Mental Health Treatment Requirements

Peer-reviewed research on the effectiveness and impact of sentences, orders, and requirements.

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Summary

This effectiveness bulletin reviews and summarises the evidence for the effectiveness of mental health treatment requirements in improving psychiatric symptoms and reducing reoffending. Mental health treatment requirements (MHTRs) can be attached to Community Orders or Suspended Sentence Orders under paragraphs 16-17 of Schedule 9 to the Sentencing Act 2020. They are intended for offenders with mental health needs who do not meet the threshold for a prison sentence or for treatment in a secure hospital setting.

While there appears to be an association between mental disorder and offending, it is not clear whether this relationship is causal and, therefore, whether treating mental disorder will reduce offending. Emerging evidence has shown positive mental health gains for MHTR recipients post-treatment. There is some evidence that MHTRs can reduce reoffending when compared to Community Orders without an MHTR and short prison sentences. However, further research is required to verify these positive initial findings.

Mental Health Treatment Requirements: Legal provisions

This bulletin is based on a research review of available studies on mental health treatment requirements (MHTRs) published since 2012, focusing on evidence of their effectiveness in improving symptoms and reducing reoffending.

MHTRs are for convicted offenders whose offences fall below the threshold for a prison sentence and who have mental health needs that do not require treatment in a secure hospital setting (National Offender Management Service, 2014, p. 1). For example, where the person does not pose a significant risk to themselves or to others and detention in hospital is therefore unnecessary, or where appropriate treatment is available in the community and the offender is willing to engage with it. MHTRs can be added to Community Orders and Suspended Sentence Orders for adults under Schedule 9 to the Sentencing Act 2020. They may be combined with other requirements, such as unpaid work requirements, curfews, or drug or alcohol treatment requirements.

An MHTR can only be made where the individual's mental condition:

(a) requires treatment;

(b) may be susceptible to treatment; and

(c) does not warrant the making of a hospital order or guardianship order under the Mental Health Act 1983.

The Court must further be satisfied that:

(a) arrangements have been made; or

(b) arrangements can be made for the treatment intended to be specified in the order; and

(c) that the offender has expressed willingness to comply with the requirement (the consent condition) (paragraph 17 of Schedule 9 to the Sentencing Act 2020).

An MHTR can require the offender to submit to mental health treatment for a particular period. This treatment may be (a) in-patient treatment, (b) institution-based out-patient treatment, or (c) practitioner-based treatment (paragraph 16(1) of Schedule 9 to the Sentencing Act 2020).

There are two MHTR pathways: primary care and secondary care. Individuals assigned to primary care are overseen by a qualified psychologist and offered 12 sessions of cognitive behavioural therapy. The secondary care pathway is available for those with more significant, complex and/or long-term mental disorders that impact upon their daily functioning. These individuals are overseen by local secondary care community adult mental health services, and a psychiatrist will usually be responsible for their care (Arsuffi et al., 2024). While primary care MHTRs are now available in most places in England, secondary care MHTRs are still underused (Arsuffi et al., 2024).

If the offender is suspected of breaching an MHTR, they can be referred to a court. If the court finds the order has been breached without reasonable excuse, it can (a) impose a fine of up to £2,500, (b) change the terms of the Community Order to make them more demanding, or (c) re-sentence the offender for the original offence. If the offender is found to have 'wilfully and persistently' breached the MHTR, the court may choose to impose a custodial sentence (paragraphs 10-11 of Schedule 10 to the Sentencing Act 2020).

MHTRs are rarely used

While it is estimated that 40% of offenders serving Community Orders have a diagnosable mental health condition, MHTRs have been little used (Judicial College, 2021, Chapter 4, para. 127). In 2019, MHTRs accounted for just 0.4% of requirements commenced under Community Orders or Suspended Sentence Orders (Ministry of Justice, 2020, para. 108). The uptake of MHTRs has since increased, following a drive to improve partnership working between health and criminal justice services to ensure that courts are provided with the information and treatment plans required to make an order (Kimbell, 2023). In 2024, 4,880 MHTRs were made: 2,976 for Community Orders and 1,904 for Suspended Sentence Orders (Ministry of Justice, 2025, Table 6.8). That year, MHTRs accounted for 2.8% of requirements commenced under Community Orders and Suspended Sentence Orders (ibid).

The rate of MHTRs remains low despite evidence of high levels of mental health needs amongst offenders on probation. While there are no large-scale representative studies of rates of psychiatric disorders in this population, a study of 173 randomly sampled probation supervisees in Lincolnshire gives an indication. It estimated that 17.3% of the sample were experiencing a major depressive episode, 2.3% were experiencing either a manic or hypomanic episode, 11% had a current psychotic disorder, and 47% had probable personality disorder (Brooker et al., 2012, p.529). These rates are slightly lower than those recorded amongst samples of prisoners, but they are significantly higher than those amongst the general population of England and Wales, where the estimated prevalence of psychotic disorders, mood disorders, and personality disorder are 1%, 5% and 12% respectively (Tyler et al., 2019; National Institute of Health and Care Excellence, 2017). Exceptionally high rates of personality disorder amongst offender populations may be explained in part by the incorporation of offending behaviour into the diagnostic criteria for antisocial personality disorder (see O'Loughlin, 2024, Chapter 2).

Barriers to the use of MHTRs

MHTRs are a promising means of ensuring that people with mental health conditions in contact with the criminal justice system can receive treatment in the community. They can provide an alternative to imprisonment, which can 'exacerbate mental ill health, heighten vulnerability and increase the risk of self-harm and suicide' (Bradley, 2009, p.7). There are several barriers to making MHTRs that need to be overcome to increase their use. These include (Scott and Moffatt, 2012 and Molyneaux et al., 2021):

- Poor understanding and awareness of MHTRs amongst court, probation and health professionals
- Limited screening for mental health problems in criminal justice settings
- Uncertainty amongst health professionals as to who should receive an MHTR
- A tendency to exclude certain groups from MHTRs due to their diagnosis
- Difficulties in accessing suitable community mental health care
- Uncertainty as to how to manage breaches by offenders and ethical concerns
- The need to obtain the offender's consent to the requirement

Barriers to service user engagement with MHTRs include the service user having poor insight into their mental health difficulties, drug use, and high levels of distress (Kotterbova and Lad, 2022). Having at least one previous recorded offence also predicts non-engagement with an MHTR intervention, but it is not clear why this is the case (Kotterbova and Lad, 2022). As noted above, work is underway to improve partnership working to facilitate the making of MHTRs, and a national evaluation of MHTRs has been published with recommendations for further improvements to the service (Callender et al., 2024).

Mental Disorder and Offending

There is an uncertain association between mental disorder and offending. While there are no published studies of rates of mental disorder amongst people given Community Orders, research demonstrates that rates of many types of mental disorder are significantly higher amongst prisoners and those on probation than in the general population (Tyler et al., 2019; Brooker et al., 2012). However, it is difficult to establish a causal connection between mental ill-health and offending. The evidence is more supportive of the view that mental disorder is one factor amongst many that contribute to offending, and that the interaction between mental disorder and factors including social deprivation, unemployment, homelessness, and substance misuse is complex (O'Loughlin et al. 2022, p.14; National Institute for Health and Care Excellence, 2017, p. 20).

While there is evidence of a link between certain diagnoses and violent behaviour, 'most people with mental disabilities are not violent, and most violence is not committed by people with mental disabilities' (O'Loughlin and Peay, 2023, p. 207). A meta-analysis examining studies of rates of violent offending amongst samples of people diagnosed with specific mental disorders estimated that 5% of those diagnosed with mental illness (excluding those with personality disorders, schizophrenia and substance misuse) committed a violent crime over a 5–10-year period. For those diagnosed with personality disorders and schizophrenia spectrum disorders, the rate increased to 6–10%. For those diagnosed with substance misuse disorders, the rate was more than 10% (Whiting et al., 2021, p. 150). By comparison, the estimated general population rate of violent offending was 0.6% and 0.9% over a 10-year period (Sariaslan et al., 2020, p. 363).

While these studies show an association between mental disorder and offending, it is not clear whether this relationship is one of direct causation. Elevated offending rates amongst those with certain mental health conditions may be alternatively attributable to other factors that affect them, such as social exclusion, poverty, or homelessness (Trebilcock and Weston, 2020, p.27-30). Or, the mental disorder and the offending may have a common cause, such as adverse childhood experiences. Further research is required to more fully understand the association between mental disorder and offending.

Treatment may help to reduce reoffending, but more research is needed

Given the uncertain nature of the relationship between mental disorder and offending, it is unclear whether treating mental disorder will necessarily result in a reduction in reoffending. A recent meta review by the Ministry of Justice concluded that 'there is insufficient evidence that interventions to address mental health needs reduce reoffending' (Cordle and Gale, 2025, p.50). This is not to say that mental health treatment is ineffective in reducing reoffending. Rather, there is a lack of robust studies demonstrating a direct link between treatment and reductions in reoffending (Cordle and Gale, 2025).

The gold standard for demonstrating that mental health treatment reduces reoffending would be a study that randomly assigned a treatment group and a control group with the same characteristics to treatment or no treatment and followed both groups for a long enough period to determine levels of reoffending in each. This type of study is generally considered not to be feasible in sentencing, as the aim is to tailor the sentence to the offender and the offence. The next best study design is to compare outcomes for matched cohorts of offenders who share the same characteristics but who were sentenced differently. This is the design employed by the existing evidence, but with some caveats.

There is some evidence of reductions in reoffending following mental health treatment, including from a study that matched offenders with psychosis sent by a court for treatment with offenders

not sent for treatment who had similar characteristics (Weatherburn et al., 2021). More robust studies examining a broader range of treatments for mental disorder are required to more convincingly demonstrate effectiveness in reducing recidivism. The same can be said for the evidence on MHTRs, considered in the next section.

Evidence suggests that MHTRs improve mental health

Existing evidence suggests that MHTRs do have a positive impact on mental health outcomes. An evaluation study of MHTRs compared 452 participants' scores on measures of mental health prior to engaging in treatment and after completing treatment. It found that MHTRs are associated with improvements in mental health outcomes, including significant reductions in distress, anxiety and depression symptoms for those who completed treatment (Callender et al., 2023). The average scores for global psychological distress, anxiety and depression were in the moderate range before participants completed their MHTRs and in the mild range after completion (Callender et al., 2023). These findings were all statistically significant. The study has limitations: it did not use a control group that did not complete the intervention and it did not include non-completers of the programme, who accounted for a quarter of all those given an MHTR in the study (Callender et al., 2023). The study does not specify the reasons for non-completion, but a more recent report found that non-completers waited 21 days longer than completers to start their treatment, suggesting that delays between sentencing and starting treatment may contribute to participants not completing an MHTR intervention (Callender et al., 2024). Nevertheless, the evidence suggests that MHTRs are a promising means for improving mental health outcomes for offenders: a group that is disproportionately affected by mental health problems.

Evidence suggests that MHTRs reduce reoffending

Research commissioned by the Ministry of Justice published in 2018, based on data for matched cohorts of offenders from 2010 to 2011, found that MHTRs resulted in a significant reduction in reoffending over a one-year follow-up period (Hillier and Mews, 2018, p.6). Where an MHTR formed part of a Community Order, the study found a reduction in reoffending of around 3.5 percentage points, and it found a reduction of around 5 percentage points where the MHTR formed part of a Suspended Sentence Order (Hillier and Mews, 2018, p.6). Offenders with significant psychiatric problems who were given a Community Order or a Suspended Sentence Order had lower odds of reoffending compared to similar offenders who had been given short-term prison sentences (Hillier and Mews, 2018, p. 6).

The 2018 study used data from the Offender Assessment System (OASys) to identify cases in which mental health needs were flagged. OASys is completed by non-medical professionals and the reliability of the mental health variables in the data was unknown. The results of this study should therefore be interpreted with caution as it is unclear how well-matched the treatment and control groups were. Other factors not included in the analysis may account for the differences in outcome. In addition, the study is based on proven reoffending rates, which refers to offences committed in England or Wales that have been proven through caution or court conviction. These rates do not take account of underreporting, attrition and delays in the criminal justice system and are therefore not representative of all crimes committed by the sample.

The same study indicated that, where short custodial sentences were used rather than a Community Order or Suspended Sentence Order, individuals who were flagged as having current psychiatric problems had higher levels of reoffending compared to those who were not flagged as having any psychiatric problems. These findings were statistically significant (Hiller and Mews, 2018, p.4-6). Over five years, 67% of those given Suspended Sentence Orders and 69% of those given

Community Orders reoffended (Hillier and Mews, 2018, p.4). According to the study, the odds of reoffending were 11% higher amongst those with significant current psychiatric problems (Hillier and Mews, 2018, p.6). These findings should similarly be interpreted with caution as they were based on OASys data.

A Ministry of Justice review published in 2024, based on 2018 national sentencing data, compared outcomes for a cohort of offenders who had received Community Order treatment requirements[1] with matched cohorts of offenders with the same characteristics, who had received Community Orders without a treatment requirement, or a short custodial sentence (Challom-Judge and Martin, 2024). The review found that the reoffending rate amongst MHTR recipients within one year of being sentenced was lower than amongst those on a Community Order without a Community Order treatment requirement (27% versus 34%). It was also lower amongst MHTR recipients compared to those who had received a short custodial sentence (27% versus 36%) (Challom-Judge and Martin, 2024, p.4-5). MHTR recipients were less likely to reoffend and to receive a custodial sentence than those who had received a short custodial sentence for their initial offence (28% versus 45%) (Challom-Judge and Martin, 2024, p.5). These results were statistically significant.

According to the 2024 study, MHTRs were more effective in reducing reoffending than alcohol treatment requirements (ATRs) (see our bulletin on ATRs) or drug treatment requirements (DTRs). There was no statistically significant difference in reoffending between those who had received an ATR and those who had received a Community Order with no treatment requirement, and only a slight difference between those who had received an ATR and those who had received a short custodial sentence (Challom-Judge and Martin, 2024, p.3). There was no difference in reoffending rates at all between those who had received a DTR and those who had received a Community Order with no treatment requirement or a short custodial sentence (Challom-Judge and Martin, 2024, p.3-4).

Again, these results should be interpreted with caution as the mental health data on which the 2024 analysis was based came from OASys and the study is based on proven reoffending rates.

Conclusion

While there appears to be a relationship between some types of mental disorder and (violent) offending, it is unclear whether the relationship is one of direct causation. This is because it is difficult to separate out mental health problems from other factors that may contribute to offending. The evidence base for the effectiveness of MHTRs in improving psychiatric symptoms and reducing reoffending is promising. Based on existing studies, they appear to be more effective than alcohol or drug treatment requirements in reducing reoffending. However, more robust studies are needed to demonstrate their effectiveness with greater confidence, particularly studies comparing well-matched cohorts of offenders based on accurate data about their mental health status and other relevant characteristics. In addition, proven reoffending rates may not paint an accurate picture of recidivism, and longer timescales may be required to gain a more accurate picture of the effectiveness of MHTRs.

[1] In the study, “Community Order treatment requirements” referred to alcohol treatment requirements, drug rehabilitation requirements, and MHTRs.

This Bulletin is part of a series on the effectiveness of sentencing in England & Wales. Other Effectiveness Bulletins can be found here.

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References

Arsuffi, L., Ozcelik, K., Bingham, C., Taylor, P.J., French, M. (2024) 'A community-based treatment and rehabilitation pathway for people with mental disorders recently convicted of an offence'. *BJPsych Bulletin*. 48(5), 277-280.

Brooker, C., Sirdifield, C, Blizard, R., Denney, D. and Pluck, G., 2012. 'Probation and mental illness'. *Journal of Forensic Psychiatry & Psychology*, 23:4, 522-537.

Bradley, KJC (2009) *The Bradley Report: Lord Bradley's Review of People with Mental Health Problems or Learning Disabilities in the Criminal Justice System*. London: Department of Health.

Callender, M., Sanna, G.A., Cahalin, K. (2023) 'Mental health outcomes for those who have offended and have been given a mental health treatment requirement as part of a Community Order in England and Wales'. *Crim Behav Ment Health*, 33, 386–96.

Callender, M., Allen, B., and Cahalin, K. (2024) *Community Order Treatment Requirement: Multisite Report. July 2020 – June 2024*. Northampton: Institute for Public Safety, Crime and Justice.

Challom-Judge, R. and Martin, E. (2024) *Evaluation Report: The Impact of Being Sentenced with a Community Order Treatment Requirement (CSTR) on Proven Reoffending*. London: Ministry of Justice.

Cordle, R. and Gale, E. (2025) *Reducing Reoffending: A Synthesis of Evidence on Effectiveness of Interventions*. London: Ministry of Justice.

Hillier, J. and Mews, A. (2018). *Do Offender Characteristics Affect the Impact of Short Custodial Sentences and Court Orders on Reoffending? Analytical Summary 2018*. London: Ministry of Justice.

Judicial College (2021) *Equal Treatment Bench Book*. London: Courts and Tribunals Judiciary

Kimbell, J. (2024) 'Increasing the use of treatment requirements (MHTR and ATR) in criminal justice: A path to rehabilitation'. GovNet Justice, 18 October 2024. Accessible from https://blog.govnet.co.uk/justice/increasing-the-use-of-treatment-requirements

Kotterbova, E. and Lad, S., 2022. 'Predictors of engagement in female offenders accessing mental health treatment requirements'. *Journal of Forensic Psychiatry & Psychology*, 33:1, 53-67

Ministry of Justice (2020) *A Smarter Approach to Sentencing*. London: HMSO.

Ministry of Justice (2025) *Offender Management Statistics Quarterly: October to December 2024. Probation 2024. Probation: 2024 (tables)*. Available from https://www.gov.uk/government/statistics/offender-management-statistics-quarterly-october-to-december-2024.

Molyneaux, E. Vera San Juan, N., Brown, P., Lloyd-Evans, B. and Oram, S. (2021) 'A pilot programme to facilitate the use of mental health treatment requirements: Professional stakeholders' experiences'. *British Journal of Social Work*, 51, 1041–1059

National Institute for Health and Care Excellence (2017) *Mental Health of Adults in Contact with the Criminal Justice System: NICE guideline [NG66]*. Manchester: National Institute for Health and Care Excellence

National Offender Management Service (2014) *Mental Health Treatment Requirements: Guidance on Supporting Integrated Delivery*. London: National Offender Management Service.

O'Loughlin, A. and Peay, J. (2023) 'Mental health, mental disabilities, and crime'. In: Liebling, A., Maruna, S. and McAra, L. (Eds) *The Oxford Handbook of Criminology*. Oxford: OUP.

O'Loughlin, A. (2024) *Law and Personality Disorder: Human Rights, Human Risks, and Rehabilitation*. Oxford: OUP

O'Loughlin, A., Gormley, J., Willmott, L., Bild, J., Roberts, J. and Draper, A. (2022) *Mental Health and Sentencing: Literature Review*. Scottish Sentencing Council.

Sariaslan, A., Arseneault, L., Larsson, H., Lichtenstein, P., Fazel, S., 2020 'Risk of subjection to violence and perpetration of violence in persons with psychiatric disorders in Sweden'. *JAMA Psychiatry*. 77(4), 359–367

Scott, G. and Moffatt, S. (2012) *The Mental Health Treatment Requirement: Realising a better future*. London: Centre for Mental Health.

Trebilcock, J.D. and Weston, S.K. (2020) *Mental Health and Offending: Care, Coercion and Control*. Abingdon: Routledge.

Tyler, N., Miles, H. L., Karadag, B., and Rogers, G. (2019) 'An updated picture of the mental health needs of male and female prisoners in the UK: prevalence, comorbidity, and gender differences'. *Social Psychiatry and Psychiatric Epidemiology*, 54(9), 1143-1152

Weatherburn, D., Albalawi, O., Chowdhury, N., Wand, H., Adily, A., Allnutt, S., & Butler, T. (2021) 'Does mental health treatment reduce recidivism among offenders with a psychotic illness?'. *Journal of Criminology*, 54(2), 239-258.

Whiting, D., Lichtenstein, P., and Fazel, S. (2021) 'Violence and mental disorders: A structured review of associations by individual diagnoses, risk factors, and risk assessment'. *The Lancet Psychiatry*, 8(2), 150-161