Serving a community sentence with a Mental Health Treatment Requirement: offenders' perspectives

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Abstract

Background: Safe alternatives to custody for offenders with mental disorder are vital, not least as self-harm and violence rates are rising among them in prisons. In England and Wales, the Criminal Justice Act 2003 allows a Mental Health Treatment Requirement (MHTR) to supplement a community or suspended prison sentence, but this combination is poorly understood and rarely sought.

Aim: To explore offenders' perspectives on the MHTR.

Methods: We interviewed all 25 consenting offenders under an MHTR in two probation areas. Verbatim transcripts of their audio-taped narratives were analysed using grounded theory methods.

Results: Their core concern was 'instability', characterised mainly by health and social difficulties, and resolved by achieving stability, which included not re-offending as well as becoming healthy, substance free and 'having a life'. Most considered the MHTR helped their motivation and service provision, but some cited poor supervisor accessibility, supervisor role confusion and sense of stigma under the order as stressful and threatening good outcomes.

Conclusions: This first account of offenders' perspectives on the MHTR suggests a model in which, under it, offenders see themselves making progress as courts require. They understand the risk of return to court and imprisonment if in breach. This model of understanding how MHTRs work could provide for professional guidance and evaluation of their effectiveness.

Introduction

Worldwide, there is a higher prevalence of mental disorders among prisoners than expected from general population figures (Fazel and Baillargeon, 2011; Fazel and Seewald, 2012). In England and Wales, coupled with recognition of the ever expanding prison population, growing concerns about safety have led independent reviewers to call for greater use of diversion into community services at every stage of the criminal justice process for offenders with mental disorder (Bradley, 2009; Corston, 2007). Short prison sentences have been failing offenders and the general public alike in terms of reoffending (National Audit Office, 2010), while community sentences may be more effective (Prison Reform Trust, 2012). Ginn (2013) drew attention to potentially substantial cost savings per person on community sentences rather than in prison. Since then, need for diversion of people with mental ill-health has grown as suicide rates in prison reached a record high in 2016 and self-harm incidents, already in the tens of thousands, rose by 23% (Ministry of Justice, 2017a).

The Criminal Justice Act 2003 replaced previous community sentences with the community order and the suspended (prison) sentence. One or more of twelve requirements may be attached to create a bespoke community sentence. The Mental Health Treatment Requirement (MHTR) is one of these, usually used in conjunction with a supervision requirement, so that the offender must see both a probation officer and a mental health professional. In 2006 just 725 were implemented (Seymour & Rutherford 2008) among 128,336 community orders – 0.56% (Ministry of Justice, 2009). In spite of a slight rise in use of community sentences since then, use of the MHTR has fallen. In 2016 only 391 (0.3%) of 130,761

community orders included an MHTR, and 278 (0.38%) of 72,274 suspended sentences (Ministry of Justice, 2017). This is unlikely to be due to absence of need among community based offenders as rates of mental disorders among those under probation supervision are high (Brooker et al, 2012).

Use of the MHTR depends on courts knowing about it and/or requests to the courts – from probation officers, lawyers, mental health professionals or the offender him- or her-self. Khanom et al (2009) found that criteria for who should receive an MHTR were not clear to the professionals interviewed and the option of an MHTR was rarely discussed with offenders. An important factor in making the order is that the offender should agree to it, as there are serious sanctions for not complying, including resentencing for the original offence and a potential further sentence for breach of the order. So, how do offenders themselves construe an MHTR?

Mair & May (1997) evaluated offenders' views of probation, but none of their participants was known to have a mental disorder and this study preceded current legislation. A later study, concurrent with present legislation, made no inquiry into offenders' perceptions or understanding of the MHTR (Mair & Mills 2009).

Given the widespread poor understanding of these requirements and the absence of a theory of outcome, we chose a grounded theory approach to investigate offenders' experiences of an MHTR. This opened the way to going beyond the descriptive level and find a theoretical model of the core experience and its resolution, grounded in the open-ended interview data, which could explain the

value or limitations of such an approach. Such a model might then provide a basis for testing use of the order in practice.

Methods

Application for ethics approval was made through the Integrated Research Application System (IRAS). Approval was granted by the NHS Multi-Centre Research Ethics Committee (MREC 08/H0704/141), having taken account of the views of all relevant agencies.

Study information was provided for probation officers in two probation areas (Hertfordshire, England and South Wales). They were then asked to invite participation by all offenders who, during the four months of data collection, had been serving a community or suspended prison sentence with an MHTR for at least three months. Specification of the minimum length served was to ensure they had enough experience of an MHTR to be able to offer informed views. The researcher discussed the study with those who came forward before seeking written consent. Each participant was assured that everything in the research interview would remain confidential except for two sorts of information – if s/he said s/he was thinking of self-harm or of harming another person. In that event, the researcher would report this specific information to the offender manager.   Each was also assured that a decision to participate or not would not affect their treatment or management in any way. The two researchers conducting the interviews (one at each site) had been trained in open-ended interviewing and had wider experience of interviewing research participants, but no experience of working in the probation service or clinically, thus reducing risk of anticipatory bias. Both were completely independent

of the probation and healthcare practitioners involved and neither had any contact with the offenders except during the research interview.

Face to face semi-structured interviews were completed with consenting offenders, each in a private room in the probation office or clinical setting, as convenient for the participant. First, each was engaged in recording some simple factual information about him-/her-self, such as age and area of residence, to build confidence in talking with the interviewer, then s/he was asked about her/his personal experiences of the MHTR. S/he was asked to speak about it as freely as possible and only general prompts were offered. If s/he had not already done so, each was then encouraged to talk about his/her supervisors as well as the services and about his/her aspirations, if any, for the order (e.g. tell me a bit about your probation officer/offender manager …. and your relationship with him/her). Finally, when each seemed to have no more to say, s/he was asked to note any specific benefits of the requirement, then any difficulties encountered with it. On completion, the offender was offered a £10 shopping voucher for his/her time. Interviews lasted 45-60 minutes. They were audio-taped where possible, and all tapes or notes transcribed in full at the earliest opportunity. Tapes and transcripts were anonymised.

Five randomly selected interview transcriptions were analysed by two researchers (AM, PJT), blind to each other, using a grounded theory approach (Glaser and Strauss, 1967). There was over 90% agreement on first level categories; AM completed the remaining transcript analyses alone. The narratives were closely

inspected and categories generated from key words that emerged from the text. Each new category was compared to other categories as they emerged, using the process of constant comparative analysis. Dimensions of categories thus came from the data rather than being deduced or forced from previous theory. During the process of selective coding, important categories were allowed to merge into more general categories, or themes.   The core category was recognised as the one that could best encompass and explain the experience of the MHTR.

Results

Sample characteristics

Twenty-five of the sixty-four offenders identified with an MHTR completed the full interview. Interview completers were similar to the others in sex distribution (4/5 male), history of mental health concerns (80-90%) and broad index offence category: a third of both interviewed and un-interviewed offenders had an interpersonal violence conviction, and the rest criminal damage, drug or acquisitive convictions. The supplementary online table lists participants by gender appropriate but false names (for identity protection, used for illustrative quotations). Their median age was 34 (range 19-59). Just over half (14, 56%) had a criminal record before this episode.   Nearly half (12, 48%) had been diagnosed with schizophrenia; five with depression or anxiety; five with long-standing behavioural/personality disorders; one had no discernible diagnosis, two were under continued assessment.

Data from all 25 transcripts were included in the analysis, although, in fact no new categories of information emerged after the eighteenth narrative, suggesting data saturation at this point.

Narrative data categories

Thirty-one first level categories emerged. These are shown with the supporting data of illustrative statements in Table 1.

Table 1 about here

The core category

A core category of 'instability' or 'chaos' seemed to best encompass the experience of the range of mental health difficulties, social vulnerabilities and offending behaviours described and – to these offenders and, as they perceived it, to others – the uncertain and often unforeseen interactions between these difficulties. Instability amounted to chaos when boundaries between the manifestations of their disordered mental state and their disruptive offending and their social difficulties seemed to them to be hardly there:

> I'm a bit paranoid sometimes…. I get a bit paranoid about I'm gonna get my head kicked in…. where do I go if they attack me…. then I think I should be carrying my knife…. not to use it but to protect myself – Tim

Perceptions that it was the professionals whose view of the offender could be chaotic, as one aspect of his or her problems destabilized another, were also apparent:

the thing is they're gonna see arson, they're not gonna see this woman was

suicidal and it was a suicide attempt – Dina

Almost all of the mental disorder related statements included reference to how the disorder was destabilising their lives in some way, but instability also came from participants' descriptions of being vulnerable and victimised, whether more-or-less accidentally:

I've fallen over at my head, I've fallen over at my knee. I've hurt my body –Tim

or because someone else had taken advantage of their disorder-related vulnerability:

I'm just unconscious and they robbed my pockets….my meds had gone and my

mattress was turned over – Steven.

An emergent model of progress or relapse

The offender-participants, however, envisaged resolution of this core concern - by becoming stable, which encompassed recovering their health, not reoffending, 'getting their life back' and achieving things that they wanted to do, like getting a job:

I just want to get well really – Peter

learn not to reoffend – Brian

to return to, you know, my life basically, get my life back – Ryan

Figure 1 shows the model of their experience. The double headed arrow between the poles of instability/chaos and stability illustrates that they were aware that, although they wanted stability, and felt themselves to be moving towards it, movement in that single positive direction was not the only likely outcome. Even after achievement of some stability, some recognised that they could slip back into less stable states, and that movement in either direction along the continuum could occur at any point. The MHTR was generally viewed as most likely to facilitate movement towards stability, as illustrated by the heavier arrows pointing in that direction along the continuum, but participants also had some experience of how the order could impose barriers to their perceptions of progress – or actual progress - as also shown in the model. For most the adverse effects of the order were less powerful than its more positive effects, hence the slender arrows pointing towards the unstable/chaotic direction of movement.

Figure 1 about here

Details of the MHTR experience according to the model

When the MHTR was seen as facilitating progress, there were two main classes of explanations offered, not mutually exclusive – that it had some direct effect on the offender-participant or that it brought professional resources. In the model, these are shown as potential mediators between the MHTR and its direction of influence on the paths between instability and stability. Thus, in the first category, some thought it could boost their own personal resources, particularly motivation – more-or-less directly:

> it gets me out of the house; it gets me motivated - Zachary

or through allowing them to believe that practical goals could be achievable

have my kids back – Adam

get a flat – Arthur.

or that freedom after the scare of imprisonment made the effort worthwhile:

it's given me freedom, I could have been put away …. A community order from

the judge was a result – Mike.

Some experiences on the edge of negativity could also have a positive effect:

I just want to get the order over and done with - Matthew

Professionals – especially clinicians, but also probation staff – were seen as

facilitating movement towards stability in the practical support and more specific

skills they provided, ranging from 'help' and a 'safety net' to some direct and

specifically desired health impact:

To finally have a diagnosis. And make them understand it, which I've got now –

Grace

The participants also offered descriptions of what the MHTR did for them which

seemed directly compatible with its primary purpose – to facilitate change in their

mental health

It's good to talk to people, because I bottle things up – Robert

Some said it provided them with access to some resources, such as relevant courses.

They also saw the requirement as making a difference to how they were treated by

professional staff:

when I'm in here it's different, they all understand – Dina.

Their concept of the MHTR as a 'safety net' was coupled with their recognition that their assorted problems were associated with an ever present risk of backwards movement, and relapsing into instability again.

The aspects of the MHTR which were seen as barriers to progress yielded the four themes shown under the continuum arrow in the figure – the order as disappointing, stressful, stigmatizing and/or frustrating. Disappointment was not commonly expressed, but when so reflected a gap between expectations and reality:

> *I thought I would get more help …. It's not any different to what I was doing before – Katie*

Sense of being stressed by the order emerged in more than one form. Several expressed phobic anxiety about travelling, or some other mental state limitation, which seemed not to have been recognised by the clinicians and which could limit their ability to keep appointments:

> *sometimes you feel really bad in yourself so you just don't want to go - Samuel.*

Fairly simple difficulties, like availability of public transport, or the means to pay for it created attendance anxiety for some:

> *I had to borrow six pound off an old lady – Steven*

Nevertheless, although all seemed to recognise that failing to comply with their agreement to the MHTR could result in a return to court and even imprisonment, only some said that they felt really stressed by this, particularly following from fear of not having the resources or the ability to keep appointments:

> *if I don't turn up I can go back to court and to prison, and that terrifies me – Dina*

Although our sense was that these potential compliance difficulties were generally part of the mental health and social instabilities with which these participants needed help, some of their observations showed that they accepted some personal responsibility

> *stressful, yeah. It's my own fault, though – Nigel.*

"Stigma" emerged as potentially inhibiting true community reintegration and stability:

> *I don't like to tell people … they just see it like 'oh my God, she's a criminal' – Dina*

Frustrations arose when participants felt unclear about what was expected of them:

> *it needs to …. say on it in black and white – Felicity*

Participants picked up very clearly if professional communication faltered, adding to any other frustrations:

> *I had a bit of a crisis, and I had to phone [the probation officer (PO)]; well, I shouldn't be phoning the PO – I should be phoning them [the mental health team] first - Felicity*

That said, it was one or two participants who seemed particularly frustration prone, this time drawing out the frustration that help was hard to access, again Felicity first, although not alone here:

> *I've only seen her once. I don't think she's doing treatment – Felicity;*

Still nothing's happened … I was supposed to have help … I can't tell you if the

mental health is good because they're not giving nothing to me – Jasper.

There was some recognition that, frustrating though it might be, the MHTR could not

and, perhaps, should not provide instant solutions as individual needs would vary:

trying to find what works best for the individual - Katie.

Discussion

This is the first study of offenders' perspectives of an MHTR.   Taken together, these

offer a model of MHTRs as promoting health and preventing reoffending. The model

could support practitioners in monitoring their effectiveness. Most participants

mentioned at least one specific mental health problem, and at least one social and

one crime related need – suggesting that teaming the social work expertise of the

probation staff with the mental health expertise of the clinical staff was indeed a

good combination for them.

Practical difficulties in fulfilling requirements and risk of breach

The offenders were all aware of the risk that their failure to keep an appointment

might result in return to court for breach of the order and possibly consequent

imprisonment. This is good in the sense that it illustrated that they had fully

understood their position, so to this extent the contract between them, the court

and their social and mental health supervisors seemed valid. Appointment failure

threats to the success of the order and the offender seem avoidable. Support with

some real practical difficulties in keeping the many different appointments required,

and to minimize the stress that this engendered in the context of established mental health problems, would follow logically, providing the probation officer/offender manager and clinician recognise the difficulties. Their awareness of any real barriers to the offender-patient keeping appointments coupled with specific plans accordingly could ensure that the sentence is manageable.   We are unaware of specific guidance on this.

Professionals and their communication

A sense of poor communication between offender-managers/probation officers and clinicians was highlighted by some of these offender-patients. This sometimes contributed to a feeling that nobody was truly interested, led to confusion about requirements and may, if real, have promoted the concerns about insurmountable practical barriers to keeping to the contract on attendance component of the contract. There may have been more in offender perception than in real communication difficulties - Mair and Mills 2009 noted that even offenders without the complication of more than one regular supervisor may find it difficult to understand the need to meet with different people – but Rutherford (2010), while not interviewing offenders, found actually poor inter-agency communication in another context – recommending such orders in the first place. He considered this a reason for under-use of the MHTR.

It might be anticipated that communication difficulties could arise because of the different disciplinary backgrounds and professional ethics of the two staff groups. Medical staff, for example, have expressed concerns about the prospect of breach as

a direct harm to the patient and dislike being drawn into a disciplinary role, while probation staff have reported being daunted by technical clinical language and thinking that clinicians do not take risk of reoffending seriously enough. Both groups are under-resourced, and communication with each other over and above direct contact with the offender-patient a real burden in time-poor services. Nevertheless, it seems intrinsic to the principles of the order that any real or perceived communication difficulties between professional groups are resolved. The Ministry of Justice (2011) advised that 'Treatment Plans' and 'Sentence Plans' should be implemented to improve inter-professional communication. While undoubtedly sound advice, the practitioners should be speaking with each other regularly; offender-patients wanted to be able to see that and, indeed, should be constantly aware of it. Further, probation and mental health trusts need to agree information sharing policies. There are precedents for this in multi-agency public protection panel work (e.g. Royal College of Psychiatrists, 2013), and similar principles could be applied to joint community sentence work. Success may be optimised by having small teams in each setting dedicated to this work, who get to know each other well.

Then, too, offenders must become "active participants in their own care" (Lamberti 2007) in order to promote behavioural change and prevent recidivism. Clarity between professionals about what is expected will help the offender towards clearer communication him/herself, reduce stress in the relationships and even help offenders to feel less stigmatised. The offenders here had a sense that other professional groups and the public reacted differently to them once they heard about their MHTR. Seymour and Rutherford (2008) identified this as a potential

barrier to the implementation of MHTRs, and suggested that even offenders who consent to drug or alcohol treatment orders may refuse an MHTR although having a mental illness as an underlying cause.   Public engagement and education about such requirements could also be helpful (Thornicroft et al. 2007).

Limitations

This is a small study, relying on offender-patients' subjective experiences of a little used community provision. Although the interviewees were similar in some simple respects – sex, broad offence type and history of mental disorder – to those who chose not to participate with the interviews, we cannot rule out the possibility that those wanting to tell their stories would have been having different experiences from those not wanting to. Our study drew on offender-patients from only two centres in England and Wales, so may not be geographically generalisable. Furthermore, repeated changes to the organisation and staffing of probation services since the data were collected, may not only explain the falling use of the MHTR, it may have affected offender-patient perspectives, so our findings may not be generalisable across time. They do, however, provide pointers for future work.

Future research

Although the official figures suggest lower re-offending rates under community or suspended prison sentences than custodial sentences of up to one year (Mews et al, 2013), this work suggested variation according to whether supervision orders had been imposed. Research evidence on the value of an MHTR specifically is lacking, but in the USA, 'mandated' or 'assisted' community treatment' has been shown to have clear benefits in terms of both reduced hospitalisation and reduced re-

offending (Swartz et al, 2007). These authors observed that the order *per se* seemed

to have benefit over and above enhanced services, but noted that these aspects are

inter-linked: 'It is also important to recognize that the AOT [assisted outpatient

treatment] order exerts a critical effect on service providers, stimulating their efforts

to prioritize care for AOT recipients' (pviii, col 2, last line).   Our model provides a

testable hypothesis that offenders who have some awareness of the extent to which

their mental state and social life are unstable may benefit most from the criminal

justice system and clinicians coming together in a formal arrangement to provide the

framework for gaining or regaining stability and, thereby, desistance from offending.

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Online supplementary table: Offender-participant characteristics

Research name	Age band in years*	Previous conviction: yes/no	Offence of violence against the person: yes/no
Adam	20-29	Yes	Yes
Dave	40+	Yes	Yes
Harry	20-29	Yes	Yes
Jasper	19 or under	No	No
Liam	40+	Yes	No
Nigel	20-29	Yes	No
Peter	30-39	Yes	No
Steven	20-29	Yes	No
Tim	40+	No	No
Grace	30-39	No	No
Zachary	30-39	Yes	Yes
Arthur	20-29	Yes	No
Nicola	40+	No	No
Josh	40+	No	No
Ryan	30-39	No	Yes
Felicity	30-39	Yes	No
Brian	20-29	Yes	Yes
Mark	40+	No	Yes
Oscar	20-29	Yes	No
Matthew	20-29	No	Yes
Robert	30-39	Unknown	No
Dina	40+	Yes	No
Samuel	40+	No	No
Katie	20-29	Yes	Yes
Mike	30-39	Yes	No

*Given the small number of participants, age bands rather than specific ages are presented as an extra confidentiality safeguard

Table 1: Emergent categories, themes and core categories of experience of the mental health treatment requirement (MHTR)

Themes	Emergent Categories	Example of narrative illustrative of category
Unstable mental health	Suffering	"Before the probation I suffered a lot and I was being admitted to hospitals and I was not feeling well at all" (Ryan)
	Paranoia / psychosis	"I'm a bit paranoid sometimes…I get a bit paranoid about I'm gonna get my head kicked in…where do I go if they try to attack me…then I think should I be carrying my knife…not to use it but to protect myself" (Tim)
	Suicidal behaviour	"I took the rope up the woods, put the rope around my neck and around the tree, but the tree broke when I jumped" (Harry)
	Self-harm	"When you're on your own you think what can I do now and you snap think and you're going out and you end up injuring yourself, I take it out on myself, I've fallen over at my head, I've fallen over at my knee. I've hurt my body." (Tim)
	Substance misuse	"I want to be able to go out and have a drink and not 21 drinks" (Zachary) "Every day I do need a spliff, because if I don't my anger and my temper will be so bad I'd probably come in here and punch the fuck out of the door or something" (Harry)
	Healthcare failures	"My GP, my local doctors yeah, they just don't understand me at all", "she never seen me for like 2 years my original GP because I freaked her out like" (Robert)
Social instability	Vulnerability	"I was attacked. I was a victim of a violent crime I was" (Arthur)
	Need peace/to be alone	"live a life of peace" , "people won't leave me alone like" (Steven) "I don't hang around with the people I used to hang around with anymore" "I keep myself to myself" (Adam)
	Wanting a life	"to return to you know, my life basically, get my life back" (Mark)

	Offending	"if I do it the wrong way I know what's gonna happen, I'm gonna end up in jail and I don't wanna go back there" *(Zachary)*
MHTR as a potential stabiliser	Provides help	"It helps people…giving people the extra help" (Nigel)
	Provides understanding	"To finally have a diagnosis. And make them understand it. Which I've got now" (Grace)
	A "safety net"	"it's a bit of a safety net I suppose" (Felicity)
	Information and advice provider	"it's gave me things to realise and think about" (Mike)
	Someone to talk to	"it's good to talk to people. Because I bottle things up" (Robert)
	Someone to listen	"someone's willing to listen" (Harry)
	Provides support	"I now get a social worker, a CPN and two psychiatrists looking after me" (Grace)
	Access to other services	"I think the anger management course was good" (Robert)
	Access to medication	"I get my tablets" (Dave)
	Provides motivation	"It gets me out of the house, it gets me motivated" (Zachary)
	Goal setting	"to try and get a job" (Jasper)
	Provides freedom	"it's gave me freedom. I could have been put away…. a community order from the judge was a result" (Mike)
	Improved sense of health	"healthy again and back to my old health" (Peter)
Frustrations with the MHTR	Intrusive/constraining	"I just want to get the order over and done with, because I wanna move abroad really" (Matthew)
	Stigmatising	"I don't like to tell people…. they just see it like oh my God she's a criminal" (Dina)
	Confusing	"it possibly needs to be a bit clearer", "to

		say on it in black and white" (Felicity)
	Disappointing	"I thought I'd get more help" "it's not any different to what I was doing before" (Katie)
	Professional communication	"the care coordinator is gone…now [the PO] has got nobody she can contact, so she's not sure if she's breaking the order or not" (Felicity)
	Access difficulties	"getting here", "I had to borrow six pound off an old lady" (Steven)
	Stressful	"stressful yeah. It's my own fault though" (Nigel)
	Individual need	"trying to find what works best for that individual" (Katie)

Figure 1: Model of the offenders' perspectives

MHTR

Within the offender
Provides motivation
- ✓ To achieve a goal
- ✓ To get order over

Provides freedom

Professionals provide
- ✓ Help
- ✓ Understanding
- ✓ Support
- ✓ Safety net
- ✓ Advice
- ✓ Talking
- ✓ Listening
- ✓ Access to services
- ✓ Medication

INSTABILITY/CHAOS
- ✓ suffering
- ✓ Paranoia
- ✓ Suicidal behaviours
- ✓ Self-harm
- ✓ Substance misuse
- ✓ Healthcare failures
- ✓ Vulnerability
- ✓ offending

STABILITY
- ✓ Achieving health
- ✓ No offending
- ✓ Having a life (goals)
- ✓ Peace and quiet

Frustrations with operation of the order
- o Confusing
- o Poor professional communication
- o Hard to access
- o What works for the individual

Frustrations with experience of the order
- o Stigmatising
- o Stressful
- o Disappointing

MHTR

Key:

⬠ End points

▢ Process

Arrows indicate direction and weight of influence

Grey shading indicates more negative experiences and processes