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## Key Messages

- The preliminary evidence shows mental health benefits for individuals who completed the mental health intervention as part of a Mental Health Treatment Requirement (MHTR). Data were collected as part of a national multi-site evaluation being completed by the Institute for Public Safety, Crime and Justice, based at the University of Northampton.
- Assessment data were provided for **2,249** individuals, of who **1,204** had started the intervention and **477** had completed the intervention. This policy paper focuses on health change for individuals who successfully complete the intervention, with breach rates and non-completion data not being presented.
- **For cases where both pre-intervention and post-intervention data were provided, statistically significant positive change was identified for all measures, demonstrating efficacy and the importance establishing MHTR pathways across England and Wales**:
    - ***Global distress*** measured using CORE-34 on average was scored **57.7** at the start of intervention (moderate psychological distress) to **33.7** at the end of intervention (low psychological distress).
    - ***Anxiety*** measured using GAD-7 on average was scored **12.8** at the start of intervention (moderate anxiety) to **7.2** at the end of intervention (mild anxiety).
    - ***Depression*** measured using PHQ-9 on average was scored **14.8** at the start of intervention (moderate depression) to **8.1** at the end of intervention (mild depression).
- Overall, the preliminary evidence demonstrates how most individuals experience a significant positive change following intervention, suggesting that MHTR programmes are very promising. As the evaluation progresses, links between such health gains and reoffending will be explored. However, the policy paper provides some evidence to support and consider further expansion of CSTR programmes nationally.

## What is the problem?

The proportion of Community Sentences Treatment Requirements (CSTRs), especially Mental Health Treatment Requirements (MHTRs), as part of Community Orders has been very low. This coupled with significant mental health needs of offenders alongside rising concerns about the effectiveness of short-term sentences establishes the importance of offering a positive alternative to address underlying needs. There is limited evidence that demonstrates the effectiveness of MHTRs at improving health outcomes to reduce likelihood of reoffending.

## Introduction

This Policy Brief explores health outcomes for individuals who complete a mental health intervention as part of a MHTR. It summarises health outcomes and measured change using a range of psychometric measures. Data were provided from a national multi-site evaluation being completed by the Institute for Public Safety, Crime and Justice, based at the University of Northampton, and were from the following sites: Bedfordshire, Black Country, Birmingham, Cambridgeshire, Cornwall, Essex, Gloucestershire, Hertfordshire, Northamptonshire, Plymouth, Staffordshire, Swansea and Wiltshire.

## What are Mental Health Treatment Requirements?

MHTRs sit alongside Drug Rehabilitation Requirement (DRR) and Alcohol Treatment Requirement (ATR) under the umbrella of 'Community Sentence Treatment Requirements' (CSTR). They were introduced in their current form in 2003 in England and Wales to enable Judges and Magistrates to tailor sentences according to the nature of the offence and the offender. MHTRs have been used in very few cases, despite evidence of high proportions of convicted offenders presenting with mental health conditions, and drug and alcohol misuse. MHTRs may be used in relation to any mental health issue, including personality disorders and neurodevelopmental disorders. MHTRs can be provided by a broad range of Clinicians as long as the requirement is clinically supervised by or under the supervision of a suitably specialist registered medical practitioner or registered psychologist (CJA, 2003).

## What does the mental health intervention involve?

The MHTR intervention involves 10-12, 50-minute sessions across the Community Order as specified by the Court, where the individual meets with the Primary Care MHTR Practitioner under supervision of the Clinical Lead. The interventions will be individually tailored to the needs of each client and therefore will vary within and between sites. Critically, the content of

each intervention should be determined in respect of issues and needs identified in the MHTR Practitioner Assessment as well as issues and needs that are identified through practice.

## About the Evaluation

The evaluation began formally on August 1st 2020. It involves 4 key activities in each site:

- Interviews with individuals who receive mental health interventions;
- Interviews with professionals working across MHTR pathway;
- Secondary data analysis of process data; and
- Analysis of outcomes and reoffending.

There are currently 14 sites involved in the evaluation. The evaluation has been reviewed by the University of Northampton Research Ethics Committee, the National Health Research Authority and the National Research Committee. Each site receives a bespoke report every 6 months throughout the project.


## Exploring Health Outcomes

The following analysis focuses on comparing outcomes for individuals assessed for MHTR after July 2020 and before August 2022. The aim is to identify change between the first and final session of the intervention. Data were collected by the Assistant Psychologists in each site as part of practice.

## Assessment and Start of Intervention

In total, there were 2,249 cases provided in the dataset for MHTR where service users had been assessed, of those, 1,204 have started the intervention. Of individuals who started the mental health intervention,

- 38% were female and 60% male, with 2% missing. It should be noted that 2 sites included females exclusively;
- the age of cases ranged between 18 and 80 years, with the average being 35 years of age;
- ethnicity was not recorded for 323 of cases, which equates to 14% of the sample. Of those remaining, 1,726 (78%) were from a white background, 53 (2%) were from a 'mixed' ethnic background, 55 (2%) were Asian and 48 (2%) were black and 1 (1%) was from an 'other' background;
- the most frequent offence type was violence against the person, motoring offences (include driving under the influence) and possession of an offensive weapon; and
- a range of additional vulnerabilities identified for individuals being sentenced to MHTR in addition to mental health, primarily anxiety and depression, trauma and substance misuse.

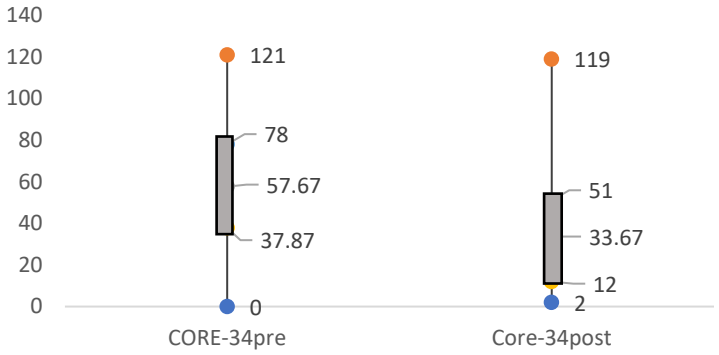
## Global Distress

Global distress is measured using the CORE-34 - 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:

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

There were 309 cases with pre and post scores on the CORE-34. 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 $t(308) = 16.893$, $p<0.01$.**

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




Reliable change for the CORE-34 is change that exceeds that which might be expected by chance alone or measurement error. For the CORE-OM, this is represented by a change of 5 or more in the clinical score. In a 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 (between -4 and +4) and the remaining 10% (33) saw a reliable worsening (5+).

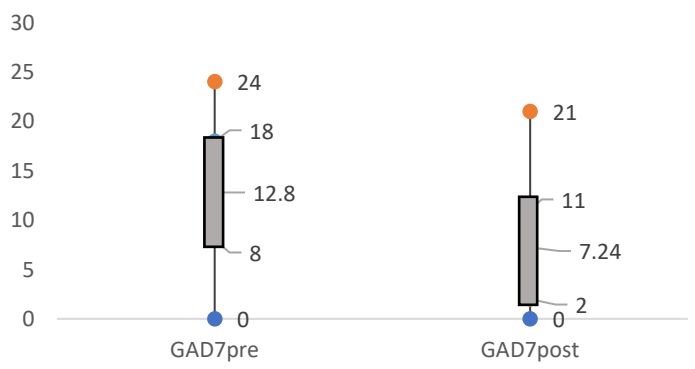
## Anxiety

Anxiety is measured using the GAD-7 – a 7-point measure for generalised anxiety disorder (GAD). Scores for each measure are assessed between 0-3 and overall results are interpreted into the following levels:

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

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.**

GAD-7 Pre/Post Range and Mean, 14 Sites, Jul 20 - Jul 22
(Grey = IQR Midspread)




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+).

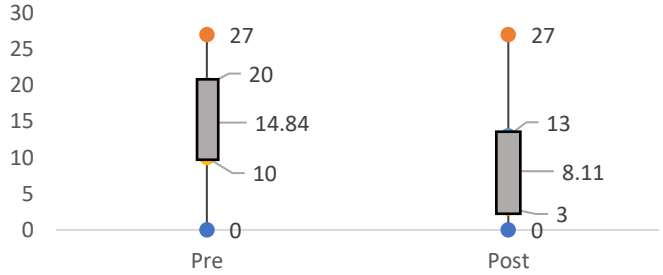
## Depression

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:

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

There were 446 individuals with pre and post PHQ-9 scores. The average pre-score was 14.84 (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.**

PHQ-9 Pre/Post Range and Mean, 14 Sites, Jul 20 - Jul 22
(Grey = IQR Midspread)




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).

## Discussion and Implications

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.**

There are challenges at establishing a reliable picture of compliance and completion, as the data set continues to develop across sites. Further work will be completed to assess compliance and engagement within defined time periods in the future to resolve this. An important line of future enquiry will be offending outcomes for individuals who have completed mental health intervention, with insufficient evidence available at present. However, existing evidence suggests that improved health outcomes should lead to lower recidivism.

The analysis presented in this policy paper demonstrates how mental health interventions delivered as part of a MHTR have mental health benefits for individuals who complete, with statistically significant benefits being identified for global distress, anxiety and depression.

**Therefore, the evidence presented suggests MHTRs may offer a positive alternative to short-term custodial sentences, improving the health of individuals sentenced and addressing a largely unmet need within the offender population.**

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