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The Impact of the Mental Health Treatment Requirement (MHTR) Service on Psychological Distress, Mental Health Recovery-Related Quality of Life, and Shame of Individuals Convicted of a Criminal Offence

Chris Griffiths, Kate Walker, Liv Coelho, Regina Pinto, Jasmine Sarai, Megan Andrew, Olivia Hopkins-Young, Laura Giddings, Harmony Jiang, Elliott House, Maiara Pereira Cunha

Northamptonshire Healthcare NHS Foundation Trust, Berrywood Hospital, Northampton, UK
Email: Chris.Griffiths@nhft.nhs.uk

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Abstract

Background: The Mental Health Treatment Requirement (MHTR) is a court sentencing option for individuals convicted of a criminal offence when there is a link between their mental health and offending which requires community-based treatment. To improve mental health and reduce reoffending, the MHTR service seeks to understand service users' needs and goals and provides appropriate psychological therapy and connection with supportive community services. Aims: This study investigated the impact of an MHTR service on service users' psychological distress, mental health recovery-related quality of life, and shame. Methods: The study design was open-label and did not have a control. Measures used were Clinical Outcomes in Routine Evaluation (CORE-34), Recovering Quality of Life (ReQoL-20), and Experience of Shame Scale (ESS). Participants: Twenty-one MHTR service user participants, thirteen males (62%) and eight females (38%). The ages ranged from 19 to 66 years, with an average age of 37 years. Results: At the end of the MHTR the CORE-34 and ReQol-20 scores significantly improved, with large effect sizes; all four CORE-34 domains (including "risk") significantly improved. There was a significant improvement in ESS overall score with a moderate effect size; all three ESS domains significantly improved. CORE-34 reliable improvement was 76% and ReQoL-20 reliable improvement was 57%. CORE-34 remission rate was 24%. Conclusions: Improvements on the ReQoL-20 indicate the positive impact of MHTR on the individual's mental health recovery, real-world functioning, and quality of life. CORE-34 improvements indicate a positive impact on reducing psychological distress

and risk, which is associated with reducing reoffending. Improvements on the ESS indicate the positive impact of MHTR on reducing shame-related distress which is associated with reduced self-criticism, anger, and antisocial traits. Further research required has been identified. Evidence indicates that MHTR is effective in meeting its goals and should be appropriately resourced to meet demands.

Keywords

ReQoL-20, CORE-34, EQ-5D-5L, Quality-of-Life, Shame, Offenders, Mental Health, Distress, Recovery, MHTR, Reoffending

1. Introduction

Many individuals convicted of criminal offences experience mental health problems; compared to the general population, prevalence rates of mental illness are higher (Brown et al., 2022; Fazel & Baillargeon, 2011; Fazel & Seewald, 2012). Individuals convicted of offences with experience of mental illness are twice to four times as likely to violate conditions set or reoffend (Skeem et al., 2006; Whiting et al., 2021), and they are often not given the support and treatment that they need (Skeem et al., 2006). They can be difficult to treat due to their complex histories, circumstances and issues that they experience (Barnao & Ward, 2015); compared to the general population, they have higher rates of physical health issues, risk and security needs, unemployment, financial insecurity, housing issues, illiteracy, histories of abuse and violence, self-harm, and social deprivation (Callender et al., 2023). Their needs and risks are often considered too high or complex by mainstream community services and so they can be excluded from access (Vaughan & Stevenson, 2002).

The Mental Health Treatment Requirement (MHTR) order is a sentencing option for individuals convicted of offences who experience low to medium level mental health issues which is assessed as being associated with their offending (Callender, 2025; NHS, 2025). Individuals convicted of offences are considered for an MHTR where they are suitable for mental health support and interventions in the community, do not experience psychosis, do not require in-patient mental health treatment (Callender, 2025; NHS, 2025); they often have experience of high levels of stress, anxiety, and depression (Callender, 2025; NHS, 2025). The MHTR service aims to ensure the service is accessible to the most disadvantaged members of the community (including minority ethic groups, individuals with additional learning/communication needs, physical/mental disability, and people with protected characteristics as defined in the Equality Act [2010]) (Callender, 2020).

To receive an MHTR, a person is assessed (considering their full life circumstances) by the MHTR team (senior assistant and qualified clinical psychologists) to see if they meet requirements (Callender, 2025). The proposed treatment/intervention plan is discussed with the Court Duty Officer (CDO) who will include it

in the Pre-Sentence Report (PSR), along with any other community requirements. The CDO will present the PSR proposal to the court; the court then decides if a person receives the offer of an MHTR. Around 70% of those assessed are considered suitable and approximately 67% complete their MHTR (Callender et al., 2025). To receive an MHTR, the convicted individual needs to consent to receive and attend the MHTR order (Callender, 2020).

The MHTR service seeks to understand service users' needs and goals and enable access to appropriate community services to improve health and socially related outcomes and reduce re-offending risk (Callender, 2025; Walker & Griffiths, 2023). This is done through the development of a trusting therapeutic professional relationship, shared goals, individualised support, and evidence-based psychological therapy (Callender, 2025; Walker & Griffiths, 2023). The MHTR support and interventions are clinically supervised by the MHTR clinical psychologist lead and delivered by trained MHTR practitioners (senior assistant psychologists [SAPs]). Practitioners use a semi-structured interview that focuses on engagement, motivation, and fact-finding, and it captures relevant information such as mental health and forensic history, vulnerabilities (including history of trauma and abuse, drug and alcohol issues), current mental-health treatment, personal circumstances, life problems, barriers to attendance, day-to-day functioning, values, what matters to the individual, needs, and goals (Callender, 2025; Walker & Griffiths, 2023).

Psychological interventions are individually tailored to the needs of each service user. The support and interventions typically involve 10 - 12 sessions of 50 - 60 minutes each over approximately six months, where the individual meets with the MHTR practitioner every two weeks. The intervention may typically involve psychological formulation and skills and techniques from the following options: psychoeducation, relaxation breathing exercises, mindfulness, Compassion Focused Therapy (CFT); Dialectical Behaviour Therapy (DBT); Cognitive Behavioural Therapy (CBT); and Behavioural Activation (BA) (Callender, 2025).

The intervention typically involves psychological formulation, from which the treatment plan is developed. Regarding the theoretical approach, therapies such as Compassion Focused Therapy (CFT), Dialectical Behaviour Therapy (DBT), and Cognitive Behavioural Therapy (CBT) may be used, along with their respective techniques, to support the client according to their needs (Callender, 2025).

In the context of offending behaviour, shame is a powerful and often under-recognised emotion (leading to a pervasive sense of defectiveness, inferiority, and social rejection) with implications for psychological functioning and treatment engagement (Tangney et al., 2011). Higher levels of shame are associated with increased self-critical thinking and decreased self-reassuring thinking (Harman & Lee, 2010). Shame relates to feelings of inadequacy, self-criticism, and secondary emotions such as anger (Gilbert, 1998; Tangney & Dearing, 2003; Harman & Lee, 2010; Irons & Lads, 2017). The experience of committing a criminal offence can be highly shame-evoking and is associated with elevated levels of anger, including both in-

wardly directed and outward expressions of anger (Wright et al., 2018). Individuals can feel "trapped" in their feelings of shame, meaning it is difficult to move beyond the feeling; these effects can be longstanding which supports a need to address shame within therapeutic interventions (Roth et al., 2022).

Shame is linked to psychopathology, aggression, and antisocial personality traits in offenders (Morrison & Gilbert, 2001) and higher levels of shame predict increased recidivism, suggesting shame's potential role in offending behaviour (Tangney et al., 2011). This suggests that shame may negatively impact compassionate thinking and contribute to broader mental health difficulties, which are often present in individuals accepted for an MHTR. In addition, shame about mental illness is linked to more negative attitudes toward seeking help, suggesting it may act as a significant barrier to engaging in mental health treatment (Rüsch et al., 2014). These findings support the need for therapeutic interventions within MHTR to include a focus on reducing shame and fostering self-acceptance, ideally through trauma-informed, compassion-focused frameworks.

Using a single cohort pre-post follow-up design to assess the effectiveness of an MHTR, clinically significant improvements have been found on measures of anxiety, depression, psychological distress, social problem solving, emotional regulation, and self-efficacy (Long et al., 2018; Callender, 2021). In the latest Community Sentence Treatment Requirement Multisite Report (Callender et al., 2025) there were 1,931 individuals with pre and post CORE-34 psychological distress scores, the average baseline score indicated moderate average psychological distress, the average post score indicated improvement to mild psychological distress, and the average reduction was statistically significant, with 76% experiencing reliable change. Professional stakeholder interviewees described: 1) the key benefits of MHTRs as increasing community sentencing options, addressing gaps in service provision, and facilitating individuals convicted of offences' access to community services; 2) key challenges included effective multi-agency working, complexity of needs, and motivation to engage; and 3) success factors as dedicated staff and providing a broad range of support to meet needs (Molyneaux et al., 2021). Service users' poor insight into mental health difficulties, current drug use, factors related to offending history, and psychological distress scores significantly predict poor engagement in MHTR (Kotterbova & Lad, 2022).

Service users have reported that psychological therapy as part of the MHTR allowed them to "talk about things unsaid in the past"; engagement within an MHTR prompted participants to reflect on their self-perception, reassess their life choices, and identify additional support needs (Butler & Ledwith, 2021, p. 257). MHTR service users have reported that often their core concern about their lives was their instability, which was improved by not offending, becoming healthier, being substance-free, having a meaningful life, and achieving goals; the MHTR helped their motivation and enabled a more stable life (Manjunath et al., 2018). Service users saw the MHTR as a "safety net" and a source of information and advice, that it provided someone to talk to, someone who would listen, professional support, an op-

portunity for goal setting, and access to supportive community services and appropriate medication (Manjunath et al., 2018). Frustrations with the MHTR have included it being intrusive, stressful and stigmatising, and some have found it difficult to attend appointments (e.g., cost of transport) (Manjunath et al., 2018). Analysis of in-depth interviews with fourteen individuals convicted of offences who completed their 12-week MHTRs found that a strong therapeutic alliance, an individualised approach, and offering flexibility around delivery promoted engagement with the MHTR; an MHTR can improve mental health, self-worth, and self-compassion, and reduce offending through providing service users with tools, techniques, and strategies to promote positive behavioural changes in their lives (Walker et al., in press).

This study uses the Clinical Outcomes in Routine Evaluation (CORE-34), Recovering Quality of Life (ReQoL) and Experience of Shame Scale (ESS) to understand the impact of the MHTR on psychological distress, mental health recovery-related quality of life, and shame. The ReQoL-20 is an assessment measure not used in the MHTR service; therefore, this research aimed to assess its acceptability and feasibility and contextualise its usage by offering to service users and calculating correlations with the CORE-34 measure of psychological distress, which is used as a standard within MHTR services across the UK.

2. Methodology

2.1. Design

An open-label design with no control group using pre-, mid-point, and post-intervention outcome measures.

2.2. Approval

The project was undertaken from June 2023 to June 2025. Ethical approval for the study was gained from the NHS Healthcare Trust Institutional Review Board (IRB) where the services were based (reference for NHS trust approval: MHTR-Experience) and NHS Health Research Authority (HRA) research ethics committee (REC) reference: 22/EE/0151. The study was undertaken in accordance with the Declaration of Helsinki.

2.3. Measures

1) Recovering Quality of Life (ReQoL) (Keetharuth et al., 2018). ReQol-20 is a self-reported quality of life (a measure of the impact of mental health problems on people's lives) for people with mental health conditions. Items cover the following areas of quality of life: meaningful activity; belonging and relationships; choice; control and autonomy; hope; self-perception; well-being, and physical health. Test and retest reliability is acceptable, it has robust structure properties and good internal construct validity (Keetharuth et al., 2018, 2021). An increase in 10 points or more denotes a reliable improvement. Clinical range of mental illness is defined as a score between 0 and 49; a score above 50 is considered non-

clinical (Keetharuth et al., 2021). ReQoL-20 was specifically designed to measure mental health service users' perspectives of recovery and quality of life (Keetharuth et al., 2021).

2) Experience of Shame Scale (ESS) (Andrews et al., 2002a). The ESS assesses characterological, behavioural, and bodily shame; the use of the ESS has shown that shame is significantly negatively correlated with positive mental health and greater life satisfaction (Andrews & Hunter, 1997) and positively correlated with general psychopathology, with support for reliability and psychiatric validity of the ESS construct (Vizin et al., 2016). Higher scores indicate more shame. A cutoff score of 71 on the total ESS score is used to distinguish between normal or non-clinical levels of shame and more problematic or clinical levels of shame (Andrews et al., 2002a).

3) Clinical Outcomes in Routine Evaluation (CORE-34) (Evans et al., 2000). The CORE-34 is a 34-item self-report measure that assesses psychological distress across four domains: well-being (subjective wellness), problems/symptoms (degree of anxiety and/or depression), functioning (perceived coping) and risk (both to self and others). The questionnaire has been shown to have strong reliability (>0.75, <0.95) and validity (Evans et al., 2002). Scoring is composed of a total sum for wellbeing (four items), problems/symptoms (12 items), functioning (12 items) and risk (six items). Higher scores indicate more psychological distress. Score ranges: 0 - 4: healthy/non-clinical; 5 - 9: mild non-clinical; 10 - 14: mild psychological distress; 15 - 19: moderate psychological distress; 20 - 24: moderate-to-severe psychological distress; and 25 and above: severe psychological distress.

Client data obtained from clinical records

Following informed consent, NHS medical notes/records, health assessment forms, and MHTR service documents were reviewed to collate routinely collected data: 1) age; 2) sex; 3) ethnicity; 4) diagnoses.

2.4. Inclusion and Exclusion Criteria

Participants were individuals who had been reviewed and recommended for an MHTR, court-ordered to receive one, and had consented to attend an MHTR. These individuals were offered participation in the research study and provided informed consent to take part. Inclusion criteria required participants to receive an MHTR and be capable of providing informed consent. Exclusion criteria comprised a lack of capacity to consent or failure to complete the MHTR order.

2.5. Participants

A total of 21 participants were recruited: 13 males (61.9%) and 8 females (38.1%), aged 19 to 66 years (M_{age} = 37.1 years). Eight participants had no formally recorded mental health diagnoses. **Table 1** lists mental health diagnoses for the 13 participants reporting mental health diagnoses. **Table 2** presents participants' self-reported ethnicity group.

Table 1. Diagnoses.

Diagnosis	Number of participants (percentage)
Depression	10 (76.9%)
Anxiety	6 (46.2%)
Emotionally Unstable Personality Disorder (EUPD)	4 (30.8%)
Bipolar disorder	1 (7.7%)
Mixed anxiety and depressive disorder	1 (7.7%)
Asperger syndrome	1 (7.7%)
Post-traumatic stress disorder (PTSD)	1 (7.7%)

Table 2. Ethnicity.

Ethnicity	Number of participants (percentage)
White British	18 (85.7%)
White European	1 (4.8%)
Black or Black British: Caribbean	1 (4.8%)
Black or Black British: Other	1 (4.8%)

2.6. MHTR Intervention

A meeting was arranged with the service user, their probation officer, and the MHTR practitioner (senior assistant psychologist) to facilitate a thorough discussion of the treatment process. During this meeting, the practitioner explained the structure and expectations of the service, ensuring the service user had a clear understanding of what was involved. Initial meeting discusses goals, needs, and support. The interventions were delivered by trained senior assistant psychologists (SAPs) under weekly supervision from a clinical psychologist. Each MHTR consisted of 12 sessions, each lasting approximately 60 minutes. Sessions were typically held every two weeks. At the outset, a collaborative formulation is created between the service user and the practitioner. The MHTR practitioner works with the person to improve their mental health, their ability to self-manage and cope, and to decrease their distress and risk of re-offending. The practitioner employs an integrative approach that includes psychoeducation, Compassion-Focused Therapy (CFT), Dialectical Behaviour Therapy (DBT), Cognitive Behavioural Therapy (CBT), Acceptance and Commitment Therapy (ACT), and/or value-based solution-focused therapy. The specific interventions are tailored to address the unique needs of each service user.

2.7. Procedure

The three self-report measures were completed prior to start of the MHTR, after approximately 6 sessions (the mid-point) and at the end of the MHTR.

2.8. Statistical Analysis

Paired-sample t-tests were used to compare changes to determine if there was a statistically significant difference in CORE-34, ReQoL and ESS scores at baseline, mid-point, and post-intervention. Spearman's rho was used to calculate correla-

tions between the measures. Data were analysed using the statistical software package SPSS version 30.

3. Results

3.1. Descriptive Statistics

Average scores are presented in the tables below. Table 3 shows average CORE-34, ReQoL, and ESS total scores at baseline, mid-point, and post-intervention.

Table 3. Mean total scores at baseline, mid-point, and follow-up.

	CORE-34 total score	ReQoL total score	ESS total score
Baseline	*M* = 48.00, S*D* = 29.66, clinical score = 14.18	*M* = 44.24, *SD* = 18.21	*M* = 69.48, *SD* = 20.18
6 sessions	*M* = 36.24, *SD* = 24.58, clinical score = 10.66	*M* = 51.62, *SD* = 19.16	*M* = 60.43, *SD* = 22.21
12 sessions	*M* = 29.62, *SD* = 22.48, clinical score = 8.71	*M* = 56.86, *SD* = 16.76	*M* = 58.29, *SD* = 21.87

Table 4 presents mean scores across CORE-34 domains. Table 5 shows average scores for ESS domains. To calculate the CORE-34 clinical score, the total score is divided by the number of completed items and then multiplied by ten.

Table 4. CORE-34 domain scores.

	Wellbeing	Problems/ Symptoms	Functioning	Risk
Baseline	*M* = 7.10, *SD* = 4.75	*M* = 22.38, *SD* = 13.52	*M* = 16.62, *SD* = 11.16	*M* = 1.90, *SD* = 3.53
6 sessions	*M* = 4.86, *SD* = 4.21	*M* = 17.43, *SD* = 11.69	*M* = 12.67, *SD* = 8.17	*M* = 1.29, *SD* = 2.26
12 sessions	*M* = 4.43, *SD* = 3.30	*M* = 14.19, *SD* = 12.29	*M* = 10.43, *SD* = 7.77	*M* = 0.48 *SD* = 1.03

Table 5. ESS domain scores.

	Characterological Shame	Behavioural Shame	Bodily Shame
Baseline	*M* = 30.86, *SD* = 11.02	*M* = 26.95, *SD* = 7.63	*M* = 11.67, *SD* = 4.42
6 sessions	*M* = 27.19, *SD* = 11.49	*M* = 23.76, *SD* = 8.54	*M* = 9.48, *SD* = 4.08
12 sessions	M = 26.52, SD = 10.90	M = 22.29, SD = 8.72	M = 9.48, SD = 4.18

3.2. CORE-34

There was a significant decrease in the overall CORE-34 score. From baseline to 6 sessions: 2.678 ($p = 0.007$), large effect size ($r = 0.584$). From baseline to 12 sessions: 3.460 ($p < 00.1$), large effect size ($r = 0.755$). 16 participants (76.19%) showed reliable improvement (≥5-point decrease) from baseline to final follow-

up. 5 participants (23.81%) obtained remission (score < 10) at final follow-up.

3.2.1. CORE-34 Wellbeing Domain

There was a significant decrease in CORE-34 wellbeing score of 2.504 ($p = 0.012$) from baseline to first follow-up (6 sessions), with a large effect size ($r = 0.546$) and 2.812 ($p = 0.005$) from baseline to final follow-up (12 sessions) with a large effect size ($r = 0.614$), indicating a significant improvement in psychological distress related to wellbeing.

3.2.2. CORE-34 Problems and Symptoms Domain

There was a significant decrease in CORE-34 problems and symptoms score of 2.430 ($p = 0.015$) from baseline to first follow-up (6 sessions), with a large effect size ($r = 0.530$) and 3.175 ($p = 0.001$) from baseline to final follow-up (12 sessions), with a large effect size ($r = 0.693$), indicating a significant improvement in psychological distress related to problems and symptoms.

3.2.3. CORE-34 Functioning Domain

There was a significant decrease in CORE-34 functioning score of 2.646 ($p = 0.008$) from baseline to first follow-up (6 sessions), with a large effect size ($r = 0.577$), and 2.841 ($p = 0.005$) from baseline to final follow-up (12 sessions), with a large effect size ($r = 0.620$), indicating a significant improvement in psychological distress related to functioning.

3.2.4. CORE-34 Risk Domain

There was a non-significant decrease in CORE-34 risk score of 0.539 ($p = 0.590$) from baseline to first follow-up (6 sessions), with a small effect size ($r = 0.118$), and a significant decrease in CORE-34 risk score of 1.970 ($p = 0.049$) from baseline to final follow-up (12 sessions), with a moderate effect size ($r = 0.430$), indicating a significant improvement in psychological distress related to risk.

3.3. ReQoL-20

There was a significant increase in ReQoL-20 overall score of 2.523 ($p = 0.012$) from baseline to first follow-up (6 sessions), with a large effect size ($r = 0.551$), and 3.146 ($p = 0.002$) from baseline to final follow-up (12 sessions), with a large effect size ($r = 0.687$). 12 participants (57.14%) showed reliable improvement in ReQoL-20 score (% who increased by 10 points or more) from baseline to final follow-up. 5 participants (23.81%) obtained recovery/remission in ReQoL-20 score (% who moved from below 50 to 50 or above) from baseline to final follow-up.

3.4. ESS

There was a significant decrease in ESS overall score of 2.371 ($p = 0.018$) from baseline to first follow-up (6 sessions), with a large effect size ($r = 0.517$), and 2.110 ($p = 0.035$) from baseline to final follow-up (12 sessions), with a moderate effect size ($r = 0.460$).

3.4.1. ESS Characterological Domain

There was a significant decrease in ESS characterological score of 2.207 ($p = 0.027$) from baseline to first follow-up (6 sessions), with a moderate effect size ($r = 0.482$), and 1.993 ($p = 0.046$) from baseline to final follow-up (12 sessions), with a moderate effect size ($r = 0.435$), indicating improvements in self-perception, self-evaluation and emotional regulation.

3.4.2. ESS Behavioural Domain

There was a significant decrease in ESS behavioural score of 2.157 ($p = 0.031$) from baseline to first follow-up (6 sessions), with a moderate effect size ($r = 0.471$), and 2.784 ($p = 0.005$) from baseline to final follow-up (12 sessions), with a large effect size ($r = 0.608$), indicating improvements in shame about actions, self-compassion and less avoidance and withdrawal.

3.4.3. ESS Bodily Shame Domain

There was a significant decrease in ESS bodily shame score of 2.817 ($p = 0.005$) from baseline to first follow-up (6 sessions), with a large effect size ($r = 0.615$), and 2.570 ($p = 0.010$) from baseline to final follow-up (12 sessions), with a large effect size ($r = 0.561$), indicating improvements in body-related self-perception and reduced distress about physical appearance.

3.5. Correlational Analysis

Baseline correlations:

Correlation between CORE-34 and ReQoL = $p(19) = -0.910$, $p = 0.001$. There was a significant negative correlation between baseline overall CORE-34 and baseline overall ReQoL scores; a higher baseline CORE-34 score was strongly correlated with a lower baseline ReQoL score. Correlation between CORE-34 and ESS = $p(19) = 0.643$, $p = 0.002$. There was a significant positive correlation between baseline overall CORE-34 and baseline overall ESS scores; a higher baseline CORE-34 score was moderately associated with a higher baseline ESS score. Correlation between ESS and ReQoL = $p(19) = -0.685$, $p < 0.001$. There was a significant negative correlation between baseline overall ESS and baseline overall ReQoL scores; a higher baseline ESS score was moderately correlated with a lower baseline ReQoL score.

Mid-point correlations (after 6 sessions):

Correlation between CORE-34 and ReQoL = $p(19) = -0.941$, $p < 0.001$. There was a significant negative correlation between mid-CORE-34 overall score and mid-ReQoL overall score; a higher CORE-34 score was strongly correlated with a lower ReQoL score after completing 6 sessions. Correlation between CORE-34 and ESS = $p(19) = 0.341$, $p = 0.130$. There was a non-significant positive correlation between mid-CORE-34 overall score and mid-ESS overall score. Correlation between ReQoL and ESS = $p(19) = -0.351$, $p = 0.118$. There was a non-significant negative correlation between mid-ReQoL overall score and mid-ESS overall score. **Table 6** shows the correlations between measures post-MHTR.

Post-MHTR correlations:

Correlation between CORE-34 and ReQoL = $p(19) = -0.906$, $p < 0.001$. There was a significant negative correlation between post-CORE-34 overall score and post-ReQoL overall score; a higher CORE-34 score was strongly associated with a lower ReQoL score. Correlation between CORE-34 and ESS = $p(19) = 0.344$, $p = 0.127$. There was a non-significant positive correlation between post-CORE-34 overall score and post-ESS overall score. Correlation between ReQoL and ESS = $p(19) = -0.420$, $p = 0.058$. There was a non-significant negative correlation between post-ReQoL overall score and post-ESS overall score.

Table 6. Correlations between measures post-MHTR.

	ReQoL	CORE-34	ESS
ReQoL	___	___	___
CORE-34	0.905*	___	___
ESS	0.420	0.344	___

*Significant at $p < 0.001$.

4. Discussion

This study investigated the impact of the MHTR on mental health recovery-related quality of life, psychological distress, and shame. Significant improvements were found across all these domains, indicating the positive effects of the MHTR. These findings support the continued—and potentially expanded—implementation of MHTRs. The positive outcomes seen are important in the context of this cohort which often difficult to engage with and treat due to physical health needs; risk and security issues; high levels of unemployment; financial insecurity; housing issues; illiteracy; histories of abuse, violence, and self-harm; and social deprivation (Barnao & Ward, 2015; Callender, 2020). The MHTR services' success in improving mental health and reducing psychological distress and risk indicates potential reduction in breaches of court conditions and reoffending, risk of which is higher for individuals convicted of offences who have experience of mental illness (Skeem et al., 2006; Whiting et al., 2021).

The CORE-34 outcomes demonstrated that MHTR can be effective in treating symptoms of psychological distress. There were significant improvements in all CORE-34 sub-domains (well-being, functioning, problems and symptoms, and risk). Reliable improvement (76%) in this study matched the latest Community Sentence Treatment Requirement Multisite Report (Callender et al., 2025). The average score for the MHTR clients moved from "clinical" psychological distress range to 'non-clinical' range. However, less than a quarter experienced remission, indicating the challenging nature of enabling of individuals convicted of offences to have levels of psychological stress considered to be non-clinical, and the ongoing impact of current and historical factors causing psychological stress (Barnao & Ward, 2015; Callender, 2020).

At baseline ReQoL average scores showed that mental health problems had a severely negative effect on participants' lives. Post-treatment improvements on

the ReQoL-20 demonstrated a positive impact of the MHTR on an individual's real-world functioning, quality of life and mental health recovery, on factors that are important to people in their everyday lives (Keetharuth et al., 2018, 2021). The average scores for the MHTR clients moved from being in the ReQoL-20 "clinical" range to "non-clinical" range, indicating less need for mental health treatment and services. The ReQoL-20 demonstrated strong negative correlations between CORE-34 at baseline, follow-up, and change over time, indicating that it is an effective measure of the impact of psychological distress symptoms on mental health recovery-related quality of life. The ReQoL-20 demonstrated negative but non-significant correlations with experience of shame. Further research could investigate the effect of shame levels on mental health recovery-related quality of life and consider whether addressing factors related to shame can enhance functioning, quality of life and mental health recovery.

The ReQoL was co-developed with people with lived experience of mental illness (Keetharuth et al., 2018). It is designed to assess the quality of life consistent with the themes of mental health recovery for people with mental health conditions to help define needs and strengths and decide what support or services people receive (Keetharuth et al., 2018). This study showed that the ReQoL can be successfully collected by MHTR practitioner psychologists and MHTR service users can complete it, demonstrating acceptability and feasibility of the ReQoL-20. The ReQoL-20 was designed to enable a move from symptomology to broader recovery-based assessment and defining needs, strengths and support required (Franklin et al., 2021), and its inclusion as a part of assessment and a measure of change in MHTR can possibly facilitate more focus towards service user-defined mental health recovery.

At the start of the MHTR participants reported shame levels close to those typically seen in clinical populations, according to the original Experience of Shame Scale (ESS) guidelines. The average shame scores for the MHTR clients were close to the ESS definition "clinical" range, indicating high levels of shame in this group, which is consistent with evidence showing that shame is prevalent among individuals with complex trauma histories, especially in offender populations (Tangney et al., 2011). The reduction in ESS scores observed at follow-up indicates that MHTR may be effective in addressing shame.

Further analysis identified a significant positive correlation between baseline ESS scores and CORE-34 scores, indicating that higher levels of shame were associated with increased psychological distress. This supports prior theoretical and empirical findings linking shame to broader emotional dysregulation and psychopathology (Andrews et al., 2002b; Goss & Gilbert, 2002). Notably, this correlation was no longer statistically significant at follow-up, suggesting that while shame and distress are closely related initially, their trajectories may diverge over time with targeted intervention. This pattern aligns with evidence that shame-focused treatments can disrupt the reinforcing cycle between self-conscious emotions and general psychological distress (Goffnett et al., 2020). This potential mechanism could be investigated with further research.

Significant improvements were also noted across all three ESS subdomains—characterological, behavioural, and bodily shame—highlighting a broad-based impact of the intervention. Characterological shame, often associated with entrenched negative self-perceptions and identity disturbance, is particularly relevant in forensic clients with histories of complex trauma and institutionalisation. Behavioural shame, which pertains to specific actions or perceived moral failings, and bodily shame, often linked to stigma and earlier experiences of abuse or neglect, are also highly prevalent in offender populations (Gilbert, 1998; Tangney et al., 2007). These findings underscore the potential utility of integrative, trauma-informed interventions such as MHTR in addressing the multifaceted nature of shame in forensic populations.

Qualitative research has described how the MHTR improves outcomes. Those interviewed report that the MHTR helped them to implement healthy lifestyle behaviours, thus improving physical and mental health (Walker et al., in press). Participants reported reductions in drug and alcohol use (Walker et al. in press) which can reduce offending (Bennett et al., 2008; Newbury-Birch et al., 2016) and improve mental health (Jané-Llopis & Matytsina, 2006). Participants also reported doing more physical exercise which can positively impact mental health (Mikkelsen et al., 2017; Smith & Merwin, 2021). Evidence indicates the benefit of MHTR practitioners' application of collaborative formulation, building strong therapeutic relationships, and using an individualised holistic approach (Walker et al., in press). Both quantitative and qualitative findings provide evidence that the MHTR facilitates meaningful psychological and functional improvements.

4.1. Further Research

Future research should explore the longer-term impact of MHTR on an individuals' mental health, ability to cope and manage, quality of life, and reoffending. Of those who start MHTR, 74% complete it, with a third of these attending 6-11 sessions, i.e., less than the standard 12 sessions (Callender, Sanna, & Cahalin, 2023). Future research could be conducted with those who did not engage, chose to drop out, or were unable to complete for reasons they had no control over, to inform sentencing decisions, needs of this group and how to address them, and to better understand MHTR service user engagement. A national multi-site qualitative study interviewing service users and MHTR staff is needed to explore the needs of MHTR service users, how best to meet those needs to achieve MHTR required outcomes; to identify which aspects of MHTR interventions are effective and why to improve outcomes (Butler & Ledwith, 2021; Callender, Sanna, & Cahalin, 2023; Walker et al., in press). It would also be beneficial to examine which therapeutic components, such as compassion-focused, schema, or cognitive-behavioural approaches, are most effective in addressing specific domains of shame within forensic populations. MHTR currently excludes those with psychosis; individuals convicted of offences with psychosis could also benefit from an MHTR consideration. Extending MHTR to those with psychosis and conducting research

on MHTR for those with psychosis. Implementing and further evaluating the ReQoL-20 as an assessment tool within MHTR could help define individuals' needs and strengths, as well as the support or services they receive.

4.2. Limitations

This study lacked a control group, limiting the ability to attribute observed improvements solely to the MHTR. In this study males were overrepresented, so this research is less relevant to females. The majority identified as "White British", so this research is less relevant to other ethnic groups. The exclusion of participants who failed to complete the MHTR order introduces a potential selection bias; the findings reflect outcomes for programme completers and may not generalize to all individuals who begin an MHTR. All participants were attending an MHTR delivered by one English county-based NHS trust, limiting its generalisability to other MHTR providers; however, all MHTR providers' work is based on the MHTR manual (Callender, 2025). As participants were assessed immediately after the end of the MHTR only short-term outcomes could be reported.

5. Conclusion

This research aligns with national MHTR results of positive impact on psychological distress and risk factors (Callender et al., 2025). In addition, it provides insights into and evidence for the positive impact of the MHTR on shame (and ESS domains of shame) and mental health recovery-related quality of life. These outcomes support not only the current delivery of MHTRs but also broader implementation.

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Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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