acjrd 14th Annual Martin Tansey Memorial Lecture

Probation and Mental Health: Do We Really Need Equivalence? [1]

Charlie Brooker [2]

Summary: A 'Zeitgeist' is defined as 'the defining spirit or mood of a particular period of history as shown by the ideas and beliefs of the time', and I am pleased to say I think this is what is currently happening with probation and mental health. For too long, mental health has been the poor relation in probation practice — a situation that seems to be gradually changing. This paper draws from a series of research studies, undertaken locally, nationally and across Europe, to show that we are beginning to understand more and more about probation and the mental health of its clientèle. There are still serious gaps in our research knowledge, for example, about effective interventions, but the last decade has clarified the direction of travel that is required. The paper questions whether clients with mental health problems in probation require 'equivalence'. That is, the same services that other members of the general population can access, who live in the community. I argue that the complexity of clients' presentations does not equate to what is currently available in the community. Thus, new thinking is required, and much more research is needed to examine, for example, the role of assertive-outreach principles and models of service provision — perhaps alongside a sub-group of specialist Probation Staff specifically trained in mental health. There is a long way to travel before we can say that all Probation clients are receiving the mental health services they need.

Keywords: Mental health, probation, prevalence studies, systematic review, personality disorder, suicide, assertive outreach

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Introduction

Many thanks to the Association of Criminal Justice Research and Development for the very kind invitation to give the Martin Tansey Memorial lecture. When I look back at the list of former Martin Tanseyites, it is, indeed, an honour to have been now included in this group.

Before I begin to discuss the topic of probation and mental health, I think it might be useful to say something about my background. I trained as a mental health nurse in the 1970s. I then left nursing to obtain a full-time Social Science degree. I returned to London to work in community mental health in Central London, where at that time, we were in the middle of the huge programme to close the large psychiatric hospitals. Many patients were discharged from these large institutions with little more than a rail warrant, and many chose to come to London as surely 'the streets were paved with gold'? Commentators, especially in the US — and I'm thinking of Fuller-Torrey here — have argued that the hospital-closure programme was a disaster, especially for the Criminal Justice (CJ) system. He surveyed all US states and concluded that there were more people with a mental illness in prisons than in mental health beds.

After being involved with planning the closure of a large North London Hospital, Friern Barnet, I returned to academe to obtain a Master's degree and, with this qualification in my pocket, I progressed to a PhD with backing from the Department of Health. The PhD examined the impact of training Community Psychiatric Nurses (CPNs) to work with the families of those caring for someone with a psychosis living at home.

I went on, after some years and more funded research, to become Professor of Mental Health at both Manchester and Sheffield Universities. Early in the year 2000, I was asked to work with a new directorate at the Department of Health, entitled 'Offender Health'. I took a one-year sabbatical to embed myself in the world of offenders and their health needs. This programme was very much focused on prisons, and it became more and more apparent to me that probation was being overlooked. This was reinforced by the microscopic focus on probation in Lord Bradley's report on the CJ and mental health. In a new Chair at Lincoln University, we conducted one of the most robust studies ever undertaken into the prevalence of mental health disorders in probation, using a stratified random sample. This

was in 2012, and since then my major focus has been this area of work. I am going to take you on a whistle-stop tour of some of our research. I say 'our' research because most, if not all, of this work has been conducted with Dr Coral Sirdifield who, at this point, I would like to acknowledge. She and I are currently editing a book on probation and mental health, which hopefully will be published early in 2022.

A 'Zeitgeist' is defined as 'the defining spirit or mood of a particular period of history as shown by the ideas and beliefs of the time', and I am pleased to say I think this what is currently happening with probation and mental health. We have the Council of Europe conducting a survey within its 47 probation jurisdictions on probation and mental health — this, with a view to producing a White Paper. The Confederation of European Probation (CEP) has an active workstream and buoyant MH group; Ireland has just conducted its own research on this topic, ably led by Dr Christina Powell (a topic I return to); there are too, in England, a number of initiatives, most importantly, a thematic review of mental health across the CJ system, which will be completed in August.

I examined the 13 previous Martin Tansey lectures to look for references to mental health simply by searching for the term 'mental health'. There were 22 references altogether, with 13 references from one speaker, Professor Wexler, who spoke about therapeutic jurisprudence, so maybe this was to be expected. Only Paul Senior mentioned mental health in his paper on 'integrated offender management' (although there were several references to prison mental health). So, the time has come to broadcast far and wide the message about probation and mental health.

Having said this about the mental health content of previous Martin Tansey lectures, I do not mean to cast aspersions on the Association of Criminal Justice; Research and development (ACJRD) or, indeed, any of the previous speakers. I know, for example, that the ACJRD's mental health working group has, over the years, produced important papers on young people and the Criminal Justice system; and the effects of drugs and alcohol on mental health; and various ACJRD seminars have addressed mental health issues too.

The prevalence of mental health problems in probation

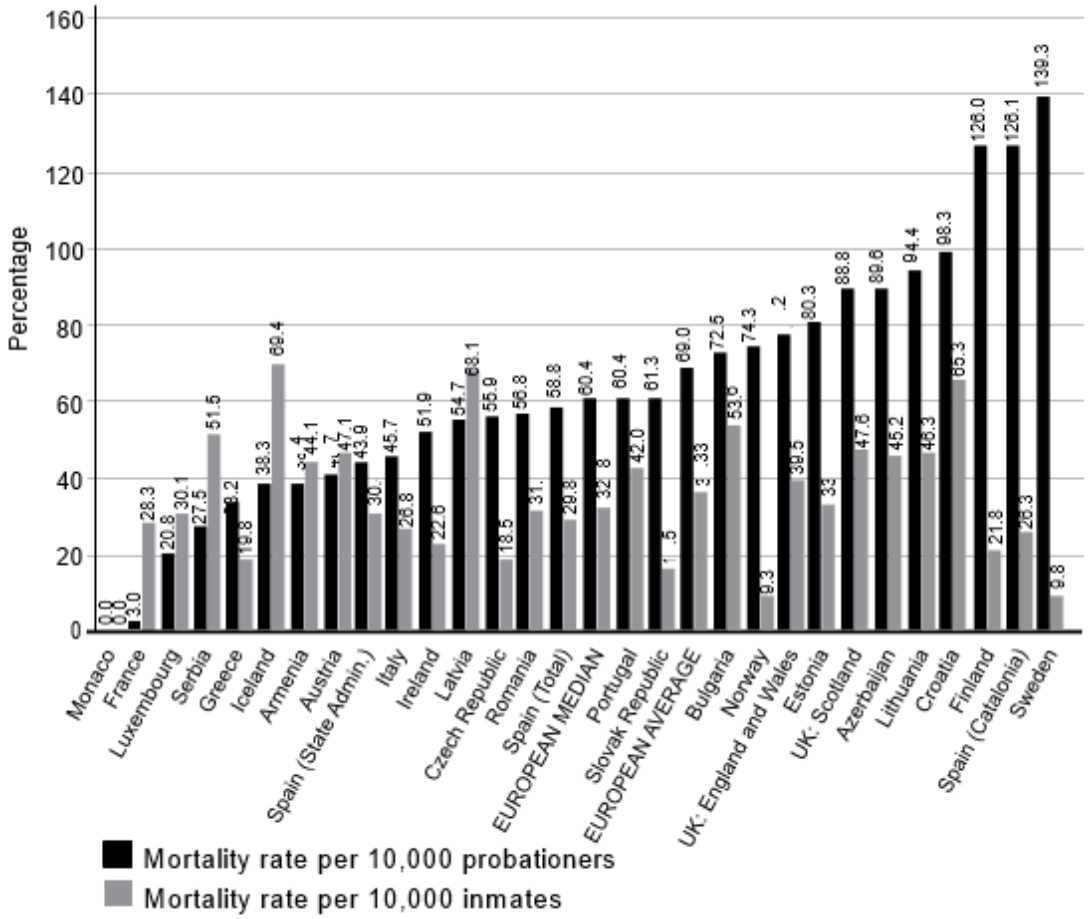
It is clear that those serving a probation order are a vulnerable group, and, of course, this reflects itself in health status. Table 1 shows that in a sample of probationers in Derbyshire and Nottinghamshire, both the physical and mental health dimensions of the SF-36 (a global measure of health status) are significantly worse for probationers than for Social Class V of the general population (Brooker *et al.*, 2009).

Table 1: Comparison of physical and mental component summary scores (SF-36) for probation sample and general population social class V

	Nottinghamshire mean (SD)	**Derbyshire mean (SD)**	**Total offender sample mean (SD) (95% CI)**	**General population social class 'manual' mean (SD)**
Physical component summary	47.34 (13.17)	46.52 (12.74)	46.95* (12.94) (45.04–48.88)	48.93 (10.74)
Mental component summary	46.60 (12.36)	46.93 (12.71)	46.75* (12.49) (44.91–48.60)	49.93 (10.38)

It is not only that health status is so poor, but death itself is far more likely, especially for those at the point of leaving prison. Bingswanger *et al.* (2007) looked at deaths of those released from the Washington State Department of Corrections, and found that, compared to the general population, death rates were 12.5 times higher in the first two weeks following release. Overdose and suicide figured highly in the cause of death. Similarly, the SPACE project (Aebi *et al.*, 2018) has studied death rates of probationers and prisoners across Europe and found that in nearly every country these rates are higher for probationers (see Figure 1).

Figure 1: Deaths of inmates per 10,000 inmates and deaths of probationers per 10,000 probationers during 2017 (n=27)



Just how vulnerable are those on probation to formal mental health problems? The most rigorous study, using a random sample, that has looked at this question was undertaken across the county of Lincolnshire, and a series of papers have been published from this study, which report: the prevalence of mental health disorders in probation (Brooker *et al.*, 2012); the literature on prevalence of mental health disorders in probation (Sirdifield, 2012); personality disorder in probation (Pluck *et al.*, 2011); suicide and probation (Pluck and Brooker, 2014); and engaging service-users in research (Sirdifield *et al.*, 2016). Overall, the prevalence study showed that 38.7 per cent of the sample had an identifiable mental health disorder (see Table 2). In addition, the research established that: 47 per cent had a likely personality disorder; co-morbidity with drug/alcohol problems was marked (see Table 3); and there was a strong association with mental health disorders and personality disorder.

Table 2: Prevalence of mental health disorders in the Lincolnshire probation sample

Disorder	**N**	**%**	**CI (95%) (%)**
Mood disorders			
Major depressive episode	25	14.5	9.2–19.7
Mania (manic episode/hypomanic episode)	4	2.3	0.1–4.6
Any mood disorder	26 (31)	15.0 (17.9)	9.7–20.4 (11.3–27.3)
Anxiety disorders			
Panic disorder	2	1.2	0.0–2.8
Agoraphobia	17	9.8	5.4–14.3
Social anxiety	11	6.4	2.7–10.0
Generalised anxiety	6	3.5	0.7–6.2
OCD	3	1.7	0.0–3.7
PTSD	8	4.6	1.5–7.8
Any anxiety disorder	37 (47)	21.4 (27.2)	15.3–27.5 (18.4–38.3)
Psychotic disorders			
With mood disorder	5	2.9	0.4–5.4
Without mood disorder	9	5.2	1.9–8.5
Any psychotic disorder	14 (19)	8.1 (11.0)	4.0–12.2 (5.8–20.0)
Eating disorders			
Anorexia nervosa (including binge eating/purging type)	0	0.00	N/A
Bulimia nervosa	4	2.3	0.1–4.6
Any eating disorder	4 (9)	2.3 (5.2)	0.1–4.6 (1.6–15.5)
Any current mental illness	47 (67)	27.2 (38.7)	20.5–33.8 (27.7–51.1)
Likely personality disorder	82	47.4	40.0–54.8

Note: With the exception of personality disorder, Ns are shown for the 88 participants who completed the full interview. For the major diagnostic categories, weighted prevalence figures are shown in brackets to account for

false negatives on PriSnQuest. The prevalence of personality disorder was based on SAPAS scores, which were available for all 173 participants.

Table 3: Prevalence of mental health disorders and co-occurring substance use

Disorder	**Alcohol problem (AUDIT score of 8+) (n=96)**			**Drug problem (DAST score of 11+) (n=21)**			**Any substance misuse problem (n=104)**		
	N	**%**	**CI (95%) (%)**	**N**	**%**	**CI (95%) (%)**	**N**	**%**	**CI (95%) (%)**
Any current mood disorder (n=26)	20	76.9	60.7–93.1	5	19.2	4.1–34.4	21	80.8	65.6–95.9
Any current anxiety disorder (n=37)	25	67.6	52.5–82.7	6	16.2	4.3–28.1	26	70.3	55.5–85.0
Any current psychotic disorder (n=14)	9	64.3	39.2–89.4	3	21.4	0.0–42.9	10	71.4	47.8–95.1
Any current eating disorder (n=4)	3	75.0	32.6–100.0	0	0.0	N/A	3	75.0	32.6–100.0
Any current mental illness (n=47)	31	66.0	52.4–79.5	10	21.3	9.6–33.0	34	72.3	59.6–85.1
No current mental illness (n=41)	10	24.4	11.3–37.5	31	75.6	62.5–88.8	7	17.1	5.6–28.6

The study also examined the needs of probationers using the CANFOR-S. The CANFOR was developed by PriSM at the Institute of Psychiatry to assess the needs of individuals with severe mental illness (Phelan *et al.*, 1995). The short version of this tool was included in the study and investigates a range of 25 areas in which people may have difficulties, whether people are receiving help in these areas, and whether they are satisfied with any help that they are receiving or perceive the area to be still a problem for them.

Our study found that 'unmet' needs were siginificantly higher in the group of probationers with a mental health disorder compared to those probationers who were not mentally ill (see Table 4). The needs most often unmet concerned the following areas of life: safety to self; physical health (four times more likely to die from violent deaths and twice as likely to die from natural causes); daytime activities; alcohol and drugs; agreement with prescribed treatment; money and company. A more recent survey has confirmed a similar prevalence for mental illness amongst probationers in Ireland (Power, 2020).

Power found that 40 per cent on a Probation Supervision Order, compared to 18.5 per cent of the general population, present with symptoms indicative of at least one mental health problem. Women present with higher rates of active symptoms and higher rates of contact with services currently and in the past for mental health problems. The study also found that 50 per cent supervised by the Probation Service in the community who present with mental health problems also present with one or more of the following issues as well: alcohol and drug misuse, difficult family relationships, and accommodation instability. Power argues that there are significant and unmet psychological and psychiatric needs among persons subject to Probation Supervision, and improved access and engagement routes to mental health services are badly needed.

Table 4: Differences in CANFOR-S scores comparing major mental health disorders with no disorder

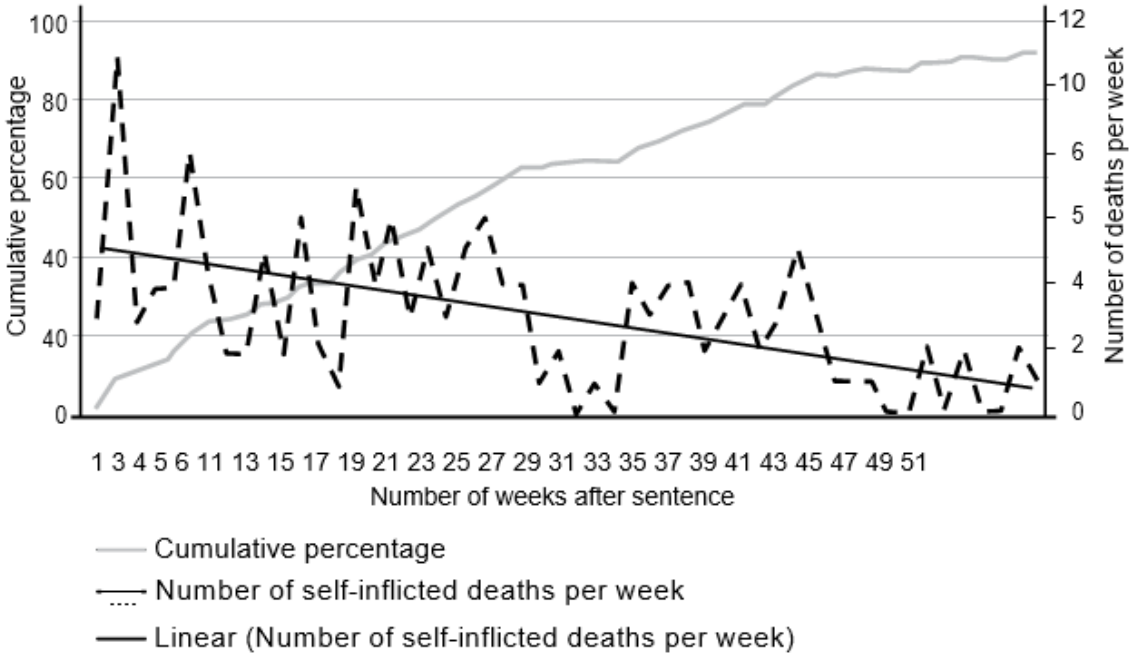
Disorder	**Type of need**	**Mean CANFOR score**	**Standard deviation**	**Inter-Quartile range**	**Mann-Whitney U Test***
Any current disorder	Met need	2.83	2.37	1.13–3.88	z= –2.161 p=0.031
	Unmet need	7.70	6.13	2.45–11.70	z= –4.155 p=<0.001
	Total need	10.53	6.31	5.50–15.10	z= –4.517 p=<0.001
No current mental illness	Met need	1.83	1.83	0.50–2.74	N/A
	Unmet need	2.68	3.42	0.39–4.78	N/A
	Total need	4.59	3.72	1.507.38	N/A

** Table is based on the n=88 who were PriSnQuest Positive.*

Safety to self is a key issue in probation. The Ministry of Justice in England collates key statistics on suicides, and has done so for a number of years, allowing trends to be established. An important paper by Philips *et al.* (2018) discussed these trends over the period between 2010 and 2017. Philips and colleagues reported that the rate of suicide amongst those under community supervision between 2010/11 and 2015/16 was nearly nine times higher than in the general population, and was also higher than amongst the prison population. This reflects findings from an earlier study, which also suggested that

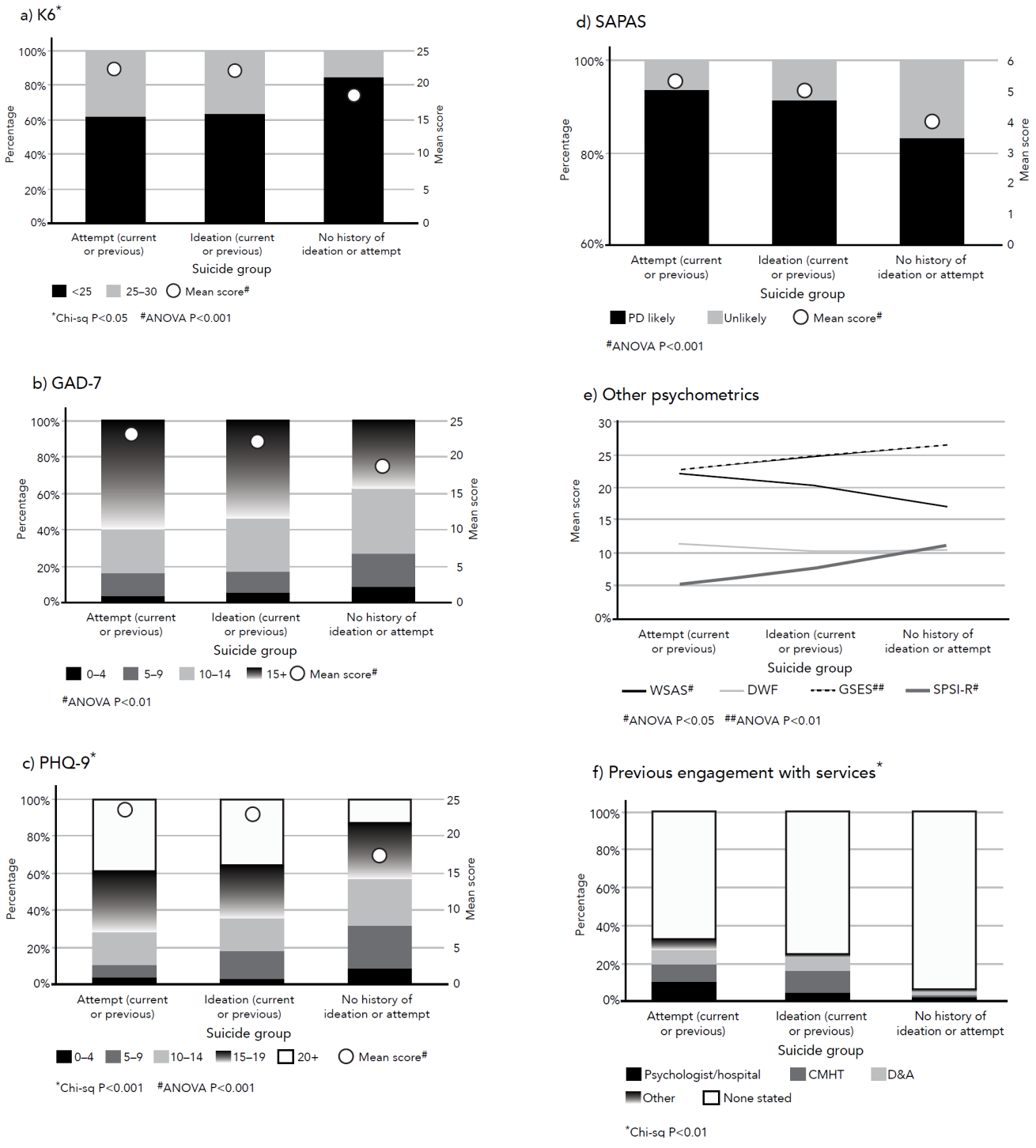
rates of suicide are higher in the probation population than amongst prisoners (Sattar, 2001). The study also provided key information and showed that the risk of suicide is much higher in the first few weeks after release and diminishes as time progresses (see Figure 2).

Figure 2: Number of deaths per week after sentence and cumulative percentage of self-inflicted deaths in England 2015–16



A recent paper (Brooker *et al.*, 2021) has reported data on suicide that has been subject to secondary analysis from an original study by Fowler and his colleagues (Fowler *et al.*, 2020). This paper presented secondary analysis of data previously used to evaluate the outcome of delivering psychological treatment to probationers in London. A sample of probation service-users who screened positive for clinically significant symptoms of distress, and were subsequently assessed and offered treatment (n=274) were allocated retrospectively to one of three groups: those with a history of suicidal ideations but no suicide attempts (ideation group), those with a history of a suicidal act (attempt group), or a control group where suicide was not evident (no-history group). Results indicate no significant difference between the ideation and attempt groups, but significant differences between these and the no history group.

Figure 3: Illustration of the differences in psychometrics and engagement with services between the different suicide groups

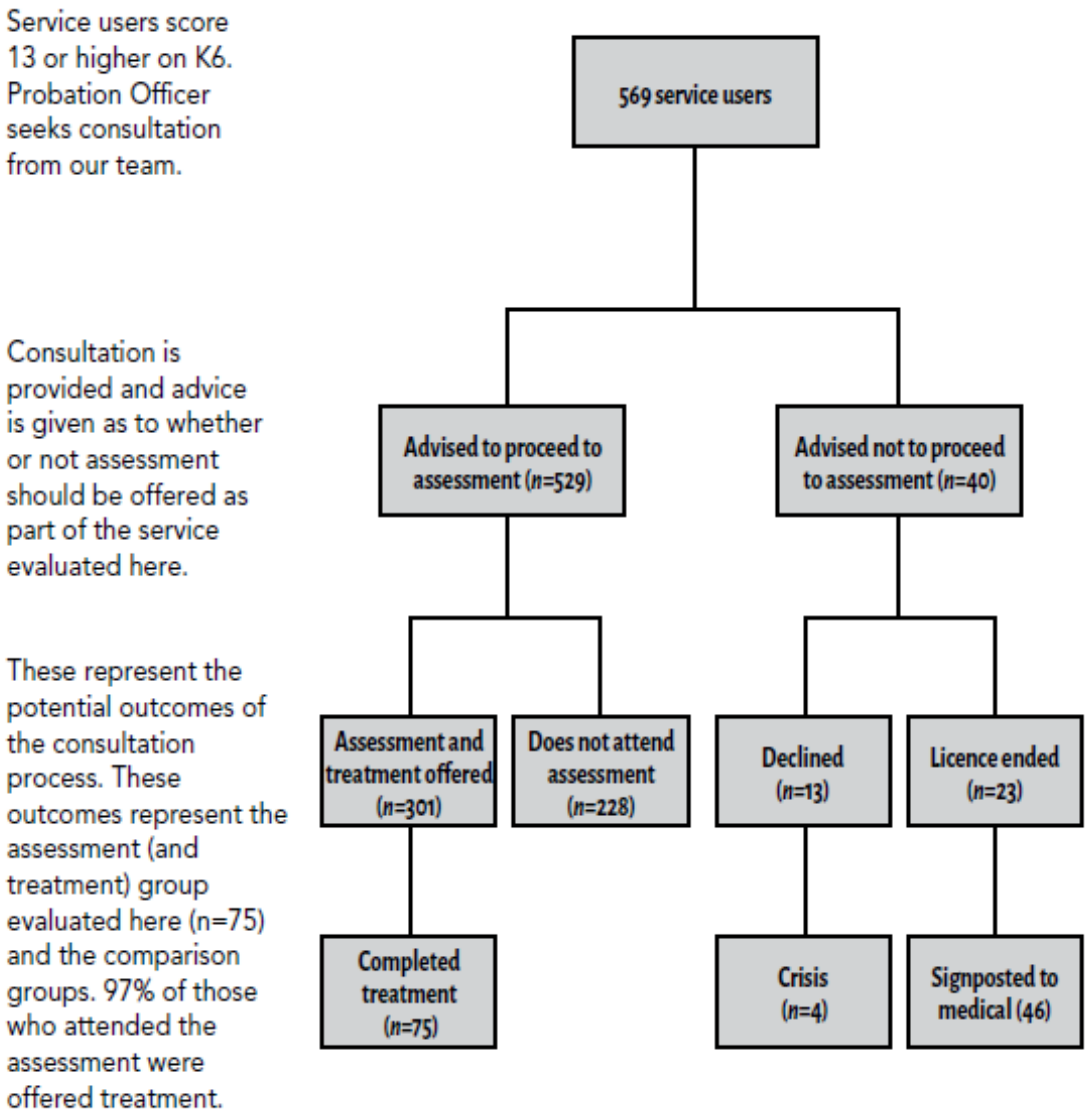


The findings are discussed within the context of the suicide ideation-to-action models that have been debated in other offender settings. We conclude that a more nuanced understanding of suicidal acts and suicide attempts is required in probation services, including a prospective study that tests the ideation-to-action model.

A recent systematic review of suicide in probation has been undertaken (Sirdifield *et al.*, 2019). In the paper, we provide an up-to-date summary of what is known about suicide and suicidal ideation and probation. This includes estimates of prevalence and possible predictors of suicide and suicidal ideation. A total of 5,125 papers were identified in the initial electronic searches but, after careful double-blind review, only one paper related to this topic met our criteria, although a further 12 background papers were identified, which are reported. We concluded that people on probation were a very high-risk group for completed suicide, and factors associated with this include drug overdose, mental health problems, and poor physical health. There is a clear need for high-quality partnership working between probation and mental health services, and investment in services, to support appropriate responses to suicide risk. Similarly, a systematic review has been undertaken by the same research group on mental health and probation (Brooker *et al.*, 2019). Here, a narrative systematic review was also undertaken of the literature concerning the mental health of people on probation. In this paper, we provide an up-to-date summary of what is known about the most effective ways of providing mental healthcare for people on probation, and what is known about the relationship between different systems and processes of mental healthcare provision, and good mental health outcomes for this population. A total of 5,125 papers were identified in the initial electronic searches but after careful double-blind review only four papers related to mental health that met our criteria, although a further 24 background papers and 13 items of grey literature were identified, which were reported. None of the included studies was a randomised controlled trial although one was quasi-experimental. Two of the other papers described mental health disorders in approved premises, and the other described the impact and learning from an Offender Personality Disorder project. We concluded that the literature is bereft of evidence on how to effectively provide mental healthcare for people on probation. However, since our review was published, a study has been reported on psychological treatment for those screened positive for mental health problems in the London Probation Service (Fowler *et al.*, 2020). Treatment was offered to all those who scored higher than 13 on the K-6 (Cornelius *et al.*, 2013). As Figure 4 shows, over the course of the study, 569 service-users screened positive for a mental health problem; of these, 301 (63 per cent) were assessed and offered treatment. Overall, 75 people completed treatment, which represents just 13 per cent of all those initially screening positive. The group of treatment-completers achieved significant improvements on symptom severity and duration at follow-up, and were

less likely to reoffend. However, even when it is offered on site, it is clear that engaging probationers in psychological treatment poses all sorts of challenges, and sample attrition is likely to be high for a variety of reasons.

Figure 4: Referral throughput figures from the study by Fowler *et al.* (2020)



The systematic reviews were part of the same National Institute for Health Research (NIHR) funded project which examined the extent to which Clinical Commissioning Groups (CCGs) and Mental Health Trusts (MHTs) provided services to people serving probation orders in England (Sirdifield *et al.*, 2019). As has been shown, despite often having complex health needs, including a higher prevalence of mental health problems, substance misuse problems and physical health problems than the general population, this socially excluded group of

people often do not access healthcare until crisis point. This is partly due to service-level barriers such as a lack of appropriate and accessible healthcare provision. A national survey of all CCGs (n=210) and MHTs (n=56) was conducted in England to systematically map healthcare provision for this group. We compared findings with similar surveys conducted in 2013 (Brooker and Ramsbotham, 2014) and 2016 (Brooker *et al.*, 2017). A good response was obtained, and the data analysed represented responses from 75 per cent of CCGs and 52 per cent of MHTs in England. We found that just 4.5 per cent (n=7) of CCG responses described commissioning a service specifically for probation-service clients, and 7.6 per cent (n=12) described probation-specific elements within their mainstream service provision. Responses from 19.7 per cent of CCGs providing data (n=31) incorrectly suggested that NHS England, rather than CCGs, is responsible for commissioning healthcare for probation clients.

Table 4: Overarching categories of services commissioned by CCGs in 2017 (*N*=157)

Type of service	**A probation-specific service was commissioned or provided *n* (%)**	**Probation-specific elements within a mainstream service *n* (%)**	**CCGs that commission this type of service *n* (%)**
Any health service	7 (4.5%)	12 (7.6%)	19 (12.1%)
Any mental health service	2 (1.3%)	14 (8.9%)	16 (10.2%)
Physical health service	2 (1.3%)	1 (0.6%)	3 (1.9%)

Responses from 69 per cent (n=20) of MHTs described providing services specifically for probation service clients, and 17.2 per cent (n=5) described probation-specific elements within their mainstream service provision. This points to a need for an overarching health and justice strategy that emphasises organisational responsibilities in relation to commissioning healthcare for people in contact with probation services, to ensure that there is appropriate healthcare provision for this group.

Such a strategy arrived in England in 2019 (NPS, 2019) but, sadly, with little reference to NHS commissioning responsibilities. It was written in terms of the following subheadings: mental health and wellbeing; substance misuse; suicide reduction; social care; physical health;

learning disabilities and finally the offender personality disorder pathway. In each of the sections there is a subheading entitled 'What NPS will do' and this example is for suicide prevention:

> In the first instance, NPS will achieve the commitment to ensure the safety of all individuals under our supervision as far as reasonably possible by utilising internal and external data to understand the risk profiles of people under our supervision in relation to suicide. Subsequently, NPS will use this data to address identified risks.
>
> NPS is also committed to raising awareness and understanding of suicide prevention as well as of the heightened risk of suicide for individuals under our supervision and will develop the workforce to address these vulnerabilities. For example, NPS has produced the Approved Premises Reducing Self-Inflicted Death Action Plan 2018–2021.
>
> Additionally, NPS will provide comprehensive support and guidance for staff and promote effective monitoring and research to enhance care and welfare of staff and individuals under NPS supervision. Moreover, NPS is committed to working with internal and external stakeholders to achieve our goal to reduce the number of self-inflicted deaths under community supervision. For example, NPS will look to engage more closely with Local Authority Suicide Prevention Action Plans and Adult Safeguarding Boards. (NPS, 2019, p. 15

However, nothing is stated in the strategy about how such objectives will be monitored/evaluated, and two years later we have little idea about the full impact of the overall plan.

The aforementioned research review leads to a number of conclusions:

- Recognition and assessment of mental health problems and suicidality by probation staff
- Healthcare funding for probation where needs are highly complex (dual diagnosis and personality disorder

- The lack of rigorous research on effective mental health interventions for probationers
- If mental health problems were detectable, but they are complex, how do you develop pathways between probation and mental health services?
- High levels of suicide a significant issue in their own right (interesting studies emerging from Belgium by Favril and his colleagues)

So, to come back to the title of the lecture — in the late 1990s, we thought what we needed in England was 'equivalent' mental health services for people who are in the criminal justice service. But I think the complexity of needs in probation — mental health problems; substance abuse and personality disorder — really leave open the question, do these equivalent services exist?

The answer to this question is 'no' and leads me to a very banal conclusion. It might well be that the most effective mental health service for people on probation is based on the principles of assertive outreach. Those in the target group for Assertive Outreach have been described as follows by the National Forum for Assertive Outreach as:

> Specifically, those referred to Assertive Outreach are people with whom mainstream mental health services have found it difficult to engage, and with histories including a severe and enduring mental illness, social chaos, high use of inpatient beds, and with multiple complex needs. To be effective teams must deliver a mix of evidence based psychosocial intervention and intensive practical support from multi-skilled and multi-disciplinary practitioners. The focus of the work must be on engagement and rapport, building up, often over the long-term, strong relationships. Effective teams aim to replicate the findings of numerous international randomised controlled trial studies comparing ACT with standard care.

We have seen how in the Fowler study in London there was remarkable attrition throughout the process: people not turning up for appointments and dropping out for a variety of

reasons. We know that people's lives are not organised. 'Chaotic' is the word often used, and with assertive outreach you have workers with smaller caseloads who make it their business to know in detail about the lives of people that with whom they are working. For example, where they go, which kind of cafés they frequent, and so on. In Assertive Outreach, there is a broader appreciation of the lives people lead that focuses not just on mental health symptoms but other crucial needs too, such as housing, education and employment.

Our systematic reviews have shown that there is little evidence for effective interventions in mental health, suicide prevention or substance misuse for probationers. Clearly this group of people often have complex needs and lead disorganised lives as the prevalence studies show. This does not fit with the modern 'two hits and you're out' philosophy of mental health service access. The Assertive Outreach model of service delivery could seem to be an appropriate one, but this is often regarded as outdated and is rarely offered. Equivalence might not be the best way to approach mental health service access for probationers. Especially as most mainstream service personnel often assume that offenders will be 'dangerous'. The role of the Probation Officer with mentally ill people should be clarified urgently. It is clear that the research that exists is but a few faltering steps down a very long road.

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