Institute for
Public Safety
Crime and Justice

Community Sentence Treatment Requirement Multisite Report July 2020 – July 2022

Authors:
Professor Matthew Callender
Greta Sanna
Kathryn Cahalin
Joanna Binley

September 2022

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, Birmingham, Black Country, Cambridgeshire, Cornwall, Derbyshire, Essex, Gloucestershire, Hertfordshire, Northamptonshire, Plymouth, Staffordshire, Swansea and Wiltshire. This report relates to the period of July 2020 to July 2022, with data being provided for 2,552 cases.

Overall, there were:

- 2,552 cases submitted
    - 2,249 assessments for MHTR
        - 1,749 individuals found suitable for MHTR following assessment
            - 1,403 sentenced to MHTR (or dual diagnosis)
                - 1,153 with intervention start date
                    - 973 with pre-intervention scores
                        - 459 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 (81%) were for MHTR only, with 8% 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, 77% 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 (91%) 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 89% being passed within one month of assessment. 25% 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, 89% were sentenced to MHTR (inc. Dual Diagnosis) and 11% were declined.

Start of Intervention: Overall, there were 1,403 sentenced to an MHTR (or Dual Diagnosis) and there were 1,153 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: 21% severe psychological distress, 22% moderate-to-severe psychological distress, 23% moderate psychological distress, and 26% mild and below mild psychological distress.
- GAD7: 49% severe anxiety, 24% moderate anxiety, and 27% mild and below mild anxiety.
- PHQ9: 33% severe depression, 27% moderately severe depression, 21% moderate depression, and 19% mild or below mild depression.

Outcomes and Change: There were 627 individuals with a recorded end date. Outcomes and change were:

- CORE-34: In the sample of 309, 77% (239) saw a 5 or more point reduction in their pre to post CORE-34 score. 12% (36) saw no reliable change (i.e. between -4 and +4) and the remaining 10% (33) saw a reliable worsening (5+).
- GAD-7: In the sample of 447, 58% (260) saw a 4 or more point reduction in their pre to post GAD-7 score. 38% (168) saw no reliable change (i.e. between -3 and +3) and the remaining 4% (8) saw a reliable worsening (4+); and
- PHQ-9: In the sample of 446, 55% (244) saw a 6 or more point reduction in the PHQ-9 score. The remaining 45% (202) 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 (2.5%, 11).

Observations:

Overall, the analysis and results presented from across the 14 sites are very positive. For most individuals who started an MHTR intervention since July 2020 and successfully completed it, statistically significant positive change was identified using the CORE-34, GAD-7 and PHQ-9. Therefore, based on the analysis of 24 months data, the evidence demonstrates how MHTR interventions are having a statistically significant benefit in terms of mental distress, anxiety and depression.

When considering the overall distress profiles of cohorts of individuals starting the intervention alongside the cohorts completing the intervention, with the proportions of the cohort being identified as having either severe or moderate-to-severe distress by CORE-34 (38% to 11%), GAD-7 (43% to 15%), and PHQ-9 (55% to 20%) reduces significantly.

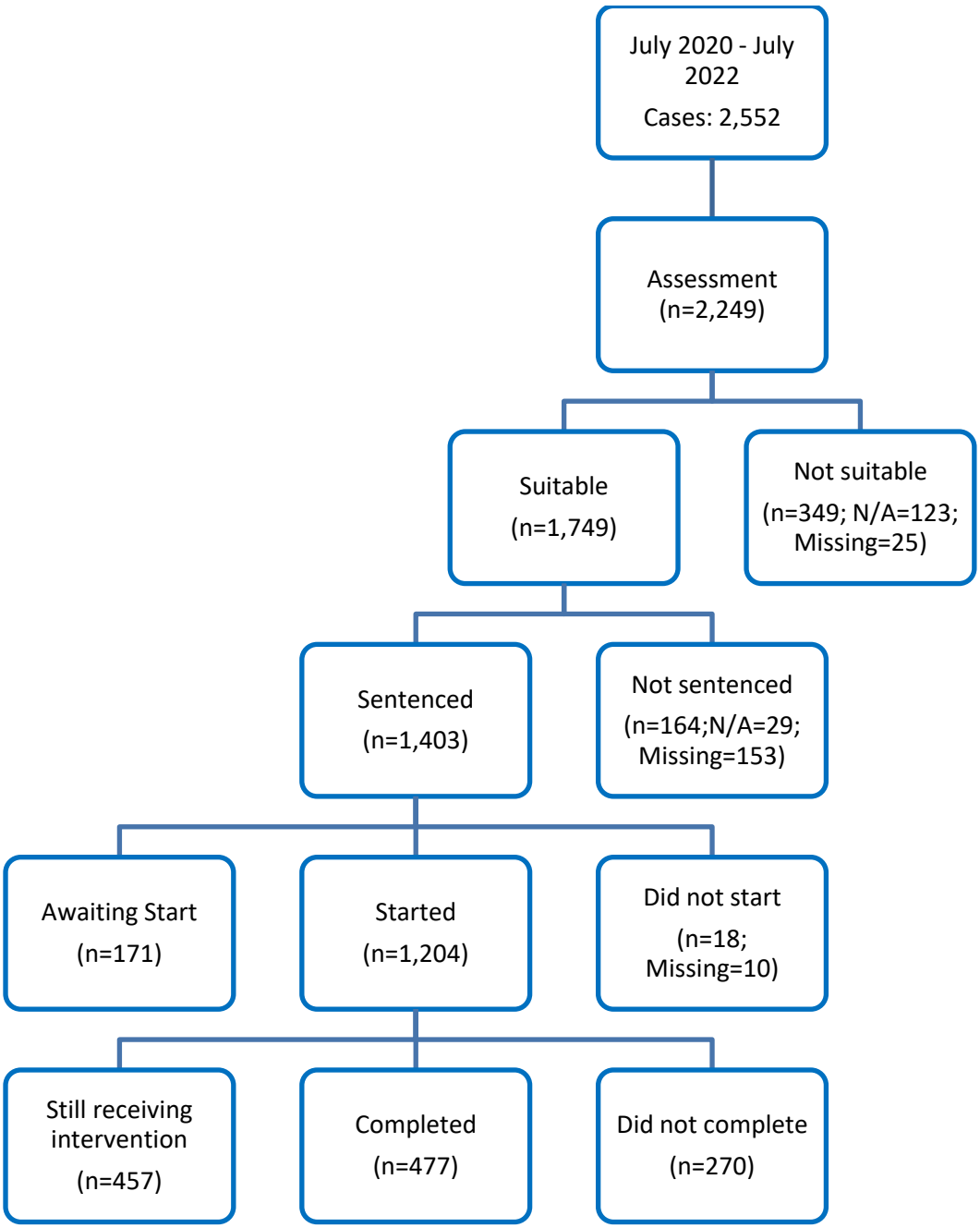
This report for the first time has presented an overview of the proportions of individuals who do not complete the intervention, representing c. 20% of those who have been sentenced to an MHTR. It is important to note the proportions of individuals not completing the intervention varies between sites and does not necessarily reflect a negative outcome for the individual. In each of the local reports, the reasons for non-completion will be presented to enable sites to take action where necessary to further explore or address non-completion.

Key observations are:
- Recommendations from the last round of reports (March 2022) still apply and should be considered alongside observations below, specifically:
    - Numbers of referrals, assessments and individuals sentenced for MHTR should be reviewed and reflected upon by local boards in relation to numbers coming into contact with the criminal justice system who meet the criteria for a Community Order.
    - Sites with limited diversity in terms of ethnicity should conduct separate investigations to ensure equality.
    - Mechanisms to enable combined orders (i.e. MHTR&ATR or MHTR&DRR) should be reviewed to ensure opportunities are not missed to address multiple needs of individuals.
- The length of time passed from both date of assessment and/or date of sentence to date of intervention start may have an impact on likelihood of intervention completion. This will be explored further by the evaluation team to analyse trends/patterns and outcomes.
- In terms of sentencing outcomes, 50% of individuals not sentenced to an MHTR but who were found suitable for MHTR following assessment were sentenced to a custodial sentence. The lengths of these sentences should be assessed and further work with the judiciary should be undertaken if there are multiple instances of short-term sentences are identified.
- There are inconsistencies in the files, and it remains a priority for sites to ensure data provided is accurate. Specifically, in addition to what was outlined in previous reports, dates of assessment, sentence, intervention start and end are critical as are identified vulnerabilities during assessment.

Contents

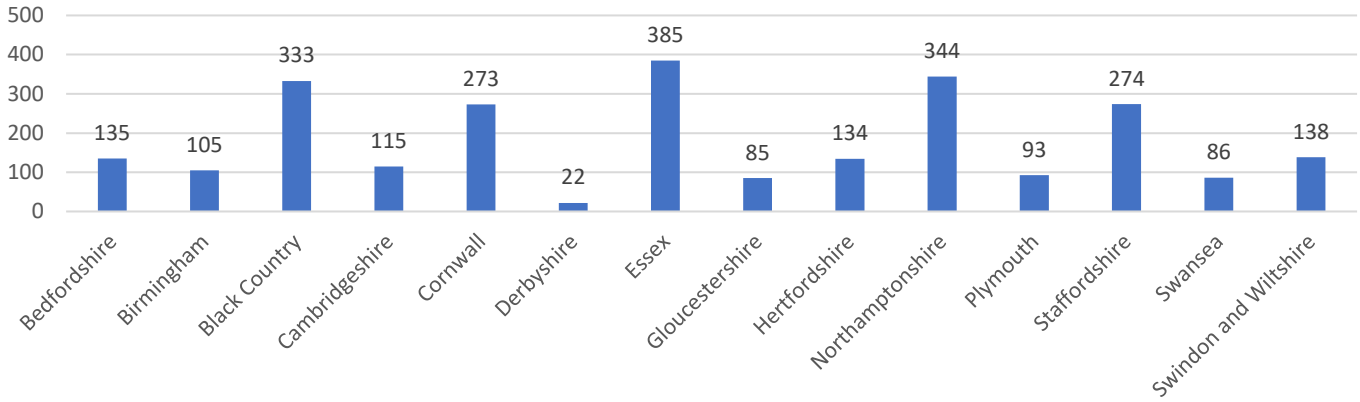
1. Introduction

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, Birmingham, Black Country, Cambridgeshire, Cornwall, Derbyshire, Essex, Gloucestershire, Hertfordshire, Northamptonshire, Plymouth, Staffordshire, Swansea and Swindon & Wiltshire. This report relates to the period of July 2020 to July 2022, with data being provided for 2,552 cases.



Across the sites, most cases were in Essex (n=358). Some of these sites were not operational for the full 2 years.

Fig 1.1 Total number of cases per Site, July 2020 - July 22, 14 Sites



When cases are organised into six-month periods, Figure 1.2 shows that the number of cases in the evaluation is increasing. Birmingham, Cornwall, Derbyshire, Gloucestershire, Plymouth, Swindon and Wiltshire are additional sites included in the analysis compared to previous reports.

Fig 1.2 Total Cases per Site - 6 Monthly, Jul 20 - Jul 22, 14 Sites

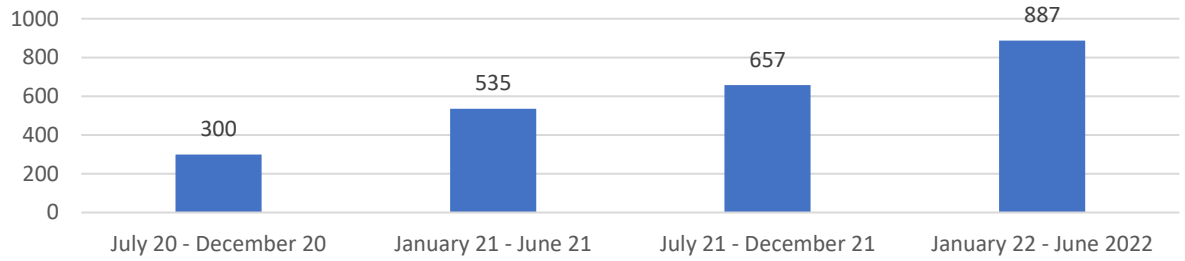
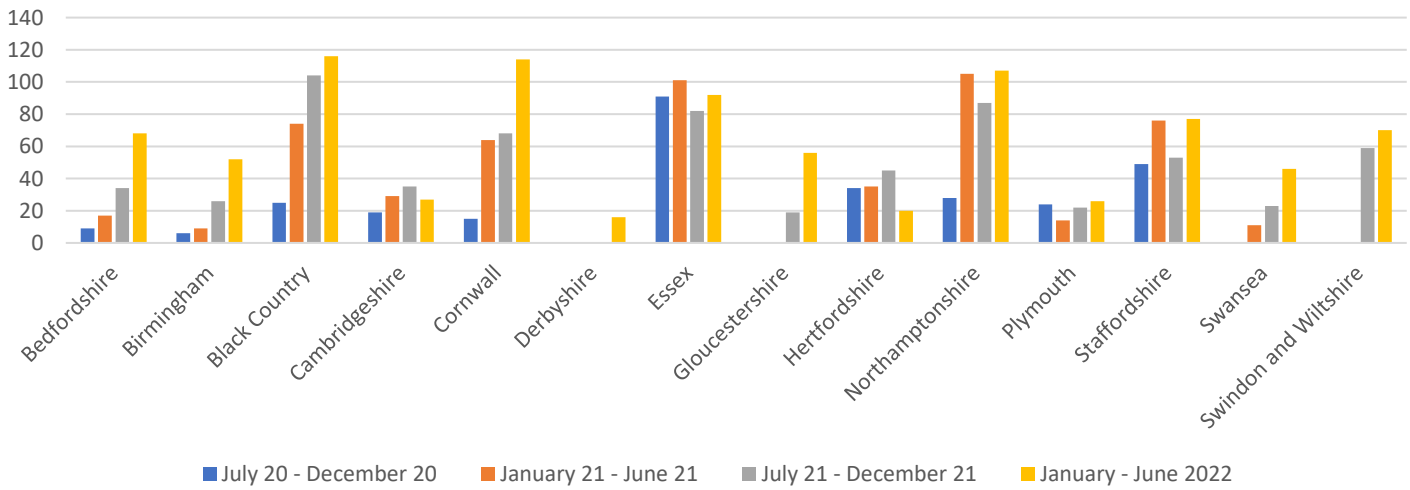


Figure 1.3 shows the total number of cases provided by each site broken down into 6 monthly periods from the start of the evaluation in July 2020. It should be noted sites started providing cases at different points in the evaluation and some sites are currently back dating their data files.

Fig 1.3 Total Cases per Site - 6 Monthly, Jul 20 - Jul 22, 14 Sites

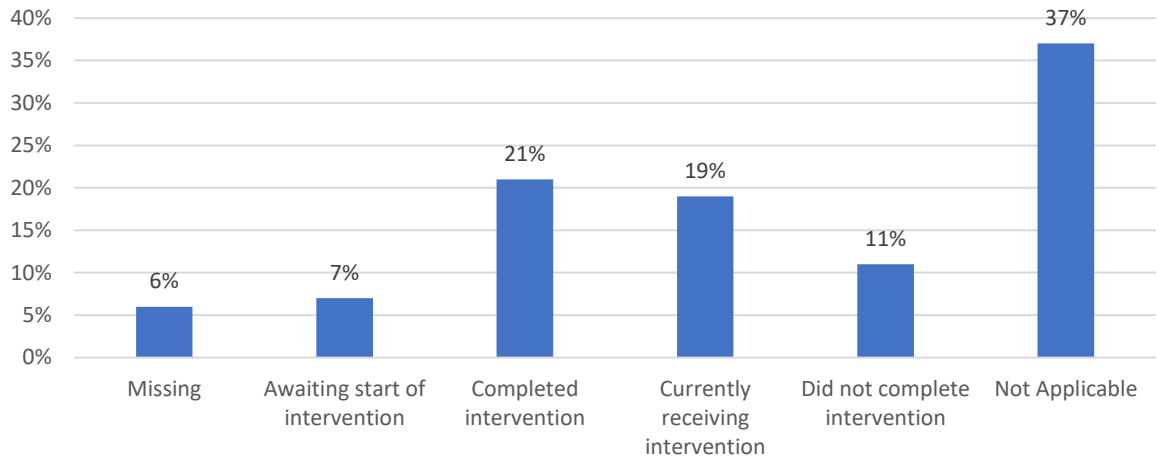


A new tab was introduced labelled 'client status' which allows practitioners to identify between:

- 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 2,579 cases overall that were provided.

Fig 1.4 Client Status, 14 Sites, Jul 20 - Jul 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.

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. Engagement
6. Outcomes and Change
7. Observations

2. Assessment and Demographic Overview

This section provides an overview of assessment and demographic data between July 2020 and June 2022. Figure 2.1a 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. Figure 2.1b shows, however, this positive trend remains when controlling for the start dates of different programmes.

Fig 2.1a Assessments by Month, 14 Sites, Jul 20 - Jun 22

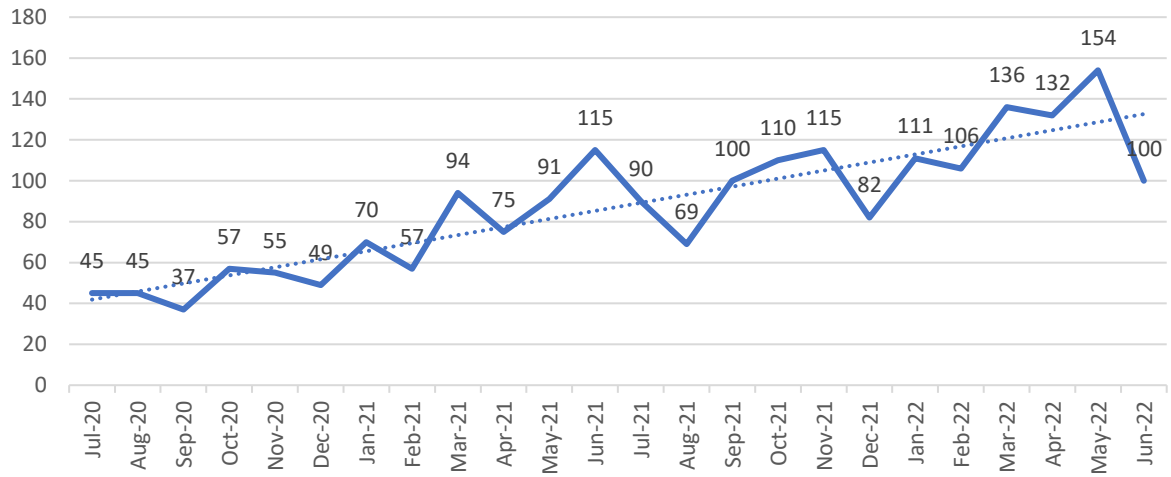


Fig 2.1b Assessments by Month per Site (based on evaluation start date), 14 Sites, Jul 20 - Jun 22

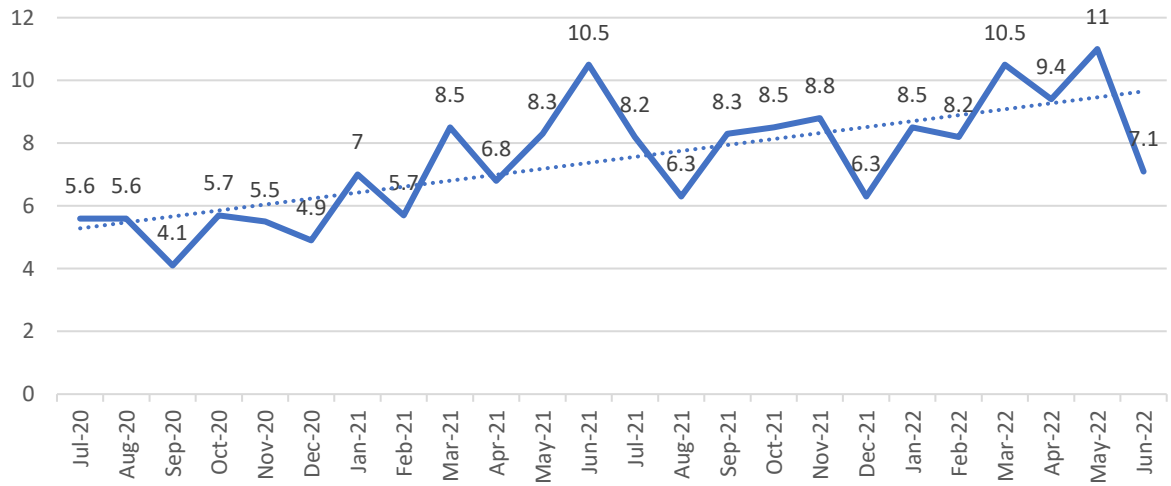
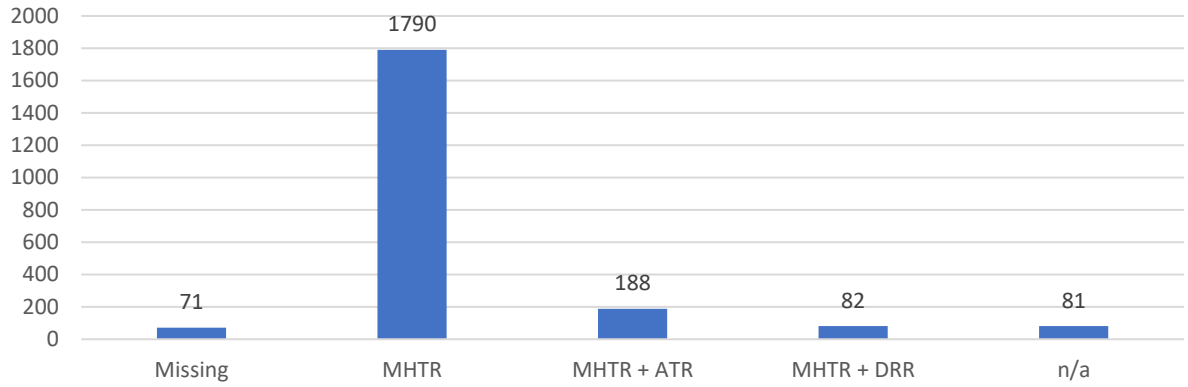


Figure 2.2 shows that most (81%) assessments were completed for MHTR only, with 8% and 4% being assessed for MHTR & ATR or MHTR & DRR respectively. It should be noted, however, MHTR practitioners may not be aware if an assessment has taken place for ATR or DRR. Therefore, these figures should be treated with caution.

Fig 2.2 Assessment Type, 14 Sites, Jul 20 - Jul 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

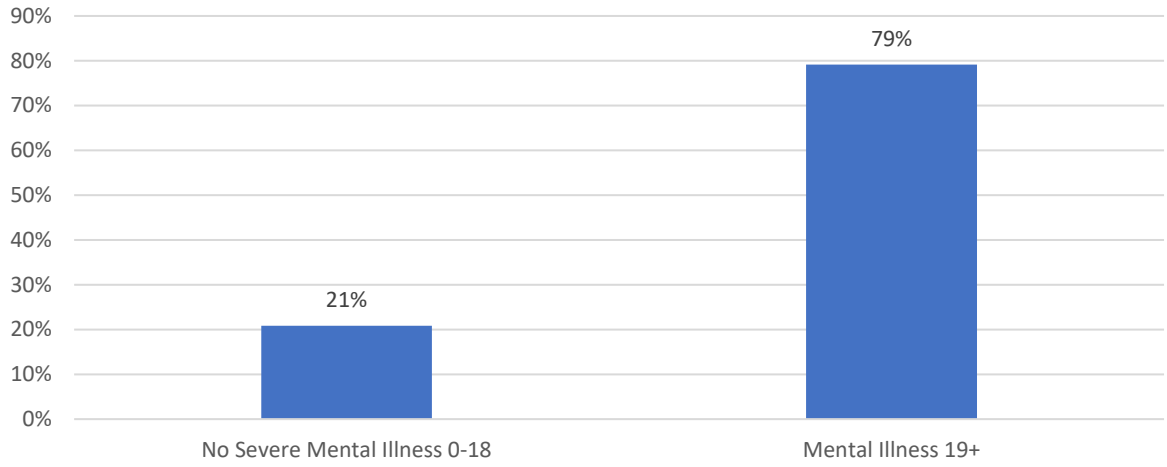
Site	K6	K10	CORE-10	CORE-34	GAD-7	PHQ-9
Bedfordshire						
Birmingham						
Black Country						
Cambridgeshire						
Cornwall						
Derbyshire						
Essex						
Gloucestershire						
Hertfordshire						
Northamptonshire						
Plymouth						
Staffordshire						
Swansea						
Wiltshire						

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 326 individuals assessed using K6, 258 (79%) were found to be in mental distress.

Fig 2.3 Assessment - K6, 1 Site



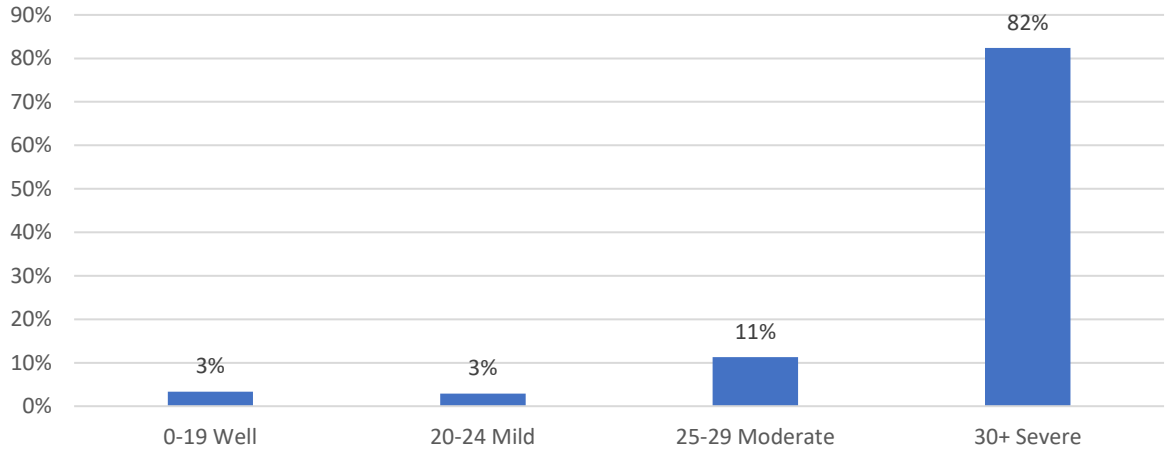
K10 Scores

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 415 individuals (Beds: 6; Blacks: 20; Cambs: 100; Corn: 139; Herts: 32; Plym: 13; Swin/Wilt: 105) assessed using K10, most individuals were identified as being in severe level of distress.

Fig 2.4 Assessment - K10, 7 Sites



CORE-10 Scores

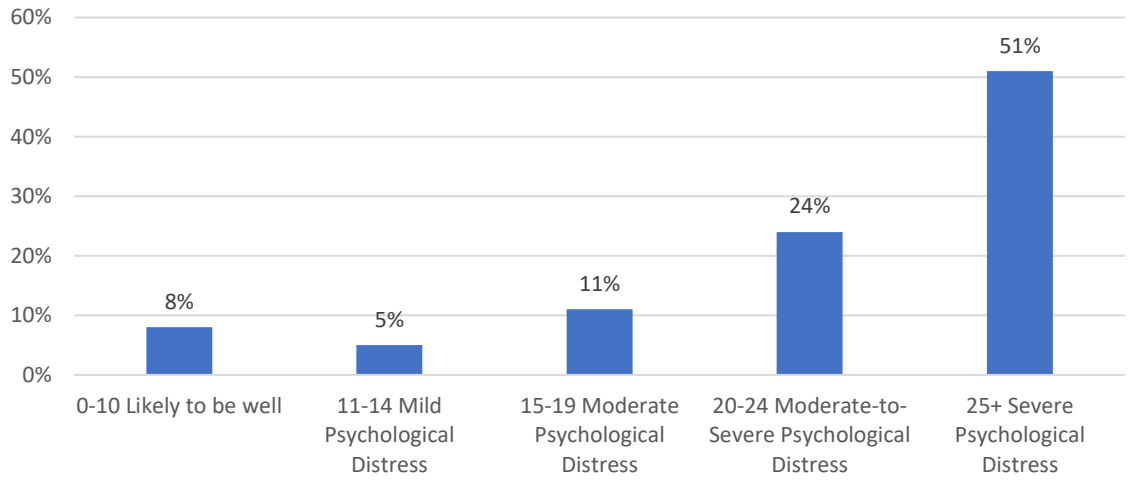
The CORE-10 is a shortened version of the CORE-34, with items covering anxiety, depression, trauma, physical problems, functioning and risk to self. Higher scores indicate higher levels of general psychological distress. Scores range from 0 – 40 and is interpreted in the following levels:

- 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 696 individuals (Birm: 65; BC: 49; Corn: 238; Glou: 16; Staff: 241; Swin/Wilt: 87) assessed using CORE-10, most individuals were identified as being in severe psychological distress.

Fig 2.5 Assessment Outcome for CORE-10 accross 6 Sites



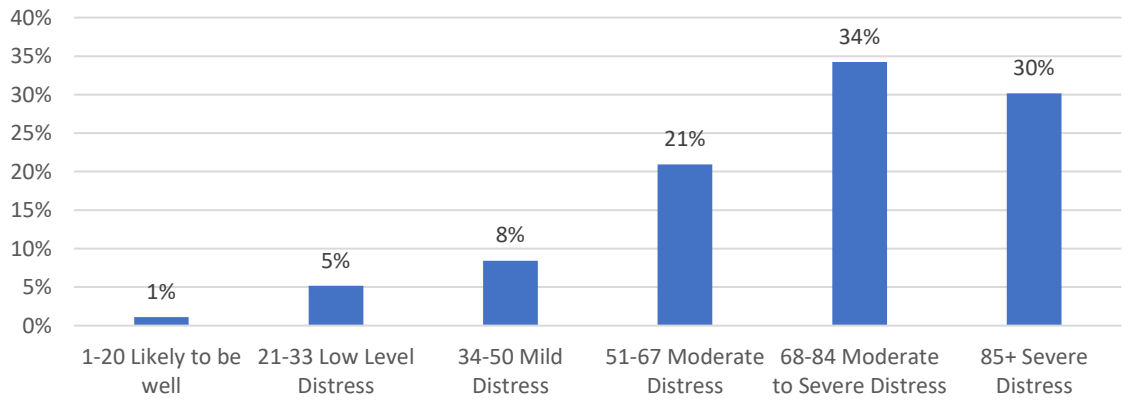
CORE-34

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.

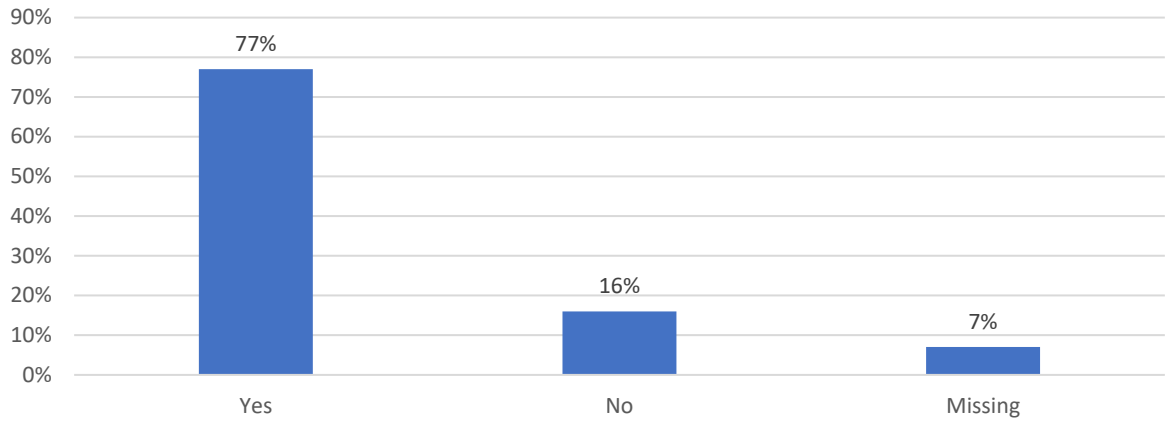
Of 368 individuals (BC: 7; Derb: 18; Glou: 48; North: 105; Plym: 15; Swan: 78; Swin/Wilt: 97) assessed using CORE-34, 79 (51%) were identified as being in mental distress, with 111 in severe mental distress.

Fig 2.6 Assessment Outcome for CORE-34 across 6 Sites



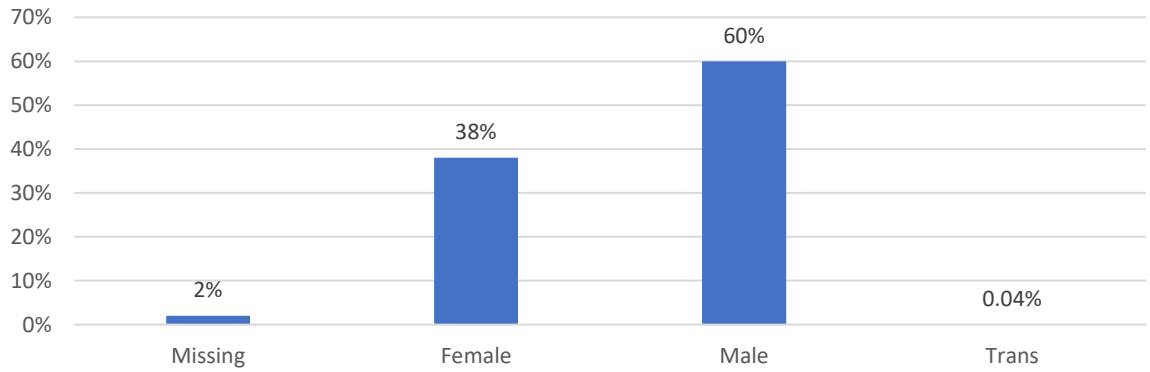
In total following assessment, 1714 (77%) individuals were identified as being suitable for MHTR intervention.

Fig 2.7 Assessment - Suitibility, 14 Sites, Jul 20 - Jul 22



Demographic data presented in this Chapter are based on the 2,115 assessments completed. Figure 2.8a illustrates gender of those assessed, showing higher proportions of men than women.

Fig 2.8a Assessments - Gender, 14 Sites, Jul 20 - Jul 22



It is noted, however, these are differences when looking at the results at a local level, with some sites focussing on female only pathways.

Fig 2.8b Assessments - Gender, 12 Sites, Jul 20 - Jul 22
(Excluding female only sites)

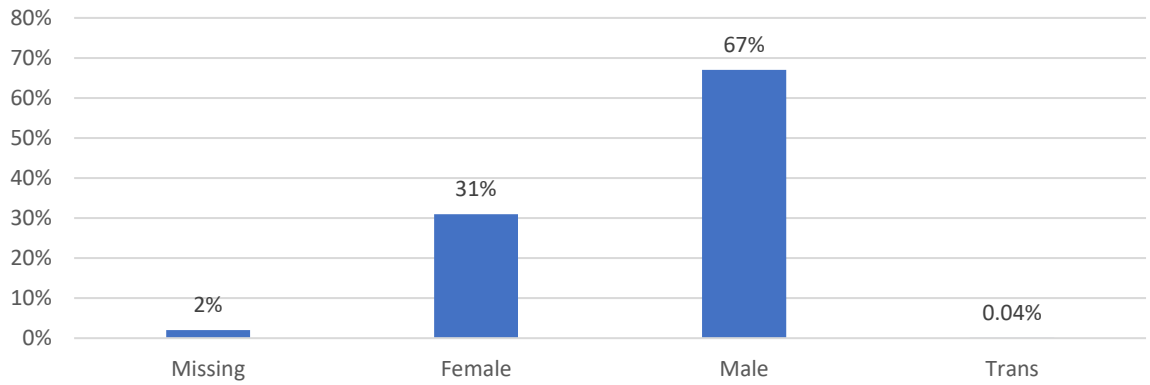


Figure 2.9 shows that most individuals assessed were aged between 25 and 34 years, followed by 35 – 44 years.

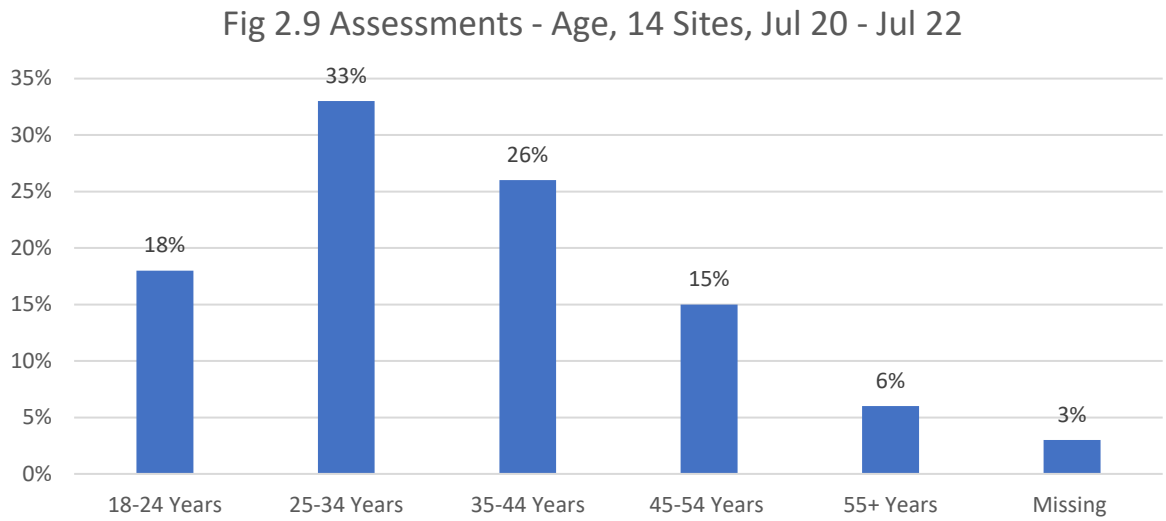
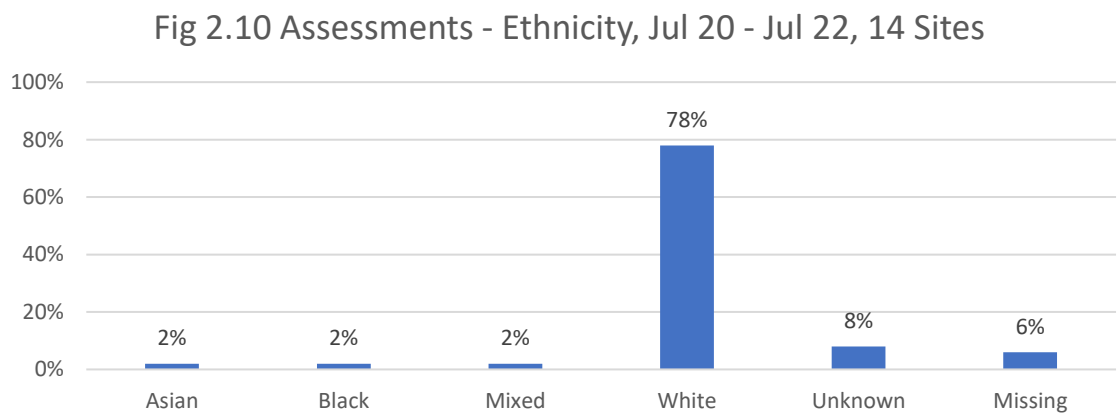
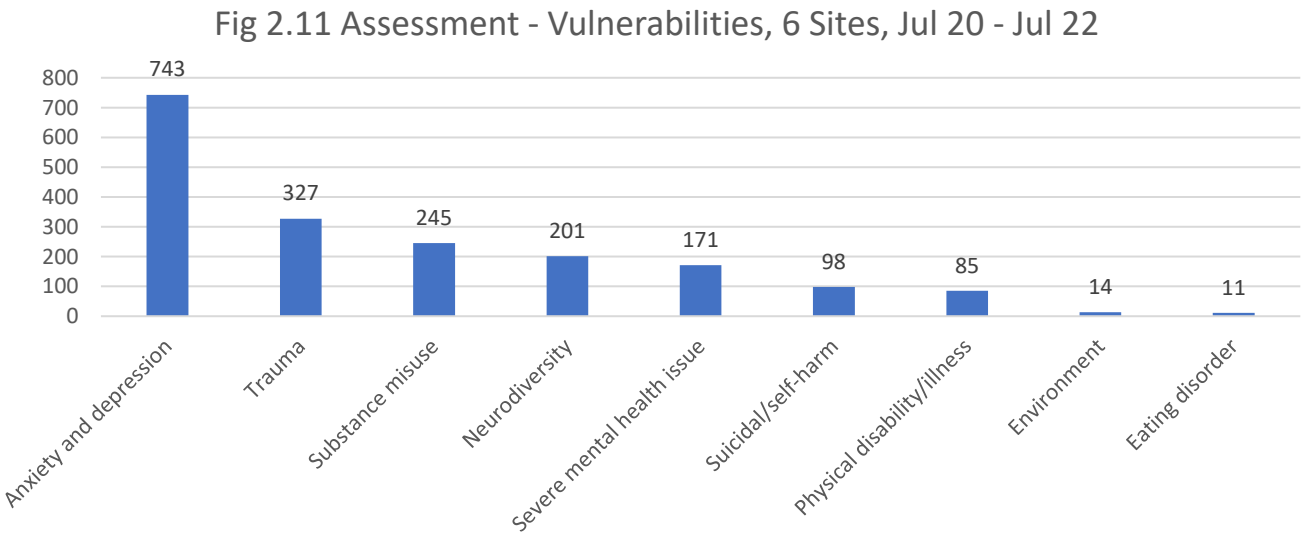


Figure 2.10 shows that most individuals assessed were White (78%). 6% of those assessed were from Asian, Black and Mixed ethnic groups.





There were a range of vulnerabilities identified during the assessment process in 6 sites, illustrating the diversity and complexity of needs, illustrated in Figure 2.11. In total, 1,895 vulnerabilities were identified in the assessment, with the most frequent being anxiety and depression (743), and trauma (327). It should be noted multiple vulnerabilities may be noted for individuals.

Within the files, 52 (2%) individuals were identified as meeting perinatal criteria, with 27 being pregnant at the point of assessment. Of those assessed, 80 (8%) were sole carers and 130 (6%) had previously served in the armed forces.

Figure 2.12 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.

Fig 2.12 Assessments - Offence Types, Jul 20 - Jul 22, 14 Sites

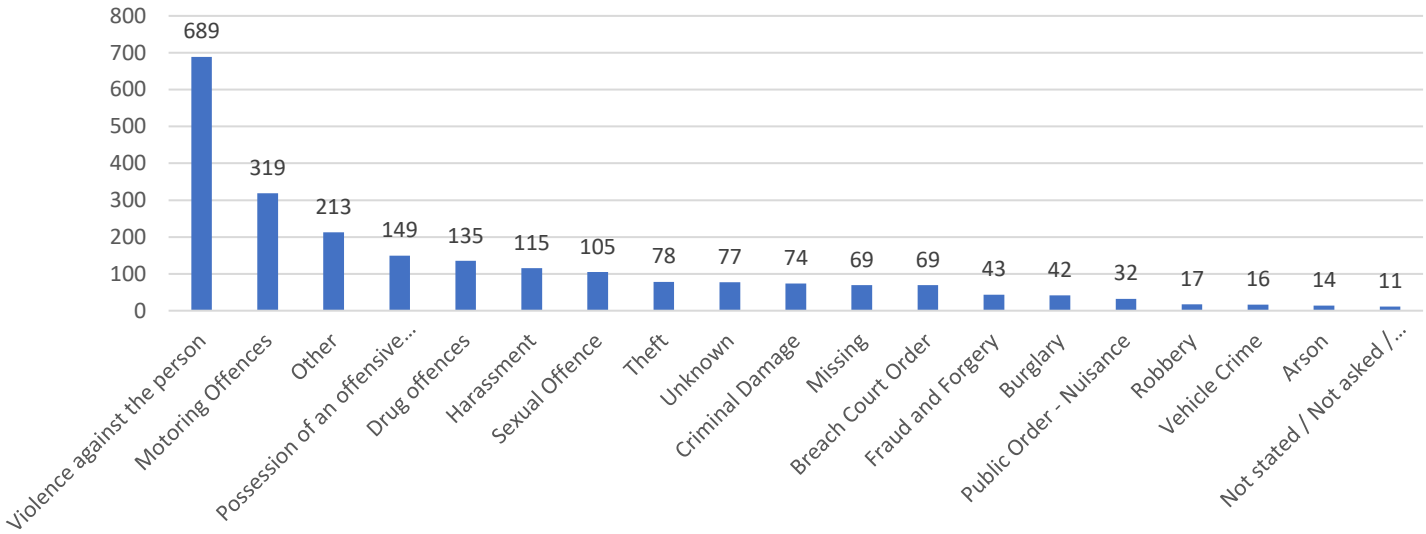
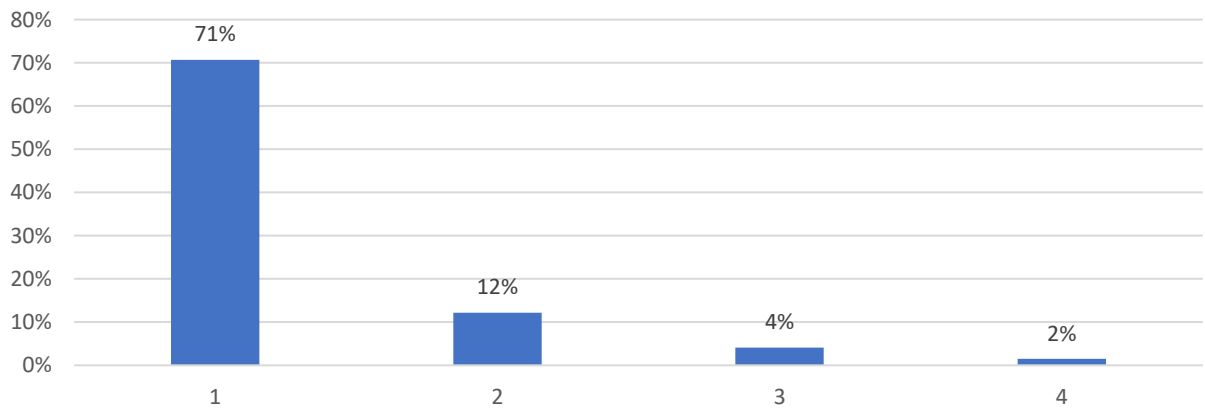


Figure 2.13 shows that most individuals had only one offence recorded at point of assessment within the file.

Fig 2.13 Number of Current Offences per Person, Jul 20 - Jul 22, 14 Sites



3. Sentencing

This section relates cases where a sentencing outcome was provided (n = 1,567).

Figure 3.1a shows sentence date by month, illustrating an increase in sentences over time. Figure 3.1b shows the average number of sentences per month per site.

Fig 3.1a Sentence Date by Month, 14 Sites, Jul 20 - Jun 22

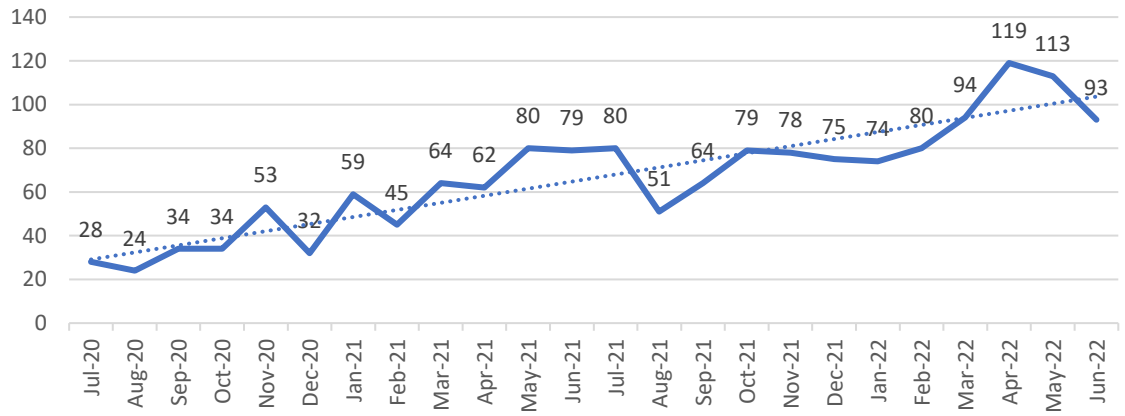
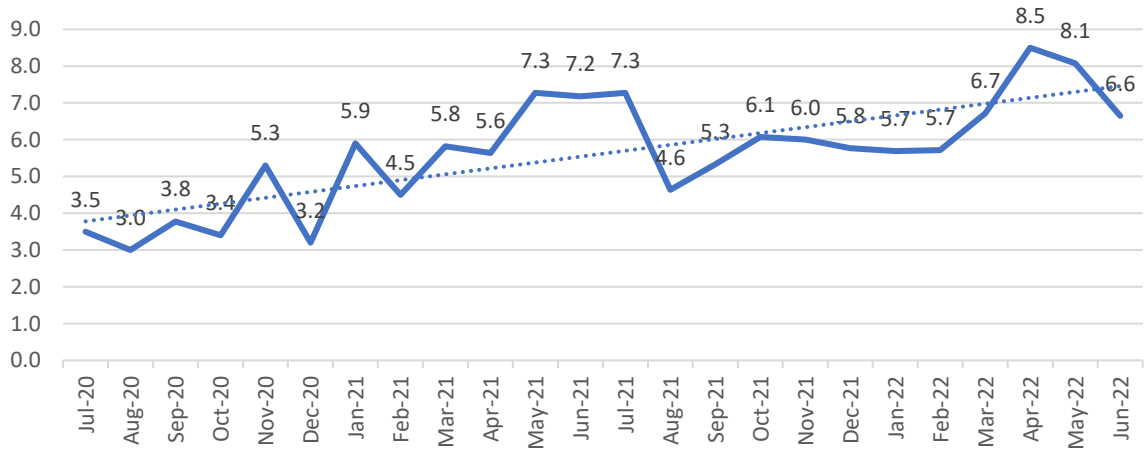


Fig 3.1b Sentence Date by Month, 14 Sites, Jul 20 - Jun 22
(Divided by number of Sites)



The gap between assessment and sentencing for most cases was within one month, with 495 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) - 6-Monthly

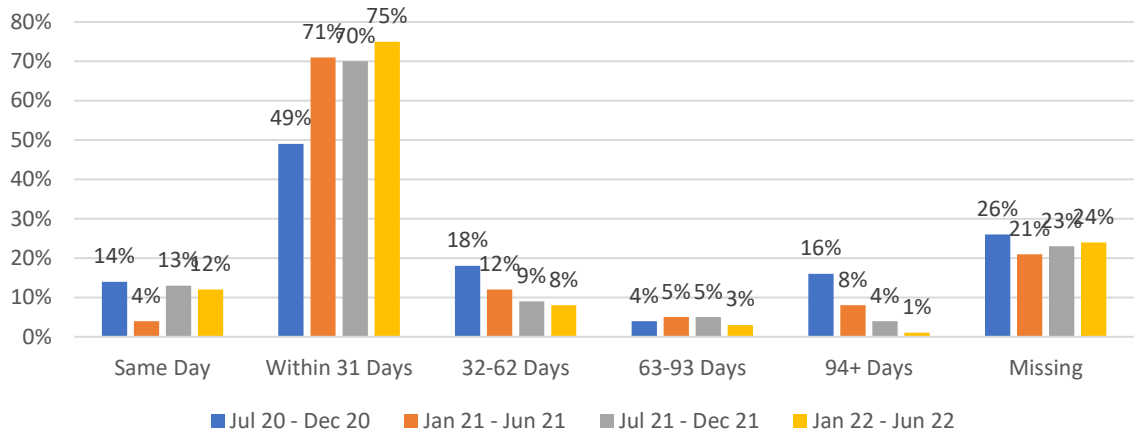


Fig 3.3 Assessment to Sentence Gap (Days), 14 Sites, Jul 20 - Jun 22

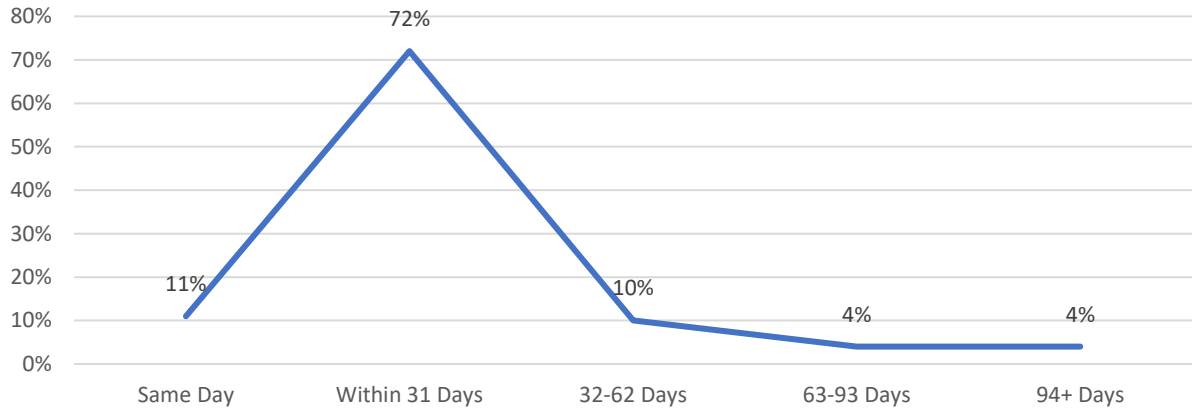
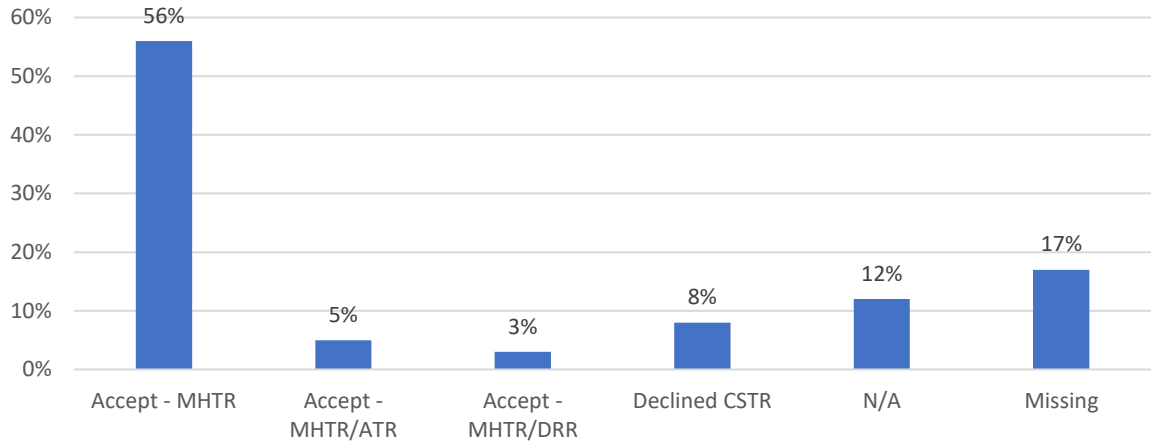


Figure 3.4a shows cases where a sentencing outcome was provided only (n = 1,403). Most individuals assessed and recommended as suitable for an MHTR were sentenced to an MHTR (64%). There were 8% of cases where the recommendation for an MHTR was declined. Missing cases and N/A include cases where sentence has not yet been passed.

Fig 3.4a Sentence Outcome, 14 Sites, Jul 20 - Jul 22



When excluding missing cases and N/A, the proportion of sentence outcomes which included an MHTR or Combined Order was 89%.

Fig 3.4b Sentence Outcome, 14 Sites, Jul 20 - Jul 22

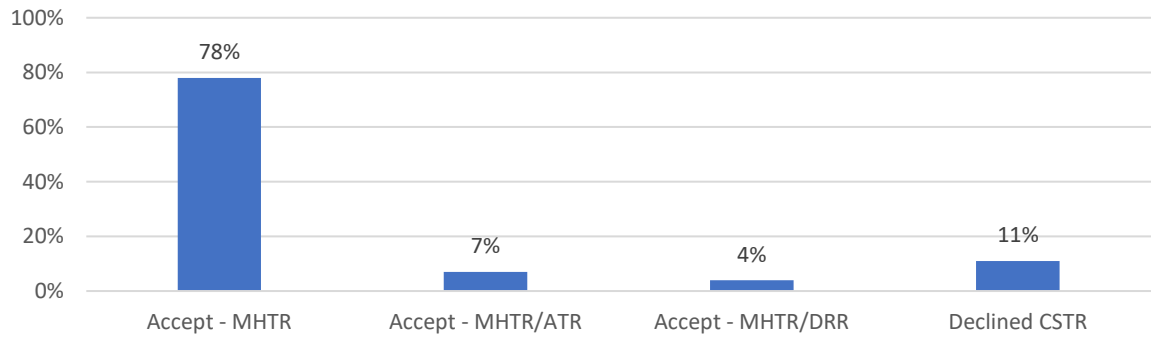
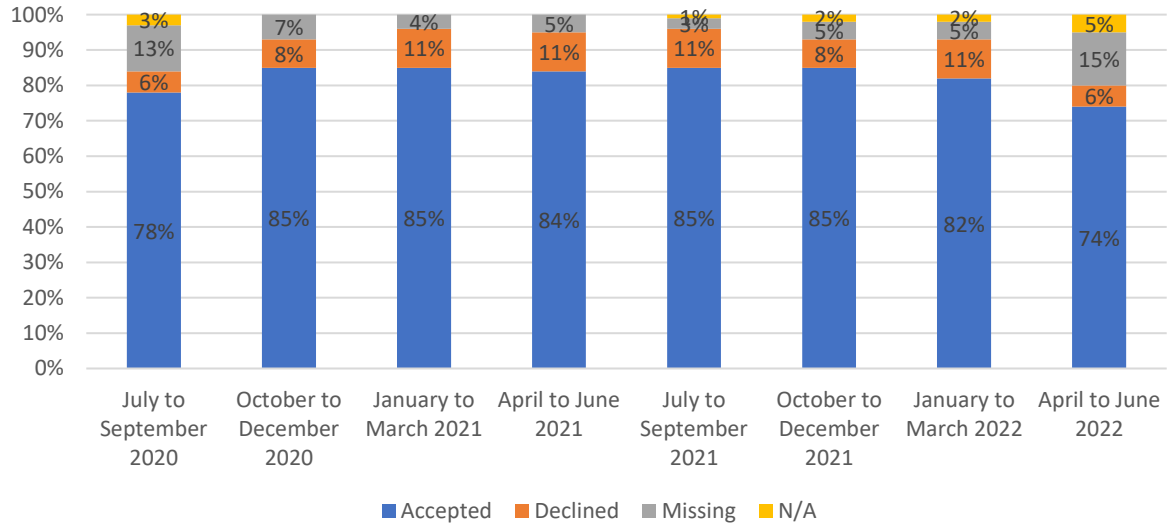
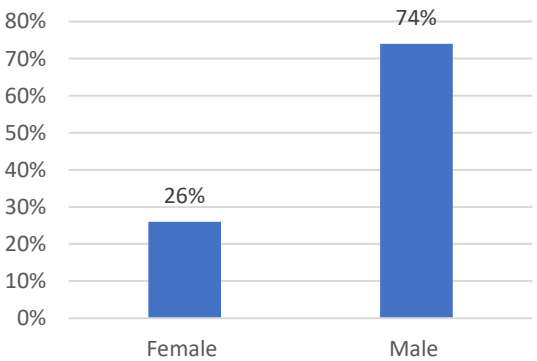


Fig 3.5 Percentage of Sentenced to MHTR of those found suitable, 3 monthly, 14 sites, Jul 20 - Jul 22

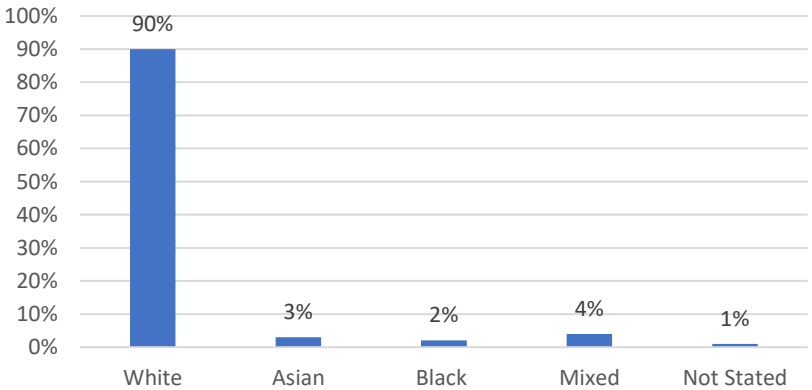


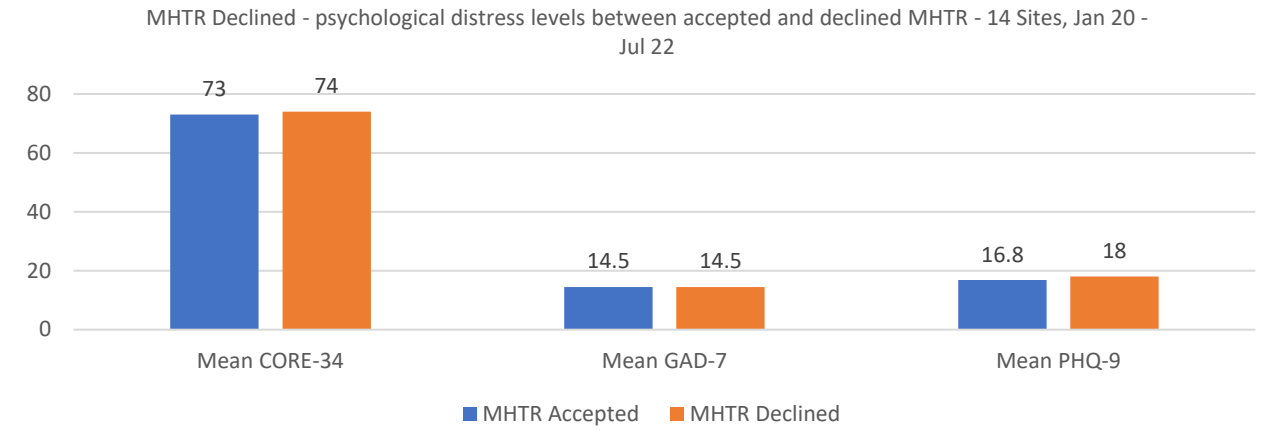
When analysing potential differences between individuals sentenced to an MHTR and those for whom the MHTR was declined, there seem to be no significant difference in demographics, vulnerabilities or level of distress.

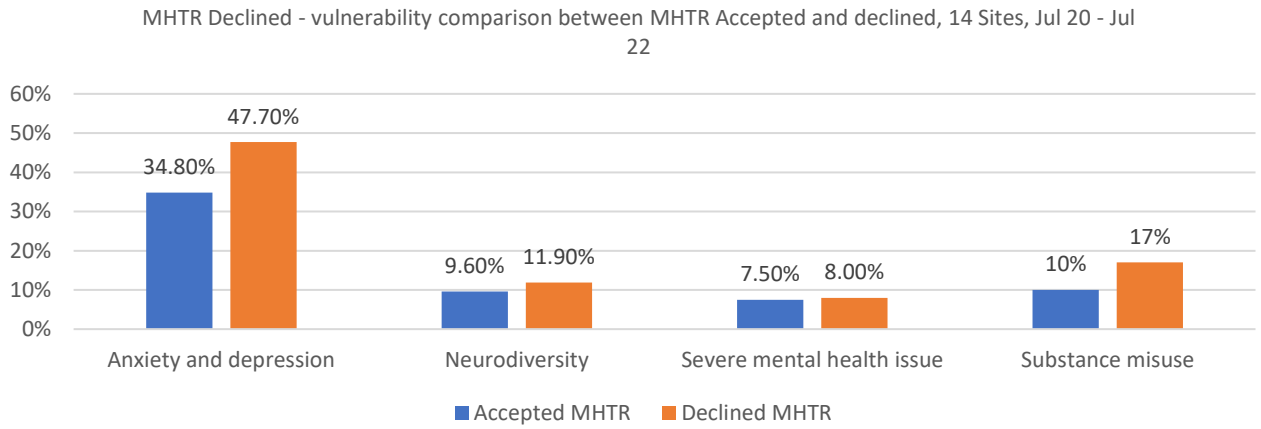
CSTR Declined - Gender, 14 Sites, Jul 20 - Jul 22



MHTR Declined - Ethnicity, 14 Sites, Jul 20 - Jul 22

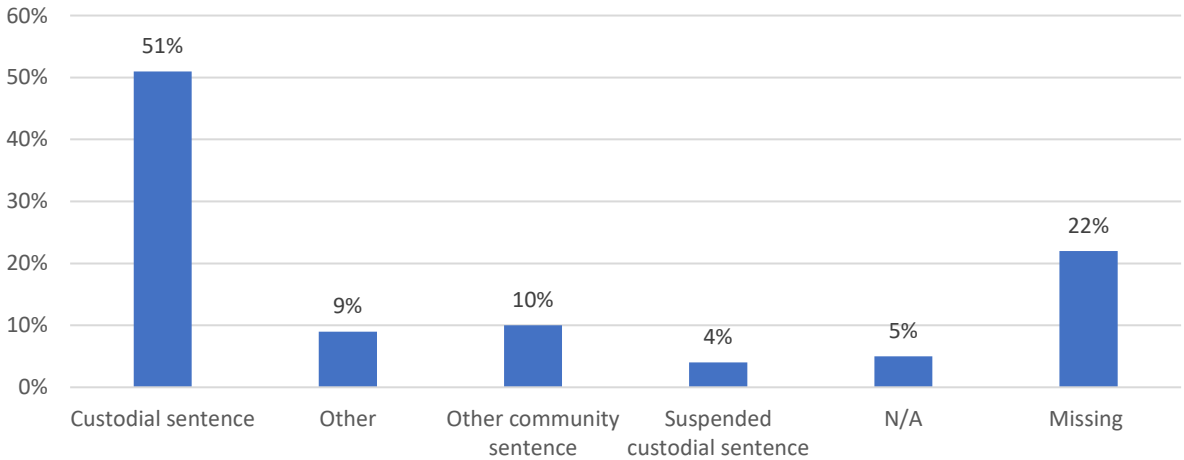






In the 164 cases where MHTR was declined, Figure 3.6 shows what sentences were passed. Most frequently, (51%) custodial sentences were passed where MHTR was recommended.

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 1,153 cases with an intervention start date. Figure 4.1 shows the client status of individuals with a start date.

Fig 4.1 Client Status, 14 Sites, Jul 20 - Jul 22

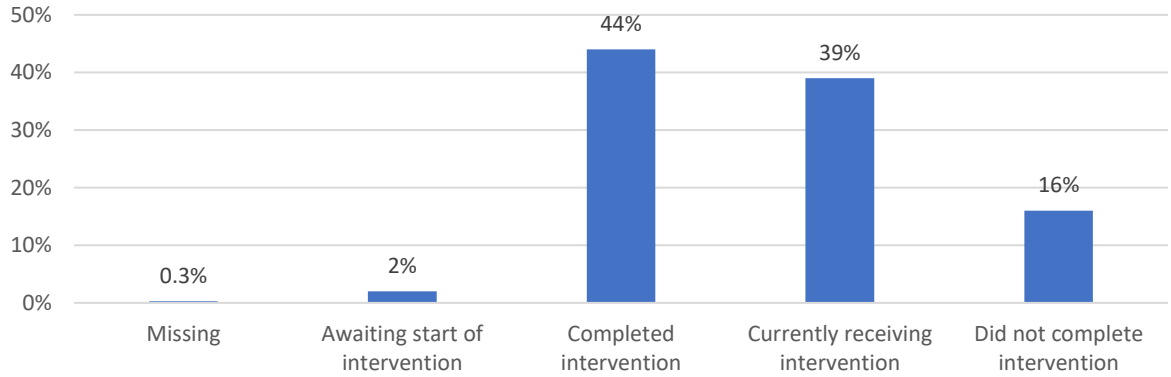


Fig 4.2a shows the number of interventions starting each month has risen over time, peaking in November 2021. Given that new sites joined the programme at later date, Figure 4.2b shows the average number of interventions pe month divided by the number of sites contributing data to the evaluation at that given time.

Fig 4.2a Intervention Start Dates, 14 Sites, Jul 20 - Jul 22

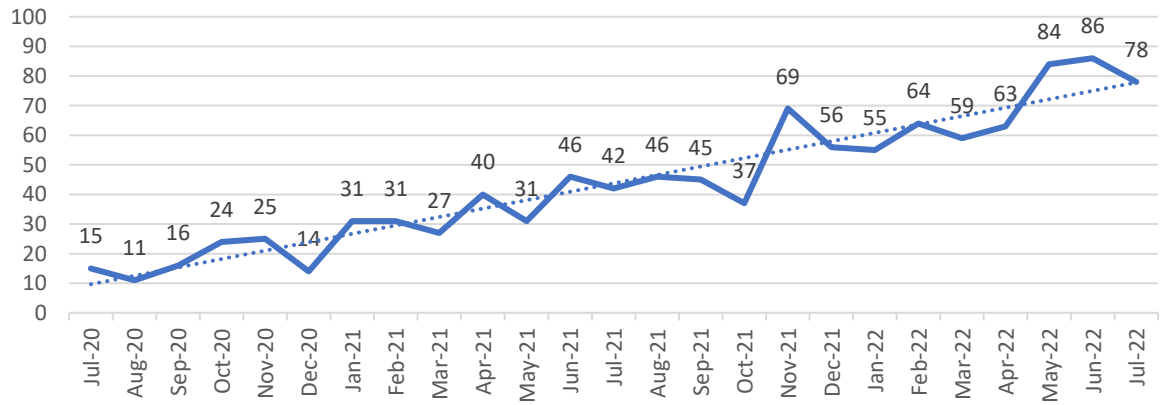
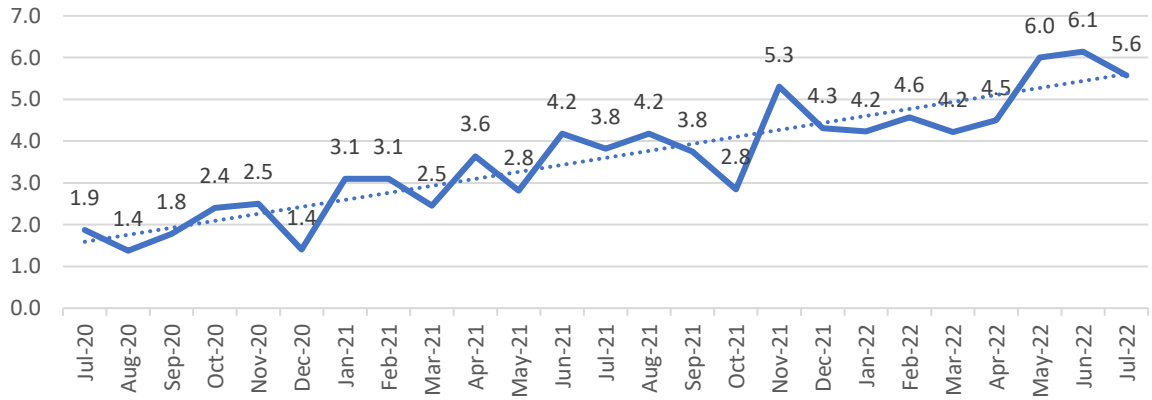


Fig 4.2b Intervention Start Dates, 14 Sites, Jul 20 - Jun 22
(Divided by number of Sites)



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

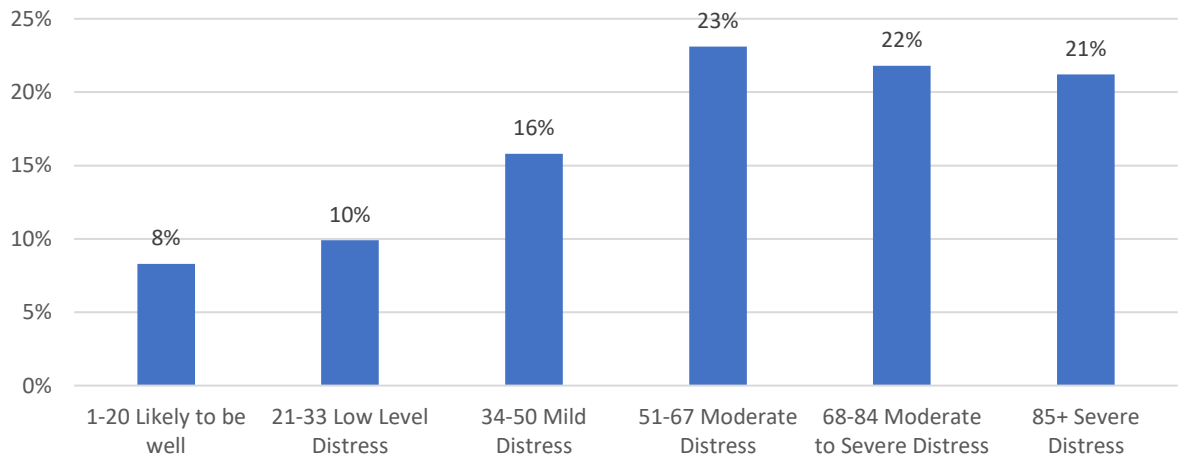
CORE-34

There were 631 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 (22%).

Fig 4.3 Start of Intervention - CORE-34, 14 Sites, Jul 20 - Jun 22



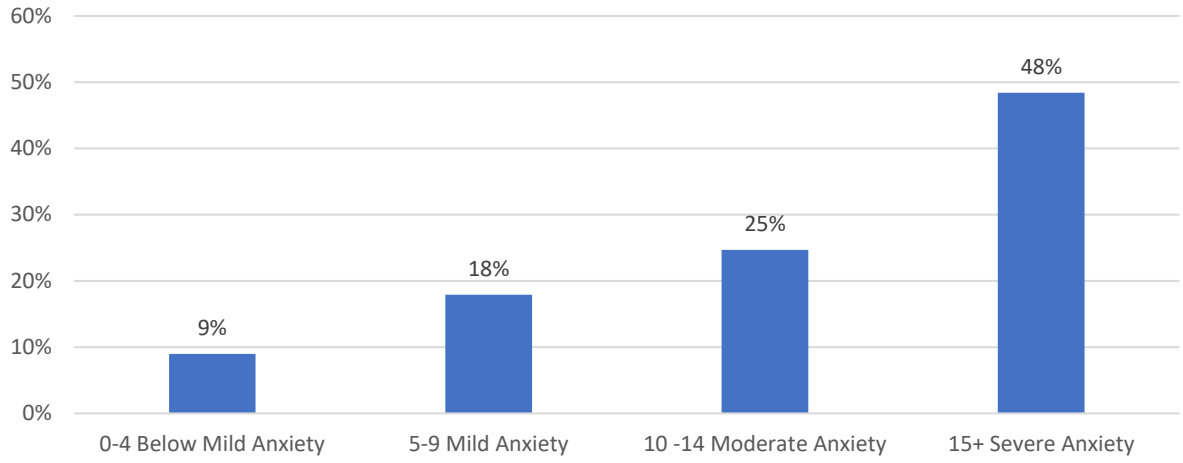
GAD-7

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 971 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 - GAD-7, 14 Sites, Jul 20 - Jul 22



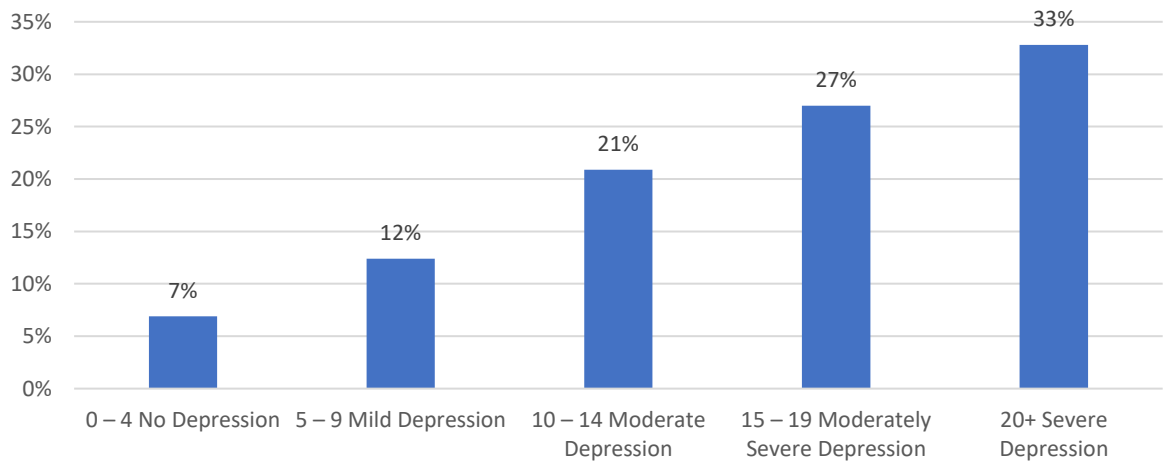
PHQ-9

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 973 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, 14 Sites, Jul 20 - Jul 22

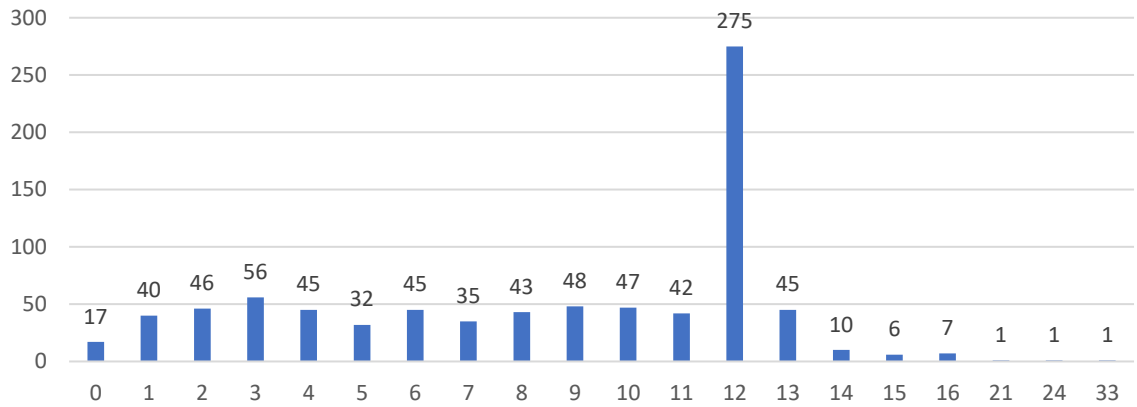


5. Engagement

This section of the report focuses on the pathway and profiles of programme non-completers in comparison to programme completers to provide insight on the differences between these cohorts. The aim is to identify areas of improvement with regards to non-completer identification and pathways.

Out of the individuals that had a recorded start day for the treatment, 17 were recorded as having no or zero sessions. Of 825 remaining the average number of sessions attended was 8.7. 33% (275) of the sample had 12 sessions, 32% (260) had 6-11 sessions, 27% (219) had 1-5 sessions and 9% (71) 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.

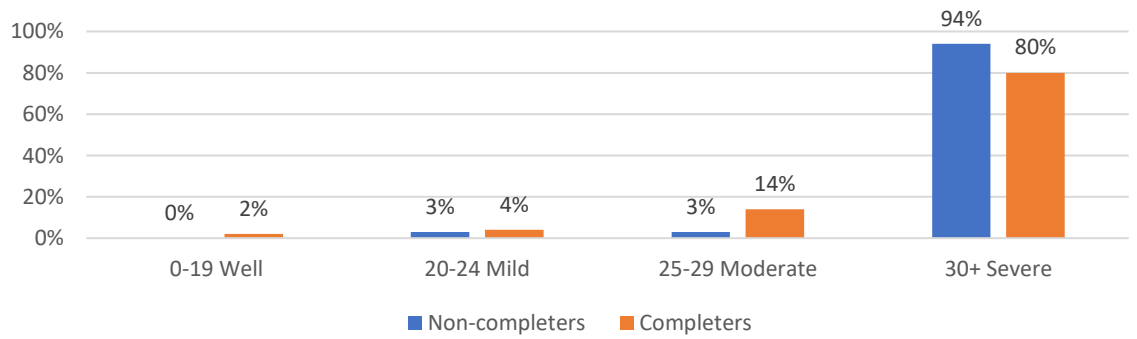
Figure 5.1 Number of sessions service users with a start date, 14 sites, Jul 20-Jul 22



As previously stated, 1,403 individuals were sentenced to an MHTR, of which 1,153 had a start date of intervention. Of those who started 487 individuals were either awaiting to start the intervention, currently completing the intervention or their client status was not provided. This section will analyse the remaining 666 service users who were divided in program completers (491) and non-completers (175).

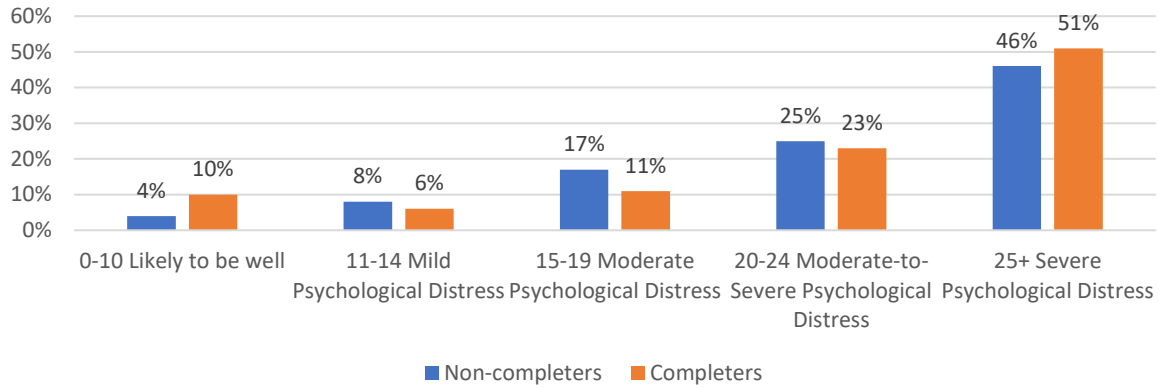
Of the 7 sites who used K10 for their assessments these are the difference between the distress profiles of completers and non-completers.

Fig 5.2 Engagement - K-10 assessment for completers and non completers, 7 Sites



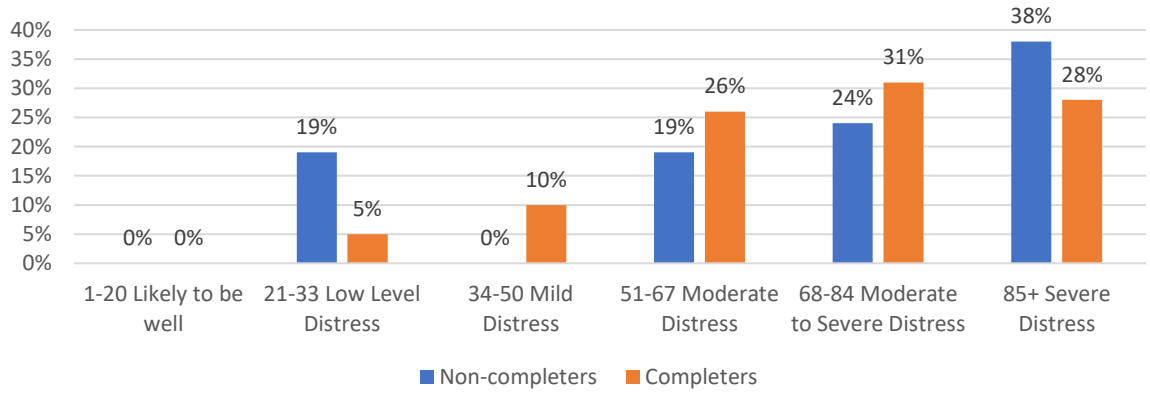
Of the 6 sites who used CORE-10 for their assessments these are the difference between the psychological distress profiles of completers and non-completers.

Fig 5.3 Engagement - CORE-10 assessment for completers and non completers, 6 Sites



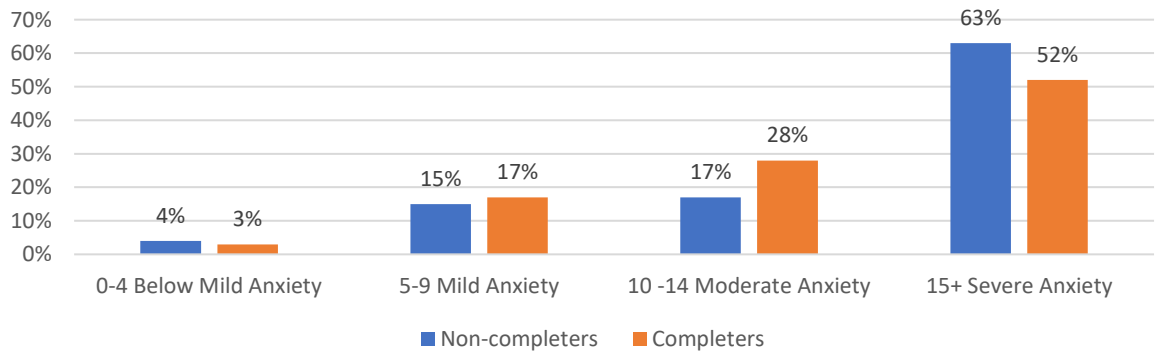
Of the 7 sites who used CORE-34 for their assessments. Figure 5.4 shows the differences between the general psychological distress profiles of completers and non-completers.

Fig 5.4 Engagement - CORE-34 assessment for completers and non completers, 7 Sites



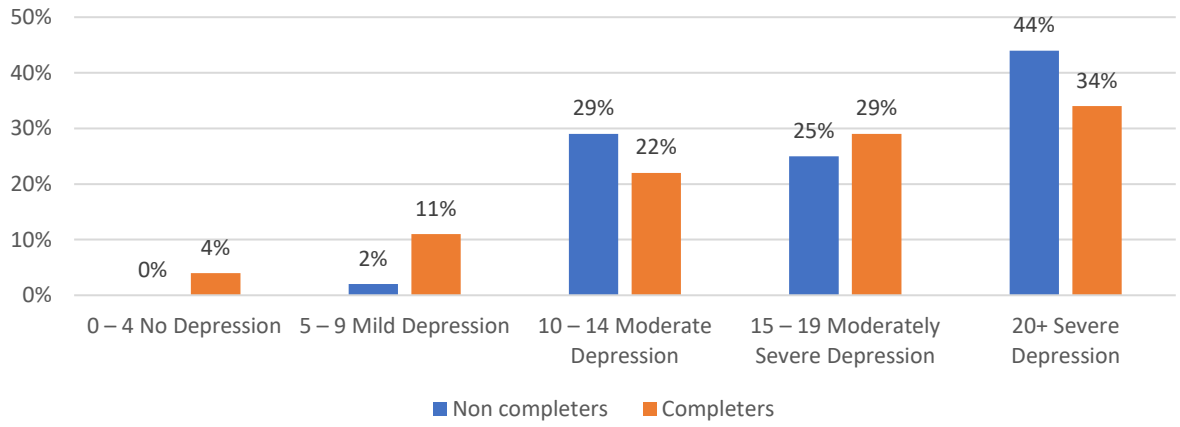
Of the 6 sites who used GAD-7 for their assessments. Figure 5.5 shows the differences between the anxiety profiles of completers and non-completers.

Fig 5.5 Engagement - GAD-7 assessment for completers and non completers, 6 Sites



Of the 6 sites who used PHQ-9 for their assessments. Figure 5.6 shows the differences between the depression profiles of completers and non-completers.

Fig 5.6 Engagement - PHQ-9 assessment for completers and non completers, 6 Sites



Data provided from the assessments seem to suggest that non completers start on average from higher levels of psychological distress, anxiety and depression. These cases must however be treated with caution due to the difference in the number of observations in both samples.

Figure 5.7 shows the percentages of vulnerabilities identified within the sample of intervention completers and non-completers for the 6 sites which provided that data. Figure 5.7 shows slightly higher proportions of non-completers for individuals who are neurodiverse and for those with severe mental illness.

Fig 5.7 Engagement - Vulnerabilities between completers and non-completers, 6 Sites

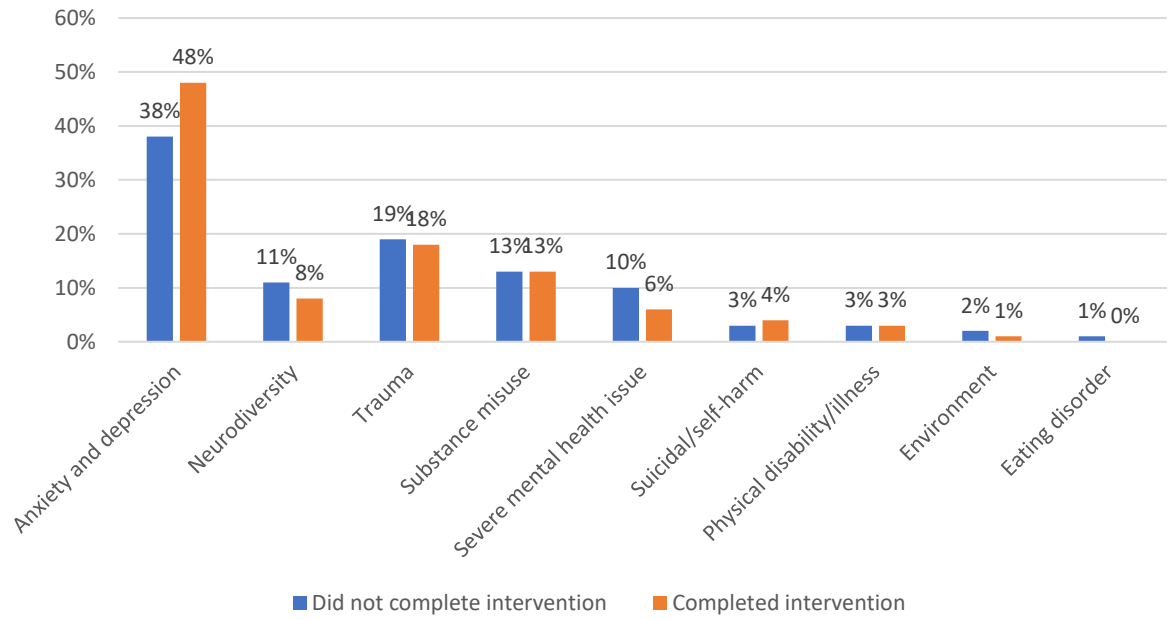
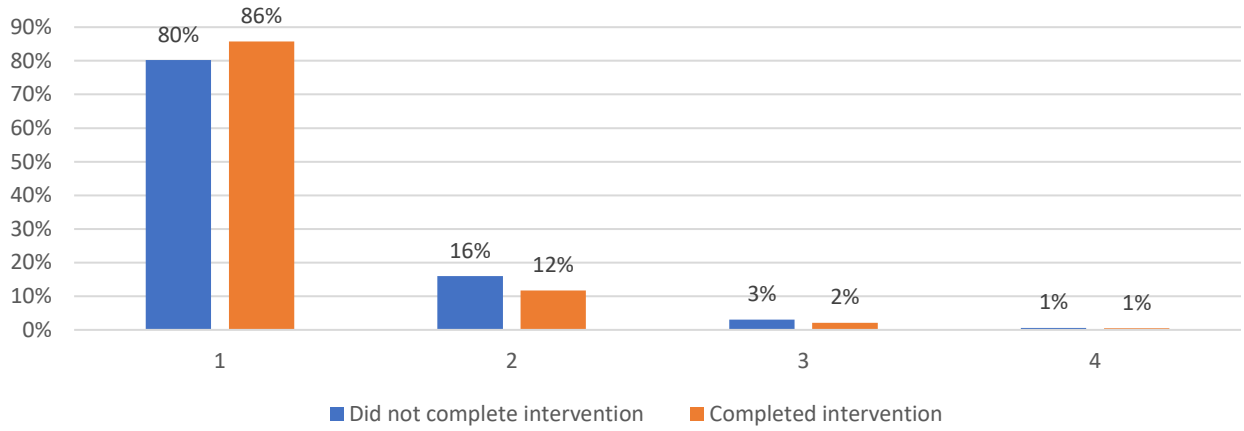


Figure 5.8 shows proportions of having one or more offences where treatment completers were slightly more likely to have 1 offence only instead of two.

Fig 5.8 Engagement - Number of offences, completers vs non-completers, 14 Sites



Figures 5.9 and 5.10 show the percentage of individuals who did not complete the intervention during intervals of 6 and 3 months. This data evaluates only individuals who either have completed the program or have been categorised under non-completed status. It appears there is a slight increase in the likelihood of non-completing over time, this might be due to new sites entering the programme at later stages.

Fig 5.9 Engagement - Percentage of non-completers 6 monthly, 14 Sites

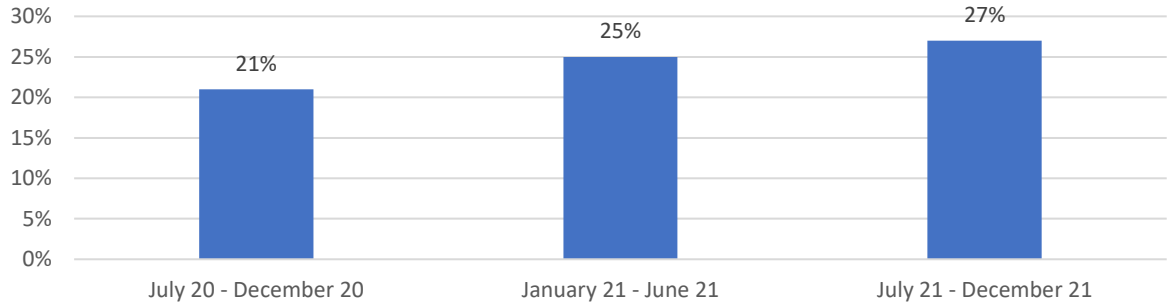


Fig 5.10 Engagement - Percentage of non-completers 3 monthly, 14 Sites

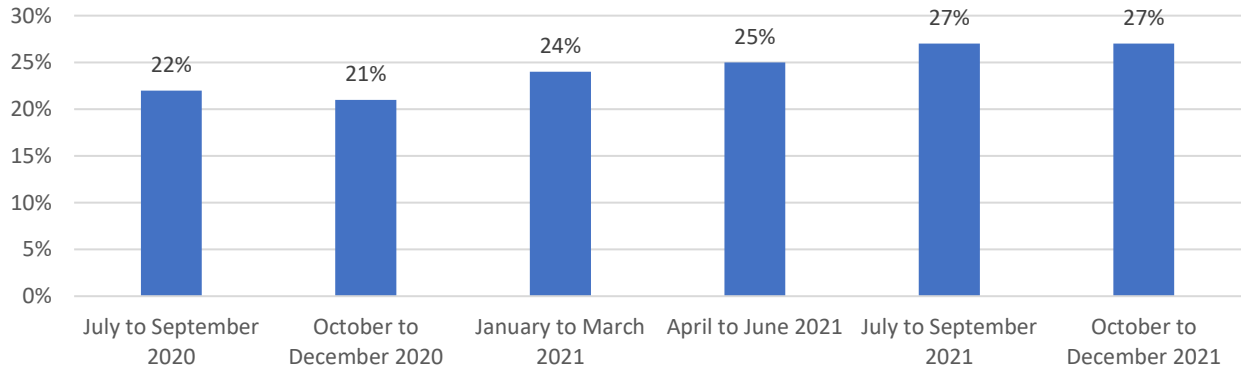
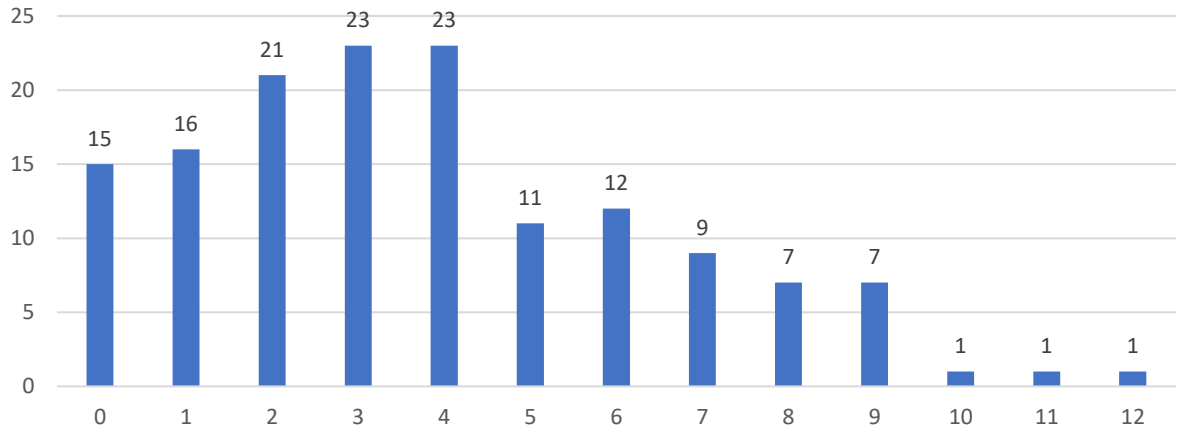


Figure 5.11 shows the number of attended sessions treatment non-completers attended. 147 non completers attended one or more sessions suggesting the possibility that programme might have small benefits even to non-completers.

Fig 5.11 Engagement - Number of attended sessions for treatment non-completers, 14 Sites



Figures 5.12a and 5.12b show the mean number of days between assessment to start date between treatment completers and non-completers. It shows that the mean number of days is higher for treatment non-completers suggesting the period of time between assessment and sentence might affect likelihood of completing the intervention. In Figure 5.11b, 80% of the sample is within the grey boxes to exclude the effect of outliers.

Fig 5.12a Engagement - Mean number of days between assessment and start date (Grey = IQR Midspread)

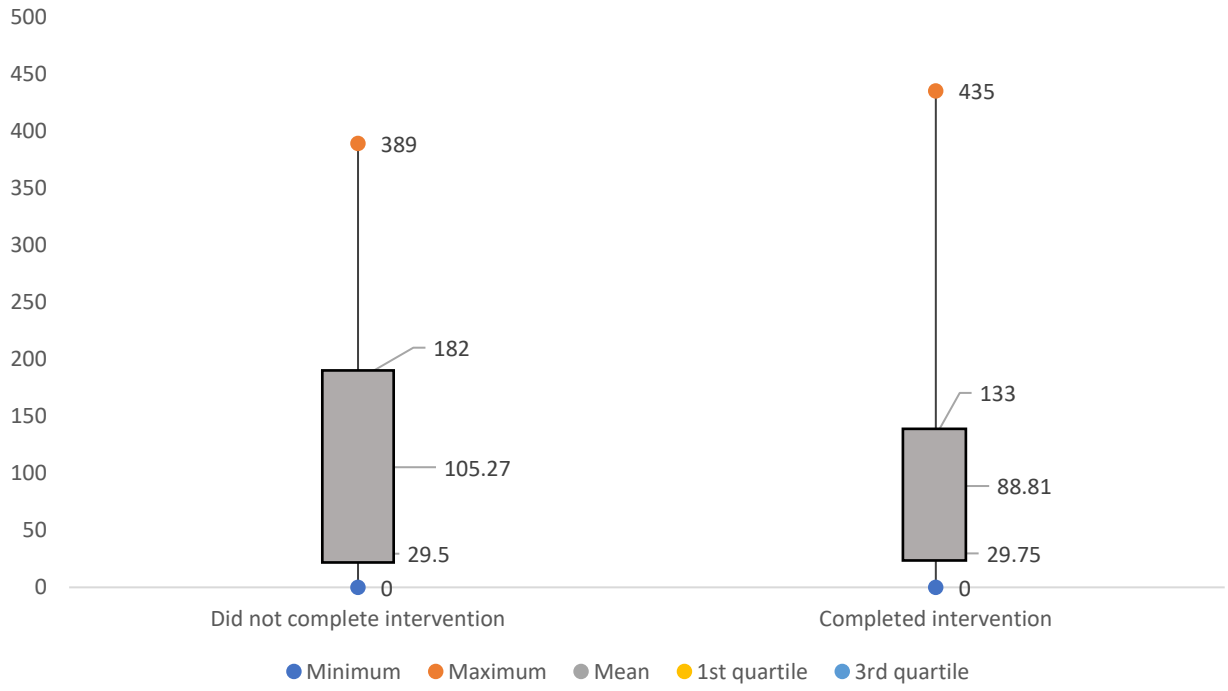


Fig 5.12b Engagement - Mean number of days between assessment and start date (Grey = 80% of Cohort)

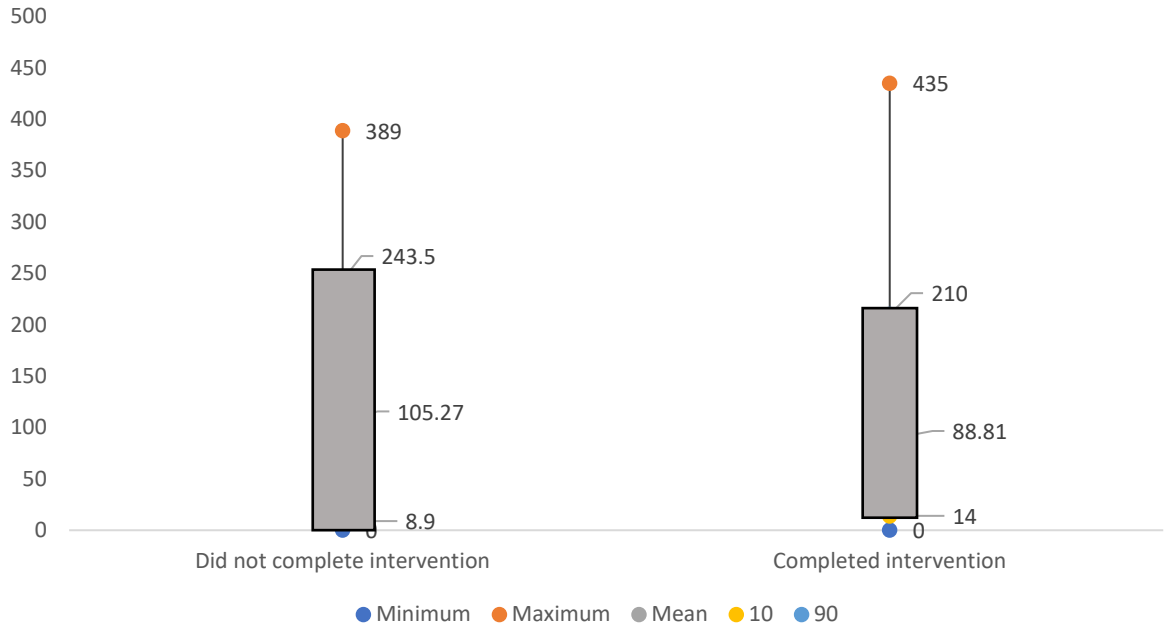


Figure 5.13 illustrates the proportion of service users who have completed the intervention, who are currently receiving it and who have not completed it. To account for within site variation of these proportions, graphs 5.13a to 5.13d present the data from 5 established sites.

Fig 5.13 Client status, 6 monthly, 14 Sites, Jul 20 - Jun 22

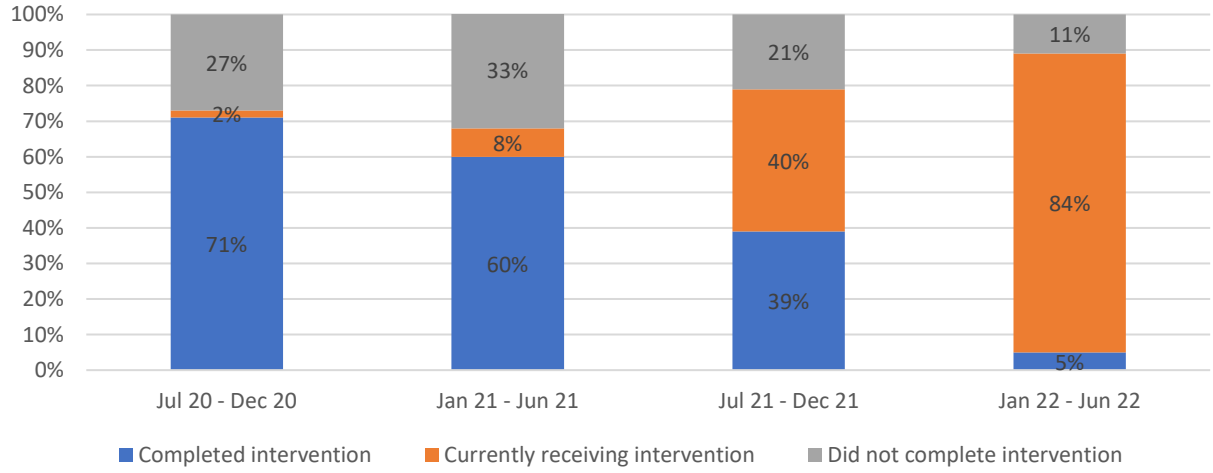


Fig 5.13a Client status, 6 monthly, Jul 20 - Jun 22

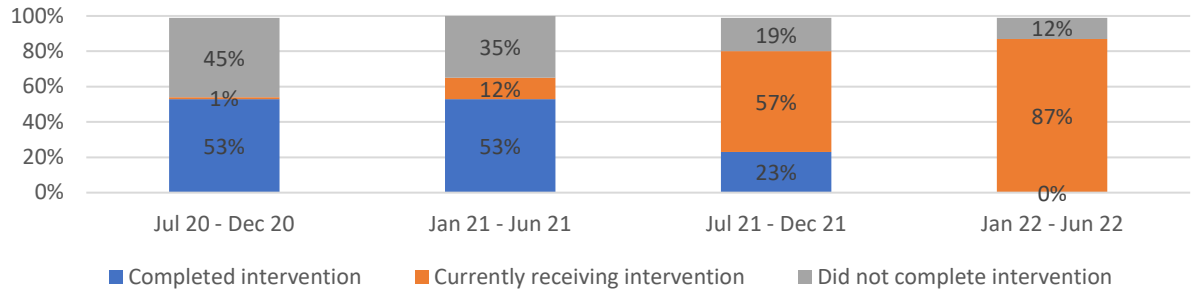


Fig 5.13b Client status, 6 monthly, Jul 20 - Jun 22

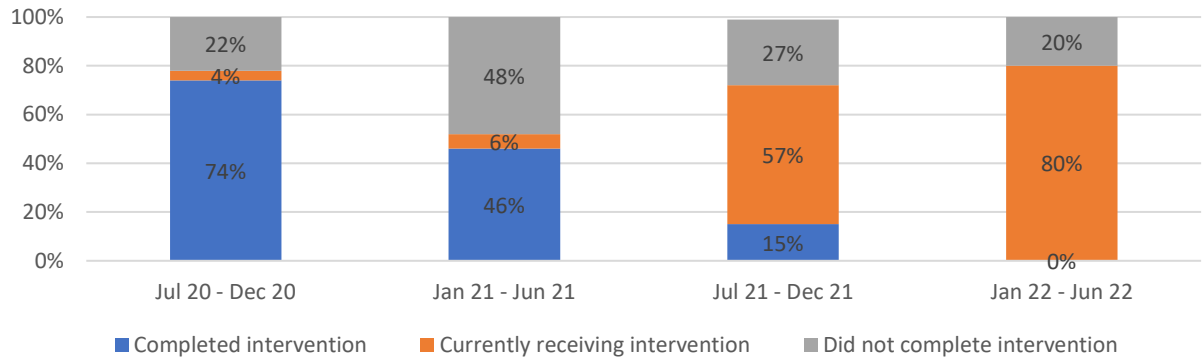


Fig 5.13c Client status, 6 monthly, Jul 20 - Jun 22

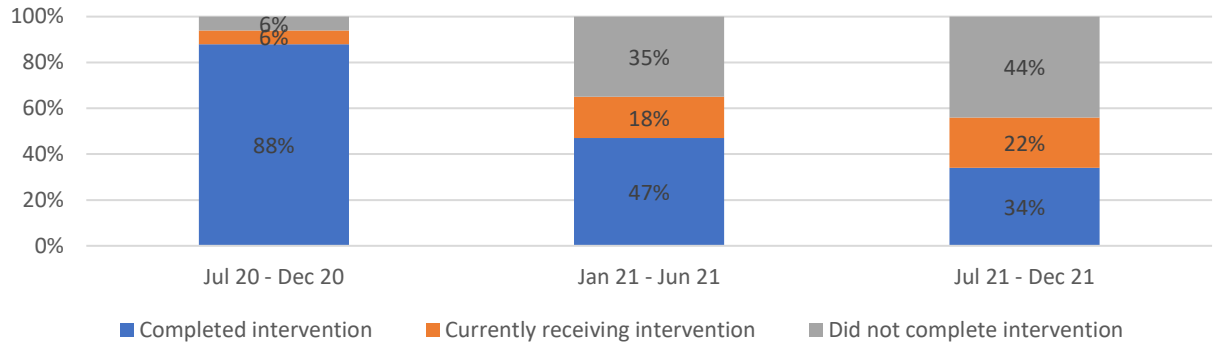
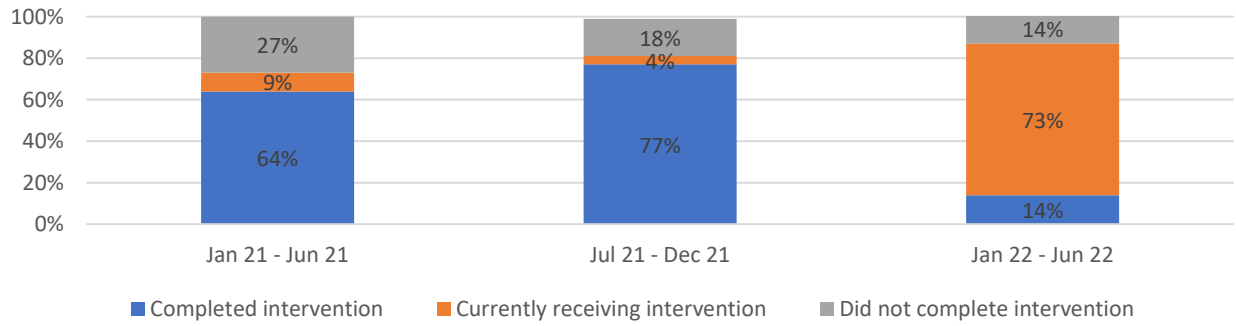
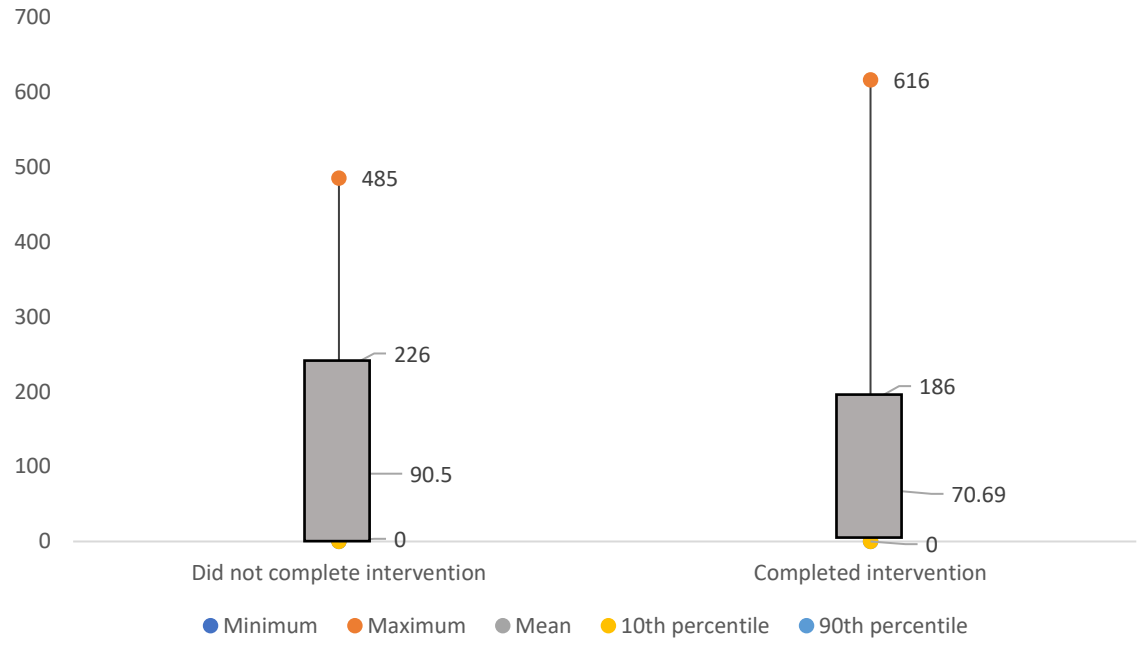


Fig 5.13d Client status, 6 monthly, Jul 20 - Jun 22



Finally, Figure 5.14 below illustrates how individuals who did not complete the treatment (Mean=91) had on average a longer waiting time between their sentencing and the start date of intervention than those completing the treatment (Mean=71).

Fig 5.14 Engagement - Mean number of days between sentence and start date (Grey = 80% of Cohort)



6. 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 the intervention, as levels of missing data restrict insight.

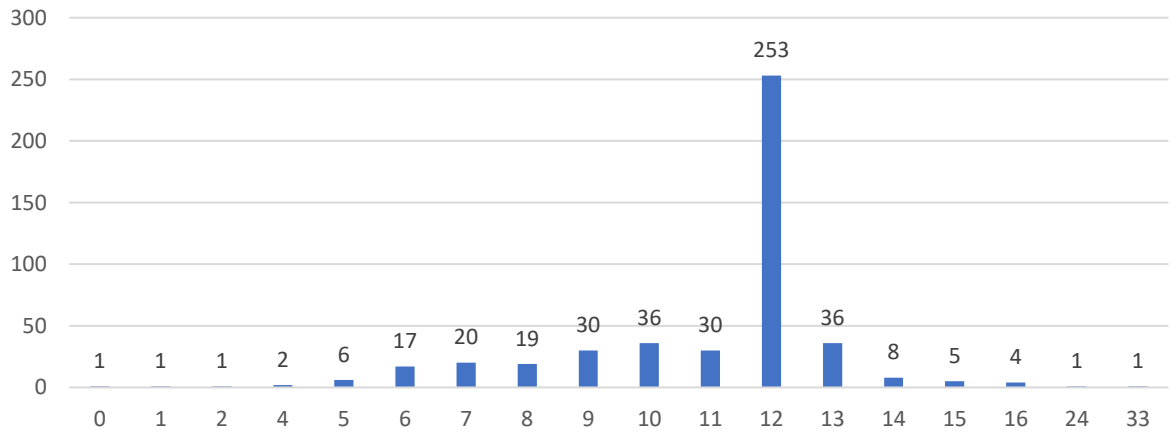
Overall, there were 627 individuals with a recorded end date of intervention across 14 sites. Of those 1 (0.2%) was recorded as 'Awaiting start of intervention', 483 (77%) are recorded as completing, 15 (2%) are recorded as 'currently receiving the intervention', 124 (20%) are recorded as 'not completing the intervention' and for 4 (0.6%) the client status is 'Not Applicable'. Therefore, the dataset requires tidying at a local site level to reassess client status to address contradictory information.

For those that are recorded as not completing reasons given were:

- Discharged ('not workable') (10)
- Moved out of area (11)
- Did not engage (55)
- Breached/ committed further offence (17)
- Died (3)
- Needs had been met through other MH support/ therapy (4)
- Court order expired (10)
- Had no MH needs (4)
- Physical condition (2)
- A reason was not given for 13 cases.

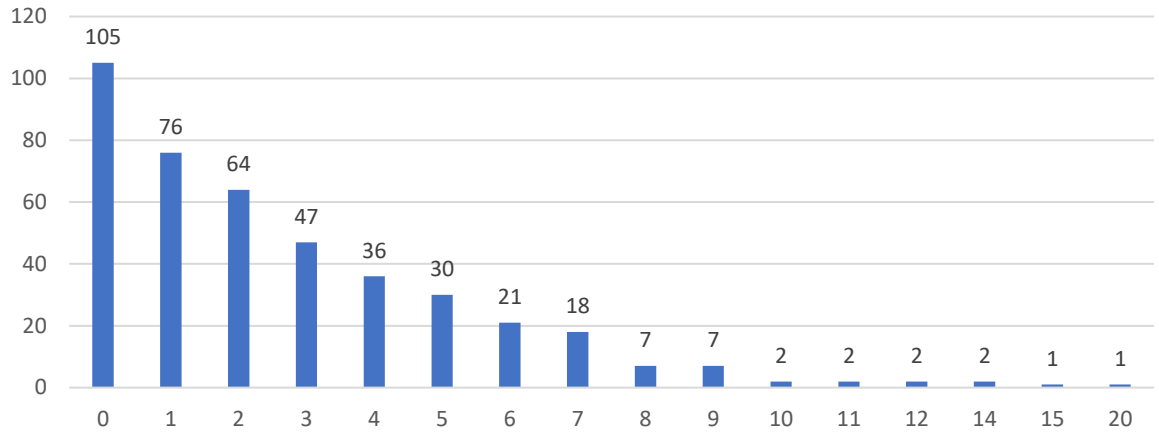
Out of the individuals that completed the treatment, 1 was recorded as having no or zero sessions. Out of the remaining 470 the average number of sessions attended was 11.1. 54% (253) of the sample had 12 sessions, 32% (152) had 6-11 sessions, 2% (10) had 1-5 sessions and 12% (55) had more than 12 sessions.

Figure 6.1 Number of sessions service users had upon completion, 14 sites, Jul 20-Jul 22



Out of 421 individuals who completed the intervention and for whom the number of missing sessions was provided, 316 (75%) had one missed session or more. The average number of missed sessions for those that did miss a session was 2.7 sessions. It is noted that frequencies of missed sessions are likely to have been influenced by Covid restrictions.

Figure 6.2a Number of missed sessions service users had upon completion, 14 Sites, Jul 20-Jul 22



In the data there were 88 (3%) reported breaches. The type of breach was recorded in 34 cases as 'breach of MHTR', 24 was recorded as 'breach of combined order', 53 were recorded as 'not applicable' and 2 were recorded as 'Breached by probation' and 'Breached due to reoffending'.

Fig 6.2b Reason for Breach, 14 Sites, Jul 20 - Jul 22

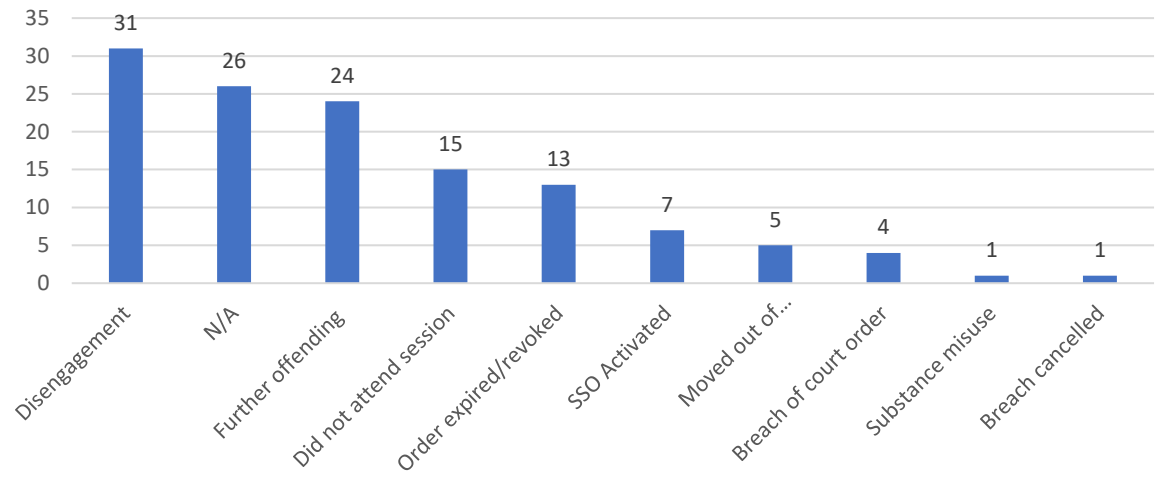
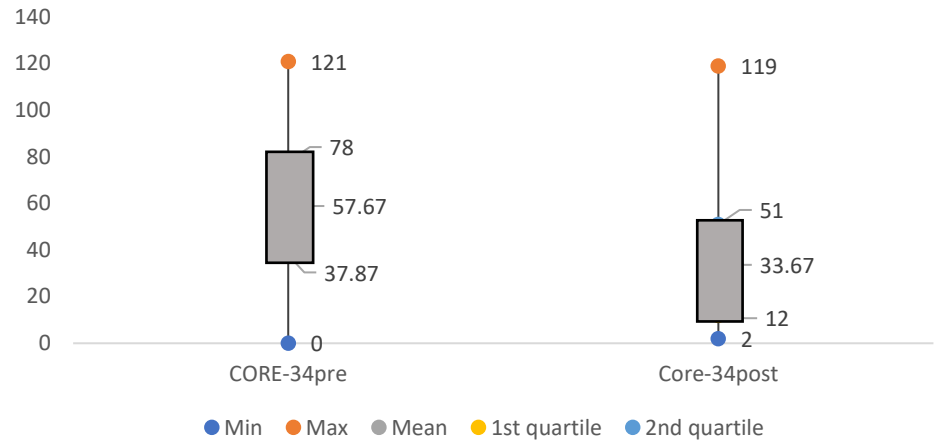


Figure 6.2b illustrated the recorded reasons for 127 breaches.

CORE-34

There were 309 individuals with pre and post CORE-34 scores. The average pre-score was 57.67 (in the mid-range of moderate psychological distress). The average post score was 33.67 (which is at the higher end of low psychological distress). The average reduction was -24 and this difference was statistically significant $t(308) = 16.893$, $p<0.01$.

Fig 6.3 CORE-34 Pre/Post Range and Mean, 14 Sites, Jul 20-Jul 22
(Grey = IQR Midspread)



1-20 Likely to be well
21-33 Low Level Distress
34-50 Mild Distress
51-67 Moderate Distress
68-84 Moderate to Severe Distress
85+ Severe Distress

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 308, 77% (239) saw a 5 or more point reduction in their pre to post CORE-34 score. 12% (36) saw no reliable change (i.e. between -4 and +4) and the remaining 10% (33) saw a reliable worsening (5+).

For those within the group that saw a reliable change the mean pre-score was 62.70 (this would be categorised as moderate psychological distress) whereas for those with no reliable change the mean pre-score was 41.46 (this would be categorised as mild psychological distress). Therefore, those that saw a positive change were on average starting 21.24 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 29.29 (therefore on average a 33.4-point reduction in their pre to post score).

The graph below illustrates 6 different cohorts presenting different levels of distress at the start if the intervention. It is clear from the graph that individuals who start from a category presenting a higher level of distress present the highest benefits at the end of the intervention.

Fig 6.4a Mean level of distress before and after treatment for different distress profiles, 14 Sites, Jul 20 - Jul 22

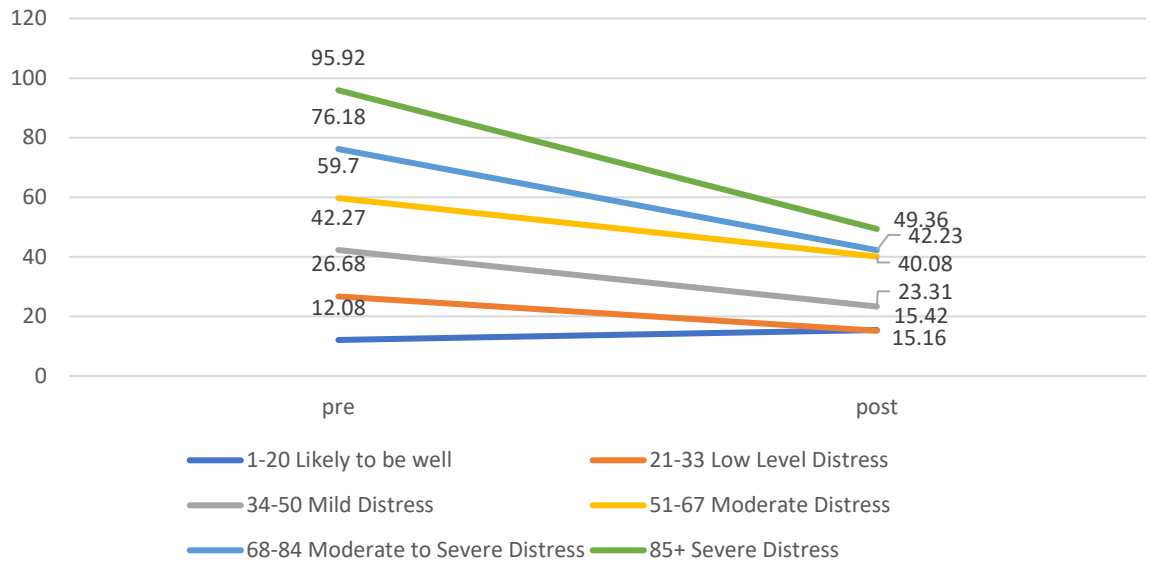
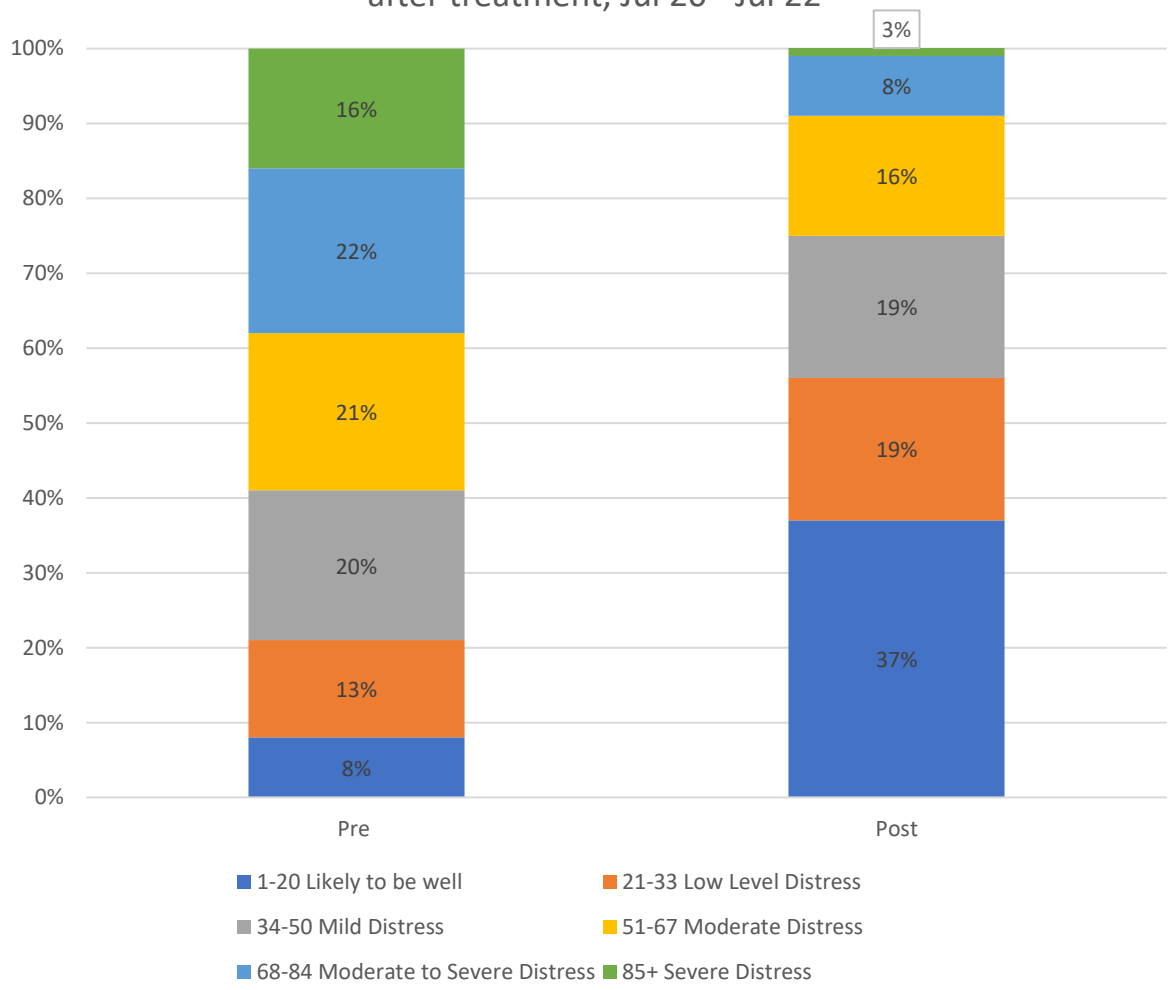


Fig 6.4b Percentage of different distress profiles before and after treatment, Jul 20 - Jul 22

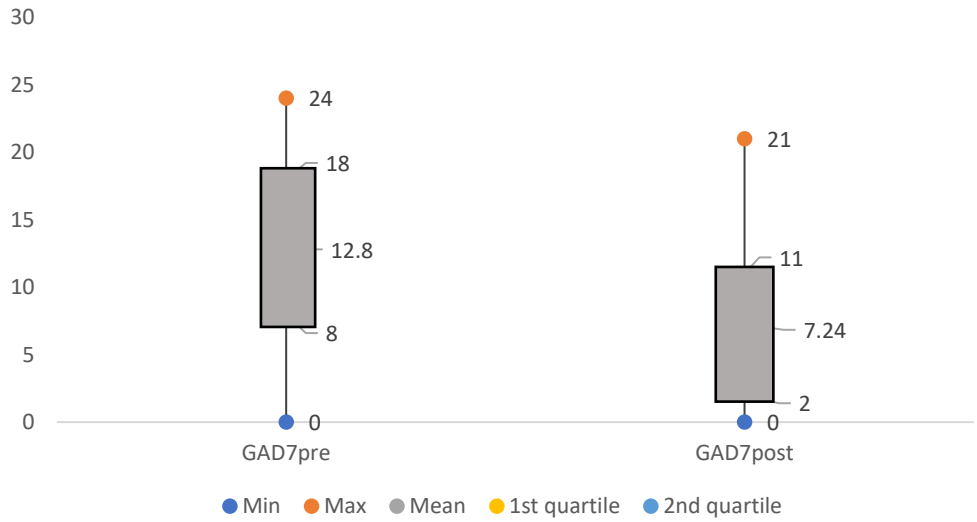


GAD-7

There were 447 individuals with pre and post GAD-7 scores. The average pre-GAD-7 score for this group was 12.8 (Mid moderate anxiety) and the average post score was 7.24 (Mid mild anxiety). Therefore, the average reduction was -5.6 and this difference was statistically significant t (446) = 19.194 and p<0.01.

Fig 6.5 GAD-7 Pre/Post Range and Mean, 14 Sites, Jul 20 - Jul 22

(Grey = IQR Midspread)



0-4 Below Mild Anxiety
5-9 Mild Anxiety
10-14 Moderate Anxiety
15+ Severe Anxiety

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 446, 58% (260) saw a 4 or more point reduction in their pre to post GAD-7 score. 38% (168) saw no reliable change (i.e. between -3 and +3) and the remaining 4% (18) saw a reliable worsening (4+).

For those within the group that saw a reliable positive change the mean pre-score was 14.60 (this would be categorised as the top end of moderate anxiety) whereas for those with no reliable change the mean pre-score was 10.30 (on the cusp of mild and moderate anxiety). Therefore, those that saw a positive change were on average starting 4.3 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 4.96 therefore on average about a 10-point reduction in their pre to post scores.

The graph below illustrates 4 different cohorts presenting different levels of anxiety at the start if the intervention. It is clear from the graph that individuals who start from a category presenting a higher level of anxiety present the highest benefits at the end of the intervention.

Fig 6.6a Mean level of distress before and after treatment for different general anxiety profiles, 14 Sites, Jul 20 - Jul 22

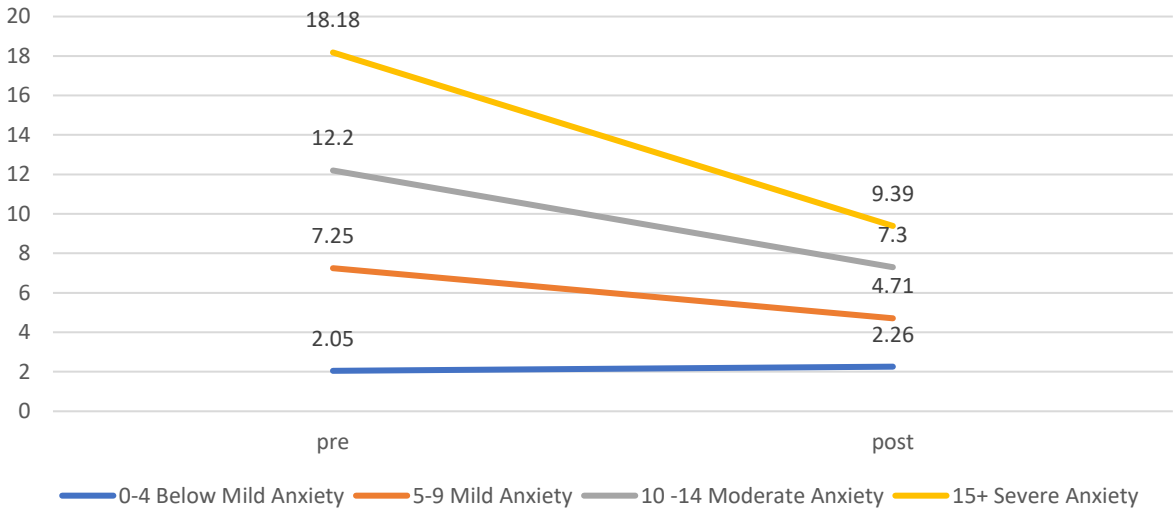
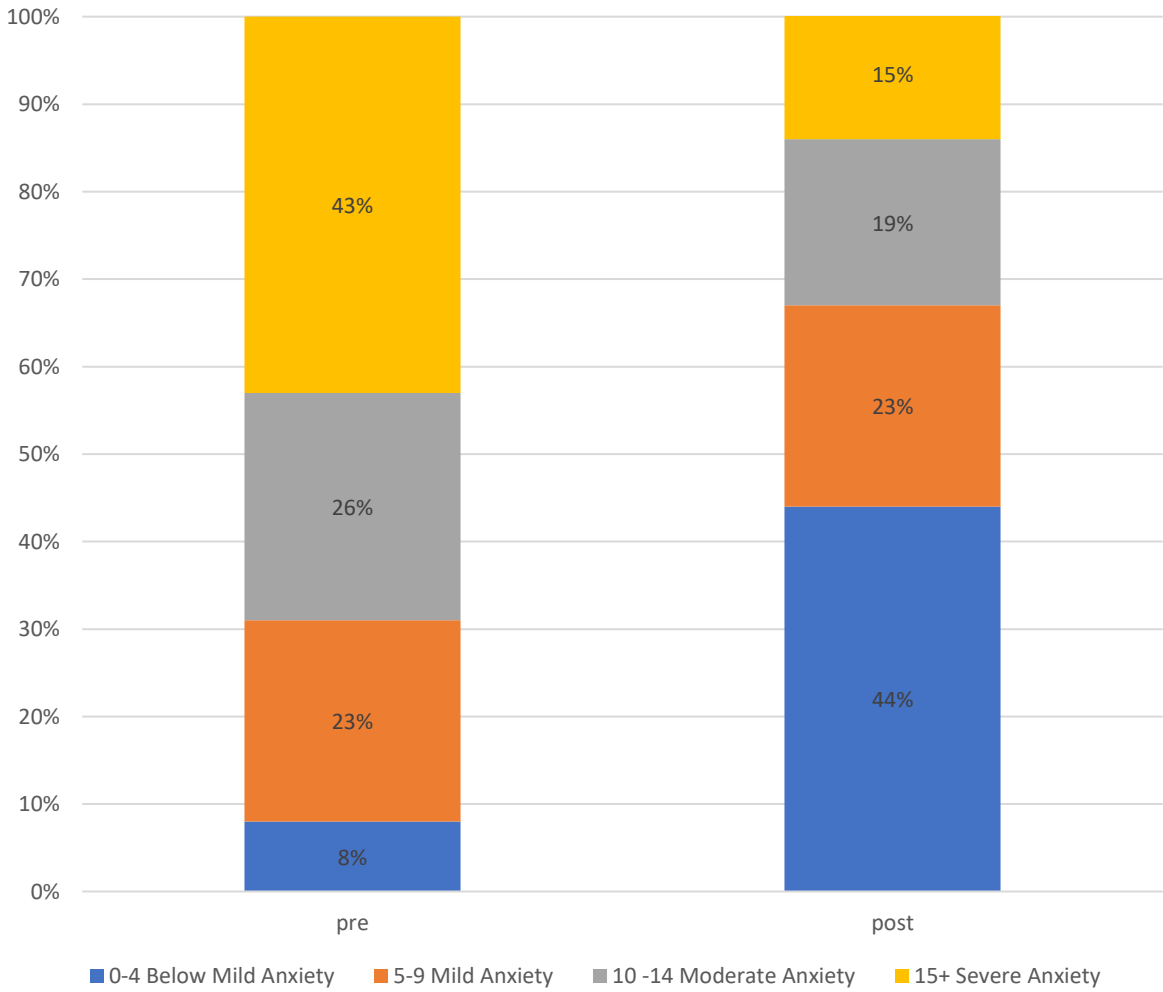


Fig 6.6b Percentage of different anxiety profiled before and after treatment, Jul 20 - Jul 22

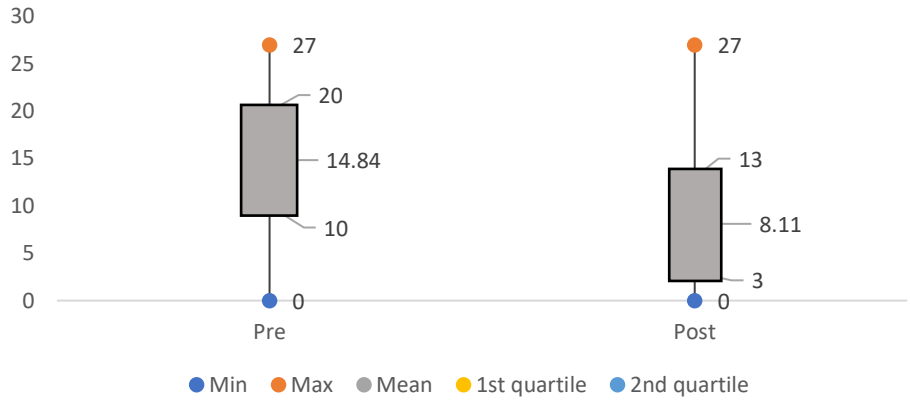


PHQ-9

There were 446 individuals with pre and post scores on the PHQ-9. The average pre-score was 14.84 (on the cusp of moderate to moderately severe depression) and the average post score was 8.11 (mild depression). Therefore, the average reduction was -6.73 and this difference was statistically significant t (445) = 20.735, p<0.01.

Fig 6.7 PHQ-9 Pre/Post Range and Mean, 14 Sites, Jul 20 - Jul 22

(Grey = IQR Midspread)



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

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 446, 55% (244) saw a 6 or more point reduction in the PHQ-9 score. The remaining 45% (202) saw no reliable change (i.e. between -5 and +5) or a reliable worsening (i.e. 6+). Those that saw a worsening in the PHQ-9 were a minority (2.5%, 11). 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 17.64 (this would be categorised as moderately severe) whereas for those with no reliable change the mean pre-score was 11.62 (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 6 (therefore on average a 12- point reduction in their pre to post score).

The graph below illustrates 5 different cohorts presenting different levels of anxiety at the start if the intervention. It is clear from the graph that individuals who start from a category presenting a higher level of anxiety present the highest benefits at the end of the intervention.

Fig 6.8a Mean level of depression before and after treatment for different depression profiles, 14 Sites, Jul 20 - Jul 22

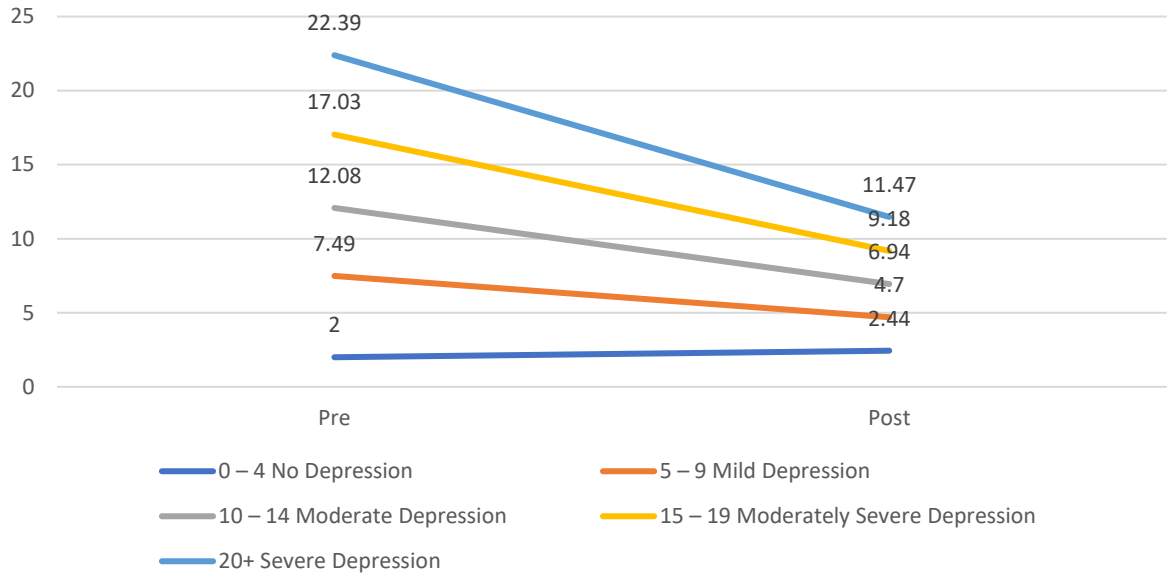
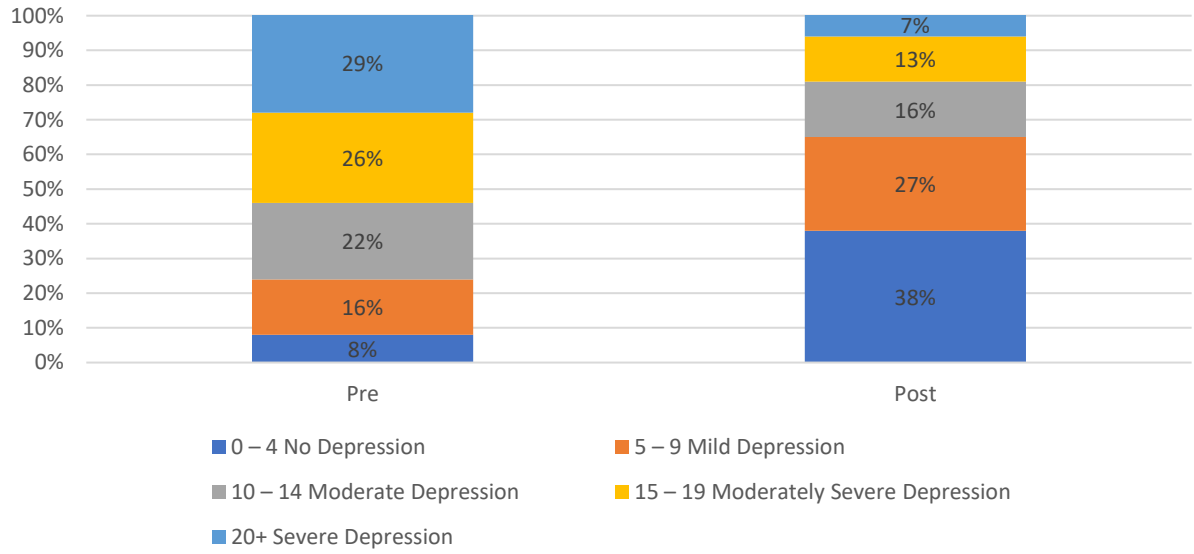


Fig 6.8b Percentage of different depression profiles before and after treatment, Jul 20 - Jul 22



7. Observations

Overall, the analysis and results presented from across the 14 sites are very positive. For most individuals who started an MHTR intervention since July 2020 and successfully completed it, statistically significant positive change was identified using the CORE-34, GAD-7 and PHQ-9. **Therefore, based on the analysis of 24 months data, the evidence demonstrates how MHTR interventions are having a statistically significant benefit in terms of mental distress, anxiety and depression.**

When considering the overall distress profiles of cohorts of individuals starting the intervention alongside the cohorts completing the intervention, with the proportions of the cohort being identified as having either severe or moderate-to-severe distress by CORE-34 (38% to 11%), GAD-7 (43% to 15%), and PHQ-9 (55% to 20%) reduces significantly.

This report for the first time has presented an overview of the proportions of individuals who do not complete the intervention, **representing c. 20% of those who have been sentenced to an MHTR**. It is important to note the proportions of individuals not completing the intervention varies between sites and does not necessarily reflect a negative outcome for the individual. In each of the local reports, the reasons for non-completion will be presented to enable sites to take action where necessary to further explore or address non-completion.

Key observations are:

- Recommendations from the last round of reports (March 2022) still apply and should be considered alongside observations below, specifically:
    - **Numbers of referrals, assessments and individuals sentenced for MHTR should be reviewed and reflected upon by local boards in relation to numbers coming into contact with the criminal justice system who meet the criteria for a Community Order.**
    - **Sites with limited diversity in terms of ethnicity should conduct separate investigations to ensure equality.**
    - **Mechanisms to enable combined orders (i.e. MHTR&ATR or MHTR&DRR) should be reviewed to ensure opportunities are not missed to address multiple needs of individuals.**
- The length of time passed from both date of assessment and/or date of sentence to date of intervention start may have an impact on likelihood of intervention completion. This will be explored further by the evaluation team to analyse trends/patterns and outcomes.
- In terms of sentencing outcomes, **50% of individuals not sentenced to an MHTR but who were found suitable for MHTR following assessment were sentenced to a custodial sentence**. The lengths of these sentences should be assessed and further work with the judiciary should be undertaken if there are multiple instances of short-term sentences are identified.
- There are inconsistencies in the files, and it remains a priority for sites to ensure data provided is accurate. Specifically, in addition to what was outlined in previous reports, dates of assessment, sentence, intervention start and end are critical as are identified vulnerabilities during assessment.

IPSCJ Point of Contact: Professor Matthew Callender
matthew.callender@northampton.ac.uk
@MattCallender1

IPSCJ Address:
Institute for Public Safety, Crime and Justice,
University of Northampton,
University Drive, Waterside Campus,
Northampton,
NN1 5PH
United Kingdom

IPSCJ Telephone:
+44 (0) 1604 89 3304

IPSCJ Email:
ipscj@northampton.ac.uk

Visit the IPSCJ Webpage:
https://www.northampton.ac.uk/research/research-institutes/institute-for-public-safety-crime-and-justice

Explore the IPSCJ on Pure:
https://pure.northampton.ac.uk
Institute for Public Safety, Crime & Justice — University of Northampton's Research Explorer

Follow IPSCJ on Twitter:
@ipscj