March 2025

RR3
Reducing Reoffending
Third Sector Advisory Group

RR3 Special Interest Group on Community Provision 2024-25: Report 1

Mental health treatment in the community for people in contact with the criminal justice system

Introduction

The Reducing Reoffending Third Sector Advisory Group (RR3) provides the key interface between the voluntary sector, and the Ministry of Justice (MoJ) and His Majesty's Prison and Probation Service (HMPPS), in order to increase mutual understanding and build a strong and effective partnership. The group is made up of senior leaders from the voluntary sector and meets quarterly with civil servants to provide guidance and feedback on MoJ policy developments.

The RR3 convenes Special Interest Groups (SIGs) to advise on specific areas of policy and practice as the need arises. This SIG, comprising 28 voluntary organisations, explored the resourcing and modelling of community provision for people in contact with the criminal justice system. This report focuses exclusively on the provision of mental health services in England, and a second report will cover drug and alcohol treatment services. The detail covered in this report is based on issues specifically raised by the SIG participants.

There is limited mental health provision specifically catering for people coming out of prison, alongside growing demand on voluntary services in the community to support of a range of mental health needs. This is despite significant, clinical need and a lack of parallel, statutory mental health service involvement. Demand for the statutory services that are available is continuing to outstrip supply, and funding restraints are restricting the ability of voluntary organisations to cater for the wide range of needs that people are presenting with. Additionally, inequitable access to mental health services, exacerbated by historical mistrust of the statutory sector, remains a significant barrier for racially minoritised individuals in accessing essential services.

This report starts by illustrating the demand for mental health support and highlighting the number of people under probation supervision presenting with mental health needs, before mapping the current landscape of mental health provision across the statutory and voluntary sectors. There follows an analysis of a range of existing pathways, including current challenges – particularly the NHS's RECONNECT service, the Offender Personality Disorder (OPD) Pathway, and Commissioned Rehabilitative Services (CRS). It will then highlight the challenges faced by voluntary organisations, grouped under the following themes:

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- Funding and navigating the funding process
- Diminished treatment capacity
- Postcode lottery
- Inequitable access to services for racially minoritised people
- Dual diagnosis
- Undiagnosed mental health conditions
- Voluntary organisations 'filling gaps' in statutory provision
- Ineffective partnership working
- Low uptake of Mental Health Treatment Requirements (MHTRs)
- Rigid service specification and siloed commissioning
- Registering with GPs

The report concludes with a series of practical recommendations, developed in collaboration with the organisations who contributed to the work of the SIG.

The demand for mental health support

In April 2023, the Centre for Mental Health published a report analysing mental health services in prison. Surveying three-quarters of prisons and Young Offender Institutions in England, it found that 'more than 7,700 people in prisons surveyed were receiving support from a mental health service while in custody. This equates to one prisoner in seven getting support from mental health services, which rises to more than one in four among women in custody'.[1]

Given that screening for mental health issues in prison does not capture the extent of need, it is likely that the number of people in prison requiring support is significantly higher.[2] This can be seen in the number of people presenting with mental health issues when under probation supervision. In a report on community sentences published in December 2023, the House of Lords Justice and Home Affairs Committee found that '38% of people on probation (c. 91,000 people at any point in time) have mental health issues'. Despite this, only 1,302 people started mental health treatment as part of a community sentence in 2022.[3]

Mapping the landscape - the availability of support on release

NHS RECONNECT

Continuity of care between prison and the community is critical to ensuring that mental health needs are addressed post-release. The primary mechanism in support of this care is the RECONNECT service which is a 'care after custody service that seeks to improve the continuity of care for people leaving prison with an identified health need'.[4] RECONNECT – commissioned by NHS England – enables providers to work with people 'three months prior to release and up to six months, post-release'. At this stage, it is expected that people would have started to receive support from the agencies that they had been signposted and referred to, and/or that part of this support (such as with housing applications) would have been completed. It is important to note that RECONNECT applies to all health-related support, and not exclusively to those identified as having mental health needs.

There is also the 'Enhanced RECONNECT' service, which can only be accessed via referrals from probation or other selected statutory agencies and connects people to specialist services. People who come through this pathway often present with particularly complex needs, as services in the community are not best placed to work with these individuals due to the nature of the need. Support can last up to 12 months, post-release.

RECONNECT services are designed to 'facilitate engagement with community-based health and support services'[5], yet one of the challenges is 'finding services that they can make referrals to'. Further, voluntary providers of mental health services referenced the consistent issue of 'too many services that refer, signpost and only offer short-term support, with not enough services that provide treatment, long-term support and specialist interventions.'

SIG participants also reported difficulties accessing service user information ahead of release. This leads to difficulties in being able to understand the nature or extent of interventions that have started while a person is in prison. Many people serving short prison sentences do not receive the mental health support they need as there isn't adequate time to assess them, which has a knock-on impact on their continuity of care in the community.

Once a person is released, we were told that the 'offer available through-the-gate is almost nothing. We are finding it increasingly difficult to provide support and to link people struggling with their mental health into community support'. This is exacerbated by a disconnect between staff in prisons and voluntary organisations in the community, which creates additional barriers to accessing support for people leaving prison. In particular, SIG participants referenced the essential role of probation in facilitating information sharing, and the need for access to 'systems' that would enable voluntary sector services to reduce the burden on probation. Certain voluntary providers undertake their own screening when they do have access to the relevant systems, which benefits probation by reducing the demand on their services and ensures that people are not missed at the critical, release stage.

The Offender Personality Disorder (OPD) Pathway

Highlighted as a 'good example of strong, multi-agency working' by SIG participants, the OPD Pathway is a 'jointly commissioned initiative between NHS England and HMPPS aimed at supporting and managing offenders with complex mental health needs'.[6] The pathway, which is commissioned on a 'regional basis in line with NHS England regional boundaries', enables the provision of psychologically-informed services for people who have the most serious mental health needs. As part of the 2023-28 OPD Strategy, £72 million of funding has been committed, which does not include additional funding for 'aligned services that deliver important parts of the pathway'.[7]

For women in contact with the CJS, SIG participants reported that the OPD pathway 'works well', with women on the pathway receiving an intensive package of support. Described as a 'rounded service', the pathway provides access to GPs and specialist mental health care, which can be in addition to therapeutic support from specific women's centres. As part of the service, the women on the pathway have access to mentors who help them to navigate the system and the range of services that they need to access. One advantage of the pathway is the 'room that has been made for the voluntary sector', seen as a recognition of the value that the sector can bring. One provider reported that a further advantage of the OPD service, in London, was the inclusion of lived experience mentors, but that this element was removed when the service was re-procured. Despite this, London was held up as an example of strong collaboration between health stakeholders and the voluntary sector, with wraparound support, based on need, offered to people on probation.

Community Rehabilitative Services (CRS) provision

Participants highlighted the provision of person wellbeing (PWB) services as part of existing CRS contracts, as one avenue via through which people are able to access support. The limitation of this pathway is that the service on offer is focused on low-level, wellbeing support. SIG participants working for CRS providers explained that many of the personal wellbeing referrals that they receive are for people who are in crisis and who therefore require a more formal intervention, with the PWB service not the right service to provide that intervention. Further, it was understood that probation have limited options regarding other services with which to refer people into, highlighting a gap in provision for services available to address mental health needs.

The challenges for voluntary organisations

Funding and navigating the funding process

Unsurprisingly, funding was considered to be the greatest challenge facing voluntary organisations when considering the provision of mental health support to people in contact with the criminal justice system. The most obvious impact of insufficient funding for mental health services is the subsequent effect on public safety. The SIG heard of the imminent cliff-edge in funding – including funding for organisations working in the area of violence against women and girls (VAWG) – at the end of the 2024/25 financial year, which is creating significant barriers to continuity of support. One SIG participant described funding as 'piecemeal and short-term', a further obstacle to the provision of continued support, which is leading to organisations having to put staff on notice every six months.

Additionally, it was emphasised that local authority funding is in crisis and, as key commissioners of local services, this has a particular impact on the provision of locally tailored support services. Participants agreed that a change of approach is needed so that the provision of these services is viewed and commissioned as 'business as usual' services, to avoid voluntary organisations having to be reliant on short-term funding cycles. For example, there is an ongoing lack of certainty about the funding that Integrated Care Boards (ICBs) will receive from NHS England (NHSE), which hinders the sector from being able to effectively plan and fund mental health services in any given areas.

With the funding that is available, it is difficult for voluntary organisations to navigate the system given that funding processes can be different in every area – such as the different 'ICB offers' in different areas. This is exacerbated by many voluntary organisations not having the resources to bid for multiple pots of funding. For smaller, specialist organisations in particular, this creates significant and particular challenges. We heard that the monopolisation of funding by larger organisations can restrict the specialist offer of smaller organisations, which has a knock-on effect on both treatment capacity and quantity. One participant highlighted the difficulty in being able to provide the economies of scale that larger organisations can, which is often more attractive to statutory commissioners. Provision on a large scale often leads to the 'bare minimum' in terms of the intervention offer, with subsequent and inevitable impact on treatment capacity.

This funding landscape can often translate into difficulties for the people accessing the multitude of services that are on offer. For example, people will be accessing services commissioned via the CFO-Evolution programme, alongside accessing support via CRS provision. There is significant overlap between many of these services, which can cause difficulties for people in understanding what is on offer.

'The last thing I heard was of a six-month waiting list for MHTRs after receiving an order'

Diminished treatment capacity

The provision of mental health support in the community is limited – which continues to be a wider societal challenge. We heard from one SIG participant that 'the availability of talking therapies is really challenging in the community. The waiting lists are massive. By the time people actually get an appointment, if they are referred, their mental health has gone from mild to moderate to much more extreme.' The over-specification of service provision further exacerbates this challenge, with people having to 'fit into' specific services leading providers spending more time declining referrals than helping people to move on.

Capacity is also not simply a question of demand versus supply – it relates to the availability of support for specific cohorts of people, including people who are neurodivergent. People with complex needs, including those who struggle to engage with services, often get struck off from services. As a result, getting support can be very challenging.

The issue is particularly acute for those in a crisis situation, who require access to immediate support on their release from prison. This challenge, we heard, stems not just from general pressures on community mental health services, but due to the lack of bespoke mental health services for people who have been released from prison. This issue of a lack of bespoke mental health support for people leaving prison would not be as pressing were mainstream support available to all, regardless of the extent of need. As one participant told us 'most of the time, support is provided via signposting to other services, and the services that are available are patchy in terms of their provision. We really struggle in terms of signposting. And waiting lists are huge. There's a real shortage of one-to-one support, whether it's face-to-face or online.' Additionally, the support that does exist is often peer-to-peer, group therapy, which often does not incorporate clinical practitioners.

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Postcode lottery

This is a common issue when analysing service provision for people in contact with the criminal justice system - service provision differs markedly depending on the area in which a person is being released to. We were told 'in one area you might get an MHTR, but in other areas they don't exist'. For women coming out of prison, we were told that mental support is 'piecemeal in the community' and that provision is highly dependent on the area in which a woman is released.

This variation is not simply restricted to treatment requirements and is apparent throughout every stage of a person's interaction with the CJS. For example, the use of Out of Court Disposals (OOCD) is patchy, and their availability again depends on the area in which they are being issued. There is also the issue of the availability of meaningful provision that can significantly address need.

This response to need, as noted above, is inequitable and is also driven by the varying capacities, criteria and priorities of statutory commissioners. This is particularly applicable with regards to the differing capacities of NHS Trusts.

This lottery in provision exists in prisons too. Some prisons, for example, offer low-intensity Cognitive Behavioural Therapy (CPT) and wellbeing coaches. Yet this is not uniform practice across the prison estate.

Inequitable access to services for racially minoritised people

Dr. Niquita Pilgrim, Co-Founder of the Cultural Connection, joined the SIG to highlight the significant barriers to accessing mental health care for racially minoritised individuals. She focused on the underutilisation of MHTRs among Black and Asian individuals despite a high level of mental need within these communities. While there is a lack of publicly available data that disaggregates MHTR issuance by ethnicity, it is clear that MHTRs remain significantly under-utilised across the system given that only '3,484 mental health treatment requirements were included in a community or suspended sentence order in 2023.'[8] Further, given continuing racial disparities in sentencing, including that Black and Asian defendants are more likely to receive an immediate custodial sentence,[9] this sentencing disparity likely contributes to the lower issuance of MHTRs to racially minoritised individuals.

Dr Pilgrim went on to note that: 'these challenges are both structural and rooted in a broader history of systemic mistrust, stemming from discriminatory practices and coercive treatment that have affected these communities for decades. This mistrust impacts engagement with mental health services, particularly for those in contact with the criminal justice system'.[10] This has led to many people from racially minoritised backgrounds 'getting lost completely' when they leave prison, a situation exacerbated by the lack of culturally appropriate or targeted support services available, which results in missed opportunities for continuity of care. As Pilgrim explains 'mainstream interventions, such as Cognitive Behavioural Therapy (CBT), often fail to meet these needs as they do not adequately consider cultural, social, and historical factors influencing mental health for racially minoritised groups".[11]

On release, many individuals refuse to engage with services which they perceive as harmful extensions of the state. Dr. Pilgrim told the SIG that 'this mistrust is exacerbated by the disproportionate use of sectioning under the Mental Health Act 1983 (revised in 2007), where Black individuals are more likely to be sectioned than their White counterparts.'[12]

There is also a distinct lack of partnership working focused on racially minoritised people, and a lack of opportunity to co-produce and co-design opportunities in support of racially minoritised people.

Dual diagnosis

There are many people in contact with the criminal justice system who required support addressing a range of often overlapping issues. Yet, many statutory mental health services will not support people who, for example, have not addressed their substance misuse issues. The challenge voluntary organisations can face is in supporting people to address mental health needs concurrently with substance misuse issues given the criteria that is in place for accessing certain services. The result is people being forced to navigate different, siloed services. This is exacerbated by how services are funded – with funded support available to address one component of a person's issues at any given time. SIG participants agreed that the solution is for the provision of coordinated, high-quality, integrated interventions for mental health, trauma and

Undiagnosed mental health conditions

For people who go undiagnosed when they are in prison or who tend to have what is often termed as lower-level mental health needs, such as anxiety or depression, they often fall through the gaps of the provision that is on offer, with no specifically tailored provision. This is despite the need for support often being significant. Further, a person's mental health challenges that are deemed as low-level in prison, often rise on release from prison due to the barriers to resettlement faced by many, and this can be anticipated by providers. We heard that this was a particular challenge faced by organisations supporting women, with need heightened due to instability and the level of change experienced following a women's release from prison. For the higher-risk cohort, there tends to be a clearer pathway of support – towards hospitalisation, for example or via the Offender Personality Disorder (OPD) pathway – which dictates that a person accessing support is 'likely to have a severe form of personality disorder.'. The gap in support is between the low-level wellbeing offer and the high-level OPD offer, which is where most people sit – with often fluctuating levels of and undiagnosed need.

Voluntary organisations 'filling gaps' in statutory provision

There is ongoing pressure on statutory services throughout the criminal justice system – through court backlogs, overcrowding in prisons and an increased number of people under probation supervision. These pressures have led to an ever-increasing demand for support from the voluntary sector. In Clinks' most recent State of the Sector research, the majority of organisations surveyed reported that the level, complexity, and urgency of their service users' need had increased. No organisations reported that the level, complexity or urgency of need had decreased in 2022/23, emphasising the increasing demand on voluntary organisations in the criminal justice sector.[13]

Further, we were told that the threshold to accessing statutory support continues to increase, and that unless a person is in 'absolute crisis', they will often not meet the need for statutory intervention. For those who do access a statutory intervention, this can be very limited and not cater for fluctuating need This leaves the voluntary sector as the only means by which people can access support. We heard from women's centres that much of the mental health support that they provide is drawn from multiple different funding pots and isn't funded directly by statutory funders. In Northamptonshire and Milton Keynes, for example, there is not directly commissioned mental health service for men and women leaving prison. This leaves the onus on the voluntary sector to fill these gaps, despite it being increasingly difficult to cater for increased demand and complexity, as well as to recruit and retain well-trained staffed, without access to accredited training options and the necessary funding.

Ineffective partnership working

Participants highlighted ongoing challenges regarding ineffective partnership working, that can prevent voluntary organisations from addressing complex and overlapping needs. Specifically, it was highlighted that rigid service specifications, and the resulting funding attached to these services, often only allows for service providers to work with a distinct group of people in order to keep receiving repeat funding. This can act as a barrier to partnering with different organisations working with different people.

Additionally, probation is struggling to cater for the increased demand for services which can act as an obstacle to effective partnership with the voluntary sector. SIG participants referenced important information being missed from referrals into community health services as evidence of the difficulties in working with probation. A further area of challenge included a lack of openness with regards to different aspects of the system talking to one another and sharing information.

Probation in Greater Manchester was used by participants as an example of best-practice, with key elements including the co-location of services and focus on having a 'team around the person'. Participants noted that being in the same room as probation officer can be very beneficial and is a way of being able to move forward in partnership with probation. The OPD Pathway was highlighted as service that works well, given that the work is co-located, but it was also noted that challenges remain due to staffing shortages.

Low uptake of Mental Health Treatment Requirements (MHTRs)

As previously noted, only 1,302 people under probation supervision were sentenced to mental health treatment as part of a community sentence in 2022. This is despite evidence that reoffending rates are lower for people receiving MHTRs, when compared to reoffending rates for both short custodial sentences and for community sentences without treatment requirements attached. A 2024 analysis published by the Ministry of Justice found that 'MHTR recipients had a lower reoffending rate than those on a community sentence without a CSTR by 8 percentage points (27% for MHTR recipients and 34% for recipients of a community sentence without a CSTR) and short custodial sentence recipients by 9 percentage points (36% short custodial sentence recipients'.[14] There has also been a wider trend that has seen a significant decrease in the number of people sentenced to community sentences – down from nearly 150,000 between January and December 2012 to 71,745 between January and December 2023.[15] The barriers to increasing uptake of MHTRs are varied. There is significant pressure on court teams due to the ongoing backlogs across the court system. Probation staff are facing pressure to deliver pre-sentence reports (PSRs) and to complete assessments as part of these reports and yet the number of PSRs written in England and Wales has decreased significantly – from 211,494 in 2010 to 103,004 in 2019. There was a further decrease between 2019 and 2023, to 91,368.[16] This is despite Ministry of Justice data highlighting that 'those who received a PSR oral or PSR fast delivery were more likely to successfully complete their court order, compared with a group of similar offenders who did not receive a PSR'.[17]

Dr. Niquita Pilgrim, Co-Founder of the Cultural Connection, highlighted the underrepresentation of Black and Asian individuals in the uptake of MHTRs, which she attributed to 'multiple systemic factors, including sentencing biases, a lack of culturally informed assessment tools and an over-reliance on punitive rather than rehabilitative measures.' A range of reviews illustrate these barriers. The Bradely Report Review found that Black and Asian people are less likely to be sentenced to MHTRs due to persistent biases and a lack of culturally responsive treatment pathways.[18] The Lammy Review found that Black individuals are frequently perceived as less amenable to rehabilitation, leading to sentencer preference for custodial sentences over therapeutic alternatives. This can lead to the limiting of opportunities for effective mental health intervention, as well as entrenching the cycle of reoffending due to untreated mental health issues.[19]

SIG participants also noted that there is a lack of awareness among sentencers regarding the availability of treatment requirements, which often results in the requirements not forming part of community sentences. Participants agreed that more needs to be done to ensure that all relevant stakeholders, including sentencers themselves, are aware of the availability of treatment requirements alongside ensuring an understanding of how they can be included as part of a community sentence. This is in addition to providing sentencers with examples of positive outcomes for people sentenced to MHTRs, alongside resources from NHS England dedicated to MHTRs SIG participants also recommended that a streamlined process, coupled with a quicker turnaround, would lead to an increased uptake.

It was also noted that the issue of low uptake was not restricted to the utilisation of MHTRs. We also heard from one provider, of a 'low uptake of our IOM offer' and having to 'chase around probation officers asking them to refer in'. IOM refers to the Integrated Offender Management programme, which was designed as a 'programme to facilitate teamworking by police, probation, and other agencies to deliver a local response to persistent and problematic offending'.[20] In both instances, the issue stems from a lack of communication between various agencies regarding the availability of treatment and services that could significantly benefit people who are in contact with the criminal justice system and present with mental health issues.

'They're trying to pigeonhole people into one set'

Rigid service specification and siloed commissioning

The lack of distinct, and flexible, mental health services for people coming out of prison was repeatedly referenced by SIG participants as an acute challenge. The lack of flexibility, as one SIG participant noted, leads to community mental health teams often discharging people because they are using substances. This is as mainstream services are not commissioned specifically to support people in contact with the CJS and are therefore not tailored to need. The result is people being forced across different, siloed services, unable to access holistic support catering to a range of need. Additionally, this lack of flexibility does not allow for services to be responsive to changes in need. Delivering mental health support in isolation can be particularly challenging for organisations supporting women. Women experiencing mental health issues often faced increased challenges in other areas, and without additional, wraparound support these challenges can be exacerbated. The SIG heard that mental health provision for depression, without domestic abuse counselling and healthy relationship group work would have limited impact.

This rigidity in service provision can often stem from siloed commissioning processes. There are a wide range of commissioners who commission services for a range of need, but this doesn't necessarily allow for the integration of services and the subsequent provision of holistic support. As a result, commissioning can create arbitrary boundaries, preventing people from accessing the support that they need. Participants recommended that commissioning budgets should be pooled in order to allow for more holistic outputs catering for a range of overlapping needs.

Registering with GPs

Additionally, many people leaving prison are not registered with a GP. For the services that are available, there was a consensus that 'often it's trying to fit the person to a service, rather than the other way round' – with this particularly applicable to the many people suffering from trauma. This report provides further detail on this issue of rigid service specification in the challenges section.

Conclusion

There is significant demand for mental health support from people in contact with the criminal justice system, which is continuing to increase given the ongoing cost of living and housing crises. This demand is also likely to increase given the increased number of releases resulting from the Government's Standard Determinate Sentences (SDS), early release scheme. With the recently announced Independent Sentencing Review and the creation of a new Women's Justice Board – which has an explicit objective of reducing the number of women in prison – demand for treatment in the community will only grow. Contact with the criminal justice system already re-traumatises people who have often already faced multiple disadvantage and/or Adverse Childhood Experience (ACEs). Without access to sufficiently resourced mental health treatment on release or during a community sentence, it is inevitable that there will be poorer mental health outcomes.

Recommendations

1) Appropriate support at first contact with the criminal justice system

• Greater investment in early intervention to avoid criminalisation and to ensure that health interventions are available in place of criminal justice interventions, where appropriate

• More effective use of Out of Court Disposals, including the setting of a minimum level of intervention that is available regardless of locality, strengthened through the provision of holistic, mental health support that is enabled by clearly established referral pathways to support from voluntary providers

• Increased use of social prescribing interventions in the community

2) Appropriate support mechanisms in place ahead of sentencing, including at arrest

• Through the establishment of mental health-specific courts

• Through the provision of high-quality pre-sentence reports, produced in collaboration between probation and voluntary sector support services; designed to demonstrate that, where possible, a person can engage with treatment in the community and that their risk can be managed, in order to ensure an increased likelihood of a community as opposed to a custodial sentence

• Guaranteed provision of specialist key workers in police custody suites and at court

• Provision of Treatment Requirement Link Workers available to start working with people ahead of sentencing in order to address any barriers between support services created by siloed working

3) Support in preparation for and on release from prison

• By ensuring that voluntary organisations are funded to provide care navigators in every resettlement prison, to work closely with prison mental health teams

• Supported by an increased number of psychologists per prison

Recommendations (cont.)

• Through the commissioning of a national network of Departure Lounges, providing access to a range of services on the day of release from prison

• Enabling the continuation of structured treatment for people who are recalled and then re-released from prison (so as to avoid the need for further referrals and increased waiting times for treatment)

• Supported by maintaining a register of people who have mental health treatment requirements so that people do not need to be re-assessed when they are recalled and then re-referred on released (allowing the option for interventions to be re-opened on release)

4) Treatment and support in the community

• Explore Enhanced Combination Orders (NI)

• Explore re-introducing Intensive Community Orders

• Guarantee universal coverage of Community Sentence Treatment Requirements; in addition to providing a tiered offer, allowing for the provision of primary and secondary MHTRs, for example

• Guarantee universal coverage of dual diagnosis orders, combining drug and alcohol treatment with mental health support, where required, and accompanied by the necessary funding

• Ensuring that the developing of a new National Peer Mentoring Framework enables the commissioning of peer mentoring schemes that support the wellbeing of the people accessing services; while ensuring that vetting barriers are removed
• Supported by an increased number of psychologists per prison

• Embedding dual diagnosis workers within local mental health services

• Embedding mental health liaison workers, responsible for providing support with low-level mental health work, within the provision of the next generation of CRS contracts

5) Improving training and guidance

• By establishing standardised guidance on the minimum level of interventions, regardless of locality, and embedded within the practice of both statutory and non-statutory stakeholders

• Through the co-production of culturally informed training for practitioners that provide MHTRs, including through lived experienced involvement in the design and delivery of interventions

• Through enabling the staff of voluntary sector providers access to accredited training in clinical and therapeutic areas, without the financial burden falling on the voluntary organisation

Recommendations (cont.)

• Through, as recommended in Switchback's Mental Health and Prison Release Report, training probation officers in mental health with a focus on how to support someone who is struggling[21]

6) More effective commissioning

• Coordinated public health commissioning targeting dual diagnosis, and breaking down barriers between existing service delivery

• Resourcing of the voluntary sector to provide targeted support for racially minoritised people, enabling the delivery of culturally-informed services by organisations led by and for racially minoritised people

• Commissioning of mental health practitioners based within women's centres and wellbeing hubs across the country, in order to reduce the waiting times of women seeking mental health support. Such practitioners will be able to provide substantial mental health input and treatment and appropriate therapy options, and not be limited to referring and signposting women, and liaising with mental health services

• Embedding lived experience in the co-production of service design, with a focus on the development and implementation of trauma-informed approaches. This will ensure that the views and expertise of people who have previously access services are leveraged to more effectively shape future service design

• To be achieved through the established of Lived Experience Advisory Councils to provide guidance on the relevant pathways available to people in contact with the criminal justice system

7) Funding

• A commitment to maintain the Mental Health Investment Standard, which ringfences spending on mental health by Integrated Care Boards, to ensure that mental health spending at a local level rises alongside spending on physical health

End notes

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