Her Majesty's Inspectorate of Probation

Maximising positive mental health outcomes for people under probation supervision

Coral Sirdifield and Charlie Brooker

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Contents

Foreword

HMI Probation is committed to reviewing, developing and promoting the evidence base for high-quality probation and youth offending services. *Academic Insights* are aimed at all those with an interest in the evidence base. We commission leading academics to present their views on specific topics, assisting with informed debate and aiding understanding of what helps and what hinders probation and youth offending services.

This report was kindly produced by Dr Coral Sirdifield and Professor Charlie Brooker, highlighting the importance of maximising positive mental health outcomes for people under probation supervision – both for the individuals themselves and in terms of wider societal benefits. While there are various barriers, there are a number of steps that service users, professionals and policy makers can take to help overcome these barriers. There is also a role for researchers in strengthening the evidence base, with a need for investment in research and evaluation linked to potential models of good practice. Most immediately, those working in health and justice need to be aware of the potential for exacerbation of mental health issues due to the impact of the COVID-19 pandemic. As part of recovery planning work, systems need to be in place to ensure that both staff and those being supervised can access appropriate support.

Dr Robin Moore
Head of Research

Author profile

Dr Coral Sirdifield is a Research Fellow at the University of Lincoln. Her research interest is in understanding health needs, improving health and social care provision, and reducing health inequalities, particularly for those in the criminal justice system. Her research has included studies across the criminal justice system. Most recently her work has focused on identifying the prevalence of mental illness and substance misuse amongst people on probation, mapping healthcare provision for people on probation in England, and producing a probation healthcare commissioning toolkit.

Professor Charlie Brooker is an Honorary Chair based at Royal Holloway, University of London. The main focus of his research has been the health, particularly the mental health, of people in the criminal justice system. He has also conducted health needs assessments in settings such as sexual assault referral centres, young offender institutions, prisons, probation, and police custody. He has recently been advising the Irish Probation Service on mental health and suicide.

The views expressed in this publication do not necessarily reflect the policy position of HMI Probation.

1. Introduction

There is a limited evidence base on the mental health needs of people under probation supervision. Many of the existing research studies focus on particular sub-sets of the probation population. This, combined with methodological differences between studies, makes it hard to compare findings across the literature. However, we can tentatively conclude from the research that does exist that there is a high prevalence of mental illness in probation populations around the world, with many people under probation supervision experiencing more than one mental illness (co-morbidity) and/or a combination of mental illness and substance misuse (dual diagnosis) (Brooker et al., 2020; Sirdifield, 2012).

Examples from the UK literature include a study of seven Approved Premises in one part of England in which staff were asked to complete the General Health Questionnaire with participants within two weeks of their admission. Here, there was a high rate of co-morbidity: one in four (25%) were recorded as having a psychiatric diagnosis, with 41% of those with a mental illness being recorded as having a secondary diagnosis (Hatfield et al., 2004). In a study of a specialist Approved Premises for men with mental illness where 81% of residents had a psychiatric diagnosis, there was a high rate of dual diagnosis, with over half of the population studied having previous alcohol abuse or dependence, and over half having misused drugs (Geelan et al., 2000).

Brooker et al. (2012) studied a stratified random sample of people on probation across one English county, including (but not limited to) those in Approved Premises (n=173). This study employed a two-phase screening design using established screening tools (the PriSnQuest and the MINI) (Shaw et al., 2003; Sheehan et al., 1998).

- The weighted prevalence estimates suggested that about two in five (39%) of the sample had a current mental illness.
- Overall, 5% had an eating disorder, 11% had a psychotic disorder, 18% had a mood disorder, and 27% had an anxiety disorder.
- Almost half of the sample (49%) screened positive for a past/lifetime disorder, with 19% screening positive for a lifetime psychotic disorder, and 44% screening positive for a mood disorder.
- Of the 47 participants who screened positive on PriSnQuest and MINI for a current mental illness, 73% also had a substance abuse (alcohol or drug) problem.

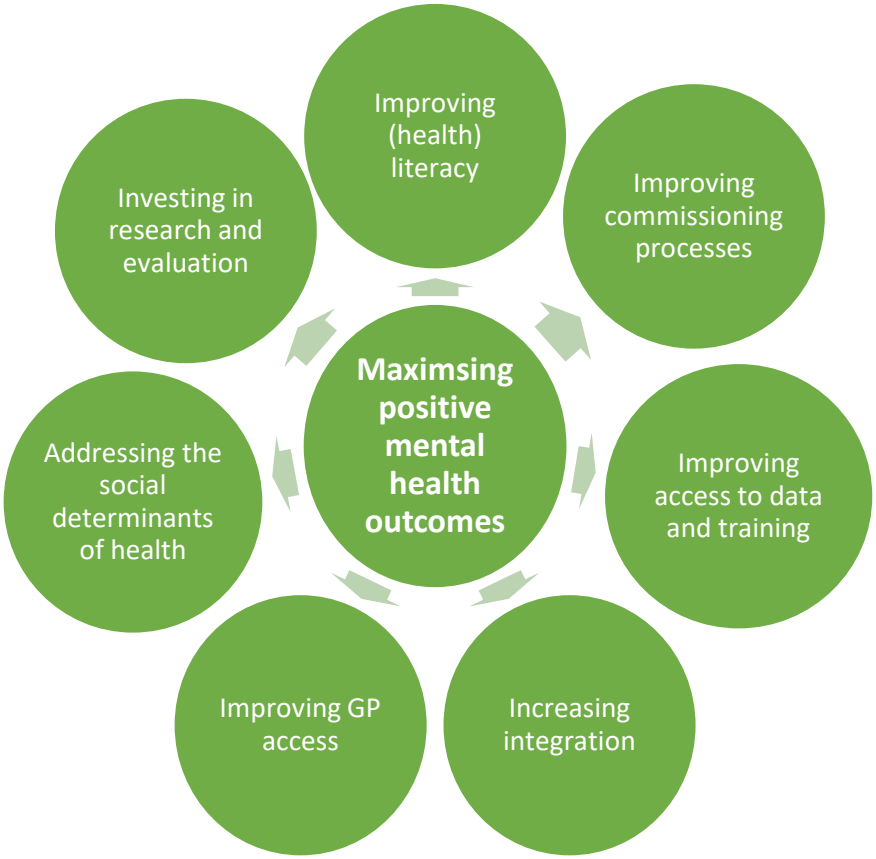
Rates of personality disorder are also known to be high amongst those under probation supervision (Brooker et al., 2012; Geelan et al., 1998; Knauer et al., 2017). Similarly, rates of suicide and suicidal ideation are much higher in probation populations than in the general population (National Probation Service, 2019; Sattar, 2003). Recent figures for those under probation supervision in England over a five-year period point to a suicide rate that is nearly nine times higher than in the general population (Phillips et al., 2018).

The National Probation Service (NPS) recognises the importance of focusing on health, and has a commitment to 'improve the health and wellbeing of people under probation supervision, and contribute to reducing health inequalities within the criminal justice system' (National Probation Service, 2019: 10). It is important to maximise positive mental health outcomes and ensure provision of equivalent mental health services for a number of reasons:

1. To improve the health and wellbeing of these individuals.
2. As part of a wider agenda to reduce health inequalities across society.
3. To improve compliance with probation.
4. To reduce reoffending and thereby future criminal justice costs.
5. To produce a wider community dividend through benefits such as reduced fear of crime and reduced NHS costs (National Probation Service, 2019; NOMS, 2004; Revolving Doors Agency, 2017).

Recently, probation staff and those working in other agencies supporting people in the criminal justice system have had to rapidly change their practice as a response to the COVID-19 pandemic. Presently, there is little research to show the impact on the mental health of those under supervision. The social distancing measures in place across England and Wales may have created additional stress for both staff and those being supervised, and made it difficult to maintain supportive relationships (Musimbe-Rix, 2020). Discussion of sensitive issues such as mental health, and identifying signs of deteriorating mental health, is also likely to have been problematic whilst supervision is 'locked down'. In some cases, necessary changes to practice may have caused disruption to care, or meant that care has to be accessed digitally or over the phone. In others, it may be that the situation has acted as a catalyst for existing efforts to improve partnership working between health and justice agencies. It is important that the potential for exacerbation of mental health issues is considered in the Probation Business Recovery Programme planning.

This paper provides an overview of what the research literature tells us about barriers to maximising positive mental health outcomes for the probation population, together with practical suggestions for how to overcome these potential barriers, covering the areas set out in the figure below.



2. Maximising positive mental health outcomes: Barriers and enablers

> *'The fact that…people in different social circumstances experience avoidable differences in health, well-being and length of life is, quite simply, unfair'*
>
> (Marmot et al., 2010: 16).

As stated above, the rates of mental illness, suicide, and suicidal ideation are considerably higher in those under probation supervision than in the general population. Estimates suggest that around two in five people under probation supervision will have a current mental illness, and often this is combined with a substance misuse problem.

Avoidable differences in health are determined by a number of factors. They can be influenced by modifying our own individual risk behaviours, for example, through improving diet and exercise. However, health is also influenced by the availability, accessibility and quality of healthcare; and increasingly, there is recognition of the role of wider social determinants of health such as income, housing, access to green spaces, and educational attainment (Marmot et al., 2020).

2.1 Potential barriers

Research suggests that people under probation supervision can encounter many barriers to maximising positive mental health outcomes. Despite having a high level of mental health need, many people in this population do not access mental health services until they are at crisis point. This results in use of expensive care such as Accident and Emergency departments, which could potentially have been avoided if services had been accessed earlier. Causes of a lack of engagement with services and poor health are varied, and encompass inter-connected personal level, service level, and societal level factors. Some of these are outlined below.

Poor past experiences: Often people under probation supervision report poor past experiences of accessing care, and mistrust of healthcare staff (Revolving Doors Agency, 2017).

Low levels of literacy and health literacy: Many people under probation supervision have low levels of literacy. They are also likely to have low levels of health literacy – 'the personal, cognitive and social skills which determine the ability of individuals to gain access to, understand, and use information to promote and maintain good health' (Nutbeam, 2000: 263).

Sub-optimal commissioning processes: Currently, the majority of healthcare for people on probation is commissioned by Clinical Commissioning Groups (CCGs), with people on probation being expected to access care in the same way as the general population. Alongside this, Local Authorities commission public health services such as treatment for substance misuse problems. However, research suggests that many CCGs are unaware of their responsibility to commission healthcare for those under probation supervision, mistakenly thinking that this is the responsibility of NHS England, who commission

healthcare in secure environments such as prisons (Brooker et al., 2017; Sirdifield et al., 2019).

Moreover, even when organisations are aware of their responsibilities, commissioning decisions are not always informed by information on the health needs of people under probation supervision and the extent to which they are being met by current service provision. The Health and Social Care Act 2012 placed a duty on both CCGs and Local Authorities to work together to produce a Joint Strategic Needs Assessment through their local Health and Wellbeing Board to inform commissioning priorities in their region. This can include assessments of the needs of 'vulnerable groups'. Those under probation supervision are cited as an example of such a group in policy documents (Department of Health, 2013; Revolving Doors Agency, 2017). However, relatively few Joint Strategic Needs Assessments currently consider the needs of the probation population (Revolving Doors Agency, 2017).

Limited evidence base – data, research and training: Arguably one of the reasons why commissioning is not always informed by an assessment of the health needs of the probation population is a lack of appropriate data on these individuals' health needs that is accessible to commissioners. A recent review of the literature has shown that very little research is available that examines the most effective approaches to improving mental health outcomes for adults on probation, including reducing rates of suicide (Brooker et al., 2020; Sirdifield et al., 2020a). Consequently, it is difficult to ensure that practice and commissioning are evidence-based.

Probation staff receive relatively little training around identifying and managing mental health problems in their caseload, meaning that issues can remain unidentified. For example, one study found that only a third of current psychotic disorder cases were recorded in probation case files (Brooker and Sirdifield, 2013).

A lack of appropriate provision for complex needs: The sub-optimal commissioning processes, together with the difficulties that commissioners and providers face as a result of cuts to funding, mean that in some cases, the complexity of individuals' health needs results in them falling through gaps between service provision or being unable to access care in a timely fashion (NHS England, 2016; Plugge et al., 2014). Shortcomings in provision were highlighted in the Bradley Report, and research suggests that similar issues are still being encountered over a decade after this report was produced (Sirdifield et al., 2020b).

Complexity of the healthcare landscape: Difficulties in accessing services are further complicated by the complex and constantly changing nature of the healthcare landscape. For example, changes in the geographical boundaries within which services are available, the referral criteria for services, and changes in local providers make it difficult for both those under probation supervision, and criminal justice staff, to navigate and maintain relationships with services (Sirdifield et al., 2020b).

Poor GP access: General Practitioners (GPs) provide mental health treatment and advice, and act as a gateway to accessing other mental health care. However, people under probation supervision are sometimes unable to register with a GP prior to release from prison, or are refused registration on the basis of concerns about behaviour difficulties (Revolving Doors Agency, 2013; Sirdifield et al., 2020b). This can cause problems with accessing care, and continuity of care, including gaps in access to medication after release from prison.

Under-use of Community Sentence Treatment Requirements: Research has shown that Mental Health Treatment Requirements are currently under-used. Work is being undertaken to increase the use of these requirements (Khanom et al., 2009; National Probation Service, 2019).

Negative social determinants of health: Whilst clearly not everyone under probation supervision is the same, many people in contact with probation experience negative social determinants of health such as unemployment, homelessness, poor quality housing, and low levels of education. As stated in the Marmot Review (2010), health inequalities result from social inequalities like these. In addition, one study has pointed to these inequalities, together with issues such as the stress of being on probation, leading to health being perceived as a relatively low priority (Plugge et al., 2014).

2.2 Potential enablers

There are a number of steps that individuals under probation supervision, professionals working in the health and justice field, policy makers, and researchers can take to maximise positive mental health outcomes for people under probation supervision. Such steps are outlined in this section.

Improving literacy and health literacy: It is important that all professionals share information in accessible language. However, work is also needed beyond this, to improve both the literacy and the health literacy of the probation population.

Improving commissioning processes and provision for complex needs: It is important that organisations recognise and act upon their roles and responsibilities with regard to the health of people under probation supervision. These roles and responsibilities have been set out in policy documents, and are also summarised in a probation healthcare commissioning toolkit available from: https://probhct.blogs.lincoln.ac.uk/.

Ideally, Health and Wellbeing Boards should consider the needs of those under probation supervision, and undertake 'gap' analysis to examine the extent to which these needs are met by service provision. This should support the provision of services or models of practice that are designed to work with individuals with complex needs. Guidance to assist organisations in conducting health and social care needs assessment of people under probation supervision in the community will be available from Public Health England later this year.

The NPS Health and Social Care Strategy 2019-2022 includes an objective to 'strengthen partnerships at all levels to improve pathways into mental health treatment and services, particularly aiming to inform local commissioning processes for appropriate services that adequately cater to the needs of this complex cohort'. Commissioning could be improved if probation had a voice in local Health and Wellbeing Boards. Involvement in commissioning could operate at a number of levels including sharing of information to inform needs assessment and gap analyses described above, jointly creating service specifications, and jointly agreeing pathways into care.

Improving access to data and training: A combination of factors result in a paucity of freely available data about the mental health needs of people under probation supervision and the extent to which they are being met by existing service provision. These data are needed if we are to improve commissioning as described above.

It seems simple to say, but probation staff need access to training, and to screening processes that support them to identify and record likely cases of mental illness. Training should also include suicide prevention. While arguably probation staff should not be asked to make a diagnosis of mental illness, they do have a role in identifying likely cases that could benefit from onward referral, and in collecting data that can inform commissioning decisions. Indeed, the NPS Health and Social Care Strategy 2019-2022 states as follows:

> *'NPS will also seek to influence commissioning processes, where possible, by providing accurate data to demonstrate the prevalence of need and efficacy of health and social care interventions. Additionally, NPS will support staff by providing the appropriate information, guidance and training to enable them to feel more confident when engaging with health and social care agencies'*
>
> (National Probation Service, 2019: 8)

Screening individuals under probation supervision has resource implications, and care needs to be taken not to overburden probation staff. However, this may be possible through the introduction of short screening tools such as the Kessler 6 or the Core 10 (Barkham et al., 2013; Kessler et al., 2002). Indeed, as a result of a project responding to the under-use of Mental Health Treatment Requirements in England and Wales, the K6 is now used to assess psychological distress for people under probation supervision in one NPS area (Fowler et al., 2020; Long, 2016). The score recorded is used to determine whether or not an individual would benefit from receiving an intervention, and treatment is then provided by a charity working in partnership with probation.

Mental health awareness training and screening procedures could be enhanced by co-locating mental health staff alongside probation staff as we have seen in the Offender Personality Disorder Pathway and the introduction of Psychologically Informed Planned Environments. These have shown positive impact on probation staff's professional identity and confidence in working with people with personality disorder (Castledine, 2015; Ramsden et al., 2016).

In the longer term, it would be helpful if changes could be made to the way that data on health needs are collected and shared between organisations, and if health and justice organisations could work together to create joint indicators for the quality of care that people under probation supervision receive.

Increasing integration between health, social care, and probation services may help to simplify the health landscape. Co-location of staff and services can help to increase staff's knowledge, skills, and understanding of each other's roles. This could potentially be supported by the developing Integrated Care Systems.

Improving GP access: GP practices have been required to accept requests to pre-register prisoners approaching the end of their sentence since 2017 (Ministry of Justice, 2019). To overcome this barrier, some areas are operating GP registration schemes, and in other areas GPs are proactively working with probation to overcome problems with continuity of care and access to healthcare by basing themselves in probation Approved Premises on a regular basis. It may be that RECONNECT Care After Custody helps with overcoming this barrier in the future (NHS England, 2019).

Addressing the social determinants of health: The Marmot Review 10 years on points to the continuing need to tackle the social determinants of health across society. This should include those under probation supervision. Public Health England provide a Fingertips profile

to support work to reduce the impact of the social determinants of health, which is available here: https://fingertips.phe.org.uk/profile/wider-determinants. Marmot Indicators for local authorities are also available from the fingertips website.

Investing in research and evaluation: There are numerous examples both on the ground and in the literature of work that has been undertaken to improve pathways into mental health care for people under probation supervision. Not all of these have been the subject of formal research or evaluation, but they may prove useful starting points from which evidence-based practice could be developed in the future (see 2.3). There is a clear case for investment in research linked to potential models of good practice.

2.3 Potential models of practice to explore

Overall, there is a paucity of research literature on which we can base definite conclusions about evidence-based practice for maximising positive mental health outcomes for people under probation supervision. There are also notable gaps in the research literature. For example, one strand of a recent systematic review (Sirdifield et al., 2020a) was only able to identify one research paper that focused on suicide in probation and provided insights into how the management of suicide prevention could be improved (Borrill et al., 2017).

The wider systematic review identified some models of practice which have simply been *described* in the literature, rather than being the subject of research or evaluation. These may provide a foundation from which research into evidence-based practice could be developed. They are briefly outlined below.

- **Diversion programmes:** Numerous attempts have been made to introduce models of practice that divert individuals identified as having a mental illness away from the criminal justice system and into treatment. Liaison and diversion teams are now in place in most areas of England and Wales, and the literature offers some insight into key ingredients for their success (Durcan, 2014).
- **Psychiatric input in probation:** An example of a third sector service providing psychiatric input to probation is provided in the paper by Fowler et al. (2020), where initial findings point to a positive impact for those that engage with the intervention. There are also examples of probation Approved Premises that specifically aim to provide services to individuals with mental illness, and examples of partnerships between forensic psychiatry services and probation Approved Premises, such as that described by Nadkarni et al. (2000). A final example of partnership working between mental health and probation is the Offender Personality Disorder pathway, where, as stated above, there is some evidence to suggest that working in partnership with mental health staff is improving probation staff's confidence in working with people with personality disorder.
- **Specialist caseloads:** Skeem et al. (2006) share research findings around 'speciality caseloads' in the USA. These caseloads consist exclusively of individuals with mental

illness, and on average, usually consist of around 45 cases – around a third of the size of a traditional caseload in the USA. Staff working with these caseloads receive regular mental health training (20-40 hours a year), and take a problem-solving rather than punitive approach to non-compliance. Staff also work directly with external service providers, including attending meetings rather than simply making referrals (Skeem and Eno Louden, 2006). Positive outcomes are reported in terms of increased rates of linking probation clients with treatment services, improved wellbeing of probation clients, and reduced risk of probation violation.

3. Conclusion

It is important to maximise positive mental health outcomes for people under probation supervision, both for the benefit of these individuals, and also because this will produce wider societal benefits. To support this agenda, the following is required:

1. All probation clients should have their mental health assessed and recorded. This will require investment in training and ideally should take place as a part of mandatory probation staff training.
2. Aggregate level data on health needs should be shared with service commissioners.
3. The number of Joint Strategic Needs Assessments that include the health needs of people under probation supervision needs to increase substantially.
4. Gap analyses need to be conducted to assess the extent to which the needs of people under probation supervision are currently being met.
5. Investment by CCGs (and in the future Integrated Care Systems) needs to increase to ensure sufficient appropriate service provision is available to meet the complex needs of this population.
6. Clear pathways into services need to be created between probation and Mental Health Trusts.
7. All Local Authorities need to acknowledge the high level of suicide in probation populations in their suicide prevention strategies.
8. Investment needs to be made into research and evaluation to investigate the effectiveness of different models of working to improve mental health outcomes for people under probation supervision.
9. Those working in health and justice need to be aware of the potential for exacerbation of mental health issues due to the impact of the COVID-19 pandemic. As part of recovery planning work, systems need to be in place to ensure that both staff and those being supervised can access appropriate support. This could be via dedicated phone lines, support with accessing primary care, and closer partnership working with local Mental Health Trusts and voluntary sector agencies.

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The HMI Probation Research Team can be contacted via
HMIProbationResearch@hmiprobation.gov.uk