

Mental health outcomes for those who have offended and have been given a Mental Health Treatment Requirement as part of a Community Order in England and Wales

Matthew Callender  | Greta Arancia Sanna | Kathryn Cahalin

Institute for Public Safety, Crime and Justice,
University of Northampton, Northampton, UK

Correspondence

Matthew Callender, Institute for Public Safety,
Crime and Justice, University of Northampton,
Development Hub – Room 10, Northampton
NN1 5FS, UK.

Email: matthew.callender@northampton.ac.uk

Abstract

Background: Growing evidence of mental disorders among people going through the criminal justice system suggests the potential benefit of courts adding a Mental Health Treatment Requirement (MHTR) when sentencing an offender to a Community Order (sentence) in England and Wales. Although available since 2003, MHTRs have not been widely used, and there is little evidence on outcomes.

Aim: To conduct the first large-scale evaluation of mental health outcomes of people with an MHTR as part of their community sentence across multiple sites in England and Wales.

Methods: Data were collected from 14 sites in England and Wales about individuals who were given an MHTR as part of a community sentence. They were assessed before and after this. During the MHTR, they received a psychotherapeutic intervention by assistant psychologists in a primary care framework. Measures of psychological distress (Clinical Outcomes in Routine Evaluation—Outcome Measure), anxiety (Generalised Anxiety Disorder-7) and depression (Patient Health Questionnaire) were completed before the MHTR was implemented and after completion.

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Results: Where paired sample *t*-tests and Wilcoxon signed ranked tests were used, with samples ranging between 309 and 447 individuals, clinically significant changes were obtained for all measures. Most individuals (63%) were identified as experiencing a reliable change in at least two out of the three scales. Finally, a negative linear relationship, between measures at the start of the intervention and reliable change, was identified with higher pre-measures, indicating that more initial distress, anxiety and/or depression were associated with more sizeable changes.

Conclusions: This paper provides the first substantial evidence in support of the MHTR within a primary mental healthcare framework as an effective pathway to reduce mental health problems among individuals under probation supervision as part of a sentence after conviction for a criminal offence. This supports the expansion of the provision across England and Wales. Future research should take account of the non-completers and explore the relationship between the MHTR, mental health improvements and reoffending.

KEYWORDS

Community Order, mental health treatment requirement, offender, probation, wellbeing

1 | INTRODUCTION

The British Government has long acknowledged the disproportionate numbers of people with mental health problems being imprisoned (Home Office, 2006) and the inadequate state of mental health treatment while in custody (Duncan, 2008). Such concerns are consistent with the worldwide literature on mental disorders in prisons (e.g. Fazel et al., 2016). The need to improve mental health care for offenders, who often have poorer mental health than the general population, has been justified on the basis of three arguments: the moral case, the public health case and the economic case (Brooker et al., 2009; Sirdifield, 2012). Morally, offenders with mental health disorders should have access to the same quality of care as the general population (Brooker et al., 2009). With regard to public health, the criminal justice system should be seen as an opportunity for early mental health intervention. Finally, the economic case argues that mental healthcare for offenders has the potential to reduce crime (Home Office, 2004) and financial burden on society (Senior et al., 2020).

In response to these arguments, there have been efforts to improve mental healthcare in prisons, often overlooking, however, individuals receiving a community sentence. Brooker et al. (2012) estimate that approximately 39% of individuals in the probation population are suffering from mental illness, with anxiety disorders as the most prevalent. Their study further suggested that 48% of their sample had personality disorders and 60% had misused substances. Not only do mental disorders appear to be endemic to the probation population but there is evidence suggesting their rate is increasing (House of Commons Justice Committee, 2021).

Attempts to improve the management of offenders with mental disorder have led to the revived implementation of the Mental Health Treatment Requirement (MHTR) as one of the 13 options included in the Community Order, that is a sentence served in the community under the oversight of the Probation Service as specified in the Criminal Justice Act - 2003 (Home Office, 2003). The MHTR requires those sentenced and giving consent to the mental health component to attend for treatment under the supervision of a named clinician in the community while also serving the sentence for their offence. Mental healthcare delivery is broadly considered in three care bands—primary refers to that which might be delivered in general practice, while secondary refers to highly trained specialist input provided by mental health trusts or boards; tertiary care is even more specialist and generally delivered in hospital, so unlikely to be relevant here. Thus, primary care MHTRs may be appropriate for people who have mental disorder requiring treatment, but disorder that is not so severe as to warrant secondary care or hospitalisation under the Mental Health Act 1983/2007. Lasting up to 36 months, MHTRs may be used in conjunction with any of 13 other requirements, to tailor the order to the individual's problems. The most commonly applied in conjunction with an MHTR are Alcohol Treatment Requirements (ATRs) or Drug Rehabilitation Requirements (DRRs) and supervision by a probation officer as well as a mental health professional (Manjunath et al., 2018).

Although evidence for effectiveness has been little sought; preliminary findings such as those by Long et al. (2018) show evidence of clinically significant reductions in levels of anxiety and depression for service users engaging in programmes within the MHTR framework. Nonetheless, MHTRs remain widely underused even in the face of the growing prison and probation population (Hillier & Mews, 2018; Scott & Moffatt, 2012).

Seymour et al. (2008) suggest that the main reasons for the low uptake of MHTRs are the legislative obstacles, including the need for offender-patient consent, lack of mental health provision for offenders in the community and the difficulty in obtaining psychiatric assessment. In addition, when individuals are sentenced due to alcohol or drug requirements alongside mental health requirements, the former needs are more likely to be prioritised compared to the latter (Mair, 2011). A further reason, however, might also be related to the lack of awareness of MHTRs and dearth of evidence of the potential benefits for the individual offender or reducing community harms from offending (Khanom et al., 2009).

To address the low use of MHTRs, in 2017 five pilots were launched across England to introduce and embed a recognised pathway and provision to support the use of MHTRs (Long et al., 2018). It was anticipated that increasing availability of primary care-level MHTR services would also increase sentencing options, reducing the dependence on short-term prison sentences as well as improving access to mental health treatment for people under probation supervision (NHS England and NHS Improvement, 2022; Sentencing Council, 2020). There was some evidence of positive impact on service users who provided largely positive qualitative feedback (Molyneux et al., 2021) and service user understanding of the model (Manjunath et al., 2018). Overall, the primary care MHTR pathway was identified as likely to fill a gap in service provision for individuals with mental disorders who did not meet the threshold for secondary care services.

Our aim was to estimate the likely impact of primary healthcare MHTRs on mental health by comparing mental health ratings before implementation of the order and on completion.

2 | METHODS

2.1 | Ethics

The study was approved by three bodies: the University of Northampton's Faculty of Health, Education and Society Research Ethics Committee, Health Research Authority (IRAS project ID: 289792) and the National Research Council. At the point of assessment by the respective site, individuals provide informed consent to the service provider for anonymised information being processed for the purposes of evaluation and audit.

For ethical reasons, data underpinning this publication cannot be made openly available. Further information about the data and conditions for access are available from the Institute for Public Safety, Crime and Justice, University of Northampton, at ipscj@northampton.ac.uk.

2.2 | Study design

This study was with a complete cohort of all people receiving a community sentence with an MHTR suitable for primary healthcare intervention in the 14 sites across the country that were active during the period July 2020 to July 2022. (Callender et al., 2022). Pre- and post-intervention data were collected from participants for the purpose of assessing service user health outcomes.

2.3 | Participants

Inclusion criteria were starting an MHTR within one of the participating study sites (Callender et al., 2022) from July 2020 and completing it before July 2022. As our aim was to evaluate whether completion of a primary healthcare MHTR affects health outcomes, individuals who did not complete the intervention (26% of those who started) were excluded from analysis in this paper. Completion for the purpose of this study was defined by availability of both pre- and post-assessment ratings in at least one of the measures for the individual participant rather than necessarily completion of the order.

2.4 | Measures

Recognised rating scales were to collect data on clinical symptoms before and immediately after treatment. These measures were chosen as they are widely accepted in current literature as being reliable and valid measures of symptoms and signs of disorder and because these particular tools have previously been used in relation to those with a mental state particularly likely to relate to offending (e.g. Douglas et al., 2013).

2.4.1 | CORE-OM

The Clinical Outcomes in Routine Evaluation—Outcome Measure (CORE-OM) is a 34-item scale for providing a generic measure of psychological distress (Barkham et al., 2006). For each item, the participant is asked to read a statement and indicate how often they have felt that way in the last week (e.g. 'I have felt terribly alone or isolated'). They have five options to choose from: 'Not at all', 'Only occasionally', 'Sometimes', 'Often' and 'Most or all the time'. These are scored 0–4 with the direction of the scoring of the options being dependent on whether the statement is positive or negative.

There are four domains within the 34-item scale: well-being (4 items), problems/symptoms (12 items), life functioning (12 items) and risk (6 items), with higher scores indicating a higher level of general psychological distress. All domains within the scale were shown to have a valid internal reliability with an α of >0.75 and <0.95 (Evans et al., 2002). The score can range between 0 and 136; individuals scoring 85 points or more on the scale are considered to have severe global distress.

2.4.2 | GAD-7

The Generalised Anxiety Disorder scale (GAD-7; Spitzer et al., 2006) is a 7-item scale and for each item the participant is asked to read each statement and indicate how often they have been bothered by the 'problem' over the last 2 weeks (e.g. 'Feeling nervous and anxious or on edge'). They have four options to choose from which are 'Not at all' (0), 'Several days' (1), 'More than several days' (2) and 'Nearly every day' (3). Scores are added together to provide a

total score. Individuals scoring more than 8 points out of 21 are considered as having clinically significant symptoms of anxiety. The internal consistency (Cronbach $\alpha = 0.92$) and test-retest reliability (intraclass correlation = 0.83) of the scale are high (Spitzer et al., 2006).

2.4.3 | PHQ-9

The Patient Health Questionnaire (PHQ-9) was used to determine the level of depression (Kroenke et al., 2001). This is a nine-item questionnaire operating through a four-point scale (0–3) where higher scores indicate higher severity of depression. In accordance with previous research (Kroenke et al., 2001), scores of 20 or above are considered to indicate severe depression.

2.5 | Procedure

MHTR primary care practitioners (assistant psychologists), under supervision of local clinical leads (clinical psychologist), rated the scales for global distress, anxiety and depression with all consenting offenders at the start (first session) and end of clinical intervention (last session). The intervention was delivered in one-to-one sessions by assistant psychologists, each with an accredited degree in psychology recognised by the British Psychological Society; all work was supervised by the clinical psychologist. Up to 12 sessions were offered to complete the intervention as outlined in MHTR Clinical Lead and Primary Care Practitioner manuals (Callender, 2020). Given that the intervention was individually tailored to service users, however, the number of sessions required for completion was determined according to progress and clinical need and communicated to the probation practitioner. Sessions may include working on emotional regulation (e.g. breathing and sleep hygiene), functional analysis (e.g. home tasks) or managing thoughts (e.g. using Cognitive Behavioural Therapy; Callender, 2020). Most individuals had 12 sessions (237, 55%) with a third (136, 32%) having between 6 and 11 sessions and a minority (52, 12%) having 13 to 16 sessions. The length of time over which the intervention was delivered ranged from 42 to 490 days, with an average of 138 days per intervention. For each individual, a reliable change score was calculated for all three measures taking the difference between the pre- and post-scores.

2.6 | Analytic plan

Data were analysed using SPSS Version 28. Paired sample *t*-tests were used to examine the difference between the health scores before and after intervention. As a positive change was hypothesised, a one-tailed test with a significance level of $p < 0.05$ was accepted. Effect size was calculated using Cohen's *d* (Cohen, 1977). A Wilcoxon signed rank test was also employed to verify the consistency of outcomes through a non-parametric method (Woolson, 2007). Finally, Pearson's correlation coefficient was used to assess the linear relationship between mental health scale scores at the start of the intervention and reliable change upon completion.

3 | RESULTS

3.1 | General characteristics of the sample

Of the 504 individuals recorded as completing the intervention, 52 (12%) had incomplete or unavailable pre- and post-data and were therefore excluded from the study. Within the remaining sample of 452 service users, 303 (67%)

completed both pre- and post CORE-OM measures, 446 (99%) completed both pre- and post GAD-7 measures and 446 (99%) completed both pre- and post scores in PHQ-9.

Among the 452 people participating, 245 (54%) identified as male and 199 (44%) as female; data were missing for 8 (2%) participants. Ages ranged between 18 and 65 years, with the average age being 37 years of age. Ethnicity was not recorded for 39 (9%) of the sample; for the rest, 369 (82%) described themselves as White, 11 (2%) as from a 'mixed' ethnic background, 20 (4%) as Asian, 10 (2%) as Black and 3 (1%) from 'other' ethnic backgrounds. The data were found to be consistent across all 14 sites with univariate analyses of gender, age and ethnicity showing no variation with regard to mental health outcomes. Given the tendency towards homogeneity of the sample in terms of ethnicity, it is recommended that this relationship be further explored in the future.

The most common primary offence types were 'violence against the person' (138, 31%), followed by 'motoring offences' (95, 21%), 'sexual offences' (26, 6%) and 'drug offences' (25, 6%). Of those who completed the treatment, 389 (86%) were sentenced with only one health requirement—the MHTR—while 38 (8%) were sentenced to an MHTR and an ATR and 13 (3%) were sentenced to an MHTR and a DRR. For 12 (3%) individuals, this information was not specified. Regrettably, the low percentage of individuals engaged in dual orders does not allow for a comparison between single and dual health requirements, and it is recommended that this variation in the programme be analysed more in depth in future. The mean number of days between assessment and sentence was 26; however, the range was between 0 and 380, suggesting high variation in the delays before individuals receive treatment.

3.2 | Mental state change

3.2.1 | General distress—CORE-OM scores

At the start of the intervention, 188 (60%) of the sample participants self-reported moderate, moderate-to-severe or severe psychological distress. The mean CORE-OM score was 57.67 (SD = 26.00), which is classified as moderate distress.

Reliable scale score change is change that exceeds that which might be expected by chance alone or measurement error, and the CORE-OM is represented by a change of 5 or more in the clinical score (Evans et al., 2002). In the sample of 308 treatment completers who were assessed using CORE-OM, 239 (77%) saw reliable positive pre- to post-intervention change on the CORE-OM in these terms. Thirty-six (12%) showed no reliable change and 33 (10%) deteriorated as indicated by a greater than 5-point reduction in total score. Following the treatment, 231 (75%) users were considered healthy in these terms or had only mild or low levels of general distress. The mean level of CORE-OM dropped to 33.67 (SD = 24.36), which is classified as low-level distress.

Table 1 confirms the significant reduction in global distress (CORE-OM) for individuals who completed the treatment ($t = 16.895$, $p < 0.001$ and Cohen's $d = 0.95$). A Wilcoxon signed rank provided further evidence of statistical significance ($Z = -12.790$, $p < 0.001$, $R = -0.728$). This would be considered a medium to large effect size (Rosnow et al., 2000).

3.2.2 | Anxiety change: GAD-7 score analysis

At the start of the intervention, 308 (69%) individuals were identified as having moderate or severe anxiety. The mean GAD-7 score was 12.80 (SD = 5.69), which equates to moderate anxiety.

According to Spitzer et al. (2006), a reliable change in pre- and post GAD-7 scores is represented by a 4 or more point change in scores. In the sample of 446, 260 (58%) of those completing the treatment had a positive reliable change, seeing a 4 or more point reduction in their pre- to post-treatment GAD-7 score (Bischoff et al., 2020). For 168 (38%) participants, there was no reliable change (i.e. change between -3 and $+3$), whilst the remaining 18 (4%)

TABLE 1 Symptom scale scores for treatment completers before and immediately after completion of treatment.

Assessment	N	Mean (SD) pre-intervention	Mean (SD) after intervention	Statistical value (pre-post comparison) paired sample t-test and Wilcoxon signed ranked test	Positive reliable change (%)
Global distress (CORE-OM)	309	57.67	33.67	$t = 16.893 (df308) p < 0.001$ effect size (Cohen's $d = 0.953$) $Z = -12.790, p < 0.001, R = -0.728$	77.6
Anxiety (GAD-7)	447	12.8	7.24	$t = 19.194(df446) p < 0.001$ effect size (Cohen's $d = 0.972$) $Z = -14.888, p < 0.001, R = -0.704$	58.30
Depression (PHQ-9)	446	14.84	8.11	$t = 20.735 (df445) p < 0.001$ effect size (Cohen's $d = 1.025$) $Z = -15.366, p < 0.001, R = -0.728$	54.70

Abbreviations: CORE-OM, Clinical Outcomes in Routine Evaluation—Outcome Measure; GAD-7, Generalised Anxiety Disorder-7; PHQ-9, Patient Health Questionnaire.

saw a reliable worsening (4+). At the end of the treatment, the mean GAD-7 score had fallen to 7.24 (SD = 5.82), which equates to mild anxiety.

Table 1 also shows further analyses of the anxiety scale scores, confirming a significant reduction in anxiety ($t = 19.194, p < 0.001$, Cohen's $d = 0.97$) ($Z = -14.888, p < 0.001, R = -0.704$). Following treatment, 298 (67%) of these service users had mild anxiety or none.

3.2.3 | Depression scale score change: PHQ-9 analysis

At the start of the intervention, the mean PHQ-9 score was 14.84, indicating moderate depression, with 345 (77%) individuals having moderate, moderate-to-severe or severe depression.

McMillan et al. (2010) defines a score of 6 or more as a reliable change in the PHQ-9 assessment. In the sample of 446, 244 (55%) participants saw a six or more point reduction in the PHQ-9 score, therefore achieving a positive reliable change. For 191 (42%) participants, there was no reliable change (i.e. change was between -5 and +5), whilst the remaining 11 (2%) saw a reliable worsening (i.e. 6+). Those who saw a worsening in the PHQ-9, thus constituted a tiny minority. At the end of the treatment, the mean PHQ-9 score had fallen to 8.11 (SD = 6.56) indicating mild depression.

Further analyses again confirmed that the mean reduction was significant ($t = 20.735, p < 0.001$, Cohen's $d = 1.03$) ($Z = -15.366, p < 0.001, R = -0.728$). After the intervention, 286 (64%) service users had mild depression or none detectable at all.

3.3 | Reliable change across three measures

Table 2 shows that, of the individuals who completed all three measures (303), 123 (41%) had indicated reliable change on all three measures; 67 individuals (22%) had reported reliable change on two measures and 48 (16%) participants had no positive change in any of the categories. Among the 48 participants without positive change, 26 (54%) had a negative reliable change in CORE-OM, 5 (10%) had a negative reliable change in GAD-7 and 5 (10%) had a negative reliable change in PHQ-9.

3.4 | Reliable change as a dependent measure of start of intervention values

A Pearson correlation coefficient (Sedgwick, 2012) was computed to assess the linear relationship between the level of general distress at the start of the intervention (CORE-OM) and CORE-OM reliable change. There was a significant

TABLE 2 Reliable change across measures of psychological distress, anxiety and depression.

	Frequency	Percentage
No reliable change	48	16%
Reliable change in one measure	65	21%
Reliable change in two measures	67	22%
Reliable change in all measures	123	41%

negative correlation between these two variables ($r(307) = -0.544, p < 0.001$). This suggests that higher levels of global distress at the start of the intervention will lead to higher reliable change values at the end of the intervention.

This relationship was also tested for levels of anxiety at the start of the intervention and GAD-7 reliable change with similar results ($r(445) = -0.520, p < 0.001$).

Finally, a Pearson's correlation coefficient was also computed to assess the linear relationship between levels of depression at the start of the intervention (PHQ-9) and PHQ-9 reliable change. This too was significant ($r(444) = -0.522, p < 0.001$).

These outcomes suggest that the primary healthcare intervention required is likely to have maximum impact when self-rated anxiety, depression and general distress are high at the start of the intervention.

4 | DISCUSSION

Our findings with respect to mental health outcomes among intervention completers during the first 2 years of the new primary healthcare MHTR programme are promising. With consistency across all 14 sites, then operative, self-rated anxiety, depression and general distress improved significantly; few participants were unchanged and very few apparently deteriorated.

Our findings build on previous literature that has shown that MHTRs are acceptable to and understood by the clientele (Manjunath et al., 2018) and professional staff (Molyneaux et al., 2021) alike and with significant potential in reducing reoffending (Hillier & Mews, 2018). It also adds substantially to the findings from a very similar study completed on a single site (Long et al., 2018). The significance of the results in this study are also instrumental to the wider concern of meeting the mental health needs of individuals under probation supervision. It offers hope that the aspirations for improving mental health (Brooker et al., 2009; Home Office, 2004) can be fulfilled. In this vein, the revitalised MHTR pathway represents a promising development that could transform criminal justice by improving mental health among community living offenders, with the potential for reducing recidivism and thus improving public safety and reducing the costs of crime.

4.1 | Limitations

Inevitably, our study has some limitations. There was no control group that did not receive the MHTR and little is known about the natural course of anxiety, depression and distress after a criminal conviction resulting in a community sentence. At the time of setting up the study and seeking ethics approval, it was not deemed possible to have a comparable control group that was denied an MHTR and untreated. Namely, a control group would deny individuals a pathway that could alleviate their identified mental health needs. It may be that this should be reconsidered or, at least, comparable mental state measures made with people convicted of similar offences and under community sentences but without an MHTR. A further limitation was that we did not include those people who did not complete their MHTR—a quarter of all those given the requirement. Concerns about non-completers in criminal justice programmes faring worse than those who never started are well documented (e.g. McIntosh et al., 2019), so future research should take account of this.

The study is the first stage of an ongoing investigation, and as the research progresses, these limitations will be analysed using additional data.

5 | CONCLUSION

This study is part of the first stage of evaluation of a developing nationwide programme to facilitate use of a hitherto rarely used requirement as part of a community sentence and offers the first large-scale evidence base for the effectiveness of MHTRs for improving health outcomes of offenders with mental disorders likely to be treatable in primary care and given a community sentence. We found significant positive change for most people who completed the intervention. This study, therefore, provides support for the continued expansion of MHTR provision nationally. Future research should add evaluation of those who do not complete the treatment requirements and consider those with more serious disorders who need secondary mental healthcare interventions.

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CONFLICT OF INTEREST STATEMENT

There are no conflicts of interest to declare.

DATA AVAILABILITY STATEMENT

Due to ethical/commercial issues, data underpinning this publication cannot be made openly available. Further information about the data and conditions for access are available from the Institute for Public Safety, Crime and Justice, University of Northampton, at ipsjc@northampton.ac.uk.

ETHICS STATEMENT

The study was approved ethically by the University of Northampton's Faculty of Health, Education and Society Research Ethics Committee, Health Research Authority (IRAS project ID: 289792) and the National Research Council.

INFORMED CONSENT

At the point of assessment by the respective site, individuals provide informed consent to the service provider for anonymised information being processed for the purposes of evaluation and audit.

ORCID

Matthew Callender  <https://orcid.org/0000-0003-1843-2234>

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