Institute for
Public Safety
Crime and Justice

Community Sentence Treatment Requirement Multisite Report July 2020 – January 2022

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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, Black Country, Cambridgeshire, Essex, Hertfordshire, Northamptonshire, Staffordshire and Swansea. This report relates to the period of July 2020 to January 2022, with data being provided for 1,134 cases.

Overall, there were:

- 1,134 cases submitted
    - 1,019 assessments for MHTR
        - 812 individuals found suitable for MHTR following assessment
            - 684 sentenced to MHTR (or dual diagnosis)
                - 424 with intervention start date
                    - 392 with pre-intervention scores
                        - 195 with post-intervention scores

It must be noted that the files submitted include live cases and as such would not yet have progressed beyond initial assessment.

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:

Assessment & Demographics: Overall, assessments for MHTR had increased over time across the sites. Most assessments (88%) were for MHTR only, with 7% for MHTR&ATR and 4% for MHTR&DRR. Assessment scores, regardless of psychometric used, show most individuals were identified as being in severe psychological distress. Overall, 80% of individuals assessed were found suitable for MHTR by the Clinical Lead. In terms of demographics at point of assessment, there was a relatively even split between Females and Males, with most assessments being completed with individuals aged 25-34 years. Most assessments (80%) were completed with individuals whose ethnicity was White. The most frequent primary offence type was violence against the person followed by motoring offences.

Sentencing: Overall, the number of sentences passed each month has increased over time, with 78% being passed within one month of assessment. 10% of sentences were passed on the same day as assessment. The length of time between assessment and sentence was reducing over time. Where sentences had been passed, 81% were sentenced to MHTR (inc. Dual Diagnosis) and 9% were declined.

Start of Intervention: Overall, there were 684 sentenced to an MHTR (or Dual Diagnosis) and there were 424 cases with an intervention start date. The number of intervention starts per month had increased over time, though was unevenly distributed across the sites. At the start of the intervention, the following psychometric scores were recorded:

- CORE34: 16% severe psychological distress, 21% moderate-to-severe psychological distress, 22% moderate psychological distress, and 42% mild and below mild psychological distress.
- GAD7: 48% severe anxiety, 22% moderate anxiety, and 30% mild and below mild anxiety.
- PHQ9: 38% severe depression, 27% moderately severe depression, 21% moderate depression, and 19% mild or below mild depression.

Outcomes and Change: There were 227 individuals with a recorded end date. Outcomes and change were:

- CORE-34: In the sample of 151, 81% (123) saw a 5 or more point reduction in their pre to post CORE-34 score. 9% (14) saw no reliable change (i.e. between -4 and +4) and the remaining 9% (14) saw a reliable worsening (5+).
- GAD-7: In the sample of 192, 60% (116) saw a 4 or more point reduction in their pre to post GAD-7 score. 35% (67) saw no reliable change (i.e. between -3 and +3) and the remaining 5% (9) saw a reliable worsening (4+); and
- PHQ-9: In the sample of 192, 58% (111) saw a 6 or more point reduction in the PHQ-9 score. The remaining 42% (81) saw no reliable change (i.e. between -5 and +5) or a reliable worsening (6+). Those that saw a worsening in the PHQ-9 were a minority (2%, 4).

Observations:

Overall, the analysis and results presented from across the 8 sites are very positive. For 227 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 19 months data, the evidence demonstrates how MHTR interventions are having a significant benefit in terms of mental distress, anxiety and depression.** However, due to missing data, the proportions of individuals who do not complete is not yet clear.

Key observations are:

- The volumes of cases submitted by sites varies and is shaped by the size of population covered in each area as well as by local service decision-making and practices.
    - **It is recommended that sites review the numbers of individuals being assessed and sentenced to MHTR in relation to 1. numbers of individuals coming into contact with Probation who fall within the appropriate sentencing level, 2. the relative scales of programmes, and 3. the strategic/operational aims of CSTR.**
- The proportions of individuals who are assessed for MHTR from Asian, Black, Mixed backgrounds continues to a concern.
    - **It is recommended that local MHTR Steering Groups should investigate if demographic proportions for individuals assessed for MHTR is aligned with wider demographic trends for individuals coming into contact with Probation.**
- The proportions of individuals being sentenced to Combined Orders (i.e. MHTR&ATR and MHTR&DRR) remains relatively low at 5% and 4% respectively.
    - **It is recommended that local MHTR Steering Groups review processes concerning the completion of assessments for Combined Orders and the flows of communication between relevant individuals.**
- Within the files received, these were a range of missing data and sites should seek to minimise missing data.
    - **It is recommended that practitioners review the data provided within files and add data where possible. This is especially important for dates, pre/post assessment scores, sentencing outcomes, and client status.**

Contents

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, Black Country, Cambridgeshire, Essex, Hertfordshire, Northamptonshire, Staffordshire and Swansea. This report relates to the period of July 2020 to January 2022, with data being provided for 1134 cases. Across the sites, most cases were in Essex (n=284).

Data Summary

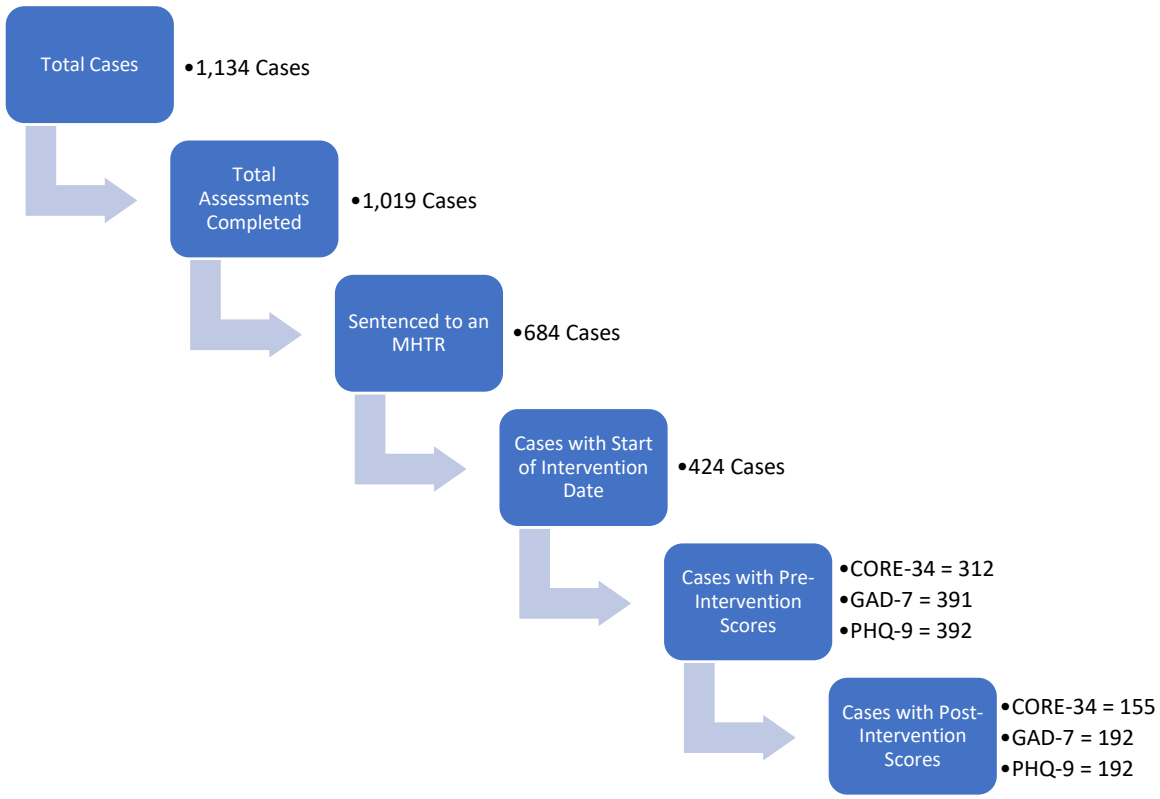
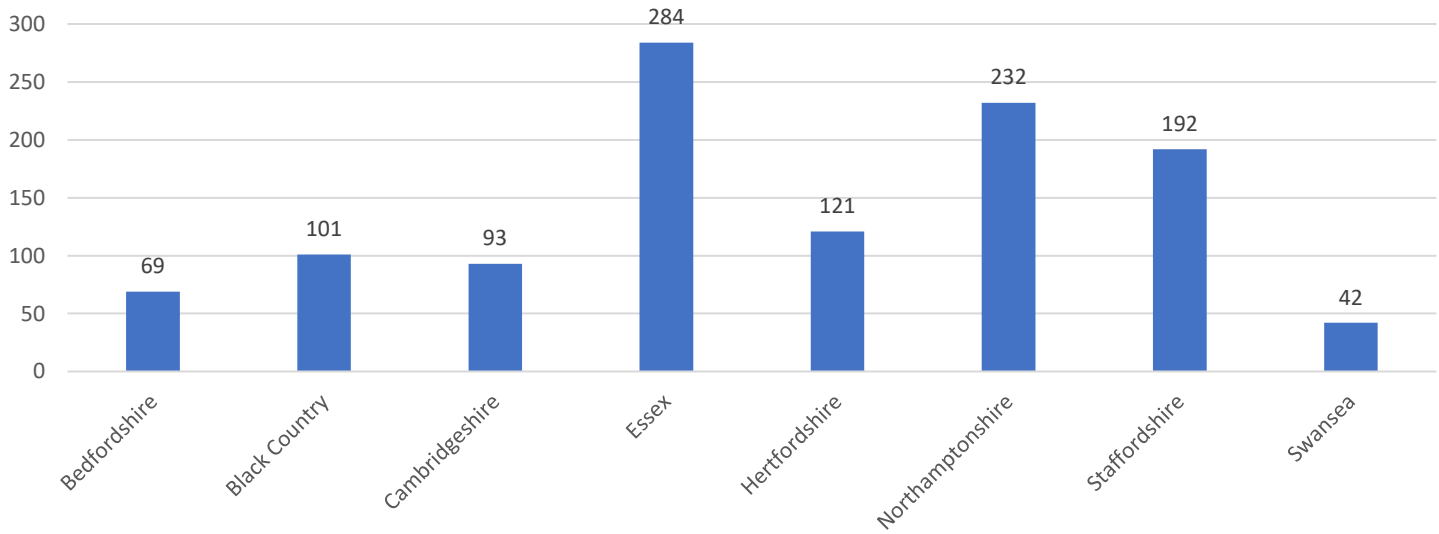


Fig 1.1 Total Cases per Site, Jul 20 - Jan 22, 8 Sites



When cases are organised into six-month periods, Figure 1.2 shows that the number of cases in the evaluation is increasing. Black Country and Swansea are additional sites included in the analysis compared to previous reports.

Fig 1.2 Total Cases - 6 Monthly, Jul 20 - Dec 21, 8 Sites

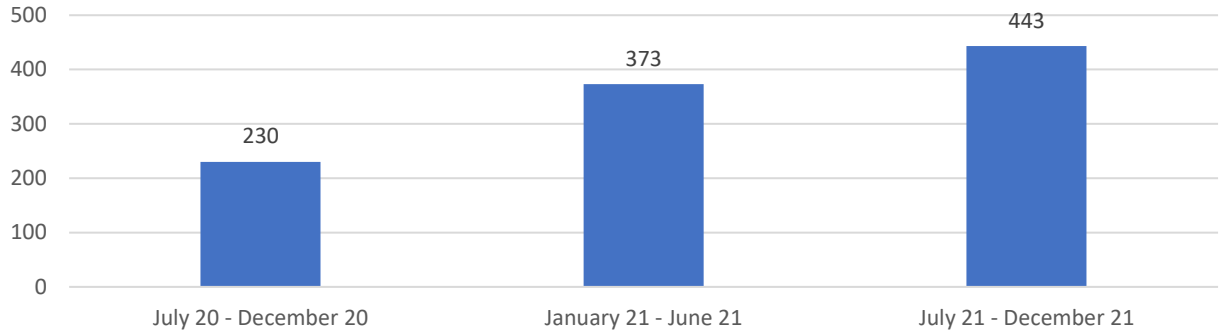
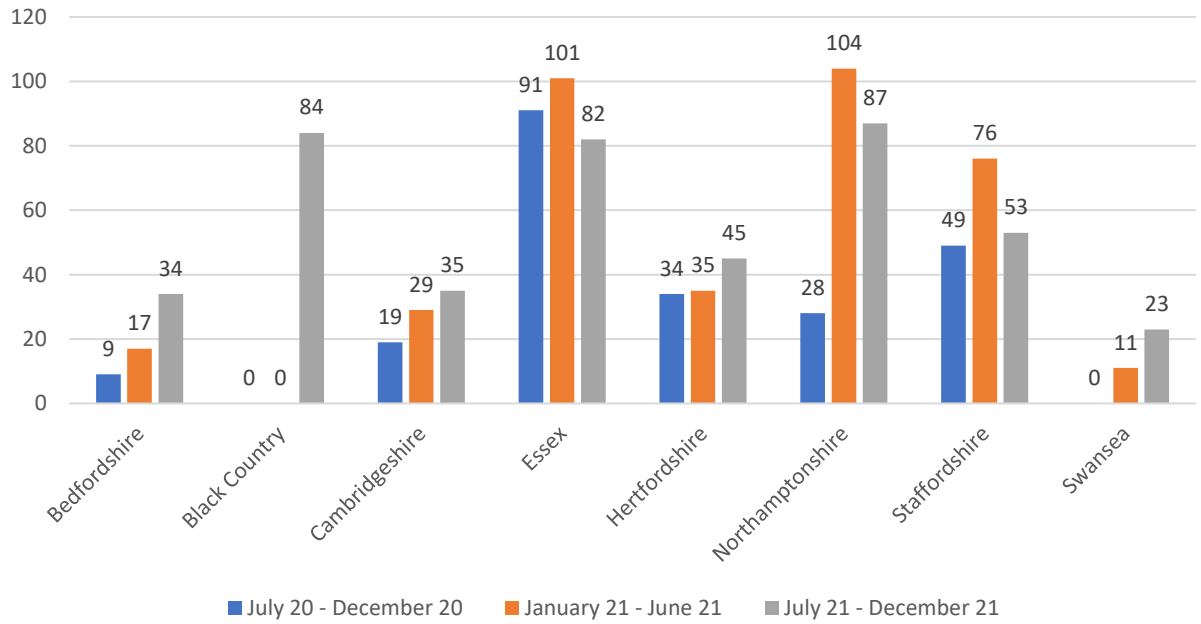


Figure 1.3 shows the total number of cases provided by each site broken down into 6 monthly periods from the start of the evaluation in July 2020. It should be noted sites started provided cases at different points in the evaluation and some sites are currently back dating their data files.

Fig 1.3 Total Cases per Site - 6 Monthly, Jul 20 - Dec 21, 8 Sites

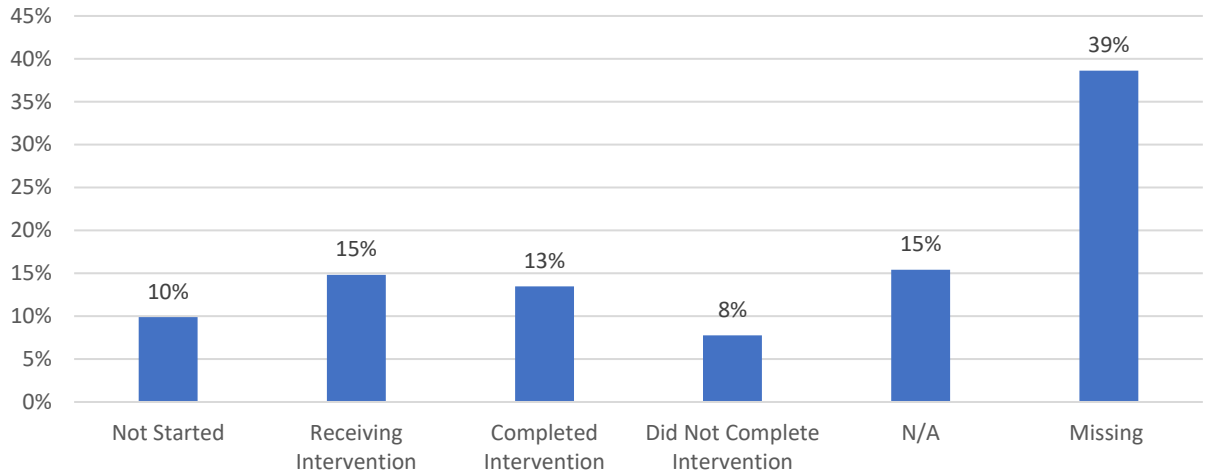


A new tab was introduced labelled 'client status' which allows practitioners to identify between:

- Cases awaiting start of intervention
- Cases where intervention had started
- Cases where intervention had been completed (i.e. successful completion)
- Cases where intervention was not completed (i.e. unsuccessful completion)
- Cases that were not applicable (i.e. not sentenced to MHTR)

Figure 1.4 shows the client status from the 1,134 cases overall that were provided. It shows that most cases (39%) did not have an up-to-date client status that was provided.

Fig 1.4 Client Status, 8 Sites, Jul 20 - Jan 22



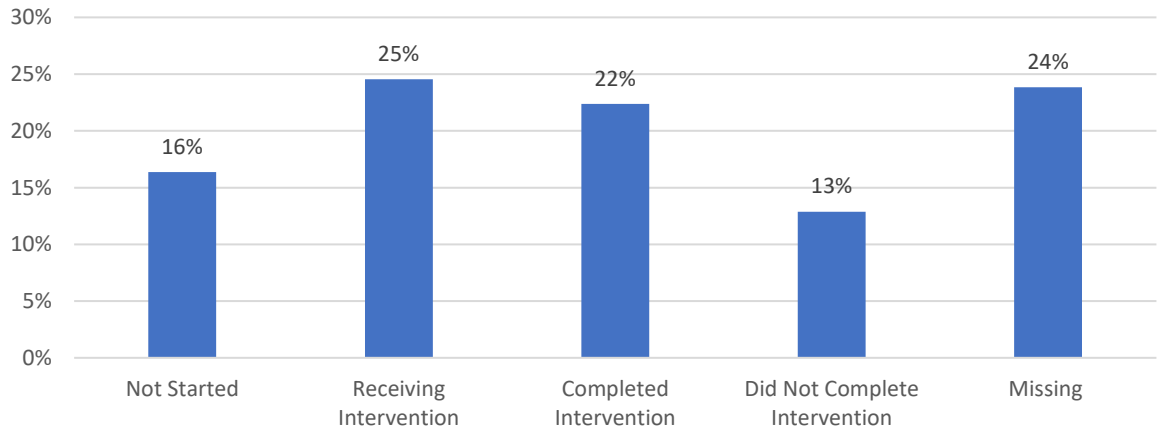
It is important to note that data in this report were processed irrespective of client status, however, it restricts the accuracy in terms of numbers of people where interventions completed or not completed.

Estimated proportions of cases in terms of client status based on other variables for individuals who were sentenced to MHTR (Figure 1.5) is provided below.

So, for example, N/A is defined as cases not found suitable or not sentenced to MHTR. Missing is defined as cases that were sentenced to MHTR but no information is provided.

It is crucial to note that the numbers of 'did not complete' includes cases from early stages in programme implementation where sites were learning about factors that shape suitability, and therefore higher proportions did not complete. Also, these proportions are heavily influenced by the results in one site, accounting for 57% of all non-completions.

Fig 1.5 Estimated 'Client Status' Sentenced to MHTR (684 Cases), 8 Sites, Jul 20 - Jan 22



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. Assessment and Demographic Overview
3. Sentencing
4. Intervention Start
5. Outcomes and Change
6. Observations

2. Assessment and Demographic Overview

This section provides an overview of assessment and demographic data between July 2020 and January 2022. Figure 2.1 shows that the number of assessments has a positive trend over time, though it is noted some sites only provide data from later time points. The differences are illustrated in Figure 1.3.

Fig 2.1 Assessments by Month, 8 Sites, Jul 20 - Jan 22

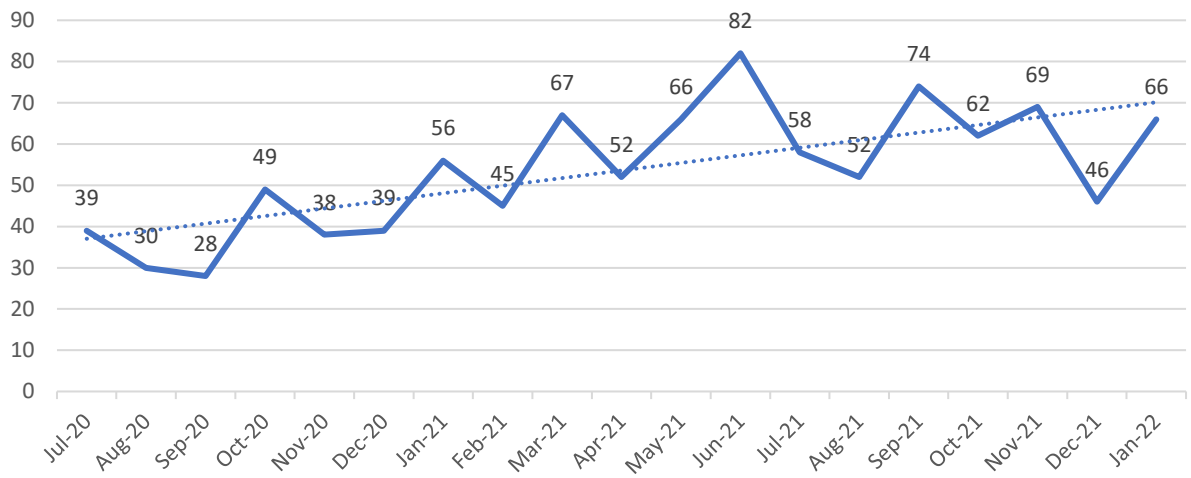
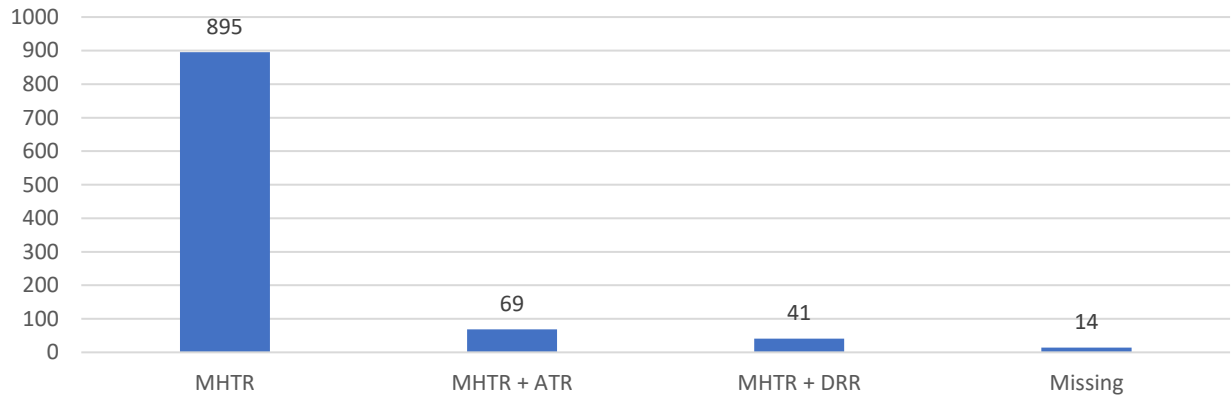


Figure 2.2 shows that most (88%) assessments were completed for MHTR only, with 7% and 4% being assessed for MHTR & ATR or MHTR & DRR respectively.

Fig 2.2 Assessment Type, 8 Sites, Jul 20 - Jan 22



The process and tools used to assess suitability for an MHTR differ between sites. 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

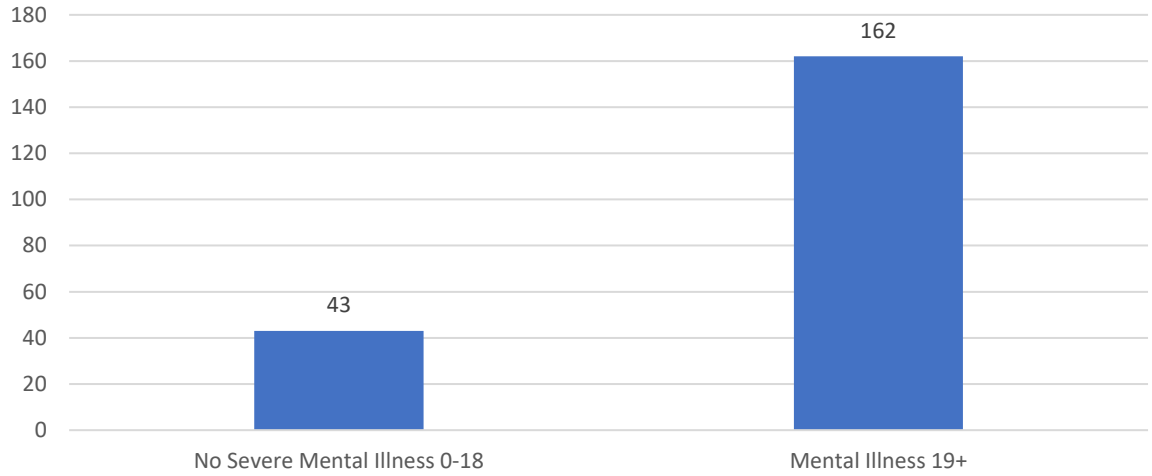
Site	K6	K10	CORE-10	CORE-34
Bedfordshire				
Black Country				
Cambridgeshire				
Essex				
Hertfordshire				
Northamptonshire				
Staffordshire				
Swansea				

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 205 individuals assessed using K6, 162 (79%) were found to be in mental distress.

Fig 2.3 Assessment - K6, 1 Site



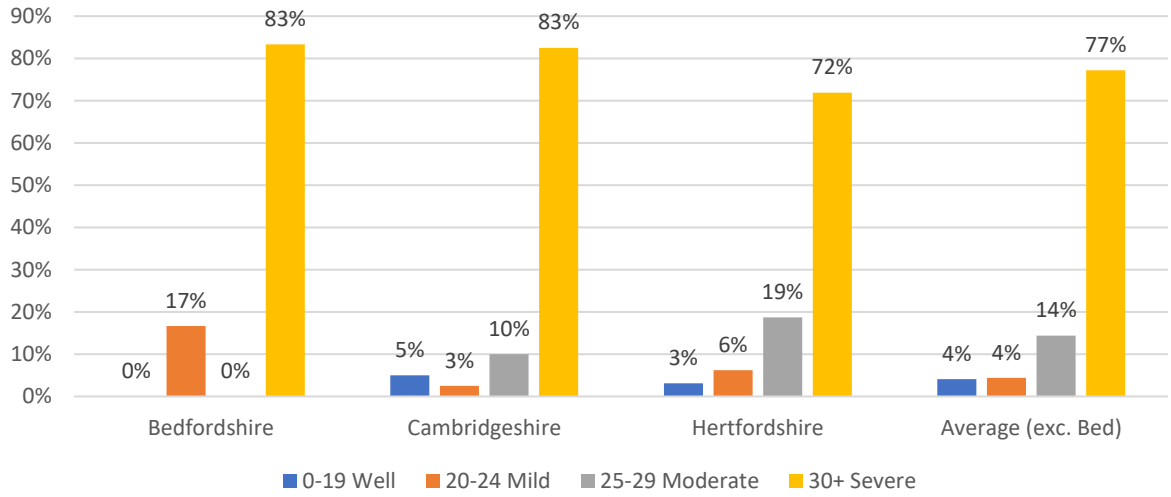
K10 Scores

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 118 individuals (Beds: 6; Cambs: 80; Herts: 32) assessed using K10, most individuals were identified as being in severe level of distress.

Fig 2.4 Assessment - K10, 3 Sites



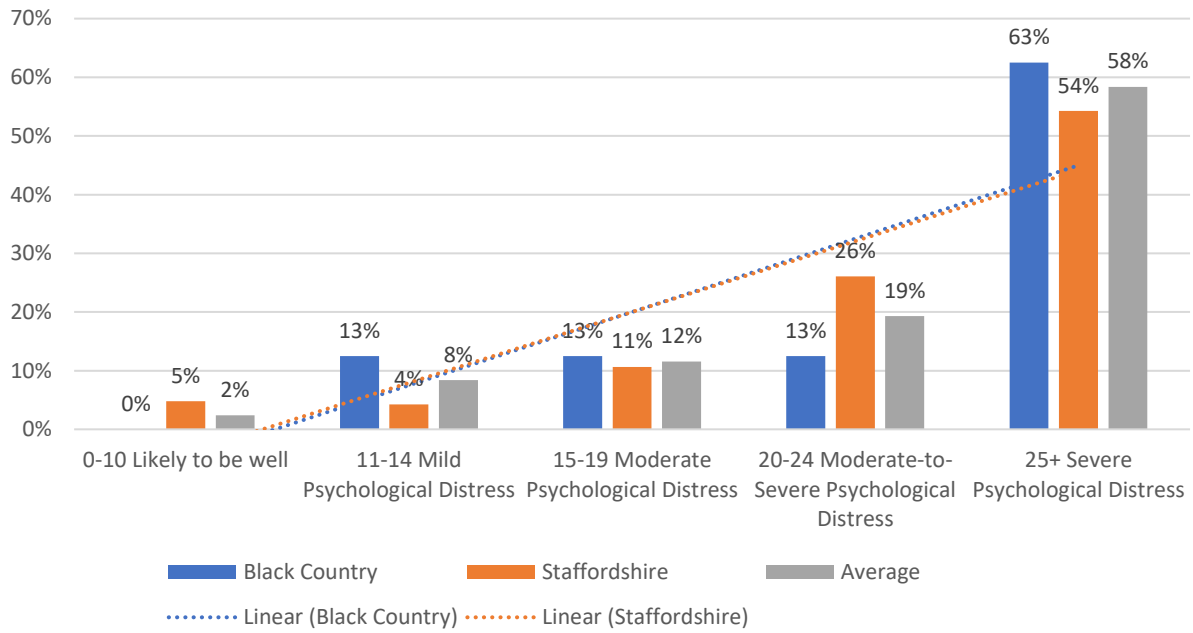
CORE-10 Scores

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 196 individuals (BC: 8; Staff: 188) assessed using CORE-10, most individuals were identified as being in severe psychological distress.

Fig 2.5 Assessment - CORE-10, 2 Sites



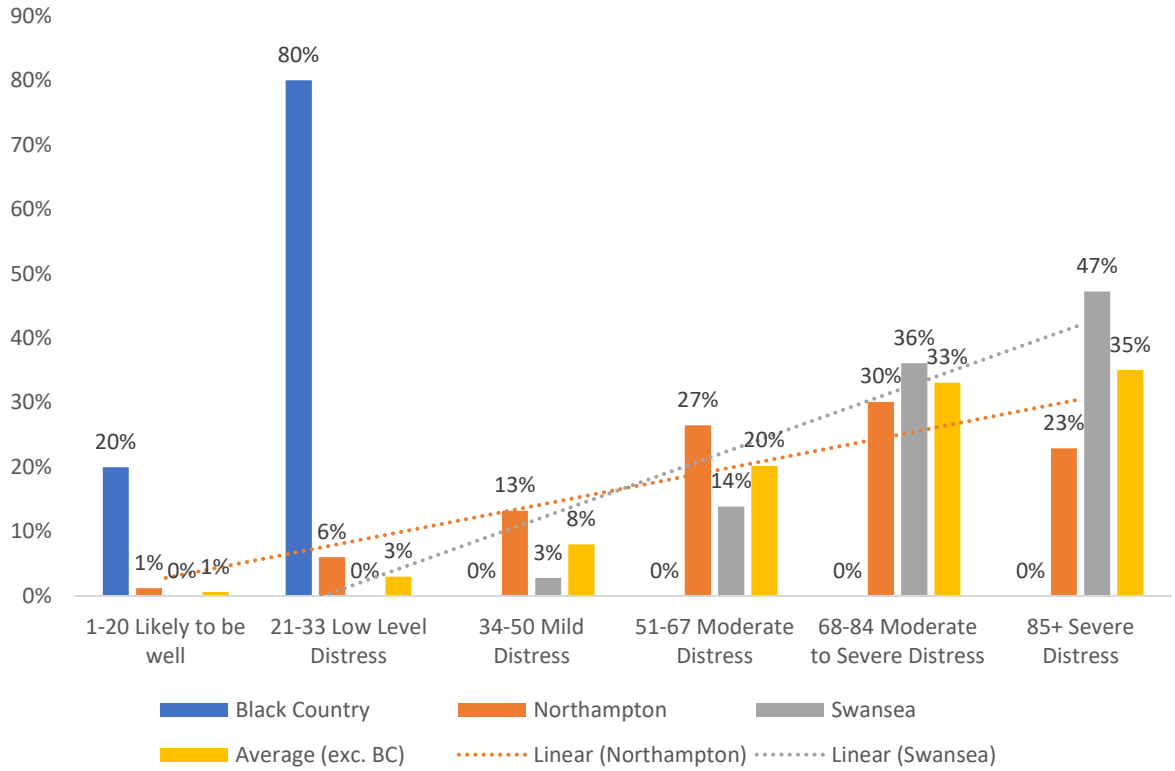
CORE-34

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.

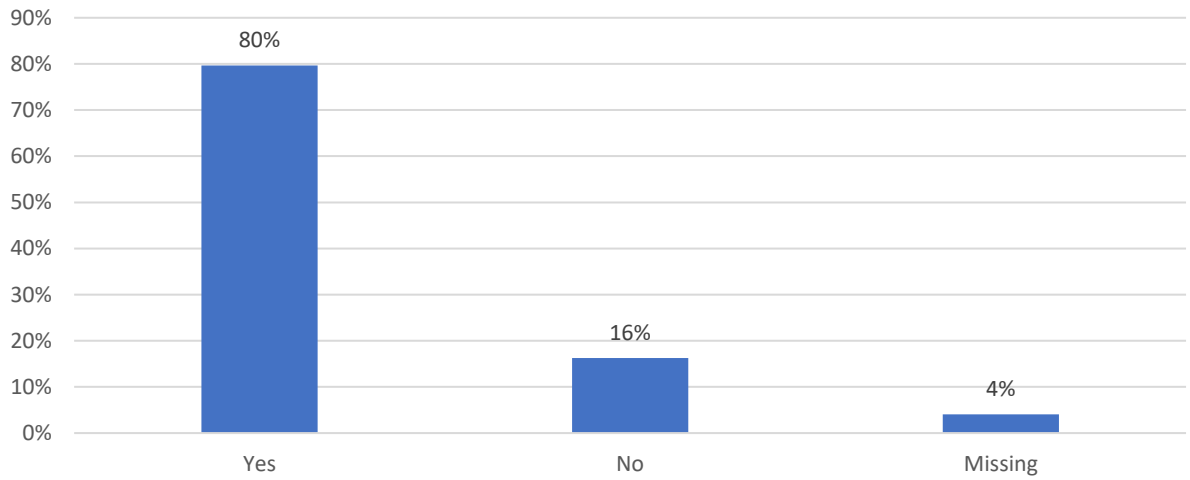
Of 124 individuals (BC: 5; North: 83; Swan: 36) assessed using CORE-34, 79 (51%) were identified as being in mental distress, with 19 in severe mental distress. There were missing data for 74 individuals, representing 48% of cases.

Fig 2.6 Assessment - CORE-34, 3 Sites



In total following assessment, 812 (80%) individuals were identified as being suitable for MHTR intervention.

Fig 2.7 Assessment - Suitibility, 8 Sites, Jul 20 - Jan 21



Demographic data presented in this Chapter are based on the 1,019 assessments completed. Figure 2.8 illustrates gender of those assessed, showing a relatively even balance between men and women. It is noted, however, these are stark differences when looking at the results at a local level, with some sites focussing on female only pathways.

Fig 2.8 Assessments - Gender, 8 Sites, Jul 20 - Jan 22

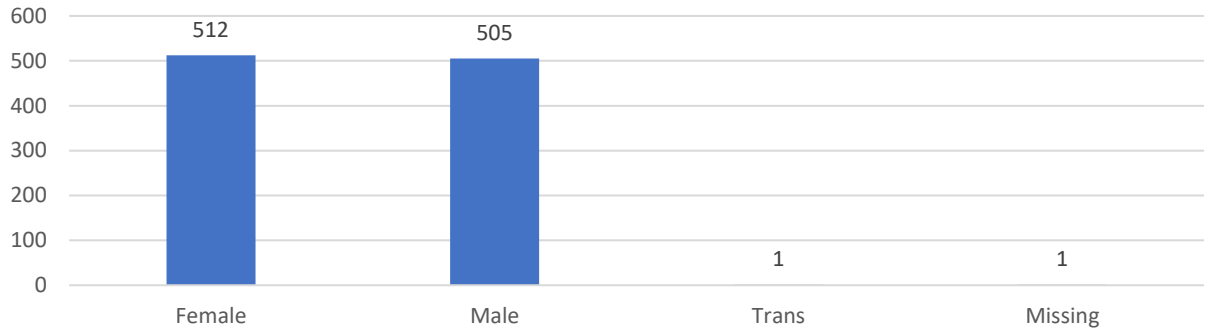


Figure 2.9 shows that most individuals assessed were aged between 25 and 34 years, followed closely by 35 – 44 years.

Fig 2.9 Assessments - Age, 8 Sites, Jul 20 - Jan 22

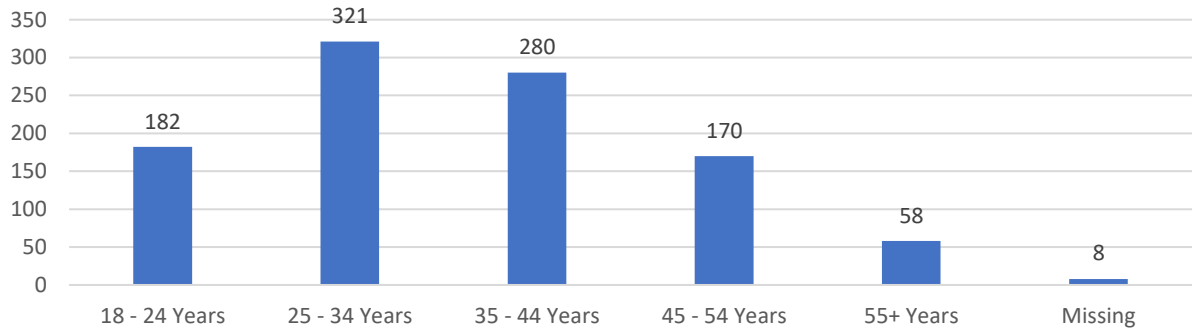


Figure 2.10 shows that most individuals assessed were White (80%). 7% of those assessed were from Asian, Black and Mixed ethnic groups.

Fig 2.10 Assessments - Ethnicity, Jul 20 - Jan 22, 8 Sites

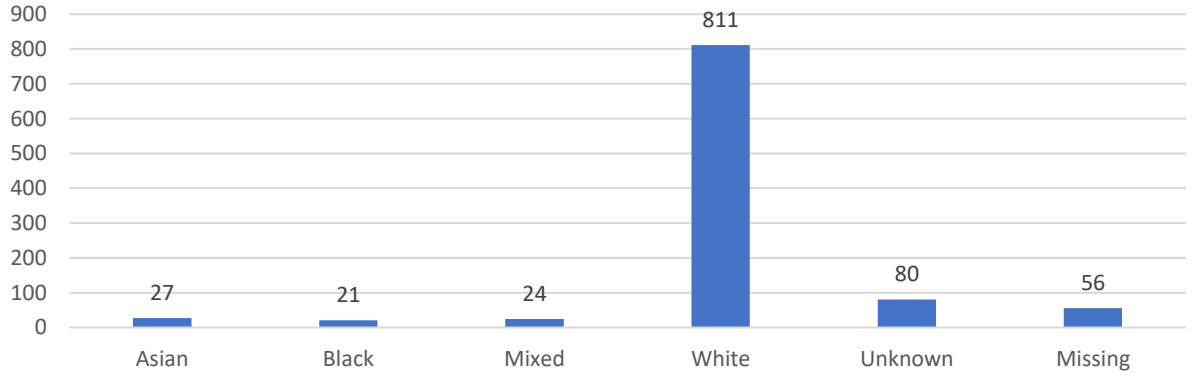
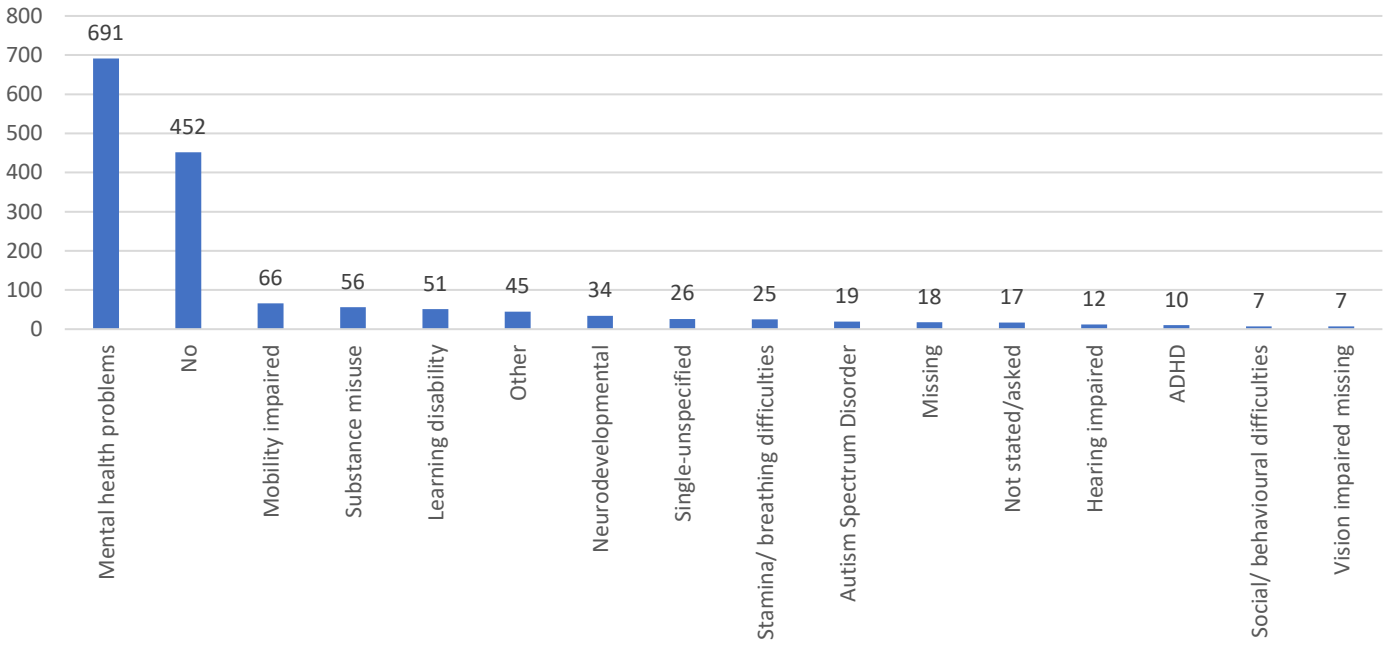


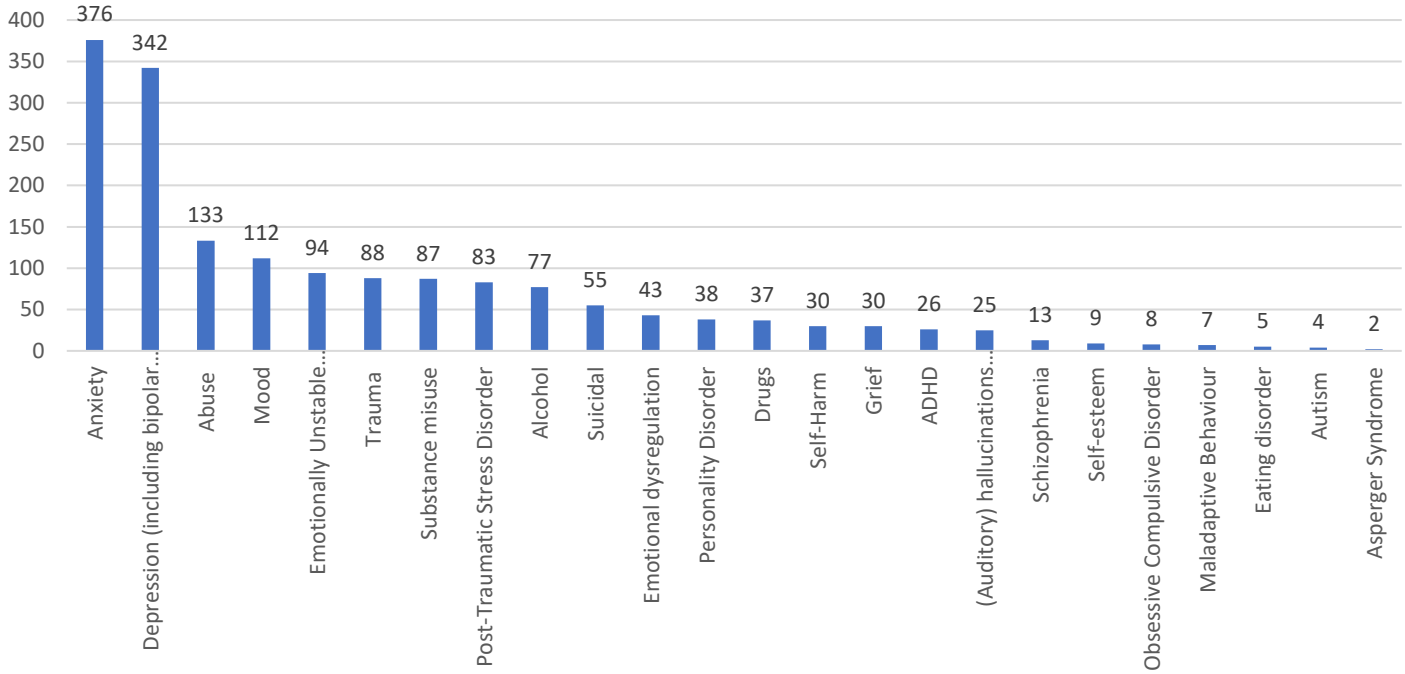
Figure 2.11 shows disability types recorded during assessment and illustrates that the most frequently recorded disability was mental health.

Fig 2.11 Assessment - Disabilities, 8 Sites, Jul 20 - Jan 22



There were a range of vulnerabilities identified during the assessment process, illustrating the diversity and complexity of needs, illustrated in the figure below. In total, 1,724 vulnerabilities were identified in the assessment, with the most frequent being anxiety (376), depression (342) and abuse (133).

Fig 2.12 Assessment - Vulnerabilities, 8 Sites, Jul 20 - Jan 22



Within the files, 34 (3%) individuals were identified as meeting perinatal criteria, with 20 being pregnant at the point of assessment. Of those assessed, 80 (8%) were sole carers and 21 (2%) had previously served in the armed forces.

Figure 2.13 illustrates the documented Primary Offence Type of individuals assessed, showing that the most frequent offence type was violence against the person, representing 30% of primary offences. This was followed by motoring offences.

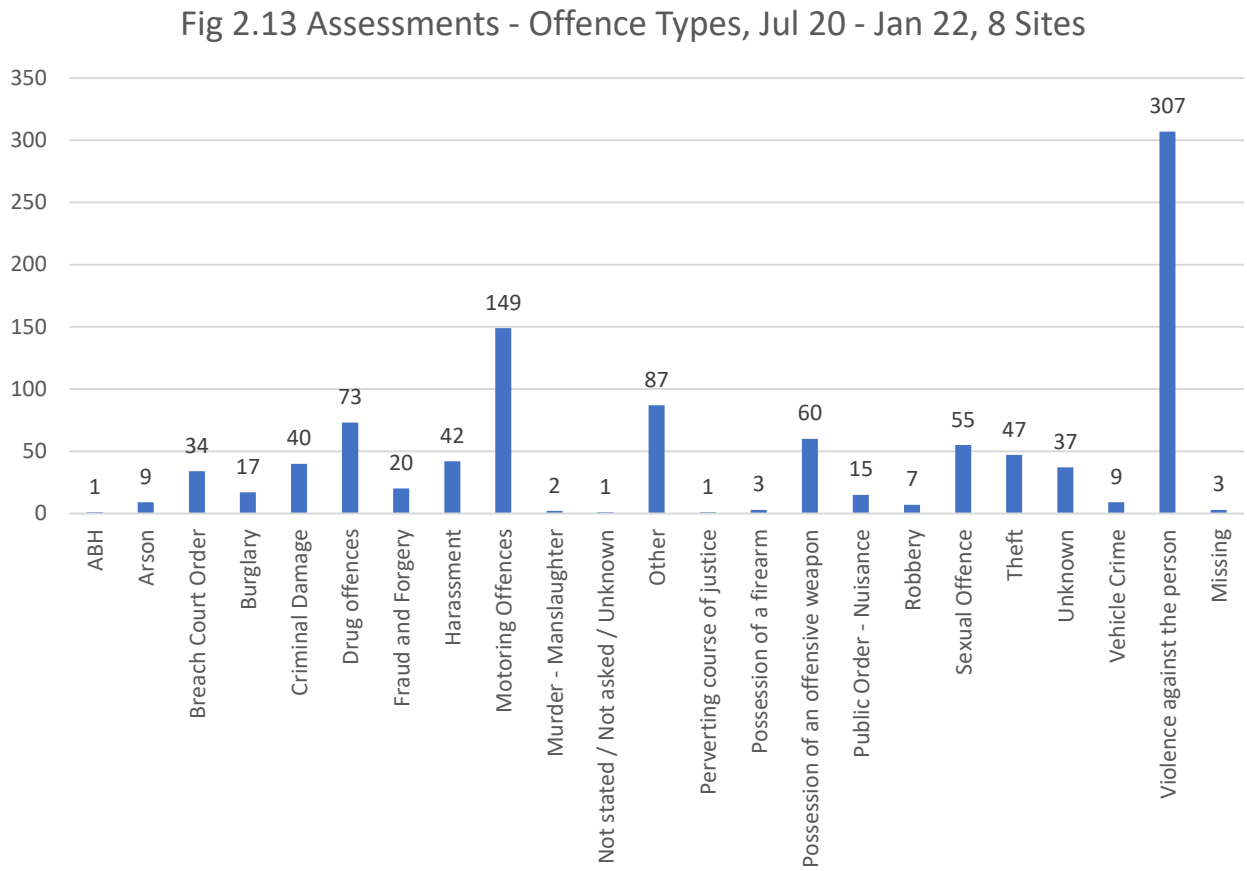
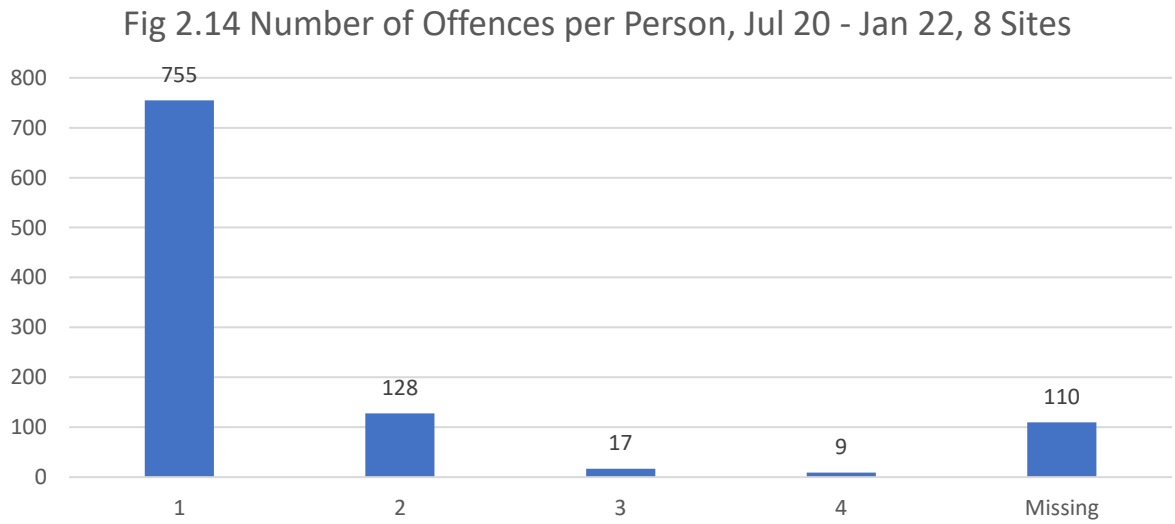


Figure 2.14 shows that most individuals had only one offence recorded within the file.

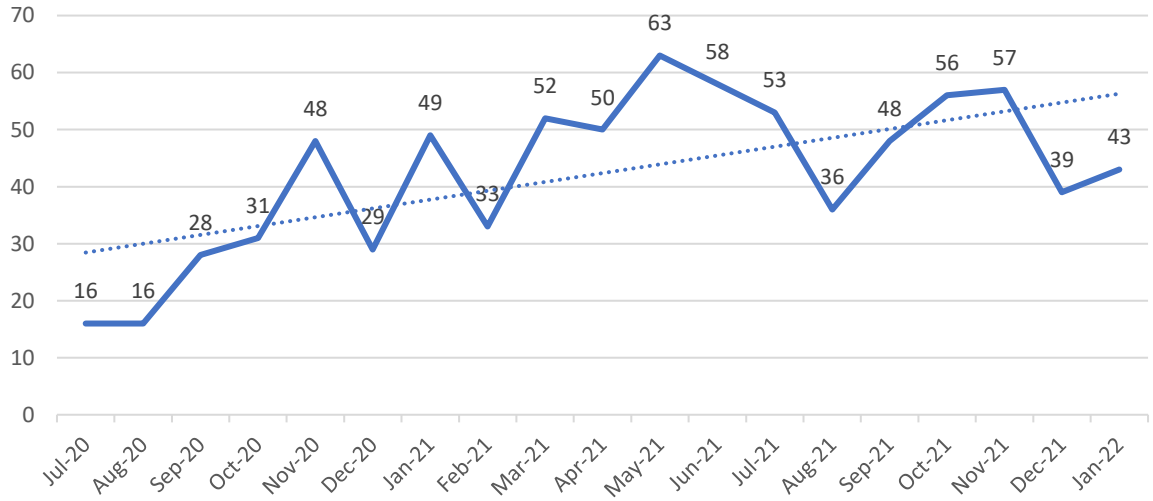


3. Sentencing

This section relates cases where a sentencing outcome was provided (n = 824).

Figure 3.1 shows sentence date by month, illustrating an increase in sentences over time.

Fig 3.1 Sentence Date by Month, 8 Sites, Jul 20 - Jan 22



The gap between assessment and sentencing for most cases was within one month, with 83 occurring on the same day. Less than 4% of cases had a gap between assessment and sentencing over 3 months.

Fig 3.2 Assessment to Sentence Gap (Days), 8 Sites, Jul 20 - Jan 22

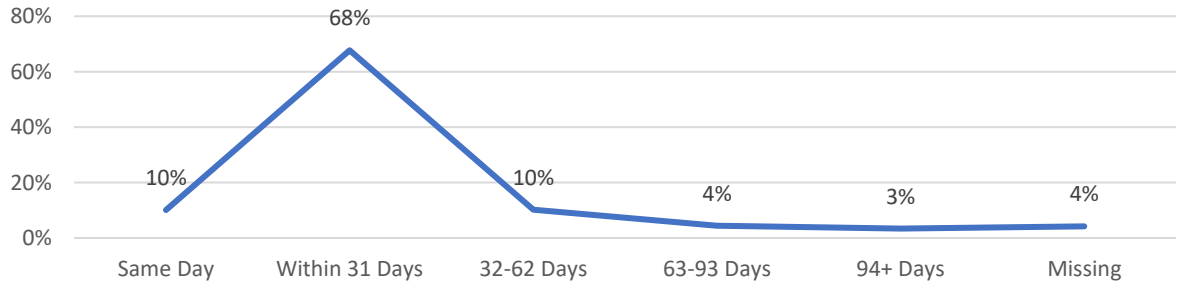


Fig 3.3 Assessment to Sentence Gap (Days) - 6-Monthly

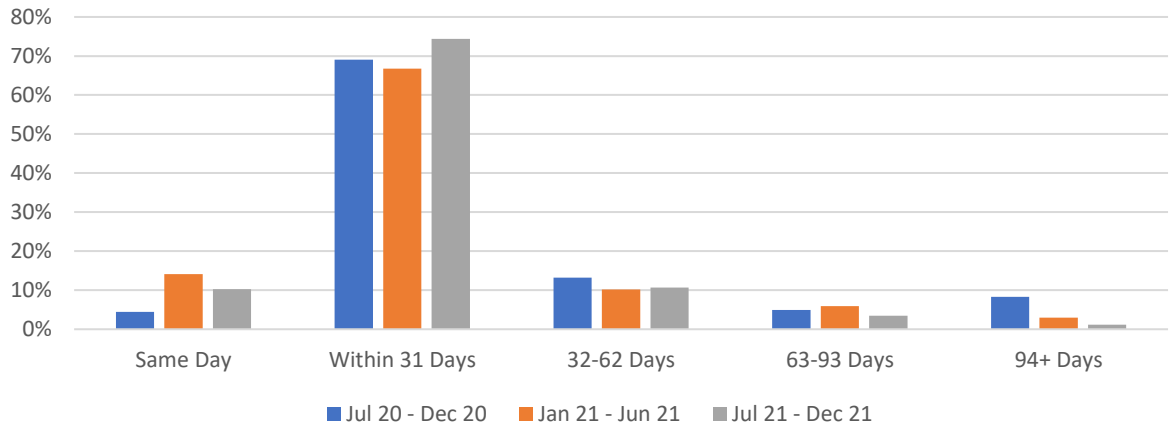


Figure 3.4 shows cases where a sentencing outcome was provided only (n = 824). Most individuals assessed and recommended as suitable for an MHTR were sentenced to an MHTR (72%). There were 9% of cases where the recommendation for an MHTR was declined. Missing cases and N/A include cases where sentence has not yet been passed.

Fig 3.4 Sentence Outcome, 8 Sites, Jul 20 - Jan 22

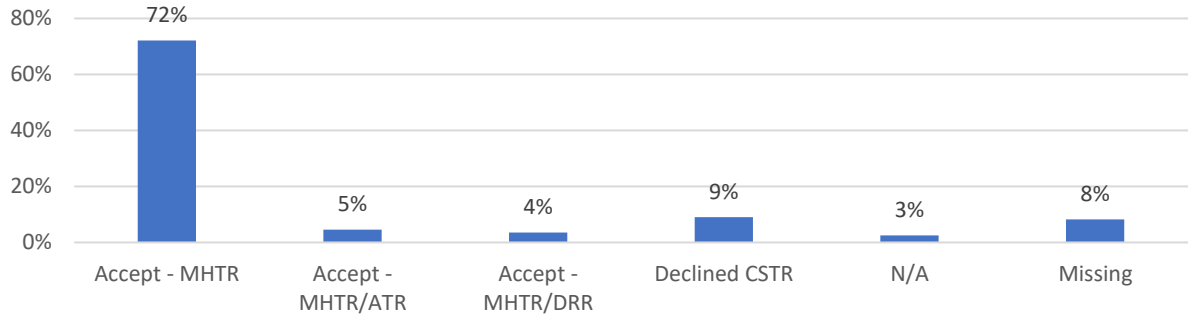
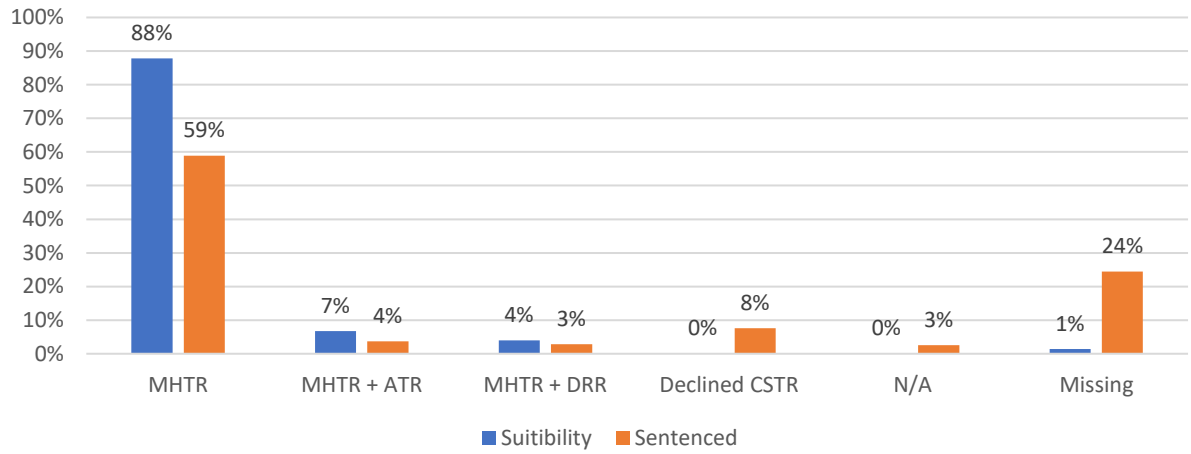


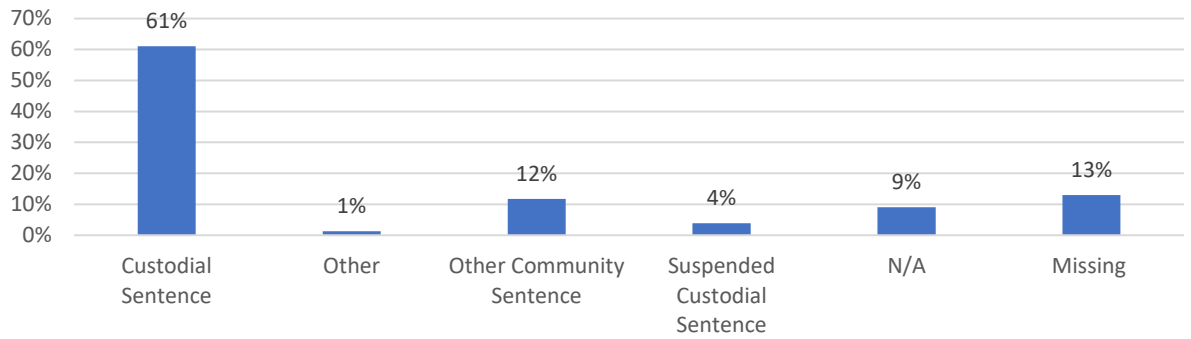
Figure 3.5, unlike Figure 3.4, includes all cases that were identified as being suitable for MHTR (n = 1019). This illustrates that Figure 3.3 represents 76% of all cases where individuals were identified as being suitable. Reasons for missing data include a sentence has not yet been passed.

Fig 3.5 Suitibility vs. Sentence Outcome, 8 Sites, Jul 20 - Jan 22



In the 77 cases where MHTR was declined, Figure 3.6 shows what sentences were passed. Most frequently, (61%) custodial sentences were passed where MHTR was recommended.

Figure 3.6 If CSTR declined, what was outcome?



4. Start of Intervention

This section provides an overview of data captured at the start of the intervention. There were 424 cases with an intervention start date. Fig 4.1 shows the number of interventions starting each month has risen over time, peaking in November 2021. Figure 4.2 shows that the peak increase in November 21 and December 21 was attributed to numbers in 3 sites.

Fig 4.1 Intervention Start Dates, 8 Sites, Jul 20 - Jan 22

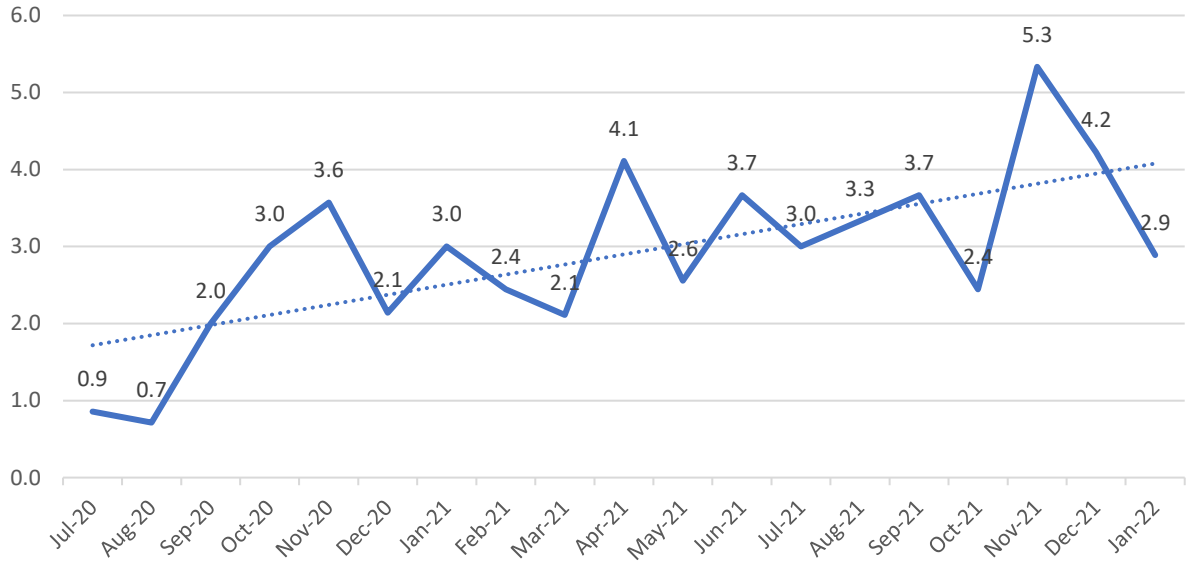
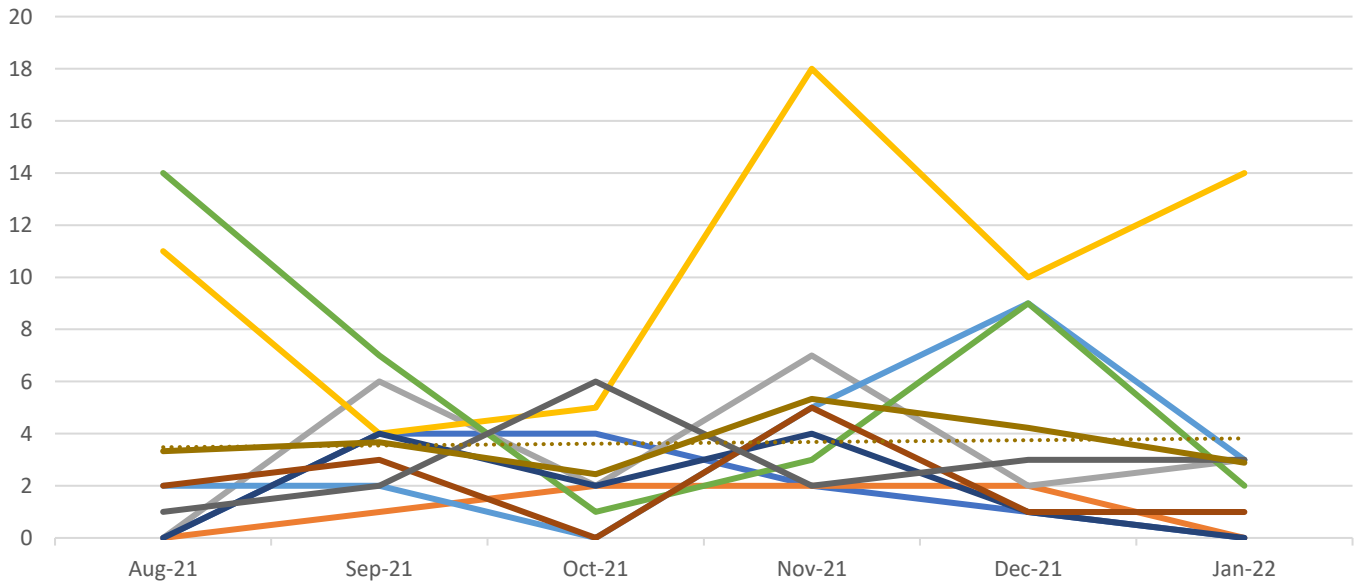


Fig 4.2 Intervention Start Date by Site, 8 Sites, Aug 21 - Jan 22



In the first session, individuals complete psychometric measures to assess severity of distress, including: CORE-34, GAD-7, and PHQ-9.

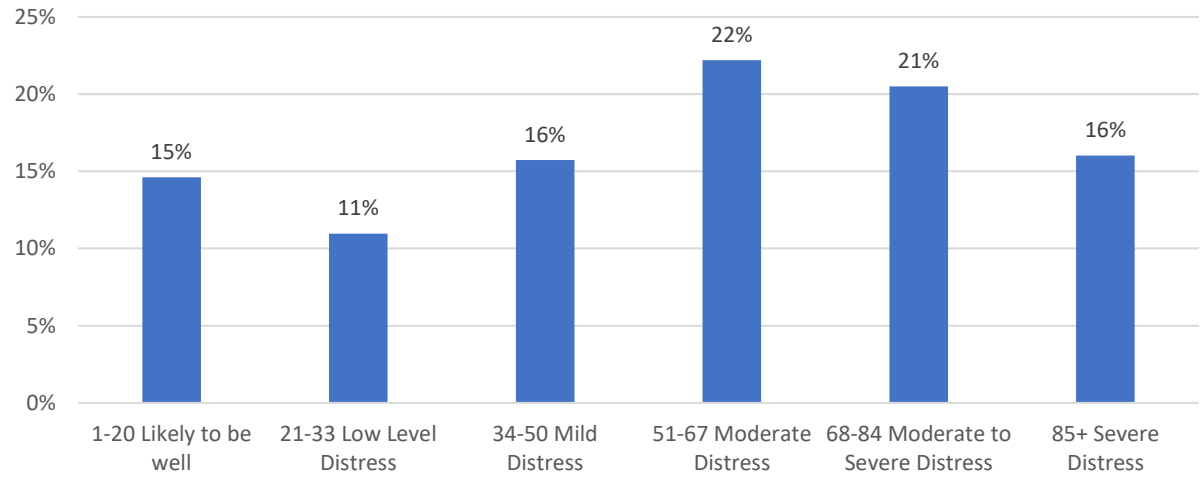
CORE-34

There were 312 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 show how most individuals were assessed to have moderate distress (23%) followed by moderate-to-severe distress (20%).

Fig 4.3 Start of intervention - CORE34, 7 Sites, Jul 20 - Jan 22



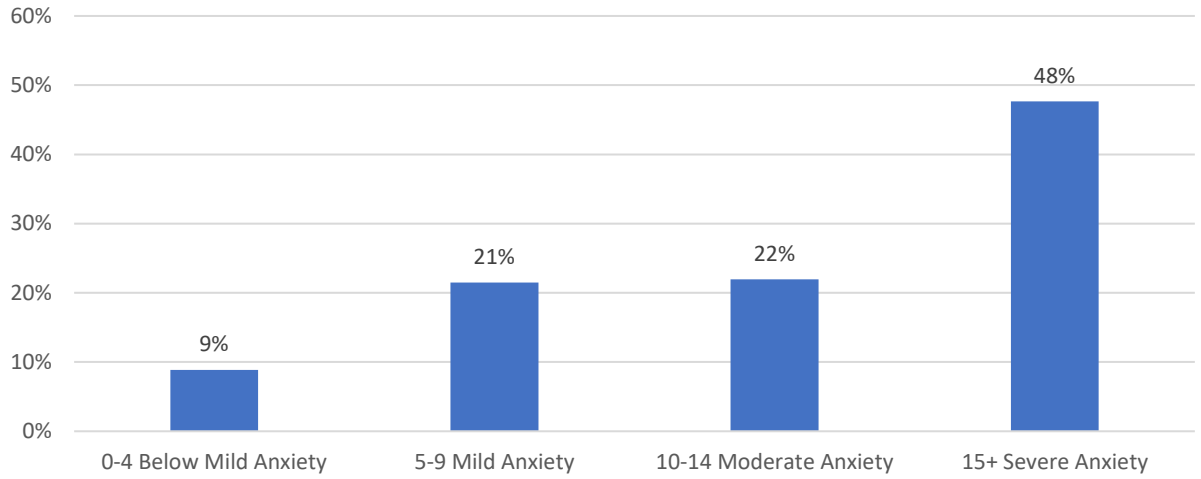
GAD-7

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 391 individuals who were assessed at the start of the intervention using GAD-7. The GAD-7 scores in the first session show most individuals (48%) have severe anxiety.

Figure 4.4 Start of Intervention - GAD7, 8 Sites, Jul 20 - Jan 22



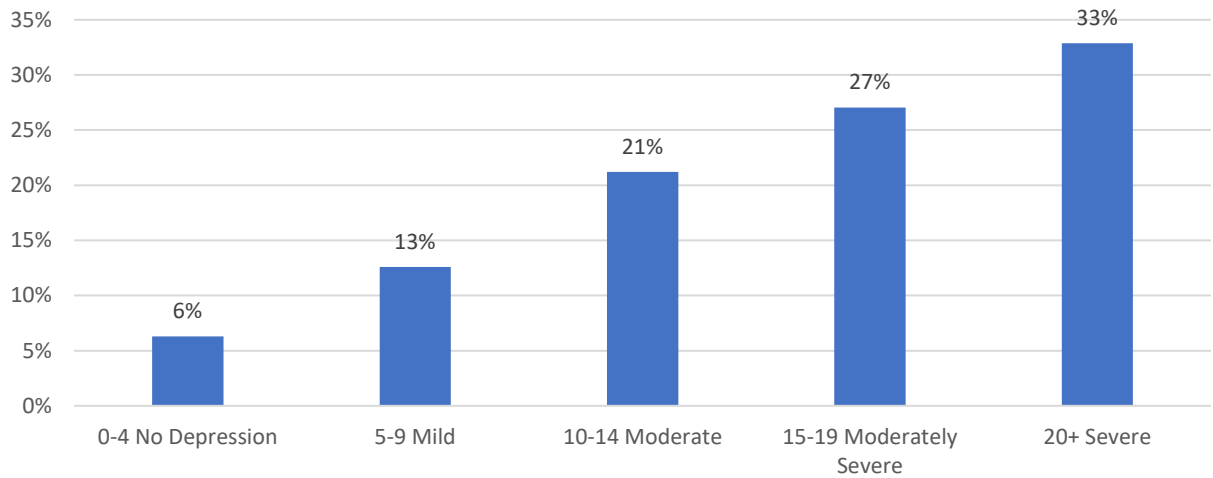
PHQ-9

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

Figure 4.5 Start of Intervention - PHQ9, 8 Sites, Jul 20 - Jan 22



5. Outcomes and Change

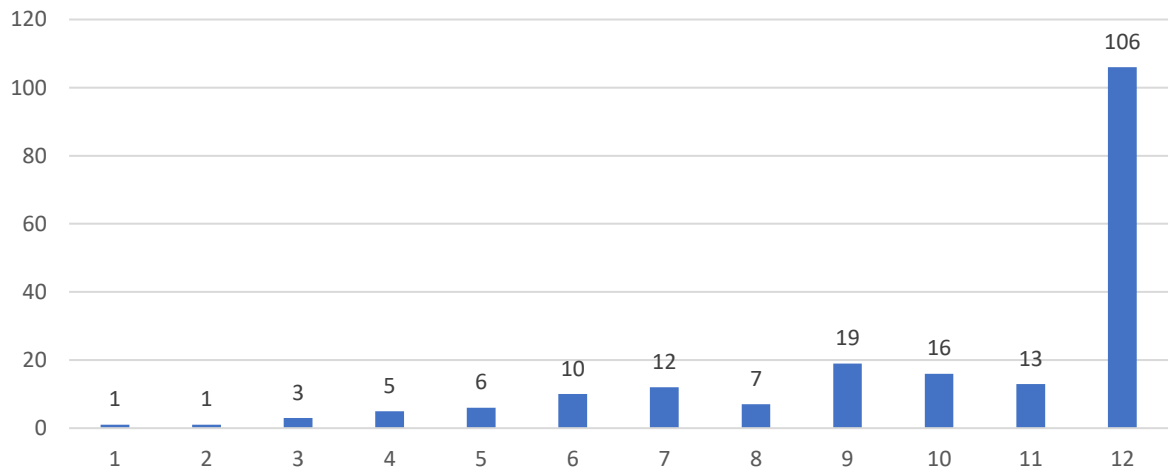
This section concerns the recorded outcomes for individuals who completed the intervention and what change was measured in the psychometric measures. Data is not presented on individuals who did not complete, as levels of missing data restrict insight. A recommendation from this report is for local sites to address missing data to enable accurate insight into levels of individuals not completing and reasons for not completing.

Overall, there were 227 individuals with a recorded end date of intervention across 8 sites. Of those 142 (63%) are recorded as completing, 7 (3%) are recorded as 'currently receiving the intervention', 23 (10%) are recorded as 'not completing the intervention' and for 55 (24%) the client status is missing. For those that are recorded as not completing reasons given were:

- Discharged ('not workable') (4)
- Moved out of area (3)
- Did not engage (3)
- Breached/ committed further offence (2)
- Died (2)
- Needs had been met through other MH support/ therapy (2)
- Mentioned once each were withdrew consent, had no MH needs, disability/ illness and court order expired.
- A reason was not given for 2 cases.

Out of 227, 12 individuals were recorded as having no or zero sessions. Of the 215 remaining the average number of sessions attended was 10.3. 49% (106) of the sample had 12 sessions, 36% (77) had 6-11 sessions, 7% had 1-5 sessions and 47% (16) had more than 12 sessions. This data should be treated with caution, as some of the cases included may have not successfully completed the intervention.

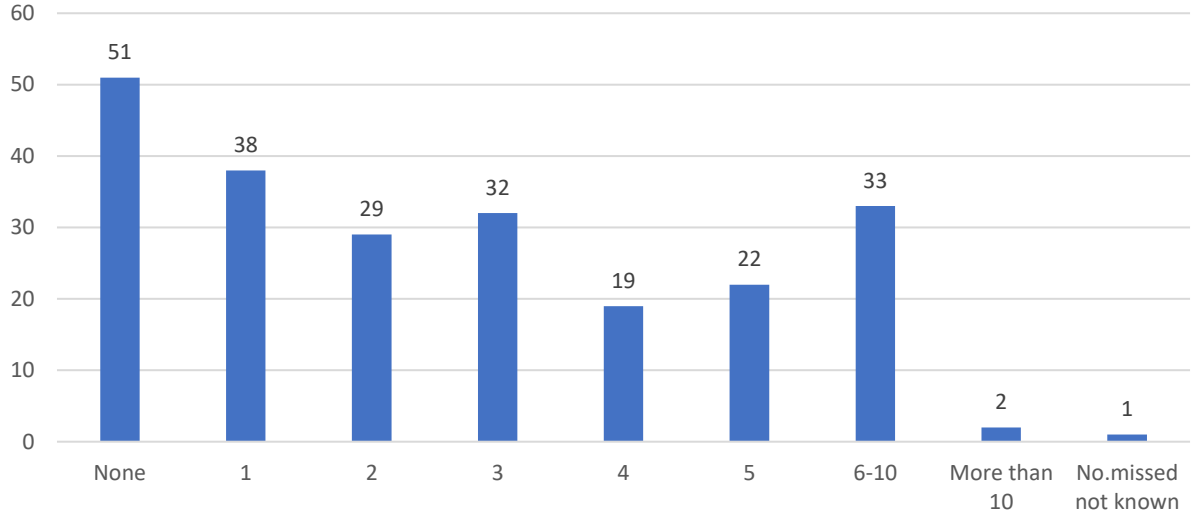
Figure 5.1 Number of sessions service users had, 8 sites, Jul 20-Jan 22



Out of 227 individuals, 176 (78%) had one missed sessions or more. The average number of missed sessions for those that did miss a session was 3.7 sessions. It is noted that frequencies of missed

sessions is likely to have been influenced by Covid restrictions and therefore, future reports will differentiate between cases during Covid and post Covid restrictions.

Figure 5.2 Number of missed sessions for those that have an end date of intervention



The following table illustrates the reasons for missed sessions. It shows the most frequent reason (26%) was illness/physical health, followed by did not attend (21%).

Reasons for Missed Sessions	**% of all reasons**
Illness/physical health	26%
AWOL/no response/DNA	21%
Forgot	7%
Work	6%
Clashed with other appt (e.g. medical/probation)	6%
Childcare related	6%
Phone or internet issues	4%
Other family related issues e.g. ill health	4%
Other	4%
Covid-related	3%
Transport issues	3%
Mental health	3%
Confusion over appt time	2%
Drink drugs related	2%
Unknown	1%
Sleep issues/ overslept	1%
Holiday	1%

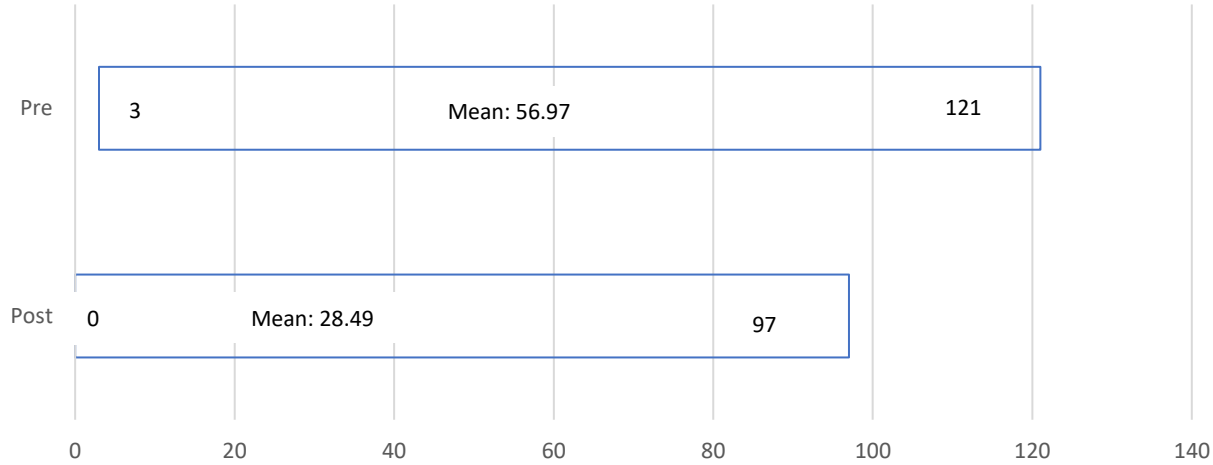
Out of the 227 there were 9 (4%) reported breaches. The type of breach was recorded in 3 cases as 'breach of MHTR', 1 was recorded as 'breach of combined order', 4 were recorded as 'not applicable' and in 1 there was nothing entered. The reason for breach was recorded as non-attendance or engagement in sessions in 6 cases. In one case it was recorded as 'changed address without permission', in one it was a breach of a non-molestation order and in one it was recorded that the breach was

cancelled. In 3 cases the outcome of the breach was to continue the order, in 1 it was to continue the order with additional requirements, in one case the MHTR was removed and in 4 the 'breach outcome' was recorded as 'n/a' or nothing was entered. It should be noted that these numbers do not include ongoing cases and therefore the file includes further breaches. As outlined at the start of this section, once files are updated with accurate client statuses, information will be provided on individuals who did not complete the intervention.

CORE-34

There were 151 individuals with pre and post Core-34 scores. The average pre-score was 56.97 (in the mid-range of moderate psychological distress). The average post score was 28.49 (which is at the higher end of low psychological distress). The average reduction was -28.48 and this difference was statistically significant $t(150) = 13.740$, $p<0.05$.

Fig 5.3 CORE-34 Pre/Post Range and Mean, 7 Sites, Jul 20-Jan 22



Reliable change for the Core 34 is change that exceeds that which might be expected by chance alone or measurement error and for the CORE-OM is represented by a change of 5 or more in the clinical score.

In the sample of 151, 81% (123) saw a 5 or more point reduction in their pre to post CORE-34 score. 9% (14) saw no reliable change (i.e. between -4 and +4) and the remaining 9% (14) saw a reliable worsening (5+).

For those within the group that saw a reliable change the mean pre-score was 61.14 (this would be categorised as moderate psychological distress) whereas for those with no reliable change the mean pre-score was 38.63 (this would be categorised as mild psychological distress). Therefore, those that saw a positive change were on average starting 22.51 points higher on the CORE-34 scale than those that did not. For those that did see a positive reliable change the average mean post score was 24.53 (therefore on average a 36.6-point reduction in their pre to post score).

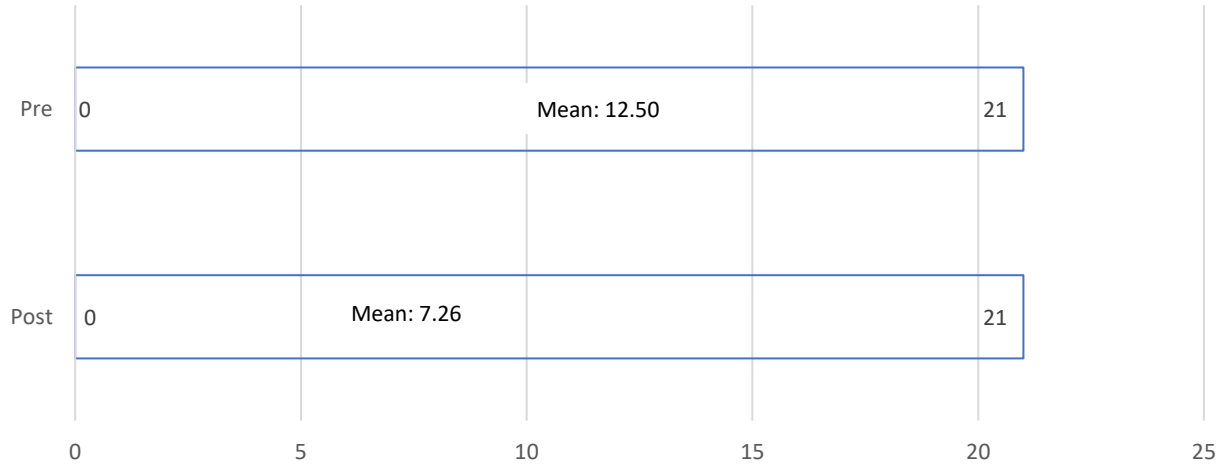
The graph below shows the mean pre and post scores for those that saw a positive reliable change, those that saw no reliable change and those that saw a reliable negative change.

GAD-7

There were 192 individuals with pre and post GAD-7 scores. The average pre-GAD-7 score for this group was 12.50 (Mid moderate anxiety) and the average post score was 7.26 (Mid mild anxiety). Therefore,

the average reduction was -5.24 and this difference was statistically significant t (191) = 11.641 and p<0.05.

Fig 5.4 GAD-7 Pre/Post Range and Mean, 7 Sites, Jul 20 - Jan 22



Reliable change for the GAD-7 is change that exceeds that which might be expected by chance alone or measurement error and for the GAD-7 is represented by a change of 4 or more in the clinical score.

In the sample of 192, 60% (116) saw a 4 or more point reduction in their pre to post GAD-7 score. 35% (67) saw no reliable change (i.e. between -3 and +3) and the remaining 5% (9) saw a reliable worsening (4+).

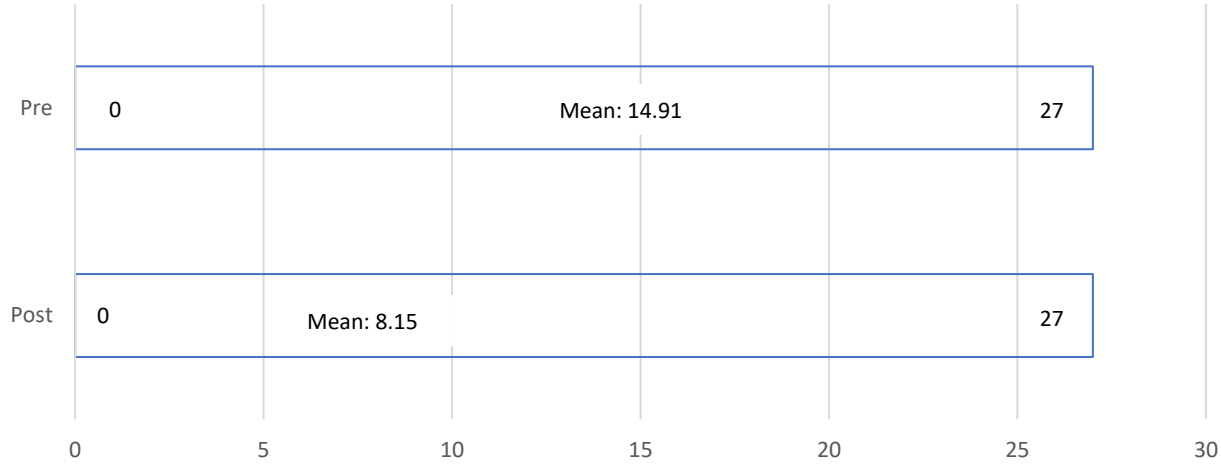
For those within the group that saw a reliable positive change the mean pre-score was 14.35 (this would be categorised as the top end of moderate anxiety) whereas for those with no reliable change the mean pre-score was 9.67 (on the cusp of mild and moderate anxiety). Therefore, those that saw a positive change were on average starting 4.7 points higher on the GAD-7 scale than those that did not. For those that did see a positive change the average mean post score was 5.2 therefore on average about a 9-point reduction in their pre to post scores.

The graph below shows the mean pre and post scores for those that saw a positive reliable change, those that saw no reliable change and those that saw a reliable negative change.

PHQ-9

There were 192 individuals with pre and post scores on the PHQ-9. The average pre-score was 14.91 (on the cusp of moderate to moderately severe depression) and the average post score was 8.15 (mild depression). Therefore, the average reduction was -6.76 and this difference was statistically significant t (191) = 13.863, p<0.05.

Fig 5.5 PHQ-9 Pre/Post Range and Mean, 7 Sites, Jul 20 - Jan 22



According to the Improving Access to Psychological Therapies: Measuring Improvement and Recovery Adult Services: Version 2 (NHS England, June 2014) the PHQ-9 score must change by more than or equal to 6 to be considered reliable.

In the sample of 192, 58% (111) saw a 6 or more point reduction in the PHQ-9 score. The remaining 42% (81) saw no reliable change (i.e. between -5 and +5) or a reliable worsening (6+). Those that saw a worsening in the PHQ-9 were a minority (2%, 4). The figure below shows the mean, minimum and maximum score for those that saw a reliable positive change as compared to those that did not see a reliable positive change.

For those within the group that saw a reliable change the mean pre-score was 17.28 (this would be categorised as moderately severe) whereas for those with no reliable change the mean pre-score was 11.67 (this would be categorised as moderate depression). Therefore, those that saw a positive change were on average starting 6 points higher on the PHQ-9 scale than those that did not. For those that did see a positive change the average mean post score was 5.93 (therefore on average a 11- point reduction in their pre to post score).

The graph below shows the mean pre and post scores for those that saw a positive reliable change, those that saw no reliable change and those that saw a reliable negative change.

6. Observations

Overall, the analysis and results presented from across the 8 sites are very positive. For 227 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 19 months data, the evidence demonstrates how MHTR interventions are having a significant benefit in terms of mental distress, anxiety and depression.** However, due to missing data, the proportions of individuals who do not complete is not yet clear.

Key observations are:

- The volumes of cases submitted by sites varies and is shaped by the size of population covered in each area as well as by local service decision-making and practices.
    - **It is recommended that sites review the numbers of individuals being assessed and sentenced to MHTR in relation to 1. numbers of individuals coming into contact with Probation who fall within the appropriate sentencing level, 2. the relative scales of programmes, and 3. the strategic/operational aims of CSTR.**
- The proportions of individuals who are assessed for MHTR from Asian, Black, Mixed backgrounds continues to a concern.
    - **It is recommended that local MHTR Steering Groups should investigate if demographic proportions for individuals assessed for MHTR is aligned with wider demographic trends for individuals coming into contact with Probation.**
- The proportions of individuals being sentenced to Combined Orders (i.e. MHTR&ATR and MHTR&DRR) remains relatively low at 5% and 4% respectively.
    - **It is recommended that local MHTR Steering Groups review processes concerning the completion of assessments for Combined Orders and the flows of communication between relevant individuals.**
- Within the files received, these were a range of missing data and sites should seek to minimise missing data.
    - **It is recommended that practitioners review the data provided within files and add data where possible. This is especially important for dates, pre/post assessment scores, sentencing outcomes, and client status.**

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