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Mental health treatment requirements (MHTRs)

A Royal College of Psychiatrists' Position Statement on customising community sentencing for offenders with mental disorder

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POSITION STATEMENT

Contents

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Executive summary

Thousands of people with mental disorder find themselves involved with the criminal justice system. Many have had some prior mental health service involvement but a lot of them have lost contact. Many spend time in prison where they are at high risk of suicide and other harms. Some are serving short sentences of imprisonment but, for those people with a mental disorder who have been convicted of a criminal offence, there are good community alternatives to imprisonment. These have the potential for restoring structure to their lives and improving health and social outcomes. There is growing evidence of association with lower risk of reoffending when community sentences are linked with treatment requirements. Offender-patients who have experienced such arrangements understand them and are generally positive about them.

For England and Wales, current relevant legislation is the Criminal Justice Act 2003. It outlines the possibility of customising community sentences, including suspended prison sentences, with a selection of requirements agreed in court, between the court, probation staff, clinicians and the offender-patient, to maximise (re)habilitation and desistance from offending. These include mental health treatment requirements (MHTR) and alcohol or drug treatment requirements (ATR/DRR), collectively known as community sentence treatment requirements (CSTRs); other possible requirements include social structuring. Northern Ireland has no such provision. In Scotland, such structured community sentencing is available under the Criminal Procedure (Scotland) Act 1995 and Criminal Justice and Licensing (Scotland) Act 2010. Many other countries have similar provisions.

Since 2017, the Department of Health & Social Care, NHS England and NHS Improvement, Public Health England and the Ministry of Justice Legislation have been rolling out a programme to improve the availability of community sentence treatment requirements. In September 2020, the Government published a White Paper, *A Smarter Approach to Sentencing*, that recommends the increased use of these sentencing options. Effective from October 2020, The Sentencing Council Guideline on sentencing offenders with mental disorder puts considerable weight on these arrangements.

Most of the developments to date have related to primary mental health care. Gaps in secondary mental health care in this context are increasingly apparent. This position paper gives an overview of the potential for secondary mental health service involvement with MHTRs and provides guidance. It encourages all psychiatrists working with adults, including older adults, and regardless of specialty, to develop a system for liaising with court diversion services and, as appropriate, overseeing and managing MHTRs. Partnerships between psychiatrists and criminal justice personnel extend resources available for working with suitable, consenting patients and provide support for psychiatrists not used to working with the courts.

Authors

Pamela J Taylor and **Josanne Holloway**, Forensic Psychiatry Faculty Chairs
Amanda Thompsell, Old Age Faculty Chair
Jane McCarthy and **Ken Courtenay** (Chair), Faculty of the Psychiatry of Intellectual Disability

With support from:

Julia Sinclair, Addictions Faculty Chair
Jim Bolton, Liaison Psychiatry Faculty Chair
Steve Pearce, Medical Psychotherapy Faculty Chair
Agnes Ayton, Faculty of Eating Disorders Chair
Joanne Black, Chair Perinatal Psychiatry
Hugo Critchley, Academic Psychiatry Faculty

Other contributing colleagues

Mignon French, Community Sentence Treatment Requirement Programme Manager, NHS England; Department of Health and Social Care, Ministry of Justice
Claire Weston, Head of Health and Justice (East), NHS England and NHS Improvement
Chloe Carter, Expert by experience
Jack Tagg, Undergraduate researcher, Cardiff University
Jody Audley, Undergraduate researcher, Cardiff University
Natasha Kalebic, Post doctorate researcher, Cardiff University
John Crighton, Chair RCPsych in Scotland
Pradeep Pasupuleti, Scottish Representative, Forensic Psychiatry Faculty, Royal College of Psychiatrists
Adrian East, Northern Ireland Representative, Forensic Psychiatry Faculty, Royal College of Psychiatrists

1. Mental Health Treatment Requirements: The clinical need

1.1 Relationships between mental disorders, offending behaviours and mismatches between needs and services

There is good evidence of a small but significant relationship between some mental illnesses and perpetration of violence and some other offending behaviours (e.g. schizophrenia and violence – Fazel et al, 2009; bipolar disorder and violence – Fazel et al, 2010; arson – Anwar et al, 2011; sex offending – Fazel et al, 2007). Some neurodevelopmental disorders (e.g. Lundström et al, 2014), including some personality disorders (e.g. Lowenstein et al, 2016), have been even more heavily implicated, although it is generally helpful to think in terms of particular neurodevelopmental problems and specific personality traits rather than over-inclusive diagnostic categories. Substance use disorders make up the other major group of disorders which carry a significantly raised risk of violence in themselves and a further elevated risk when associated with psychosis (e.g. Duke et al, 2018) and/or other disorders. The order of associations has varied little since one of the earliest population-based household studies, in the USA; Swanson et al (1990) found about 4% of people with schizophrenia had been violent – twice the rate in the general population – but 30% of those who had schizophrenia *and* substance use problems.

Concerns about raising stigma have perhaps inhibited widespread recognition of relationships between mental disorder and violence, and it is important to emphasise that at least 95% of violence is not related to mental illness. Nevertheless, the risk among people with a mental disorder of committing violence, and the even greater risk of becoming a victim of violence, cannot be ignored; both are associated with suffering and much of the violence is preventable with treatment of the disorders. Research indicates that it is mainly untreated or insufficiently treated illness that is the key problem in relation to violence with psychosis (Keers et al, 2014; NCISH, 2017). There is also clear evidence that violence by the subgroup of people with major mental illnesses is costly – estimated at over £2.5 billion in one year in England and Wales alone (Senior et al, 2020).

Worldwide, the prevalence of people with mental disorders in jails or prisons is disproportionately high relative to the general population (Fazel & Seewald, 2012). Such people often serve short sentences at any one time but often return, with treatment input almost as chaotic as their lifestyle. Community alternatives could be better for these offenders and for wider society alike, disrupting the illness-offending cycle as they support patient engagement with a structure which can facilitate treatment adherence.

At one extreme, there is powerful and detailed documentation in individual cases of the failure to match services to patient needs prior to a homicide. In England and Wales, numerous *post hoc* independent inquiries have been conducted into the service provision to someone who had been in contact with mental health services before killing another person, following the landmark *Clunis* case (e.g. Ritchie et al, 1994). Questions of prevention thus arise. A particularly high-profile case of a barely therapeutically engaged

patient who killed a stranger in the USA led to extensive and detailed documentation of the failures of services to fit with the patient's needs (Winerip, 1999). This led to new community order legislation in 1999 – 'Kendra's Law' – and the provision of relevant community structures. A recent review shows that this legislation has been used in 14,618 cases, with considerable benefits (Eide, 2017). These provisions have similarities to the underused mental health treatment requirements in England and Wales and community payback orders in Scotland, although Mental Health Court management of confessed or convicted offenders with mental disorder gives probably the closest parallel (Heilbrun et al, 2012).

1.2 Too many people with mental disorders in prison

The College is committed to the most timely and least restrictive interventions possible compatible with patient and public safety. Many people with potentially treatable mental disorders are, however, currently being sent to prison because there is nowhere else for them to go. Systematic reviews have confirmed that prisoners worldwide are about seven times more likely to have a mental illness than people in the general population (Fazel & Baillargeon, 2011). They are also more likely to have personality disorder (Fazel et al, 2016) and substance use disorders (Fazel et al, 2017). Singleton et al (1998) completed the most recent national survey of all disorders for England and Wales alone; Kissell et al (2014) highlighted the high rates of substance problems in Wales and a mismatch between needs and service availability. Further, Fazel et al (2016) found that prisoners are also at increased risk of all-cause mortality; suicide, self-harm, violence and victimisation account for much of this, and there is an even greater problem with physical ill health and so-called natural deaths.

England and Wales currently have the highest imprisonment rate in Western Europe and above average for all Council of Europe countries (Aebi et al, 2017). There is cause for further concern, in that 2018–2019 figures for England and Wales suggest all-cause mortality in prisons increased by 6% and suicide rates by 23% (Prisons and Probation Ombudsman, 2019). This rise coincided with a rise in the numbers and proportion of older people in prison. In England and Wales, in March 2018, there were already over 13,500 people over the age of 50 in prison (16% of prisoners), of whom about 5,000 are over 60 (House of Commons Library, 2019). The Prison Reform Trust (2019) added the detail that there were 1,500 prisoners over the age of 70 and 200 over the age of 80 years. In Scotland also, the numbers of older prisoners are also rising but in March 2018 they still accounted for less than 10% of the prison population; numbers are similarly more manageable in Northern Ireland (House of Commons Library, 2018).

Many of these offenders with mental disorder have struggled to maintain their full commitment to treatment in the community. Indeed, in a survey of South Wales' prisons, we found that only one in five of prisoners recruited had ever attended mental health services other than for one-off assessments (Taylor et al, 2010). Many, however, could benefit from structured, formally supervised care and treatment in the community and independent reviews have consistently recommended this (Bradley, 2009; Corston, 2007). Indeed, many of Bradley's recommendations remain pertinent over 10 years after being published:

Courts, health services, the Probation Service and the Crown Prosecution Service should work together to agree a local service-level agreement for the provision of psychiatric reports and advice to the courts. p.73

Primary care trusts (PCTs) and partners should jointly plan services for offenders to ensure effective commissioning and delivery of services. p.146

The Department of Health should include explicit reference to the needs of offenders with mental health problems or learning disabilities in future NHS Operating Framework documents. p.146

The NHS must engage offenders with mental health problems or learning disabilities with current patient and public involvement mechanisms. p.147

One of Bradley's key goals was to ensure that as many offenders as possible with mental disorders, including neurodevelopmental disorders, were diverted into appropriate community support services, if convicted using community sentences with treatment to help resolve underlying health and social problems possibly contributing towards the offending behaviours. The primary concern – for Bradley and the rest of us – is that services for offenders with mental disorders, and often related multiple and complex problems, should fit better with those needs and thus have better personal and community outcomes.

It is hard to put a figure on how many people a year might be expected to have better outcomes under a community penalty with a treatment requirement. Since 2010 the prisoner population in England and Wales has reached 88,000 but, more generally, it has been between 83,000 and 86,000, with some indication of a sustained fall towards the end of 2019; 'helped' by the COVID crisis it has been just under 80,000 for much of 2020. The proportion of people serving shorter sentences has also been falling, from above 10% serving sentences of a year or less in 2002 to around 6% in 2020 and over 30% of 1–4 years in 2005 to about 20% in 2020 (House of Commons Library, 2020). Most epidemiological research provides figures only for more serious mental disorders and does not separate according to sentence length. A Ministry of Justice study, using 2008–2011 data, provided an estimate from criminal justice staff structured assessments that about 40% of those serving a sentence of under 12 months have 'current psychological problems' (Hillier & Mews, 2018). Taking a conservative estimate of 80,000 prisoners in total, around 1,600 could have been MHTR eligible and a further 6,400 (serving 1–4 years) might have been. In 2016 only 391 (0.3%) of 130,761 community orders included a MHTR and only 278 (0.38%) of 72,274 suspended sentences (Offender Management Statistics quarterly: October to December 2016; Ministry of Justice, 2017).

Further, preliminary costings indicate that, at least in the short term, substantial cost savings are likely. Initial additional investment to set up and operate any one of the English CHTR sites described below was £75,000. The cost of a prison place for a year is estimated at £35,000. It is estimated that the 30 MHTRs made in this one site (Luton and Bedford) in the funding period would, between them, have saved about 17 years of custody and thus about £595,000 (Claire Weston, NHS England and NHS Improvement).

1.2 Already high rates of mental disorder among people under criminal justice system supervision

There is much less research into the mental health needs of offenders under criminal justice supervision in the community but a survey in one English county suggested that disorder rates are high, with estimates of 39% having mental illness, 60% substance use disorders and 48% personality disorders, with needs not necessarily being met (Brooker et al, 2012). More structured arrangements for joint community working with offenders who have mental disorder could help stabilise this group too.

2. Is there evidence of benefit with a semi-coercive element in community-based treatment?

Community treatment requirements for offenders with mental disorder – requiring joint working between offender, criminal justice and clinical staff – have been an option in England and Wales for many years. Prior legislation – the Powers of the Criminal Courts Act 1973 – provided for a probation order with a condition of treatment. In England and Wales, this has been replaced by the Criminal Justice Act 2003, which allows for community sentencing to be combined with explicit requirements, the latter subject to the agreement of the offender. Once agreed, the offender must adhere to them. In Scotland, the Criminal Procedure (Scotland) Act 1995 and the Criminal Justice and Licensing (Scotland) Act 2010 provide for similar payback orders. Northern Ireland has no such provision. More detail of how these orders work in practice is set out below but, first, what evidence is there that this is a useful approach?

Community sentences with treatment requirements should not be confused with community treatment orders. In the landmark systematic review of community treatment orders (CTOs) by Maughan et al (2013) the various forms of coercion in community treatment were conflated as if the same. Thus, this review may be misleading here. The most heavily weighed evidence for their main conclusion: "there is now robust evidence in the literature that CTOs have no significant effects on hospitalisation and other service use outcomes" came from their own randomised controlled trial of a very specific form of CTO – under mental health legislation for England and Wales – with a very specific group of patients – people with psychosis who had been under compulsory inpatient treatment – and a 'treatment as usual' condition which, in practice, differed little from the 'intervention' of adding the CTO. A CTO under the Mental Health Legislation of England and Wales is very different from a community sentence with a treatment requirement. In the case of a CTO, the patient has been sufficiently ill to have been subject to compulsory inpatient care and has no choice about the order.

Community sentence treatment requirements, by contrast, require that the person has sufficient capacity to understand court proceedings, the sentence proposed *and has agreed to it with all its requirements* before it is imposed. An element of compulsion may be experienced as those eligible may be aware of the possibility of a short prison sentence if they do not agree. There is, however, evidence from the current CSTR programme in England that people do refuse, albeit very few. An example was that one offender stated a preference for a six-week prison sentence over being obliged to attend a range of different meetings in the community over a 12–18 month period.

Once the order has been made, it has the effect of a contract between all the parties and there are, therefore, consequences if the requirements are not kept. Established failure to keep to the requirements is referred to as being in breach of the order. The probation officer overseeing the order will make the decision on breach proceedings, which may include the individual being returned to court for resentencing for the original offence. There may also be a penalty for the breach and there is a risk of imprisonment. Any return to court may, however, be used as an opportunity to restructure the sentence to make it more feasible for the offender. A 'problem-solving court' in the North of England, for example, may ask an offender returning in breach of the order to draft a

proposal of what s/he believes s/he can achieve and will consider and discuss that with the offender before deciding on next steps (for a review of problem-solving courts see Centre for Justice Innovation, 2015). No one sets up these orders to fail. A real example of an order that has proved successful is given in the box below.

Case example:

A woman in her early 30s had been struggling with mood disorder since the age of about 15 years; she had experienced various adverse events in childhood, never fully resolved. Sometimes treated with anti-depressants, nothing offered had fully resolved her difficulties and she had been suicidal on more than one occasion. Over time, she started to use alcohol to get some relief.

Matters came to a crisis in the context of employment and financial concerns, some physical health problems, relationship tensions and feeling overwhelmed with responsibility for childcare arrangements in the family. She saw her doctor and was diagnosed with borderline personality disorder. She was put on a waiting list for therapy. Still waiting, one morning things had become overwhelming and she reached out to her partner for support. Support was not forthcoming, feeling she had nowhere to turn and unable to cope with her thoughts and feelings she was left alone in her home. She started a fire to end her life.

The fire brigade attended. She had to be treated for smoke inhalation but neither she nor any of her neighbours was seriously hurt. Nevertheless, she was charged with arson – her behaviour on this occasion could have put other lives at risk too. She was convicted of the offence but the court accepted that she needed treatment and that, indeed, her safety and that of others might depend upon that in the longer term.

She agreed to a community sentence with an MHTR which immediately gave her:

- access to therapy
- probation support
- social services support
- support from family and friends
- undisrupted parenting for her own child.

She completed the sentence and has done well. Her health is much improved. She has also added volunteering to help others in similar circumstances to her family commitments and is now in stable employment.

A systematic evaluation is underway of outcomes after orders were made in Northamptonshire and Bedfordshire after implementation of the schemes there (Supporting CSTR Programme Development and Practice). An important first step in evaluating such orders, however, is to find out about users' experiences of them. Using a grounded theory approach, analysis of twenty-five verbatim records of open interviews with people serving a community sentence with an MHTR, a model emerged

revealing their core concern of instability (Manjunath et al, 2018). They saw this instability as characterised by a range of social and mental health difficulties which could be resolved by becoming healthy, free of substance misuse, desistance from offending and 'having a life'. Most found the MHTR a helpful framework for this, supporting their motivation and assuring service provision but some were critical of perceived supervisor role confusion, poor accessibility to supervisors and a few found it stressful.

A systematic review of outcomes after such community sentencing is also underway, although almost all relevant evidence is from the USA and coloured by the framework of wide availability of a non-adversarial mental health and drug court structure for offender-patients (Audley et al, 2021). In brief, there is evidence suggesting that such orders and structures may benefit the offender-patient and wider community alike. Evidence of benefit is strong in relation to people who complete such orders. Among those who do not, evidence on outcomes is mixed, some of it suggesting that reoffending rates may be higher than if legally processed and sentenced without such arrangements, although this is countered by evidence that more intensive court involvement and supervision, such as problem-solving courts, can turn around previously failing cases (e.g. Fiduccia & Rogers, 2012).

In England and Wales, it is worth noting that short prison sentences, the most likely alternative to a community sentence with requirements, have been consistently shown to be associated with a high recidivism rate; about two-thirds of people sentenced this way reoffend within 12 months (e.g. National Audit Office, 2010; Ministry of Justice, 2020). Recidivism rates have consistently been reported as lower for people serving community sentences – about one third of men and 15% of women reoffending within twelve months after community sentencing (Grünhut, 1963; Ministry of Justice, 2008; Ministry of Justice, 2020). An argument for saving costs has been made (Ginn, 2013). A Ministry of Justice study, comparing people serving under 12 months in prison without supervision on release with those under community orders or suspended sentence orders, found that not only was there a general advantage for the community order group but also there was more benefit for those with 'significant psychiatric problems' (Hillier & Mews, 2018).

3. How Mental Health Treatment Requirements (MHTRs) fit with community sentencing in the UK

3.1 Making the order

MHTRs are available only in conjunction with a community sentence or suspended prison sentence after conviction for a criminal offence. In England and Wales, the relevant legislation is the Criminal Justice Act 2003. This cautions under section 148 that:

> *A court must not pass a community sentence on an offender unless it is of the opinion that the offence, or the combination of the offence and one or more offences associated with it, was serious enough to warrant such a sentence.*

Further guidance under section 150 is that community orders are available only for an offence punishable by imprisonment, where the penalty is not fixed by law, or for persistent offenders previously fined, although the Sentencing Council Guideline on *Sentencing offenders with mental disorders, developmental disorders, or neurological impairments* (Sentencing Council, 2020; Taylor et al, in press) suggests that there may be some flexibility about whether the offence was strictly imprisonable for offenders with mental disorder. Duration of the order is determined by the court, taking account of advice from the court liaison team, the probation officer and the putative responsible practitioner. MHTRs may be included as part of a sentence to a maximum length of three years. A Government White Paper, *A Smarter Approach to Sentencing* issued in September 2020, promotes such arrangements.

The principle underlying the MHTR is that a community sentence – or suspended prison sentence – may be customised to meet the needs of the offender, the community and maximise the chances of desistance from future reoffending. Thus, there are up to 13 requirements available to the sentencer, who will determine the number to be included within the order. These are:

1. Unpaid work for up to 300 hours
2. Rehabilitation Activity Requirement (RAR)
3. Accredited Programmes for changing offending behaviour
4. Prohibition from specified activities
5. Curfew – to be in specified place at specified times
6. Exclusion requirement – must not go to specified places
7. Residence requirement – must live at specified address
8. Foreign travel prohibition
9. Mental Health Treatment Requirement – with consent
10. Drug Treatment Requirement – with consent
11. Alcohol Treatment Requirement – with consent
12. Alcohol Abstinence and Monitoring Requirement
13. Attendance Centre (for those under 25).

Community sentences – Sentencing (sentencingcouncil.org.uk)

'Unpaid work' is a way in which the offender may make some obvious recompense to the community. Some of the other requirements are more designed to reduce immediate risk – such as curfew requirements, designation of exclusion zones, prohibited activities and prohibition of foreign travel. Others are more directed towards helping the offender in the short term, with the expectation that this will benefit everyone in the longer term – these include the Mental Health Treatment Requirement, the substance use requirements, Rehabilitation Activity Requirements and accredited programme completion. The remainder – residence or attendance centre requirements – are 'either way' options, helping and protecting.

A designated probation officer/offender manager under the auspices of the National Probation Service or designated Community Rehabilitation Service holds the order once made, together with a 'responsible practitioner' if health requirements are incorporated. Each party – the probation officer, clinician-practitioner and offender-patient – has to sign the agreement.

Further details have been set out in the CSTR programme operating framework provided in partnership between the Ministry of Justice (MoJ), Department of Health and Social Care (DHSC), NHS England and NHS Improvement (NHSE/I), Her Majesty's Prison and Probation Service (HMPPS) and Public Health England (PHE).

There are further separate service description documents, one focusing on orders with primary health care requirements and one on secondary health care requriements, to which RCPsych contributed:

- CSTR programme MHTR Service description **(primary health care)**
- CSTR programme MHTR Service description **(secondary health care)**

In Scotland, the relevant legislation is the Criminal Procedure (Scotland) Act 1995, with amendments in the Criminal Justice and Licensing (Scotland) Act 2010. In Scotland, there is no age limit for the order, although the unpaid work requirement cannot apply to those under 16 years and the order is not available to the children's hearing system. It may be added to other sentences.

As in England and Wales, the offender must agree to the order, although in Scotland there is a possibility that it may be compulsory in the event of a fine default. A criminal justice social worker must make application to the court and, along similar principles, the order may be tailored by adding from up to nine requirements:

1. Unpaid work
2. Supervision
3. Compensation
4. Programmes
5. Residence
6. Conduct (constraints on behaviour, such as not going to specified places)
7. Mental health
   If the person has been diagnosed with a mental health condition that plays a role in their offending, they can receive support and treatment. This can include staying in hospital or attending medical clinics. It can also include psychological interventions or other appropriate treatment/interventions put forward by a doctor or CSTR care team. It must be confirmed that appropriate treatment is available. Details of the treatment are not to be specified.

8 Drug treatment
If the person has a drug problem, they can get treatment under this requirement. They might be ordered to attend a hospital clinic or third sector addictions service provider who has agreed to hold the order.

9 Alcohol treatment
If the person has an alcohol problem which is connected to their offending behaviour, they may be required to receive treatment by the addictions service provider who has agreed to hold the order.

Further details are provided in detailed guidance (Scottish Government, 2019).

3.2 History and development of application of MHTRs in England

Prior to current legislation in England and Wales, when similar sentencing arrangements were available to the courts under the Powers of Criminal Courts Act 1973, the clinician involved had to be a psychiatrist. Under the Criminal Justice Act 2003, this is no longer the case. A nominated, registered practitioner must co-sign the order and take formal clinical responsibility but, compatible with multidisciplinary approaches, this person could be a psychiatrist or a psychologist. Further, in response to underuse of such arrangements, in some cases it is accepted that primary care treatment requirements may suffice. This paper, however, focuses on secondary care arrangements.

It is important to recognise that such orders can only be made if there is awareness of them. Khanoum et al (2009) highlighted low recognition of their availability and value among courts and lawyers as well as probation and clinical practitioners. In the face of always low (Seymour et al, 2008) but then falling use (Ministry of Justice, 2017), the Department of Health & Social Care, NHS England and NHS Improvement, Public Health England and the Ministry of Justice have subsequently made efforts to improve uptake, developing the CSTR programme, which was initially tested in five sites: Birmingham and Solihull, Milton Keynes, Northamptonshire, Plymouth and Sefton, and which became operational between 2017 and 2018. These placed emphasis on primary healthcare mental health requirements for those whose mental health problems do not reach the threshold requirements for secondary mental health services. The programme has enabled newly commissioned services to provide primary care practitioners and clinical psychologists to provide individualised psychological interventions within a 12–15 session treatment plan, while using two of the three treatment requirements if necessary (mental health and drugs or alcohol). Subsequently, there has been movement towards promoting secondary care MHTRs for more complex cases and a second wave of sites has been launched (*Test beds: the story so far* – NHS). The second wave includes Bedfordshire, Cambridge, Essex, Hertfordshire, Staffordshire, The Black Country, Cornwall, Greater Manchester (Bolton, Salford and Trafford) and six South London Boroughs, with more areas coming on board in 2021.

The aims for the CSTR programme are to reduce reoffending and provide alternatives to short custodial sentences by improving underlying health and social problems. The programme supports development of pathways to improve screening, assessment and treatment delivery, through enhancing local partnerships and communication between

health and criminal justice services. Such partnerships also create a climate in which CSTRs are more likely to be offered in magistrates' or Crown Courts.

A preliminary process evaluation of the first wave of CSTR sites suggests the hoped-for rise in MHTRs ordered. Furthermore, as fits with knowledge of multi-morbidity in this population, about one third of the MHTRs made were in combination with a drug or alcohol treatment requirement.

CSTR protocol process evaluation summary report

3.3 How may psychiatrists link efficiently with the courts, contribute to and benefit from MHTR options?

Courts are under immense pressure to complete cases as quickly as possible. For offenders most likely to attract community sentences with one or two treatment requirements the aim generally is to sentence on the day of the hearing. The court may, however, adjourn the case on request, as it is vital that where an MHTR, with or without an alcohol or drug treatment requirement, is to be made, the responsible practitioner has sufficient knowledge of the case to be able to agree to supervise treatment and the prospective patient can have some real understanding of what that would entail so that consent is meaningful.

Most commonly, it is likely to be the Court Liaison and Diversion Services which flag cases as potentially suitable, so it is helpful if the Mental Health Trusts or Boards in the court area have explicit links with a nominated clinician or team of individuals able to respond to calls. Referrals may, of course, also come from the person's legal representative, the court or even the person themselves.

Mutual knowledge of service scope, potential for specialist provision and limitations is likely to reduce pressures when action is requested. Further, if teams know each other well, it is unlikely to be necessary for the responsible practitioner to attend court and reports may be kept brief. Indeed, each testbed site set up a multi-disciplinary steering group with strong governance processes, procedures, pathways and guidance and developed a solution-focused partnership working across health, probation and the criminal justice pathways.

The Royal College of Psychiatrists has contributed to the NHS England and NHS Improvement guidance on processes and actions required at each stage, including sample consent forms: CSTR programme MHTR Service description (**secondary health care**)

Equivalent guidance in Scotland is also available:
Community payback order practice guidance – Scottish Government

4. How MHTRs work in practice

4.1 Setting up and agreeing the supervision and treatment strategy

When the court makes a community sentence or suspended prison sentence with an MHTR, it is essential that the probation officer (in Scotland the criminal justice social worker), the clinician-practitioner and the patient meet at the earliest possible opportunity, to agree the terms of working the order. If it is impossible to meet in person within 14 days, then a phone or video conference must be set up. The patient must understand that the clinician-practitioner and probation officer/offender manager (criminal justice social worker) are working together to help him/her and to assess and manage risks of harm by and to him/her but that sanctions may apply if this is not working as agreed. Each party must be clear about his/her role and the patient must have particular clarity about what is expected, what could trigger any breach proceedings and what such proceedings could entail.

The clinician's role is primarily to engage the offender as a patient, complete a full assessment of mental health and associated social needs and treat the mental disorder(s). It will be unusual for particular treatments to be specified in the treatment requirement – the requirement is usually for attendance – nevertheless both clinician and patient must have a mutually agreed concept about what would constitute cause for clinical concern, and perhaps trigger steps on the pathway back to court, and the probation officer should be aware of the resulting clinical agreement and have an opportunity to comment or contribute. Questions to be considered and discussed openly include: How many missed appointments could trigger breach proceedings? Under what circumstances? What range and extent of refusals of treatments?

All parties should be engaged in risk assessment. In general, the probation officer will focus on risk of reoffending or harm to others. The clinician-practitioner will also be concerned with this but in addition with a range of other risks of harm including, but not confined to, self-harm or suicide and possible victimisation of the patient – perhaps through exploitation or revenge attacks, substance misuse, poor treatment compliance and physical illness. The patient should be asked to specify any risks of harm that s/he has identified and be encouraged to assess these and consider these alongside professional judgements.

In England and Wales, in relation to an MHTR made in conjunction with a suspended prison sentence only (not a community order), sections 293–295 of the Sentencing Act 2020 provide for routine judicial review. This is done in a non-adversarial hearing, albeit rarely to date. One judge with similar experience reports that "defendants like it because the judge is actually taking an interest in them and the progress they are making. Most defendants want to please and quite quickly they do, they do not want to let you down". It would be open to psychiatrists to request this option if it were to be thought helpful.

4.2 Clinical risk assessment and management

A great deal has been written about actuarial risk assessment as applied to offenders or patients but the aim of generating a numerical estimate of likely future risk of harm is of little help in clinical practice with individual patients. Indeed, Singh and colleagues (2011a & b), after systematically reviewing several instruments for doing so, expressed doubt about their value as predictive tools. Of course, any such study in a clinical context is generally confounded by the likelihood of intervention, so a definitive study of risk assessment tools in this context seems unlikely, not least because it is probably unethical.

The clinical task with respect to risk, thus, is to identify those features of the patient and his/her mental disorder and his/her environment which are likely to increase the risk of adverse outcomes and to generate a plan informed by this to reduce those risks. Use of a structured tool to help such a process is advisable for various reasons: it helps to ensure that the process is as comprehensive as possible, it facilitates communication about any perceived risks, supports planning to reduce their impact and guides monitoring of the extent to which risks may be changing. Use of checklists or tools need not be unduly onerous. Further discussion of the risks and benefits of risk assessment, with an introduction to some other aids or assessment tools, and to the related but different issue of threat assessment, may be found in Gunn & Taylor (2014).

Probably the most widely used and evaluated tool in clinical practice – which may also be used to monitor progress – is the 20-item Historical Clinical Risk (HCR-20) tool. Originally informed by systematic literature reviews (Webster et al, 1997) it has been subjected to many subsequent evaluations inside and outside the team developing it. It is now in its third version (Douglas et al, 2014). It is often referred to as a structured professional judgement scale. It requires training for optimal use and may be time consuming in very complex cases. Busy clinicians, however, may find that using a checklist based on this tool is practical and useful for screening of risk of harms.

Risk assessment: a quick HCR-20[1] based guide			
Fixed risk indicators – once only completion (although may be updated as more information arises)		**Dynamic risk indicators – baseline completion and planned reassessments**	
H (Historical) 10		C (Clinical) 5 + R (Risk Management) 5	
Item	Yes/No	Item	Yes/No
H1 Past violence		C1 Insight	
Mental disorder			
Violence risk			
Need for treatment			
H2 Other past antisocial behaviour		C2 Violent ideation or intent/threat	
H3 Relationship instability		C3 Current symptoms of major mental disorder	
H4 Employment		C4 Instability	
H5 Substance use		C5 Treatment and supervision response	
H6 Major mental disorder history		R1 Availability of services and plans	
H7 Personality disorder		R2 Stable living situation	
H8 Traumatic experiences			
As a child			
As an adult		R3 Availability of personal support	
H9 Violent attitudes		R4 Loner term likelihood of treatment/ supervision response	
H10 Prior treatment/ supervision responsive		R5 Current/ recognised future stresses	
[1] Douglas et al, 2013, 2014; Guy et al, 2013.			

Ten of the 20 items of the HCR-20 relate to relatively fixed characteristics of the person, such as events of prior violence or prior supervision failures, and require once-only rating; the only onerous rating among these – completion of the short version of the psychopathy checklist (PCL-SV) – may be safely omitted as it is a component of negligible additional value (Douglas et al, 1999). Five further items refer to clinical matters: insight, attitudes to treatment, active symptoms of major mental illness, impulsivity and responsiveness to treatment – all of which may be changed by treatment and would be encompassed in

routine clinical ratings anyway. The remaining five items relate to 'risk management'. These refer to those matters at the fringes of clinical presentation or the context of treatment that may be changed by effective treatment engagement and supervision but which may put treatment at risk of failure if not ameliorated: exposure to destabilisers (such as drugs or alcohol), lack of stable accommodation or personal support, non-compliance with remediation attempts, stress and the patient's own plans lacking feasibility. Again, these are matters which most clinicians would routinely consider when managing and treating an outpatient.

Thus, although a useful assessment of risks and needs takes time, psychiatrists recognise this and do so in some form anyway. In formal supervision it is advisable only to be more structured in their assessment and documentation. Of most importance, however, is recognition that any clinical risk assessment is merely the stepping stone to an informed treatment plan. The plan should improve health and reduce risks but, as with any intervention, needs continued monitoring – so a risk assessment is never a 'one-off'.

4.3 Advantages of working in a community sentence framework

Likely advantages for the offender-patient in terms of better treatment engagement and more effective treatment, together with reduced likelihood of reoffending, have already been noted in Section 2 above. There are advantages for the clinician too. Few of these patients will never previously have presented to services but their complex needs have commonly led to their failing to engage and sometimes to their being relabelled and simply discharged in absentia. The MHTR offers the opportunity of a whole new framework for treatment – with some offender-patients even noting explicitly that the arrangement means the services as well as the patient must commit. Probation supervision is a given, not previously available to assist the clinician; this may bring additional resources, as needed, to support attendance for appointments. Particularly valuable for those people who have comorbid substance use disorders, is that the orders offer the real prospect of expert treatment in all areas of need. While early optimism about integrated work (Meuser et al, 2003) has been followed with more mixed results (Perry et al, 2014), patients consistently express preference for the integrated approach (Schulte et al, 2011).

4.4 MHTRs for all psychiatrists, regardless of specialty

It is likely that most cases needing secondary mental health care and potentially eligible for an MHTR will be appropriately placed in general adult psychiatric services, with or without input from addictions psychiatry. Nevertheless, all specialties in psychiatry have the potential for contribution. Rising numbers of older people getting involved with the criminal justice system suggest a clear need for older age psychiatry involvement. Increasing recognition of neurodevelopmental conditions, including autistic spectrum disorders and attention deficit hyperactivity disorders as well as intellectual disabilities persisting into adulthood, is particularly welcome as people with such difficulties may be particularly disadvantaged if they get involved with the criminal justice system. Specialist commitment from neuropsychiatry and intellectual disability psychiatry will occasionally, therefore, be vital. Liaison psychiatry and rehabilitation psychiatry specialties have particular skills in the ways of working with other specialists and agencies. Forensic psychiatry tends to function as a tertiary service but is increasingly developing community services and

should take supporting or more direct treatment roles in cases as appropriate.

While people under the age of 18 may not be under such community health requirements in England or Wales, they may in Scotland. We need a continuous process of learning from each other about such differences.

Much smaller demand is likely to be placed on some of the numerically smaller specialties, including perinatal psychiatry and eating disorder psychiatry, but such expertise is undoubtedly occasionally needed with offender-patients.

For many psychiatrists, the liaison with the court and criminal justice system officers required to ensure the success of a community treatment requirement may seem just too daunting but, for most cases, it will simply provide a constructive framework which improves the chances of delivering appropriate clinical interventions. The following page with some brief answers to commonly asked questions may help.

The more of us who become familiar with community health treatment requirements – for mental health or alcohol or drug treatment – and are prepared to offer management of them in appropriate cases, the more chance we have of reducing the numbers of people with mental disorder who are inappropriately placed in prison, reducing the additional morbidity and early mortality associated with this and enhancing safety in our work and the wider community.

Appendix: Frequently asked questions

A 'registered practitioner' is required – what is that?

A psychiatrist or psychologist who is on a specialist register – in psychiatry that would be any consultant psychiatrist.

Do I have to go myself and assess the person before deciding whether the person is suitable?

Ideally yes but if court liaison team links are well established – perhaps there is even overlapping membership – it may be possible to decide whether to offer treatment without an extra interview.

What if capacity to consent to a MHTR needs to be considered?

As implementation of an MHTR requires the patient's consent, this is an important question.

There is no 'absolute capacity'. The question is always about capacity for a specific task at a specific time. In these circumstances, for a person with any long-standing condition, including intellectual disability, any doubts should have been raised at the time of police interview and again at other critical steps through the criminal justice system, including the matter of fitness to plead. Given doubts about capacity, it is important to ensure that the person affected is appropriately supported by a lay advocate (in the police station, a 'responsible adult') and a legal advisor.

The question of capacity for consent to an MHTR is made in the context of the individual having already been regarded as having the capacity to be tried in a criminal court. Although consent to treatment is different again, considerations of best interests of the person and of the least restrictive alternative become important. The most important questions are: Does the individual understand the practical steps s/he is being asked to take? Does the person have the resource, personally or otherwise, to comply? Does the individual understand that it could go worse for him/her on failure to fulfil the promise to be treated and supervised?

Who will assess the person's capacity for consent to an MHTR?

Usually, someone in the court liaison and diversion (L&D) team should have done so. The clinician considering agreement to an MHTR may accept this or may wish to conduct a personal assessment, depending in part on whether the L&D team and receiving clinician have had a previous working alliance. There are formal tests of capacity to consent to treatment (e.g. Grisso et al), generally to be conducted by a psychologist trained in use of this tool, which may add benefit where there are special concerns.

How long do I have to make a decision as to whether to agree or disagree with an MHTR?

Courts want a decision on the day but you may request an adjournment of up to 14 days for your assessment.

If I agree to be the registered practitioner for the MHTR do I have to do any extra paperwork?

You have to sign agreement as the responsible clinical practitioner. Otherwise, you simply keep clinical records as for any other patient. If the person were to be in breach of the treatment requirement, then you must record evidence for that. The probation officer may then take that back to the court, as agreed.

As the registered practitioner, do I have to provide treatment myself?

No. You must ensure that relevant treatment is available but anyone in your team may deliver it.

How specific do I have to be about the treatment?

No specificity is required by the court.

How long will the MHTR last?

As stipulated by the court but for a maximum of three years.

What extra support is available for the patient or for me to help the patient who is under an MHTR?

The probation officer/criminal justice social worker is a key resource likely to be new to the clinical team and through this it may also be possible to access other practical resources, for example help with travel to appointments. Close liaison between clinicians and probation officer throughout should maximise the benefit of the arrangement.

What will happen if I think treatment is no longer needed or suitable?

You will have to inform the probation officer and explain to the patient and then send a brief report to the court to terminate your part of the contract.

Will I have to go into court?

Probably not but the court always has the right to call you.

If the person under an MHTR doesn't engage what happens then?

Briefly document how you facilitated engagement and agree next steps with the probation officer who may take this back to the court; if possible, you will inform the patient what is happening.

If I let the probation officer know the person has not engaged, am I sending him/her back to prison?

No. Imprisonment is possible but if there are viable alternatives – and you may make suggestions here – the court may choose not to imprison.

What will happen if the person commits a crime whilst under the MHTR? Will I have to go to court?

No. You may be asked for a report relating to the period in treatment to help establish relevance of it.

References

Aebi MF, Tiago MM & Burkhardt C (2017) *Council of Europe Annual Penal Statistics.* http://wp.unil.ch/space/files/2017/04/SPACE_I_2015_FinalReport_161215_REV170425.pdf (Accessed 15 January 2021)

Anwar S, Långström N, Grann M & Fazel S (2011) Is arson the crime most strongly associated with psychosis? – A national case-control study of arson risk in schizophrenia and other psychosis. *Schizophrenia Bulletin,* **37**:580–586.

Audley J, Kalebic N, Vladu A, French M, Robinson L & Taylor PJ (2021) Outcomes of court ordered mental health treatment requirements in the community for people with mental disorder involved with the criminal justice system. Copy available taylorpj2@cardiff.ac.uk on request.

Bradley K (2009) *The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system.* Department of Health: London. www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_098698.pdf (Accessed 15 January 2021)

Brooker C, Sirdifield C, Blizard R, Denney D & Pluck G (2012) *Probation and mental illness. Journal of Forensic Psychiatry and Psychology,* **23(4)**:522–537. http://dx.doi.org/10.108 0/14789949.2012.704640

Centre for Justice Innovation (2015) *Problem-solving Courts: an evidence review.* https://justiceinnovation.org/sites/default/files/media/documents/2019-03/problem-solving-courts-an-evidence-review.pdf Accessed 15 January 2021.

Corston J (2007) *A report by Baroness Jean Corston of a review of women with particular vulnerabilities in the criminal justice system.* Home Office: London http://www.newsocialartschool.org/pdf/Corston-pt-1.pdf (Accessed 15 January 2021)

Douglas KS, Ogloff JRP, Nicholls TL & Grant I (1999) Assessing risk for violence among psychiatric patients: The HCR-20 violence risk assessment scheme and the psychopathy checklist: Screening version. *Journal of Consulting and Clinical Psychology,* **67**:917–930.

Douglas KS, Hart SD, Webster CD & Belfrage H (2013) *HCR-20V3: Assessing risk of violence – User guide.* Burnaby, Canada: Mental Health, Law, and Policy Institute, Simon Fraser University.

Douglas KS, Hart SD, Webster CD, Belfrage H, Guy LS & Wilson CM (2014) Historical-Clinical-Risk Management-20, Version 3 (HCR-20^{V3}): Development and Overview. *International Journal of Forensic Mental Health,* **13(2)**:93–108. See whole issue for further evaluations: free to download at http://www.newsocialartschool.org/pdf/Corston-pt-1.pdf (Accessed 09 February 2020)

Duke AA, Smith KMZ, Oberleitner LMS, Westphal A & McKee SA (2018) Alcohol, drugs, and violence: A meta-meta-analysis. *Psychology of Violence,* **8(2)**:238–249. https://doi.org/10.1037/vio0000106

Eide S (2017) *Assisted outpatient treatment in New York.* The Case for Making Kendra's Law Permanent. https://media4.manhattan-institute.org/sites/default/files/R-SE-0417.pdf Accessed 15 January 2021.

Fazel S, Gulati G, Linsell L, Geddes JR & Grann M (2009) Schizophrenia and violence: systematic review and meta-analysis. *PLoS Medicine*, **6**:e1000120. doi:10.1371/jounal.pmed.1002120

Fazel S, Lichtenstein P, Grann M, Goodwin GM & Långström N (2010) Bipolar disorder and violent crime. *Archives of General Psychiatry,* **67**:931–938. doi: 10.1001/archgenpsychiatry.2010.97

Fazel S & Seewald K (2012) Severe mental illness in 33588 prisoners worldwide: systematic review and meta-regression analysis. *British Journal of Psychiatry,* **200**:364–373. doi: 10.1192/bjp.bp.111.096370

Fazel S, Sjöstedt G, Långström N & Grann M (2007) Severe mental illness and risk of sexual offending in men: A case control study based on Swedish national registers. *Journal of Clinical Psychiatry,* **68**:588–596. doi: 10.4088/jcp.v68n0415

Fazel S & Baillargeon J (2011) The health of prisoners. *Lancet 2011,* **377**:956–965.

Fazel S, Yoon IA & Hayes AJ (2017) Substance use disorders in prisoners: An updated systematic review and meta-regression analysis in recently incarcerated men and women. *Addiction,* **112**:1725–1739. doi:10.1111/add.13877

Fiduccia CE & Rogers R (2012) Final-stage diversion. A safety net for offenders with mental disorders. *Criminal Justice and Behavior 2012*, **39**(4):571–583. doi: 10.1177/0093854811432527

Ginn S (2013) Promoting health in prison. *BMJ 2013*, **346**:f2216. doi: 10.1136/bmj.f2216

Grisso T, Appelbaum P & Hill-Fotouhi C (1995) The MacCAT-T:a clinical tool to assess patients' capacities to make treatment decisions. *Psychiatric Services*, **48**:1415–1419.

Gunn J & Taylor PJ (eds) *(2014) Forensic Psychiatry. Clinical, legal and ethical issues.* Chapter 22: Dangerousness, 529–550 CRC Press: Boca Raton, FL.

Guy LS, Wilson CM, Douglas KS, Hart SD, Webster CD & Belfrage H (2013) *HCR-20 Version 3: Item-by-item*

summary of violence literature. HCR-20 Violence Risk Assessment White Paper Series, #3. Burnaby, Canada: Mental Health, Law, and Policy Institute, Simon Fraser University.

Heilbrun K, Dematteo D, Yashuhara K, Brook-Holliday S, Shah S, King C, Dicarlo AB, Hamilton A & Laduke C (2012) Community-based alternatives for justice-involved individuals with severe mental illness. *Criminal Justice and Behavior 2012*, **39(4)**:351–419. doi: 10.1177/0093854811432421

Hillier J & Mews A (2018) *Do offender characteristics affect the impact of short custodial sentences and court orders on reoffending? Ministry of Justice: London.* https://www.gov.uk/government/publications/do-offender-characteristics-affect-the-impact-of-short-custodial-sentences-and-court-orders-on-reoffending (Accessed 21 January 2021)

House of Commons Library (2019) *UK Prison Population Statistics.* Briefing Paper Number CBP-04334. https://researchbriefings.parliament.uk/ResearchBriefing/Summary/SN04334 Accessed 15 January 2021.

Keers R, Ullrich S, DeStavola BL & Coid JW (2014) Association of violence with emergence of persecutory delusions in untreated schizophrenia. *American Journal of Psychiatry*, **171**:332–339. doi: 10.1176/appi.ajp.2013.13010134

Kissell AE, Taylor PJ, Walker J, Lewis E, Hammond A & Amos T (2014) Disentangling alcohol-related needs among pre-trial prisoners: a longitudinal study. *Alcohol and Alcoholism*, **49**:639–644. doi: 10.1093/alcalc/agu056

Lowenstein J, Purvis C & Rose K. (2016) A systematic review on the relationship between antisocial, borderline and narcissistic personality disorder diagnostic traits and risk of violence to others in a clinical and forensic sample*. Borderline Personality Disorder and Emotional Dysregulation*, **3(14)**:1–12. doi 10.1186/s40479-016-0046-0

Lundström S, Forsman M, Larsson H, Kerekes N, Serlachius E, Långström N & Lichtenstein P (2014) *Childhood neurodevelopmental disorders and violent criminality: A sibling control study. Journal of Autism and Developmental Disorders*, **11**:2707–2716. https://doi.org/10.1007/s10803-013-1873-0

Manjunath A, Gillham R, Samele C & Taylor PJ (2018) Serving a community sentence with a mental health treatment requirement: Offenders' perspectives*. Criminal Behaviour and Mental Health,* **28**:492–502. doi: 10.1002/cbm2096

Maughan D, Molodynski A, Rugkåsa J & Burns T (2013) A systematic review of the effect of community treatment orders on service use. *Social Psychiatry and Psychiatric Epidemiology*. doi 10.1007/s00127-013-0781-0

Ministry of Justice, HM Prison Service and Her Majesty's Prison and Probation Service. *Offender Management Statistics Quarterly* Published: 27 April 2017. https://www.gov.uk/government/statistics/offender-management-statistics-quarterly-october-to-december-2016 Accessed 15 January 2021.

Ministry of Justice (2020) *Proven reoffending statistics quarterly bulletin, England and Wales, January 2018 to March 2018.* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/861994/proven_reoffending_bulletin_January_to_March_18.pdf Accessed 15 January 2021.

National Audit Office (2010) *Managing offenders on short custodial sentences.* www.nao.org.uk/publications/0910/short_custodial_sentences.aspx Accessed 15 January 2021.

NCISH [National Confidential Inquiry into Suicide and Homicide] by people with mental illness (2017)

Annual Report (2017) http://documents.manchester.ac.uk/display.aspx?DocID=37560 Accessed 15 January 2021.

Prisons and Probation Ombudsman (2019) *Annual Report.* https://s3-eu-west-2.amazonaws.com/ppo-prod-storage-1g9rkhjhkjmgw/uploads/2019/10/PPO_Annual-Report-2018-19_WEB-final-1.pdf Accessed 15 January 2021.

Prison Reform Trust (2019) *Prison: the facts.* Bromley Briefings Summer 2019. www.prisonreformtrust.org.uk/Portals/0/Documents/Bromley%20Briefings/Prison%20the%20facts%20Summer%202019.pdf Accessed 15 January 2021.

Ritchie JH, Dick D & Lingham R (1994) *The Report of the Inquiry into the Care and Treatment of Christopher Clunis.* London: HMSO.

Schulte SJ, Meier PS & Stirling J (2011) Dual diagnosis clients' treatment satisfaction-a systematic review. *BMC Psychiatry,* **11(1)**:64. doi:10.1186/1471-244X-11-64

Scottish Government (2019) *Community Payback Order Practice Guidelines.* https://www.gov.scot/publications/community-payback-order-practice-guidance/pages/5/ Accessed 15 January 2021.

Senior M, Fazel S & Tsiachristas A (2020) The economic impact of violence perpetration in severe mental illness: A retrospective, prevalence-based analysis in England and Wales. *Lancet Public Health*, **5**:e99–106. doi: 10.1016/S2468-2667(19)30245-2

Sentencing Council (2016) *Imposition of Community and Custodial Sentences Definitive Guideline*. https://www.sentencingcouncil.org.uk/wp-content/uploads/Imposition-definitive-guideline-Web.pdf Accessed 15 January 2021.

Sentencing Council (2020) *Sentencing offenders with mental disorders, developmental disorders, or neurological impairments.* https://www.sentencingcouncil.org.uk/overarching-guides/crown-court/item/sentencing-offenders-with-mental-disorders-developmental-disorders-or-neurological-impairments/ Accessed 15 January 2021.

Seymour L, Rutherford M, Khanom H & Samele C (2008) The Community Order and the Mental Health Treatment Requirement. *Journal of Mental Health* (May) 53–65. doi:10.19164/ijmhcl.v1i17.268

Singleton N, Meltzer H, Gatward R, with Coid J & Deasy D (1998) *Psychiatric morbidity among prisoners in England and Wales.* London: Department of Health.

Swanson JW, Holzer CE, Ganju VK & Jono RT (1990) Violence and psychiatric disorder in the community: Evidence from the Epidemiologic Catchment Area Surveys*. Hospital and Community Psychiatry,* **41**:761–70. doi: 10.1176/ps.41.7.761

Swartz MS, Swanson JW, Steadman HJ, Robbins PC & Monahan J (2009) *New York State Assisted Outpatient Program Evaluation*. https://static.prisonpolicy.org/scans/NYDPH-report.pdf Accessed 15 January 2021.

Taylor PJ, Eastman N, Latham R & Holloway J (2021) Sentencing offenders with mental disorders, developmental disorders, or neurological impairments: What does the new Sentencing Council Guideline mean for psychiatrists? *British Journal of Psychiatry*. doi: 10.1192/bjp.2021.21

Winerip M (1999) Bedlam on the streets. *New York Times Magazine 23/5/1999*. http://www.nytimes.com/1999/05/23/magazine/bedlam-on-the-streets.html Accessed 15 January 2021.