Department of Health & Social Care

Community Sentence Treatment Requirements Protocol

Process Evaluation Report

June 2019

In collaboration with NHS England, Public Health England, Ministry of Justice and Her Majesty's Prison & Probation Service

Contents

1. Background	5
2. Evaluation methodology	14
3. Findings: Headline findings	20
4. Findings: Developing the CSTR pathway	26
5. Findings: How to plan better service provision	41
6. Conclusions	63
7. Annex	65

The Community Sentence Treatment Requirements (CSTR) programme aims to reduce reoffending and short term custodial sentences by addressing the health and social care issues of the offender.

To achieve this, the CSTR protocol was introduced to:

- Increase the **use of CSTRs**, including increasing the use of combined CSTRs (MHTR & ATR, MHTR & DRR*)
- Reduce the use of **short term sentencing**
- Develop **MHTR* treatment** availability
- Develop **partnerships** and effective **steering groups**
- Strive for **sentencing on the day**, wherever possible
- Increase **awareness of the judiciary** around mental health and associated vulnerabilities

* Mental Health Treatment Requirement (MHTR), Alcohol Treatment Requirement (ATR), Drug Rehabilitation Requirement (DRR)

This report details the findings from a **process evaluation** carried out to understand the implementation of the Community Sentence Treatment Requirements (CSTR) protocol.

In this **process evaluation**, we investigated how the CSTR protocol was implemented in the five testbeds.

We were interested in **understanding the experiences** of testbeds implementing the protocol, including **learnings** from the process, what **worked** and what were the **challenges**.

Monitoring all the aims of the CSTR programme was beyond the scope of a **process evaluation** over a relatively short period of time; instead we focused on understanding **how CSTRs are used**, the development of **partnerships** and **treatment availability.**

The process evaluation looked at the **initial implementation** of the protocol, over a relatively **short period of time**. Therefore, this may **not represent** current CSTR operation in the testbed sites.

The evaluation **does not** look at the **direct impact** of the protocol on individual health and reoffending outcomes.

There was **no control group** and the **timescales** were relatively short. This means that any observed change cannot be solely attributed to the protocol, and should be treated with caution.

Findings should be read in **context** and with consideration to **data limitations** and **completeness** (see footnotes).

1. BACKGROUND

- Aims of the evaluation report
- Definitions
- Policy background
- CSTR protocol, testbed sites & pathway

This report details findings from a process evaluation of the CSTR protocol, introduced in five testbed sites in late 2017 and early 2018.

This protocol sought to **facilitate collaborative working** between stakeholders involved in Community Sentence Treatment Requirements (CSTR), and **to identify and fill a gap in services** for Mental Health Treatment Requirements (MHTR).

The evaluation looked at:

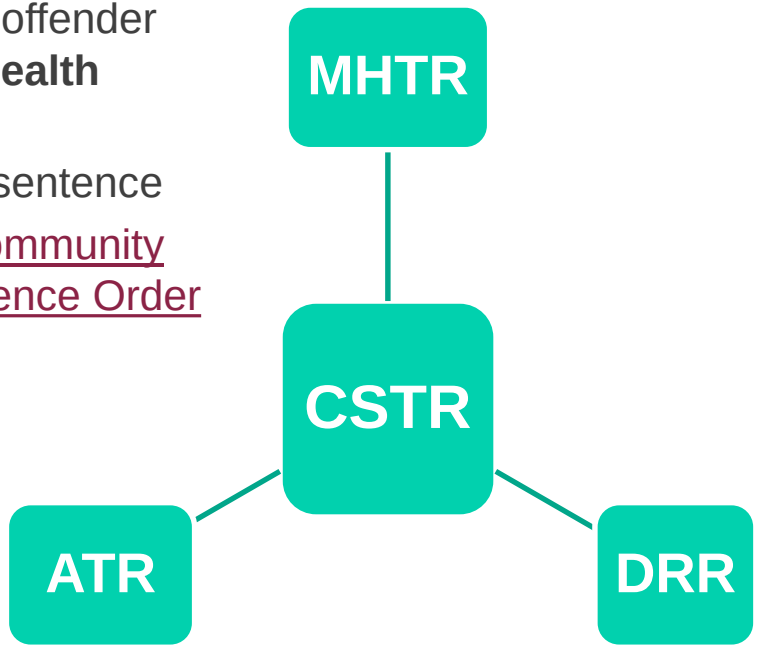
- Mental health and substance misuse **needs of offenders**
- Identifying and filling **criminal justice** and **health service arrangements** for these needs
- **Barriers** to being given a CSTR
- Whether the **protocol works**, and whether any **changes** are necessary

This report covers:

- **Background** to the policy area
- Evaluation **methodology**
- **Headline figures**
- **Developing the CSTR pathway**
- **Planning better services**
- **Conclusion**
- Annex

What are **Community Sentence Treatment Requirements** (CSTRs)?

- Community sentences issued by courts where the offender has consented to complete treatment for **mental health** problems, **drug** and/or **alcohol** misuse problems
- **Treatment** will have been arranged as part of the sentence
- Can last a maximum of three years as part of a Community Order and two years as part of a Suspended Sentence Order



There are three types of **CSTR**:

1. **Mental health** treatment requirements (MHTR)
2. **Drug** rehabilitation requirements (DRR)
3. **Alcohol** treatment requirements (ATR)

MHTR can be combined with ATR and DRR.
DRR and ATR cannot be combined (e.g. ATR/DRR, MHTR/ATR/DRR)

Who is **suitable** for a CSTR?

Offenders who :

- Are **aged 18 or over**
- Require treatment related to **mental health** and/or **substance misuse**
- Have been convicted of an offence which falls within the **Community Order** or **Suspended Sentence Order** sentencing threshold
- Have expressed **willingness to comply** with the requirement (consent)

A CSTR may be given if the court is satisfied that…

MHTR	The offender has a **mental health condition** that is **treatable** 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.
ATR	The offender is **dependent on alcohol**, and requires and may be susceptible to treatment. Their dependency does not have to have caused or contributed to the convicted offence.
DRR	The court is satisfied that the offender is **dependent on or has a propensity to misuse drugs**, and requires and may be susceptible to treatment.

How were CSTRs used before the implementation of CSTR protocol?

The proportion of CSTRs, in particular MHTRs, given as part of Community Orders (CO) and Suspended Sentence Orders (SSO), has **remained low**. **750** of 211,905 (0.35%) COs were for mental health in 2006, compared to **391** of 130,761 (0.30%) in 2016. **177** of 62,216 (0.28%) SSOs were for mental health in 2006, compared to **278** of 72,274 (0.38%) in 2016. [2]

CSTRs given as part of Community Orders and Suspended Sentence Orders between July and September 2017 in England and Wales[1]:

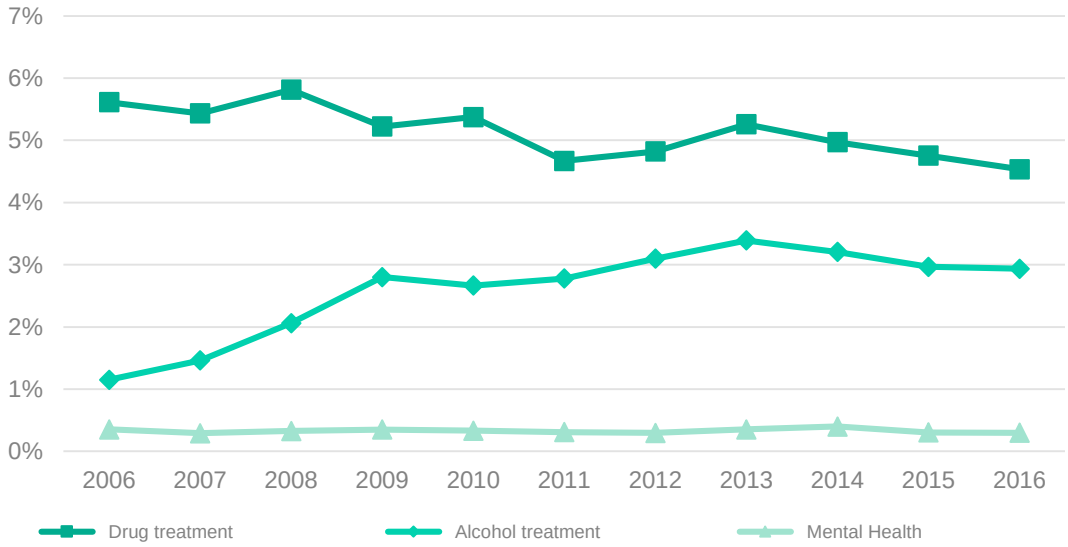
Sentence	Number of Community Orders (%)	Number of Suspended Sentence Orders (%)
Mental health	78 (0.3%)	58 (0.3%)
Drug	1,250 (4.2%)	814 (4.7%)
Alcohol	861 (2.9%)	511 (3.0%)

Various barriers have been suggested,[3] including:

- Lack of **identification of need**
- **Availability of treatment** provision
- Lower levels of need not fulfilling **eligibility criteria**

However, further work was needed to better understand these potential barriers.

CSTRs sentenced (as part of a CO) between 2006 and 2016 in England and Wales[2]:



Note: [1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/729224/probation-tables-Q12018.ods
[2] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/610980/probation-2016.xlsx
[3] https://www.crimeandjustice.org.uk/sites/crimeandjustice.org.uk/files/community-sentences-2008%20blue.pdf

What is the policy background to CSTRs?

Policy Background: Prison Safety and Reform and FYFVMH

The **Prison Safety and Reform white paper**[1]:

- Signalled drive to improve outcomes for prisoners and significantly **reduce the numbers of prisoners** within the prison estate, particularly those with **mental health problems**.
- Community sentences with treatment requirements, when appropriate, should help towards achieving this goal.

The **Five Year Forward View for Mental Health (FYFVMH)**[2] sets out ambitions:

- For **early interventions** that work in partnership across public services, and
- To intervene earlier to **prevent escalation** of mental health problems.
- The **CSTR protocol** was the government's response to Recommendation 24 of the FYFVMH, *"to develop a complete health and justice pathway to deliver integrated health and justice interventions in the least restrictive setting, appropriate to the crime which has been committed"*.[6]

Prevalence: Mental health and substance misuse needs in the offender population

It is difficult to estimate the mental health and substance misuse needs in the offender population. However, HMP Inspectorate of Prisons surveys of prisoners suggests:

- **24%** of women and **18%** of men said they had an **alcohol problem** when they came into prison[3]
- **42%** of women and **28%** of men said they had a **drug problem** when they came into prison[3]
- **65%** of women and **42%** of men in prison felt they had any emotional well-being or mental health issues[4]

In 2016-17, there were 4,320 contacts with Prison Psychiatric Inreach Services, 82.8% of these appointments were attended and the patient was seen.[5]

Note: [1] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/565014/cm-9350-prison-safety-and-reform-_web_.pdf
[2] https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf
[3] https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2018/07/6.4472_HMI-Prisons_AR-2017-18_Content_A4_Final_WEB.pdf

[4] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/629720/hmip-annual-report-2016-print.pdf
[5] https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-bulletin/mental-health-bulletin-2016-17-annual-report
[6] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/582120/FYFV_mental_health__government_response.pdf

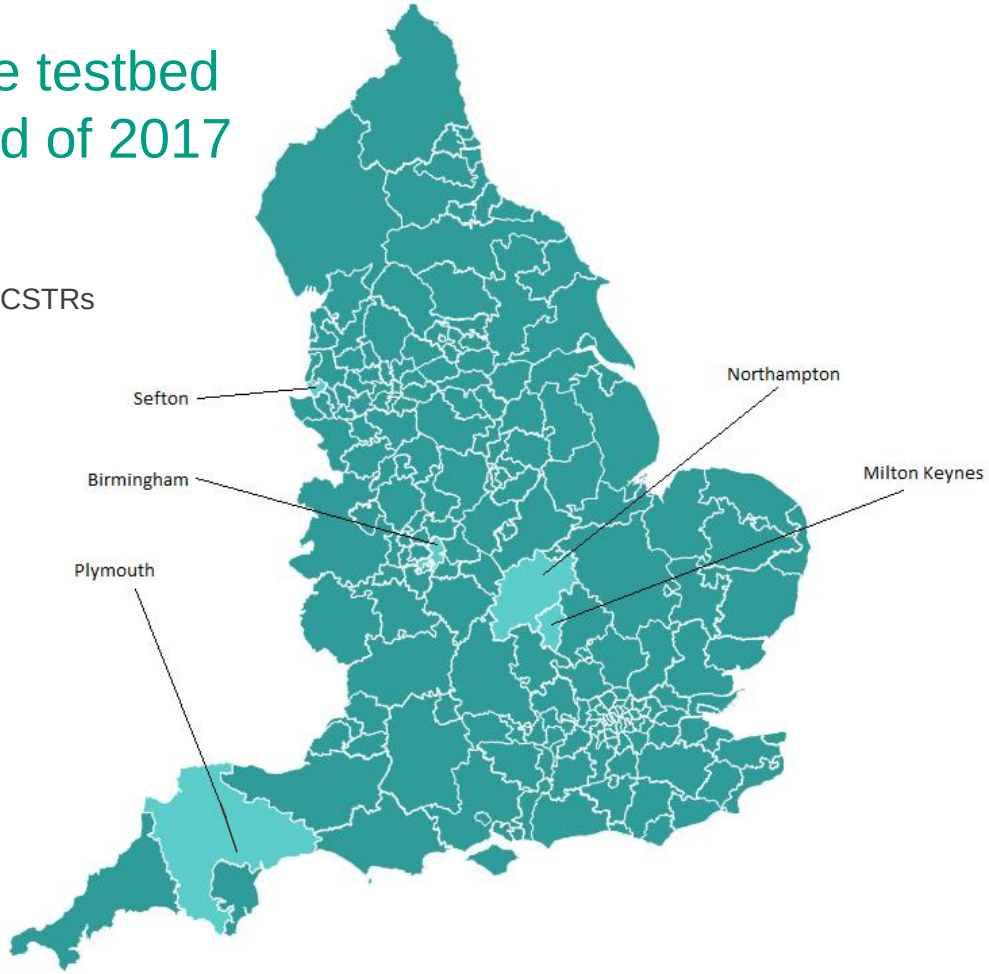
A new protocol was introduced in five testbed sites across England towards the end of 2017 and the start of 2018.

The protocol was devised to:

- Improve **join up** between different parts of the system involved in CSTRs
- **Build links** between stakeholders, and
- **Facilitate** and **encourage** the use of CSTRs

Testbed Site	Protocol Start Date
Birmingham	December 2017
Milton Keynes	October 2017
Northampton*	October 2017
Plymouth	December 2017
Sefton	DRR/ATR January 2018 MHTR April 2018

Note that whilst the testbeds were based on CCG area, some changes have been made to CCG areas and the map is not completely representative of the whole testbed site (e.g. Plymouth now sits within North, East and West Devon CCG, and the testbed only covered 3 postcode areas). *Northampton only introduced the protocol for women.



How were the testbed sites chosen?

Sites were initially identified against the following criteria:

- Local drive to become a testbed
- Existence of/will to develop partnerships
- Presence of Liaison & Diversion service, and
- Whether testbed area was contained within a court area.

Sites were selected by the CSTR board on:

- Readiness to develop
- Willingness of local courts to be part of testbed
- Reflective of different parts of the county
- Ability to offer different aspects of developing a CSTR site (e.g. urban/rural)

CSTRs sentencing 2016/17 (before protocol)

Testbed	MHTR	ATR	DRR
Birmingham	4	58	258
Plymouth	1	27	47
Milton Keynes	45	*	*
Northampton	3	120	151
Sefton	2	*	*

Sites provided 2016/17 data, * denotes where they were unable to provide data. Milton Keynes 2016/17 MHTR figures are higher as they started piloting increased use of MHTRs from April 2014.

Sefton

- Local need to increase the number of CSTRs across Merseyside, initially focusing on the **most vulnerable** in the Complex Case Court
- Low **MHTRs**, long **ATR/DRR** adjournments

Birmingham

- The **Mental Health Commission** in the West Midlands had been advocating for increased use of CSTRs, and had identified three areas to test and develop pilot schemes
- High levels of **short term custodial sentences**, with high levels of unmet need

Plymouth

- A local **scoping exercise** reviewed areas across Devon and Cornwall based on locally agreed parameters
- Significant **mental health** and **dual diagnosis** need but little support; high numbers of **short term custodial sentences**

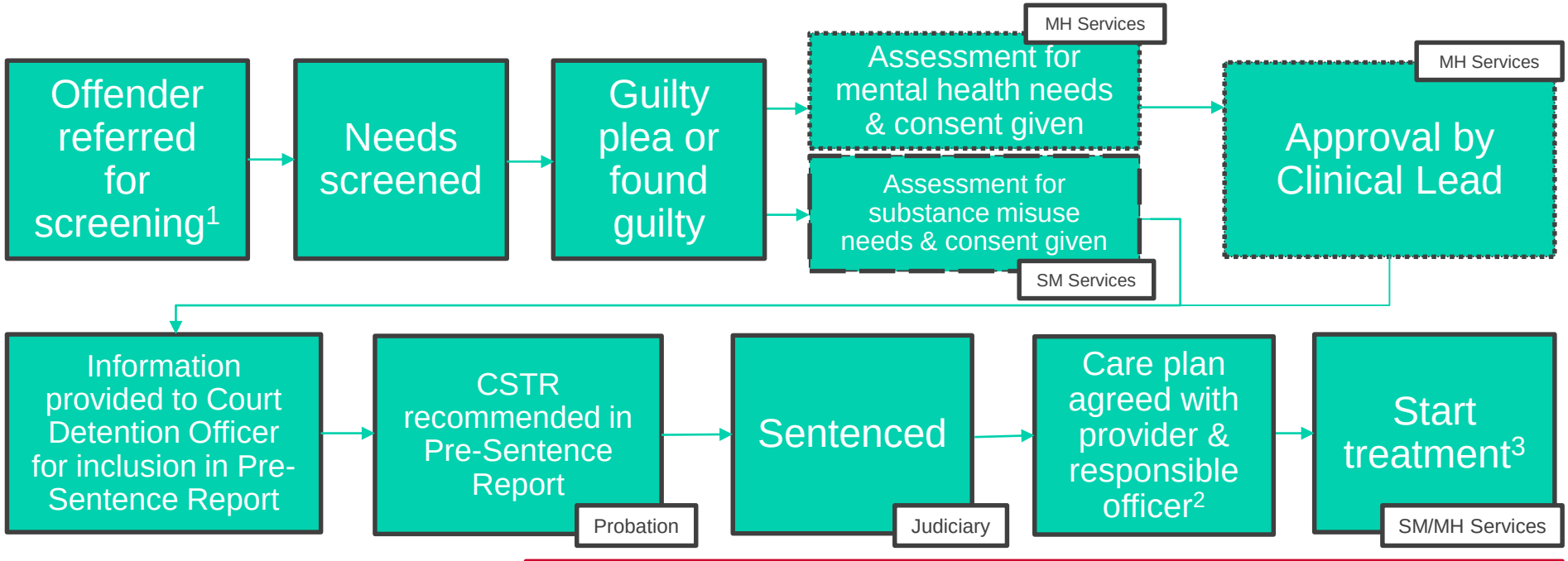
Northampton

- Initially focused on CSTRs for **women**; historically, the county had slightly higher than national average rates for **sending women to custody** on short term sentences
- **Little contact** with substance misuse services, treatment offered **in silo**
- Liaison & Diversion **struggled to link** into service providers

Milton Keynes

- Had been piloting the increased use of MHTRs for clients with **lower level mental health issues** and associated vulnerabilities since April 2014.

What happens on the CSTR pathway?



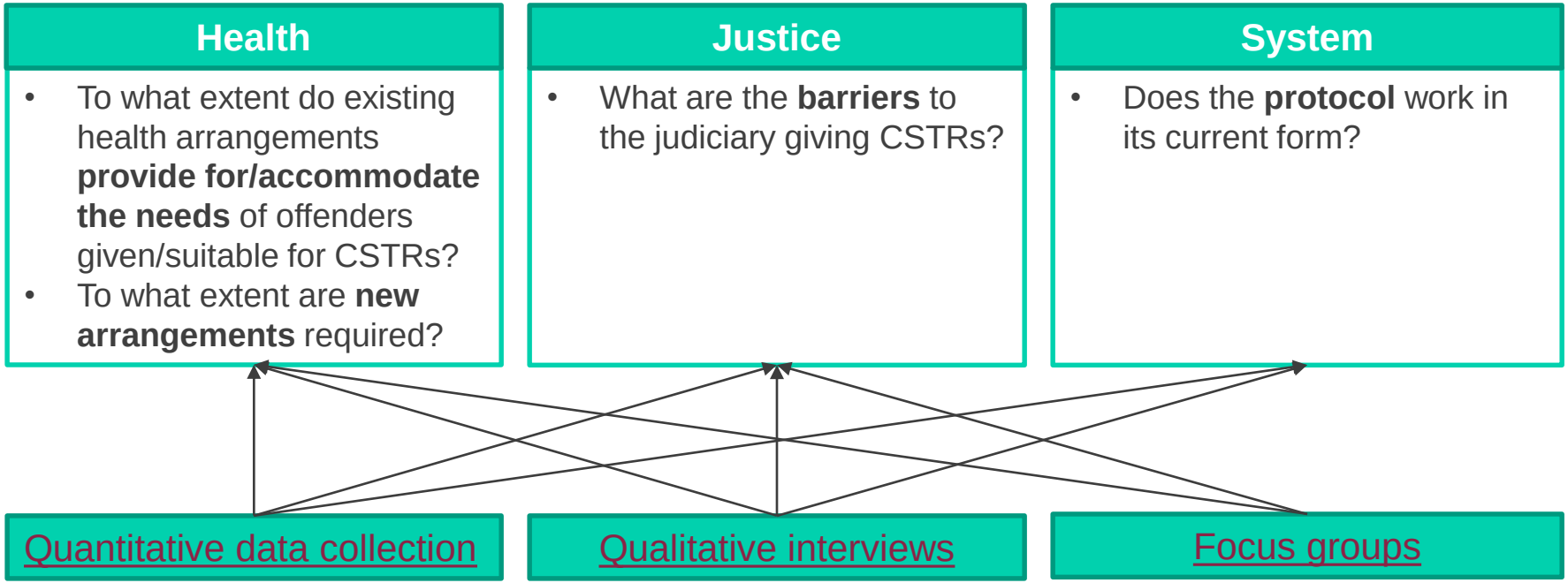
ATR, DRR & MHTR | MHTR | ATR & DRR

[1] Offenders could be referred by a range of sources, including Liaison and Diversion Services, probation, defence solicitors, in court link workers.
[2] Including treatment allocation to Community Rehabilitation Company or National Probation Service and a multi-provider meeting with the client to agree the sequence of the order (e.g. MHTR + DRR) where applicable.
[3] Mental health treatment as part of the primary MHTR pathway may involve a range of interventions, including psycho education, compassion focused therapy, cognitive behavioural therapy (CBT), behavioural activation, acceptance and commitment therapy, mindful practices and value based solution focused therapy

2. EVALUATION METHODOLOGY

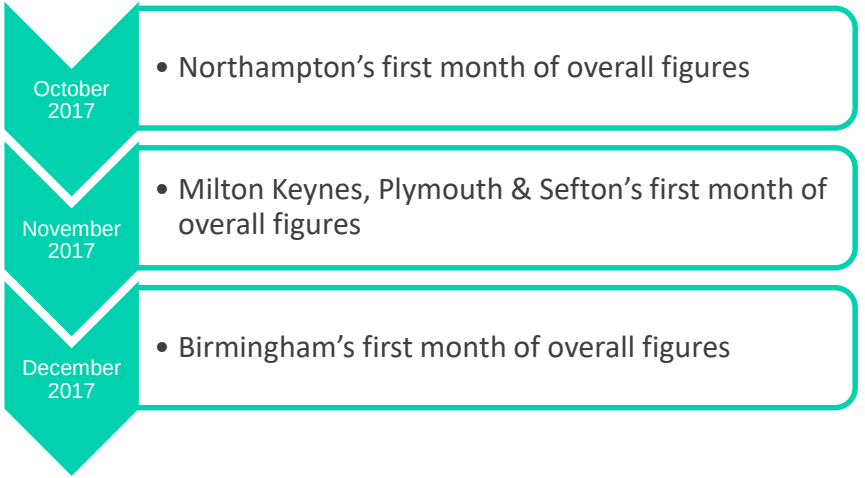
- Research Aims
- Quantitative data collections
- Qualitative stakeholder interviews
- Focus groups with service users

The process evaluation investigated **three areas,** informed by **three strands of research**:



Five testbed sites submitted **quantitative data** for each month the protocol was live.

- Each site submitted data in **aggregate** form to NHS England in June 2018, including data for each month the protocol was live in that site.
- Data was then transferred to the Department of Health and Social Care and the Ministry of Justice for analysis.
- Data was collected where possible from 5 sources:
  a. Pink Slips from Probation
  b. Pink Slips from Sentencers
  c. Mental Health Treatment Services
  d. Substance Misuse Treatment Services
  e. Overall Figures



- All testbeds submitted **Overall Figures** from **January to May 2018**, although some submitted data for the preceding months, and some also submitted data for June; these time series differ depending on the source of the data.

Testbed sites submitted data from **five sources**, in **aggregate form** for each month the protocol had been in operation

Probation Pink Slips

Completed by **probation officers** for each individual considered for a CSTR

Questions included:

- Offender **needs**
- Whether already in **treatment**
- **Suitability** for CSTR
- Reasons why CSTR **not recommended**
- Recommended **length** of order
- **Outcomes** of recommendation

See Annex A for Pink Slip

Judiciary Pink Slips

Completed by **judges** and **magistrates** for each individual considered for a CSTR

Questions included:

- **Sentence** given
- **Length** of order
- Order **requirements**
- Where CSTR not ordered, **reasons** for this & order given instead
- If CSTR had **not been available**, what they would have given instead e.g. custody

See Annex B for Pink Slip

Treatment Services

MH

Completed by **mental health treatment services**

SM

Completed by **substance misuse treatment services**

Data included:

- **How many individuals** were in treatment each month
- Type of **mental health problems** OR **substance misuse problems**
- Type of **treatment** provided
- Total number of **missed appointments**
- **Reasons** for lack of attendance

See Annex C for snapshot of spreadsheet

Overall Figures

Data included the number of:

- Individuals **screened** for a CSTR
- Individuals **assessed** for a CSTR
- Individuals who **consented** to a CSTR
- CSTRs which were agreed by a **Clinical Lead**
- Individuals **recommended** by probation for a CSTR
- Individuals **sentenced** to a CSTR
- Individuals who attended their first **treatment appointment**
- Individuals who **breached** their CSTR order

See Annex D for snapshot of spreadsheet

For completeness data, see Annex F, G and H.

The National Institute for Health Research Mental Health Policy Research Unit undertook **interviews with key stakeholders** involved in implementing the CSTR protocol in each of the five testbed sites.

- Interviews took place between **January and September** 2018.
- **38 interviews** took place with stakeholders across the five testbed sites; 52 individuals were approached for interview (14 did not take part).
- Interviews were **semi-structured** and lasted up to an hour
- Topic guides were developed for each professional group
- Interviewees were asked about their **experiences of CSTRs** and their **views on the protocol**

National Institute for Health Research Mental Health Policy Research Unit

- Established in **2017**
- Managed by academics at **UCL** and **KCL** in collaboration with City and Middlesex University.
- Aims to help DHSC make **evidence based decisions** related to mental health.

Interviewed stakeholders included:

- Liaison & diversion workers
- Probation officers
- Mental health treatment providers
- Drug and alcohol treatment providers
- Third sector organisations
- Commissioners
- Steering group chairs*
- Members of the judiciary
- CSTR programme manager*
- CSTR training provider*

*included in the totals of interviews undertaken below according to their professional background

Mental Health Services	11	Commissioners	4
Probation Services	9	Drug & Alcohol Services	4
Judiciary	4	Third Sector Organisations	2
Liaison & Diversion	4		

Clinks undertook **focus groups and interviews** with **service users** to understand their views on CSTRs

Who?

47 individuals involved in focus groups and interviews

- Experience of **Criminal Justice System,** and **mental health** and/or **substance misuse** problems
- No experience of MHTR or ATR, 5 participants had experience of DRR.
- None currently subject to any form of CSTR

6 voluntary sector practitioners involved in assessing, delivering or supporting people receiving a CSTR (not in the testbed sites) were also asked for their views on CSTRs

When?

January to July 2018

Where?

- Midlands
- South East
- London
- Wales
- Yorkshire

What?

- 2 focus groups with adult men in **prison** (N=10)
- 1 focus group with adult women in **prison** (N=5)
- 1 mixed focus group in the **community** (N=6)
- 3 focus groups with women in the **community** (N=10)

Note: Service users and practitioners involved in the Clinks work were **outside testbed sites**; their views do not relate to practice during the pilot. However, they were asked for their experience and views of CSTRs, experience of engaging with mental health or substance misuse services, whether they feel a CSTR would have been suitable for them, and any perceived facilitators and barriers to CSTRs working well.

Clinks: National infrastructure organisation supporting voluntary sector organisations working in the criminal justice system (CJS) & member of the Voluntary, Community and Social Enterprise Health and Wellbeing Alliance, a national partnership between the voluntary sector and DHSC, NHSE and PHE.

See Annex E for interview questions

3. HEADLINE FINDINGS

- Number of CSTRs screened, recommended, sentenced
- Length of order
- Alternatives to CSTR
- Attrition through the CSTR pathway
- Change in CSTRs after protocol introduction

Since the CSTR protocol was introduced: **809** offenders were screened, **488** were recommended by probation to judiciary and **441** were sentenced across all 5 test sites[1]

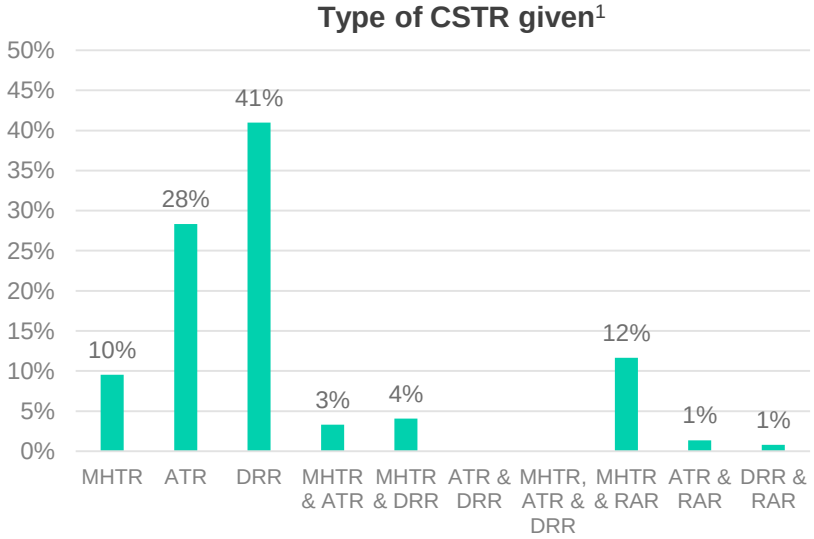
69% of screenings were for **substance misuse** problems[1]

31% of screenings were for **mental health** problems[1]

Of those sentenced to a CSTR across all 5 testbed sites:[1]

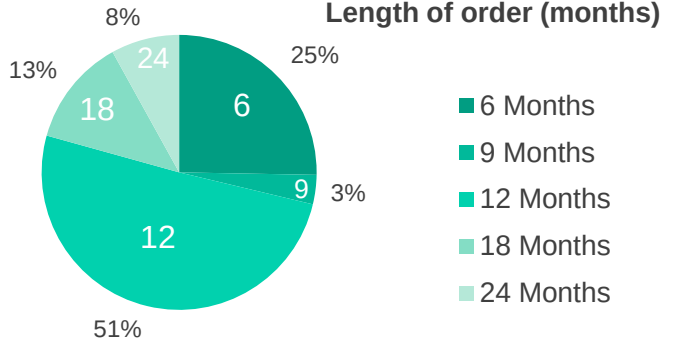
- **10%** were sentenced to an MHTR, **41%** to a DRR and **28%** to an ATR alone.
- Some offenders received sentences for MHTR with either DRR (**4%**) or ATR (**3%**)
- **Combinations of CSTRs with RARs** made up the remaining **14%** of orders

Some members of the judiciary also indicated they gave CSTRs with additional requirements, such as **Residence Orders**, **Unpaid Work** and **Building Better Relationships**.[2]



Note: [1] *Overall Figures - October 2017 to June 2018* - different time series submitted for each testbed (see relevant completeness slide for more information). The protocol went live in **the five test bed sites** at different times toward the end of 2017 and the start of 2018; the data relates to the time period the protocol started in the sites until June 2018. For site specific headline figures, see Annex. To note, we collected data on the number of ATR & DRR, and MHTR & ATR & DRR orders, but none were given across the testbed sites as it is not possible for judiciary to give combined ATR and DRR in one sentence.
[2] *Probation Pink Slips - October 2017 to June 2018* - data not available for Milton Keynes or Northampton (see relevant completeness slide for more information)

85%[1] of offenders seen by the judiciary received a sentence for a CSTR, while the remaining **15%** were sentenced to another type of community or custodial order.[2]



According to information gathered from Sentencers:[3]

- When a CSTR was ordered, the most common length of the order was **12 months**
- The length of orders ranged between **6** months and **2** years.

Of the 15% of individuals not sentenced to a CSTR:[3]

6% of offenders received sentences for **Rehabilitation Activity Requirements**

5% of offenders were given a **custodial sentence**

4% of offenders were given a **curfew**

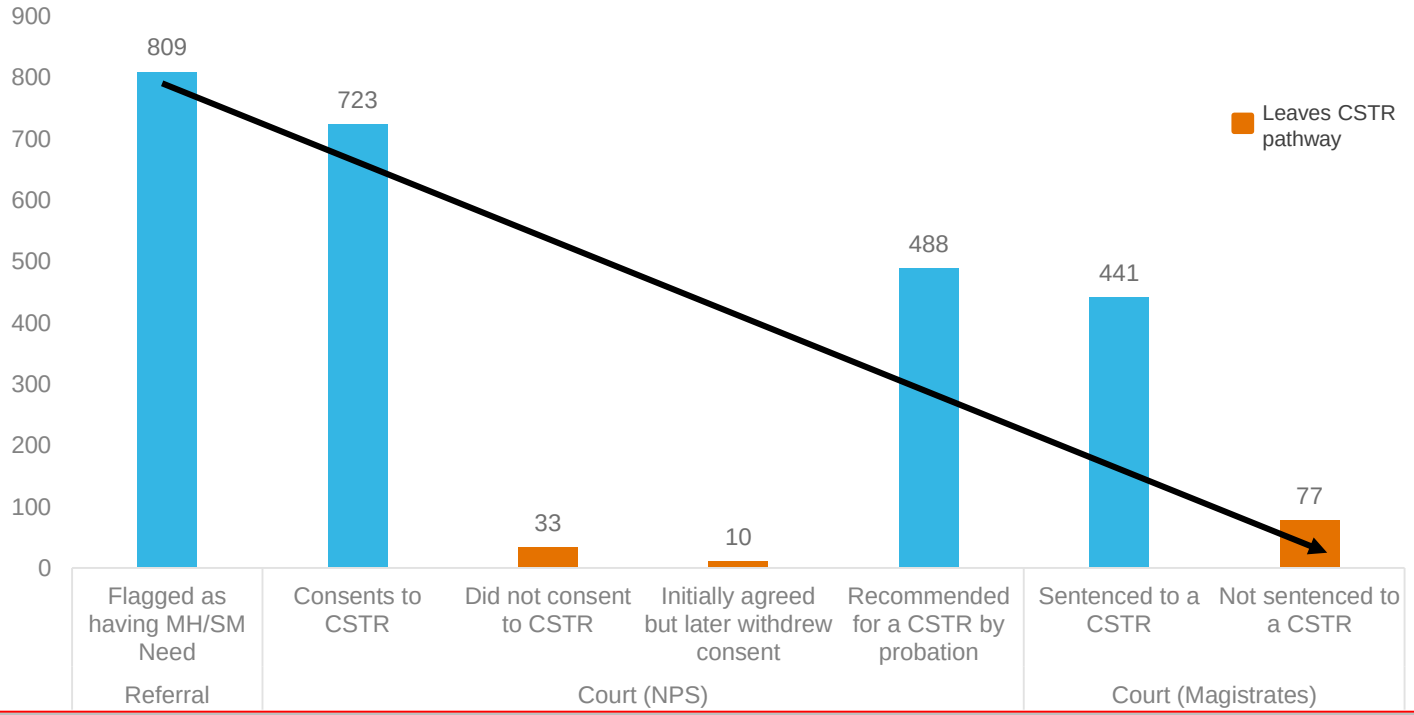
Of those given a **custodial sentence**:[3]

- Sentences ranged from **10** weeks to **220** weeks
- Most offenders were given **10** week sentences
- Others were given sentences of **14**, **16**, **26** and **82** weeks

Between November 2017 and June 2018, it is estimated that between **388 and 412 weeks** of custodial sentences were given when a CSTR was not ordered. [3,4,5]

Note: [1] 85% refers to the number of CSTR sentences given as a proportion of the total number of CSTR sentences given and not given from the Overall Figures data set.
[2] *Overall Figures - October 2017 to June 2018* - different time series submitted for each provider (see relevant completeness slide for more information)
[3] *Sentencer Pink Slip - October 2017 to June 2018* - different time series submitted for each provider (see relevant completeness slide for more information).
[4] *Probation Pink Slips - October 2017 to June 2018* - data not available for Milton Keynes or Northampton (see relevant completeness slide for more information)
[5] Probation and sentencers were both asked this question; due to data completeness, the hours of custodial time differ slightly, so a range of weeks is presented.

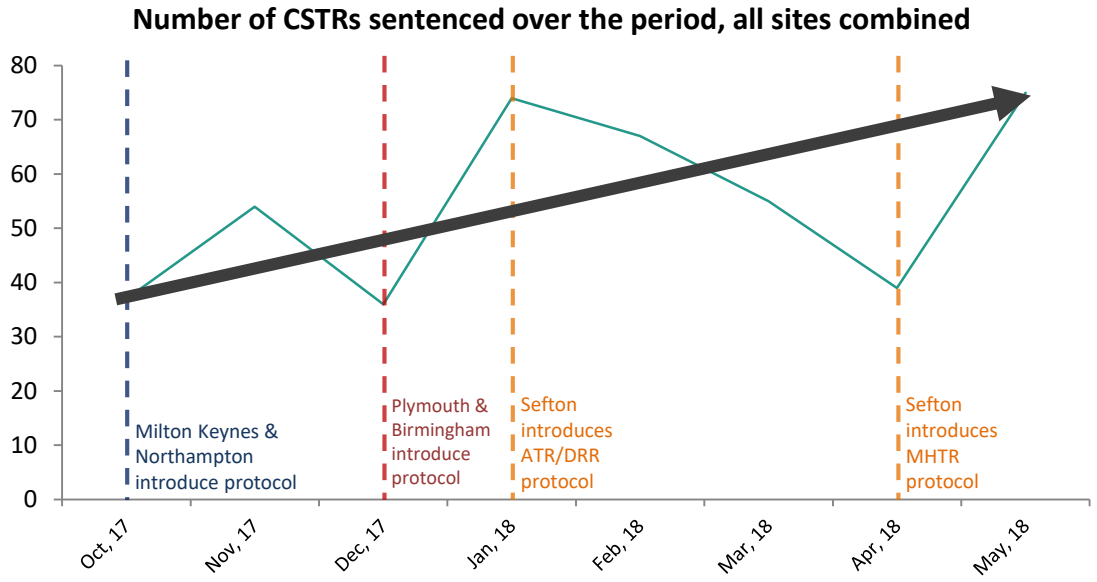
Individuals leave the CSTR pathway at different stages



- **809** individuals were flagged as having **mental health or substance misuse needs** in the CSTR pathway over the duration of the pilot.
- **94% of** individuals who reached the consent stage **consented** to a CSTR (723 of 766). **6% did not consent** or **withdrew consent** for a CSTR
- **488** individuals were **recommended** for a CSTR by probation, and **441** were **sentenced** to a CSTR by judiciary.
- **15%** of offenders seen by judiciary were **not sentenced to a CSTR** (77 of 518)
- **55** offenders **returned to court due to a breach**

Note: *Overall Figures - October 2017 to May 2018* (see relevant completeness slide for more information)
We believe there to be a data quality issue with the "Number assessed and needs identified" data item, this has therefore been omitted from the chart above.
The number who commenced treatment appears to be low (150), it's possible that this has only been recorded for MHTR – this should be used with caution.
The number of sentenced and not-sentenced exceeds those recommended for a CSTR by probation; it may be that the number of recommended is a slight undercount.

Using only the evaluation data, it is difficult to gauge whether the use of CSTRs increased after the protocol was introduced



- It is **difficult to gauge** whether the use of CSTRs changed after the protocol was introduced.
- There was a **slight increase** in the number of offenders sentenced to CSTR between October 2017 and May 2018.
- However, this is mainly due to sites **introducing the protocol at different times** and **submitting differing time series** of data.
- The data does however show a **seasonal effect** in the number of offenders being sentenced to CSTR's.
- Shortfalls in December 17 and April 18 are due to **courts being closed** over Christmas and Easter

Note: *Overall Figures - October 2017 to May 2018* (data for June has been excluded from this graph as information was only available from 2 sites (see relevant completeness slide for more information). For site specific changes in MHTR, ATR and DRR, see Annex L.

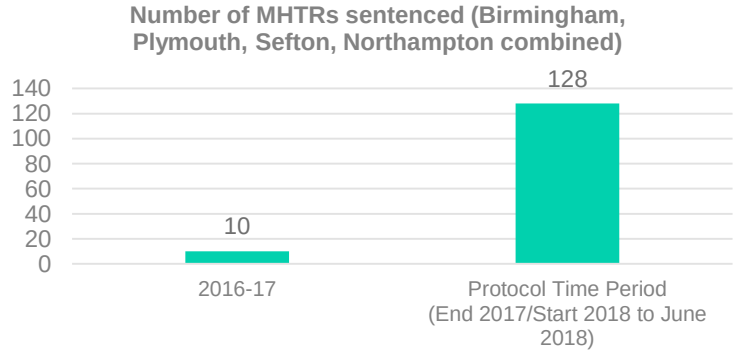
Compared to 2016-17, the process evaluation data suggests there has been an increase in MHTRs

Milton Keynes was excluded from MHTR comparison; they started a form of the protocol earlier than other testbed sites, so there was no clean comparison.

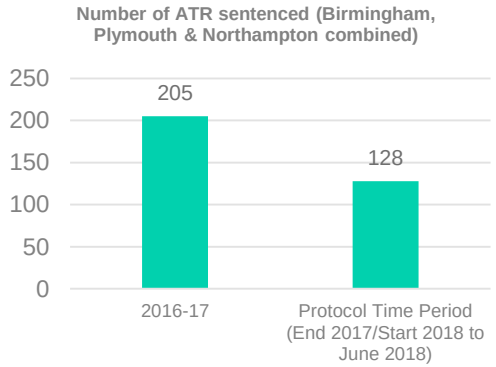
Only Birmingham, Plymouth and Northampton were able to provide the number of ATR and DRR sentences from 2016-17.

MHTR

- In **2016-17**, four testbeds reported sentencing **10 MHTRs** (excluding Milton Keynes as they implemented the protocol earlier).
- Between the protocol being introduced and June 2018, **128 MHTRs** were sentenced in the same four testbeds.



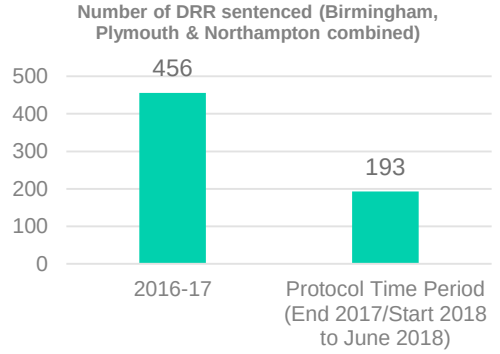
ATR



- In **2016-17**, **205 ATRs** were given in Birmingham, Plymouth and Northampton.
- Between the protocol being introduced and June 2018, **128 ATRs** were given across these three testbed sites.

DRR

- In **2016-17**, **456 ATRs** were given across Birmingham, Plymouth and Northampton.
- Between the protocol being introduced and June 2018, **193 ATRs** were given across these three testbed sites.



Note: *Overall Figures - October 2017 to June 2018* - different time series submitted for each provider (see relevant completeness slide for more information). These figures are **not directly comparable**, because the time periods are different. In addition, the process evaluation **did not use controlled conditions (e.g. Randomised Control Trial)** so we cannot attribute this increase only to the introduction of the protocol – it is likely that it contributed to the increase, but it may additionally or instead be due to other unknown external factors.

4. DEVELOPING THE CSTR PATHWAY

5.1 Identification and assessment
5.2 Service user engagement
5.3 Learning from best practice

4.1 IDENTIFICATION AND ASSESSMENT

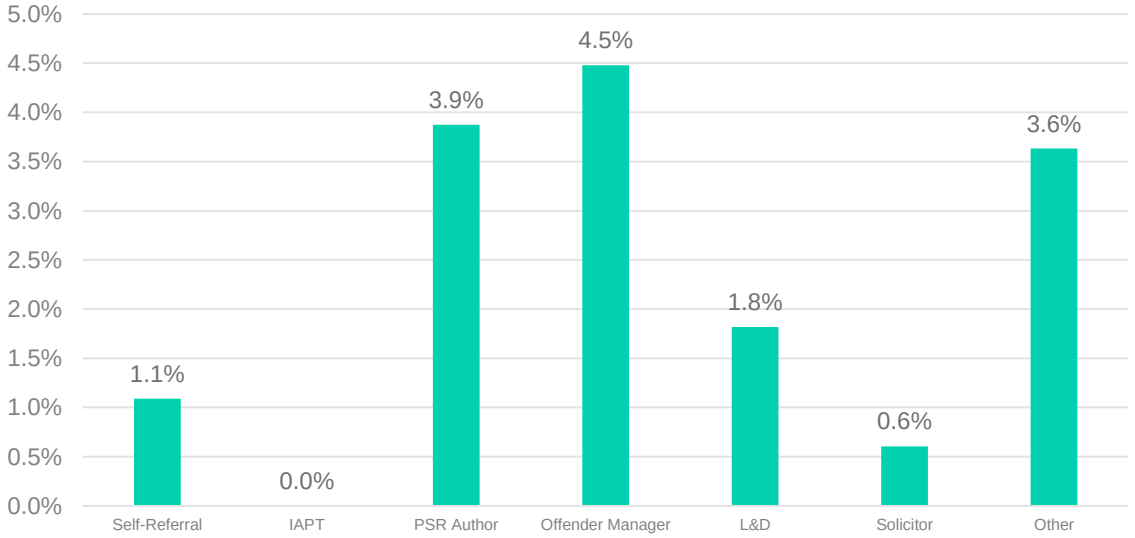
- Number of screenings in testbed sites
- Challenges for staff time
- Challenges in screenings for need

Since the CSTR protocol was introduced, **809** individuals were screened for a CSTR across the five pilot sites. Most screenings were for substance misuse problems (69%), with almost a third for mental health problems (31%).[1]

Most referrals for screening came from the **Court Duty Officer**[1]

- **85%** of referrals came from the '**Court Duty Officer**' while only **2%** came from '**L&D**'
- Amongst the **4%** of referrals that were recorded as '**Other**', the test bed sites listed referrals from:
  - **Police in custody**
  - **Arrest referral worker, and**
  - **Judiciary**

Most referrals came from the Court Duty Officer (85%), the remaining 15% came from several other sources:



Note: [1] *Overall Figures - October 2017 to June 2018* - different time series submitted for each provider (see relevant completeness slide for more information)

Practitioners encountered challenges in staff time for CSTR identification and assessment:

Capacity within the identification and screening process

Particularly where reliant on pre-existing Liaison and Diversion teams rather than having **additional staff in the courts** (e.g. assistant psychologists)

→ L&D focus on **severe mental health** problems

→ Identifying service users who would be eligible for the new MHTR pathway was an **addition to existing L&D priorities**

Fast pace at which courts operate & **accessing** court lists

Solution: Have dedicated staff in the court

The staff don't get enough time to kind of sift out and triage who should be going where…
*So L&D will be **prioritising the secondary care**.*
*The lower-level ones… I believe that **there are more clients that we could pick up** if that process is right.* Commissioner

Limited availability of Clinical Lead

Sometimes only **available for an hour a day**, although an improvement since before the pilot

→ **Solution:** Extend availability of Clinical Lead

Identification of cases **later** in the day

Solution: Arrange meetings to review the court lists first thing in the morning and change timings of staff availability for assessments to later in the day

Note: *NIHR MH PRU qualitative stakeholder interviews*

Practitioners identified challenges when screening for mental health and substance misuse needs

Unsuitable referrals for MHTR

Often found at the start of the pilot, due to mental health problems being too severe

Solution: Better communication between mental health practitioners, L&D, probation and court staff

Solution: Manage expectations about whose needs could be addressed by the MHTR pathway

Solution: Multi-disciplinary pre-court meetings were valuable for identifying individuals suitable for MHTR

Service user motivation to change

Concerns that being in court could lead individuals to exaggerate symptoms and motivation to change

If you say to people, "Do you want a bit of therapy or do you want court?" they're going to say, "I'll have the therapy," because why wouldn't you? Mental Health Services

Challenges in using assessment tools

Burden on service users from multiple assessments from different agencies

One individual felt frustration from assessing service users as not suitable for ATR or DRR but still being granted by the court

Stresses of court environment could lead to genuine but short-term elevation of symptoms

Jargon used and tick-box nature of screening tools prevent practitioner building rapport

I saw someone the other day, facing a prison sentence potentially, and they're you know panicking and shaky. So perhaps the elevation of symptoms is a natural phenomenon that you see in a court setting. Mental Health Services

Belief that clinical judgement from experienced professionals was more valuable than screening tools

Note: *NIHR MH PRU qualitative stakeholder interviews*

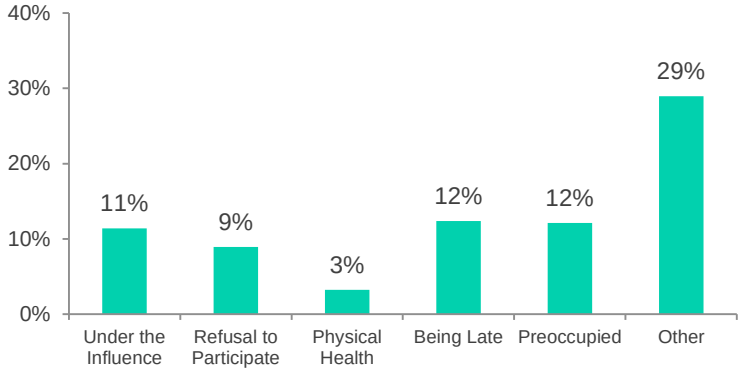
4.2 SERVICE USER ENGAGEMENT

- Missed appointments in testbed sites
- Breach
- Compulsion and consent
- Facilitators & barriers to engagement

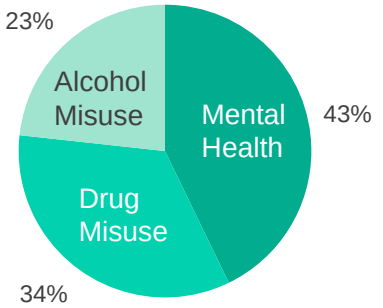
Between October 2017 and June 2018, **137** offenders missed at least 2 appointments across the 5 sites.[1] To understand the barriers service users might face in attending appointments, treatment services were asked for reasons why appointments were missed:

- The most common reason for missing an appointment was recorded as '**Other**' (29%), the next most common reasons were '**Being Late**' (12%) and being '**Preoccupied**' (12%) [2]
- Information was not collected to capture the reasons behind 'Other' [2]
- The most missed appointments were for **mental health** treatment (43%) [2]

Reason given for missing appointment[2]



Missed appointments by treatment type[2]



Note: [1] *Overall Figures - October 2017 to June 2018* - different time series submitted for each provider (see relevant completeness slide for more information)
[2] *Treatment Data - October 2017 to June 2018* - different time series submitted for each provider (see relevant completeness slide for more information)

Many stakeholders highlighted that breach had been rare in the testbed sites so far.[2] 55 offenders had returned to court due to breach.[1]

Helpful steps[2]

Last resort, only used after attempts had been made to re-engage the service user

We would look at the overall context or schedules of expectations, those sorts of ways of trying to secure compliance, before we actually go back down the route of taking them back to court

Probation Services

In some areas, **support workers** helped to re-engage service users who had missed appointments

Useful to visit **other testbeds** to see how breach was deal with

Mid-sentence reviews were seen by judiciary as a potentially valuable way to prevent breach

Note: [1] *Overall figures - October 2017 to June 2018 -* different time series submitted for each provider (see relevant completeness slide for more information); [2] *NIHR MH PRU qualitative stakeholder interviews* [3] *Clinks focus groups with service users.*

Testbed stakeholder concerns[2]

Individuals with mental health difficulties could be breached and potentially **sent to prison** for not attending MHTR appts

Some MH services felt they should be involved in **breach decisions** whereas others did not

if there was more robust enforcement of it, we would probably be more willing to take on the cases that we know have had poor engagement in the past

Drug & Alcohol Services

Enforcement: Some suggested that service users were not being breached even when they felt they should have been. This led to a lack of trust in probation and a reluctance to take on service users with a history of poor engagement

If **waiting times** for MHTRs increased, this could impact sentencer confidence in MHTRs if individuals were breached because they were unable to do the order in time

Judiciary felt the breach process needed to be balanced between considering **complexities of lives** and sufficiently robust that the **sentences remain rigorous**

Testbed challenges[2]

Some MH/SM providers had **limited understanding** of breach processes
- **Unable to describe criteria** for breach and unsure of consequences of breach

Challenging to **maintain engagement** with service users
- Aided by structure of requirement.
- Also aided if combined with broader social support, otherwise rates of breach would be much higher

Judiciary concern that breach was being used **as a sort of review process** → diminishes significance of breach → better to have a review process

Service users' concerns[3]

Concerns about:
- **Consequences** for missing an appointment, e.g. return to court/ custodial sentence
- Courts would **give up** on service users too quickly

CSTRs should include:
- **Requirements** for treatment engagement
- **Consequences** of not engaging
- **Rewards** for success (e.g. providing family interventions/practical support)
- **Allowances** for 'real life'/mitigating factors
- Proportionate **sanctions**
- **Proactive attempts** to reengage service users, if they stop attending appointments

Note: Service users were outside testbed sites, their views do not relate to practice during the pilot

Motivation and consent was a concern of practitioners and service users

Across 2 sites, 5 out of 24 cases were not recommended by probation for a CSTR because the individual did not consent.[1]

Across 3 sites, 2 out of 17 cases were not sentenced to a CSTR by judiciary because the individual did not consent.[2]

Positives

- Practitioners were initially concerned that offenders would not want to **engage** with the mental health treatment programme, but most said that this had not appeared to be an issue in practice. [3]
- Enforcement by court was seen as an additional external motivation to **maintain engagement** with treatment. [3]

Concerns

- Court ordered service users often **lacked intrinsic motivation** to engage with psychological therapy or substance misuse treatment, which reduces meaningfulness of engagement [3]
- Service users may feel compelled to **report /exaggerate positive impacts** on their mental health [3]
- Concern about compulsion and **human rights** was mentioned, but less frequently than positive of enhanced motivation [3]

they haven't gone through that process where they want their own change, it's been ordered on them by a court. And often there is a struggle for them to be motivated and to want to change their lives

Drug & Alcohol Services

Service users outside the testbed sites suggested that: [4]

The feeling that treatment was being **forced** on them could **hinder relationships** with professionals, but this could be overcome through compassion, consistency, good communication and being listened to.

People may not always have been given **sufficient time** and **information** to fully understand and consent to the treatment requirements before the sentence is imposed.

Service users felt they should have the requirements of CSTRs fully explained to them during the consent process. They also felt that practitioners carrying out the assessments should

- Have the **knowledge** and **skills** to unpack the individual's needs and circumstances, and match these to available **services and treatment**
- Be able to support the person in making an **informed decision** on whether to consent to treatment, through providing **good quality information** and using **motivational techniques** where necessary

Note: Service users were outside testbed sites, their views do not relate to practice during the pilot

Note: [1] *Probation Pink Slips - October 2017 to June 2018* - data not available for Milton Keynes or Northampton (see relevant completeness slide for more information). Birmingham were unable to collect Pink Slips, their information is therefore constrained to what is collected in the NPS database and cannot be included in this section as the data is not comparable. [2] *Sentencer Pink Slip - October 2017 to June 2018* - different time series submitted for each provider (see relevant completeness slide for more information). Only Northampton, Sefton and Milton Keynes were able to provide information for this question. [3] *NIHR PRU Qualitative Stakeholder Interviews.* [4] *Clinks focus groups with service users.* Note that service users were outside testbed sites, their views do not relate to practice **during** the pilot

Structured treatment was mentioned as important for service user engagement by stakeholders within the testbeds and service users outside the testbeds

Within testbeds: [1]

Maintaining engage was seen to be a challenge for many of the service users, given the complex and chaotic nature of their lives; the structure of the treatment requirements was thought to be beneficial.

Judiciary felt reviews provided **additional support** to and motivation for service users e.g. DRRs

> *We like the review for the DRR because it does give an opportunity to engage with that individual and say, "Actually you're doing really, really well. Carry on doing that. We know it's difficult."*
>
> Judiciary

The importance of **structured treatment** was also mentioned by service users **outside testbed sites**: [2]

Regular meetings and appointments to **remain focussed** on treatment

Service user involvement in design of care and treatment plans
- Service user must agree with need for treatment and take personal responsibility for change

Be clear about **requirements** for engaging with treatment and consequences of not doing so

Having the **same person** delivering the treatment throughout was also seen as key to building **trust**.

Women should be offered **gender-specific groups** to be able to discuss issues which they may not feel comfortable discussing with men.

Note: [1] *NIHR MH PRU qualitative stakeholder interviews* [2] *Clinks focus groups with service users.*

Note: Service users were outside testbed sites, their views do not relate to practice during the pilot

Strong service user and key worker relationships were identified as a key facilitator to service user engagement

Within testbeds: [1]

Broader support to help people benefit fully from psychological or substance misuse treatments, which included:

- Help with housing or benefits or registering with a GP
- Addressing barriers that might prevent service users from attending CSTR appointments

I think it's a big ask if you divert someone [to CSTR] and then expect them to take off and just take themselves there [to treatment]. If it was that easy they'd have done it before. Judiciary

*we can do the psychological work, but obviously these clients live within a **social context**. And what we do in a room for an hour can be very quickly undone* Mental Health Services

Build relationships between service users and frontline professionals (particularly for those who had previously felt let down by services)

I think that's certainly been an inherent part of why I think, here, it's been successful, because we've had that money to continue that service to provide that additional help and support, which isn't really probation, isn't really health, isn't really to do with the offending. It's more about providing practical assistance for that individual to then let them engage. Judiciary

Service users **outside testbed sites** also indicated the importance of relationships for service user engagement: [2]

Women-only focus groups referred specifically to the **need for compassion** and **empathy** from staff delivering a CSTR

Peer supporters should be included as part of the package of support provided as part of a CSTR [2]

Some service users wanted **advocates** (e.g. peer supporter, key worker), especially when amending a CSTR or compliance concerns

Have the opportunity to draw on **family & friend support**

Note: [1] *NIHR MH PRU qualitative stakeholder interviews* [2] *Clinks focus groups with service users.*

Note: Service users were outside testbed sites, their views do not relate to practice during the pilot

Considering individual needs was seen as a facilitator of service user engagement

They need services that are much more, as you say, personalised – and that there's a greater understanding of the context of the services

Mental Health Services

Service users outside of testbed sites mentioned: [2]

- Make allowances for **'real life'**
- Practitioners carrying out the assessments should have the **knowledge** and **skills** to unpack the individual's needs and circumstances, and match these to available **services and treatment**
- Treatment should take into account:
  - **Individual needs**
  - **Changes** in other activities
  - **Peaks** and **troughs** in recovery
- Consider **individual circumstances and progress made**

Note: Service users were outside testbed sites, their views do not relate to practice during the pilot

Within testbeds, stakeholders underlined the importance of understanding individual needs: [1]

- Understand variety of **social needs** experienced by service users and provide them with appropriate support
- The **level of motivation** that service users had to engage with CSTRs was seen as crucial, both for **completion rates** and for CSTRs to have a **beneficial** effect
  - Those who had **previously tried to access** mental health support **unsuccessfully** might be particularly motivated to engage with the MHTR intervention
- **Sequence** multiple orders

Note: [1] *NIHR MH PRU qualitative stakeholder interviews*
[2] *Clinks focus groups with service users.*

- Explore service users' **motivation** during the assessment and consent processes
- Service users might **develop** motivation to change over the course of treatment

People think, "Do you know what? I need to do something. I need to change things around." Drug & Alcohol Services

- Start MHTR treatment sessions by:
  - Focusing on **engagement**
  - Encouraging service users to identify and consider their **values**
  - Focusing on **practical issues** e.g. sleep so service users would experience some immediate benefits and feel motivated to continue to engage (although strategies were not always successful)

Practitioners and service users identified potential barriers to accessing and engaging with a CSTR[2,3]

In the decision making process…

Previous breach & poor compliance

Across 2 sites, **5 out of 24** cases were not recommended for a CSTR due to **previously failing** a CSTR.[1]

Stakeholders indicated SM services could be **reluctant** to assess and engage with people who had previously shown **poor compliance** with the service [2]

- But other SM practitioners were happy to give multiple chances to go through programme

But: service users suggested that a previous breach should **not necessarily block** them from being considered for a CSTR again. [3]

- Courts should **consider the individual circumstances** and progress made.

Engaging with treatment…

Excluding homeless clients

In one site, one individual (of 28 cases noted) was not approved for CSTR by the responsible clinician due to having no stable **accommodation**.[5]

Some stakeholders cautioned that it was **more difficult** for homeless people to benefit from CSTRs [2]

Service users outside of testbeds felt homeless people were often **excluded** from CSTRs due to the **perceived difficulty** in enforcing the sentence [3, 4]

Burden on service users

Stakeholders in testbeds felt there might be a **burden on service users** with multiple requirements (e.g. MHTR + ATR) or living far away [2]

- Testbeds managed this by sequencing and considering individual circumstances

Service users outside testbeds suggested there should be support for people to travel to **regular appointments**, e.g. rural areas [3]

For people with **low incomes** or who are **struggling financially**, any costs could **prevent** sentence completion

In the wider programme…

Public & media perceptions

One service user focus group was concerned that **public opinion** and **media** influence could be a barrier to enabling these sentences to work [3]

If there was an **incident** around an individual on a CSTR this could **jeopardise** the process and propel the feeling the public were being **'put at risk'** [3]

Note: Service users were outside testbed sites, their views do not relate to practice during the pilot

Note: [1] *Probation Pink Slips - October 2017 to June 2018* - data not available for Milton Keynes or Northampton (see relevant completeness slide for more information). Birmingham were unable to collect Pink Slips, their information is therefore constrained to what is collected in the NPS database and cannot be included in this section as the data is not comparable. [2] *NIHR MH PRU qualitative stakeholder interviews.* [3] *Clinks focus groups with service users.* [4] *From the quantitative data, we are unable to say how many homeless people were sentenced to a CSTR.* [5] *Birmingham NPS data (provided as they were unable to collect Pink Slips)*

4.3 LEARNING FROM BEST PRACTICE ACROSS SITES

- Testbed visits
- Pre-existing documentation
- Communication

A key success factor was the opportunity to share best practice and learn from both the successes and challenges of other sites.

- **Visiting sites** already running the MHTR pathway when setting up **alleviates concerns** and **builds enthusiasm**
- Using **pre-existing documentation** & learning from other sites' **processes** increased **efficiency**
- Support from the **overall programme manager** was seen as very helpful
- **Communication** between sites, e.g. discussions between clinical leads

You need to learn from each other and pinch the good stuff, and why wouldn't you? Liaison & Diversion Services

I think one of the best things they could do, really, is to contact one of the existing sites … See the enthusiasm, see what it has done, and I'm sure that they would be persuaded 100% Judiciary

Being able to talk aloud, because I realised that I don't sometimes. I go and give supervision, but I don't have that reflective time to think about overseeing it all. It's quite helpful to talk to peers to do that Mental Health Services

Note: *NIHR MH PRU qualitative stakeholder interviews*

5. HOW TO PLAN BETTER SERVICE PROVISION

6.1 Gaps in service provision
6.2 Multi-agency working
6.3 Understanding the benefits of CSTR provision
6.4 Funding
6.5 Guidance

5.1 GAPS IN SERVICE PROVISION

- Filling a service gap: Provision before the pilot
- MHTR service provision in the testbed sites
- Gaps remaining in service provision

Stakeholders emphasised the need for more CSTRs

They felt there was a need for alternatives to the revolving cycle of short term prison sentences, citing several reasons:

Negative impact of short-term custodial sentences on people's lives

> *We know if someone goes into prison for a short custodial sentence, nothing happens. It's just straight punishment. They'll come out with the same, if not more, problems than they had before because they'll have lost their benefits and probably lost their house if they had one.* Judiciary

Not perceived to be effective in reducing reoffending, particularly for those who have been through the system multiple times

> *They've been to prison for six weeks; they've been in and out of prison for the last 10 years, is it actually going to make a change on that occasion?* Liaison & Diversion

Interventions that address underlying causes of offending behaviour are needed

> *Until the push on increasing the therapeutic treatment requirements came in, benches, and I suspect more senior judges, were missing a tool that could very valuably be deployed.* Judiciary

High cost for the criminal justice system

However, judiciary were also unsure what additional benefit the MHTR would bring for people who already had **substantial input** from secondary mental health services

> *I didn't make [an MHTR] because the people who were proposed for them were usually already known to specialist services* Judiciary

Note: *NIHR MH PRU qualitative stakeholder interviews*

The MHTR pathway had filled a gap in services for mental health needs

Stakeholders felt there had been limited access for offenders to suitable mental health services

Probation indicated that most offenders **did not** already have a **treatment plan** in place[1]

- **71%** had no treatment in place
- **21%** of offenders were already in treatment
- **7%** had a treatment plan arranged

Multiple and **complex needs** experienced by many individuals in the criminal justice population were also seen to make it particularly difficult for them to **access services** in the community

For example, **mental health services** often do not accept service users with **comorbid** drug or alcohol needs

> *A lot of people who I work with, they've had abusive pasts. There's been real trauma that's happened in their lives, and they've started taking drugs as a way of being able to cope with that and almost keep a lid on some of those feelings and emotions.*
>
> Drug & Alcohol Services

Long waiting times for community mental health services were also a **barrier** to the use of CSTRs

> *There are very **few services** at the moment, that can support the needs of this, very difficult to engage, and extremely vulnerable group*
>
> Mental Health Services

> *if they were able to access this **within the community**, they would be doing it. They can't, that's why they're in the position that they're in*
>
> Third Sector Organization

> *The group that we talked about, that don't **reach the threshold** of secondary care mental health services, there is a commissioning gap*
>
> Mental Health Services

Note: [1] *Probation Pink Slips - October 2017 to June 2018* - data not available for Milton Keynes or Northampton (see relevant completeness slide for more information). [2] *NIHR MH PRU qualitative stakeholder interviews*.

Testbeds provided a service for individuals who had otherwise experienced challenges accessing MH services

Characteristics of MHTR services in testbed sites:

- More flexible approach to meet needs of service users
- Service users were generally seen to be eligible as long as they could engage with therapy
- MHTRs could now be offered to offenders who didn't meet criteria for secondary mental health services
- **Improved access to services** for those with comorbid MH and SM needs
- MH services in the community can have "very rigid criteria about abstinence"
- Increasing access to **further mental health** services or **other support services**
  - 12 week MHTR programme would not fully address complex needs of this group
  - Traditionally hard to reach group could be referred on to other services after MHTR completion

Members of the judiciary also emphasised that, as a court sentence, the **length and intensity** of the mental health intervention had to be **proportionate** to the offence, rather than based on the mental health needs of the offender

Challenges encountered in MHTR services:

- Challenges in **capacity** within treatment provision
- Issues finding suitable rooms to conduct treatments (in some sites)
- Having to provide treatments in **different premises** depending on whether service users were being managed by NPS or CRC

Note: *NIHR MH PRU qualitative stakeholder interviews*

The most common needs of offenders across sites were **Depression**, **Anxiety**, **Heroin use** and **Dependent Alcohol Use**

Mental Health

- **All five sites** reported offenders with **depression** and **anxiety**
- **3 out of 5 sites** reported needs related to **Post Traumatic Stress Disorder** and **trauma**
- **2 out of five sites** had cases of **bipolar** and **phobia disorders**
- Other needs reported less frequently were **panic disorder**, **OCD**, **adjustment disorder**, **bereavement**, **personality disorder**, **psychosis**, **delusional disorder**, **autism** and **stress**

Drug Misuse

- **All five sites** of sites reported offenders using **heroin**
- **4 out of 5 sites** reported offenders using **cocaine**
- **2 out of five sites** reported **opiate** use and offenders using **injecting drugs**
- **1 site** reported offenders with **cannabis** use

Alcohol Misuse

- **4 out of 5 sites** reported offenders with **dependent alcohol use**
- **2 out of five sites** reported **problematic alcohol use** and **binge drinking**

Due to the way the data was collected we don't know the **scale of the problem** in each site but we can infer the **most common needs across sites**

Note: Treatment Data - October 2017 to June 2018 - different time series submitted for each provider (see relevant completeness slide for more information)

However, a gap in services remains for those offenders with complex and serious mental illness

Some challenges in provision still exist for those with:[3]

- **Comorbidities**
- **Complex** needs
- **Severe** mental health problems

*the area that's lacking is the **more serious mental health issues***
Probation Service

*the need really lies – we think – with the more **serious mental health** cases*
Probation Service

- Across 2 sites, of 17 cases noted, one was not accepted in court by judiciary for being "**too serious**".[1]
- Across 3 sites, of 17 cases noted, one case was not sentenced to a CSTR because they were **not accepted by a service provider**. Another case was not sentenced as they were **already in mental health services**.[1]

- Intervention focused on relatively **low level mental health needs***
- Of those with primary care level problems, many had also experienced **substantial trauma** or **other complexities**
- However, some stakeholders said service users were **not ready to engage** in more intensive therapy when they started MHTRs
- MHTR treatments were provided by **relatively inexperienced practitioners.**

Some stakeholders felt there was a need to focus on facilitating **secondary care MHTRs**, **but** some concerns from stakeholders about **likelihood of breach** and that MHTRs would have **limited value** for those **already in contact** with MH services

Note: [1] *Probation Pink Slips - October 2017 to June 2018* - data not available for Milton Keynes or Northampton (see relevant completeness slide for more information). Birmingham were unable to collect Pink Slip's, their information is therefore constrained to what is collected in the NPS database and cannot be included in this section as the data is not comparable. [2] *Sentencer Pink Slip - October 2017 to June 2018* - different time series submitted for each provider (see relevant completeness slide for more information). [3] *NIHR PRU Qualitative Stakeholder Interviews.*

***** For more information on the **treatment** given as part of the primary care **MHTR pathway**, see Annex M.

5.2 MULTI-AGENCY WORKING

- Facilitators
- Barriers and challenges

Multi-agency working was identified as a key aspect of success for the CSTR programme[1]

Clarity

Clarity about each other's **finances**, **roles** and **responsibilities,** including **budget**

- **Joint working documents**
- Detailed **process maps**
- Clearer **protocols**
- I**nformation-sharing** protocols* and early development of **operational processes**
- **Manage expectations** around who is suitable for MHTR pathway

* Alongside a holistic package of support include **accommodation, benefits, education and family relationships,** this was also highlighted as a facilitator to success implementation of CSTRs by service users (note most did not have experience of CSTR, and were not in the testbed sites).[2]

I think one of the really important things is that the process of assessment and treatment delivery is really clear to everybody who has a role in that – and that everybody is clear about what their responsibilities are. I think that's one of the good things about the pilot, that we have achieved that.

Probation

It's probably the best example of a partnership arrangement I've been involved because everybody's seen the benefits of it and really committed, not just in turning up to the meetings and then going away and not doing anything, but actually doing stuff

Steering Group Chair

CSTR programme complemented ongoing work to improve multi-agency working

e.g. improved communication between probation and drug & alcohol services led to development of a shared spreadsheet showing the start and end dates for all ATRs and DRRs.

Structure

Operational as well as strategic **steering** group meetings

- **Co-location** of services

*It becomes a **natural synergy** of various agencies within one environment*

Probation Service

- **Joint management meetings** (probation, client and CSTR providers) after sentencing
- **NHS email accounts** for non-NHS partners to send information securely
- **Referral forms** for all agencies to add information to (rather than ad hoc telephone communication)

Note: [1] *NIHR PRU Qualitative Stakeholder Interviews.* [2] *Clinks focus groups with service users.*

Multi-agency working was identified as a key aspect of success for the CSTR programme[1]

Relationships

Dedicated team to identify and work on CSTRs, including available responsible clinician

Strong relationships between staff *

Crucial that judiciary were confident in the work of other services, as they relied on assessment and delivery teams

Useful for mental health practitioners to have **prior experience** relevant to multi-agency nature of CSTRs
If inexperienced, important to have **support** from L&D, third sector and clinical supervisors

*Anything that will **help a defendant** is always welcomed* Probation Service

Enhanced **communication**

It's not organisations that make difference, it's people, it's stakeholders, people who care Judiciary

The grassroots pressure, combined with increasing interest by senior civil servants and ministers and in sentencing policy that works rather than sentencing policy that doesn't, has led to a very fruitful coming together… You don't often get a situation where the academics, the deliverers and the policy makers are saying, "We've got to do something here." Judiciary

The crux and the key is the mental health professional who gives the thumbs up to an order from court… That's why this works over and above I think anywhere else Probation

They're helped by the fact that we've got mental health workers in court, who know a lot of the defence, or know of them. They're in a situation where they can make the recommendation and that recommendation is sufficient for the order to be made on the day… It's like being in Utopia, as it were, from the court's point of view, yes. Judiciary

* These, alongside a holistic package of support include **accommodation, benefits, education and family relationships,** were also highlighted as facilitators to success implementation of CSTRs by service users (note most did not have experience of CSTR, and were not in the testbed sites).[2]

Stakeholders

High motivation among stakeholders to engage with pilot

Steering group should be:

Multi-agency*

Non-confrontational

Regular meetings to keep people accountable

Seniority of members to facilitate implementation

Focused on finding **workable solutions**

Training, away days and **presence in court** facilitates stakeholder engagement

Note: [1] *NIHR PRU Qualitative Stakeholder Interviews.* [2] *Clinks focus groups with service users.*

Limited knowledge and experience were considered challenges to multi-agency working

Limited knowledge

Limited understanding of aspects of other agencies' work
- Functioning of court
- Structure of mental health or probation services

Some concern **about lack of belief or evidence** for effectiveness of CSTRs (but less common than belief in effectiveness)
- Need for evidence to make a **business case for** continue provision of service
- Need for **positive case studies** to motivate other professionals to engage with CSTRs

People want to see evidence… they want to hear good news stories.
Steering Group Chair

Note: *NIHR MH PRU qualitative stakeholder interviews*

Limited experience

Professionals not used to working with the **criminal justice** population
- Reluctance or refusal of some MH organisations to provide treatment spaces for people involved in the CJS

Anxiety of MH professionals about **risk of violence**
- Alleviated by putting clear process in place to monitor and respond to risk

Stigma, anxiety and **lack of awareness** about mental health, substance misuse and/or criminal justice
- Concern that this would reduce staff motivation, but some felt that this was less of an issue than anticipated

Organisations' different ways of working and competing priorities were also seen to be challenges to multi-agency working

Different ways of working

Different expertise, organisational **processes** and ways organisations viewed **service users**

*The **client** or the **participant**, **offender**, **defendant** – everyone calls that same person a different name* Steering Group Chair

Difference in **importance of consent**

Substance misuse workers *"can't do anything without client consent"*, but *"consent is not a big issue for the staff in [probation]"* Drug and Alcohol Services

Challenges with **communication** between agencies
- Aided by NHS email accounts & creation of referral form

We're not all singing from the same hymn sheet Probation Service

Differences in **staff motivation** within agencies
- Facilitated by belief in effectiveness of CSTRs

Competing priorities

Need for **time to conduct assessments** could clash with drive for same day sentencing
- Some tried to achieve **same day sentencing** wherever possible, others suggested **adjournment** might be necessary for a thorough assessment

L&D need to respond to **severe mental illness**

Concerns from non-judiciary that CSTRs could encourage **up-tariffing** or judiciary would not want to be seen as **overly lenient**

Judiciary highlighted importance of sentences being **proportionate** as MHTRs are **criminal justice interventions** with mental health service involvement, rather than being provided directly as mental health interventions

Post-sentencing relationships, particularly with CRCs, had not received enough attention in the testbeds to date

Note: *NIHR MH PRU qualitative stakeholder interviews*

5.3 UNDERSTANDING THE BENEFITS

- Improving sentencing options
- Increasing access to MH treatment
- Positive impact for service users

Stakeholders identified three key areas to benefit from CSTRs:

1. Improving sentencing options

Facilitated the use of MHTRs and made them applicable for a **larger proportion** of offenders

> *It's about **giving people choice**, decision makers choice, but also people who, potentially, can **overcome difficulties** [and] have an impact on their life, moving forward. Who wouldn't want to develop a **range of options** that give us better choices for people?* Commissioner

Improved **knowledge**, **awareness** and **skills of staff** regarding mental health

- Benefits extend beyond CSTR programme,
- Improves the way that probation staff engage with other offenders

> *As a base level, people are now far more tuned in to thinking, "Is that [MHTR] something I should be thinking about?"* Judiciary

Addresses **underlying factors** that:

- **Contribute** to offending behaviour
- **Hinder** effective rehabilitation

> *The MHTR is designed to provide, as I understand it, a significant level of psychological intervention while not over medicalising the problem, while also providing the levels of social support that deal with the chaotic lifestyle issues, as well as the traumatic issues that may be causing, or part of the cause of the offending* Judiciary

More **holistic sentencing approach**

- Judiciary said they were more likely to sentence multiple treatment requirements, partly due to increased confidence they would be properly coordinated by agencies working closely together

Potential **reductions in reoffending**

- Judiciary felt that MHTR pathway could provide MH and social support to help reduce reoffending, without removing responsibility for offence committed

> *It's about reducing offending, isn't it, and improving people's quality of life, because offending behaviour just doesn't affect the individual? It affects the victim, it affects the community; it affects all of us.* Drug & Alcohol Services

Note: *NIHR MH PRU qualitative stakeholder interviews*

Stakeholders identified three key areas to benefit from CSTRs:

1. Improving sentencing options

Reduce **reliance on custodial sentences**[1]

- Avoids negative impact of custody for offenders and their families
- Stakeholders felt substance misuse treatments was more likely to have a long-term positive impact if they are given in the community in the context of people's ordinary lives
- Saves resources due to the high costs of prison sentences
- However, some judiciary noted that they should be imposing community rather than custodial sentences anyway, if appropriate for the offence committed.

Members of the judiciary were asked "If you **did** include an CSTR **what would your** sentence have been if this was not available?"[2]

37 responses were received for this question

In almost half of cases, judiciary said they would have sentenced the individual to **custody** instead (49%).

Where judiciary specified length of order:

- Most sentences would have been for **12 or 16 weeks**.
- Sentences would have ranged from **8 to 26 weeks**.

In total, judiciary said they would have given **318 weeks** of custodial sentences, if a CSTR had not been available for 18 individuals.

The **second most** frequently used alternative order would have been a Community Order, then a High Community Order. Other, less frequently used sentences included suspended sentence orders, curfew, or increased RAR days.

Note: [1] *NIHR MH PRU qualitative stakeholder interviews*. [2] *Sentencer Pink Slip - October 2017 to June 2018* - different time series submitted for each provider (see completeness slide for more information). This data is hypothetical and therefore must be treated with caution. Only 37 responses were received to this question, and therefore the data may not be representative of all CSTRs sentenced or judiciary involved. It does suggest that in some cases, a CSTR may have been used as an alternative to a custodial sentence, but this must be treated with caution as we do not know the specific circumstances of these cases.

Stakeholders identified three key areas to benefit from CSTRs:

2. Improving access to mental health treatments

Filled **gap in services,** for offenders who did not meet criteria for secondary care mental health services

More **inclusive** & caters for **complexity of need**

No waiting lists

- Common for those receiving CSTRs to have been let down by services multiple times in the past
- Important to rebuild their trust
- Practitioners felt MHTRs prioritising offenders for MH care was justified but thought it might be an issue for colleagues/public

*In **no way** would we say that if you commit a crime you should leap forward in the waiting list to get a community service. So by providing a **bespoke intervention** that supports the other treatments, I guess that's probably a **halfway house** between the two.*

Judiciary

Positive experience of services could **increase motivation to engage** with other support

- Referrals onto other services
- CSTR may have addressed factors (e.g. substance misuse) which previously prevented them from accessing community MH provision

*It's almost like having a **golden opportunity** to put people in the right place*

Probation Service

3. Positive impact for service users

Professional stakeholders received **positive feedback** from service users about MHTRs

*It doesn't solve all of their mental health problems, but it does improve their **ability to cope with life***

Third Sector Organisation

Considered **more difficult** for those who are living in homeless or other chaotic circumstances to benefit

*Just to give them **confidence** in talking about mental health, and it being a 'thing'*

Third Sector Organisation

Improves confidence in professionals and mental health services

*Going to prison is creating **human distress**. Especially with **women with children**, who end up losing their **housing**, who end up losing their children, for not necessarily violent or sexual offending… If we can do treatment in the community, I think, then there is **less harm** going to be created overall*

Mental Health Services

Some from Drug and Alcohol Services described a positive impact of ATR and DRR on service users, others were **more cautious** and felt they worked for and not others.

More **longitudinal follow-up** will be needed to examine impact of MHTR pathway

Note: *NIHR MH PRU qualitative stakeholder interviews*

Service users outside the testbed sites were also supportive of the ambition to increase the use of CSTRs

Most participants with lived experience (39/47) felt that receiving a CSTR would be **more beneficial** to them than a custodial sentence

I would rather have a CSTR than be in prison. We get a lot of support in jail but I would receive more and better treatment in the community. Service User

Participants felt that a **CSTR** would:

- Require them to take more responsibility for their actions
- Provide an opportunity to focus on rehabilitation and move forward

In contrast, in **prison** there is a lack of focus on rehabilitation which means underlying issues are more likely to go untreated

The reason why you are there can be diluted Service User

Female participants highlighted that being offered a **community sentence** would have **benefited their families**, as they would have been able to continue **living at home** with their children.

However, one noted that this would not necessarily mean it would be better for the woman concerned.

Note: *Clinks focus groups with service users.* Most service users **did not** have direct experience of CSTRs, but were asked for their views and whether they feel they would have benefited from them.

5.4 GUIDANCE

- Funding – challenges and next steps
- Criteria for success
- Reporting lines
- Organisation and operation

There were various funding challenges during the initial implementation of the CSTR programme in the testbed sites.

- Pilot had to be supported through **existing posts** in some areas, e.g. clinical supervision → beneficial for pilot, but placed additional burden on staff

> *it has an operational knock-on to other parts of the system that aren't part of the trial* — Drug & Alcohol Services

- Unexpectedly **high administrative workload**
  - No additional money for some services providing information for pilot
  - Make admin or project management support available to reduce burden

- **Speed** at which stakeholders had been expected to establish the services and related processes
  - **Timely recruitment** of Mental Health practitioners and responsible clinician was difficult
  - Staff members had to be moved from other areas at short notice, so some **staff shortages** in some areas

- **Reliance** on one or two Mental Health practitioners
  - Anxiety reduced by multiple part time workers

- MHTR training for judiciary had not been **funded or centrally** provided, so was provided on an **ad-hoc basis**.
  - Training was **effective** and had a **positive impact**, but some felt it was **insufficient**, was **time consuming** and needed to be provided on an **ongoing basis**
  - Judiciary felt that *"there should be proper resources put in place [for training] so that the judiciary is properly supported"*

Note: *NIHR MH PRU qualitative stakeholder interviews*

Going forward, sites had concerns about future funding

Concerns

⚠ Sustainability of **support services**
- Capacity due to increasing CSTR numbers

⚠ Sustainability of **funding**
- **Every site** described the **sustainability** of funding as a major challenge, particularly for MHTRs
- Unless funding was confirmed, one site said they would have to stop accepting new MHTR patients several months before the end of pilot funding, to ensure they could complete the full 12-week programme with all service users
- Short-term funding for pilot might lead to both the **need for CSTRs** and their **effectiveness** being **underestimated**

⚠ **Sick/Maternity Pay**
- Would host organisations of mental health practitioners be solely liable for covering sick or maternity pay?

Next steps →

I would really like to see, early on, some kind of commitment that helps people understand that "Okay, we are going to go beyond a year

Commissioner

→ **Commissioners:**
- MHTR services would need to be **nationally mandated** in order to be funded by CCGs, given the current constraints on budgets

→ **Cost-effectiveness:**
- Need for evidence on cost-effectiveness to make a business case for continued provision and for positive case studies to engage other professionals.

Note: *NIHR MH PRU qualitative stakeholder interviews*

Stakeholders identified a range of areas where central guidance would be beneficial

"it's kind of everyone's business but no-one's responsibility to make sure this exists. Is it a health job? Is it a justice job? It doesn't really matter but someone needs to be responsible for it" Steering Group Chair

Expectations of the programme & main criteria for success

the outcomes are ill-defined about what we're trying to achieve here… therapeutic success… psychological recovery… reduction in recidivism? Mental Health Services

Organisation & operation

- Where should Mental Health Practitioners sit within organisational structures? In particular, should they be hosted within L&D?
- One site asked if a nurse take the role of a responsible clinician, rather than a psychologist.

Reporting lines

Who are we reporting to with the steering group? Are we reporting to the CCG, Criminal Justice, NHS England? I've no idea who we're supposed to be reporting to. Mental Health Services

Clarity over ATR and DRR requirements

- One SM service had continued to conduct twice weekly drug tests for DRRs (rather than once a week), even though it was thought to be poor use of resources, unnecessary burden to service users and increase non-attendance rates

we've stuck with a system that we've operated for the last 10 years and not changed it because we don't know whether we should change it, we don't know whether we can change it, and that was a frustration Drug & Alcohol Services

- In another SM service, drug tests were not seen to be carried out as frequently as needed for magistrates to review service users' progress on DRRs

Note: *NIHR MH PRU qualitative stakeholder interviews*

Going forward, a balance between clear guidelines and sufficient flexibility to fit with different service models was needed

Stakeholders felt that the MHTR pathway should be allowed to embed in its current form, without too many changes.

> *It's really quite important, within reason, that they don't fiddle with it too much while we're doing the pilot… The history of imaginative sentencing options is littered with failure to prove efficacy. Therefore, fine tuning too much which you're in the middle of a trial is, in my view, a bad idea.*
>
> Judiciary

This was important for providing a solid evidence base on whether the pilot was effective.

> *Some of the outcomes we need to see are one, two years away even in terms of us being reassured. So for me, I hope that people give time and thought to letting these kinds of programmes embed and grow.*
>
> Commissioner

Stakeholders also emphasised the variation in localised models of provision with the pilot:

> *We acknowledge the importance of having localised variations of a model, but then we also have to accept that we've got localised variations on the speed of uptake and the success of, because each area has unique complications... So I would say to anyone embarking on this,*
>
> *"Never get disheartened by the fact that someone has got more than you."*
>
> Liaison & Diversion Services

Note: *NIHR MH PRU qualitative stakeholder interviews*

6. CONCLUSIONS

Conclusions

The MHTR pathway has **filled a gap** in service provision for offenders with mental health problems.

- Preliminary data suggests sites saw more MHTRs sentenced during the pilot than the previous year.
- In total, 441 CSTRs (ATRs, DRRs and MHTRs) were sentenced in the testbed sites over the course of the process evaluation.
- A gap in services for those with more severe mental health problems has also been identified

Key areas of learning from the testbed sites included:

- Identification and assessment, including concerns about sufficient staff time and capacity
- Service user engagement, including concerns about breach and consent, as well as ways to facilitate this
- The desire for central guidance around certain issues, such as funding and programme expectations
- The importance of multi-agency working, and factors that challenge and facilitate co-working between agencies

7. ANNEX

- Abbreviations and definitions
- Data & methodology
- Site specific findings

Background: Definitions & Acronyms

Acronym	Term	Definition
AP	Assistant Psychologist	Provide clinical support under the direct supervision of a qualified psychologist. [10]
ATR	Alcohol Treatment Requirement	For offenders who are dependent on alcohol, and their alcohol misuse requires and may be susceptible to treatment.
BRR	Building Better Relationships	A programme designed to promote lifelong changes in behaviours and attitude which, in the past, have resulted in male service users being convicted of intimate partner violence.[1]
CO	Community Order	A community sentence combines punishment with activities carried out in the community, including one or more of 13 requirements on an offender.[2]
CSTR	Community Sentence Treatment Requirement	An umbrella term to describe DRRs, ATRs and MHTRs, for offenders age 18 or over.
DRR	Drug Rehabilitation Requirement	For offenders who are dependent or have a propensity to misuse drugs, and their drug misuse requires and may be susceptible to treatment.
IAPT	Improving Access to Psychological Therapies	Services providing evidence based treatment for people with anxiety and depression. [7]
L&D	Liaison & Diversion	Services identifying people who have mental health, learning disability, substance misuse or other vulnerabilities when they first come into contact with the criminal justice system as suspects, defendants or offenders. [8]
MH	Mental Health	Mental wellbeing and mental disorders, the latter is characterised by abnormal thoughts, emotions, behaviours and relationships with others. [12]
MHTR	Mental Health Treatment Requirement	For offenders with a mental health condition that is treatable either in a community setting or as an outpatient in a non-secure setting, but does not warrant making a hospital or guardianship order within the Mental Health Act 1983.
OCD	Obsessive Compulsive Disorder	A common mental health condition in which a person has obsessive thoughts and compulsive behaviours.[5]
-	Pink Slips	So-called because of the pink paper they are printed on; forms completed by probation officers and the judiciary for each individual considered for a CSTR; part of the process evaluation.
PTSD	Post Traumatic Stress Disorder	An anxiety disorder caused by very stressful, frightening or distressing events.[6]
RAR	Rehabilitation Activity Requirement	A requirement that the defendant participates in activity to reduce the prospect of offending.[4]
PSR	Pre-Sentence Report	The court is required to obtain a PSR prepared by the Probation Service before imposing a custodial or community sentence. It should include an assessment of the nature and seriousness of the offence, and its impact on the victim. [9]
RO	Residence Order	The offender is obliged to live at a particular address.[2]
SM	Substance Misuse	Harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs. [11]
SSO	Suspended Sentence Order	The offender does not go to prison immediately, but is given the chance to stay out of trouble and to comply with up to 12 requirements set by the court.[3]
UPW	Unpaid Work	For up to 300 hours.[2]

1 http://risemutual.org/building-better-relationships/
2 https://www.sentencingcouncil.org.uk/about-sentencing/types-of-sentence/community-sentences/
3 https://www.sentencingcouncil.org.uk/about-sentencing/types-of-sentence/suspended-sentences/
4 https://www.justiceinspectorates.gov.uk/hmiprobation/wp-content/uploads/sites/5/2017/02/Report-Rehabilitation-Activity-Requirement-Thematic-final.pdf
5 https://www.nhs.uk/conditions/obsessive-compulsive-disorder-ocd/
6 https://www.nhs.uk/conditions/post-traumatic-stress-disorder-ptsd/
7 https://www.england.nhs.uk/mental-health/adults/iapt/
8 https://www.england.nhs.uk/commissioning/health-just/liaison-and-diversion/about/
9 https://www.cps.gov.uk/legal-guidance/pre-sentence-reports
10 https://www.healthcareers.nhs.uk/explore-roles/psychological-therapies/roles/assistant-clinical-psychologist
11 http://www.who.int/topics/substance_abuse/en/
12 http://www.who.int/mental_health/management/en/

ANNEX – DATA & METHODOLOGY

Annex A – Probation Pink Slip

PROBATION FEEDBACK FORM

We would be grateful for your feedback regarding offenders who present with mental health or substance misuse issues.
Please take a few minutes to complete this form and return to the probation officer who is collating this data.

Name of Defendant	
D.O.B.	
Offence	
Sentencing Date	
CSTR Was the defendant identified as already receiving treatment for a mental health, drug, alcohol need or other need?	Yes/No
CSTR If yes by whom / which service (e.g. self / OASys, arrest referral worker, liaison and diversion)?	
Which needs (mental health, drug or alcohol or any combination) were identified?	
Has treatment been arranged: I. Yes, the person is already in treatment II. Yes, a treatment plan has been arranged III. No, no treatment is in place	

Is **the defendant** (including offence) suitable for a CSTR?	Yes / No
If yes was the recommendation included within a PSR?	

If no, what were your reasons for this? I. did not consent II. Lack of availability of drug testing III. no suitable treatment available (please expand reasons) IV. had previously failed on a CSTR (please expand reasons) V. other (please indicate)	
If **CSTR was recommended** within the PSR please state the recommended length of order	
If **CSTR was recommended** within the PSR please state all requirements	
What was the **outcome of the recommendation** to court?	
If the CSTR was **not accepted**, what were the reasons given	
If a custodial sentence was given, please state the sentence length in number of weeks.	

Thank you for your time and contribution

signed.....

Annex B – Sentencer Pink Slip

CSTR SENTENCERS' FEEDBACK FORM

We would be grateful for your feedback on the impact of the CSTR proposal on your sentencing decision.

Please take a few minutes to complete this form and return to the probation service court duty officer.

Name of Defendant	
DOB	
Offence	
Sentencing Date	
Sentence	
If CSTR was ordered, please state length of order	
If CSTR was ordered, please state all requirements given	

If you **did not** include an CSTR what were your reasons for this?	
If sentenced to custody, please state the sentence length in number of weeks.	
If you **did** include an CSTR **what would your** sentence have been if this was not available?	
Additional Comments	

[1]Thank you for your time and contribution

Signed .....

Template developed from Milton Keyes MHTR Pilot 2014

Annex C – Treatment Services Data Spreadsheet

Mental Health Treatment

Month	Number of individuals in treatment	Mental health problem - please give an idea of the type of MH problems experienced No numbers required Please provide a list of conditions combined for all months	Number per IAPT Treatment STEP Please provide numbers for all months combined Please replace low numbers 1,2,3,4 with an asterisk *				Treatment Type Number per treatment type Please provide numbers for all months combined For low numbers 1,2,3,4 please replace with an asterisk*	No. of individuals who missed appointments for being **under the influence**	No. of individuals who missed appointments for **Refusal to Participate**	No. of individuals who missed appointments for **Physical Health**	No. of individuals who missed appointments for missed for **Being Late**	No. of individuals who missed appointments for missed for **Preoccupied**	No. of individuals who missed appointments for **Other Missed**	**Total number of appointments missed**
			Step 1	**Step 2**	**Step 3**	**Step 4**								
Nov-17														
Dec-17														
Jan-18														
Feb-18														
Mar-18														
Apr-18														
May-18														
Jun-18														

Drug Misuse

Number of individuals in treatment	**Drug misuse problem - please give a idea of the type of drug problems** (No figures required, please combine this for all months)	**Number per Drug Misuse Treatment Tier** (Please provide numbers for all months combined, please replace low numbers 1,2,3,4 with an asterisk *)				**Treatment Type (Number per treatment type)** Please provide numbers for all months combined For low numbers 1,2,3,4 please replace with an asterisk*	No. of individuals who missed appointments for being **under the influence**	No. of individuals who missed appointments for **Refusal to Participate**	No. of individuals who missed appointments for **Physical Health**	No. of individuals who missed appointments for missed for **Being Late**	No. of individuals who missed appointments for missed for **Preoccupied**	No. of individuals who missed appointments for **Other Missed**	**Total number of appointments missed**

Alcohol Misuse

No. of individuals who missed appointments for **Other Missed**	**Total number of appointments missed**	**Number of individuals in treatment** (No figures required, please combine this for all months)	**Alcohol misuse problem - please give a idea of the type of alcohol problems**	**Number per Alcohol Misuse Treatment Tier** (Please provide numbers for all months combined, please replace low numbers 1,2,3,4 with an asterisk *)				**Treatment Type (Number per treatment type)** Please provide numbers for all months combined For low numbers 1,2,3,4 please replace with an asterisk*	No. of individuals who missed appointments for being **under the influence**	No. of individuals who missed appointments for **Refusal to Participate**	No. of individuals who missed appointments for **Physical Health**	No. of individuals who missed appointments for missed for **Being Late**	No. of individuals who missed appointments for missed for **Preoccupied**	No. of individuals who missed appointments for **Other Missed**	**Total number of appointments missed**

Annex D – Overall Figures Spreadsheet

Source of referral for assessment (number for each) (e.g. 4 from solicitors, 3 from self)	Court Duty Office
	Self-Referral
	IAPT
	PSR Author
	Offender Manager
	L&D
	Solicitor
	Other (please specify and add more rows above)
Number screened for Mental Health problems by L&D/link worker/court staff (e.g. using K-10, Core-10)	
Number screened for Substance Misuse problems by L&D/link worker/court staff (e.g. using AUDIT C, SADQ)	
Number assessed for a CSTR	
Number who agreed to consent to treatment	
Number who did not agree to consent to treatment	
Number who had initially agreed to treatment but later withdrew consent	
Number MHTRs agreed by Clinical Lead	
Number assessed for MHTRs but not accepted by Clinical Lead	

Number recommended for a CSTR by probation with PSR/oral report for CSTR	
Number sentenced to a CSTR	
Number not sentenced to a CSTR	
Number sentenced, by type of order MHTR, ATR, DRR, combinations of CSTRs, combinations with RAR	MHTR
	ATR
	DRR
	MHTR + ATR
	MHTR + DRR
	ATR + DRR
	MHTR + ATR + DRR
	MHTR + RAR
	ATR + RAR
	DRR + RAR
	Other (please specify and add more rows above)
Number who attended first treatment appointment	
Number of individuals missed at least 2 appointments	
Number of individuals returned to court due to breach	

Annex E – Focus Group/Interview Questions

Experiences of Community Sentence Treatment Requirements

- Have you heard of CSTRs before?
- Have you ever been offered a CSTR?
- If you have received a CSTR:
  - Was the treatment requirement for your mental health, drug or alcohol addiction, or a combination?
  - What did the treatment involve? *(e.g. residential treatment / series of regular appointments / etc)*
  - What was your experience of it? E.g. How easy was it to meet the treatment requirements? Did you find the treatment helpful?
- If you have been offered a community sentence treatment requirement but refused it, why was that?

Engaging with treatment services

- Do you think a CSTR would have been more help to you than alternative sentences you may have received? Why/why not?
- Does/would being given a CSTR change how you relate to the people treating you, compared to
  - Receiving treatment which is not linked to the courts/criminal justice
  - Receiving treatment in prison

Designing Community Sentence Treatment Requirements

- If you, or someone with the same diagnosis/needs as you, were going to be given a CSTR, what would make it work well? e.g.
  - Type of treatment offered
  - Practical considerations e.g. accessibility, timing and flexibility of appointments, frequency
  - Relationships with professionals (both treatment providers and probation staff)
  - Other support
- What would stop it from working?

From October 2017 to June 2018, the Probation Pink Slip data is **42%** complete, the Sentencer Pink Slip data is **67%** complete

Probation Pink Slip data submission, by site

	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18
Birmingham							
Plymouth							
Sefton							
Milton Keynes							
Northampton							

Sentencer Pink Slip data submission, by site

	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18
Birmingham								
Plymouth								
Sefton								
Milton Keynes								
Northampton								

- Probation Pink Slip data was not available for **Milton Keynes** or **Northampton**
- **Birmingham -** Probation pink slip data comes from NPS data systems not from the pink slips themselves.

- **Plymouth -** No information on the Sentencer Pink Slip if CSTR not ordered or not available
- **Milton Keynes -** Substance misuse numbers in treatment appear to be 'new people in treatment' rather than all people in caseload.

14% of **Probation Pink Slips were** recorded as a proportion of CSTRs considered for recommended in **Overall Figures**

12% of **Sentencer Pink Slips were** recorded as a proportion of CSTR's considered for sentencing in **Overall Figures**

From October 2017 to June 2018, the Overall Figures data is **82%** complete

- The **Overall Figures** data was reasonably well populated by the five sites.
- Some data quality issues to note:
  - Some sites have only completed “Number assessed and needs identified” for MHTR, not DRR or ATR
  - Seasonality is present in the data due to courts being closed over Christmas and Easter. This has caused shortfalls in the figures in December and April, with peaks in January and May.

Overall figures									
	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18
Birmingham									
Plymouth									
Sefton									
Milton Keynes									
Northampton									

From October 2017 to June 2018, the Treatment data is **76%** complete for mental health and **78%** complete for substance misuse

To note:

- **All 5** sites submitted **Treatment Data** for both **Mental Health** and **Substance Misuse**
- **Northampton –** No information on drug misuse and alcohol misuse treatment types, or alcohol misuse problems
- **Sefton -** No information on substance misuse treatment type
- **Plymouth -** No information on mental health treatment type

Mental Health Treatment Services data submission, by site

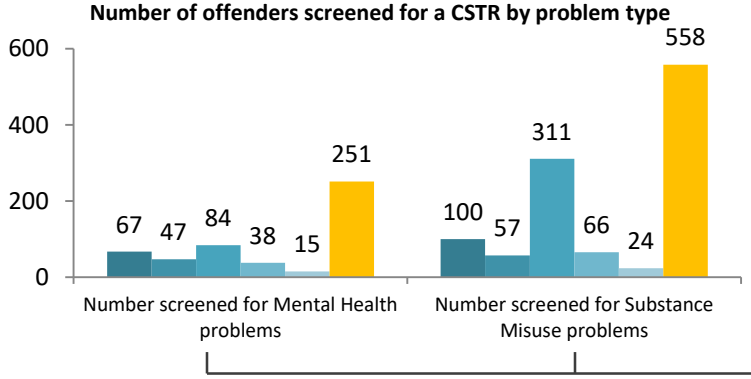
	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18
Birmingham									
Plymouth									
Sefton									
Milton Keynes									
Northampton									

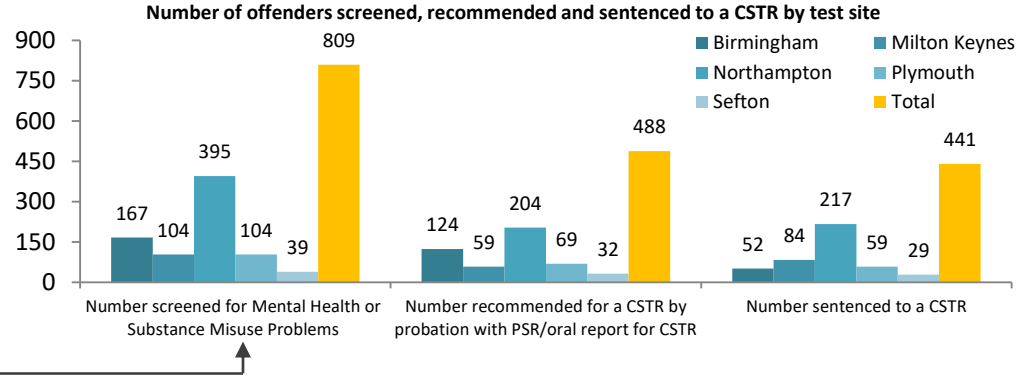
Substance Misuse Treatment Services data submission, by site

	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18
Birmingham									
Plymouth									
Sefton									
Milton Keynes									
Northampton									

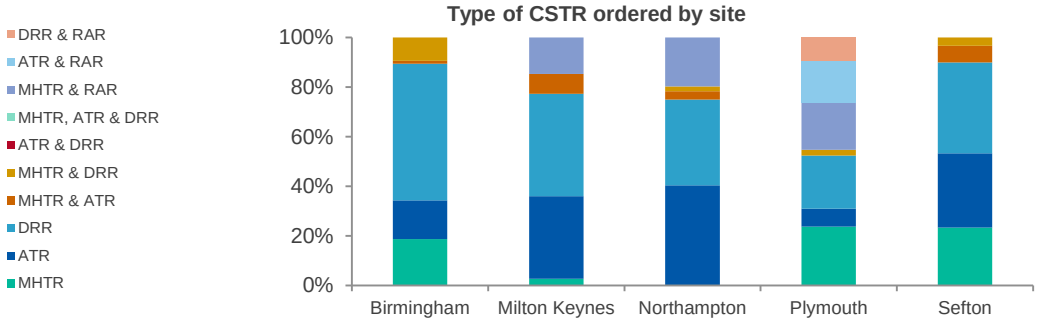
ANNEX – HEADLINE FINDINGS BY SITE

Annex I – Site specific headline figures (Screened, recommended, sentenced to CSTR, type of CSTR)





- **Northampton** had the largest number of offenders in the CSTR pathway with over **200** being sentenced whilst **Sefton**, whose protocol had been live the shortest amount of time, had the lowest with around **30**.
- **31%** of screenings were for **Mental Health** problems compared to **69%** for **Substance Misuse** problems.



- As can be seen from the graph on the left, **the type of CSTRs ordered varied across the 5 sites**
- **Milton Keynes, Plymouth and Northampton** gave more sentences **including RAR,** whilst **Birmingham** and **Sefton** gave **no orders including RAR**
- **Birmingham,** however, gave the most orders combining **MHTR and DRR**

According to information gathered from Sentencer's, when a CSTR was ordered, the most common length of the order was **12 months**

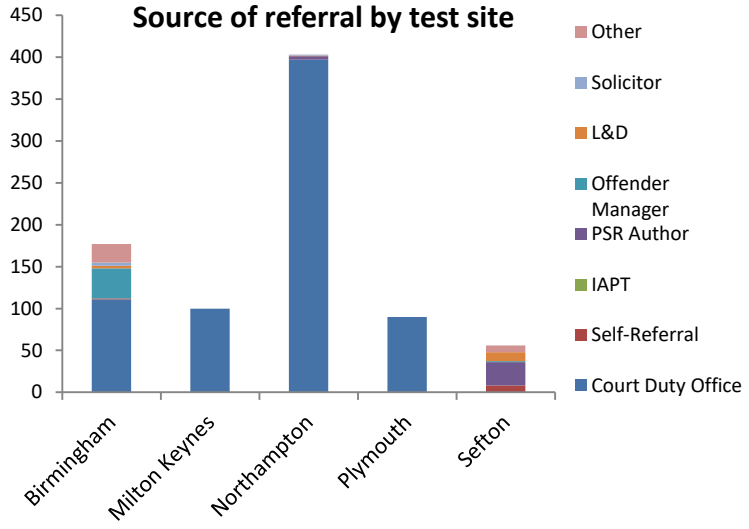
By site:

- **Sefton** were the most likely to use shorter **6** month orders
- **Milton Keynes** and **Plymouth** mainly used **12** month orders
- **Birmingham** tended to use longer orders, for example **18** and **24** months
- **Northampton's** orders ranged between **6** and **12** months

	6 months	9 months	12 months	18 months	24 months
Birmingham	-	-	1	7	3
Milton Keynes	3	3	10	1	2
Northampton	4	-	5	-	-
Plymouth	-	-	23	3	2
Sefton	15	-	5	-	1

Note: Sentencer Pink Slip - October 2017 to June 2018 - different time series submitted for each provider (see relevant completeness slide for more information)

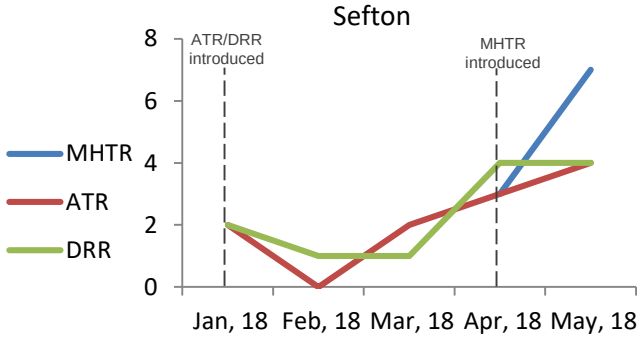
The majority of offenders have **no existing treatment plan** in place and their referrals mainly come from the **Court Duty Officer**

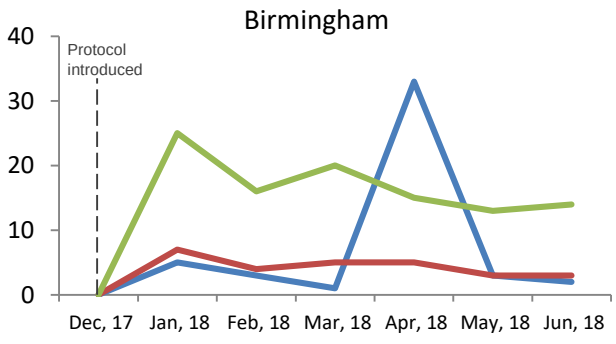


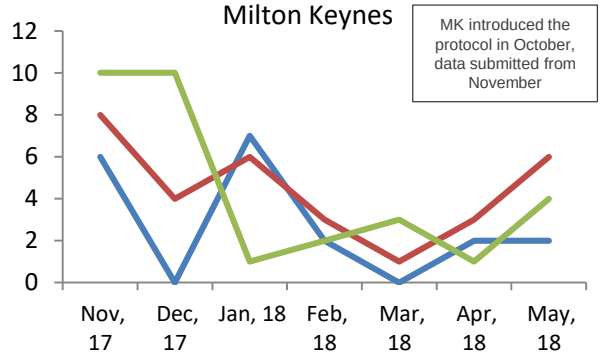
- **All referrals** in **Milton Keynes** and **Plymouth** came from the '**Court Duty Officer**', compared to **Sefton** where **no referrals** came from the '**Court Duty Officer**'
- In comparison, in **Birmingham** and **Northampton** there were a range of referral sources but the majority came from the '**Court Duty Officer**'.

Note: Referral data - *Overall Figures - October 2017 to June 2018* - different time series submitted for each provider (see relevant completeness slide for more information)
Treatment data - *Probation Pink Slips - October 2017 to June 2018* - data not available for Milton Keynes or Northampton (see relevant completeness slide for more information)

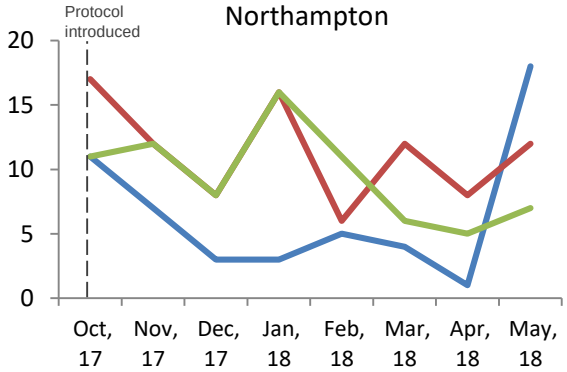
Change in the use of CSTR across the five sites:

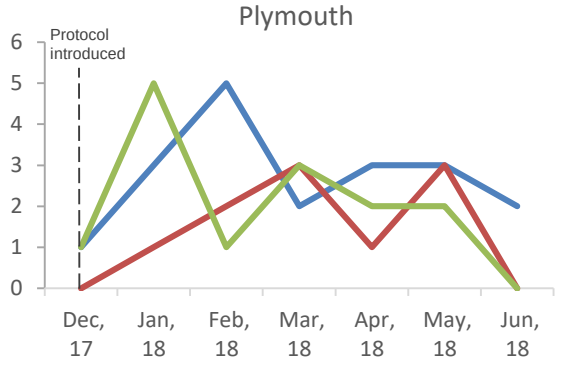






- The data shows that in some sites the use of CSTR's has increased over the period, for example in **Sefton**.
- For other sites the figures tend to **fluctuate** and a **seasonal effect** can be seen due to **courts being closed** over Christmas and Easter





Note: This slide shows all combinations of orders for MHTR, ATR and DRR (including with RAR), as a result some orders may be double counted
Overall Figures - October 2017 to May 2018 (see relevant completeness slide for more information)

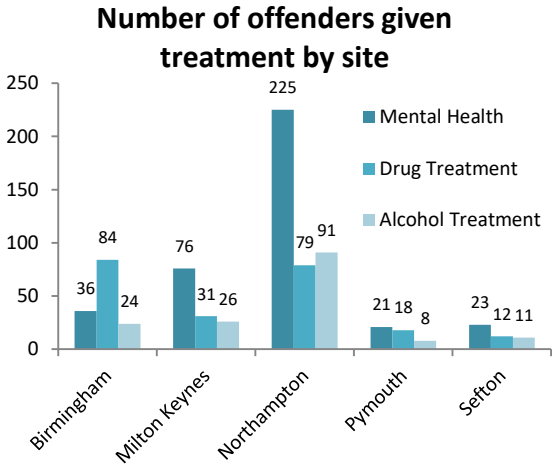
Psychological treatment developed specifically for the CSTR programme was used most regularly within an MHTR compared to **psychosocial treatment** for ATR and DRR

Mental Health

- **381** offenders were given treatment between October 2017 and June 2018 over the 5 sites.
- **All five sites** offered **psychological therapies** as part of their service; **3** sites used a **psychological treatment programme developed specifically for the CSTR programme**.

Drug Misuse

- **224** offenders were given treatment between October 2017 and June 2018 over the 5 sites.
- **4** sites offered **psychosocial treatment**
- **3** sites offered **Tier 3 treatment**
- **2** sites offered **pharmacological treatments** or the **prescription of substance substitutes**
- Other treatments offered were **reduction plans** and **recovery focused interventions**



Alcohol Misuse

- **160** offenders were given treatment between October 2017 and June 2018 over the 5 sites.
- **3** sites offered **psychosocial treatment** or **Tier 3 treatment**
- **2** sites offered **pharmacological treatments**
- Other treatments offered were **relapse prevention**, **community detox**, **reduction plans** and **recovery focused interventions**

Note: Treatment Data - October 2017 to June 2018 - different time series submitted for each provider (see completeness slide for more information)

Voluntary sector practitioners working outside of testbed sites felt that CSTRs could benefit from expanding their **eligibility criteria** make them available to a wider range of people

- Practitioners outside of testbed sites felt that the number of people who are currently considered suitable for CSTRs had been **very limited**
- CSTRs could benefit from **broadening the scope** to make them available to a wider range of people:

Primary care level mental health needs (e.g. social anxiety)

Personality disorder: (only catered for via Offender Personality Disorder Pathway for high risk offenders)

Homeless Clients: Often excluded from CSTRs due to the perceived difficulty in enforcing the sentence. May be less likely to be engaged in treatment already, but could benefit if this barrier could be overcome

Service users discussed the use of CSTRs for comorbid needs.

Some suggested a specific **'dual diagnosis'** treatment requirement, with treatment in place to support them to address both areas of need.

Others felt that would be **too much to deal with** at once.

Note: *Clinks focus groups with service users.*

Note: Service users and practitioners involved in the Clinks work were outside testbed sites, their views do not relate to practice during the pilot.