National Offender Management Service

Commissioning Group

Supporting Community Order Treatment Requirements

February 2014

Contents

Introduction

Community Orders were introduced as a sentencing option in April 2005 as one of the provisions of the Criminal Justice Act 2003. They replaced the earlier community sentence for adult offenders.

The Act provides for twelve possible requirements to be made as a condition of a community order. This document explores further the delivery of three of the requirements as part of a community order or a suspended sentence order:

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

The Welsh Government has devolved responsibility for healthcare in Wales including Mental Health Services and clinical Drug and Alcohol Services. Together for Mental Health (2012) provides its strategic direction for improving mental health and wellbeing and incorporates the Mental Health (Wales) Measure 2010 to improve services in Wales.

In England, following the Heath & Social Care Act 2012, commissioning of drug and alcohol treatment services became the responsibility of local Directors of Public Health and mental health services became the responsibility of local Clinical Commissioning Groups from April 2013.

Changes to the use of community orders were made by the Legal Aid, Sentencing and Punishment of Offenders Act 2012 (LASPO Act 2012).

This guidance builds on previous advice from the National Offender Management Service (NOMS) on the implementation of the LASPO Act 2012 , updated to reflect the changes to responsibility for probation services in England and Wales from 2014 which have resulted from the Government's Transforming Rehabilitation reforms.

Drug Rehabilitation Requirements

Background

Drug users are estimated to be responsible for between a third and a half of acquisitive crime[1] and treatment can cut the level of crime they commit by about half.[2]

Under Section 209 of the Criminal Justice Act 2003, a Drug Rehabilitation Requirement (DRR), comprising structured treatment and regular drug testing, is available to courts as a sentencing option for offences committed on or after 4 April 2005. A DRR can be made as part of a community order (CO) or a suspended sentence order (SSO). The LASPO Act 2012 removed the restriction for a DRR to have a minimum length of 6 months. These provisions aim to present local providers with flexibility to tailor requirements to individual need, changing patterns of substance misuse and moving towards a recovery-focused approach to treatment.

The DRR can be used for low, medium and high sentencing bands. The amount and intensity of the drug treatment delivered under the DRR can be tailored to individual needs regardless of the seriousness of the offence. The content and duration of the total CO should provide the overall restriction of liberty which is commensurate with the seriousness of the offence. The clinical standard for commencement of treatment is within two days of sentence for a DRR.

Under Section 210 of the Criminal Justice Act, the court may provide for the review of any DRR and must do so in the case of requirements lasting twelve months or more. The review should take the form of a written report presented by the National Probation Service to the court which includes the results of the offender's drug tests.

Drug Rehabilitation Requirements are the most commonly used of the three treatment requirements. In 2012-13 DRRs accounted for 5% of all community order or suspended sentence order requirements made. Over the same period, the total number of DRRs given as part of a CO or SSO was 13,199 (9,161 CO requirements and 4,038 SSOs).

[1] MacDonald, Z. Tinsley, L., Collingwood, J., Jamieson, P. and Pudney, S. (2005). Measuring the harm from illegal drugs using the Drug Harm Index. Home Office Online Report 24/05 http://webarchive.nationalarchives.gov.uk/20110218135832/rds.homeoffice.gov.uk/rds/pdfs05/rdsolr2405.pdf

[2] National Treatment Agency (2012) Estimating the crime reduction benefits of drug treatment and recovery www.nta.nhs.uk/uploads/vfm2012.pdf

Table 1. Use of DRRs as part of Orders 2012-13

Treatment Requirement	Community Order (2012-13)		Suspended Sentence Order (2012-13)	
	No.	%	No.	%
All	**183,357**	**100**	**82,170**	**100**
DRR	9,161	5	4,038	5

Source: MoJ, Offender Management Caseload Statistics, January-March 2012 [3]

Eligibility

Treatment must be supervised by a suitably qualified or experienced individual. Before making the requirement, the court must be satisfied that:

1. The offender is dependent on or has the propensity to misuse illegal drugs
2. The offender requires and would benefit from treatment
3. Necessary arrangements have been or can be made for treatment
4. The offender expresses his or her willingness to comply with the requirement

Drug Treatment Commissioning

In England, separate provision is not generally commissioned to support Drug Rehabilitation Requirements, rather the treatment element of DRRs will be provided from drug treatment services commissioned for the mainstream local population.

Responsibility for commissioning drug treatment services became the responsibility of Local Authority Directors of Public Health (DPH) from April 2013 following enactment of the Heath & Social Care Act 2012. DPH may choose to commission these services through local joint commissioning boards in some cases continuing to use former Drug and Alcohol Action Team (DAAT) structures. There is no statutory requirement for such joint commissioning arrangements and therefore Local Authorities and Directors of Public Health have no statutory requirement to involve providers of probation services in such arrangements but may do so voluntarily.

[3] www.gov.uk/government/uploads/system/uploads/attachment_data/file/225207/probation-tables-q1-2013.xls (Table 4.4)

In Wales, the NOMS Director of probation is responsible for the planning and commissioning of drug treatment services. For offenders not on sentence treatment requirements, drug treatment services are commissioned by the Police and Crime Commissioner.

Providers of offender management services are responsible for funding the supervision and enforcement of the Drug Rehabilitation Requirement as part of a CO or SSO, but **not** for the funding of the treatment or therapeutic testing which forms part of that requirement.

Any provider of probation services who has concerns about drug misuse by anyone on their caseload not subject to a treatment requirement or subsequent to the commencement of an order should advise the individual to make an appointment with their registered GP who can make a referral to appropriate drug treatment services.

DRR Service Specification

The detail of how a Drug Rehabilitation Requirement is expected to function, including who is responsible for specific parts of service delivery, is set out in the **Support Delivery of the Drug Rehabilitation Requirement** service specification. This forms part of NOMS Directory of Services and may be found at:

www.justice.gov.uk/downloads/about/noms/directory-of-services/drr-specification.zip

A summary quick reference pathway map for DRRs can be found in Appendix A of this document.

Table 2 provides a high level summary of the key organisations and their roles in delivering the DRR.

Table 2. Roles of the Key Agencies in Supporting DRRs from April 2014

NOMS Co-commissioning	National Probation Service (NPS)	Community Rehabilitation Company (CRC)	England; Local Authority (Director of Public Health) Wales; NOMS Director & Local Health Board	Drug Treatment Provider
• Setting the specification for the offender management of DRRs • Producing multi-agency guidance in the use of requirements • Commissioning the offender management element of DRRs from NPS and CRCs • Seeking assurance around quality and delivery • In Wales only, the NOMS Director will commission DRR treatment and testing	• Understanding current treatment provision in the local area • Arranging placement for treatment with a treatment provider prior to completing the PSR • Providing advice to the Court through PSR of eligibility and appropriateness of DRR • Assessing risk level of offender for case allocation • Funding and delivering offender management of DRR for high risk cases • Exchanging information with treatment providers • Providing reports to courts to inform reviews of DRR progress • Considering breach for failure to comply with DRR • Contributing information about the treatment needs of offenders to local authority commissioners	• Funding and delivering offender management of DRRs for medium and low risk cases • Providing information to NPS for court reviews • Referring non-compliance to NPS for breach proceedings • Providing information about current provision and barriers to effective delivery to NPS to inform future service commissioning	• Commissioning of drug treatment services to meet the needs of the local population including offenders • Commissioning drug testing services • Providing guidance on effective practice • Seeking assurance around quality and delivery • Understanding the drug treatment needs of the entire local population including offenders • Promoting the drug treatment services which have been commissioned to local partners including NPS and CRCs	• Promoting local services available with partners including NPS and CRCs • Providing advice to NPS on an offender's suitability for an DRR • Agreeing placements for offenders on DRR with NPS as part of a PSR • Delivering the treatment and testing elements of DRRs • Exchanging case information with the CRC or NPS

Alcohol Treatment Requirements

Background

Alcohol is a factor in an estimated 47% of violent crime.[4] The Alcohol Treatment Requirement (ATR) is targeted at offenders assessed as alcohol dependent, who will often have complex co-existing needs e.g. mental health, social and housing problems and require intensive, specialist, care-planned treatment e.g. day programmes, detoxification, residential rehabilitation and integrated care involving a range of agencies.

Under Section 212 of the Criminal Justice Act 2003, an ATR is available to courts as a sentencing option for offences committed on or after 4 April 2005 by offenders aged 18 or over as part of a CO or an SSO. The accepted standard for commencement of treatment is within 14 days from sentence for an ATR.

Treatment delivered under an ATR should primarily be structured treatment consisting of community-based, care-planned treatment. This may include psychosocial therapies and support, interventions for assisted alcohol withdrawal, 'detoxification' and cognitive-based treatment to address alcohol misuse. It should be suitable for moderately/severely dependent drinkers and delivered by Specialist Alcohol Workers and residential/inpatient care-planned treatment. This is likely to be suitable for those who have severe dependence who cannot be managed or may be at risk if they were to be managed in the community.

The LASPO Act 2012 removed the requirement for an ATR to have a minimum length of six months. This was consistent with evidence which suggests that effective treatment can be delivered to dependent drinkers in significantly less than six months[5] and National Institute for Health and Clinical Excellence (NICE) guidance on the management of harmful drinking and alcohol dependence.[6]

Alcohol Treatment Requirements are the second most commonly used of the three treatment requirements. In 2012-13 ATRs accounted for 3% of all community order or suspended sentence order requirements made. Over the same period, the total number of ATRs given as part of a CO or SSO was 8,550 (5,888 CO requirements and 2,662 SSOs).

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[4] Crime Survey for England and Wales: Nature of Crime tables 2011/12 http://ons.gov.uk/ons/rel/crime-stats/crime-statistics/nature-of-crime-tables--2011-12/index.html

5 UKATT Research Team(2005) Effectiveness of treatment for alcohol problems: findings of the randomised UK alcohol treatment trial (UKATT) BMJ 2005;331;541

6 National Institute for Health and Clinical Excellence (2011) Alcohol-use disorders: Diagnosis, assessment and management of harmful drinking and alcohol dependence. National Clinical Practice Guideline 115

Table 3. Use of ATRs as part of Orders 2012-13

Treatment Requirement	Community Order (2012-13)		Suspended Sentence Order (2012-13)	
	No.	%	No.	%
All	**183,357**	**100**	**82,170**	**100**
ATR	5,888	3	2,662	3

Source: MoJ, Offender Management Caseload Statistics, January-March 2012 [7]

Eligibility

An Alcohol Treatment Requirement (ATR) can be made as part of a Community Order (CO) or a Suspended Sentence Order (SSO) where:

- The offender is dependent on alcohol
- This dependency is such that it requires and may be susceptible to treatment
- Arrangements have been or can be made for treatment
- The offender expresses willingness to comply with its requirements

For those offenders who are not dependent but have associated problems, the courts will still be able to make use of either supervision or activity or rehabilitation activity requirements[8] to deliver structured brief advice or more extended brief interventions and programme requirements specifically to address alcohol-related offending behaviour.

In line with *NOMS Alcohol Interventions Guidance* (2010), a score of 20+ on the Alcohol Use Disorders Identification Test (AUDIT) is an accepted indicator of possible dependence but those scoring 18-19 in AUDIT (the higher scoring range of what was formerly harmful drinking) may also warrant further investigation of their suitability for an ATR.

[7] www.gov.uk/government/uploads/system/uploads/attachment_data/file/225207/probation-tables-q1-2013.xls

[8] The Offender Rehabilitation Bill will (subject to the approval of Parliament) make amendments to the existing statutory sentencing framework, in particular to create greater flexibility in relation to rehabilitative requirements. Provisions in the Bill will merge the current supervision requirement and activity requirement into a new single rehabilitation activity requirement

Alcohol Treatment Commissioning

In England, separate provision is not generally commissioned to support Alcohol Treatment Requirements, rather the treatment element of ATRs will be provided from alcohol treatment services commissioned for the mainstream local population.

Responsibility for commissioning alcohol treatment services became the responsibility of Local Authority Directors of Public Health (DPH) from April 2013 following enactment of the Heath & Social Care Act 2012. DPH may choose to commission these services through local joint commissioning boards in some cases continuing to use former Drug and Alcohol Action Team (DAAT) structures. There is no statutory requirement for such joint commissioning arrangements and therefore Local Authorities and Directors of Public Health have no statutory requirement to involve providers of probation services in such arrangements but may do so voluntarily.

In Wales, alcohol services are planned and commissioned by the NOMS Director. For offenders not on sentence treatment requirements, drug treatment services are commissioned by the Police and Crime Commissioner. The provider may refer to treatment services commissioned by the Police and Crime Commissioner.

Providers of offender management services are responsible for funding the supervision and enforcement of the requirement as part of a CO or SSO, but **not** for the funding of the treatment or any therapeutic testing which may take place on a voluntary basis to support treatment.

Any provider of probation services who has concerns about alcohol misuse by anyone on their caseload not subject to a treatment requirement or subsequent to the commencement of an order should advise the individual to make an appointment with their registered GP who can make a referral to appropriate alcohol treatment services.

ATR Service Specification

The detail of how an Alcohol Treatment Requirement is expected to function, including who is responsible for specific parts of service delivery, is set out in the **Support Delivery of the Alcohol Treatment Requirement** service specification. This forms part of NOMS Directory of Services and may be found at:

www.justice.gov.uk/downloads/about/noms/directory-of-services/alcohol-treatment-requirement.zip

A summary quick reference pathway map for ATRs can be found in Appendix B of this document. Table 4 provides a high level summary of the key organisations and their respective roles in delivering the ATR.

Table 4. Roles of Key Agencies in Supporting ATRs from April 2014

NOMS Co-commissioning	National Probation Service (NPS)	Community Rehabilitation Company (CRC)	England; Local Authority (Director of Public Health) Wales; NOMS Director & Local Health Board	Alcohol Treatment Provider
• Setting the specification for the offender management of ATRs • Producing multi-agency guidance in the use of requirements • Commissioning the offender management element of ATRs from NPS and CRCs • Seeking assurance around quality and delivery • In Wales only, the NOMS Director will commission ATR treatment	• Understanding current treatment provision in the local area • Arranging placement for treatment with a treatment provider prior to completing the PSR • Providing advice to the Court through PSR of eligibility and appropriateness of ATR • Assessing risk level of offender for case allocation • Funding and delivering Offender Management of ATR for high risk cases • Exchanging information with treatment providers • Considering breach for failure to comply with ATR • Contributing information about the alcohol treatment needs of offenders to local authority commissioners	• Funding and delivering Offender Management of ATRs for medium and low risk cases • Referring issues of risk and non-compliance to NPS for breach proceedings • Providing information about current provision and barriers to effective delivery to NPS to inform future service commissioning	• Commissioning of alcohol treatment services to meet the needs of the local population including offenders • Commissioning alcohol testing services • Providing guidance on effective practice • Seeking assurance around quality and delivery • Understanding the alcohol treatment needs of the entire local population including offenders • Promoting alcohol services which have been commissioned to local partners including NPS and CRCs	• Promoting local services available with partners including NPS and CRCs • Providing advice to NPS on an offender's suitability for an ATR • Agreeing placements for offenders on ATR with NPS as part of a PSR • Delivering the treatment element of an ATR • Delivering therapeutic testing in support of the ATR • Exchanging case information with the CRC or NPS or both

Mental Health Treatment Requirements

Background

Under Section 207 of the Criminal Justice Act 2003, a Mental Health Treatment Requirement (MHTR) is available to the courts as a sentencing option for offences committed on or after 4 April 2005. The requirement directs an offender to undergo mental health treatment as part of a community sentence or suspended sentence order.

Treatment may be provided in an independent hospital or care home within the meaning of the Care Standards Act 2000, a hospital within the meaning of the Mental Health Act 1983 or as a non-resident patient at a place specified in the order.

The MHTR can be used in relation to any mental health issue including personality disorders. The type of treatment is not defined and can cover a wide range of interventions. Treatment should be based on the offender being assessed as able to be treated for their mental health problem either in a community setting or as an outpatient in a non-secure setting. Options in a community setting could include Community or Forensic Mental Health Teams and GP Practices as well as voluntary organisations.

The historical use of MHTR has been low since its introduction. In 2012-13 MHTRs accounted for less than 1% of all community order or suspended sentence order requirements made (see Table 5). In 2009, the Sainsbury Centre for Mental Health published 'A Missed Opportunity' which suggested a number of barriers to its effective use[9]. The number of MHTR commencements has been falling since 2009. In 2012-13, the total number of MHTRs given as part of a Community Order or Suspended Sentence Order was 765 (567 CO requirements and 198 SSOs).

[9] A Missed Opportunity: Community Sentences and the Mental Health Treatment Requirement'. Khamon, Samele and Rutherford. Sainsbury Centre for Mental Health 2009.

Table 5. Use of MHTRs as part of Orders 2012-13

Requirement	Community Order (2012-13)		Suspended Sentence Order (2012-13)	
	No.	%	No.	%
All	**183,357**	**100**	**82,170**	**100**
MHTR	567	0.3	198	0.2

Source: MoJ, Offender Management Caseload Statistics, January-March 2012 [10]

The LASPO Act 2012 sought to address some of these barriers, for example by removing the requirement in the Criminal Justice Act (2003) and the Mental Health Act (1983) that the evidence of need for mental health treatment given in assessments to the court is given by a Section 12 registered medical practitioner. This change means that the court may seek views and assessments on the mental health treatment needs of the offender from the broader mental health community, including Community Mental Health Teams, community psychiatric nurses or Probation Trust staff,

Eligibility

Before making the order, the court must be satisfied that:

1. The mental condition of the offender requires treatment and may be helped by treatment but does not warrant making a hospital or guardianship order (within the meaning of the Mental Health Act 1983)

2. Arrangements can be made for the offender to receive treatment as specified in the order

3. The offender agrees to undergo treatment for their mental health condition

In using the MHTR the court must be satisfied that any assessment of mental health of the defendant continues to focus on the risk to self or the public, of violence and of re-offending while the activities specified in the MHTR are undertaken.

There remains some evidence of confusion amongst health commissioners and providers between an MHTR of a Community Order and the Community Treatment Order introduced in November 2008 by the Mental Health Act 2007 which is much more directive in its powers. This has led to the belief that the MHTR can be used to impose mental health treatment against an

[10] www.gov.uk/government/uploads/system/uploads/attachment_data/file/225207/probation-tables-q1-2013.xls (Table 4.4)

individual's will but the eligibility criteria as set out in legislation make it clear that this is not the case.

Consent between the defendant and the court is a condition of the use of an MHTR. However, public acknowledgement of a mental health condition carries significant social stigma which may hinder the consensual uptake of an MHTR by offenders. To prevent public declaration of mental health problems leading to reduction in the uptake of the MHTR, the court may choose to have the details of the MHTR agreed in private prior to the court hearing, between the offender manager, health professional and the defendant and for the court to subsequently ratify this agreement without further details being disclosed publicly.

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.

As Mental Health Assessments of defendants are no longer required to be prepared by Section 12 medical practitioners (MHA 1983), pre-sentence reports may advise courts of alternative suitably qualified mental health practitioners such as practitioners from local Community Mental Health Teams, a community psychiatric nurse, a psychologist or forensic psychologist or similarly recognised, qualified approved mental health practitioner.

Mental Health Service Commissioning

In both England and Wales it is important to understand that mental health services which support the treatment element of MHTRs are not specifically commissioned for offenders. Instead, offenders are part of the service user population which is intended to access the mental health treatment services commissioned for the general population.

In England, responsibility for commissioning mental health services for the general population, including offenders in the community, transferred from PCTs (now abolished) to Clinical Commissioning Groups (CCG) on April 1 2013.

In Wales, responsibility for commissioning mental health services for the general population, including offenders in the community, rests with Local Health Boards.

Mental Health Service Providers may come from a range of settings as local health commissioners determine, including Community Mental Health Teams, Mental Health Trusts, GP Practices and the voluntary sector.

Any provider of probation services who has concerns about the mental health of anyone on their caseload not subject to a treatment requirement or subsequent to the commencement of an order should advise the individual to make an appointment with their registered GP who can make a referral to appropriate mental health treatment specialists.

MHTR Service Specification

The details of how a Mental Health Treatment Requirement is expected to function, including who is responsible for specific parts of service delivery, is set out in the **Support Delivery of Mental Health Treatment Requirement** service specification. This forms part of NOMS Directory of Services and may be found at:

www.justice.gov.uk/downloads/about/noms/directory-of-services/mhtr-specification.zip

A summary quick reference pathway map for MHTRs can be found in Appendix C of this document.

Table 6 provides a high level summary of the key organisations and their roles in delivering the MHTR.

Table 6. Roles of the Key Agencies in Supporting MHTRs from April 2014

NOMS Co-commissioning	**National Probation Service (NPS)**	**Community Rehabilitation Company (CRC)**	**England; Clinical Commissioning Groups** **Wales: NOMS Director & Local Health Boards**	**Mental Health Service Provider**
• Setting the specification for the offender management of MHTRs • Producing multi-agency guidance in the use of requirements • Commissioning the offender management element of MHTRs from NPS and CRCs • Seeking assurance around quality and delivery	• Understanding current treatment provision in the local area • Arranging placement for treatment with a treatment provider prior to completing the PSR • Providing advice to the Court through PSR of eligibility and appropriateness of MHTR including arranging appropriate mental health input • Assessing risk level of offender for case allocation • Funding and delivering offender management of MHTR for high risk cases • Exchanging information with treatment providers • Considering breach for failure to comply with MHTR • Contributing information about the treatment needs of offenders to Clinical Commissioning Groups	• Funding and delivering offender management of MHTRs for medium and low risk cases • Referring issues of risk or non-compliance to NPS for breach proceedings • Providing information about current provision and barriers to effective delivery to NPS to inform future service commissioning	• Commissioning of mental health services to meet the needs of the local population including offenders • Providing guidance on effective practice • Seeking assurance around quality and delivery • Understanding the mental health service needs of the entire local population including offenders • Promoting mental health services which have been commissioned to local partners including NPS and CRCs	• Promoting local services available with partners including NPS and CRCs • Providing an assessment to NPS on an offender's suitability for an MHTR • Agreeing placements for offenders on MHTR with NPS as part of a PSR • Delivering the treatment elements of MHTRs • Exchanging case information with the CRC/NPS

Further Information

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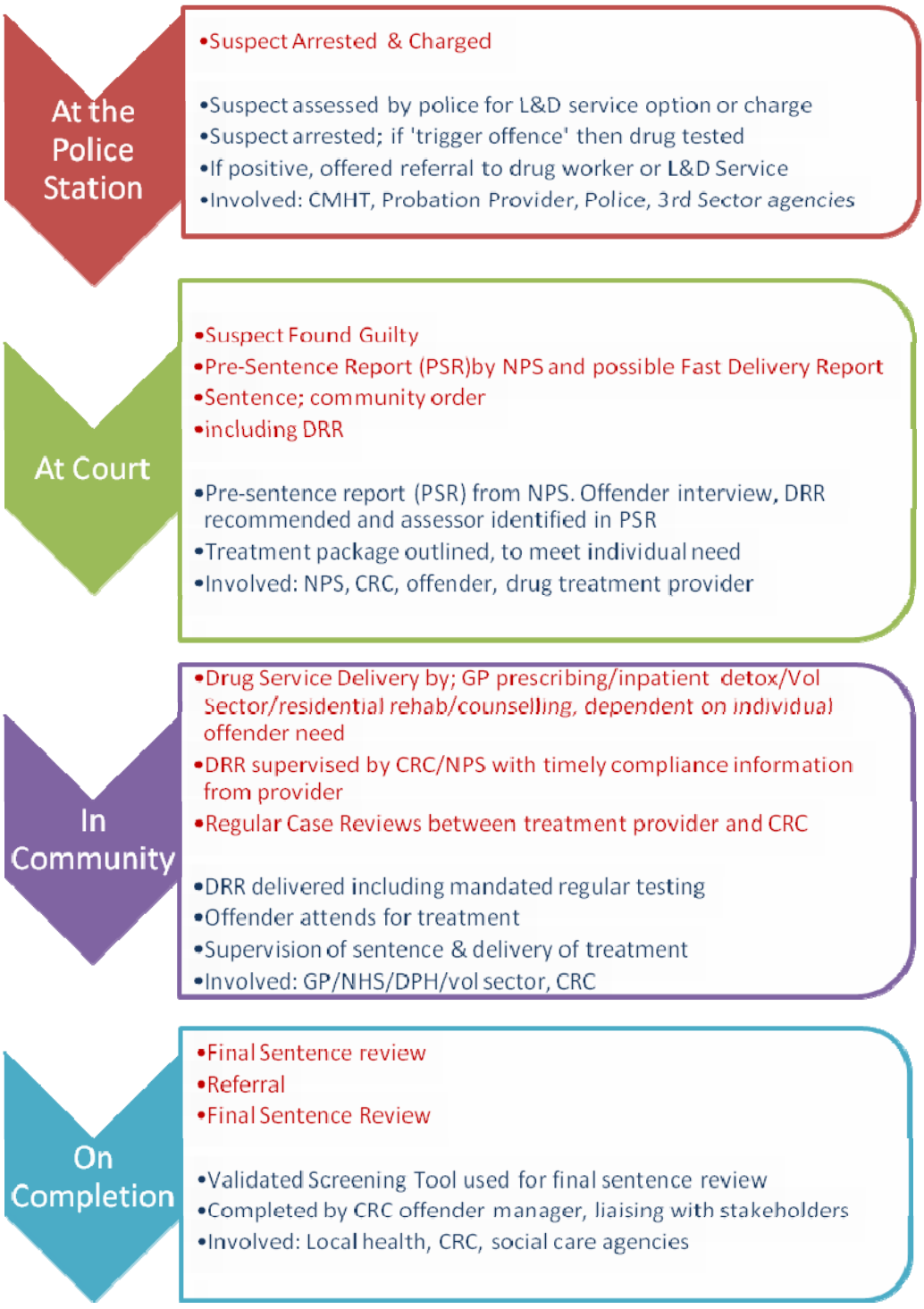
Appendices

Appendix A: DRR Pathway and Narrative



Narrative:
This narrative is intended to support the process maps above and act as an easy reference component of NOMS Guide to Treatment Requirements

Arrest
Suspect is arrested and charged at the police station. This process includes;

- ***Arrest Referral -*** Offenders are offered the opportunity to see a drug worker at arrest and assessed & referred. All those testing positive are offered an AR worker if not already seen.
- ***Testing at charge -*** All offenders over 18 charged with trigger offences tested for heroin and cocaine
- ***Bail Restriction on Bail -*** Test results provided inform bail/sentencing
- ***Required Assessment of drug dependence***

Liaison & Diversion (L&D) service options are considered at this stage by police as an alternative to arrest and charge of the suspect/offender.

Pre-sentence report
This is completed by the National Probation Service (NPS) before a case comes to court. The report refers to information gathered by the NPS on the offender which will indicate the suitability of the DRR for the offender as well as whether or not the eligibility criteria for the DRR are met. This includes that the offender is dependent on or has a propensity to misuse drugs, his or her dependency or propensity is such as requires and may be susceptible to treatment, offender consent and the availability of appropriate drug treatment services. The Pre-Sentence Report PSR also indicates to the court the suitable team or individual who has completed the DRR assessment.
The content and duration of the DRR proposed should be based on assessed treatment need with other requirements added, where appropriate, so that the restriction on liberty is commensurate with the seriousness of offence**.** The PSR will be informed by the L&D options which have been considered at the arrest stage.

Assessment of Drug Dependence
This is a pre-requisite of the DRR being used as part of a community order or suspended sentence order. This assessment may be provided by any suitably qualified professional working for the contracted treatment provider, CRC or NPS or it could be undertaken jointly.
If a DRR is going to include substitute prescribing the offender should be assessed by the relevant clinical personnel as to his/her suitability for such treatment. This clinical assessment is generally in addition to the usual probation/treatment provider assessment.
Issues around dual diagnosis (i.e. both enduring mental health and drug problems present) need to be addressed at the assessment stage. As much information as possible should be obtained about an offender's mental health if this appears to be an issue e.g. contact with relevant mental health professionals, access to psychiatric reports etc., in order to fully assess if a DRR is a suitable requirement.

Drug Rehabilitation Service Provision and Delivery
The DRR is intended as a community or suspended sentence where it is felt that a drug treatment intervention will support the offender to achieve and maintain reduced risk of reoffending, whether directly or indirectly.
The drug treatment services required to enable the DRR to be delivered come from the local drug treatment service agencies (voluntary sector and NHS) commissioned by the local authority out of their public health grant. The need for these services is specified in the local Joint Strategic Needs Assessment (JSNA), which all Health & Wellbeing Boards (HWBs) are required to produce as a guide for local health service commissioning by the Clinical Commissioning Group (CCG), local authority and Public Health England (PHE).
The treatment provided under a DRR should be tailored to individual offender need. It can include specialist prescribing; structured care planned counselling; structured day care; GP prescribing;

inpatient detoxification; residential rehabilitation; other interventions. The clinical standard requires that treatment must start within 2 working days of the order being made. Progress in treatment should be regularly assessed and reviewed throughout the order.

JSNA and JHWS

- Comprehensive guidance on this process is available at: http://webarchive.nationalarchives.gov.uk/20130805112926/http:/healthandcare.dh.gov.uk/jsnas-jhwss-guidance-published/

For the purposes of the DRR, it is vital that NPS or the local CRC is properly linked to the HWB and its processes. As no NPS or CRC is a statutory member of the HWB, the NPS or CRC will need to influence local commissioning through its links with local partners such as the Community Safety Partnership, or through the local Healthwatch or the Director of Public Health. Both of these are statutory members of the HWB and have a remit to ensure that all health service users and their voices and needs are represented at the HWB and in the health service commissioning activities of the CCG.

Connection with Offender
The DRR may only be used where the offender gives consent to this sentence option. Implicit in this consent is the agreement to have information shared between the CRC or NPS and treatment provider. Therefore, the CRC or NPS and drug treatment providers must ensure they work together in such a way as to provide the relevant supervision and treatment options, supporting the offender and each other in the process. This includes providing offenders with feedback on their progress and assistance in planning for appropriate treatment to continue after the end of the requirement. Additionally, good working partnerships between local authorities, GPs, CRC, Director of Public Health (DPH), Healthwatch and the agencies and fora which influence health service commissioning as well as the broader range of social care agencies, will support and sustain recovery in the offender.
Local protocols should be agreed to ensure appropriate risk management of offenders and clarity of agreed roles and responsibilities of the health and criminal justice contributors in delivering the elements of the DRR.

Testing
Regular drug testing is a legal requirement of a DRR. Whilst testing will usually be undertaken by the contracted treatment provider and commissioned and funded by the LA DPH (not the provider of probation services), the officer of the provider of probation service must ensure that offenders are regularly tested for the drugs most commonly associated with their offending, intermittently tested for other drugs to identify polydrug use and the drug tests and results are recorded. This will require close liaison and a clear understanding of expectations between whoever is responsible for the testing and the officer of the provider of probation services.

Due to the windows of detection in currently available drug testing kits, it would not be possible to determine whether someone has certain drugs in their system unless drug testing is carried out at least weekly. Therefore, it is recommended that weekly drug testing should be the minimum frequency whilst subject to a DRR, although in many cases more frequent testing will be appropriate depending on the drug of choice, the window of detection and the decay rates for a specific substance, in addition to the risk of re-offending and risk of harm posed by an individual offender. In order to ensure the continued confidence of the court and sentencers in the robustness of the DRR, frequency of drug testing should be agreed by the court at the point of sentence, and any changes to that frequency should be sanctioned in advance by the court.

The results of drug tests should not be viewed in isolation but considered, alongside other indicators, in the context of the offender's overall progress on the order.

Offender Management
Probation providers (CRC for offender management and NPS for advice to court or if risk is high or increases) are responsible for delivering offender management to manage the DRR on behalf of the court. The CRC or NPS will make decisions regarding breach of the conditions of the DRR based on information given them by the mental health provider and their own assessment.
The contracted drug treatment provider is responsible for delivering the drug treatment component of the DRR. This will require that inter-agency protocols are agreed which specify the responsibilities and actions taken in cases where for example an offender is non-compliant with treatment or absent. The CRC or NPS will make decisions regarding breach of the DRR based on information given them by the mental health provider and their own assessment.
The offender is allocated to the appropriate offender management tier. This will always be at least tier 2 and above and usually tier three of the Offender Management Model (OMM). A sentence plan will be developed by the officer of the provider of probation services and reviewed at regular intervals. This will necessitate contact between the officer and treatment provider as early as possible to ensure effective sentence planning.

Courts must review DRRs which are over 12 months in duration but can choose to review DRRs of any length.

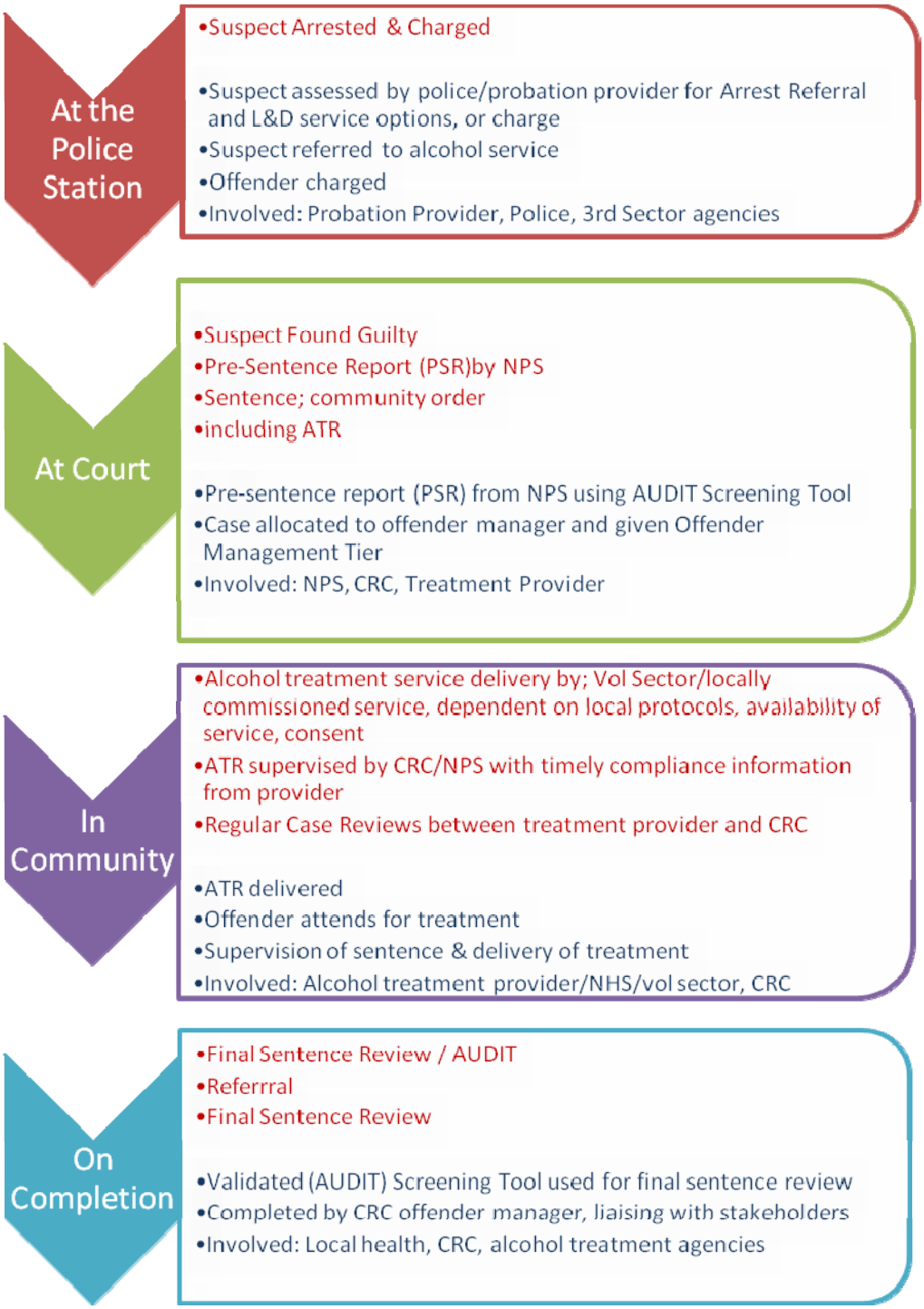
The officer of the provider of probation services must prepare a review report on the offender's progress, to the required specification and at the frequency specified by the court.

The report should be a collaborative document between treatment provider(s) and the officer of the provider of probation services, and should be discussed with the offender prior to the court review wherever possible.

Offender Health Needs Assessment (OHNA)
An OHNA is an important and useful means of ensuring that the overall picture of the health needs of offenders is clarified and provided locally to the health commissioning bodies; HWB, CCG.
This may be carried out in partnership locally by the CRC and Director of Public Health with the support of Healthwatch or local authority. Ideally, it forms part of the overall JSNA process. However, it is an important responsibility of Directors of Public Health, Healthwatch and HWBs to ensure that the JSNA process appropriately takes account of the needs of the local offender population as members of the community.
For the purposes of the DRR, this will enable the HWB and LA to commission the services needed to deliver the treatment and other rehabilitative elements of these community orders.

Completion of DRR
On completion of the DRR, the officer of the probation provider must complete a final sentence review with the offender, using a validated screening tool. This process must include the health service provider and the offender.
The officer of the provider of probation services has an important role in ensuring continuity of care and support where needed. A final sentence plan review should be undertaken and the case closed. The final sentence plan should state how any ongoing treatment needs are to be addressed when statutory supervision and the DRR ends and a referral should be made to the most appropriate agency to meet those needs.

Appendix B : ATR Pathway and narrative



Narrative:
This narrative is intended to support the process maps above and act as an easy reference component of NOMS Guide to Treatment Requirements

Arrest
***Alcohol Arrest Referral* -** Offenders are offered the opportunity to see an alcohol worker at arrest. It is important to have alcohol misuse identified early on in CJS so that ATRs are not missed. Local protocols between the provider of probation services and police, regarding the sharing of information about potential ATRs and assist the appropriate referral of offenders to probation.
L&D service options are considered at this stage by police as an alternative to arrest and charge of the suspect/offender.

Pre-sentence report
Completed by the National Probation Service (NPS) before a case comes to court. This report refers to information gathered by the NPS on the offender which will indicate the suitability of the ATR for the offender as well as whether or not the eligibility criteria for the ATR are met. This includes that the offender is dependent on alcohol; his or her dependency is such that it requires and may be susceptible to treatment, offender consent and the availability of appropriate alcohol treatment services have been ascertained.
The PSR details to the court the team or individual who has completed the ATR assessment and when the treatment will start. In addition, the PSR will be informed by the L&D options which have been considered at the arrest stage.

Assessment for Alcohol Dependence
The offender must have been assessed as dependent on alcohol as a pre-requisite of an ATR being made as part of a community order or suspended sentence order. The assessment may be provided by any suitably qualified professional working for the contracted treatment provider, CRC or NPS or it could be undertaken jointly. A validated screening tool must be used, most commonly AUDIT.
Issues around dual diagnosis (i.e. both enduring mental health and alcohol problems present) need to be addressed at the assessment stage. As much information as possible should be obtained about an offender's mental health (if this appears to be an issue) e.g. through contact with relevant mental health professionals, access to psychiatric reports etc., in order to fully assess if an ATR is a suitable requirement.

Alcohol Service Provision and Delivery
The ATR is intended as a community or suspended sentence where it is felt that an alcohol treatment intervention will support the offender to achieve and maintain reduced risk of reoffending, whether directly or indirectly.
The alcohol treatment services required to enable the ATR to be delivered come from the local alcohol treatment service agencies (voluntary sector and NHS) commissioned by the local authority out of their public health grant. The need for these services is specified in the local Joint Strategic Needs Assessment (JSNA), which all Health & Wellbeing Boards (HWBs) are required to produce as a guide for local health service commissioning by the Clinical Commissioning Group (CCG), local authority and Public Health England (PHE).
Commencement of treatment within 14 days of sentence (the clinical standard), is an explicit requirement in service specifications and contracts or service level agreements.

JSNA and JHWS

- Comprehensive guidance on this process is available at: http://webarchive.nationalarchives.gov.uk/20130805112926/http:/healthandcare.dh.gov.uk/jsnas-jhwss-guidance-published/

For the purposes of the ATR, it is vital that NPS or the local CRC is properly linked to the HWB and its processes. As no NPS or CRC is a statutory member of the HWB it will need to influence local commissioning through its links with local partners such as the Community Safety Partnership or through the local Healthwatch or the Director of Public Health. Both of these are statutory members of the HWB and have a remit to ensure that all health service users and their voices and needs are represented at the HWB and in the health service commissioning activities of the CCG.

Connection with Offender

The ATR may only be used where the offender gives consent to this sentence option. Implicit in this consent is the agreement to have information shared between the CRC or NPS and treatment provider. Therefore, the CRC or NPS and alcohol treatment providers must ensure they work together in such a way as to provide the relevant supervision and treatment options, supporting the offender and each other in the process. This includes providing offenders with feedback on their progress and assistance in planning for appropriate treatment to continue after the end of the requirement.

Additionally, good local working partnerships between GPs, CRC, DPH, CMHTs, Healthwatch and the agencies and fora which influence health service commissioning as well as the broader range of social care agencies, will support and sustain recovery in the offender.

Local protocols should be agreed to ensure appropriate risk management of offenders and clarity of agreed roles and responsibilities of the health and criminal justice contributors in delivering the elements of the MHTR.

Offender Management

Probation providers (CRC for offender management and NPS for advice to court or if risk is high or increases) are responsible for delivering offender management to manage the ATR on behalf of the court. The CRC or NPS will make decisions regarding breach of the conditions of the DRR based on information given them by the mental health provider and their own assessment.

The contracted alcohol treatment provider is responsible for delivering the alcohol treatment component of the ATR. This will require that inter-agency protocols are agreed which specify the responsibilities and actions taken in cases where for example an offender is non-compliant with treatment or absent.

The offender is allocated to the appropriate offender management tier. Offenders presenting a medium or high risk of serious harm will receive more intensive supervision than those who present a low risk of serious harm. A sentence plan will be developed by the officer of the provider of probation services and reviewed at regular intervals.

Offender Health Needs Assessment (OHNA)

An OHNA is an important and useful means of ensuring that the overall picture of health needs is clarified and provided locally to the health commissioning bodies; HWB, CCG.

This may be carried out in partnership locally by the CRC and Director of Public health with the support of Healthwatch or local authority. Ideally it forms part of the overall JSNA process.

However, it is an important responsibility of Directors of Public Health, Healthwatch and HWBs to ensure that the JSNA process appropriately takes account of the needs of the local offender population as members of the community.

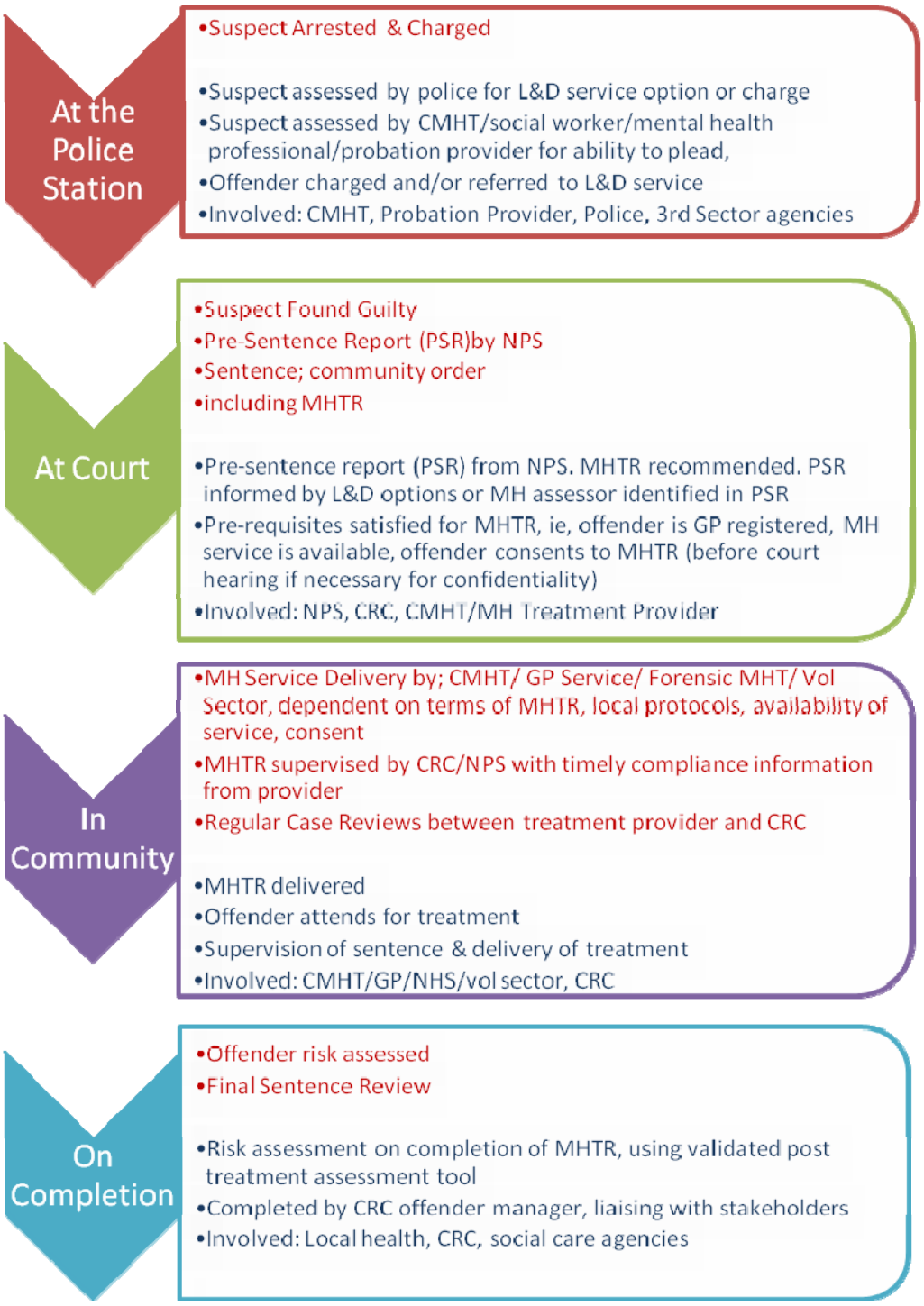
Completion of ATR

On completion of the ATR, the officer of the probation provider must complete a final sentence review with the offender, using a validated screening tool. This process must include the health service provider and the offender.

The officer of the provider of probation services has an important role in ensuring continuity of care and support where needed. A final sentence plan review should be undertaken and the case closed.

The final sentence plan should state how any ongoing treatment needs are to be addressed when statutory supervision and the ATR ends and a referral should be made to the most appropriate agency to meet those needs.

Appendix C : MHTR Pathway and Narrative



Narrative:
This narrative is intended to support the process maps above and act as an easy reference component of the Joint Guidance on Delivery of Mental Health Treatment Requirements (MHTR).

Arrest
Suspect is arrested and charged at the police station. This is the beginning stage of the offender journey. Depending on the offence, the offender may be offered the option of referral to a Liaison & Diversion service instead of proceeding to court.

Pre-sentence report
Completed by the National Probation Service (NPS) before a case comes to court. This report refers to information gathered by the NPS on the offender which will indicate the suitability of the MHTR for the offender as well as whether or not the eligibility criteria for the MHTR are met. This includes registration with a GP, offender consent and availability of appropriate mental health treatment service.
The PSR also indicates to the court, the suitable team or individual available to complete the MH Assessment for the court and is informed by L&D options which have been considered.

MH Assessment
As indicated this is a pre-requisite of the MHTR being used as a community order. Since the introduction of LASPO 2012, this assessment may be provided by any suitably qualified MH professional agreed by the court.
This may be any suitably trained MH professional working either for the CRC, local health or social care agency. For example, the assessor may be a suitably qualified approved social worker or community psychiatric nurse, with experience of working with offenders. The court is free to decide on the suitability of the assessing professional.

MH Service Provision and Delivery
The MHTR is intended as a community sentence where it is felt that mental health intervention will support the offender to maintain and achieve reduced risk of reoffending, whether directly or indirectly.
The MHTR is intended for offenders suffering low to medium mental health issues. As such the MH services required are provided through ordinary community mental health service provision. Offenders in community are entitled to access and make use of these services in the same way as the general population.
The MH services required to enable the MHTR to be delivered come from the local mental health service agencies commissioned by the local Clinical Commissioning Group (CCG). The need for these services is specified in the local Joint Strategic Needs Assessment (JSNA), which all Health & Wellbeing Boards (HWB), are required to produce as a guide for local health service commissioning by the CCG, LA and PH England.

JSNA and JHWS

- Comprehensive guidance on this process is available at: http://webarchive.nationalarchives.gov.uk/20130805112926/http:/healthandcare.dh.gov.uk/jsnas-jhwss-guidance-published/

For the purposes of the MHTR, it is vital that the local CRC is properly linked to the HWB and its processes. As no NPS or CRC is a statutory member of the HWB it will need to influence local commissioning through its links with local partners such as the Community Safety Partnership, or through the local Healthwatch or the Director of Public Health, both of which are statutory members of the HWB and have a remit to ensure that all health service users and their voices and needs are represented at the HWB and in the health service commissioning activities of the CCG.

Connection with Offender
The MHTR may only be used where the offender gives consent to this sentence option. Therefore, the probation and mental health service providers must ensure they work together in such a way as to provide the relevant supervision and treatment options, supporting the offender and each other in the process.

This will include; good working partnerships between local GPs, CRC, DPH, CMHTs, Healthwatch and the agencies and fora which influence health service commissioning.
Local protocols should be agreed to ensure appropriate risk management of offenders and clarity of agreed roles and responsibilities of the health and criminal justice contributors in delivering the elements of the MHTR.

Offender Management
Probation providers (CRC for offender management and NPS for advice to court or if high/increases) are responsible for delivering offender management to manage the MHTR on behalf of the court.
The CRC or NPS will make decisions regarding breach of the MHTR based on information given them by the mental health provider and their own assessment.
The CMHT or mental health delivery agency is responsible for delivering the mental health treatment component of the MHTR. This will require that inter agency protocols are agreed which specify the responsibilities and actions taken in cases where for example an offender is non-compliant with treatment or absent.

Offender Health Needs Assessment (OHNA)
An OHNA is an important and useful means of ensuring that the overall picture of health needs is clarified and provided locally to the health commissioning bodies; HWB, CCG.
This may be carried out in partnership locally by the CRC and Director of Public health with the support of Healthwatch or local authority. Ideally it forms part of the overall JSNA process.
However, it is an important responsibility of Directors of Public health, Healthwatch and HWBs to ensure that the JSNA process appropriately takes account of the needs of the local offender population as members of the community.
For the purposes of the MHTR, this will enable the HWB and CCG to commission the CMHT or local mental health delivery agencies to provide the services needed to deliver the mental health service components of these community orders.

Completion of MHTR
On completion of the MHTR, the officer of the probation provider must complete a final sentence review with the offender, using a validated screening tool. This process must include the health service provider and the offender.
The officer of the provider of probation services has an important role in ensuring continuity of care and support where needed. A final sentence plan review should be undertaken and the case closed.
The final sentence plan should state how any ongoing treatment needs are to be addressed when statutory supervision and the MHTR ends and a referral should be made to the most appropriate agency to meet those needs.

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