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A review of the use of mental health requirements and Community Orders

It is well documented that the prison population is increasing; so too is the number of Community Orders being imposed by the Courts. Community Orders were implemented in April 2005 following the Criminal Justice Act of 2003. Sentencers have the option of twelve requirements that they can issue as part of a Community Order, one of which is a Mental Health Treatment Requirement (MHTR). The requirement can be issued for up to three years and for a MHTR to be issued the Court must ensure the following (p. 13):

- Treatment to improve the offender's mental health will be provided.
- Any hospital treatment is not given in a psychiatric unit.
- The offender's mental health problem requires and may be susceptible to treatment, but is not serious enough to invoke the sections of the Mental Health Act 1983.
- The practitioners and services are available to carry out the treatment.
- The offender is willing to comply with the treatment.

Although the number of the Community Orders has been rising since its implementation, the use of MHTR has varied. In 2006, 725 MHTR were issued out of a total of 206,323 requirements being imposed. Unpaid work (UPW) and supervision are the most frequently used requirements and MHTR, along with residential, attendance, prohibited activity and exclusion, make up less than 1 per cent of total use. There were differences of usage among probation areas, with a considerable contrast between urban and rural areas. In 2006, 55 per cent of the MHTR were issued in London, Kent, West Midlands, Merseyside, Thames Valley, Essex and Greater Manchester Probation Areas, although these areas only accounted for 36 per cent of the total number of requirements imposed nationally. In contrast, Northampton and North Yorkshire imposed MHTR twice in 2006.

Women and men were equally likely to receive MHTR. Twenty-eight percent of MHTR were issued to BME offenders and out of that number, one in eight were issued to black or black British offenders. These statistics should be considered alongside the information that BME groups account for 9% of the general population and 25% of the prison population.

The report identifies a number of obstacles to the use of MHTR. In addition to legislative obstacles, the most significant problem encountered is getting access to psychiatric assessments to assist with the assessment process for recommending a MHTR at the sentencing stage. It is also noted that government targets might influence the demand. For example, in 2006 a total of 725 MHTR were issued, compared with 11,361 Drug Treatment Requirements (DTRs). There is a national target for achieving DTRs for both probation and partnerships, whereas there is an absence of any such target for MHTR.

Although the use of MHTR is low compared to the use of other requirements, the trend in use is increasing. However, little is known about their effectiveness and

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their impact on offenders' mental health and re-offending rates. The Sainsbury Centre for Mental Health has plans for further research into the usage of MHTR.

The Community Order and the Mental Health Treatment Requirement by Linda Seymour and Max Rutherford (2008) is produced by The Sainsbury Centre for Mental Health and can be downloaded from www.scmh.org.uk

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