacting the person's care coordinator within mental health services in the community immediately if there is a risk of self-harm or suicide, or at least within 24 hours if there are existing concerns.

If a breach occurs, the MHTR provider will report non-attendance to the Offender Manager and a treatment plan will be provided to the Offender Manager which may be presented in court. It is

recognised that reporting a breach may damage the therapeutic relationship between the MHTR practitioner and the client, however, breach is important for establishing boundaries for specific behaviours or issues of persistent non-compliance. It is crucial effective communication is maintained between the MHTR practitioner/provider and the Responsible Officer to ensure effective management of the Community Order as well as the mental health intervention.

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

Recommendation from Practice – Clinical Lead Advice

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

3.2.2. Partnership Working

CSTRs can only be delivered through defined delivery partners who work closely together in partnership, have clarity of roles, responsibilities, share information and have clear lines of communication. The delivery partners include:

- National Probation Service (NPS)
- Judiciary (Magistrates and Judges)
- Her Majesty's Court and Tribunal Service (HMCTS)
- Liaison and Diversion service (L&D) provider(s)
- CSTR providers for: MHTR, DRR and ATR
- Community Rehabilitation Company (CRC)
- Third sector organisation
- Voluntary and Lived Experience groups

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

- Police and Crime Commissioners
- Judiciary and Court Staff
- Lived experience groups
- Local Health and Social care partners (including Local Authority)

- Police
- Legal Representatives
- Crown Prosecution Service (CPS)
- Clinical Commissioning Group (CCG)
- Health and Justice Commissioners (NHS England)
- Youth Offending Team (YOT) for those in transition to adult services

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

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

Recommendation from Practice – Clinical Lead Advice

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

4. Role of the Clinical Lead

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

This chapter is based on an Assistant Psychologist acting as the Primary Care MHTR Practitioner, though the information will be relevant to other professional roles.

This chapter provides an overview of the role of the Clinical Lead and is organised into the following sections: 4.1 Clinical Lead in Practice and 4.2 Managing and overseeing the Assistant Psychologist.

4.1 Clinical Lead in Practice

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

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

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

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

Pre-Sentence:

- Communicate and confirm suitability of individuals (‘sign off’) for MHTR Practitioner Assessments; and
- Agree with NPS the information required for inclusion within the PSR.

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

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

If Clinical Lead is supervising an Assistant Psychologist who delivers the MHTR intervention:

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

Upon completion of intervention:

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

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

Recommendation from Practice – Clinical Lead Advice

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

4.2 Managing and overseeing the Assistant Psychologist

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

The activities of an Assistant Psychologist should align with the parameters as outlined by the British Psychological Society (2017), which include:

An Assistant Psychologist should be employed to (non-exhaustive list) undertake:

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

An Assistant Psychologist should not be employed to:

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

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

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

Appendix 1: Example of MHTR Practitioner Assessment Template

Action: Introduce yourself and the MHTR Practitioner Assessment

Action: Complete Psychometric Assessment:

Psychometric Assessment Outcomes

CORE-34	
PHQ-9	
GAD-7	

Action: Look at CORE assessment results

Where are the areas of difficulty and distress:

Functioning:

Symptoms:

Wellbeing:

Risk:

Semi-Structured Interview Topic Guide

About the individual:

Topics to discuss:

- Social circumstances (including, relationships, leisure requirements, daily living, educational and occupational needs, employment/vocational needs, housing, finance)
- Identification of vulnerabilities including history of trauma and abuse
- Identification of safeguarding issues
- Assessment of self-harm/suicide risk
- Speech and communication needs
- Physical health needs – management of physical health conditions
- Registered GP
- Drug and alcohol issues
- Identification of cultural and gender needs
- Medication – medication history
- Behaviours that have led to involvement with the Criminal Justice System?

About mental health:

Topics to discuss:

- Previous engagements with therapy/mental health support
    - Helpful/ Not so helpful?
- Impact of mental health on daily living
    - Have there been times when things have felt better? Enquire about helpful coping techniques?

About the intervention:

Topics to discuss:

- MHTR goals
- Main problem /difficulties
- Barriers to attendance?

Interview Close:

Is there anything you feel might be important or relevant that we haven't discussed?

Appendix 2: Example of Combined Consent (Easy read will be developed within the CSTR site)

Personal information /data

Your personal information may be shared to, gain:

- An improved assessment of your treatment needs
- An assessment of health needs
- Information regarding safeguarding and child protection (where applicable)
- Information around assessing risk
- Statistical analysis for service delivery and future funding
- Information from partner agencies
- Collate anonymised data to monitor the quality of service delivery
- Contractual obligations

What is meant by data sharing?

Sharing of personal information is strictly controlled by law and anyone receiving information is under legal duty to keep all information confidential.

There may be occasions where staff are duty bound to disclose personal information without your consent. This will only happen if there are any concerns around threats being made to self or others, safeguarding issues around adults or children or any serious criminal offence you inform us you are going to commit.

Collecting data: We collect and store your data in a specific way:

- Consent: we always seek your consent to store and share your information and ask that you sign our consent form.
- Contractual obligations: as part of the funding we receive we are required to share information with our funders.
- Legal compliance: In some circumstances, we are required to collect and process your information
- Legitimate interest: in some situations, we require your information to send you and or your GP specific details about your treatment

Retention of information

We retain your information on our active case management system from assessment to last treatment closure. Your information will then be encrypted and stored electronically and securely indefinitely.

Your rights to withdraw consent

You have the right to withdraw your consent at any time. You will be asked to renew your consent on the above principles every year if still in treatment.

Changes to your information

We want to make sure that your personal information is accurate and up to date. You may ask us to correct or remove information you think is inaccurate.

Assessing the information, we hold on you

You have the right to request a copy of the information that we hold about you. If you would like a copy of some or all of the information, please use the contact details below

Consent

Reasonable care is taken to ensure that discussions, conversations, and telephone calls relating to confidential matters cannot be overheard. Wherever possible identifying details are not shared.

Issues relating to harming themselves or others or to the safety and well-being of children must be reported to external agencies.

I have been provided with information regarding the assessment process and treatment requirements, and understand and consent to the assessment and specific requirements for treatment should one or more of the following be granted (highlight requirement assessed and granted):

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

This will include assessment for suitability (delete as required) for MHTR, DRR, ATR. If the:

1. Mental Health Treatment Requirement be granted:
    - Attendance of the 12-week programme, consisting of one hour sessions weekly
    - Engagement in therapeutic activities required for successful completion of programme
2. Drug Rehabilitation Requirement is granted
    - Engagement in therapeutic activities required for successful completion of programme
3. Alcohol Treatment Requirement is granted
    - Engagement in therapeutic activities required for successful completion of programme

Confidentiality Agreement

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

Name……. Date of Birth…….

Signature…… Date……..

GP surgery……

Appendix 3: Example of Information from Clinical Lead Approval for PSR

Mental Health Treatment Requirement **Responsible Clinician's Report**	
Name	
Date	
Initial Assessment Completed by	
Consent of defendant to assessment and treatment gained?	
Presenting problem and formulation	*Outcome of assessment / Plan:*
Screening tool assessment information is attached	
Recommendations to court from Responsible Clinician	
Treatment Plan, including details of treatment provider	
Risk Information	.
When and where initial therapy will be available	