INCREASING THE UPTAKE OF MENTAL HEALTH TREATMENT REQUIREMENTS:

CLINICAL OUTCOMES AT ONE YEAR OF A COLLABORATION BETWEEN PROBATION AND INDEPENDENT CHARITABLE PROVIDERS OF MENTAL HEALTH AND SOCIAL CARE

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EXECUTIVE SUMMARY

1. INTRODUCTION

1.1. Whilst research suggests a prevalence of mental illness of 39% for offenders under community supervision by the Probation Service, there are numerous obstacles to them accessing appropriate care and treatment.

1.2. One initiative designed to address this issue, the Mental Health Treatment (MHTR) Order has been little used.

1.3. A one year demonstrator site was established to provide an MHTR Service and to assess the effectiveness of a partnering between Thames Valley Probation, the Link Worker Charity P3 and St Andrew’s Healthcare, a charitable trust provider of mental health care.

2. THE PROJECT

2.1. An enhanced offender pathway was developed to include a rapid response MHTR Service. In an integrated service offenders supervised by probation/CRC receive both link worker support and time limited psychological treatment following an MHTR.

3. EVALUATION METHODOLOGY

3.1. Design: a single cohort pre-post follow up design was used to evaluate change in the first 12 months of the project. Mental health treatment interventions commenced as soon as feasible following sentence and often overlapped with both P3 social adjustment and offender manager input. Treatment was delivered by two psychology graduates with relevant work experience who were trained in short term (12 sessions) structured, cognitive behavioural (CBT) interventions. Supervision was provided by qualified clinical/forensic psychologists.

3.2. Interventions:
   i. A series of one hour training sessions was provided for magistrates regarding the use of the MHTR and the new service with a view to increasing the number of orders granted
   ii. Psychological interventions were adapted from two treatment manuals (Dealing With Feelings and Social Problem Solving) developed and evaluated for patients with mental health problems and offending histories.

3.3. Assessments: covered MHTR referral patterns, treatment compliance and integrity, and mental health screening (psychological distress and personality disorder). Pre-post and 2 and 6 month follow up assessments addressed symptomology (IAPT measures of depression and anxiety); coping skills (dealing with feelings; social problem solving; self-efficacy) social adjustment; criminal justice outcomes (OASys
predicted reoffending); and stakeholder (offenders, probation and magistrates) views of the MHTR Service.

4. RESULTS

4.1. Referral patterns (April 2014-March 2015): of 234 offenders managed by the Probation Service who attended Milton Keynes Magistrates Courts; 129 (55%) were assessed as having a clinically significant level of psychological distress. One hundred and eight offenders were recommended for an MHTR. Of these 32 were not given an MHTR mostly because they were given either a Drug or Alcohol Treatment Order (19) or because they were given a custodial sentence (11). The 76 MHTR orders given represent a highly significant increase compared with previous years and there was a significant reduction in psychiatric assessments.

4.2. Participants (42 males/14 females) were mostly young, unemployed with problems associated with low mood, emotional dysregulation and relationship. Nearly half were on antidepressant medication. The majority scored above the cut off for possible personality disorder and had self-reported problems with alcohol and other drugs. Despite this very few were on either a Drug (4) or an Alcohol (4) Treatment order. Participants were estimated to have a medium risk of reoffending within two years.

4.3. Treatment engagement. Twenty (of 76) disengaged from treatment. There were 5 breaches of the MHTR order. Treatment ‘drop outs’ were more to likely to have problems with Class A drugs (particularly heroin).

4.4. Treatment completers (pre-post follow up)
   i. Symptomology: clinically significant changes on measures of depression and anxiety were maintained at follow up. Using the IAPT recovery formula 85% were classified as recovered.
   ii. Coping skills: clinically significant changes in social problem solving, emotional regulation skills and self-efficacy were maintained at follow up.
   iii. Social adjustment: clinically significant changes were evident on measures of work and social adjustment and on 7 of the 10 Outcome Star for Homelessness points.
   iv. Pre-post ratings of dynamic criminogenic risk factors show that only drug misuse remained above the measures cut off points.
   v. Stakeholder views: offenders expressed a high level of satisfaction with MHTR treatment and with the P3 link work service.

4.5. Probation/CRC staff rated the MHTR Service positively noting the services co-location as key to the good interagency communication in addition to client offenders feeling empowered by the acquisition of coping skills to alleviate psychological distress. Magistrates rated MHTR training sections as informative and likely to influence future sentencing practice.
4.6. In terms of healthcare utilisation 80% of treatment completers attended general practitioners while 4% attended local community Mental Health Teams. Forty per cent were taking antidepressant medication.

5. **DISCUSSION**

5.1. This collaboration between criminal justice and mental health systems has led to a significant increase in the use of MHTR and a corresponding decrease in time consuming psychiatric assessments that do not facilitate rapid treatment.

5.2. The implementation of evidence based transdiagnostic psychological therapies within a probation/link worker service has resulted in an IAPT defined recovery rate of 85% on measures of depression and anxiety in a group of patients who were both co-morbid (for personality disorder) and dual diagnosis (for substance misuse). This contrasts with IAPT recovery rates of 46%.

5.3. Symptom reduction was complemented by a corresponding improvement in coping skills and social adjustment. This was reflected in service users satisfaction ratings of the MHTR Service (in terms of ability to manage emotions and deal with problems and in confidence to use skills taught).

5.4. A lack of self-rated and probation staff rated improvement in the area of drug misuse is reflective of the fact that the majority of those with drug problems were not receiving interventions to help them desist. Further the majority of treatment drop outs were problematic users of Class A drugs particularly heroin.

5.5. The formal breach rate in the current sample of 10% is significantly lower than rates in past studies of non-custodial sentences. That a further 21% disengaged for reasons of lack of motivation given multi-agency involvement and the adoption of the principle features of collaborative care highlights the need for further work in this area.

6. **LIMITATIONS**

6.1. Findings need to be considered in terms of the limitations of uncontrolled clinical interventions conducted in routine clinical settings.

6.2. It is not possible, given the concurrent input for treatment completors from P3 and probation, to unequivocally ascribe psychological change to treatments described.
7. IMPLICATIONS

7.1. The efficiency of the MHTR Service can be improved by addressing issues of selection, lack of treatment attendance for ‘indeterminate’ reasons, and treatment engagement. One such initiative involves ensuring that offenders have a thorough understanding of the service they are agreeing to take up.

7.2. For reasons of appropriate treatment sequencing and MHTR engagement it is recommended that dual diagnosis offenders undertake Drug/Alcohol Orders prior to, or concurrent with psychological treatment.

7.3. There is a need for large sample controlled treatment trials to confirm and extend current clinical outcomes.

7.4. This initiative has addressed the moral argument of equality of access to mental health services for offenders given a community order. The economic argument for the extended use of the MHTR in terms of a reduction in re-offending rates has yet to be made. This will be the subject of a further report.
INTRODUCTION

In England and Wales the option of incorporating mental health as part of a community sentence for offenders was originally introduced as a ‘psychiatric treatment condition’ (Criminal Justice 1948). It was subsequently replaced by the ‘Community Rehabilitation Order with a requirement for psychiatric treatment’ in 2001 and with the current Mental Health Treatment Requirement (MHTR) in 2005. The MHTR consists of 12 community orders that are designed to address the offenders criminogenic needs that are linked to the perceived risk of offending.

There is a paucity on research on the prevalence of mental illness in those presenting in courts (Bradley 2009) and offenders on probation in the UK (Sirdifield 2012). However mental disorders are highly prevalent among those under community supervisions by the probation service (Mair and May 1997) and a prevalence study by Brooker et al (2012) in one probation trust in England found that 39% of offenders are likely to experience a mental illness whilst on probation with half of that population having a past or lifetime disorder. In addition there was a high prevalence of co-morbidity (a mental illness and a personality disorder) and of dual diagnosis (a mental illness and substance misuse). The most common group of disorders are those related to anxiety (27%) and to mood disorders such as depression (18%). These findings echoed those of one of the most comprehensive USA studies of the mental health of people on probation (Lurigio et al 2003). Of those with a current mental illness, 72.3% had an alcohol or drug problem and 89.4% had a probable personality disorder (Brooker et al 2012). The profile of the Brooker et al (2012) probation sample therefore more closely resembles that of the prison population than that of the general population (Singleton et al 2001). Antisocial personality disorder has been documented in up to two-thirds of prisoners (Singleton et al 1998) and is particularly associated with increased rates of unemployment, homelessness, relationship difficulties, substance use recidivism (Khalifa et al 2010) and treatment non completion (McMurran et al 2010). Borderline personality disorder (BPD), more often associated with female offenders, is also associated with high rates of substance abuse (Chapman and Cellucci 2007). Offenders with serious mental illness are twice as likely to fail in community supervision (Skeem and Louden 2006). In a study of an unmatched USA sample of 613 probationers followed for three years Dauphinot (1996) found that probationers with mental illness were significantly more likely to have probation revoked that those without (37% compared with 24%).

Findings in the prison population attest to the complexity of clinical presentations among those with the co-occurrence of mental illness with substance abuse and personality disorder (Sirdifield et al 2009). Such offenders with mental health difficulties receiving community supervision are frequently failed by services that are not geared towards the needs of this population (Skeem and Louden 2006). Like other criminal justice institutions, the probation service was not designed to meet the unique challenge of individuals with mental illness (Skeem et al 2006). This, in addition the excessive number of treatment non-completers (66.5%) in HM Probation Services Pathfinders initiative (designed to address criminogenic needs of cognitions, basic skills, resettlement and so forth), may account for the negligible affects \( r= 0.03 \) of the initiative (Correctional Services Accreditation Panel 2004; Hollin et al 2004). In the USA a growing body of literature suggests that speciality agencies (where offenders with mental illness are assigned to probation officers with some mental health training and relatively small caseloads) hold promise for improving clinical and criminal outcomes for probationers with mental illness (Skeem and Louden 2006). In the UK the employment of mental health workers by the probation service has shown promise (Cohen et al 1999). Mentally disordered offenders however, are not deemed a serious enough problem to warrant intervention by forensic psychiatric services but their needs are deemed too complex by mainstream community care services (Vaughan & Stevenson 2002). This despite their clear vulnerability given a high incidence of substance abuse, personality disorder and history of suicidal behaviour (Vaughan & Stevenson 2002). The co-
morbidity problem is one of many that provide an obstacle to accessing treatment services such as Improving Access to Psychological Therapies (IAPT) where only half of referrals actually receive treatment (Richards and Borglin 2011). Offenders on probation in addition, find it difficult to engage for reasons that include concern around stigmatisation, disenchantment with mental health services (Vaughan and Stevenson 2002) and problems in forming a therapeutic relationship that are reflective of personality disorder (Pluck et al 2011) and chaotic lifestyles that reflect social care needs.

Despite the above there has been an under use of MHTR, (Khanom et al 2009), such that these constitute less than 1% of requirements made as part of community orders (Scott and Moffatt 2012). Indeed 'The Bradley Report five years on' noted a decline in the use of the MHTR service since 2009 (Durcan et al 2014). A recent survey of the seven years from 2008 to 2014 also noted a decrease in the overall number of Community orders issues although the proportion of MHTR orders had remained constant (Rajput et al 2015).

While the link between mental illness and reoffending is controversial (Morrissey et al 2009), one American study found recidivism rates for offenders with mental illness to be nearly twice as great as those for the general prison population (Baillargeon et al 2009). Given the belief that wider use of MHTRs will improve (mental) health outcomes, improve/reduce reoffending and reduce the cost of crime (Scott and Moffatt 2012), it is important to address and overcome the perceived barriers to the use of MHTRs for offenders on probation.

These include:

- The belief that there is no suitable treatment available and that offenders would be better treated in primary care (Khanom et al 2009).
- A failure by criminal justice staff to identify those who might benefit from MHTR because of inadequate mental awareness training (Bradley 2009).
- Lack of awareness about MHTRs among healthcare staff.
- Reluctance among criminal justice staff to address offenders’ mental health needs and lack of awareness of local health services among court staff.
- The lack of formal service level agreement, between mental health and criminal justice services (Hean et al 2009).
- The lack of service provision for those with dual diagnosis.
- Restrictive criteria for accessing psychological treatment and long waiting lists.

To address this issue a demonstrator project initiative was established in April 2014 to evaluate the effectiveness of an integrated mental health and criminal justice initiative. This project is a joint venture between Thames Valley Probation Service, the charity People Potential Possibilities (P3) that provides social, educational, vocational and practical support for offenders and St Andrew’s Healthcare (a Charitable Trust and Independent provider of mental health care).

This clinical service evaluation has addressed the following questions:

(i) Has criminal justice staff education provision led to increased use of MHTR?
(ii) Has MHTR decreased psychological distress, improved coping and work/social adjustment?
(iii) Has the MHTR reduced (probation) estimated risks of reoffending at two years post intervention?
(iv) For what type of offender is MHTR most effective?
(v) What are the characteristics of offenders who derive most/least benefit from MHTR?
THE PROJECT

The establishment and assessment of a new service provision in relation to the MHTR was developed through a partnership between Thames Valley Probation Service, St Andrew’s Healthcare and P3. Other groups involved included court workers (clerks, bench chairs, and magistrates), Police Offender Health/Liaison and Diversion Team, the local Health Trusts, Housing Support agencies, Clinical Commissioning Groups and faith organisations.

At the point of project initiation the work of the Probation Service serving a population of 280,000 was augmented by P3 court-link services that provided psychosocial interventions across reducing reoffending pathways; housing, education, employment and training, family and relationships, finance, benefit and debt, physical health, substance misuse and attitudes and behaviours.

To further develop the service and the use of MHTR, a rapid response mental health assessment and treatment programme was developed and delivered by St Andrew’s Healthcare. This innovative approach was to ensure speedy diversion into effective mental health treatments; to concurrently address re-offending, mental health and social care issues; to support equal access to mental health service provision and to include those with concurrent substance abuse problems. A secondary aim was via education and training to raise awareness of the mental health issues of offenders, MHTR and the new service among lawyers, magistrates, police officers and probation officers.

Funding for a one-year demonstration site was given by NHS England.

An enhanced offender pathway was developed to include the rapid response assessment and treatment of mental health problems. In this system offenders supervised by probation services may also receive P3 input and/or help with mental health problems (St Andrew’s). Referrals, the majority based on cases opened by probation officers, can be made to the P3 Probation Court Link Worker Service who offer a home visit and assess the need for interventions that include housing, finance and benefit, relationships, substance misuse, attitudes and behaviour.

An initial assessment is completed at court by P3 and probation officers who produce a response for the judiciary to help determine the best sentencing option. In the new working model the P3 assessments include the administration of a screening tool to assess for mental health problems [the Kessler 10, Kessler et al (2002) a measure of psychological distress]. Offenders scoring above the cut off for a clinically significant level of distress are then assessed by mental healthcare staff, using interview and further psychometric baseline measures in order to provide the psychological report required to support a MHTR recommendation. Such assessments make recommendations regarding the psychological treatment interventions and, or the need for, psychiatric screening, psychotropic medication or onward referral to the community mental health service. This enhanced offender journey is described in Figure 1.
In an integrated service, offenders supervised by Probation can receive link worker input from P3 alone or from St Andrew's Healthcare and P3. P3 caters for offenders over 18 years of age who have difficulty engaging with other services, have a chaotic lifestyle with poor coping skills, present with complex/multiple needs (drug use, alcohol, accommodation) who feel depressed, withdrawn or confused and who are ready to receive help. Link worker intervention offered provides the practical and psychosocial support necessary to ensure that the best use is made of any psychological treatment offered. All three services (Probation; St Andrew’s Healthcare and P3) were co-located in the probation service offices.
METHODOLOGY

PARTICIPANTS

Participants are those assessed as having mental health needs and who have been given a MHTR.

DESIGN

A single cohort pre-post follow up design was used to evaluate change in the following domains:

- Mental health and wellbeing
- Coping skills
- Social adjustment
- Criminal justice outcomes

Mental health treatment interventions commenced as soon as feasible following sentence and often overlapped with P3 social adjustment input. These were delivered by two psychology graduates who had relevant work experience and who were trained in short term, structured, cognitive behavioural (CBT) interventions. Supervision was provided by a qualified clinical/forensic psychologist.

Mental health outcome data was collected and scored by the two therapists. An external consultant commissioned to provide independence of evaluation will assess clinical and criminal justice data (including satisfaction data; magistrates’ use of MHTR before and after intervention), health utilisation patterns by offenders; determine the extent to which involvement in the pilot negates referral to another statutory organisation; assess treatment fidelity and statistically analyse all data gathered and use this information to address defined service evaluation questions.

INTERVENTIONS

A. Training of Judiciary

A series of one-hour training sessions were provided for Magistrates serving the Milton Keynes court. Training was undertaken by one of the Project Leaders who was also a Magistrate: it covered the eligibility criteria for MHTR; signs and symptoms to look for to help identify offenders suitable for MHTR; what factors need to be in place for the court to recommend an MHTR; how breaches of a MHTR can be managed; which local organisations can offer mental health assessments, advice and treatment locally; and what the MHTR demonstrator project can offer offenders with mental health issues. The aim of the training was to raise awareness of the MHTR among Magistrates serving the projects catchment area and to increase the number of MHTR and given to those who might benefit.

B. Psychological Intervention

Within the demonstrator site model the delivery of psychological assessment and treatment service was undertaken by two assistant psychologists following training in psychometric test administration and treatment interventions. Assistant psychologists based within the Probation Service building are supervised by qualified psychologists working in forensic psychiatric settings.
Assessment of the offender’s mental health issues used a semi-structured interview that is both motivational and fact-finding. The interview captures a range of data including mental health and forensic history, current involvement in treatment, use of medication, and life problems. Psychometric assessments screen for psychological distress, personality disorder, depression, anxiety, self-efficacy and social adjustment. Interviews and psychometric test data determine the appropriate psychological interventions, which could include a recommendation regarding assessment for medication or psychiatric screening.

Treatment interventions delivered were dictated by the following considerations:

1. The nature of the offending client whose mental health problems encompass in the main personality disorder, depression and anxiety (Brooker et al 2012).
2. The need for evidence based interventions of proven effectiveness with forensic psychiatric populations.
3. The need for a manualised CBT approach to help ensure treatment integrity, consistency of application and delivery by a wide range of treatment personnel.
4. A transdiagnostic approach (Barlow et al 2011) aimed to developing and enhancing coping skills relevant to a wide range of psychological problems. This approach formulates deficits in emotional regulation as key maintainers of anxiety and depression (Barlow et al 2011).
5. The provision of interventions that is comprehensible by the majority of adults including those of borderline intelligence.
6. The need, especially for offending populations, for psychological interventions to involve motivational and therapeutic alliance building strategies (Costanguary et al 2010).

Following assessment, decisions were made about the type and duration of treatment. The treatment intervention offered was structured, short term skills training to promote behaviour change. Training accordingly focused on managing emotions and social problem solving. Individual treatment was adapted from treatment manuals developed and evaluated for patients with mental health problems and offending histories:

(i) Dealing with Feelings (Long et al 2011)
   Sessions cover distress tolerance, emotional regulation and reducing emotional vulnerability. Individuals also develop individual relapse prevention plans based on what they have found helpful. It is adapted from dialectical behaviour therapy skills training (Linehan 1993).

(ii) Social Problem Solving (Long et al 2011)
   This treatment is adapted from the five step problem solving training manual (Nezu et al 2007) and from the ‘Stop and Think’ problem solving therapy for personality disordered offenders (McMurran et al 1999).

Clients were offered up to 12 sessions of either Dealing with Feelings or Social Problem Solving, or in some instances, both therapies. Those who failed to attend two consecutive agreed appointments were regarded as having breached their MHTR. Every effort was made to avoid this by maintaining phone contact with the client and by helping to remove obstacles to attendance. In working in an informed way with probation and providers of social care the psychological treatment service adopted many of the principle features of collaborative care (Katon et al 1999; 2011) including telephone case management to improve treatment engagement, compliance and outcomes (Gilbody et al 2006).
ASSESSMENTS

A. Demographics

- Demographic data was collected from probation services and P3 files and self-report prior to commencement of treatment. This included: age/gender/employment history/forensic history (number and category of previous convictions); marital status, dependents and children; social support in community (family Y/N); previous psychiatric mental health and treatment history; previous MHTR; whether diagnosed with Autism Spectrum Disorder (ASD) or Learning Disability (LD); use of psychotropic medication (anxiolytics, antidepressants, antipsychotics); substance abuse history (alcohol/other drugs). Data collected mirrored that collected by the Liaison and Diversion Service.

B. Analysis of Referral Pattern

- No. of MHTRs April 2013 – March 2014 and April 2014 – March 2015
- No. K10s completed by P3
- No. of referrals who met K10 criteria for assessment
- No. mental health assessments
- No. MHTR order recommendations and orders
- No. not met K10 threshold
- No. MHTR refused by Bench
- No. MHTR refused by offender
- Breach rate of MHTR group
- No. referred to Commissioning Mental Health Team (CMHT) (April 2014 to March 2015) and to other helping agencies
- No. of clients seen by P3 (no MHTR)
- No. of clients seen by P3 (with MHTR)

C. Treatment Compliance and Integrity

- Records were kept of sessions prescribed (number) and attended. Treatment completion was defined as attendance at two thirds or more of prescribed sessions (Long et al 2014). Reasons for non-completion were recorded.
- Concomitant referrals to/attendance at other accredited programmes (drug rehabilitation or alcohol treatment) during study and at follow up.
- Onward referral by therapist/other (e.g. P3) to General Practitioner or other services along with attendance and outcome (e.g. antidepressant medication prescribed).
- Treatment integrity was assessed by an ad hoc purpose made measure to record adherence to manualised treatment sessions in terms of content and procedure (Long et al 2011). The agreed method of integrity audit and monitoring was unannounced random ‘sitting in’ on sessions (with client agreement) by supervising staff familiar with manual content. Specific recording sheets noted the extent of adherence to the treatment manual and session guides. Observation of selected sessions and case note recordings to be used.

D. Mental Health Screening (pre)

- Kessler Psychological Distress scale (K10; Kessler et al 2002). This global measure of distress produces scores ranging from 10 to 50. Scores of 20 and
above are likely to indicate a mental disorder. Those scoring 20 or above to be referred on for possible recommendation for MHTR.

- Standardised Assessment of Personality – Abbreviated Scale (SAPAS; Pluck et al 2012). This 6 item scale developed for use with probationers will assess for personality disorder.

E. Symptomology (pre-post 2 month and 6 month follow up)

- Patient Health Questionnaire (PHQ-9; Kroenke et al 2001)
  The PHQ-9 was developed and validated as a measure of depression. There are 9 items which are scored 0 to 3 providing a 0 to 27 severity score. Depression severity is ranked as minimal (0 - 4), mild (5 – 9), moderate (10 – 14), moderately severe (15 – 19) and severe (20 – 27), a score of 10 or above is optimum for identifying depressive symptoms likely to be of clinical severity (Gilbody et al 2007; Kroenke et al 2001). The PHQ-9 has good internal consistency with outpatient alcohol and drug abusers and is recommended for use with individuals with substance abuse disorders (Dum et al 2008).

- Generalised Anxiety Disorder 7 (GAD-7; Spitzer et al 2006)
  This 7 item scale is scored 0 – 3 providing a 0 – 27 severity score. The GAD-7 has good psychometric properties with a score of 8 being optimum for identifying symptoms of general anxiety disorder, panic disorder, post-traumatic stress disorder or social anxiety disorder (Kroenke et al 2007).

F. Coping Skills

- Dealing with Feelings Questionnaire (DWFQ; Long et al 2013) (pre-post and 2 and 6 month follow up). The DWFQ is a 4 item self-report measure that covers the ability to (a) tolerate emotional distress, (b) engage in activities to reduce negative mood, (c) engage in pleasant activities on a daily basis and (d) to recognise changes in mood.

- Social Problem Solving Inventory – Revised (SPSI-R:S; D’Zurilla et al 2002) (pre-post, 2 and 6 month follow up). This 25 item self-report questionnaire has 5 subscales: Positive Problem Orientation (PPO), Negative Problem Orientation (NPO), Rational Problem Solving (RPS), Impulsivity/Carelessness Style (ICS) and Avoidance Scale (AS). Subscales scores combine to give a total Social Problem Solving score. Constructive problem solving is indicated by higher scores on NPO, ICS and AS. Information of reliability and validity is documented by D’Zurilla et al (2002). The measure has been widely used in assessing the treatment outcomes in personality-disordered offenders (McMurran et al 2005).

- Generalised Self-Efficacy Scale, GSES; (GSES; Jerusalem and Schwarzer 1992) (pre-post, 2 and 6 month follow up). The GSES is a 10 item self-administered scale that assesses the strengths of an individual’s belief in his or her own ability to respond to difficult situations and to deal with any associated obstacles or setbacks. Test and re-test reliability was found to be 0.63 and in terms of predictive validity the measure correlated positively with self-esteem (0.40) and optimism (Schwarzer 1993).

G. Social Adjustment (pre; post and 2 and 6 month follow up)

- Work and Social Adjustment Scale (WSAS; Mundt et al 2002). The WSAS is a reliable and valid measure of self-reported functional impairment. Five items cover the effect of an individual’s psychological disorder on their ability to work,
on home management, social and private leisure activities and to form and maintain close relationships.

- **Outcome Star for Homelessness (OSH) ([http://www.outcomesstar.org.uk](http://www.outcomesstar.org.uk))**
  The OSH developed in 2006 is one of a family of tools designed to promote and measure client change on a 10 point rating 'star point' that tracks a journey of change from 'stuck' to self-reliance in ten areas:

  1. Motivation and taking responsibility
  2. Self-care and living skills
  3. Managing money and personal administration
  4. Social networks and relationships
  5. Drug and alcohol misuse
  6. Physical health
  7. Emotional and mental health
  8. Meaningful use of time
  9. Managing tenancy and accommodation
  10. Offending

The measure is completed collaboratively by P3 staff with the client according to the attitudes and behaviours expected at each of the points on each scale. A pilot study (AnyBodyCan Limited, 2008) of 3 UK facilities involving 33 participants showed a mean score on admission of 5.9 with a mean improvement score of 1.9 resulting in an overall mean of 7.8.

**H. Criminal Justice Outcomes**

Measures cover predicted reoffending using the following

- **Offender Assessment System (OASys)**
  OASys have been used by Her Majesty's Prison Service and the National Probation Service since 2002 to measure the risks and needs of criminal offenders under supervision. Rating by probation officers address 3 separate risks.

  a) **Offender Group Reconviction scale version 3 (OGRs 3)** is a standardised actuarial risk assessment tool that is used to predict re-offending. Static factors (e.g. age at first offence, nature and frequency of offending, number of custodial sentences etc.) are used to predict the percentage likelihood of the offender reoffending within a 12 or 24 month period.

  b) **General Gravity Predictor (GGP)**. This assessment consists of factors that provide a static, a dynamic and a total score. Dynamic factors include accommodation, education, emotional wellbeing, drug and/or alcohol use, lifestyle, relationships, thinking and behaviour and attitudes. Each dynamic factor has a different ‘cut off’ score.

  c) **Violence Predictor (OVP)**. This is a clinical assessment based on the knowledge and experience of the assessor. It refers to harm that is difficult or impossible to recover from.

  OSAys assessments are made at the start and end of the probation period.

**I. Stakeholders View of MHTR**

i. **Offenders’ satisfaction with MHTR Service**
• An offender satisfaction questionnaire was developed following a focus group (Kruegar 1994) with 4 clients who had completed treatment. A 7 item questionnaire (rated on a 5 point scale) covered overall satisfaction with mental health treatment; progress in ability to manage emotions and problem solve; confidence in ability to use skills learnt in treatment; satisfaction with session material; benefit of completing treatment for the future.

ii. Offenders Satisfaction with P3 Service

• P3 ‘Have we Helped?’ Questionnaire
  This ad hoc 16 item assessment of the benefits of P3 Link Worker involvement covers on a five point scale (from ‘improved a lot’ to ‘got a lot worse’) the following areas: levels of strews; understanding of rights; ability to deal with problems; where to get help; feelings about my future; housing situation; income; management of money; education/training/employment; family situation; behaviour; health; confidence; overall enjoyment of life; control over my life; and control over drug and alcohol issues.

iii. Probation Service Satisfaction with MHTR Service

An ad hoc National Probation Service, Thames Valley CRC questionnaire was devised to assess satisfaction with the MHTR service by officers whose clients had received the MHTR Service. Six questions were rated on a five point scale with supplementary qualitative questions thus:

(i) Overall satisfaction with the MHTR service; and the 3 most important aspects of the service;
(ii) Overall effectiveness of the working relationships between probation, P3 and St Andrew’s Healthcare; and what was it about the service that was effective;
(iii) Client benefit from the MHTR service; if yes in what ways;
(iv) Client coping skills improvement; and how this was evidenced;
(v) Whether they would recommend the MHTR service to other clients with mental health problems; and whether they would consider any particular cohorts to benefit more or less from this service;
(vi) Whether co-location of the services in one venue contributed for effective communication and the other advantages of co-location.

iv. Magistrates’ satisfaction with MHTR Training and usage of the MHTR

• An ad hoc 14 item questionnaire was devised to assess Magistrates satisfaction with their MHTR training in terms of presentation, design and achievement of objectives. Other questions covered knowledge and management of the MHTR, those it would be offered to, local mental health and project specific mental health treatment provision. Answers were rated on a 1 (strongly disagree) to 5 (strongly agree) scale.

J. Healthcare Utilisation Patterns by Offenders given MHTR

Numbers of offenders given MHTR order
• Registered with GP
• Registered with CMHT
• On prescribed medication (antidepressants, anxiolytics, anti-psychotics)
FOLLOW UP

Mental health – 2 and 6 month follow ups were conducted by assistant psychologists.

ETHICAL APPROVAL

The study was deemed service evaluation by St Andrew’s Healthcare Research Manager.

STATISTICAL ANALYSIS

Preliminary analyses were conducted to check the data for any outliers or errors to exclude violations of normality, linearity and homoscedasticity. None were found. Means, standard deviations, frequencies and percentages were calculated as appropriate for data on patient characteristics and treatment received. Comparisons between treatment completers and non-completers used independent t tests. Where applicable a one way repeated measures ANOVA was administered to compare pre-treatment, post treatment and six month follow up scores. Pre and post intervention treatment scores were analysed using paired t tests. A Bonferroni correction was used to correct for Type I error. The assessment of pre-post change was based on several methods used to define the outcome of treatment: (i) Rates of likely depression and anxiety pre and post treatment by PHQ-9 and GAD-7 cut –offs, (ii) ‘IAPT Recovery Rates’ where recovery = (pre-treatment PHQ-9>9 or pre-treatment GAD-7>7) and (post-treatment PHQ-9<10 and post-treatment GAD-7<8) to determine the proportion of clients who were unlikely to be cases of depression and/or anxiety post-treatment of those who were likely cases of depression and/or anxiety pre-treatment.

Pre-post effect sizes, calculated for each paired t test comparison, used a common index (the d statistic; Rosnow and Rosenthal 1989) where d of 0.20 is a small effect, d of 0.50 a moderate effect and d of 0.80 or greater a large effect. Effect sizes can be taken as indicators of clinically significant change with research indicating that a medium effect size corresponds to change of significant magnitude to be evident to a careful observer (Eisen et al 2007).

The clinical significance of change was also assessed using the Reliable Change Index (Jacobson and Truax 1991). Results were deemed reliable if the RCI was above 1.96 or below -1.96 standard deviations from group norms. Clinically significant change is defined or the score at which the probability of coming from a clinical and non-clinical distribution is equal. Scores below this point are classified as the non-clinical range. Clinically significant change requires that a person is above the cut off pre-treatment (is in the clinical range) but below it are at post-treatment.
RESULTS

REFERRAL PATTERNS

Two hundred and thirty offenders who had Probation Service input came before Milton Keynes Magistrates in the first year of the project (April 2014 – March 2015). The referral patterns generated by these offenders are shown in Figure 2. Thus 177 (73%) were referred to the P3 link working charity because of the perceived need for practical, social, educational or vocational support. Of 148 offenders assessed by P3 using the K10, 129 scored above the cut off indicating a clinically significant level of psychological distress (i.e. 55% of offenders coming before magistrates in Milton Keynes who had Probation Service input). A total of 129 offenders were offered a psychological assessment and a 123 attended a semi structured interview by St Andrew’s Healthcare leading to 108 being recommended for a MHTR community order. The reasons for not being suitable for a MHTR (N=15) were primary problems with alcohol/ drugs (N=6) psychological distress related only to outcome of court case (N=2) issues that could be addressed through social interventions alone (N = 4); and refusal of treatment (N=3). In all 76 (70%) of those recommended were granted a MHTR order by the Court. The reasons for those recommended (N=32) not being given a MHTR are given in Figure 2.

The 76 MHTR orders given in the first year of the project in contrast to just 1 MHTR made in Milton Keynes (2012/2013) and 8 for the rest of Thames Valley (2014/15). In addition only 3 psychiatric court reports were commissioned during the first year of the project in contrast to 33 in the previous year.

Figure 2: Mental Health Screening and Mental Health Treatment Requirement (MHTR) Orders over one year
MHTR PARTICIPANTS

A total of 56 people (42 males and 14 females) participated in a MHTR between April 2014 to March 2015 of which 48 people completed their treatment and 8 people remained in treatment at the end of year 1. The mean age of the participants was 31.5 years, (S.D. 8.67; Range 19 to 53 years). The majority (N=38; 68%) were unemployed but indicated they had adequate social support (N=45; 80%). The presenting problems were typically associated with low mood (N=50; 90%), anger (N=41; 73%), relationship problems (N=47; 84%) and emotional dysregulation (N=54, 96%). In all 24 people (43%) were on antidepressants and 2 people (4%) were on anxiolytics. Ten people (18%) had psychiatric history of which 4 had been treated as inpatients at some point of their lives. There were 10 people (18%) with a diagnosis of learning disability and 3 participants (5%) had an Autistic Spectrum Disorder diagnosis.

At screening 64 (83%) scored above the cut-off point (score 3 or more) for possible personality disorder on the SAPA (Pluck et al 2012). In terms of risk 24 participants (43%) were assessed as being at risk of self-harm, 36 (64%) as being a risk to others, and 7 (13%) were assessed as being at risk from others.

A total of 38 (68%) reported having a problem with alcohol (68%), however only 4 of them were on an Alcohol Treatment Requirement Order. Similarly 40 (71%) reported having drug problems (71%) of which 4 were placed on a Drug Treatment Requirement order. Out of 56 people 29 described problems with use of both alcohol and other drugs (52%). The major drug of choice was cannabis (N=29; 52%), followed by alcohol (N=19; 34%), heroin/crack cocaine (N=5; 9%) and legal highs (N=2; 3%).

The majority of participants had at least one previous conviction (N=46; 82%) with a mean age at first offence of 17.6 years (SD=82; Range 13 – 33 years). The majority of participants (N=29;48%) had been arrested for minor violence (such as common assault, grievous bodily harm and harassment): other offences included, theft (N=10; 16%), breach of order (N=6; 11%), criminal damage (N=5; 9%), Animal Cruelty (N=2; 4%), racial abuse/drunk and disorderly (N=2; 4%), drugs related offences (such as possession and supply) (N=3; 5%), making off without payment (N=1; 2%), affray, and arranging/facilitating the commission of a child sex offence (N=1; 2%).

In terms of risk: the OGRS score for the group indicated a 45.6% (medium risk) likelihood of reoffending within two years; OGP score gave a 40-49% chance of reoffending within two years, while the OASys Violence Predictor (OVP) score gave a 30-39% (medium risk) chance of reoffending within two years.

There were no statistical differences between treatment completers (n=48) and those still in treatment (N=8) in terms of age, presenting problems and offence history.

TREATMENT ENGAGEMENT

Of 76 people given a MHTR 20 disengaged with the service. The reasons for disengagement are presented in Figure 3.
At the end of the study period 48 clients had completed treatment and 8 were still in treatment: of the treatment completers 42 (87%) attended a two month and 37 (77%) attended a six month follow up. There was no statistical differences between treatment completers (N=48) and those who disengaged from the treatment (N=20) in terms of gender, presenting problems and offending. Likewise there were no statistical differences between treatment completers (N=48) and those still in treatment (N=8) in terms of age, presenting problems and offence history.

Treatment completers were older than treatment ‘drop outs’ [m=40.1yrs SD=1.2 V M=28.8yrs, SD=2.3; t=4.12(df1) p<0.05]. ‘Drop-outs’ were more likely to have problems with class A drugs (particularly heroin) (N=15, 75%) than treatment completers (N=3, 61%) [x² =13.45 (df1) p<0.05]. In contrast more treatment completers reported having problems with cannabis than ‘drop-outs’ [N=26, 54% v N=6, 12.5%; x² =12.54 (df1) p<0.05].

Treatment completers (N=48) were offered a total of 733 therapy sessions (Mean = 15.27; Range 12-24). A total of 573 sessions (78%) were attended (Mean = 11.89; Range 7-12) over a Mean period of 3.79 months (Range 2-6 months).
TREATMENT COMPLETERS: PRE-POST COMPARISONS

A. Symptomatology

As indicated in Table 1, there was a significant reduction in K10 psychological distress for treatment completers. Following treatment 39 clients (81%) were below the measure cut off point of 20 with 5 (10%) classified as mild mental disorder (scores 20 – 24). These results were maintained at 2 and 6 month follow up with no mean difference in overall psychological distress between post group and follow up scores. Effect sizes were large for depression and moderate for anxiety.

Overall 46 scored above the cut-off point on both the PHQ-9 and GAD-7 with 1 scoring above the cut off on either the PHQ-9 or the GAD-7 while 1 scored below the cut off on both. Thus a total of 47 (97%) were above the cut off points on either PHQG or the GAD-7 which indicates they meet the criteria for a diagnosis compared to 10 people (21%) above the cut off for PHQ-9 and 7 people (15%) who were above the cut off for the GAD-7 at six months follow up.

Table 1: Symptomatology for Treatment Completers: pre-post and follow up

<table>
<thead>
<tr>
<th>Assessments</th>
<th>Pre Group (N = 48)</th>
<th>Post Group (N = 48)</th>
<th>Statistical Value (pre-post comparison)</th>
<th>Reliable Change Index RCI</th>
<th>2 months Follow Up (N = 42)</th>
<th>6 month Follow Up N = 37</th>
<th>Statistical Value (post-follow up)</th>
<th>ANOVA statistics Pre, post and 6 months follow up comparisons Univariate F Ration</th>
<th>Clinically significant N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Symptomatology</strong></td>
<td></td>
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<tr>
<td>Kessler Psychological Distress Scale (K10)</td>
<td>33.5 (6.2)</td>
<td>19.9 (3.5)</td>
<td>t=3.56 (df1) p&lt;0.05 Effect size r=0.8</td>
<td>2.34</td>
<td>16.5 (2.4)</td>
<td>17.2 (2.1)</td>
<td>NS</td>
<td>13.23 p&lt;0.01</td>
<td>39 of 48 (81%)</td>
</tr>
<tr>
<td>Patient Health Questionnaire (PHQ-9)</td>
<td>17.61 (2.1)</td>
<td>6.36 (4.6)</td>
<td>t=4.99 (df1) p&lt;0.01 Effect size r=0.84</td>
<td>2.21</td>
<td>6.01 (2.1)</td>
<td>7.1 (0.7)</td>
<td>NS</td>
<td>14.43 p&lt;0.01</td>
<td>38 of 48 (79%)</td>
</tr>
<tr>
<td>Generalised Anxiety Disorder 7 (GAD-7)</td>
<td>14.1 (4.3)</td>
<td>5 (2.2)</td>
<td>t=4.89 (df1) p&lt;0.05 Effect size r=0.79</td>
<td>2.05</td>
<td>5.3 (3.5)</td>
<td>6.2 (4.2)</td>
<td>NS</td>
<td>9.27 p&lt;0.05</td>
<td>41 of 48 (85%)</td>
</tr>
</tbody>
</table>

NS= not significant
Table 1 shows a significant reduction in depressive symptoms for treatment completers on the PHQ-9. The number of individuals scoring above the cut off fell from 47 (98%) to 11 (23%). This reflected a pre-post decrease in scoring in the severe (n=9v0); moderate severity (n=17v1); moderate (n=20v10) and mild (n=1v0) categories.

Anxiety symptomatology also reduced significantly with clients scoring above the cut off falling from 46 (96%) to 6 (12%). This reflected a pre-post decrease in scoring in the severe (n=8v0); moderately severe (n=20v0); moderate (n=17v6) and mild (n=1v6) categories.

Change observed was reliable and clinically significant in between 79% and 85% of participants. Using the ‘IAPT Formula’ (Richards and Borglin 2011) to calculate recovery (patients who are above case threshold on either GAD-7 or PHQ-9 at assessment and who are then below threshold on both measures post treatment follow up) 41 (85%) were ‘recovered’.

B. Coping Skills

The pre and post treatment scores on the various measures of coping are given in Table 2. Scores on the Dealing with Feelings Questionnaire changed significantly reflecting an improvement in ability to tolerate emotional distress; to engage in activities to reduce negative mood; to engage in pleasant activities on a daily basis and to recognise changes in mood. Effect sizes were moderate on all questions with the exception of ability to recognise mood change. The self-rated social problem solving ability of the completers improved significantly over the course of treatment. This was reflected in all subscales but particularly on scores of Negative Problem Orientation and Avoidance Style. Effect sizes were high for Total Problem Solving and for 3 of 5 subscales. A significant improvement in self-efficacy (GSES) was also apparent (effect size moderate) and was maintained at follow up. Scores reflected a (mean) change from one standard deviation below the norm (pre-treatment) to a score within the normal range post treatment.
### Table 2: Coping Skills for Treatment Completers: pre-post and follow up

<table>
<thead>
<tr>
<th>Assessments</th>
<th>Pre Group (N = 48)</th>
<th>Post Group (N = 48)</th>
<th>Statistical Value (pre-post comparison)</th>
<th>Reliable Change Index RCI</th>
<th>2 months Follow up (N = 42)</th>
<th>6 month Follow Up (N = 37)</th>
<th>Statistical Value (post-follow up)</th>
<th>ANOVA statistics Pre, post and 6 months follow up comparison</th>
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<tbody>
<tr>
<td></td>
<td>Mean (SD)</td>
<td>Mean (SD)</td>
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<td></td>
<td>Mean (SD)</td>
<td>Mean (SD)</td>
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<td>Univariate F Ratio</td>
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<tr>
<td>Coping Skills</td>
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<tr>
<td>Dealing with Feelings Questionnaire (DWF)</td>
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</tr>
<tr>
<td>Ability to Tolerate Emotional Distress</td>
<td>2.01 (1.2)</td>
<td>4.02 (1.01)</td>
<td>t=4.56 (df1) p&lt;0.01</td>
<td>1.98</td>
<td>3.56 (0.87)</td>
<td>4.12 (1.2)</td>
<td>NS</td>
<td>12.45 p&lt;0.01</td>
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<td></td>
<td></td>
<td></td>
<td>Effect size r=0.67</td>
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<tr>
<td>Ability to Engage in Activities to Reduce Negative Mood</td>
<td>2.21 (0.98)</td>
<td>3.82 (1)</td>
<td>t=3.76 (df1) p&lt;0.01</td>
<td>2.11</td>
<td>3.41 (1.2)</td>
<td>3.21 (1.1)</td>
<td>NS</td>
<td>11.45 p&lt;0.01</td>
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<td></td>
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<td></td>
<td>Effect size r=0.63</td>
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<tr>
<td>Engagement in Pleasant Activities on a Daily Basis</td>
<td>3.73 (1.32)</td>
<td>5.01 (0.24)</td>
<td>t=4.01 (df1) p&lt;0.01</td>
<td>2.12</td>
<td>4.12 (0.32)</td>
<td>3.74 (0.6)</td>
<td>t=2.98 (df1) p&lt;0.05</td>
<td>NS</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Effect size r=0.56</td>
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<tr>
<td>Ability to Recognise Changes in Mood</td>
<td>3.21 (1.13)</td>
<td>4.23 (1.02)</td>
<td>t=3.98 (df1) p&lt;0.01</td>
<td>1.97</td>
<td>4.01 (0.93)</td>
<td>4.32 (1.2)</td>
<td>NS</td>
<td>9.11 p&lt;0.01</td>
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<td></td>
<td></td>
<td></td>
<td>Effect size r=0.43</td>
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<tr>
<td>Social Problem Solving Inventory (SPSI) Total Score</td>
<td>6.8 (0.1)</td>
<td>16 (1.1)</td>
<td>t=3.77 (df1) p&lt;0.01</td>
<td>1.98</td>
<td>13.4 (0.32)</td>
<td>12.3 (1.3)</td>
<td>NS</td>
<td>12.3 p&lt;0.01</td>
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<td></td>
<td></td>
<td></td>
<td>Effect size r=0.98</td>
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<tr>
<td>Positive Problem Orientation</td>
<td>1.4 (0.2)</td>
<td>2.6 (0.2)</td>
<td>t=2.74 (df1) p&lt;0.05</td>
<td>2.01</td>
<td>2.6 (1.1)</td>
<td>2.4 (0.98)</td>
<td>NS</td>
<td>11.65 p&lt;0.01</td>
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<td></td>
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<td>Effect size r=0.99</td>
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<tr>
<td>Negative Problem Orientation</td>
<td>0.8 (0.43)</td>
<td>3 (0.6)</td>
<td>t=4.32 (df1) p&lt;0.01</td>
<td>2.34</td>
<td>2.8 (0.65)</td>
<td>2.3 (1.32)</td>
<td>NS</td>
<td>13.56 p&lt;0.01</td>
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<td></td>
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<td>Effect size r=0.90</td>
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<tr>
<td>Rational Problem Solving</td>
<td>2 (1.01)</td>
<td>3 (0.13)</td>
<td>t=1.32 (df1) p&gt;0.05</td>
<td>1.93</td>
<td>2.6 (0.12)</td>
<td>2.3 (1.01)</td>
<td>NS</td>
<td>NS</td>
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<td></td>
<td></td>
<td></td>
<td>Effect size r=0.57</td>
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<tr>
<td>Impulsivity/ Carelessness</td>
<td>1.2 (0.2)</td>
<td>3.8 (1.4)</td>
<td>t=3.32 (df1) p&lt;0.05</td>
<td>2.22</td>
<td>3 (0.3)</td>
<td>1.7 (0.6)</td>
<td>t=2.77 (df1) p&lt;0.05</td>
<td>NS</td>
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<td></td>
<td></td>
<td></td>
<td>Effect size r=0.79</td>
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<tr>
<td>Avoidance Style</td>
<td>1.4 (0.3)</td>
<td>3.6 (0.76)</td>
<td>t=2.95 (df1) p&lt;0.01</td>
<td>1.98</td>
<td>2.4 (0.5)</td>
<td>2.8 (0.34)</td>
<td>NA</td>
<td>13.12 p&lt;0.01</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Effect size r=0.88</td>
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<tr>
<td>Generalised Self-Efficacy Scale (GSES)</td>
<td>22.46 (5.2)</td>
<td>33.36 (3.9)</td>
<td>t=3.89 (df1) p&lt;0.05</td>
<td>1.11</td>
<td>32.41 (2.8)</td>
<td>24.03 (1.5)</td>
<td>t=3.43 (df1) p&lt;0.05</td>
<td>8.99 p&lt;0.01</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Effect size r=0.76</td>
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</tbody>
</table>
C. Social Adjustment

As shown in Table 3, using clinically significant criteria on the WSAS self-report scale of functional impairment attributable to identified problems there is a significant reduction in score from one suggesting moderately severe or worse psychopathology/functional impairment (M=23.33, SD=6.3) to one (M=6.73, SD=1.2) associated with subclinical populations. The most significant changes occurred in the areas of ability to work, home management, social leisure activities and the ability to form and maintain close relationships.

Table 3: Work and Social Adjustment for Treatment Completers: pre-post and follow up

<table>
<thead>
<tr>
<th>Assessments</th>
<th>Pre Group (N = 48)</th>
<th>Post Group (N = 48)</th>
<th>Statistical Value (pre-post comparison)</th>
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<th>Statistical Value (post-follow up)</th>
<th>ANOVA statistics Pre, post and 6 months follow up comparisons Univariate F Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work and Social Adjustment Scale (WSAS) Total score:</td>
<td>23.33 (6.3)</td>
<td>6.73 (1.2)</td>
<td>t=3.74 (df1), p&lt;0.01</td>
<td>8.81</td>
<td>6.22 (4.5)</td>
<td>5.98 (3.4)</td>
<td>NS</td>
<td>12.54 p&lt;0.01</td>
</tr>
<tr>
<td>Because of my problem my ability to work is impaired</td>
<td>5.6 (1.26)</td>
<td>1.1 (0.12)</td>
<td>t=3.44 (df1), p&lt;0.01</td>
<td>3.42</td>
<td>1.24 (0.9)</td>
<td>1.22 (0.7)</td>
<td>NS</td>
<td>9.10 p&lt;0.01</td>
</tr>
<tr>
<td>Because of my problem my home management is impaired</td>
<td>4.1 (1.11)</td>
<td>0.87 (0.23)</td>
<td>t=4.03 (df1), p&lt;0.01</td>
<td>2.54</td>
<td>1.22 (0.6)</td>
<td>1.45 (0.8)</td>
<td>NS</td>
<td>13.12 p&lt;0.01</td>
</tr>
<tr>
<td>Because of my problem my social leisure activities are impaired</td>
<td>4.55 (1.3)</td>
<td>1.34 (0.22)</td>
<td>t=2.91 (df1), p&lt;0.01</td>
<td>3.25</td>
<td>1.18 (1.1)</td>
<td>1.2 (0.9)</td>
<td>NS</td>
<td>13.45 p&lt;0.01</td>
</tr>
<tr>
<td>Because of my problem my private leisure activities are impaired</td>
<td>3.85 (1.4)</td>
<td>1.02 (0.26)</td>
<td>t=3.32 (df1), p&lt;0.05</td>
<td>4.01</td>
<td>1.45 (1)</td>
<td>1.41 (1.1)</td>
<td>NS</td>
<td>9.14 p&lt;0.01</td>
</tr>
<tr>
<td>Because of my problem my ability to form and maintain close relationships with others is impaired</td>
<td>5.2 (1.25)</td>
<td>2.4 (0.37)</td>
<td>t=4.11 (df1), P&lt;0.01</td>
<td>2.98</td>
<td>1.14 (0.9)</td>
<td>1.2 (0.8)</td>
<td>NS</td>
<td>10.9 p&lt;0.01</td>
</tr>
</tbody>
</table>

NS= not significant
Figure 4 shows changes in pre-post Outcome Star for Homelessness Ratings.

As shown in Table 4, the OSH ratings showed a statistically significant improvement pre-post P3 involvement (that varied between 12 and 16 weeks) on 7 of the 10 star points: Physical health; emotional and mental health; managing tenancy and accommodation; offending; self-care and living skills; managing money and social networks and relationships). Overall pre-post ratings showed a significant improvement score of 4.16 resulting in an overall mean of 7.79 (SD=0.7). There were no significant improvements in the areas of drug and alcohol misuse; meaningful use of time; and motivation and taking responsibility. Follow up assessments showed maintenance of improvements with no significant difference between post intervention and 6 month follow up.
### Table 4: Outcome Star for Homelessness (OSH) Ratings: pre-post and follow up

<table>
<thead>
<tr>
<th>Outcome Star for Homelessness (OSH)</th>
<th>Pre Group (N = 48)</th>
<th>Post Group (N = 48)</th>
<th>Statistical Value (pre-post comparison)</th>
<th>2 months Follow up (N = 48)</th>
<th>6 month Follow Up (N = 48)</th>
<th>Statistical Value (post-follow up)</th>
<th>ANOVA statistics Pre, post and 6 months follow up comparisons Univariate F Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug and alcohol misuse</td>
<td>4.5 (1.3)</td>
<td>5 (0.7)</td>
<td>NS</td>
<td>7.6 (1.1)</td>
<td>8.1 (0.6)</td>
<td>NS</td>
<td>11.12 p&lt;0.01</td>
</tr>
<tr>
<td>Physical health</td>
<td>1.3 (2.4)</td>
<td>9.8 (0.2)</td>
<td>t=4.36 (df1), p&lt;0.01</td>
<td>9.5 (0.3)</td>
<td>9.4 (0.2)</td>
<td>NS</td>
<td>13.23 p&lt;0.01</td>
</tr>
<tr>
<td>Emotional and mental health</td>
<td>6.3 (1.4)</td>
<td>8.2 (0.7)</td>
<td>t=43.87 (df1), p&lt;0.05</td>
<td>7.9 (1)</td>
<td>8.4 (0.4)</td>
<td>NS</td>
<td>9.43 p&lt;0.01</td>
</tr>
<tr>
<td>Meaningful use of time</td>
<td>6.8 (1.1)</td>
<td>7.1 (1.1)</td>
<td>NS</td>
<td>7.2 (1.2)</td>
<td>6.9 (2.1)</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td>Managing tenancy and accommodation</td>
<td>4.5 (2.1)</td>
<td>9.3 (0.3)</td>
<td>t=4.32 (df1), p&lt;0.05</td>
<td>9.1 (0.5)</td>
<td>9.4 (0.1)</td>
<td>NS</td>
<td>12.34 p&lt;0.01</td>
</tr>
<tr>
<td>Offending</td>
<td>2 (1.4)</td>
<td>6.7 (1.01)</td>
<td>t=2.99 (df1), p&lt;0.05</td>
<td>7.1 (1.1)</td>
<td>6.8 (0.7)</td>
<td>NS</td>
<td>11.34 p&lt;0.01</td>
</tr>
<tr>
<td>Motivation and taking responsibility</td>
<td>5.2 (1.4)</td>
<td>5.1 (1.5)</td>
<td>NS</td>
<td>6.7 (1.1)</td>
<td>6 (0.1)</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td>Self-care and living skills</td>
<td>1.3 (0.4)</td>
<td>8.6 (0.3)</td>
<td>t=4.12 (df1), p&lt;0.01</td>
<td>9.1 (0.4)</td>
<td>8.7 (0.4)</td>
<td>NS</td>
<td>10.01 p&lt;0.01</td>
</tr>
<tr>
<td>Managing money</td>
<td>1.2 (0.4)</td>
<td>8.7 (1.1)</td>
<td>t=3.94 (df1), p&lt;0.01</td>
<td>9.1 (0.5)</td>
<td>8.8 (1.1)</td>
<td>NS</td>
<td>14.72 p&lt;0.01</td>
</tr>
<tr>
<td>Social networks and relationships</td>
<td>3.2 (1.1)</td>
<td>9.4 (0.3)</td>
<td>t=3.89 (df1), p&lt;0.01</td>
<td>9.6 (0.1)</td>
<td>9.5 (0.2)</td>
<td>NS</td>
<td>10.21 p&lt;0.01</td>
</tr>
<tr>
<td>Total</td>
<td>3.63 (1.3)</td>
<td>7.79 (0.7)</td>
<td>t=4.2 (df1), p&lt;0.01</td>
<td>8.29 (0.7)</td>
<td>81.7 (0.5)</td>
<td>NS</td>
<td>12.45 p&lt;0.01</td>
</tr>
</tbody>
</table>

NS = not significant

### D. Predicted Criminal Justice Outcomes

The scores on OGRS3 showed a significant pre-post reduction in the estimated likelihood of reoffending within 2 years [pre group likelihood of reoffending = 45.6% versus post group = 39.3% $\chi^2 = 12.34$ (df1) p<0.01]. This was reflected in a significant change on the General Gravity Protector (OGP) from 40-49% likelihood of reoffending in 2 years to 30-39% $\chi^2 = 13.09$ (df1) p <0.01. In terms of change on the dynamic OGP risk factors it is apparent that all areas, except accommodation, were above the cut off threshold indicating a significant problem. Post group ratings however, showed below cut off scores for areas labelled attitudes, thinking and behaviour, alcohol misuse, lifestyle and associates, relationships, education training and employment. Only drug misuse remained significantly above the cut off post treatment (see Fig 5).
Violence Predictor (OVP) scores reduced from 30-39% (medium risk) of likelihood of reoffending within 2 years to 20-29% (low risk) \[X^2=13.01 \text{ (df1) } p<0.01\].

STAKEHOLDERS VIEWS OF MHTR

(i) Client satisfaction with MHTR service

As shown in Table 5 clients had a high level of satisfaction with the MHTR service (ratings on a 1-5 scale with higher scores indicating higher satisfaction).

Table 5: Service Users Satisfaction with MHTR Service (N=46)

<table>
<thead>
<tr>
<th>Question</th>
<th>Mean Score (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Overall satisfaction with MHTR service</td>
<td>4.13 (0.76)</td>
</tr>
<tr>
<td>2) Progress in ability to manage emotions</td>
<td>3.78 (0.23)</td>
</tr>
<tr>
<td>3) Progress in ability to deal with problems</td>
<td>3.87 (0.78)</td>
</tr>
<tr>
<td>4) Confidence to use skills taught in treatment</td>
<td>4.30 (0.11)</td>
</tr>
<tr>
<td>5) Benefit of MHTR treatment for the future</td>
<td>4.43 (0.34)</td>
</tr>
<tr>
<td>6) Satisfaction with content of treatment</td>
<td>3.91 (0.52)</td>
</tr>
</tbody>
</table>
(ii) Client satisfaction with P3

Client mean ratings (1-5) on the ‘Have We Helped Questionnaire’ showed the highest improvement ratings for control over my life (M=4.8), housing situation (M=4.8), ability to deal with problems (M=4.6), the way to manage my money (M=4.6) and overall enjoyment of life (M=4.6). Other areas were rated as follows: my behaviour (in relation to what others expect) (M=4.3); my understanding of my rights and knowledge of where to get help (both M=4.2); levels of stress and income (both M=4.1). Lowest improvement ratings were evident in my control over drugs and alcohol (M=3.1), my health (M=3.5), involvement in education/training/employment (M=3.5), my confidence (M=3.7) and my feelings about my future (M=3.7).

(iii) Probation service satisfaction with MHTR service

Probation service/CRC staff responses to the satisfaction with the MHTR Service questionnaire (rated on an I-5 scale) were positive. Officers were very satisfied with the MHTR Service (mean score=4.6); felt that their service worked very effectively with the MHTR provision (mean score=5); and that co-location of services had contributed to effective communication between the services (mean score=4.9). Probation staff felt that their clients had benefited from the MHTR Service (mean score=4) and had improved their coping skills (mean score=4.3). The majority (mean score=4.7) would recommend the current service to future clients with mental health problems.

Qualitative comments by probation/CRC officers were grouped under the following themes:

- Service delivery

Staff noted the simple referral process and the convenience of co-location of probation, P3 and mental healthcare staff when arranging joint appointments. Regular inter agency communication and case discussion, with prompt and detailed feedback to offender managers along with a common outlook in terms of case management was also noted.

- Client benefit

Staff noted that benefit to the offender was often apparent after the first MHTR appointment and that service users frequently talked about coping skills they had learned in a positive way. They noted that service users who attended MHTR services felt supported and empowered. One respondent noted that their client had, as an indirect result of treatment, built up the confidence to leave an abusive relationship.

(iv) Magistrates satisfaction with MHTR training

Thirty of a random sample of 35 magistrates (86%) completed a training satisfaction questionnaire. Magistrates positively rated their training about the MHTR as well as designed (m=4.2), well presented (m=3.9) and felt that it achieved its objectives (m=4.2). They noted that the MHTR training would influence their future practice (m=3.8) and that they would recommend the training to other (m=4.5). The training increased magistrates understanding of MHTR eligibility criteria (m=4.3), the signs/symptoms might identify a suitable individual for a MHTR (m=4.7), what needs to be in place for court to recommend a MHTR (M=4.5), how MHTR breaches could be managed (m=4.5), which organisations can offer mental health assessments, reports and advice to the courts (m=4.1) which organisations can provide mental health assessments, advice and treatment (m=4.1).
HEALTHCARE UTILISATION PATTERNS BY OFFENDERS GIVEN AN MHTR

Of 48 treatment completers 42 (87.5%) attended other interventions with 40 (83%) attending their general practitioners and 2 (4%) attending their local Community Mental Health Team (CMHT). Forty four were on psychotropic medication particularly antidepressants (N=19; 40%) and anxiolytics (N=2; 4%).

Three were concurrently attending Alcohol Treatment Requirements (ATR 6%) and 4 people were attending Drug Treatment Requirements (8%). Six completers (not given ATR or DTR) voluntarily sort treatment/support (e.g. A.A.) to address their substance misuse problem.
DISCUSSION

While the current initiative represents one of a number of models designed to increase the collaboration between the criminal justice and the mental health systems (Morrissey et al 2009) this is the first within the UK to deliver a therapeutic response at the point of sentencing for offenders with mental health problems. The significant increase in the provision of MHTR community orders in the first year of the project has been associated with a decrease in the number of psychiatric reports requested that are time consuming and do not lead to a rapid treatment. This confirms earlier findings, that in most cases an initial screening report provides sufficient information to the court without the need for a psychiatric report (Hean et al 2009).

Several enabling factors to improve access routes to mental health service have been addressed (Brookes et al 2011) in this project. These include co-location of services, mental health awareness training and an identified point of contact with mental health services. Key characteristics of the MHTR pilot included rapid treatment response and close inter agency working for mentally ill offenders. These features parallel those of the U.S.A Mental Health Courts (MHCs) that achieve a common consensus of how therapeutic jurisprudence would best serve mentally ill offenders and a rapid link to Mental Health Services (Hernickx et al 2005). While, at the time of writing, reoffending rates for treatment completers in the present study have not been tracked over a significant time period, data from an evaluation of the Clark County Mental Health Court indicates that the overall crime rate for MHC participants was reduced 4.0 times one year post enrolment in the MHC compared with one year pre enrolment for those who had ‘graduated’ from the programme (Hernickx et all 2005).

This evaluation has shown that the implementation of evidence based psychological therapies within a probation service or court link worker setting for offenders given a community order are associated with pre or post follow up effect sizes that were large or moderate for anxiety or depression with clinically significant change in 79% of treatment completers on PHQ-9 measure of depression and 85% of treatment completers on the GAD-7 measure of anxiety. While clients received 12 treatment sessions in contrast to the 6 sessions typical of low intensity IAPT services ( Richards et al 2011), 85 % were recovered using the IAPT recovery formula in contrast to the 46% of the 7859 IAPT patients reported in a recent study ( Richards et al 2011). Further these rates were achieved with a group who, although mostly on antidepressant medication (79%) also had a probable personality disorder (83%), problematic use of alcohol (68%) or other drugs (71%) and had limited previous exposure to psychotherapy.

These results were achieved by a rapid response manualised treatment delivered by assistant psychologists that addressed transdiagnostic coping skills. Symptom reduction in treated patients was reflected in a corresponding improvement in the coping skills of social problem solving, the ability to tolerate emotional distress, to recognise mood change, and to engage in activities to reduce negative mood. Results suggest that an adapted coping skills component of Dialectical Behaviour Therapy (DBT) which considered responsivity in its construction and delivery, and which was neither patronising, too slow nor too demanding (M'CMurran and M'Culloch 2007) is of benefit to dual diagnosis offenders (Long et al 2011). There is empirical support for the role of social problem –solving as a casual factor in the conceptual constellation of substance use, personality disorders and criminality (Dreer et al 2005). In the current study improvement in social problem solving skills was associated with a reduction in symptomatology (Nezu et al 2004) reflecting the employment of a wide range of psychological skills (Pakasistani 2000). While the benefit of improvement in social problem solving in terms of reconviction have yet to be established, previous work (Steele 2002) detailing the results of a 1 year follow up of a National Probation Service programme, found the reconviction rate for treatment completers was considerably below that for controls (33% as against 53%). Finding of a significant increase in self-efficacy reflect treatment completers increased belief in their ability to deal with everyday demands and challenges of community
life which is associated with positive treatment outcomes in a variety of treatment contexts including substance misuse (Long et al 1998). These results were reflected in service user’s satisfaction ratings with the MHTR service (in terms of ability to manage emotions, and deal with problems and in confidence to use skills taught in treatment) and with the P3 link worker service (improved rating of ‘control over my life’ and ‘ability to deal with the problems’).

Mental health problems, by their nature, are likely to be associated with other needs. Indeed a national survey of OASYs assessment concluded that offenders with mental health problems had greatly increased needs in every other dynamic risk factor category (HMPI 2007). Post treatment self-ratings of improvement in social adjustment for treatment completers were evident in the domains of ability to work (WASA); management of home or accommodation (WASA; OSH) close relationships and social leisure activities (WASA); Managing Money (OSH); self-care of living skills (OSH); and physical health (OSH). Further change in OASys dynamic risk rating from above the cut-off point in all areas except for drugs, reflects both mental health improvement and the benefit of concurrent combined probation and link worker interventions. In this regard supporting desistance from crime is consistent with the Recovery approach in mental health (Shepherd et al 2008) which emphasises building strengths by developing positive social bonds, meaningful occupation, stable accommodation and addressing health needs. Key to the Recovery approach is engendering a sense of hope for the future by enabling individual to achieve choice, control and opportunities to build a better life.

A lack of self-rated and probation staff rated improvement in the area of drug misuse was perhaps reflective of the fact that the majority of those with drug problems were not receiving interventions to help them desist. However the wisdom of engaging psychological treatment prior to addressing substance misuse problems is questionable for a number of reasons. Firstly it violates the clinical rule of appropriate sequencing of coping skills treatment for forensic clinical populations, (Long et al 2014). Secondly, the combination of a substance-use disorder and a co- psychiatric condition has a detrimental impact on treatment engagement and therapeutic outcomes due to the complex interaction of the two problems (DiClementi et al 2008). In addition to lack of adherence to medication regimes, symptom exacerbation, and poor social adjustment, treatment is characterised by a lack of therapeutic engagement, poor motivation to change and frequent relapse (Day et al 2010). In this regard it is noteworthy that 75% of treatment drop outs in the study were problematic users of Class A drugs particularly heroin. Of the few methodologically acceptable evaluations in this area (McMurran 2005) it has been shown that prescription of pharmaceutical heroin (diamorphine) is superior to methadone at keeping people in treatment and reducing crime (McCusker and Davies 1996; Metrebian et al 2001).

Breach rates of community orders has traditionally been high (Mai and Mills 2009) with an almost 500% increase in imprisonment for breach of non-custodial sentences between 1995 and 2009 (Ministry of Justice 2009). The formal breach rate in the current sample of 10% with a further 21% disengaging for reasons of lack of motivation or unwillingness to attend or reoffending provides no room for complacency.

Problems in engagement in those offenders identified as having mental health problems are well known with a 22% rate of failure to attend in previous surveys (Cohen et al 1999). Client non-attendance in 22% of mutually agreed sessions for treatment completers in this evaluation however, is concerning given multi agency involvement and a system of telephone and text prompting. Long waits for treatment are associated with less reliable appointment keeping (Rao et al 2000) but in the current project the therapeutic input was immediate. However non-attendance rates were more than double than that reported in Community Mental Health Teams (McLachlan 2015). Whilst staff persistence led some clients to complete treatment who would otherwise have defaulted (some clients attended only 50% of agreed sessions) the issue is not just the waste of valuable clinical time but the potential capping of numbers of suitable clients that can be treated within the system. In the current project a total of 160 hours of scheduled face to face contact was not used, the equivalent of an additional 13 clients who could have completed on MHTR. A further
consideration is cost: it is estimated that missed appointments cost the NHS an estimated £585 million per year (Dr Foster Intelligence 2012).

The multiple nature of the psychological, social and forensic problems presented by those referred to the probation or CRC service leads inevitably to the conclusion that successful rehabilitation will be the result of effective multi agency collaborative working. As noted by Farrall (2004, p12) with reference to the Probation Service; “cognitive behavioural work should complement the social and economic interventions undertaken to assist probationers.” This, in turn, relates to the importance of staff buy-in particularly given previous work suggesting probation service concerns that standardised treatment programme delivery was associated with a devaluation of their traditional skills (Rex et al 2003). The high satisfaction rating by probation staff and magistrates with the MHTR service and with the probation link worker service enhanced by rapid response psychological help suggests effective and non-competitive inter agency working. While the impact of the “Hawthorne Effect” (Parsons 1974) on a new national development cannot be discounted, the overall clinical results are encouraging.

The ultimate test of any psychological intervention with offenders, of course, is whether it reduces subsequent re-offending. The current initiative has addressed the moral argument: that offenders should have equality of access to mental health services. The economic argument has yet to be established. While probation service pre- post OGR3 ratings, predicted a post intervention reduction in offending in association with an estimated reduction in dynamic risk of reoffending factors, the ultimate test of effectiveness is the 2 year pre-post incidence of offending. This will be the subject of a further report.

LIMITATIONS

The findings of this study must be considered in terms of the limitations of uncontrolled clinical interventions conducted in routine clinical settings. The sample size of treatment completers on a single site was small and we do not know how many of the cohort would have been subject to spontaneous remission (Young 2006) once the stress of a court appearance and criminal justice disposal had occurred. Effect sizes for depression may have been inflated by the ‘remoralisation’ (feeling hopeful) effect observed in patients with anxiety disorder (Richards & Borglin 2011). Despite independent data evaluation all measures were collected by treatment staff and it is possible that the demand characteristics of the situation may have influenced results. Although assessment used a semi structured interview with psychometrics no formal diagnosis of clients was possible. Finally given for the majority the concurrent input from the P3 charity and probation, it is not possible to unequivocally ascribe psychological change to the treatments described.

IMPLICATIONS

These relate to improving the efficiency of the MHTR service by addressing issues of both selection, lack of treatment attendance for "indeterminate" reasons (such as travel problems, health, missed communications and so on) (Briggs and Turner 2003) and engagement and outcomes. Given the time constraints that surround the assessment of clients for MHTR suitability the following is proposed.

1. Assessment

   a) Clients who exceed the KIO cut off who are previously known to meet exclusion criteria or are known to have a psychotic illness will not routinely be assessed for psychological treatment
b) Psychological assessment should cover an information checklist of key points relating to the MHTR order, the nature of treatment and the rules of engagement to address previous negative views of psychological help. Following the treatment interview the treatment report to be written while the client reflects on the information given. The client is than seen for a second time (15-30 minutes later) and their understanding of the information on the checklist is reviewed. Once the interviewer is assured the client understands the nature of the therapy and the commitment they sign a contract of agreement and are informed of the recommendation.

c) Given the problems of engagement of drug (particularly heroin) users only substance misusers with a concomitant DRR or intention to concomitantly address their drug issues will be recommended for an MHTR. This is of particular importance if treatment approaches are conceptually at odds, for examples 12 steps abstinent approaches and moderation- oriented self-control training.

2. Engagement

a) Delay MHTR sessions (for those with DRR, RAR, P3 appointments) to avoid volume of appointments obstacle to engagement for selected clients.
b) Offer evening appointments (2x per week) for MHTR clients in employment
c) Text appointment reminders on both the day before and the day of the appointment.
d) Bunch appointments (e.g. probation, P3, MHTR to minimise travelling and days of engagement.

3. Outcomes

a) There is a need for research with a larger sample to address in details factors that contribute to breach rates and to assess clinical outcomes over a longer time period.
b) Two month follow up sessions to be extended beyond outcomes data gathering to provide treatment “booster” (review of skills learnt and used) sessions.
REFERENCES


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