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Key Messages

For most females 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**.

MHTRs can be included within a Community Order or Suspended Sentence Order, **with demonstrable health benefits for females**.

The benefits of MHTR as an alternative to custodial sentences are not only for the individual but also reduces the impact on families and children.

Pathway

MHTRs are effective as part of a Community Order for all individuals, with females progressing through the MHTR pathway more successfully than males.

It is estimated that 4-in-5 females will complete the intervention as 1-in-5 (19%) females who are sentenced to MHTR do not complete the intervention.

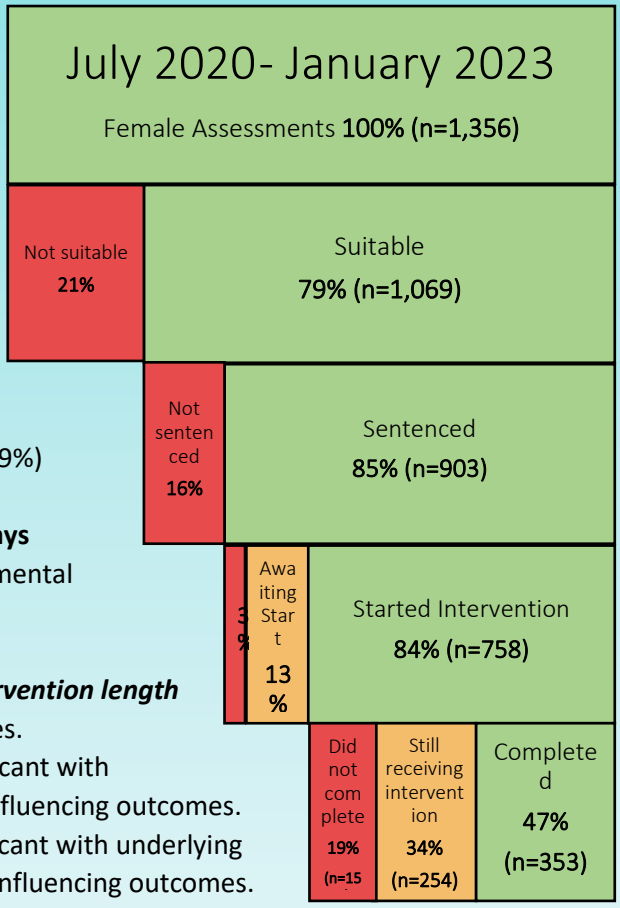
An identified principal factor affecting completion rates was the **number of days between sentence and start date**. Delays in the process also reduced the mental health benefits from the intervention.

Outcomes and additional factors

CORE-34: The average reduction of -20.7 was statistically significant with ***intervention length*** and ***time between sentence and start date*** negatively influencing outcomes.

GAD-7: The average reduction was -4.7. This difference was statistically significant with ***substance misuse*** and ***time between sentence and start date*** negatively influencing outcomes.

PHQ-9: The average reduction was -6.2. This difference was statistically significant with underlying vulnerabilities of ***severe mental health*** and ***anxiety/depression*** positively influencing outcomes.

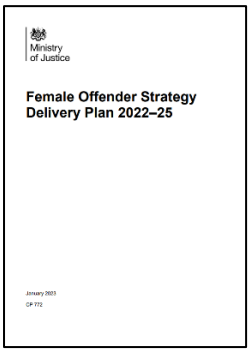


What is the problem?

To date, there is no available evidence that details outcomes of MHTRs for females, which is critical to an assessment of the viability of MHTRs to support females as part of a Community Order or Suspended Sentence Order. This brief, therefore, is the first to provide evidence on health outcomes specific to females through mental health intervention, via MHTR pathways, in support of the Female Offender Strategy.

Introduction

The use of Mental Health Treatment Requirements (MHTRs) since the piloting of MHTR pathways in 2017 has grown significantly. MHTR pathways are on course to be available in all areas of England by April 2024. This will enable all individuals who meet the criteria for intervention to address underlying mental health needs to be assessed for MHTR. This marks a significant shift within the criminal justice system.


Ministry of Justice

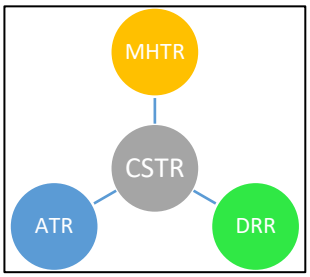
Female Offender Strategy Delivery Plan 2022–25

Female offenders are a cohort that stand to benefit significantly from the resurgence of MHTR pathways in England, given the significant mental health needs associated with offending behaviours as evidenced in the Female Offender Strategy[1]. Indeed, the recent Female Offender Delivery Strategy Delivery Plan 2022–25[2] identified MHTRs as a key pathway to see fewer females serving custodial sentences and rather being managed successfully in the community.

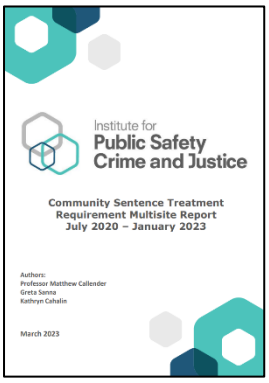
The IPSCJ began an independent evaluation of Primary Care MHTRs in several sites in England and Wales in July 2020 and this policy brief, for the first time, provides insight into outcomes for females who have been assessed and sentenced for an MHTR. This paper provides an overview of the demographics of this cohort, information on how females experience the MHTR pathway, evidences health outcomes for females and identifies statistically associated factors linked with health outcomes.

[1] Ministry of Justice (MoJ) (2023a) [2] Ministry of Justice (MoJ) (2023b)

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 Community Sentences according to the nature of the offence and the offender. In 2017, five pilots across England were launched to introduce and embed a recognised pathway and provision to enable the use of MHTRs[2].



IPSCJ Evaluation

Anonymised data has been collected and is being analysed as part of the Institute for Public Safety, Crime and Justice's (IPSCJ) Multisite Evaluation[3] since July 2020. Previously published IPSCJ policy briefs have demonstrated the mental health benefits of MHTRs[4]; explored how the MHTR process has an impact on outcomes [5]; and outcomes for different profiles of service users[6]. As part of the MHTR evaluation the IPSCJ has engaged with female offenders carrying out interviews to understand the experiences of women involved in the programme. Quotes from the interviews are presented across this brief.

MHTRs and the Female Offender Strategy

The Female Offender Strategy, published in July 2018, sheds light on the complexities and obstacles faced by female offenders. This cohort is characterised by significant levels of childhood trauma as well as substance misuse and mental illness[7]. Additionally, as stated by Light et al.[8], the epidemiological characteristics of female offenders are dissimilar to those of male offenders suggesting the evidence base for interventions should be gender specific. For example, women are twice as likely to report suffering from anxiety and depression and more likely to report symptoms of psychosis[9].

Over three quarter of female offenders receive sentences of less than 12 months, where contact with the Criminal Justice System, and being in custody in particular, limits women's ability to address the issues at the root of their offending[10] as well as having a significant impact on families and children. Furthermore, data showed that of the women released between April and June 2016, 56.1% reoffended within a year.

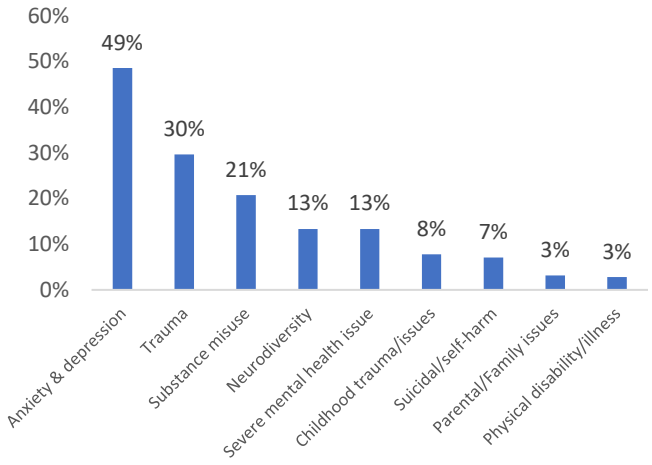
Evidence has shown that a more effective alternative to custody at reducing reoffending is that of Community Orders, supporting women with their mental health as well as facilitating engagement with employment and secure, stable accommodation. Mental Health Treatment Requirements, in particular, were shown to provide improved sentencing options, by reducing short term sentences, as well as improving access to mental health treatment for offenders and having an overall positive impact on service users who provided largely positive feedback[11].

MHTRs are critical to the successful delivery of the Female Offender Strategy. Regrettably, there is a scarcity of evidence on MHTR outcomes, especially on female offenders. This policy brief begins to address this lacuna by presenting an analysis focused on MHTR outcomes on female offenders and factors affecting the programme pathway and mental health outcomes.

[2] Long *et al.* (2018) [3] Callender *et al.* (2023) [4] Callender *et al.* (2022a) [5] Callender *et al.* (2022b) [6] Callender *et al.* (2022c) [7] McClellan, *et al.* (1997) [8] Light, *et al.* (2013) [9] MOJ (2013). [10] MOJ (2018). [11] Molyneaux et al. (2021)

Demographics

Fig 1. Vulnerabilities, 15 sites, Jul 20 - Jan 23



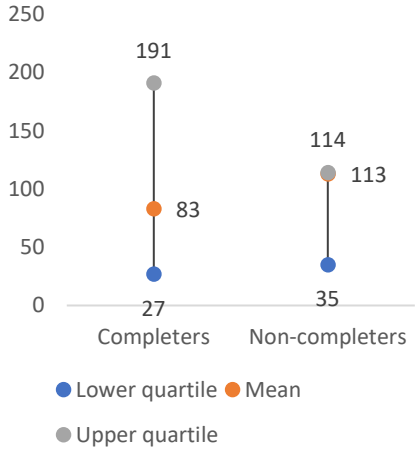
The present analysis was conducted on a sample 1,356 women who were assessed for MHTR between July 2020 and January 2023. The most frequent offence type was violence against the person (34%), followed by motoring offences (16%) and drug offences (7%). Of the women assessed and for who data were available, most (61%) were aged between 25 and 44 years old and identified as White (78%). 185 (14%) were sole carers, and 71 (5%) were identified as meeting the perinatal criteria with 37 (3%) being pregnant at the time of assessment. A range of vulnerabilities were identified from 15 sites (n=1,042) from which data was available at point of assessment. Most frequently females were identified as having anxiety and depression (49%), trauma (30%) and substance misuse (21%). It should be noted that two female-only sites were included in the analysis contributing 326 cases.

Pathway

Females progress through the MHTR pathway more successfully than males. Upon closer look at the pathway, data seems to suggest that females go through the pathway more effectively, than males with higher proportions of women being found suitable after assessment (79% compared to 75% for males) and higher proportion of females getting sentenced after being found suitable (85% compared to 78% for males).

…if it can keep women out of prison… [so they] can continue their normal lives, then 100% this programme is fantastic.

Fig 2. Mean number of days between sentence and start date



In total, around 1-in-5 females (17%) who are sentenced to MHTR will not complete the intervention for a variety of reasons. The most frequent reported reason for non-completion was non engagement (58, 38%) and committed further offence (32, 21%). The high percentage of non-completion rates due to non-engagement suggests further analysis should be directed towards factors that measure and facilitate engagement. This avenue for maximising treatment benefits will be explored in future.

An identified principal factor affecting completion rates was the number of days between sentence and start date, with intervention completers having a significantly lower mean number of days between sentence and intervention start date compared to non-completers (83 days to 113 days respectively). This relationship was found to be statistically significant (F=1.355 p=.013). This suggests that longer waiting times negatively affect likelihood of treatment completion and should therefore be an area of focus to increase engagement.

Delays in the process also reduced the mental health benefits from the intervention, having a significant negative impact on global distress measured using CORE-34 (t=2.085, p<.05), anxiety measured through GAD-7 (t=3.400, p<.001) and depression measures using PHQ-9 (t=4.000, p<.001). Overall, the analysis demonstrates how delays between sentence date and start of intervention negatively affect completion rates and the size of intervention benefit and should be an area of focus to improve programme outcomes.

I do think the programme does help… and do you know what it has kept me out of prison, and its kept me with my son and family, and I remain in my job, so I am very lucky.

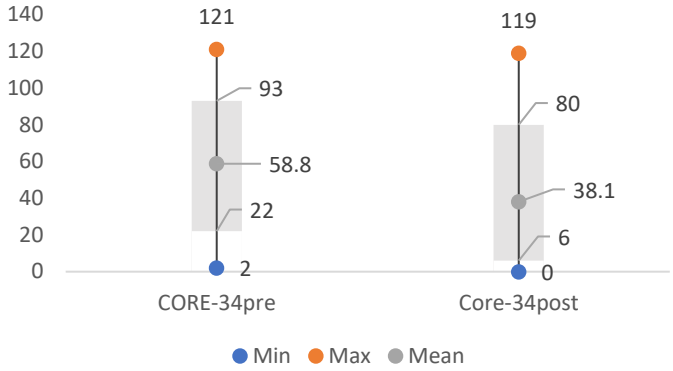
Outcomes

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:

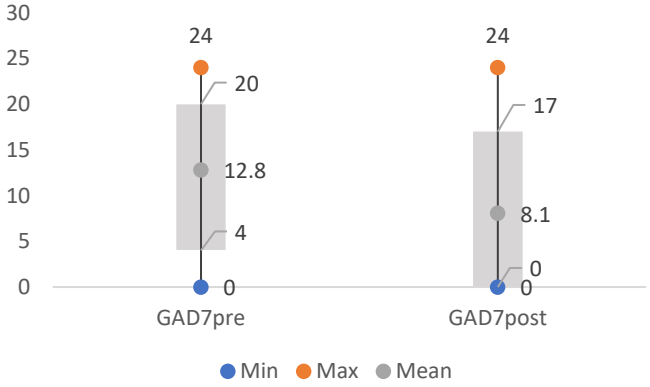
- 1-20 - healthy;
- 21-33 - low level psychological distress;
- 34-50 - mild psychological distress;
- 51-67 - moderate psychological distress;
- 68-84 - moderate-to-severe psychological distress;
- 85+ - severe psychological distress.

Fig 3. CORE-34 Pre/Post Range and Mean, Female Offenders, Jul 20-Jan 23
(Grey = 80% of cohort)



There were 247 cases with pre and post scores on the CORE-34. The average pre-score was 58.8 (in the mid-range of moderate psychological distress). The average post score was 38.1 (which is at the higher end of mild psychological distress). **The average reduction was -20.7 and this difference was statistically significant t(246) = 11.443, p<0.01.** 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 246, 70% (171) saw a 5 or more-point reduction in their pre to post CORE-34 score, 13% (31) saw no reliable change (between -4 and +4) and the remaining 18% (44) saw a reliable worsening (5+).

Fig 4. GAD-7 Pre/Post Range and Mean, Female Offenders, Jul 20 - Jan 23
(Grey = 80% of cohort)



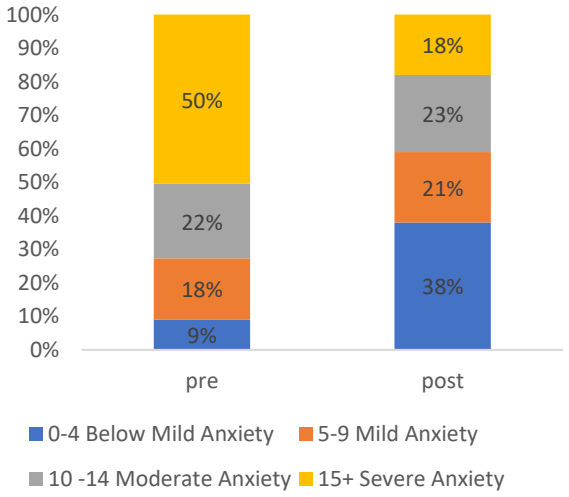
Anxiety

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 299 females 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 8.1 (Mid mild anxiety). **Therefore, the average reduction was -4.7 and this difference was statistically significant t (298) = 13.210 and p<0.01.** 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 299, 51% (152) saw a 4 or more point reduction in their pre to post GAD-7 score. 45% (133) saw no reliable change (i.e. between -3 and +3) and the remaining 5% (14) saw a reliable worsening (4+).

Fig 5. Percentage of different anxiety profiles before and after treatment

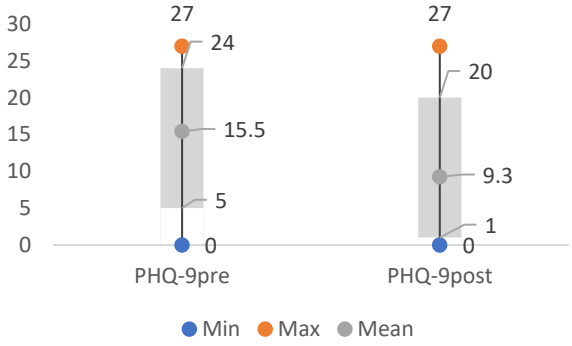


Depression

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

Fig 6. PHQ-9 Pre/Post Range and Mean, Female Offenders, Jul 20 - Jan 23
(Grey = 80% of cohort)



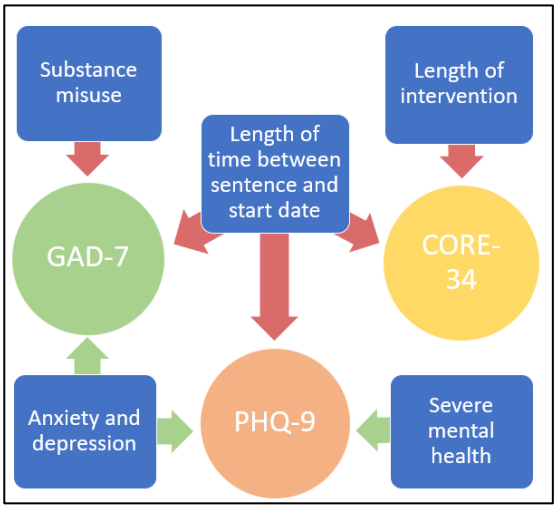
There were 302 females with pre and post PHQ-9 scores. The average pre-score was 15.5 (moderately severe depression) and the average post score was 9.3 (between mild and moderate depression). **Therefore, the average reduction was -6.2 and this difference was statistically significant t (301) = 12.142, p<0.01.** 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 302, 48% (144) saw a 6 or more point reduction in the PHQ-9 score. The remaining 52% (158) 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 (4%, 13).

She made me feel better about myself that was the most important thing for me.

Factors Influencing Mental Health Outcomes

A preliminary analysis was completed to identify factors affecting mental health outcomes. The analysis was subdivided in factors affecting global distress (CORE-34), anxiety (GAD-7) and depression (PHQ-9).

Global Distress: Change measured by CORE-34 was primarily influenced by the programme pathway including the ***length of intervention*** and the ***length of time between sentence and start date***. The relationship between the length of intervention and global distress outcomes was found to be statistically significant (t=2.108, p<.05) where interventions that were longer were associated with weaker outcomes.



Anxiety: Change measured by GAD-7 was primarily associated with the identified vulnerabilities of ***substance misuse; anxiety and depression*** and the ***length of time between sentence and start date***. The relationship between substance misuse and outcomes in anxiety was found to be statistically significant with females reported as engaging in substance misuse benefitting to a lesser extent from the MHTR intervention (t=2.326, p<.05).

Yeah, I loved going there to be honest, because it was all girls all in the same environment, so it was really nice to talk to everybody

Depression: Change measured by PHQ-9 was primarily associated with identified vulnerabilities of ***severe mental health*** and ***anxiety and depression*** alongside the ***length of time between sentence and start date***. There was a statistically significant relationship found between severe mental health vulnerabilities and PHQ-9 mental health outcomes (t=-2119, p<.05) as well as a statistically significant relationship between reported anxiety and depression and PHQ-9 mental health outcomes (-2.179, p<.05). Here, females with reported vulnerability of anxiety, depression or severe mental health at point of assessment had on average higher drops in depression levels after the programme.

Discussion and Implications

This analysis presented in this policy brief for the first time provides robust evidence to show MHTRs offer effective interventions for female offenders, in terms of reducing mental distress, anxiety and depression. **For most females 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.** This is critical to further strengthen MHTR pathways for all alongside developing bespoke support packages for females considering underlying vulnerabilities.

Female offenders are a diverse population with a range of vulnerabilities that need to be met through tailored, flexible interventions. Many are sole carers and meet the perinatal criteria. As such **the benefits of MHTR as an alternative to custodial sentences are not only for the individual but also reduces the impact on families and children**.

The analysis documents how MHTRs can included within a Community Order or Suspended Sentence Order **with demonstrable health benefits for females**. Further evidence should be focused on exploring the sustainability of mental health benefits and patterns of reoffending behaviour. However, the growth of provision available to sites nationally is supported through this analysis, with MHTR pathways supporting positive change for female offenders.

In terms of developing the programme an area of focus highlighted by the brief should be that of **reducing the delays between sentencing and start date** that are associated with lower completion rates and reduced mental health outcomes. This brief also identifies additional factors affecting outcomes including length of intervention, severe mental health and substance misuse. Further research in this area could support the development of tailored interventions; triage processes; and maximising treatment benefits.

Overall, this brief provides the first evidence of the benefits MHTRs on female offender mental health. In line with the Female Offender Strategy, data suggests MHTRs **could provide a compelling alternative to custody for female offenders**, addressing mental health needs while reducing the detrimental effects of interacting with the Criminal Justice System on their long-term health and families.

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Bibliography: **(1)** Callender, M., Sanna, G., & Cahalin, K. (2022). Mental Health Treatment Requirement (MHTR) Northampton: IPSCJ. Evaluation–Health Outcomes (Part 1). **(2)** Callender, M., Sanna, G., & Cahalin, K. (2022). Exploring Effects of Process Delays on MHTR Outcomes (Part 2) **(3)** Callender, M., Sanna, G., & Cahalin, K. (2022). Exploring diversity across MHTR Outcomes (Part 3) **(4)** Ministry of Justice (MoJ) (2023a). Female Offender Strategy. [online] Available at: https://www.gov.uk/government/publications/female-offender-strategy. **(5)** Ministry of Justice (MoJ) (2023b). Female Offender Strategy Delivery Plan 2022 to 2025. [online] Available at: https://www.gov.uk/government/publications/female-offender-strategy-delivery-plan-2022-to-2025. **(6)** Long, C. G., Dolley, O., & Hollin, C. (2018) The use of the Mental Health Treatment Requirement (MHTR): Clinical outcomes at one year of a collaboration. Journal of Criminal Psychology. **(7)** McClellan, D.S., Farabee, D., & Crouch, B.M. (1997). Early victimisation, drug use and criminality: A comparison of male and female prisoners. Criminal Justice and Behavior, 24, 455–476. **(8)** Ministry of Justice (MoJ) (2018) Female Offender Strategy. London: HMSO. **(9)** Molyneaux, E., Vera San Juan, N., Brown, P., Lloyd-Evans, B., & Oram, S. (2021). A pilot programme to facilitate the use of mental health treatment requirements: Professional stakeholders' experiences. The British Journal of Social Work, 51(3), 1041-1059.