Institute for
Public Safety
Crime and Justice

Community Sentence Treatment Requirement Multisite Report July 2020 – July 2021

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About the Institute for Public Safety, Crime and Justice

Established in 2014, the Institute for Public Safety, Crime and Justice (IPSCJ) at the University of Northampton delivers high quality research and evaluation, insight, and innovation in the fields of public safety, crime and justice. The IPSCJ is situated at the interface between practice, policy, and academia, adopting an evidence-based approach to enhance public service delivery models, organisational strategy, and outcomes for service users. The IPSCJ collaborates with partner organisations at local, regional, national, and international scales to address key global challenges of the 21st century. The core mission of the IPSCJ is to support positive evidence-based policy and practice change for the benefit of society.

The IPSCJ has five research and evaluation portfolios:

Health and Justice: We explore intersections between health and justice, working with a wide range of partners and agencies in community and prison settings. Example projects include:

- Evaluating Community Sentence Treatment Requirements in England, funded by NHS England and NHS Improvement and local CSTR Programme Boards
- Assessing the Effectiveness of Mental Health Street Triage in the East Midlands, funded by Northamptonshire Office of Police, Fire and Crime Commissioner

Children and Young People: We work with children and young people taking a child-centred and participatory approach to research and evaluation. Example projects include:

- National evaluations of the Mini Police and Volunteer Police Cadets, funded by the Home Office Police Transformation Fund
- Fast-tracking vulnerable young people into the police cadets in Nottinghamshire, funded by the Volunteer Police Cadets
- Evaluating early intervention pilots in Northamptonshire with young people at risk of exclusion, funded by Northamptonshire Office of Police, Fire and Crime Commissioner

Citizens in Policing: We investigate the roles, functions, and contributions of volunteers within public safety and policing. Example projects include:

- Exploring synergies within volunteering in law enforcement and public safety in the UK and Japan, funded by the Economic and Social Research Council
- National programme of research in partnership with the NPCC portfolio for Citizens in Policing, funded by the Home Office Police Transformation Fund

Organisational Development: We support organisations to understand practices, structures, and cultures to improve efficiency and lead change. Example projects include:

- Organisational development programme with the East Midlands Specialist Operations Unit (EMSOU), funded by EMSOU
- Place-based leadership development in Kenya and Uganda, funded by the Danish Institute Against Torture
- Workforce engagement in Leicestershire Police and Northamptonshire Police, funded by Leicestershire Police and Northamptonshire Police

Equality, Vulnerability and Inclusion: We empower individuals and communities whose voices are not often heard to take part in research and evaluation. Example projects include:

- Understanding serious violence in Nottingham City and Nottinghamshire, funded by Nottinghamshire Office of Police and Crime Commissioner
- Evaluation of Women's Health Services for Perinatal Female Offenders in HMP Peterborough, funded by NHS England and NHS Improvement – East of England

Executive Summary

This report presents analysis from the Community Sentence Treatment Requirement Multisite Evaluation, completed by the Institute for Public Safety, Crime and Justice. Data were provided from Bedfordshire, Cambridgeshire, Essex, Hertfordshire, Northamptonshire and Staffordshire. This report relates to the period of July 2020 to July 2021, with data being provided for 646 cases.

The aim of the report is to provide a high-level overview across the participating sites, to complement local reports provided to each local CSTR programme Board to support local programme development, evidence and understanding of identified patterns across the wider dataset.

Overview:

Demographics: Of individuals assessed for an MHTR (198), around half (52%) were female, most were aged between 25 and 34 years (32%) and, where ethnicity was recorded, were predominantly White (94%). There were 18 women who were pregnant at point of assessment and an additional 10 who would be considered as being on the perinatal pathway. 8% (52) of those assessed were sole carers and there were 9 (1%) individuals identified as previously serving in the armed forces. Mental health disability was identified in 75% of individuals. The most frequent offence type for those assessed (30%) was violence against a person.

Assessment: 550 individuals were assessed for MHTR with no ATR/DRR (85%), 52 (8%) for MHTR/ATR and 32 (5%) for MHTR/DRR. There were 4 different psychometric measures used across the sites as part of the assessment (K6 – 1 site; K10 – 3 sites, CORE-10 – 1 site and CORE-34 – 1 site). Across the different measures, most identified severe levels of mental distress. In terms of probation risk score, the most common risk score provided was medium, representing 45% of scores. During assessment, anxiety and depression were identified in 47% and 38% respectively. 82% of those assessed were identified as suitable for MHTR, with most frequent reasons for unsuitability being complexity (23), risk (17) and above primary care threshold (11).

Sentencing: The frequency of sentences passed increased over time, with peaks in May 2021 and June 2021. 79% of sentences were passed within 31 days of assessment. Most recommendations for MHTR or dual diagnosis were agreed (90%), though 46 were declined. Of 46 of the declined cases, a custodial sentence was passed (36). There were 177 identified multidisciplinary meetings held following sentencing, with 27% happening within 2 weeks when identified. There were 44 individuals who were sentenced to MHTR&ATR or MHTR&DRR.

Start of Intervention: There were 221 cases where the MHTR intervention was started, with the number of intervention starts increasing over time. In 5 of 6 sites, CORE-34, GAD-7 and PHQ-9 were completed (with one site using K6 in stead of CORE-34), revealing most commonly moderate-to-severe or severe mental distress for 38% using CORE-34, severe anxiety for 44% using GAD-7 and severe depression for 33% using PHQ-9.

Intervention Length and Engagement: Intervention length was recorded for 94 individuals, with 59 lasting between 3 and 6 months. It should be noted that some sites do not record the number of sessions received or missed until end of intervention, however, there were 414 sessions identified as being missed. Most frequently, the reason for missing sessions was illness or physical health (86, 21%), followed by AWOL/no response/DNA (47, 11%). Of the 221 who started the intervention, 23 breaches were identified. Of those who breached, 6 received a custodial sentence.

Outcomes and Change: There were 97 individuals with a recorded end date and post measures completed. Outcomes and change were:

- **K6**: 25 completed and average reduction was -2.68. This difference was not statistically significant ($t(24) = 2.007$, $p>0.05$);
- **CORE-34**: 63 completed and average reduction was -29.83 and this difference was statistically significant $t(62) = 9.317$, $p<0.05$;
- **GAD-7**: 88 completed and the average reduction was -5.32 and this difference was statistically significant $t(87) = 8.424$ and $p<0.05$; and
- **PHQ-9**: 88 completed and the average reduction was -6.67 and this difference was statistically significant $t(87) = 9.009$, $p<0.05$.

Observations:

Overall, the analysis and results presented from across the 6 sites are very positive. For 97 individuals who were assessed and started the MHTR since July 2020, statistically significant positive change was identified using the CORE-34, GAD-7 and PHQ-9. **Therefore, based on the analysis of 13 months data, the evidence demonstrates how MHTR interventions are having a significant benefit in terms of mental distress, anxiety and depression.**

Key observations are:

- The low numbers of people (representing 5% of all assessments, though it is noted ethnicity was not recorded for 22% of assessments) from Black and Ethnic Minority backgrounds who are being assessed and sentenced to MHTR is a significant concern, which requires investigations in each site to ensure the equality.
  - **It is recommended that each Board undertakes a review of their pathway to identify if people from BAME groups are screened out or diverted onto other pathways.**
- The numbers of individuals with a wide variety of disabilities (other than mental health) is high, demonstrating an inclusive pathway which may divert such individuals from custody. There were 26 individuals who were identified as having a neurodevelopmental disability, which may be higher given the range of conditions that may be defined as such.
  - **It is recommended further clarity is provided to Primary Care Practitioners to ensure consistency between sites in terms of data recorded.**
- Violent offences represent approximately a third of all offences captured, which emphasises the importance of ensuring appropriate risk assessments are completed to ensure the safety and welfare of practitioners and service users.
- The numbers of assessments and individuals sentenced to MHTRs is increasing and represents 87% of all assessments. Assessments for combined orders for ATR and DRR represent 8% and 5% of all assessments.
  - **It is recommended local Boards review if numbers of individuals being considered for combined orders matches with local service levels of needs and explore strategies and approaches to improve numbers.**
- The assessment processes continue to identify significant levels of mental health needs for individuals on this pathway, which strongly supports the continuation and expansion of sites across England.
- Of the 221 individuals who began the intervention, there were 414 sessions missed by individuals tracked (where missing data is entered as 0 missed sessions). It should be noted some individuals have not yet completed the intervention. Of the 48 individuals who had completed 12 or more sessions, the average number of missed sessions per person was 2.15. It should be noted approximately 1-in-10 missed sessions were where individuals failed to attend without notice.
  - **It is recommended that the Clinical Lead and Primary Care Practitioner forums, and local programme Board operational groups, reflect on numbers of missed sessions to reduce numbers of missed sessions as well as consistently address/respond to incidents of missed sessions.**

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1. Introduction

This report presents analysis from the Community Sentence Treatment Requirement Multisite Evaluation, completed by the Institute for Public Safety, Crime and Justice. Data were provided from Bedfordshire, Cambridgeshire, Essex, Hertfordshire, Northamptonshire and Staffordshire. This report relates to the period of July 2020 to July 2021, with data being provided for 646 cases. Across the sites, most cases were in Essex (n=203).

The aim of the report is to provide a high-level overview across the participating sites, to complement local reports provided to each local CSTR programme Board to support local programme development, evidence and understanding of identified patterns across the wider dataset.

The report is structured into the following sections:

2. Demographic Overview
3. Assessment
4. Sentencing
5. Intervention Length and Engagement
6. Outcomes and Change
7. Observations

2. Demographic Overview

This section provides a demographic overview of individuals assessed for an MHTR between July 2020 and July 2021.

Overall, 646 assessments were completed, with Figure 2.1 showing just over half (53%) of assessments were with females, though it must be noted that 2 sites (Cambridgeshire and Hertfordshire) are exclusively female. Figure 2.3 shows that most individuals were assessed were aged between 25 – 34 years, followed closely by 35 – 44 years. In terms of ethnicity, Figure 2.4 shows that most individuals were White (73%) though 22% of cases were not known or identified. This means 5% were with people from an Asian, Black or Mixed ethnic group.

Fig 2.1 Assessments - Gender, 6 Sites, Jul 20 - Jul 21

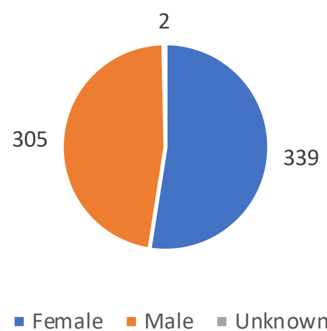


Fig 2.2 Assessments - Age, 6 Sites, Jul 20 - Jul 21

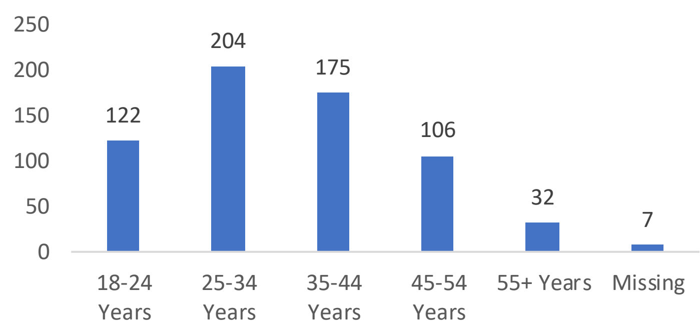
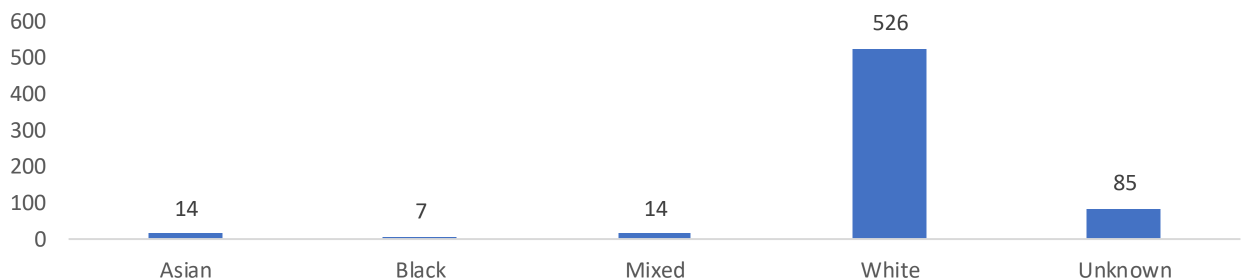


Fig 2.3 Assessments - Ethnicity, 6 Sites, Jul 20 - Jul 20



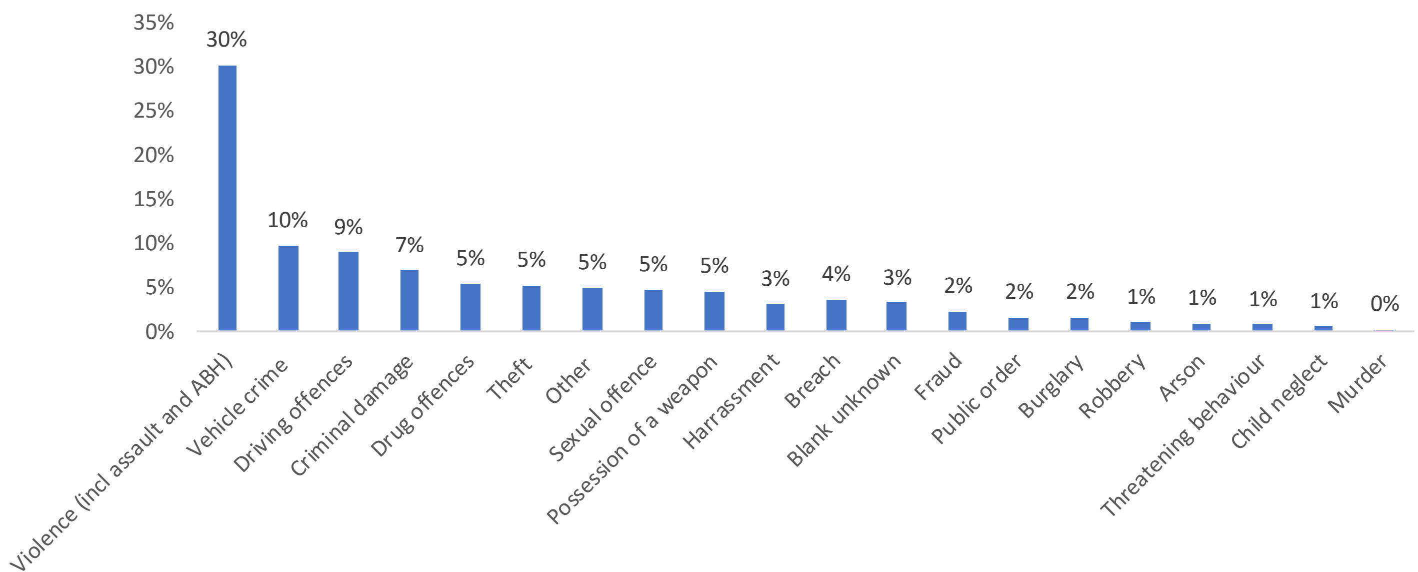
At the point of assessment, there were 18 women who were pregnant, with a further 10 having been pregnant or had an abortion/miscarriage in the past 12 months. Therefore, of assessments with women, 8% would be considered at a point on the perinatal pathway. Of those assessed, 52 (8%) were identified as being a sole carer and 9 were identified as having previously served in the armed forces.

Table 2.1 illustrates the most frequently identified disabilities across the 6 sites, showing that 75% had a mental health disability, 4% had a neurodevelopmental disability and 4% were identified as having an unidentified disability.

Table 2.1 Disabilities

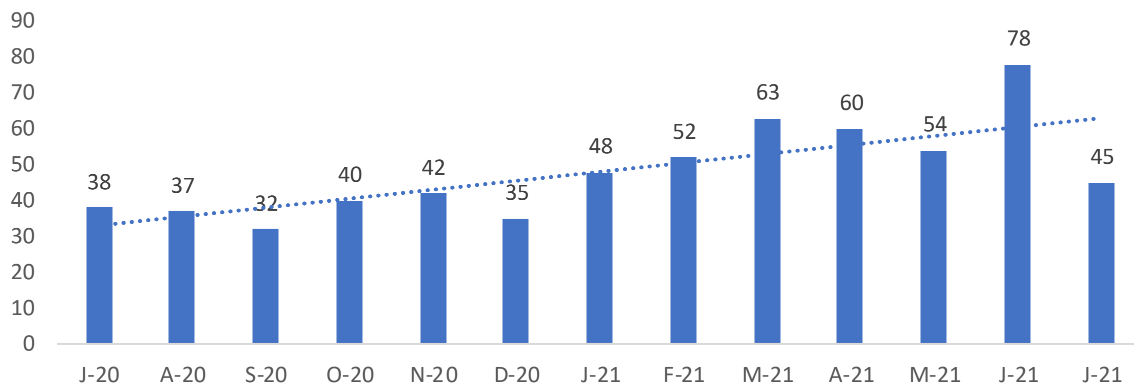
Disability	Frequency	% of all identified disabilities
Mental health/ illness	487	67%
Neurodevelopmental	26	4%
Other	24	3%
Substance misuse	19	3%
Mobility	19	3%
Physical	18	2%
COPD/ breathing	17	2%
LD	15	2%
ADHD	14	2%
Dyslexia	11	2%

The most frequent offence type within those assessed was violence, representing 30% of offence types recorded. The second most frequent offence type was vehicle crime, representing 10% of offence types recorded.

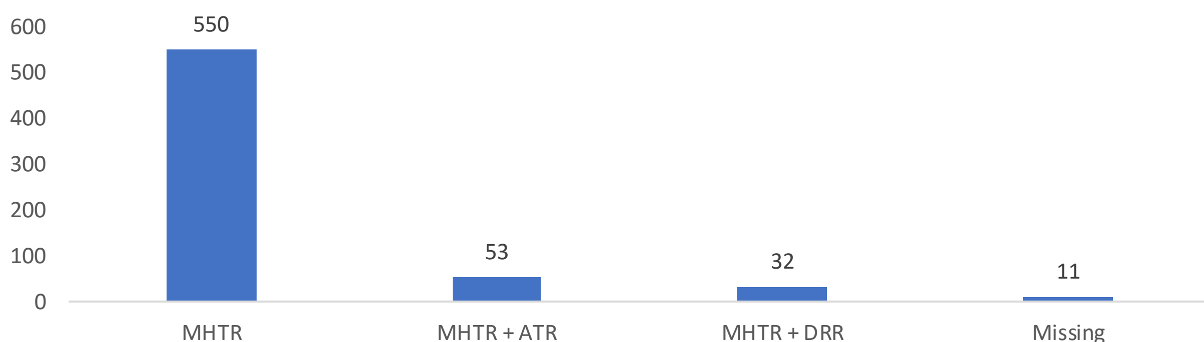


3. Assessment

This section relates to data concerning the assessment of individuals for an MHTR. Figure 3.1 illustrates the number of cases per month assessed, illustrating a trend increase over time. The average number of assessments each month per site ranged from 5.3 to 13.0.



Most individuals were assessed only for MHTR (87%) and no other Treatment Requirements, with 53 individuals being assessed for both MHTR/ATR and 32 for MHTR/DRR (**dual diagnosis assessments representing 13% of all assessments**).



The process and tools used to assess suitability for an MHTR differ between sites, with some using the K6/10 and others using CORE10/34 (See Table 3.1). This variability presents a challenge at interpreting effectiveness of assessment processes and later outcomes, though will allow for comparison between areas.

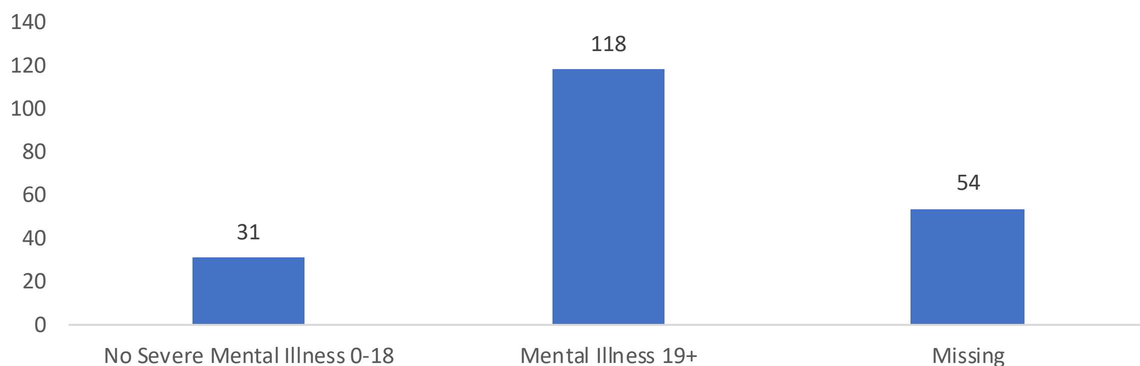
Table 3.1: Assessment Tool by Site

Site	Assessment Tool
Bedfordshire	K10
Cambridgeshire	K10
Essex	K6, GAD, PHQ9
Hertfordshire	K10
Northamptonshire	CORE-34
Staffordshire	CORE-10

K6 Scores

The K6 was used in 1 site. The K6 (Kessler-6) is a non-specific distress scale that screens for severe mental illness, containing 6 items. Score range from 6 – 30, with higher scores indicating a greater tendency towards mental illness. Score 19 and over indicate mental distress.

Of 203 individuals assessed using K6, 118 (58%) were identified as being in mental distress. There were missing data for 54 individuals, representing 27% of cases.

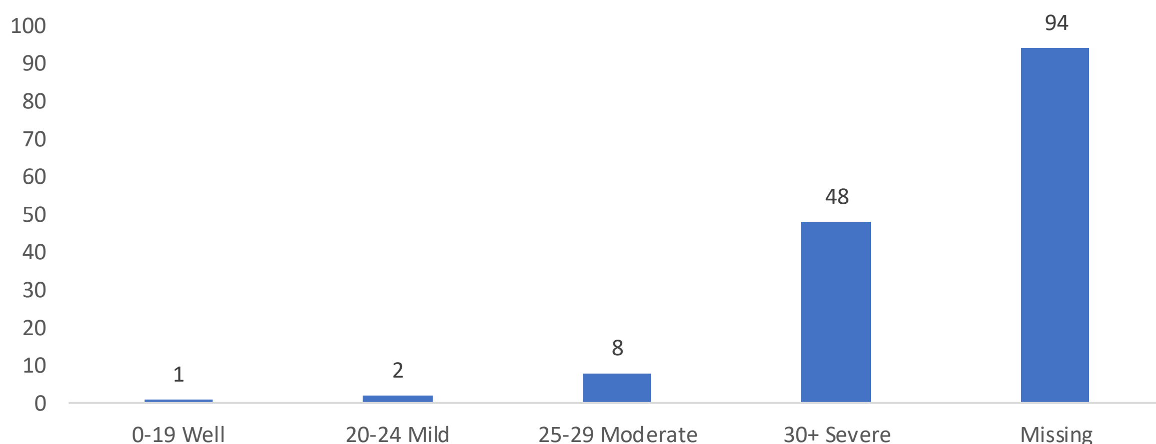


K10 Scores

The K10 was used in 3 sites. The K10 (Kessler-10) is a self-report 10-item questionnaire to assess anxiety and depressive symptoms in the previous 4 weeks. Scores range from 10-50 and is interpreted in the following levels:

- Scores under 20 are likely to be well;
- Scores 20-24 are likely to have a mild mental disorder;
- Scores 25-29 are likely to have a moderate mental disorder; and
- Scores over 30 are likely to have a severe mental disorder.

Of 153 individuals assessed using K10, 58 (38%) were identified as being in mental distress, with 48 in severe mental distress. There were missing data for 94 individuals, representing 61% of cases.

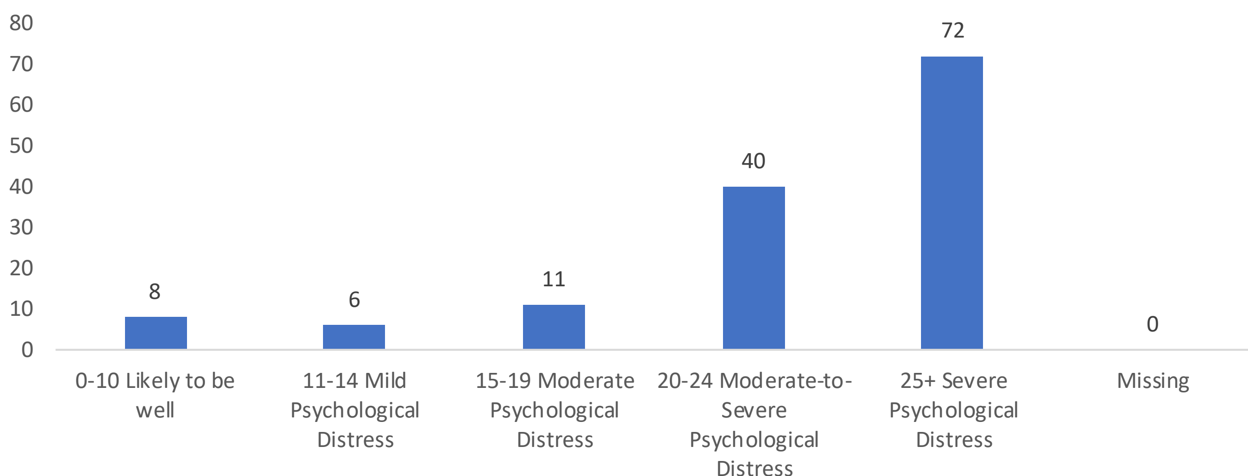


CORE-10 Scores

The CORE-10 is a shortened version of the CORE-34, with items covering anxiety, depression, trauma, physical problems, functioning and risk to self. Higher scores indicate higher levels of general psychological distress. Scores range from 0 – 40 and is interpreted in the following levels:

- Scores under 10 are likely to be well;
- Scores 11-14 are likely to have mild psychological distress;
- Scores 15-19 are likely to have moderate psychological distress;
- Scores 20-24 are likely to have moderate-to-severe psychological distress; and
- Scores over 25 are likely to have severe psychological distress.

Of 137 individuals assessed using CORE-10, 129 (94%) were identified as being in mental distress, with 72 (53%) being in severe psychological distress. There were no missing data.

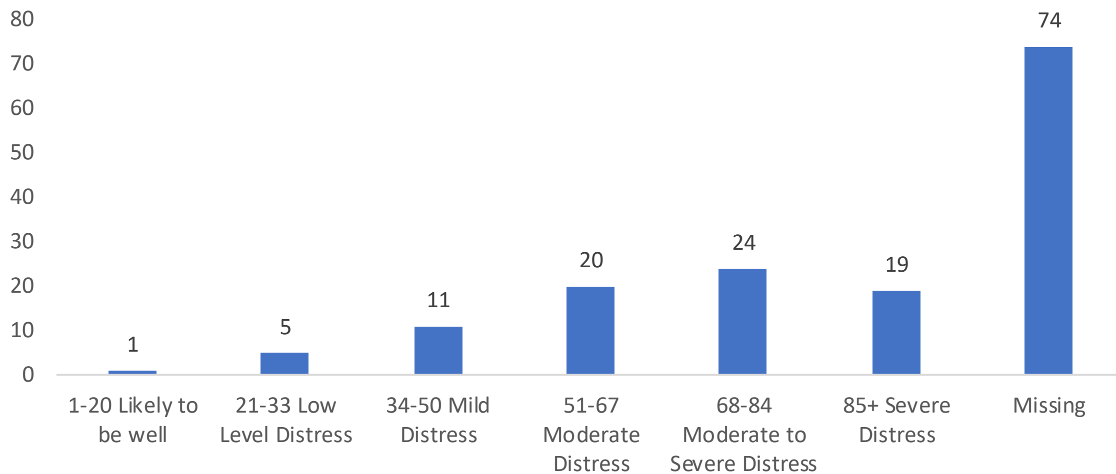


CORE-34

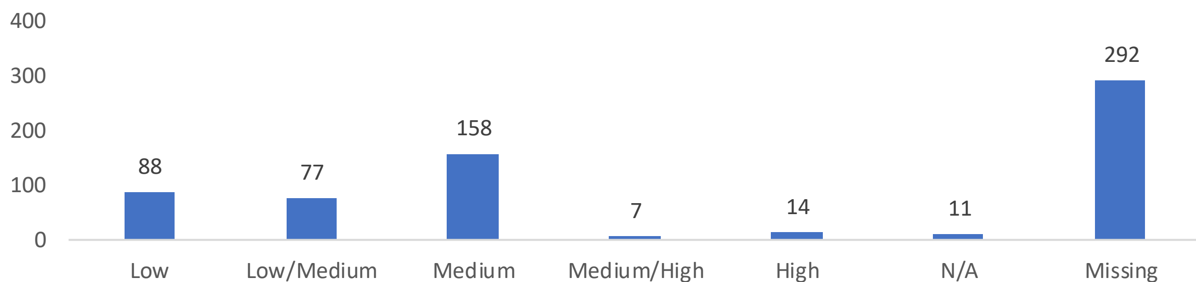
The CORE-34 is a generic measure of psychological distress across four domains: wellbeing (4 items); problems/symptoms (12 items); life functioning (12 items) and risk (6 items). Higher scores indicate higher levels of general psychological distress. Scores can be interpreted into the following levels:

- Scores 1-20 are likely to be healthy;
- Scores 21-33 are likely to be low level psychological distress;
- Scores 34-50 are likely to be mild psychological distress;
- Scores 51-67 are likely to be moderate psychological distress;
- Scores 68-84 are likely to be moderate-to-severe psychological distress; and
- Score 85+ are likely to be severe psychological distress.

Of 154 individuals assessed using CORE-34, 79 (51%) were identified as being in mental distress, with 19 in severe mental distress. There were missing data for 74 individuals, representing 48% of cases.



Whilst most individuals assessed were likely to have high/severe mental health needs, Fig 3.7 shows that 158 (24%) individuals were assessed as having a medium Probation risk score status captured using OASys (an actuarial risk and needs assessment). Data were not provided for 292 individuals, representing 45% of the sample.

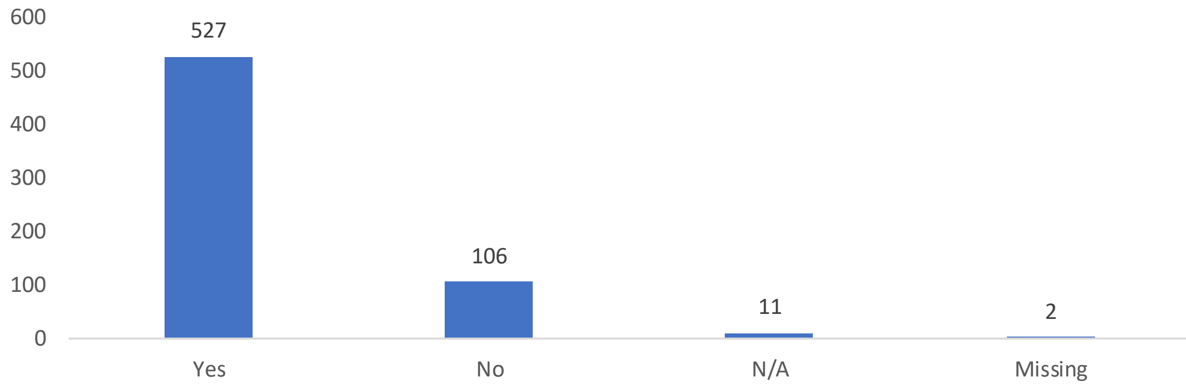


There were a range of vulnerabilities identified during the assessment process, illustrating the diversity and complexity of needs, illustrated in the Table below. In total, 1,032 vulnerabilities were identified in the assessment, with the most frequent being anxiety (29%), depression (24%) and mood (8%).

Table 3.2: Identified Vulnerabilities

Anxiety	301	Sexual	25
Depression	251	Drugs	20
Mood	83	Grief	18
Post-Traumatic Stress Disorder	58	Emotionally Unstable Personality Disorder	17
Trauma	51	Schizophrenia	11
Abuse	46	Maladaptive Behaviour	7
Alcohol	39	Self-esteem	4
Personality Disorder	34	Obsessive Compulsive Disorder	4
Suicidal	32	Autism	2
Self-Harm	28	Asperger Syndrome	1

Of the 646 assessments between July 2020 and July 2021, 528 (82%) were identified as being suitable for an MHTR and approved by the Clinical Lead.

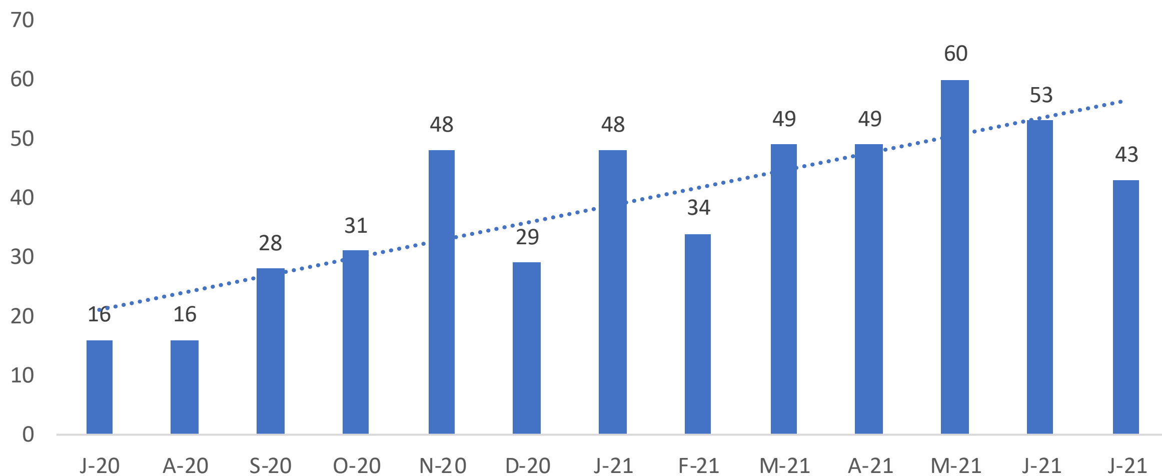


For the 106 individuals identified as not being suitable for the MHTR, the most frequent reasons were being complexity (23), risk (17) and above primary care threshold (11).

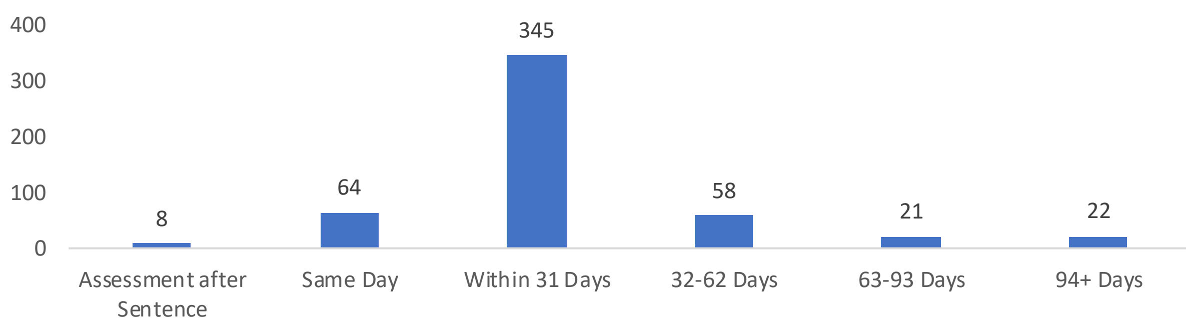
4. Sentencing

This section relates to sentencing outcomes for individuals assessed and found suitable for a MHTR.

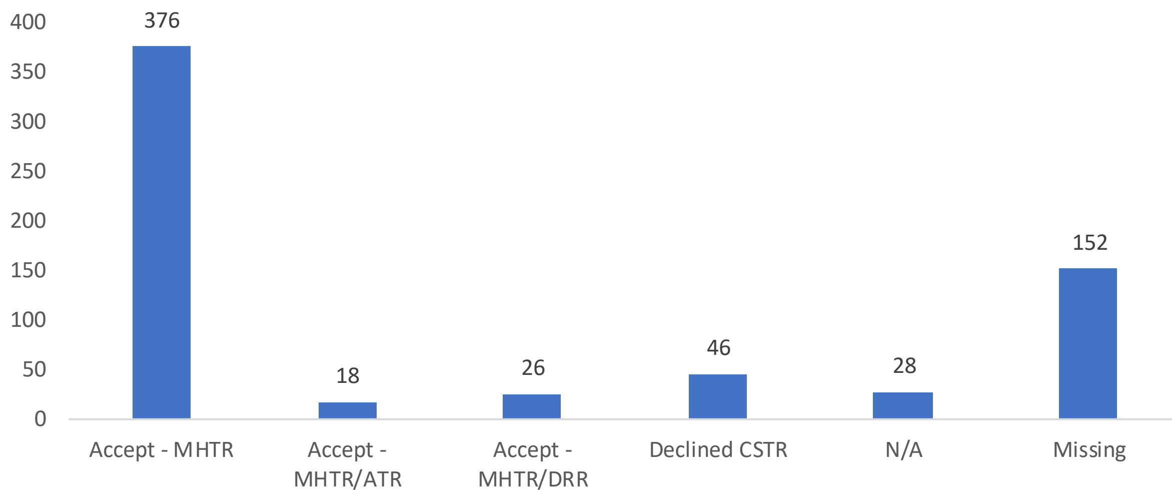
Based on assessments completed between July 2020 and July 2021, there were 504 individuals with a date of sentence. The pattern shows an observable positive trend over time.



There were 518 cases with dates provided for both assessment and sentencing. The gap between assessment and sentencing for most cases was within one month, with 64 occurring on the same day. Less than 5% of cases had a gap between assessment and sentencing over 3 months.

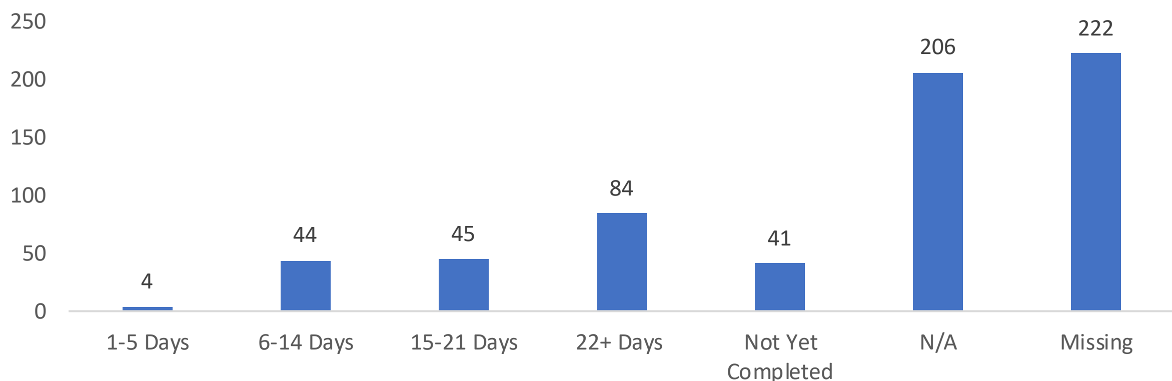


Most individuals assessed and recommended as suitable for an MHTR were sentenced to an MHTR (376, 58%). There were 46 (7%) cases where the recommendation for an MHTR was declined. Missing cases and N/A include cases where sentence has not yet been passed.



In the 46 cases where MHTR was declined, the most frequent outcomes were custodial sentences (36), other community sentences (8) and suspended sentences (2).

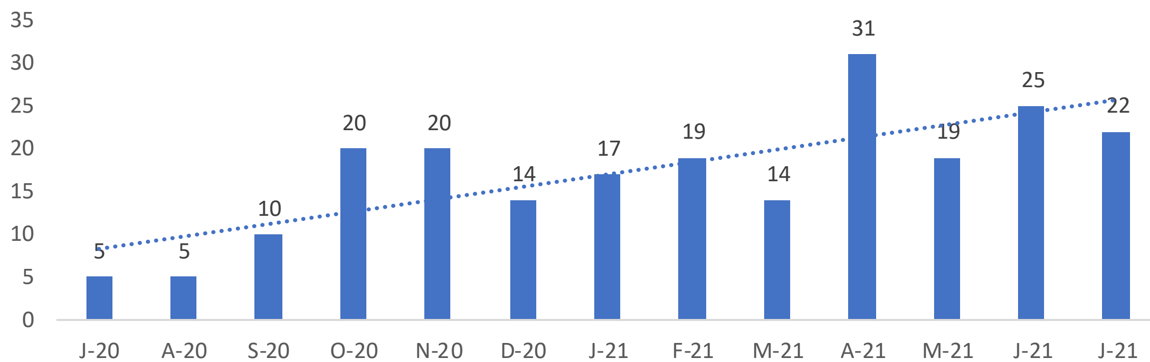
Following sentencing, a multidisciplinary meeting usually is completed between the primary care MHTR practitioner, Probation and other treatment practitioners. There were 177 multidisciplinary meetings noted as having been completed in the local files, with a further 41 which had not yet been completed.



The agreed sequencing for treatment, in sentences including ATR and DRR in additions to MHTR, was provided for 12 cases. In 5 cases, treatment requirements were completed simultaneously (4 x MHTR/ATR and 1 x MHTR/DRR), in 5 cases agreed to complete ATR before MHTR and in 2 cases agreed to complete DRR before MHTR.

5. Start of Intervention

This section provides an overview of data captured at the start of the intervention. There were 221 cases with an intervention start date. Fig 5.1 shows the number of interventions starting each month has risen over time, peaking in April 2021. Between August 2020 and January 2021, there were on average 2.39 intervention starts per site, compared with on average 3.61 intervention starts between February 2021 and July 2021.



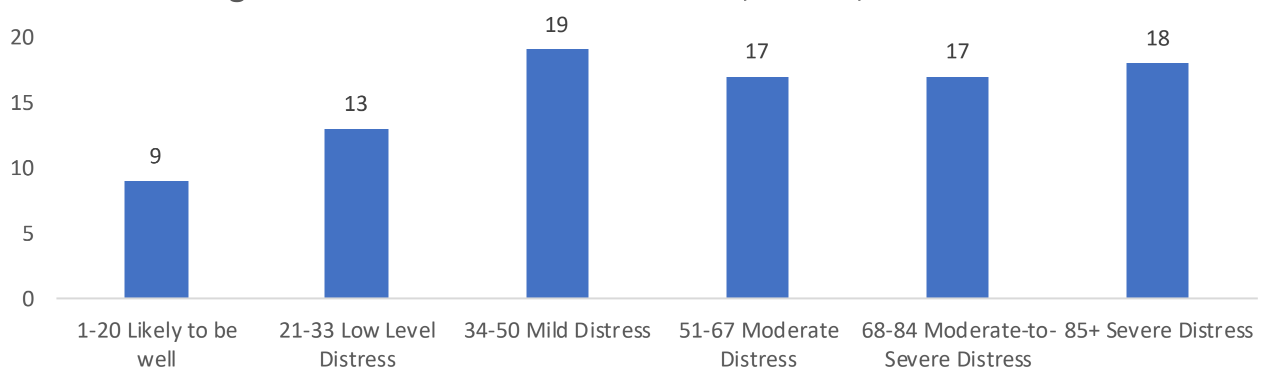
In the first session, individuals complete psychometric measures to assess severity of distress, including: CORE-34, GAD-7, and PHQ-9. In one site (Essex), Kessler 6 is used to assess severity of distress rather than CORE-34.

CORE-34

There were 93 individuals who were assessed at the start of the intervention using CORE-34. Scores can be interpreted into the following levels:

- Scores 1-20 are likely to be healthy;
- Scores 21-33 are likely to be low level psychological distress;
- Scores 34-50 are likely to be mild psychological distress;
- Scores 51-67 are likely to be moderate psychological distress;
- Scores 68-84 are likely to be moderate-to-severe psychological distress; and
- Score 85+ are likely to be severe psychological distress.

The CORE-34 scores in the first session show how recorded distress scores were relatively even from mild distress to severe distress.



Kessler-6

In Essex, there were 71 individuals assessed at the start of intervention using K6. Scores range from 6 – 30, with higher scores indicating a greater tendency towards mental illness. Scores 19 and over indicate mental distress.

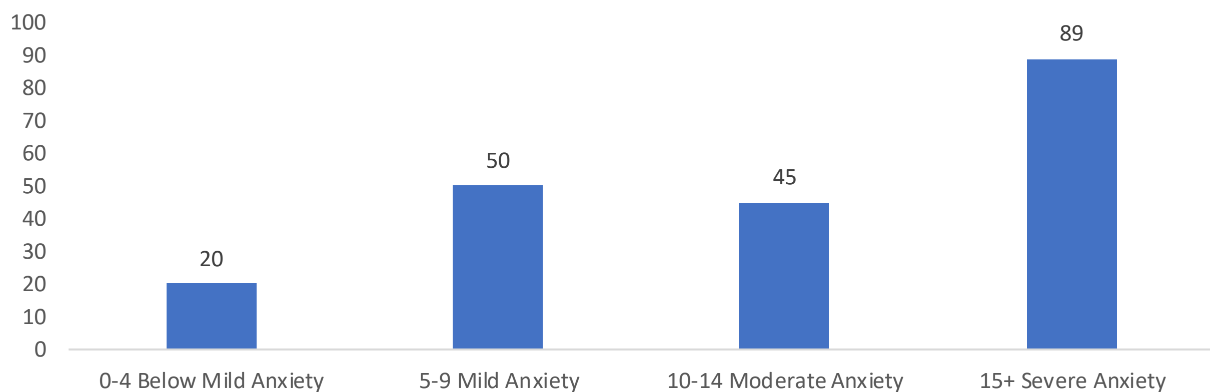
Of the 71 individuals assessed at the start of the intervention using K6, 43 (61%) scored 19 or over.

GAD-7

The next measure is the GAD-7, which measures generalised anxiety disorder (GAD). Scores for each measure are assessed between 0-3 and overall results are interpreted into the following levels:

- Score 0-4 Below Mild Anxiety;
- Scores 5-9 Mild Anxiety;
- Scores 10-14 Moderate Anxiety; and
- Scores 15+ Severe Anxiety.

There were 204 individuals who were assessed at the start of the intervention using GAD-7. The GAD-7 scores in the first session show most individuals (44%) have severe anxiety. There were 20 individuals (10%) who were measured as having below mild anxiety.

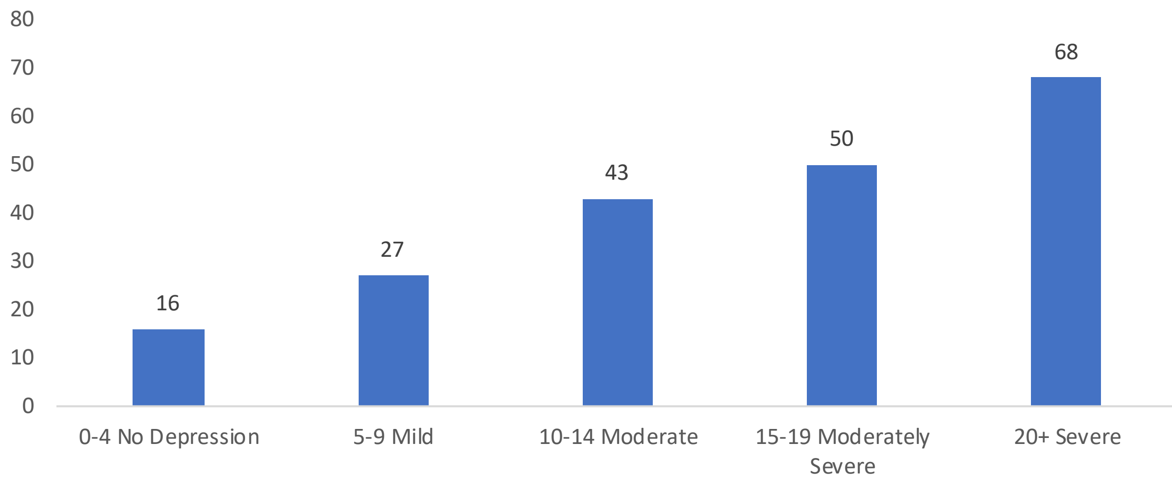


PHQ-9

The next measure used was the PHQ-9 - Patient Health Questionnaire. The PHQ-9 is a brief depression severity measure, where scores for measure are assessed between 0 -3, with higher scores indicating higher severity of depression. Scores are interpreted into the following levels:

- Scores 0 – 4 No Depression
- Scores 5 – 9 Mild Depression
- Scores 10 – 14 Moderate Depression
- Scores 15 – 19 Moderately Severe Depression
- Scores 20+ Severe Depression

There were 204 individuals assessed using PHQ-9 at the start of the intervention. Most individuals (33%) were assessed as having severe depression.

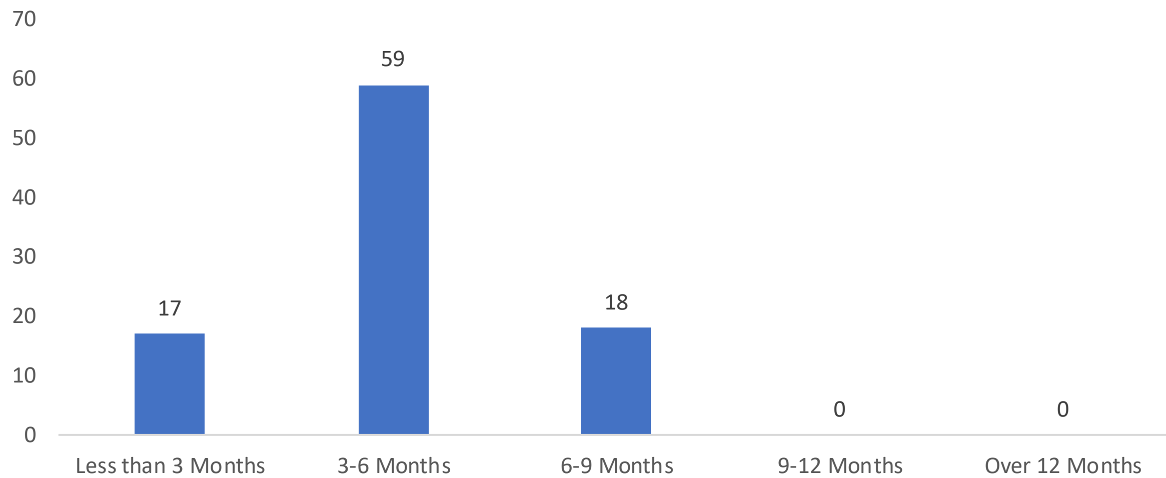


Overall, there were significant levels of mental distress measured in the population of individuals who began an MHTR intervention between July 2020 and January 2021. Levels of anxiety and distress were most likely to be severe for those beginning interventions.

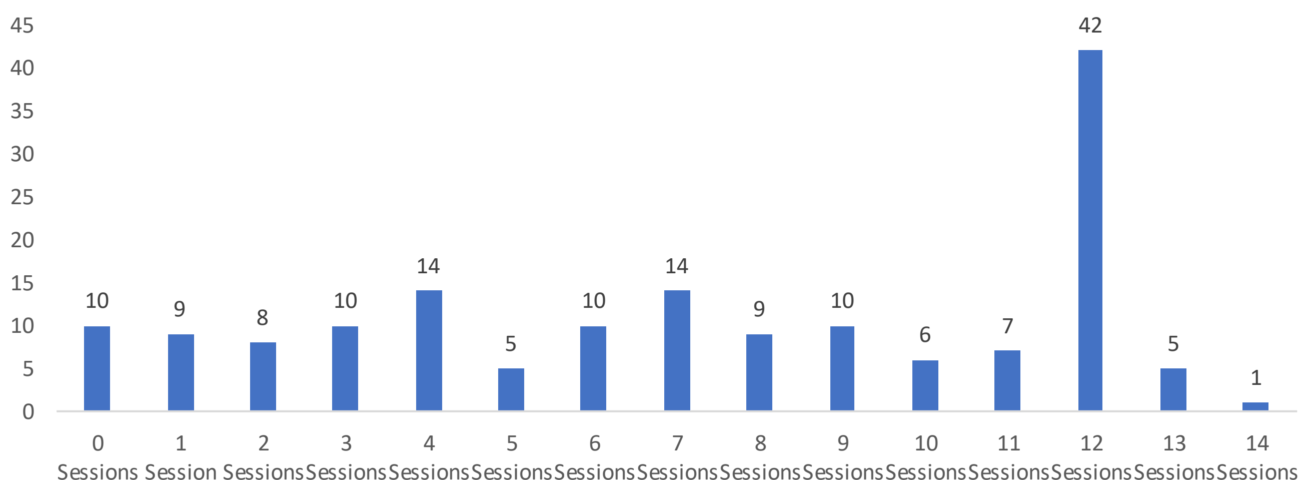
6. Intervention Length and Engagement

This section concerns the overall length of the mental health interventions and the engagement of individuals.

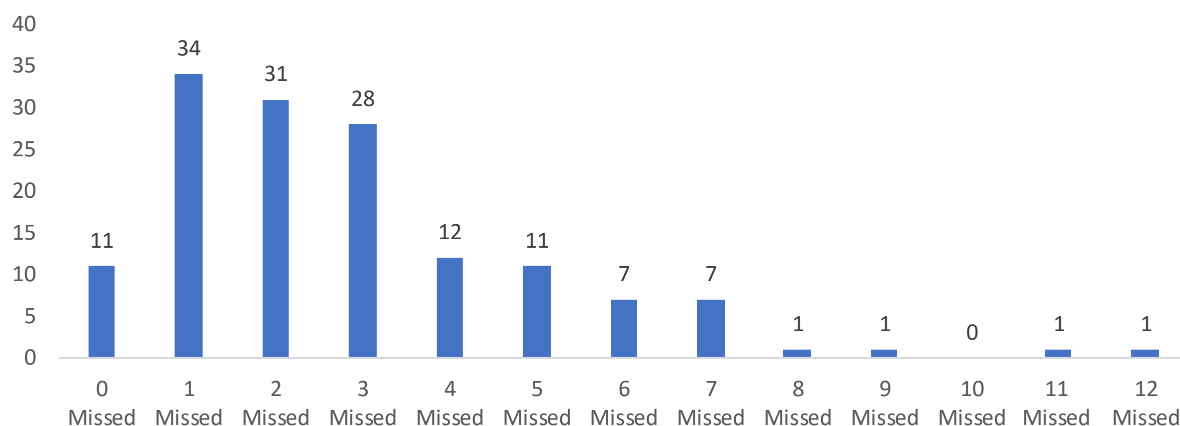
Intervention length was recorded for 94 individuals, with most interventions lasting between 3 and 6 months. No individuals were received interventions over a longer period than 9 months.



In terms of engagement with the intervention between July 2020 and January 2021, there were 1,176 sessions recorded as being delivered to individuals across the 6 sites. It should be noted that this number does not include sessions delivered to individuals who began the intervention before July 2020. It should also be noted that some sites do not record this number until the intervention has been completed.



Overall, of the 221 individuals who began the intervention, there were 414 sessions missed by individuals tracked (where missing data is entered as 0 missed sessions). It should be noted some individuals have not yet completed the intervention. Of the 48 individuals who had completed 12 or more sessions, the average number of missed sessions per person was 2.15.



The most common reasons for missed sessions are in the table below, illness or physical health was the most common reason.

Table 6.1: Reasons for Missed Sessions

Reasons for Missed Sessions	**Frequency[1]**	**% of all reasons**
Illness/physical health	86	21%
AWOL/no response/DNA	47	11%
Work	23	6%
Phone or internet issues	12	3%
Forgot	19	5%
Unknown	7	2%
Clashed with other appt (e.g. medical/probation)	13	3%
Confusion over appt time	12	3%
Drink drugs related	7	2%
Childcare related	12	3%
Covid-related	8	2%
Transport issues	8	2%
Sleep issues/ overslept	8	2%

Of the 221 individuals who began the intervention, there were 23 breaches recorded. For most individuals, the reason for breach was non-compliance or non-attendance. There were 3 individuals where it was noted further crimes had occurred. Where outcomes were recorded for the breach, 6 sentenced to custody.

[1] It is important to recognise that the frequencies relate to the numbers of missed sessions and not individuals. There were, in some cases, multiple reasons for missing a session. On occasions where there were missed sessions, treatment providers liaised with Probation Practitioners to re-engage an individual.

7. Outcomes and Change

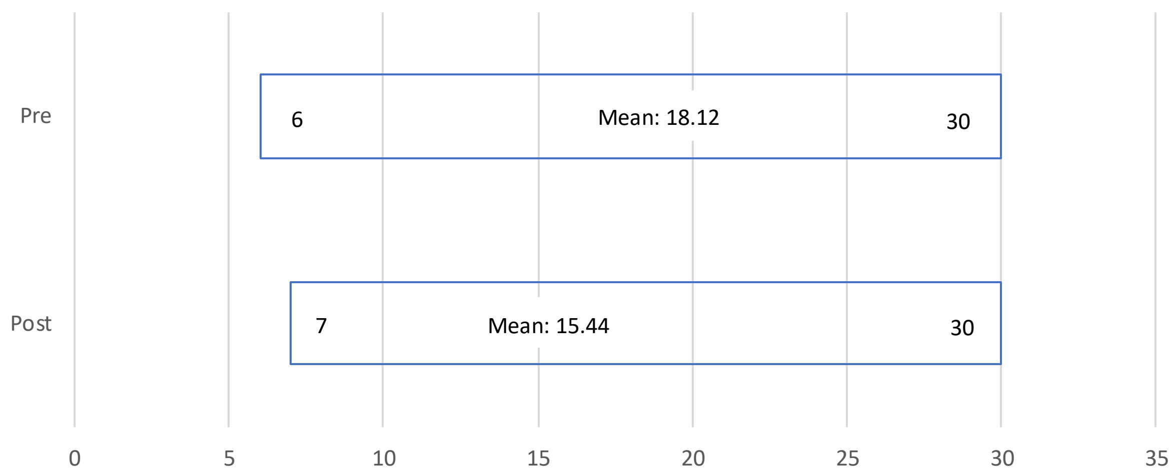
This section concerns the recorded outcomes for individuals and what change was measured in the psychometric measures.

Overall, there were 97 individuals with a recorded end date of intervention across 6 sites.

K6

There were 25 individuals who had pre and post K6 scores. The average pre-score was 18.12 and the average post score was 15.44 (scores 19 or over indicate mental distress). The average reduction was -2.68. This difference was not statistically significant $t(24) = 2.007$, $p>0.05$.

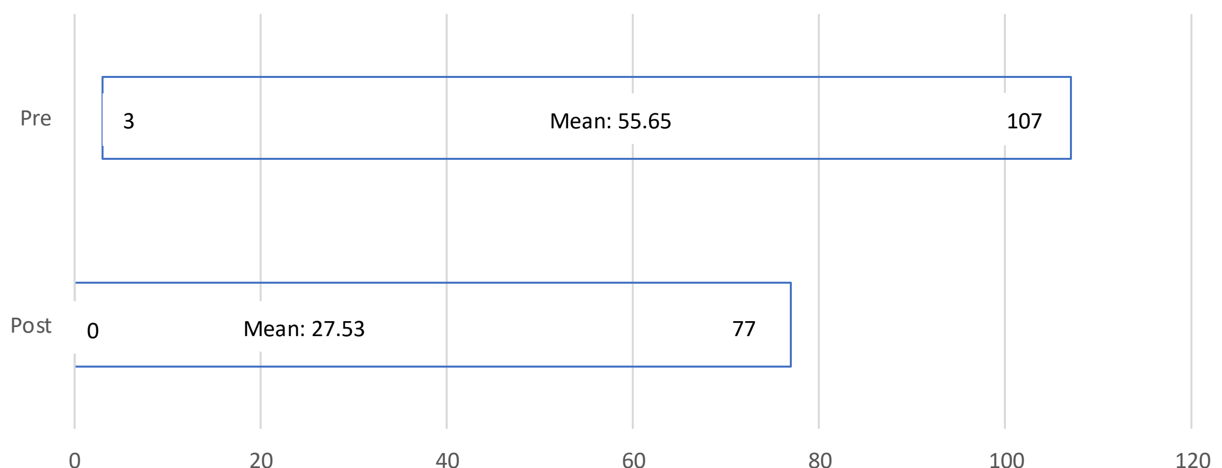
Fig 7.1 K6 Pre/Post Range and Mean, 1 Site, Jul 20 - Jul 21



CORE-34

There were 63 individuals with pre and post Core-34 scores. The average pre-score was 55.65 (in the mid-range of moderate psychological distress). The average post score was 27.53 (which is at the higher end of low psychological distress). The average reduction was -29.83 and this difference was statistically significant $t(62) = 9.317$, $p<0.05$.

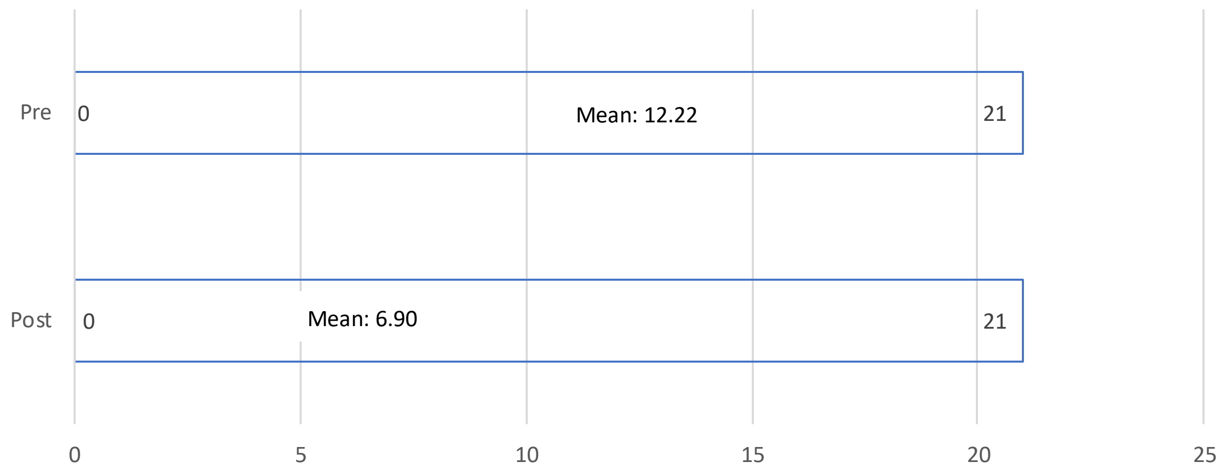
Fig 7.2 CORE-34 Pre/Post Range and Mean, 6 Sites, Jul 20 - Jul 21



GAD-7

There were 88 individuals with pre and post GAD-7 scores. The average pre-GAD-7 score for this group was 12.22 (Mid moderate anxiety) and the average post score was 6.90 (indicating the lower end of mild anxiety). Therefore, the average reduction was -5.32 and this difference was statistically significant t (87) = 8.424 and p<0.05.

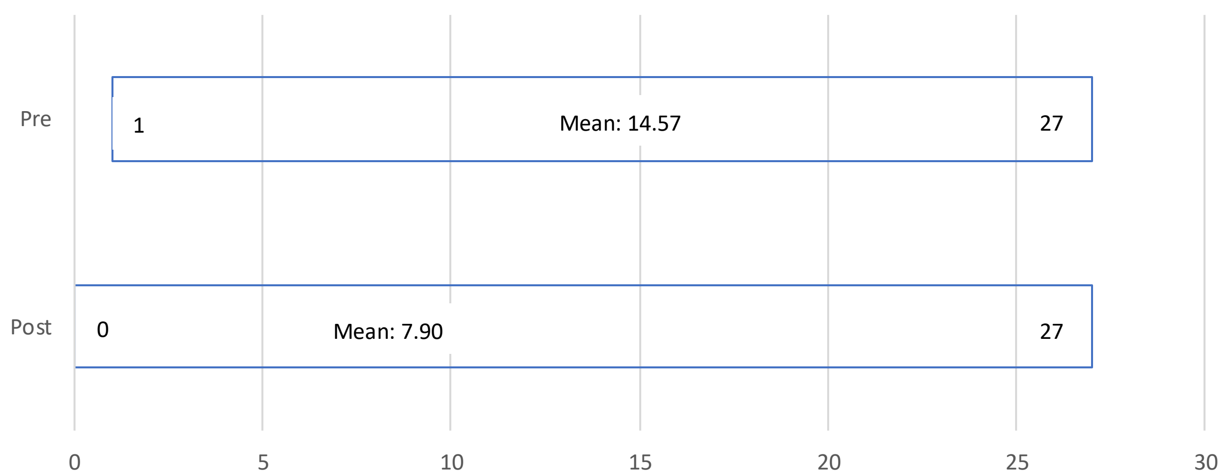
Fig 7.3 GAD-7 Pre/Post Range and Mean, 6 Sites, Jul 20 - Jul 21



PHQ-9

There were 88 individuals with pre and post scores on the PHQ-9. The average pre-score was 14.57 (on the cusp of moderate to moderately severe depression) and the average post score was 7.90 (mild depression). Therefore, the average reduction was -6.67 and this difference was statistically significant t (87) = 9.009, p<0.05.

Fig 7.4 PHQ-9 Pre/Post Range and Mean, 6 Sites, Jul 20 - Jul 21



8. Observations

Overall, the analysis and results presented from across the 6 sites are very positive. For 97 individuals who were assessed and started the MHTR since July 2020, **statistically significant positive change** was identified using the CORE-34, GAD-7 and PHQ-9. **Therefore, based on the analysis of 13 months data, the evidence demonstrates how MHTR interventions are having a significant benefit in terms of mental distress, anxiety and depression.**

Key observations are:

- The low numbers of people from Black and Ethnic Minority backgrounds (representing 5% of all assessments, though it is noted ethnicity was not recorded for 22% of assessments) who are being assessed and sentenced to MHTR is a significant concern, which requires investigations in each site to ensure the equality.
    - **It is recommended that each Board undertakes a review of their pathway to identify if people from BAME groups are screened out or diverted onto other pathways.**
- The numbers of individuals with a wide variety of disabilities (other than mental health) is high, demonstrating an inclusive pathway which may divert such individuals from custody. There were 26 individuals who were identified as having a neurodevelopmental disability, which may be higher given the range of conditions that may be defined as such.
    - **It is recommended further clarity is provided to Primary Care Practitioners to ensure consistency between sites in terms of neurodevelopmental disability data recorded.**
- Violent offences represent approximately a third of all offences captured, which emphasises the importance of ensuring appropriate risk assessments are completed to ensure the safety and welfare of practitioners and service users.
- The numbers of assessments and individuals sentenced to MHTRs is increasing and represents 87% of all assessments. Assessments for combined orders for ATR and DRR represent 8% and 5% of all assessments.
    - **It is recommended local Boards review if numbers of individuals being considered for combined orders matches with local service levels of needs and explore strategies and approaches to improve numbers.**
- The assessment processes continue to identify significant levels of mental health needs for individuals on this pathway, which strongly supports the continuation and expansion of sites across England.
- Of the 221 individuals who began the intervention, there were 414 sessions missed by individuals tracked (where missing data is entered as 0 missed sessions). It should be noted some individuals have not yet completed the intervention. Of the 48 individuals who had completed 12 or more sessions, the average number of missed sessions per person was 2.15. It should be noted approximately 1-in-10 missed sessions were where individuals failed to attend without notice.
    - **It is recommended that the Clinical Lead and Primary Care Practitioner forums, and local programme Board operational groups, reflect on numbers of missed sessions to reduce numbers of missed sessions as well as consistently address/respond to incidents of missed sessions.**

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