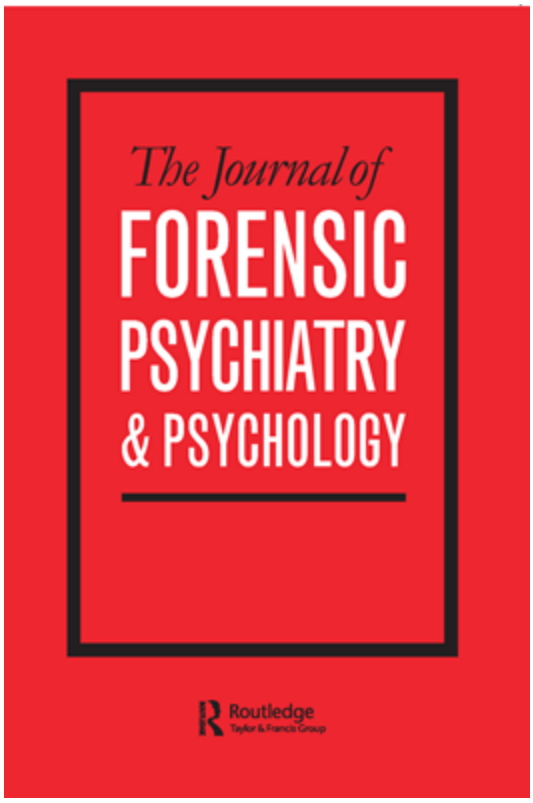

Barriers to accessing psychological treatment for medium to high risk male young offenders

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Abstract

Within the young offender population, rates of personality disorder and mood disorders are considerably higher than both the general and adult offender population. Despite this high level of need and high risk of harm, psychological services within prisons are widely underutilized. Little is known about the barriers to accessing treatment for young offenders. This study investigated barriers to accessing psychological treatment for male young offenders detained in a UK prison. There were 128 participants, aged 18-21. A cross-sectional design compared self-reported barriers and psychological distress for Black and Minority Ethnic (BME) and White young offenders not accessing treatment, as well as those who were.

A preference for self-reliance, a lack of trust in the prison system, lengthy waiting times and a general reluctance to talk about emotions were the most commonly cited barriers. BME young offenders not engaged in treatment reported significantly more barriers to accessing treatment than BME young offenders who were engaged in treatment, but both BME groups had equal levels of psychological distress. There was no significant difference between BME and White young offenders in the number of barriers reported, including stigma barriers. Future research should evaluate interventions to increase access for this marginalised population.

Key words: barriers; psychological treatment; young offenders; ethnicity; stigma

Introduction

Younger offenders should be considered a particularly high-risk and high needs group. Prevalence rates for mental health problems are considerably higher than both the adult offender and general community population (Fazel, Doll & Langstrom, 2008). Antisocial Personality Disorder is diagnosable in 81% of sentenced male young offenders compared to 46% of sentenced male adult offenders and rates of depression are also high (Lader et al., 2000). In response to these difficulties a range of psychological treatments are provided within youth offender institutions within England and Wales aiming to address offending behaviours and related mental health difficulties.

The challenges of engaging this population effectively in treatment are significant. For example, young offenders are significantly more likely to drop out of offence focused interventions (Olver & Wong, 2011) and a diagnosis of personality disorder has been associated with higher rates of treatment dropout (Craissati & Beech, 2001). In addition, as offenders age their rates of help-seeking often increase with adult offenders being significantly more likely to seek professional help for mental health problems than young offenders (Mitchell & Latchford, 2010; Nesset et al.,2011; Skogstad, Deane & Spicer, 2006). Reinsmith- Meyer et al. (2014) found that amongst American prisoners in need of treatment, as assessed by personality and mood measures, 18.5% did not participate in any formal treatments or services at all. This untreated group were disproportionately young and male.

Stigma has been found to act as a significant barrier to accessing psychological treatment amongst the adult offender population (Williams, Skogstad & Deane, 2001). Concerns about what other inmates may think and worries about being seen as ‘’weak’’ or a ‘’snitch’’ have been found to influence decisions to seek mental health care in prison, with

newly incarcerated prisoners being particularly affected by social perceptions (Morgan, Rozycki & Wilson, 2004; Williams, Skogstad & Deane, 2001).

Distrust is another commonly named barrier to accessing psychological treatment in American prisons (Durrah, 2013; Morgan et al. 2007). A lack of trust in prison psychologists was identified as a barrier to disclosing suicidal thoughts amongst adult male offenders in New Zealand (Skogstad, Deane & Spicer, 2005). Concerns about information given in therapy being ‘’used against them’’ has also been named as a concern in an American study (Morgan, Rozycki & Wilson, 2004). A qualitative study in a UK prison also found distrust was a major barrier to accessing care amongst male adult offenders, with distrust often related to negative beliefs that healthcare professionals ‘’don’t really care’’ (Howerton et al., 2007). However, the generalisability of this UK study is limited as participants were recruited from a prison in southwest England that holds mostly adult White British offenders, - whereas the UK prison population has an over-representation of young men from BME backgrounds (Hagell, 2002).

Ethnicity has been found to have an impact on accessing psychological treatment whilst in prison, with American prisoners requesting psychological help upon admission being more likely to be from a White ethnic group than non-requesters (Diamond et al. 2008). Within the UK, Black prisoners with personality disorders are less likely to receive treatment than White prisoners (Coid et al., 2002). This is despite offender screening approaches for personality disorder identifying high levels of need across all ethnicities (Minoudis et al., 2012). Another UK study found feelings of isolation and powerlessness acted as barriers to engagement for BME male adult offenders living in a prison based therapeutic community (Brookes, Glynn & Wilson, 2012). A report from Her Majesty’s Inspectorate of Prisons (2007) found BME prisoners report being distrustful of what they perceive to be ‘White services’ in prison. These findings suggest offenders from BME backgrounds face additional

barriers to accessing psychological treatment compared to offenders from White backgrounds.

Levels of psychological distress can also act as an important factor in seeking psychological help whilst in prison. Higher levels of psychological distress have been found to increase help seeking amongst adult male offenders (Williams, Skogstad & Deane, 2001). Male prisoners with more emotional instability and reported generalized fear are also more likely to express a need for psychological help in prison (Bulten, Nijman & van der Staak, 2009). Diamond et al. (2008) found most male prisoners who self-refer for psychological help upon admission report significant psychological symptoms such as nervousness, racing thoughts and depression.

Overall, the most common barriers arising in the adult offender population are stigma concerns and distrust, with ethnicity and level of psychological distress also having an influence. However, there is a distinct lack of quantitative research in this area within the UK prison system. Many of the adult forensic studies described were not carried out in the UK, with the majority being American studies where the criminal justice system and prison system varies widely from state to state and is not comparable with the UK prison system.

Furthermore, the forensic literature described here all used adult offenders as participants. None of these studies focused specifically on the young offender population (aged 18-21). Young offenders differ across many variables compared to adult offenders. They are still cognitively developing, are more challenging to manage, are more likely to violently re-offend and have higher attrition rates from treatment programmes (NOMS, 2015). Due to these differences it is unlikely they will face the same barriers as adult offenders. The barriers to accessing treatment for detained young offenders have not yet been empirically investigated. The present study aimed to address this gap.

In line with future research recommendations in the literature (Abram et al. 2008; Chitaseban et al., 2011; Morgan et al., 2007) the present study adopted a quantitative methodology, recruited a larger sample from a UK prison, focused on high risk young offenders and explored the impact of treatment stigma, psychological distress, ethnicity and pathological personality traits. It was hypothesised that 1) Young offenders not engaged in treatment will report significantly more barriers to accessing treatment than young offenders who are engaged in treatment, 2) BME young offenders will report significantly more barriers to accessing treatment than White young offenders, 3) Ethnicity, level of psychological distress, number of barriers and pathological personality traits will act as significant predictors to engagement in treatment.

Method

Participants

Participants were recruited from a young offenders' prison in Southern England.

Measures

All participants had been screened for pathological personality traits using a national screening tool embedded in the Offender Assessment System[1] (OASys), the OASys Antisocial Personality Disorder Screen (Ministry of Justice, 2015) which gives a score ranging from 0-10, higher scores indicate higher levels of anti-social personality traits. Participants in this study had scores ranging from 2-10 (mean = 7, SD= 1.79). 'Engaged in treatment' was defined as currently enrolled on any of the high intensity treatment

[1] OASys is the structured professional judgement risk assessment used on all offenders in the English and Welsh criminal justice system.

programmes delivered in the prison, including an Offender Personality Disorder (OPD)[2] therapies service and HMPPS offending behaviour programmes. 'Not engaged in treatment' was defined as any young man not enrolled on an appropriate treatment programme or disengaged from or refusing OPD or offending behaviour programmes. In addition, two self-report measures were used in this study.

The Barriers To Accessing Treatment in Prison (BATP)

This is a 32 item self-report measure used to gather data on barriers to accessing treatment. This measure was adapted from an existing measure, the Barriers to Accessing Care Evaluation (BACE; Clement et al. 2012) with the authors' permission. (See Appendix 1 for details on the development of the BATP). This measure provided three sets of scores; a sum total score which reflects how many barriers the participant reported as relevant (maximum 32), a mean rating score which reflects to what extent the participant reported the barrier as affecting them: not at all, a little, quite a lot, a lot (maximum 96) and a treatment stigma score which reflects how many stigma barriers the participant endorsed (maximum 10). At the end of the BATP participants could note any additional barriers not listed. The 32 item BATP scale as a whole was found to have a high level of internal consistency (α=.858). The 10-item treatment stigma subscale of the BATP was also found to have a good level of internal consistency (α= .825).

Clinical Outcomes in Routine Evaluation Outcome Measure (CORE-OM)

To measure psychological distress the Clinical Outcomes in Routine Evaluation Outcome Measure (CORE-OM) was used. This is a 34 item self-report questionnaire, which

[2] The OPD service is jointly commissioned between HMPPS and the NHS to support high risk offenders. It provides evidence based therapies for personality disorder including Mentalisation Based Therapy (MBT) or Schema Therapy.

covers four dimensions: subjective wellbeing, problems/symptoms, life functioning, risk/harm. The responses are averaged to produce a mean score to indicate the level of current psychological distress from 'healthy' to 'severe'. This measure has been found to have good internal and test- retest validity (α= 0.75-0.95) for large clinical and non-clinical samples (Evans et al. 2000).

Ethics

Ethical approval for the study was obtained from the Royal Holloway University of London (REC Project ID: 40) and HMPPS Ethics Committees (Ref: 2017-113).

Procedure

Prior to starting data collection, there was a service user consultation to inform the recruitment strategy and procedures for participation. An opportunity sampling approach was taken. All potential participants were approached in the prison library, on residential wings or in the OPD service. If they showed an interest in the study, the researcher would see them individually in a quiet location, read the information sheet out and ask for any questions. After providing informed written consent, the researcher read the questions on the two measures and participants indicated their responses. Following this, clinical, demographic and risk data were extracted from electronic HMPPS records. This included treatment status, index offence, ethnicity and risk level.

Analysis

A series of independent t-tests compared differences between BATP and CORE-OM scores according to ethnicity and treatment status. An a-priori power analysis (β=0.80, α=0.05) showed for a medium effect size of 0.5 a total of 128 participants were required with 64 in each group, BME and White. A multiple logistic regression analysis was carried out to investigate predictors of engagement in treatment. For this analysis the BATP stigma barriers

(total 10) were entered separately from the remaining questionnaire items, which were named 'BATP non-stigma barriers'. It was therefore possible to assess the degree to which each of the variables (Ethnicity, Psychological Distress, Antisocial Personality Traits, BATP non-stigma barriers, and BATP stigma barriers) independently predicted whether male young offenders engaged in psychological treatment in prison.

Results

A total of 128 male young men were recruited: 64 in treatment (32 BME and 32 White) and 64 not in treatment (32 BME and 32 White). All participants were aged between 18-21 with a mean age of 19.82 years. In terms of offences, 50% of the sample had committed violent offences, 26% committed sexual offences and 24% committed other offences, such as burglary.

Across the whole sample the most commonly reported treatment barrier was *''wanting to solve the problem on my own''* which 78.9% of participants endorsed. The next most commonly reported treatment barrier was, *''Lack of trust in the prison system which these services are based in'',* which 73.4% of participants endorsed. The treatment stigma barriers were not as common, with less than 41% of participants endorsing any of the stigma barriers. The most frequently reported stigma barrier was *''not wanting details of my treatment or problems to be on my notes''* which 40.6% of the sample reported. An additional barrier was reported by 11 participants which was experiencing conflict with other prisoners on the same programme, consequently hindering their access to the treatment. The average CORE-OM score for the participants in this study fell in the 'mild range'. See Table 1 for mean BATP total and CORE-OM total scores.

[Table 1 near here].

Contrary to the first hypothesis, no significant differences were found between the BME and White young offenders on the number of barriers reported, mean ratings of the barriers or the number of stigma barriers reported.

Examining the second hypothesis, it was found, BME young men not engaged in treatment reported significantly more barriers to accessing treatment (M=3.78, SD= 1.03) than BME young men engaged in treatment (M= 2.67, SD=1.13), $t(62)$= -4.09, p=.000. It was also found BME young men not engaged in treatment had significantly higher mean ratings of the barriers (M=5.14, SD= 1.38) than BME young men engaged in treatment (M =3.55, SD = 1.66), $t(62)$= -4.13, p=.000.

BME young men not engaged in treatment also endorsed significantly more stigma related barriers (M=1.46, SD= .89) than BME young men who were engaged in treatment (M= .90, SD= .82), $t(62)$=-2.61, p=.011. Equal levels of psychological distress were reported across BME young men engaged in treatment (M= 8.65, SD= 5.44) and not engaged in treatment (M= 9.25, SD = 6.01), $t(62)$= .48, p=.632. Unlike the BME young men there were no significant differences in the number of barriers or levels of distress between the White young men engaged in treatment and those not engaged in treatment.

The logistic regression found all five variables entered together was significantly accurate in predicting whether or not male young offenders engaged in treatment ($X^2(5)$ = 17.19, p=.005). Overall this model correctly predicted whether or not male young offenders would engage in treatment in 65% of the cases (overall case prediction). This model correctly classed 71% of the treatment cases as 'in treatment' (sensitivity) and correctly classed 57% of the no treatment cases as 'not in treatment' (specificity).

After controlling for shared variance with the other three variables, Antisocial Personality Traits (B= .36, SE= .13 p=.007) and BATP non-stigma treatment barriers (B= -

.09, SE= .05, p =.033) showed significant predictive status with regard to engagement in psychological treatment. Higher OASys Antisocial scores increased the likelihood of being engaged in treatment whereas higher scores on the BATP non-stigma barriers decreased the likelihood of being engaged in treatment. Ethnicity, (B= -.19, SE= .41, p= .630), Psychological Distress (B= .05, SE=.04, p= .884) and BATP stigma barriers (B= -.16, SE=.28, p=.563) were not independently predictive of engagement in psychological treatment.

Discussion

Using a newly developed measure, the BATP, this study has investigated the barriers to accessing psychological treatment for medium to high risk male young offenders serving a custodial sentence in a UK prison. The most commonly named barriers were related to a lack of trust, a general reluctance to talk about emotions, preference for self-reliance and institutional barriers. The results of this study would suggest treatment stigma may not be a primary barrier to accessing treatment for this population, out of the top ten barriers reported none were treatment stigma related. This contrasts with much of the previous research using adult offenders where stigma related concerns were commonly reported to act as barriers to accessing treatment (Deane, Skogstad & Willaims, 1999; Williams, Skotsgad & Deane, 2001). The study suggests stigma is less problematic for younger men and there are other barriers more likely to discourage them from engaging in treatment.

Contrary to the first hypothesis, no significant difference was found between the White and BME groups in either the total number of treatment barriers reported, total number of stigma barriers reported or the types of barriers. These findings contrast with much of the previous research which suggests BME groups may face a greater number of barriers to

accessing care and report more stigma concerns (Hines-Martin et al., 2003; Memon et al., 2016; Mishra et al., 2008).

However, within the BME group, BME young men not currently engaged in treatment, reported significantly more barriers to accessing treatment than BME young men who were currently engaged in treatment. The no treatment BME group also reported the barriers affecting them to a greater extent and reported more treatment stigma barriers than the BME treatment group.

Despite presenting with equal levels of psychological need, the no treatment BME group were not engaged in psychological treatment and it is possible this is due to facing a greater number of barriers to accessing this treatment in prison. This effect was not seen for the White treatment versus no treatment comparisons so it seems this effect was unique to the BME young offenders only. Within the BME group, the treatment and no treatment group's ten most commonly reported barriers were the all same. This indicates the difference between the BME groups is one of magnitude, a higher number of reported barriers and ratings of the barriers, rather than a difference in the type of barriers reported.

With regards to the last hypothesis, two variables were found to act as independent significant predictors of engagement psychological treatment whilst in prison. Firstly, a higher number of self-reported non-stigma treatment barriers decreased the likelihood of a participant being in treatment. Based on previous literature (Morgan, Rozycki & Wilson, 2004; Williams, Skogstad & Deane, 2001) this result was expected and suggests the more psychological and structural barriers a young offender faces, the less likely they are to be engaged in treatment. Secondly, a higher score on the OASys Antisocial screen increased the likelihood of a participant being in treatment. The literature has traditionally considered antisocial personality traits to act as a significant hindrance to engagement (Shaw &

Edelmann, 2017). The finding in this study is potentially an artefact of the OPD and HMPPS screening practices which specifically target medium to high risk young offenders meaning participants engaged in treatment are likely to have higher levels of antisocial personality traits.

Strengths of current study

The current study has been able to improve upon the methodology of the previous forensic literature in this area. This is the first quantitative investigation of the barriers to accessing psychological treatment for medium to high risk male young men serving a prison sentence in the UK. Most other forensic research in this area has used adult offenders, qualitative methodology and has been largely carried out in the USA.

Half of the participants in the current study were young BME males (n=64) which is more reflective of the UK prison population than any previous UK study investigating barriers to accessing treatment in offender populations. Furthermore, it was well powered for the main hypotheses and managed to recruit the 128 participants required to achieve a medium effect size of 0.5.

The use of the newly developed BATP measure allowed participants to respond to a list of 32 treatment barriers. The BATP measure as a whole and the treatment stigma subscale were found to have high levels of internal consistency. The present study also examined actual behaviour in terms of treatment engagement rather than using hypothetical scenarios or examining intentions to engage in treatment in the future. This is likely to have enhanced the validity of the findings.

Limitations of current study

It should also be acknowledged the study had a number of limitations. Firstly, it was limited due to the self-report methodology used. Both the BATP measure and CORE-OM

measure could have been affected by social desirability bias or response bias (e.g. 'mid-point' responding; Furnham & Henderson, 1982) which are limitations of all self-report measures. These self-report biases are particularly relevant to hold in mind when conducting research in a prison with a disempowered group of participants who may be fearful of the consequences of giving truthful answers.

The average CORE-OM score fell in the 'mild range' despite there being many clear indicators of high levels of psychological distress being present. For example, 50% of participants living on the vulnerable prisoner wing, taking prescribed medication for mood difficulties or being on an ''Assessment, Care in Custody and Teamwork'' (ACCT) plan[3]. The CORE-OM was perhaps not a sensitive enough measure for this population, who are particularly reluctant to describe their thoughts and feelings, future research could explore this further.

There were some limitations with the sample in this study. The participants were homogenous in terms of age, risk level and gender. However, there were other potentially confounding variables such as sentence length and treatment history that were not controlled for and could have affected the results. Due to the nature of the prison, there was also a higher proportion that had committed sexual offences compared to other young offender prisons. Furthermore, the cross-sectional design of the study means that no conclusions about causality can be drawn.

Future research directions

Future research could use a longitudinal design and explore additional variables such as index offence, sentence length and treatment history to see whether they have any impact

[3] ACCT plans are commenced in prison following incidents of, or concerns about, self-harm and suicidal intent. The process is followed and reviewed until the risks have reduced.

on engagement in treatment. It would also be beneficial to use an alternative measure of psychological distress.

Within the BME participants there was a subgroup of BME young men who despite having equal levels of psychological distress and living in the same environment as other BME young men, face additional psychological, structural and social barriers to accessing treatment. Future research should endeavour to explore why these BME young men face more barriers to accessing care than other BME young men. It will also be important to explore what may help facilitate access to psychological treatment for this particular group.

The concern about conflict with other prisoners acting as a barrier to seeking help also requires further investigation.

Clinical implications

The results of this study suggest treatment related stigma is not a primary barrier to accessing treatment in prison for young offenders. It seems internal beliefs, for example about not needing treatment, were more problematic barriers than perceived stigma. Interventions targeted at changing offenders' attitudes towards treatment may help to facilitate access.

The results from this study also suggest there were many environmental barriers preventing young men from engaging in treatment, such as not knowing where to get help or having to wait a long time for help. The onus here would be on services within prisons to conduct more assertive outreach work to identify prisoners in need of psychological support and provide more literature on the residential wings explaining how to seek help in the prison environment. It would also be useful to help increase young offenders sense of control over seeking and engaging in treatment, for example allowing self-referrals and clear communications about how to do this.

Conclusions

This study has been able to address a significant gap in the clinical forensic literature and demonstrate that negative attitudes relating to psychological treatment and environmental barriers can hinder access to evidence based psychological treatments for male young offenders. It is hoped these novel findings, in addition to the recommended future research, will increase understanding of the barriers to accessing psychological treatment for young men in prison and lead the way for the development of interventions to facilitate access for this marginalised population.

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Appendix 1: Development of the BATP

- The adapted self-report scale for use in this study was called 'Barriers to Accessing Treatment in Prison' (BATP). It had 32 items covering a range of potential barriers.
- Ten items covered treatment stigma (3, 4, 7, 8, 10, 14, 16, 18, 22, 24), for example ''feeling embarrassed or ashamed''.
- Five items from the original BACE were removed as they were not applicable, for example ''having problems with childcare while I receive mental health care.''
- Fifteen items had minor amendments to the wording (1,3,4,5,11,12,16,17,18,19,23,24,25,28,29) to make the items applicable for a prison population, for example item 27 of the BACE ''Difficulty taking time off work'' was adapted to ''Difficulty taking time off from prison job or education (if applicable)''.
- Fourteen items remained the same as in the original BACE (2,6,7,8,9,10,13,14,15,20,21,22,26,27), for example ''Thinking I did not have a problem''. Finally, 3 items were added (30, 31, 32) these include ''Lack of trust in the professionals providing care and treatment'', ''Lack of trust in the prison system which these services are based in'' and ''Concern about my personal safety whilst participating in a treatment programme''.
- An open-ended question was also added to allow participants to describe additional barriers not listed on the measure '' If there are any other issues which have ever stopped, delayed or discouraged you from getting or continuing with treatment whilst in prison please describe them here''.

Barriers to Accessing Treatment in Prison (BATP)

Instructions:

Below you can see a list of things which can stop, delay or discourage people from seeking professional care or treatment whilst in prison.

By professional care, we mean help from staff such as a psychologist or counsellor. By treatment, we mean programmes and groups in both the Pathways OPD service and the HMPPS treatment programmes (e.g. TSP and RESOLVE).

Have any of these issues ever stopped, delayed or discouraged you from getting or continuing with professional care or treatment whilst in prison?

		Please circle one number on each row to indicate the answer that best suits you			
Item	**Barrier**	This has stopped, delayed or discouraged me **NOT AT ALL**	This has stopped, delayed or discouraged me **A LITTLE**	This has stopped, delayed or discouraged me **QUITE A LOT**	This has stopped, delayed or discouraged me **A LOT**
1	Being unsure where to go to get help	0	1	2	3
2	Wanting to solve the problem on my own	0	1	2	3
3	Concern that I might be seen as weak	0	1	2	3
4	Concern that it might harm my chances when applying for a job in prison	0	1	2	3
5	Problems with movements across the prison needed to access the services	0	1	2	3
6	Thinking the problem would get better by itself	0	1	2	3
7	Concern about what my family might think, say, do or feel	0	1	2	3
8	Feeling embarrassed or ashamed	0	1	2	3
9	Preferring to get alternative forms of care (e.g. traditional / religious healing)	0	1	2	3
10	Concern that I might be seen as 'crazy'	0	1	2	3
11	Thinking that treatment would probably not help	0	1	2	3

12	Care from my own ethnic or cultural group not being available	0	1	2	3
13	Being too unwell to ask for help	0	1	2	3
14	Concern that people I know might find out	0	1	2	3
15	Dislike of talking about my feelings, emotions or thoughts	0	1	2	3
16	Concern that people might not take me seriously if they knew I was receiving professional help	0	1	2	3
17	Concerns about the therapies or treatments available.	0	1	2	3
18	Not wanting details of my treatment or problems to be on my notes	0	1	2	3
19	Having had previous bad experiences with health care professionals	0	1	2	3
20	Preferring to get help from family or friends	0	1	2	3
21	Thinking I did not have a problem	0	1	2	3
22	Concern about what my friends might think or say or do	0	1	2	3
23	Difficulty taking time off from prison job or education (Not applicable)	0	1	2	3
24	Concern about what people on my wing might think say or do	0	1	2	3
25	Having no one who could help me access treatments	0	1	2	3
26	Having asked for help but not receiving it	0	1	2	3
27	Having asked for help but having to wait a long time before receiving it	0	1	2	3
28	Concern that staff will not understand cultural issues that are important to me	0	1	2	3
29	Concern I will be treated unfairly by staff because of my ethnic background	0	1	2	3
30	Lack of trust in professionals providing care and treatments	0	1	2	3

31	Lack of trust in prison system which these services are based in	0	1	2	3
32	Concern about my personal safety whilst participating in a treatment programme	0	1	2	3

If there are any other issues which have ever stopped, delayed or discouraged you from getting or continuing with treatment whilst in prison please describe them here:

……
……

If there is anything you think would make it easier for you to access and continue with treatment whilst in prison describe it here:

……
……

Thank you for taking the time to complete this questionnaire

Table 1. Mean BATP total and CORE-OM total scores

	Whole Sample		BME Whole Sample		White Whole Sample		BME in treatment		BME no treatment		White in treatment		White no treatment	
	M	**SD**	**M**	**SD**	**M**	**SD**	**M**	**SD**	**M**	**SD**	**M**	**SD**	**M**	**SD**
BATP. Total No. Barriers (max 32)	12.33	7.57	12.39	8.74	13.06	6.71	8.41	6.31	15.31	8.96	12.75	6.67	12.84	6.66
CORE-OM Total Clinical Score (max 40)	10.17	6.65	9.15	5.79	11.22	7.29	8.56	5.44	9.25	6.20	10.50	8.04	11.96	6.33