THE PROBATION SERVICE

MOVING FORWARD TOGETHER: MENTAL HEALTH AMONG PERSONS SUPERVISED BY THE PROBATION SERVICE

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An tSeirbhís Phromhaidh
The Probation Service

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Foreword

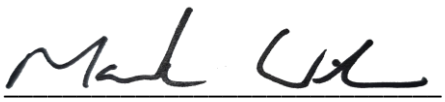
The Probation Service is committed to delivering evidence based policy and practice. Research and evaluation of what we do, and how we do it, improve our knowledge and understanding and inform better practice.

This report, 'Moving Forward Together: Mental Health among persons supervised by the Probation Service', seeks to highlight the important issue of unmet mental health needs among vulnerable men and women living in the community subject to Probation Service supervision in Ireland. The studies show that many people supervised by the Probation Service are living with mental health problems and many are not engaged with any service for mental health intervention or support.

Historically, people who experience mental health problems have often been left without a voice and marginalised, particularly in a criminal justice context. This research sets out to quantify and evidence this. The Probation Service, working with mainstream Mental Health Services partners, can address the gaps in services and engage with and support our clients appropriately.

As Director of the Probation Service, I would like to thank Dr. Christina Power, the author of this report, and all of the Probation Service staff who have contributed to this very important and valuable research study. Without their input, experience and commitment, this report would not have been possible. Thank you also to all those people who have offered additional support, knowledge and experience.

This report marks an important step in informing and developing best practice for working with people with mental health problems and delivering integrated interventions with mainstream health services in the community. To address this complex set of problems and provide mental health care services, a cross agency and focussed government approach is required. I will look forward to the Probation Service contributing to and supporting that solution focused approach for the benefit of everyone and trust that this report will assist us improve on the delivery of appropriate services to those with whom we work.



Mark Wilson, Director

Acknowledgements

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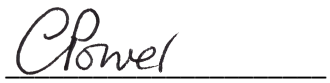
I would also like to acknowledge the support of Professor Charlie Brooker, Royal Holloway, University of London, for his long-time interest and expertise in this field of study and, in particular, to thank him for his continued advice and guidance.

Thank you all.



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Executive Summary

Internationally, the prevalence of mental health problems and mental disorder among people subject to Probation Service supervision is significantly higher than in the general population. The studies in this report, conducted last year, show that Ireland is no exception.

- In these studies, at least 40% of adults on a Probation Supervision Order, compared to 18.5% 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.
- Approximately 50% of all people supervised by the Probation Service in the community that 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.
- There are significant and unmet psychological and psychiatric needs among persons subject to Probation Supervision. These findings show that we need improved access and engagement routes to mental health services; there is a need for cross agency working and a focused government approach to ensure this can happen.

Key findings identified from the third and largest study in this Report indicate that:

- **43%** experience **Active Symptoms of Mental Health Problems** (**57% women; 40%** men):
    - Most often anxiety and depressive symptomatology;
    - **10%** experience symptoms indicative of **serious** and/or **severe and enduring mental health problems**.
- **30%** are engaged with a service **for Mental Health Assessment and/or Intervention currently** (**49%** women; **28%** men):
    - Mostly through their GP/medication (20%) and most often women;
    - 1.4% are engaged with Primary or Secondary Care Psychology Services.
- **56%** have had some form of **Mental Health Assessment and/or Intervention in the Past** (**70%** women; **52%** men):
    - Most often through their GP with medication;
    - **11%** of persons have had **In-Patient Psychiatric Care in the Past.**
- **41%** are identified as having a known **Mental Health Diagnosis** provided by a qualified clinician (**52%** women**; 38%** men):
    - **16%** Anxiety disorder and **15%** Mood disorder;
    - **8%** Schizophrenia/Primary Psychotic Disorder (**1%** general population worldwide).
    - **4%** Personality disorder and related traits, comparatively low when compared to other Probation Service jurisdictions **(e.g. 47%).**

- **1 in 10** persons supervised by the Probation Service in the community are identified as experiencing active **Suicide ideation/plans (10%) (16%** women; **8%** men).

- **1.5% of men (6 men) are considered to be in severe distress and in imminent danger of causing harm to self and/or harm to others.**

- **One specialist team reported:**

    - **43%** with **active symptoms** indicative of mental health problems;
    - **14%** with a **formal diagnosis of Schizophrenia or other primary psychotic disorder;**
    - **9.5%** past contact with **Child and Adolescent Mental Health Services**;
    - **9.5%** identified as engaging in **deliberate self-harm**;
    - **36%** identified as having experienced **childhood trauma;**
    - **19%** engaged with **some form of service for mental health problems**.

- **One general supervision team reported:**

    - **1 in 5 men (19%)** have had **In-Patient Psychiatric Care** in the Past;
    - **14%** expressed active **Suicide ideation/plans;**
    - **83% of women** had **Mental Health Assessment and/or Intervention in the past**.

- **High mental health problem co-morbidity with:**

    - Alcohol and drug misuse **(51%);**
    - Difficult family relationships **(49%);**
    - Accommodation instability **(47%).**

Key issues for the Probation Service in the findings include:

- There are **significant unmet psychological and psychiatric needs among those persons subject to Probation Supervision and limited Mental Health Service engagement.**

- There is a need to strengthen **knowledge** and **develop skills-based training in mental health** for Probation Service staff to aid recognition of mental health problems and where identified, ensuring that the appropriate services are involved at assessment and/or intervention.

- There is a need to improve and strengthen **Probation Service engagement with mainstream primary care and forensic and community mental health service providers and the development of joined-up strategies and interventions.**

The findings provide the Probation Service, Department of Justice and the Department of Health with data confirming high prevalence of mental health problems among person subject to probation supervision. There is a clear need for enhanced co-ordination and improved access routes to appropriate mental health services for individuals presenting with a range of mental health problems and possible co-occurring needs. It also highlights the need for increased cross-agency, inter-disciplinary working and joint working by the services and professionals.

CHAPTER 1: INTRODUCTION

1.1 Background to the report

1.1.1 Internationally there is a high prevalence of mental illness and high rates of co-morbidity in offenders on probation (Sirdifield, 2012). Mental illness does appear to be associated with non-compliance with probation and to influence offending. Treating mental illness has been identified as potentially improving criminal justice as well as health outcomes (Brooker, Sirdifield and Marples, 2019).

1.1.2 Effective joint working between Mental Health and Probation Services can be effective in supporting recovery for those presenting with mental health problems among offenders. However, access to mental health services by persons subject to Probation Service supervision is often problematic and lacking co-ordination despite the likely link between mental health problems and offending.

1.1.3 In Ireland there has been a paucity of data and research on mental health problems among persons subject to Probation Service supervision. A number of small-scale practitioner studies (Griffin, 2008; Cotter, 2015; Foley, 2016) highlighted concerns regarding the incidence of mental health problems among the population. The studies were limited in their focus but were instrumental in drawing attention to the field by identifying significant gaps in knowledge and the need for further evaluation and action. At that time the Probation Service did not have its own psychology resources and had limited engagement with the general psychology services, which did not, in most instances, provide forensic psychology services.

1.1.4 Early discussions with Criminal Justice and Health Service interests did identify potential benefits in co-operation and co-ordination to address issues and gaps in service provision. Within the Department of Justice discussions were initiated between the Probation Service and the Irish Prison Service (IPS) following the 'New Connections' Report on the IPS Psychology Service in 2015 (Porporino, 2015).

1.1.5 The 'New Connections' Report' recommended joined-up interventions with other services, especially the Probation Service. A small group of IPS Psychology Service and Probation Service managers were tasked with developing an overarching strategic plan for how Psychology and Probation would work in a joined up fashion within prisons, and to support more effective reintegration of offenders post-release in the community.

1.1.6 In Europe research had shown that the prevalence of various mental health problems among probationers was high compared to the general population. The Confederation of European Probation (CEP), with Europris, the European Prisons network hosted an international expert workshop in Dublin in 2017 on mental health in criminal justice that further assisted progress in informing and supporting the importance of co-operation and joint working in addressing mental health issues in criminal justice.

1.1.7 The Irish Prison Service and Probation Service's strategic plan for 2018 – 2020[1] committed the Services to greater cohesion to reduce offending behaviour to promote safer communities. It also committed to enhanced delivery of existing joint initiatives along with development

[1] https://www.irishprisons.ie/wp-content/uploads/documents_pdf/IPS-PS-Strategic-Plan-2018-2020.pdf

opportunities for collaboration and information sharing. A senior Irish Prison Service psychologist was assigned to the role based in Probation Service Headquarters on a full time basis. This appointment has provided the Probation Service with dedicated specialist mental health expertise and enabled the development of this research project.

1.1.8 The psychologist role provides a specialist level of psychological expertise to the Probation Service. It requires building strong relationships with the Probation Service both in HQ and nationally, and engaging closely with the senior management team in Probation Service HQ. Development of closer working practices between the Probation Service and the Irish Prison Service, is a priority along with contributing to the development of pathways to accessing psychological support for Probation Service clients in the community, specialist psychological assessment, intervention and case management input, through psychological consultation and contributing to the training and development of Probation Service staff.

1.1.9 A further aspect of the role is to enhance engagement with specialist forensic and mainstream community based Mental Health Services and Primary Health Care Services to address the psychological needs of probation clients. That is, having a detailed knowledge of, and ability to identify and access, specialist and general Psychological support within Ireland that will enhance the knowledge of Probation Officers and the provision of care to clients.

1.2 Psychological Consultation: Responding to concern regarding mental health problems among persons subject to Probation Supervision

1.2.1 A core theme which emerged though the consultation process was Probation Officer concerns regarding client mental health and identification of symptoms indicative of mental health problems causing considerable psychological distress which may be associated with increased risk of offending. Probation Officers reported considerable unmet mental health need among their clients and identified difficulty getting their clients access to appropriate mental health services to address their needs. It is often acknowledged that many individuals become engaged with the Criminal Justice System due to unmet mental health need[2].

1.2.2 It has been clear, based on the feedback during consultations, that there is a need to get a clearer understanding of the difficulties and to develop formal pathways between the Probation Service, Irish Prison Service, mainstream forensic and community Mental Health Services and Primary Care Mental Health Services. Making links with statutory and non-statutory Mental Health Services and understanding their role has been a core part of the role of the psychologist. Based on communication with a range of senior national and local stakeholders it has become increasingly apparent that in order to develop links and formal pathways for our clients, the Probation Service requires a clearer understanding with respect to service users mental health needs.

1.3 Mental Health Problems among persons subject to Probation Supervision

1.3.1 In 2017, The Probation Service Annual Report[3] recognised that mental health problems "may have a direct and or indirect link with offending and impacting on capacity to intervene

[2] https://www.mentalhealthreform.ie/wp-content/uploads/2017/09/Submission-on-review-of-A-Vision-for-Change.pdf

[3] The Probation Service (2017). Annual Report: Lasting Change Through Offender Rehabilitation. http://www.justice.ie/en/JELR/Pages/Probation_Service_Annual_Report_2017.

effectively with service users" (pg. 11). In view of this, the Probation Service made a commitment for 2018 to strengthen mental health awareness in the Service, with particular focus on raising awareness of mental problems, personality disorders and indicators of deliberate self-harm behaviours and suicide. A working group focused on mental health was set up and the Probation Service made a long-term commitment to skills-based training for Probation Officers in risk assessment and safety planning using STORM, a self-harm mitigation model.

1.3.2 In December 2017, the Probation Service hosted the CEP[4] and EuroPris[5] workshop on mental health problems in prison and probation in Dublin as part of its recognition of the need for action on mental health problems in criminal justice https://www.cep-probation.org/looking-back-on-a-successful-mental-health-in-prison-and-probation-workshop/.

1.3.3 In 2019, as the psychologist in post, I initiated the preparatory work on these studies examining mental health problems among persons subject to Probation Service supervision, which comprise this report. Before turning to the current studies, it is important to contextualise mental health in the broader sense by reviewing national policy for mental health in Ireland beginning with '*A Vision for Change*' (2006).

1.4 A Vision for Change: Report of the Expert Group on Mental Health Policy 2006

1.4.1 *'A Vision for* Change' (AVFC)[6] is the government mental health policy detailing the model of Mental Health Service provision in Ireland from early 2006 – mid 2020. It is described as a framework for building and fostering positive mental health across the community and for providing accessible, community-based, recovery focussed specialist services for people with mental health problems. The expert group concluded:

"Each citizen should have access to local, specialised and comprehensive mental health service provision that is of the highest standard" (pg. 8).

1.4.2 The AVFC outlined recommendations for forensic Mental Health Services for individuals with mental health problems who come into contact with the criminal justice system and those with aggressive or challenging behaviour (p.39)[7]. The expert group emphasised that forensic Mental Health Services should have a "*strong community focus*" and individuals in the criminal justice system should have the right to be treated in non-forensic Mental Health Services unless there are "*cogent and legal reasons why this should not be done*"[8]. Furthermore, it was noted that:

"*The Nationwide Probation Service carries an extensive caseload of ex-prisoners and people who have not served sentences. Many have had, or currently have, mental health problems. Some may be in contact with Mental Health Services and others may not be, even though they require such contact. Therefore it is essential that there are linkages between the Probation*

[4] Confederation of European Probation (CEP) Promote the social inclusion of offenders through community sanctions and measures such as probation, community service, mediation and conciliation: https://www.cep-probation.org/

[5] EuroPris Promoting Professional Prison Practice https://www.europris.org/

[6] https://www.hse.ie/eng/services/publications/mentalhealth/mental-health---a-vision-for-change.pdf

[7] '*A Vision for Change*', pg. 39

[8] '*A Vision for Change*', pg. 137

Service and the relevant generic mental health services and, where appropriate, Forensic Mental Health Services to ensure a linked approach and, particularly, continuity of care" (pg.141).

1.4.3 There has been limited progress in this area following on from AVFC in 2006, and Mental Health Reform[9] provided a progress and implementation report in 2015, titled '*A Vision for Change Nine Years On: A coalition analysis of progress*'[10].

1.4.4 In a subsequent submission to a review of '*A Vision for Change*'[11], Mental Health Reform highlighted ongoing concerns regarding unmet need for Mental Health Services for those individuals who fall within the remit of the Criminal Justice System. They recommended that the Government uphold the existing recommendations set out in AVFC on mental health in the Criminal Justice System (pg.116). Furthermore, they included additional recommendations, two of which being:

"Recommendation 1: Individuals with mental health difficulties should be diverted from the criminal justice system at the earliest possible stage, and have their needs met within community and/or non--forensic mental health services" (pg.117).

"*Recommendation 5: A range of community mental health supports should be made available to individuals following their release from prison. Such supports should include the availability of a range of talking therapies"* (pg.126).

1.4.5 Three action points were listed which included greater collaboration and development of protocols between the IPS and HSE Mental Health Division; community follow up from IPS where necessary; the HSE to provide training and guidance to community mental health staff on working with individuals who have previously engaged in the Criminal Justice System; encourage staff and services to proactively work with this client group of individuals (pg.126). However, there was no specific reference to those individuals engaged within Probation Services in the community who have not been in custody and to date there has been little, if any, progress in this area for individuals engaged with the Probation Service.

1.4.6 Despite little progress to date, Mental Health Reform remains active in the area. In July 2019, Mental Health Reform provided a Pre-Budget Submission for 2020[12] for the Department of Health, which included seven recommendations for investment in mental health. The recommendations called for an increased budget to increase staffing to ensure service users have access to appropriate mental health care; increase capacity of the counselling in Primary Care to meet the growing demand and extend service access to those on low incomes: investment in Primary Care Psychology services and increase capacity of national advocacy services for children and adults.

1.4.7 Along with increasing Service capacity, Recommendation 3 calls for *"The Departments of Health and Housing to provide a national sustainable funding stream for tenancy sustainment*

[9] Mental Health Reform is Ireland's leading national coalition on mental health www.mentalhealthreform.ie
[10] https://www.mentalhealthreform.ie/wp-content/uploads/2015/06/A-Vision-for-Change-web.pdf
[11] https://www.mentalhealthreform.ie/wp-content/uploads/2017/09/Submission-on-review-of-A-Vision-for-Change.pdf.
[12] Mental Health Reform: Promoting Improved Mental Health Services Pre-Budget Submission 2020 (July 2019)

reports, where required for individuals with severe and enduring mental health difficulties…" (pg.1). It is anticipated that the implementation of these recommendations will benefit persons supervised by the Probation Service. This recommendation is also again included in the Mental Health Reform pre-budget submission 2021[13].

1.4.8 Overall, there has been little progress in the area of increased access to mental health care for persons supervised by the Probation Service following '*A Vision for Change*' in 2006 and *'A Vision for Change Nine Years On: A coalition analysis of progress'* in 2015.

1.4.9 In June 2020, the new Mental Health Policy, *'Sharing the Vision'*[14] was published. Disappointingly, '*Sharing the Vision'* does not make reference to individuals who are subject to a Probation Supervision Order. There is a further need for a specific recommendation stipulating the provision of equivalency of health care for persons supervised by the Probation Service. The establishment of the policy's National Implementation and Monitoring Committee does provide an opportunity to develop policy recommendations and improve practice in these areas.

1.4.10 There is a need for trustworthy data related to the mental health problems among those persons subject to probation supervision and their access to services for mental health assessment and/or intervention. It is also important to review any previous existing service data and develop an evidence informed and structured action plan moving forward.

[13] Mental Health Reform: Invest in Mental Health Pre-Budget Submission 2021

[14] https://www.gov.ie/en/publication/2e46f-sharing-the-vision-a-mental-health-policy-for-everyone/

CHAPTER 2: MENTAL HEALTH IN PROBATION SERVICES INTERNATIONALLY AND IN IRELAND

2.1 Mental Health in Probation Services Worldwide

2.1.1 The prevalence of mental health disorders amongst Probation Service clients is as high, if not higher, than in prison populations (Geelan et al., 2000; Brooker et al., 2012; Sirdifield, 2012). However, the nature of disorders is complex with high levels of co-morbidity including personality disorder, substance misuse and psychosis.

2.1.2 Despite the complexity of mental health disorders faced by this group, Mental Health Services and Probation Services working together have attempted to promote models that engage probationers and a number of these models have been evaluated. For example, in the United States, Lamberti et al., (2004) used assertive outreach programmes in an attempt to reduce re-offending and treat serious mental health disorders. Mitton et al., (2007) described a diversion programme run in Canada to the same end; use of Mental Health Services decreased as did visits to Accident & Emergency departments. At six-month follow-up, however, 50% of the sample had been lost to attrition so little is known about the longer-term consequences.

2.1.3 Clayton et al., (2013) in their 'citizenship' project allocated people at random with a serious mental health disorder who had been charged with a criminal offence in the last two years into an intervention that consisted of; individual peer mentor support, an 8-week citizenship course, and an 8-week valued role component. Alcohol and drug use decreased for the experimental group and quality of life increased. There are two noteworthy aspects to this study. First, this is the only randomised controlled trial in the whole of the literature. Second, a total of 114 people in total were recruited from just two community mental health centres – a high number of those with both a serious mental illness and a criminal conviction in the last two years.

2.1.4 In a series of innovative programmes, Skeem and Louden (2006) described the use of 'speciality caseloads' in the United States. In this model of working, Probation staff work with reduced mental health caseloads, receive training and on-going supervision in mental health and are also trained to use problem solving strategies. The authors concluded that working in this way is more effective than traditional models of probation service delivery: well-being improves; treatment services are better engaged; and the likelihood of probation violations is lower. Finally, Herinckx et al. (2005) found that using a variety of approaches such as crisis intervention and medication monitoring had a meaningful impact on the length of in-patient treatment in a mental health facility.

2.1.5 Probation Service clients face both system-level and personal-level barriers to accessing mental healthcare. Many people in contact with Probation are not registered with a GP, and/or only access healthcare during crises (Revolving Doors Agency, 2017). Sometimes Services simply do not exist to meet their needs, and sometimes Services are difficult to access due to their location, problems with their opening hours, restrictive referral criteria and poorly understood access routes (Brooker et al., 2012). Moreover, the health needs of people in contact with Probation and how best to structure service provision to make health care

accessible to and appropriate for this group are rarely considered by healthcare commissioners especially in England (see Brooker and Ramsbotham [2014] for example).

2.1.6 Many people subject to probation supervision serving a Probation Order have at least one mental health disorder (Brooker, 2020). Research examining the effectiveness of interventions for this group is scant especially where a client might be experiencing a number of mental health disorders. A variety of different approaches have been undertaken to attempt to engage clients in mental health service delivery but are often devised solely as one-off studies (Brooker, 2020).

2.1.7 In a recent unique study by Fowler and colleagues (2019), all clients supervised by the Probation Service in London were screened at assessment for mental health problems. A sub-group of 569 clients were identified and referred onwards to a specialist mental health service. Of those clients screened as positive, 301 clients were referred onwards for psychological assessment and intervention. A total of 75 clients completed the intervention. A significant positive impact was reported in a six-month follow-up across measures of depression, anxiety and general distress and social functioning. Furthermore, 74 per cent of participants committed no further offences in the 12 months following treatment. Even accounting for the positive outcomes, 228 clients failed to engage with the initial engagement by not attending for their first appointment. It appears that there are additional factors which may impact on or influence client engagement with Services for mental health support.

2.1.8 Fowler et al., reported that a key issue related to client engagement with Mental Health Services was instability of housing/accommodation. This supports Maslow's theory of hierarchy of need (1943). That is, having basic physiological needs such as food, water, warmth and rest and safety and security needs, in place before addressing psychological needs, esteem needs, self-fulfilment and self-actualisation. According to Maslow, in order to move through the stages and progress, each stage must be satisfied within the individual himself or herself.

2.1.9 In a further study highlighting considerable concern regarding the mental health needs of clients engaged with Probation Services, Philips, Padfield and Gelsthorpe (2018) analysed deaths among those subject to criminal justice supervision in the community. They found that the suicide rate among people under probation supervision, including those serving a community order, suspended sentence order or on licence/post-release supervision, is significantly higher than the general population and also higher than those in custody.

2.1.10 Furthermore, a recent systematic review and meta-analysis conducted by Skinner and Farrington (2020) indicated that community offenders are significantly more likely to commit suicide compared with non-offenders and at any age. Furthermore, findings show that offenders have over four times more chance of committing suicide than non-offenders and community offenders generally have a significantly higher possibility of suicide at any age (pg. 2). This is highly concerning and a matter of priority for the Probation Service and the wider health care services. Furthermore, "*New anxieties and stressors such as Covid-19 and attendant in personal and social circumstances can heighten risk"* according to the

International COVID-19 Suicide Prevention Research Collaboration writing in The Lancet Psychiatry[15] (2020). The authors commented:

"Suicide is likely to become a more pressing concern as the pandemic spreads and has longer-term effects on the general population, the economy and vulnerable groups".

2.1.11 The findings suggest that individuals engaged with the Probation Service in the community are a vulnerable group of individuals and attention and action is required. For those individuals facing existing social and economic inequalities, many of whom are engaged with the Probation Service, those inequalities will be exacerbated due to COVID-19.[16]

2.1.12 In a 2020 recent report focussed on trauma-informed practice in Probation Services, McCartan (2020), focuses on risk factors including trauma and adversity and their impact on offending behaviour (pg. 8). The author argues that *"becoming aware of past trauma, helps services to understand why some individuals engage in criminogenic behaviour, both initial offending and reoffending"* (pg. 8).

2.1.13 This position fits with previous studies using the Adverse Childhood Experience (ACEs) approach, which identify early childhood experiences, such as parental conflict, witnessing physical abuse, being physically, emotionally or sexually abused, and observing alcohol and drug abuse at a young age, as having significant, negative outcomes over the lifespan (e.g. Felitti et al., 1998). Higher exposure to adverse childhood experiences is associated with many negative life outcomes, such as, increased risk of chronic disease, poor health, premature morbidity and mental health problems (Felitti et al., 1998).

2.1.14 Authors Sheffler et al., (2020) highlight the accumulating research documenting the link between early adverse and stressful life experiences, particularly childhood abuse, and risk of developing of a range of mental disorders in adulthood (e.g. Afifi et al., 2008). Studies consistently show a relationship between adverse childhood experiences and development of mood disorders and anxiety disorders in adulthood (e.g. Li D'Arcy and Meng, 2016; Chapman et al., 2004).

2.1.15 In studies of offending behaviour, higher ACE scores have also been linked to future risk of incarceration and suicide attempts (De Ravello, Abeita, & Brown, 2008), intimate partner violence (Crane et al, 2013), recidivism (Manchak, Skeem, & Douglas, 2008), violence as an adult (Pournaghash and Feizabadi, 2009; Whitfield, Anda, Dube, and Felitti, 2003), violence by individuals with psychopathy (Kolla et al., 2013) and substance abuse (Bowles, DeHart, & Webb, 2012) (Moore & Tatman, 2016).

2.1.16 With regards to the Probation population, Moore and Tatman (2016) examined the extent to which ACE scores could predict risk using the LSI-R risk assessment tool of future offending in those convicted of an offence. Their analysis suggested that early negative experiences can predict future risk. The authors suggested using an additional screening tool before completing a comprehensive evaluation of risk. They argue that early identification of adverse experiences can provide a focus towards therapeutic resources and services where needed to

[15] https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(20)30171-1/fulltext

[16] Mental Health Reform Briefing for President Michael D. Higgins' Office: The impact of COVID-19 on mental health in Ireland 15th May 2020.

address past trauma, which would potentially reduce future risk of recidivism (p. 155). It can be said that this is an overly simplistic and perhaps reductionist approach, however, the studies clearly show the importance of recognising and understanding the possible impact of early adverse childhood experiences, in particular for those who come into contact with the Probation Services.

2.1.17 Taking into account these factors, it is clear that there is a need to take a trauma-informed approach to service delivery. It is widely acknowledged that there is a lack of trauma-informed service provision both nationally and internationally. There is a need for all sectors, including Health and Social Care and Criminal Justice Services to recognise the signs indicative of trauma, to understand the wider impact of trauma for the individual and their families and organisations, and to be responsive through development of policies and practice. A commitment to trauma informed practice is identified in the new Mental Health Policy *'Sharing the Vision'* Service Delivery Principles (pg.17 for a full definition):

"It simply means that the service system needs to be aware of and respond to the presence of trauma in people who may be using a wide variety of supports." (pg. 17).

2.1.18 For the Probation Service in moving towards becoming trauma-informed service, McCartan (2020) stipulates the need to recognise and acknowledge the impact that trauma can have on an individual, including but not limited to ACEs, and provide the person with the appropriate support (pg.8). McCartan advocates for a "*person first*" approach to developing a trauma-informed approach in both policy and practice. We need to adopt a strength-based approach to working with clients and appreciate the role of resilience.

2.1.19 Treisman (2020) conceptualises the process of becoming a trauma-informed organisation along a continuum, using the 'trauma river'. It starts with becoming trauma aware and trauma sensitive through to becoming trauma informed and trauma responsive. The present studies help the Probation Service in Ireland with the first part along the continuum, by becoming aware of the challenges that clients encounter with regards to their mental health problems and the impact individually and systemically.

2.1.20 When considering trauma informed delivery, it is also of particular note that there is a high prevalence of mental health problems co-existing alongside other difficulties, more specifically addiction. This is particularly significant among individuals engaged with Probation Services (Brooker et al., 2012). Given the significant overlap between mental health problems and addiction, there is an urgent need for improved access to dual diagnosis services. That would enable more effective integration between specialist addiction therapy and recovery for those affected by addiction with co-occurring mental health problems such as depression, anxiety, trauma and suicidal ideation.

2.1.21 In addition, and importantly, there are other vulnerable populations whose needs require specific attention and targeted interventions such as women, ethnic minorities, and individuals presenting with neurodiversity, learning disabilities and acquired brain injury

2.2 Mental Health Problems among persons subject to Probation Service Supervision

2.2.1 Mental health problems among persons in the community subject to Probation Service supervision in Ireland are an ongoing concern. Probation Service staff have raised concerns regarding what has been perceived as an increase in the number of clients on their caseloads presenting with a range of mental health problems over several years and limited access and engagement with forensic and community Mental Health Services and Primary Care Psychology Services (e.g. CIPC). There is sparse empirical research or data to support this anecdotal information; however, three small scale practitioner studies have been conducted by Probation Officers between 2008 and 2015.

2.2.2 The first practitioner research study (Griffin 2008, unpublished) explored mental health, trauma and bereavement based on a Probation Officer review of 112 supervision cases. Of those, 39 per cent (*n*= 44) were reported to have had a mental health problem over the course of their lives, with depression being most frequently reported (18%). Of the twenty-eight clients who reported a bereavement over their life, 20 per cent (*n* = 23) made a link between their bereavement and their offending. Eight of those clients reported symptoms indicative of mental health problems; two had psychiatric inpatient history and four were involved with specialist Mental Health Services.

2.2.3 Cotter (2015) reviewed the prevalence of mental health problems among adults serving a Probation Service Supervision Order examining data extracted from anonymised Level of Service Inventory Revised Assessments (LSI-R)[17]. Of the 6,018 LSI-R assessments conducted by Probation Officers with 4,884 clients in 2012, 30.8 per cent were rated as experiencing 'moderate interference', (some signs of distress, mild anxiety or mild depression); 3 per cent were reported as having 'severe interference' (active psychosis); 33.7 per cent were assessed as having had 'mental health treatment in the past', 15.8 per cent were engaging in some form of psychiatric treatment at the time of assessment, and 12.6 per cent were identified as requiring a psychological assessment.

2.2.4 Foley (2016) surveyed the nature and prevalence of mental health in one Probation Service region, including four supervision teams. The study also aimed to address another primary concern expressed by Probation Service staff, dual diagnosis of mental health problems and poly-drug use. In one team surveyed, 74 per cent of women (*n* = 17) and 12 per cent of men were reported as having mental health problems. Depression was the main type of mental health problem reported, closely followed by suicidal ideation and self-harm, consistent with the previous studies. Dual diagnosis was a significant problem for almost all clients.

2.2.5 These studies highlight concerns regarding the incidence of mental health problems among persons subject to probation supervision in Ireland. They are also indicative of the complexities in conducting applied research in the area of mental health in the Probation Service. They were singular and isolated studies limited by low return rates and restricted to a team or one region and small numbers. Even so, these studies highlight a need for further

[17] Level of Service Inventory – Revised (LSIR) is the primary risk/needs assessment instrument used by the Irish Probation Service in assessment. It was developed by Don Andrews, Ph.D. and James Bonta, Ph.D and is published by Multi-Health Systems Inc. (MHS) www.mhs.com

evaluation in the area and support the ongoing and increasing concerns voiced by many Probation Officers managing complex cases where mental health problems are problematic.

2.3 Summary

2.3.1 There are significant gaps in our knowledge with regards to the nature and extent of the mental health problems of persons supervised by the Probation Service and little is known of the potential barriers to accessing the appropriate services in a timely manner. There has been little information or research data to inform the development of a Probation Service Mental Health Strategy. This has been an issue for the Mental Health Working group in considering how the Probation Service can develop those links with community services and there has been an effort to reach out to services. Furthermore, the Mental Health Working Group also identify that there is a need to review and, if appropriate, further develop the internal system for collation of national suicide statistics within the Probation Service to inform early intervention strategies and identify potential specific risk factors.

2.3.2 There is lack of trusted service data, essential in developing national and local service policies, linkages and training. The Probation Service is in need of evidence to support strategic service planning and to develop relationships with colleagues in Health Services, specifically Mental Health Services. It is essential that the Probation Service can appropriately support those individuals transitioning from custody to the community and also provide those supervised in the community equal access to services to meet their needs and their resettlement into the community for those on community supervision. Consideration should also be given to closer working and joint partnerships between The Probation Service and Diversion programmes, early intervention services, employment services and housing projects where a need is identified.

2.4 The Mental Health Evaluation Studies 2019

2.4.1 This report presents the findings from three internal and incremental studies conducted in the Irish Probation Service in 2019 exploring Mental Health among persons subject to probation supervision.

2.4.2 The first exploratory study presents analysis of the Level of Service Inventory – Revised (LSI-R, Andrews & Bonta, 2004) data collected routinely by the Probation Service between 2017 and 2018. The second pilot study expanded on the LSI-R study, using a self-report survey with Probation Officers from one Probation Service team and the Global Assessment of Functioning (GAF) APA (1994). A third, larger scale study, replicated the second pilot study using the previous learning and findings across a representative sample of five Probation teams.

2.4.3 The overall objective of the three studies was to explore mental health problems among Probation Service clients. To achieve this the following aims were identified:

- To explore and identify indicators of mental health problems among clients engaged with the Probation Service from the perspective of Probation Service staff and gain a greater understanding of clients' engagement and access to mental health services.
- To provide the Probation Service, Department of Justice and the Department of Health with data and evidence of the need for appropriate Mental Health

Services and for cross-agency and interdisciplinary working with Probation Service clients presenting with a range of mild, moderate and, severe and enduring mental health problems.

- Provide evidence to progress the recommendations from The Report from the Expert Group on Mental Health Policy '*A Vision for Change'* (2006) and *'A Vision for Change: Nine Years On'* (2015) and *'Sharing the Vision'* (2020).
- To provide trusted data and evidence to identify need, to develop effective intervention strategies, and provide training in the area of mental health for Probation Officers to support case management planning.

CHAPTER 3: THE STUDIES FORMING THE PROBATION SERVICE MENTAL HEALTH EVALUATION

Study 1: Exploratory analysis of The Level of Service Inventory – Revised (LSI-R) 'Emotional/Personal' questions 2017 – 2018

Introduction

The Level of Service Inventory – Revised (LSI-R, 2004) is an actuarial assessment tool used by The Irish Probation Service to identify a persons' level of risk and needs with regard to recidivism. The risk assessment instrument includes five validated questions on mental health contained within the 'Emotional/Personal' subcomponent that provide an important insight into mental health functioning. Ratings provided by Probation Officers are informed by available information including client self-report, practitioner judgement and collateral information.

Research design and methodological approach

Methodological approach

An anonymised exploratory analysis of statistical data from the Probation Service related to prevalence of mental health was undertaken in January 2019. The data was collected from LSI-Rs completed by Probation Officers in 2017 to 2018. Anonymised data pertaining to the 'Emotional/Personal' sub-component of the LSI-R instrument was extracted from the overall dataset. The LSI-R questions contained within the 'Emotional/Personal' subcomponent asked if the person experienced: 'Moderate interference' (some signs of distress, mild anxiety or mild depression); 'Severe interference' (active psychosis); 'Mental health treatment – Past'; 'Mental health treatment – Present'; and 'Psychological assessment indicated'.

Ethical considerations

Ethical issues were taken into account, including confidentiality, anonymity and data protection. Access to data was approved by the senior management team with ethical approval from the Probation Service research committee[18]. The Probation Service statistician provided the researcher with access to an anonymised subset of the raw data. All data was kept strictly confidential and only the researcher had access to the data. Team names were not published to ensure team, client and data anonymity.

Data collection and analysis

The Statistical Package for the Social Sciences (SPSS) was used in the analysis of the quantitative data. The data was analysed using descriptive and frequency analysis and comparison of means data (t-tests, ANOVA). Data was screened and coded for gender, geographical region, age and team.

Results

[18] Date of approval: 24/05/2019.

Descriptive results

A total of 9,534 LSI-R assessments completed by adult, community based teams between 2017 and 2018 were included in the analysis[19]. Men comprised 82.6 per cent (*n* = 7,873) of the population and women 17.4 per cent (*n* = 1,661). The mean age was 30.4 years of age (*n* = 9,529; *SD* = 10.4); 30 years for men (*n* = 7,870; *SD* = 10.4) and 32 years for women (*n* = 1,659; *SD* = 10.4).

Thirty-seven per cent of the total sample were aged 18 to 24 years of age (37%; *n* = 3,505), 34 per cent were aged 25 – 34 years (*n* = 3,260), 23 per cent 35 to 49 years (*n* = 2,204), 4 per cent were aged 50 to 59 years (*n* = 404), and 2 per cent were aged 60 years or above (*n* = 148).

Thirty-one teams represented five regions across the Irish Probation Service: Dublin North and North East (11.6%; *n* = 1,101), Dublin South and Wicklow (28.7%; *n* = 2,734), Midlands and South East (21.8%; *n* = 2,075), South West (20.9%; *n* = 1,995) and West, North West and West Meath (17%; *n* = 1,624). The South West region has the highest percentage of women in their population (22.2%; *n* = 442).

The Level of Service Inventory – Revised (LSI-R) 'Emotional/Personal' questions

Distribution of data from LSI-R questions is presented overall and for men and women.

Table 1 Number and percentages across LSI-R questions overall and for men and women

LSI-R questions (Q46-50)	**Men**				**Women**				**Overall**			
	Yes		No		Yes		No		Yes		No	
	%	n	%	n	%	n	%	n	%	n	%	n
Moderate interference	38.8	2744	61.0	4308	53.4	813	46.4	707	41.4	3557	58.4	5015
Severe interference	3.3	237	96.2	6812	3.5	54	96.4	1473	3.4	291	96.3	8285
Mental health (Past)	35.7	2523	64.0	4521	52.0	794	47.3	722	38.6	3317	61.0	5243
Mental health (Present)	17.8	1261	81.9	5789	30.8	468	69.0	1050	20.1	1729	79.6	6839
Psychological assessment indicated	12.7	949	85.8	6391	13.1	204	85.6	1337	12.8	1153	85.8	7728

Table 1: LSI-R data overall and for men and women

Over 40 per cent of the population were identified as having mental health problems which moderately interfered with their lives and 3.4 per cent had mental health problems which severely interfered with their lives; 36 per cent of men, while 52 per cent of women, reported receiving past mental health treatment. A similar difference was noted with current treatment, with 17.8 per cent of men reported being presently involved in treatment, compared to 30.8 per cent of women. A

[19] Excluding Young Persons' Probation, Resettlement and Prison and Community

psychological assessment was indicated in 12.8 per cent of cases, which was similar for men and women.

Figure 1 Percentages of LSI-R 'Emotional/Personal' question data overall and for men and women

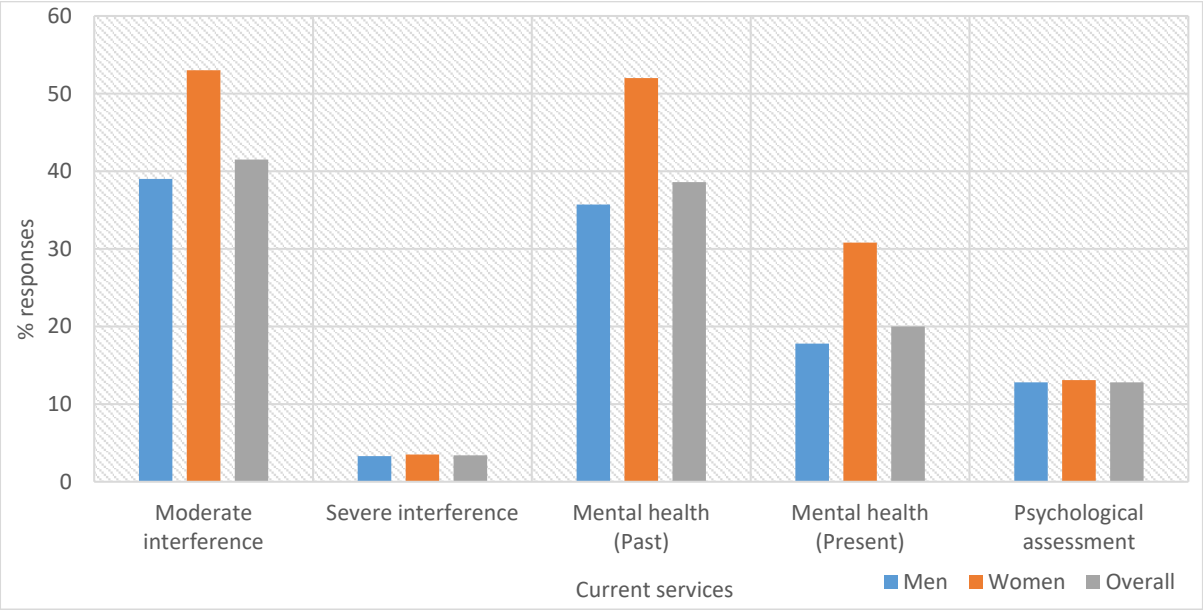

Figure 1: LSI-R data overall and for men and women

Distribution of data for each LSI-R 'Emotional/Personal' question across age group

Table 2 Number and percentages of LSI-R question data by age group

Age range (years)	**LSI-R questions (Q46-50)**									
	Moderate interference		Severe interference		Mental health (Past)		Mental health (Present)		Psychological assessment indicated	
	%	n	%	n	%	n	%	n	%	n
18 to 24	36.5	1154	2.9	91	33.3	1054	15.2	482	13.8	460
25 to 34	42.4	1236	3.6	105	40.0	1168	20.9	609	12.4	381
35 to 49	47.2	942	3.9	77	44.3	888	25.1	501	12.2	253
50 to 59	44.1	161	3.3	12	41.9	153	27.9	102	11.6	47
60 over	46.0	63	4.4	6	38.2	52	24.8	34	8.0	11

Table 2: LSI-R data by age group

Nearly half of those aged 35 to 49 years (47.2%) were identified as experiencing mental health problems which moderately interfered with their lives (men 44%; 60% women), and approximately 25 per cent were engaged with a service for mental health problems at the time of the assessment. Of those aged 18 to 24, over a third (36.5%) were identified as experiencing mental health problems and 15 per cent were accessing a service for mental health problems. A similar pattern is evident across the age group, there is a gap between the number of individuals identified as experiencing mental

health problems which impact moderately and/or severely on their lives and the number of those engaged with a service.

Figure 2 Percentages of 'Emotional/Personal' LSI-R data by age group

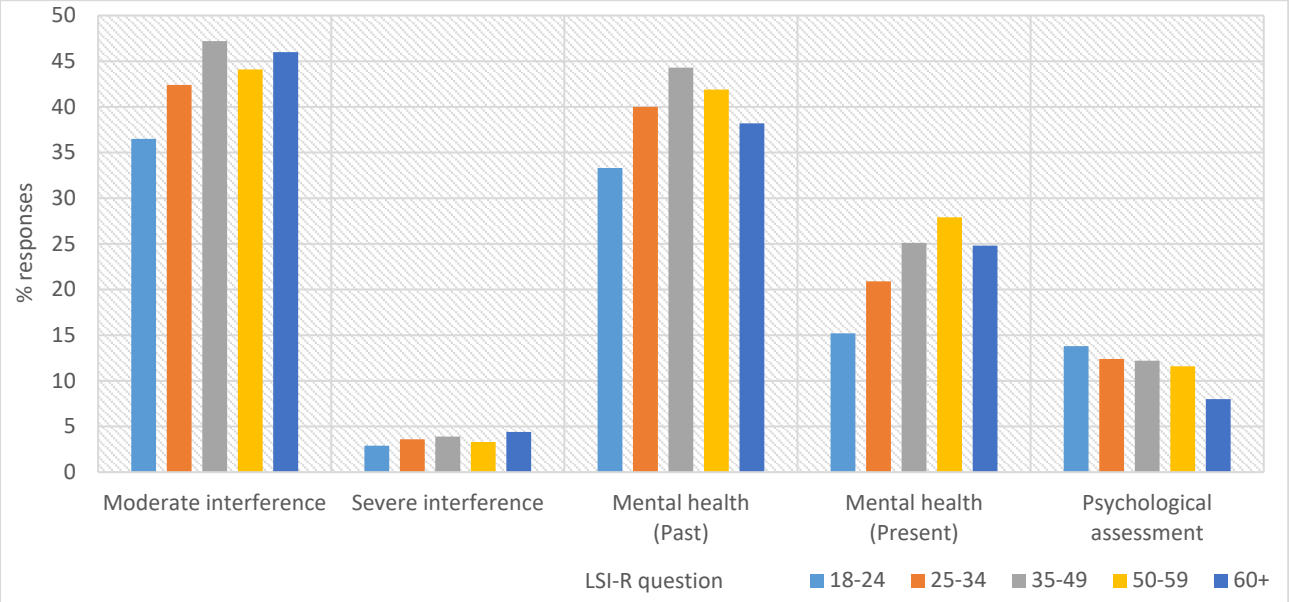

Figure 2: LSI-R data by age

Distribution of data for each 'Emotional/Personal' LSI-R question across geographical region

Table 3 Number and percentages of LSI-R question data by region

The Probation Service Region	**LSI-R questions (Q46-50)**									
	Moderate interference		Severe interference		Mental health (Past)		Mental health (Present)		Psychological assessment indicated	
	%	n	%	n	%	n	%	n	%	n
Dublin North and North East	35.2	388	3.2	35	36.6	359	17.9	176	12.3	127
Dublin South and Wicklow	45.4	1117	4.0	98	32.8	808	15.0	368	14.3	370
Midlands and South East	41.1	761	3.3	62	41.5	769	24.5	455	11.1	215
South West	34.6	691	3.1	56	42.1	767	20.9	381	11.7	219
West, North West and West Meath	36.9	600	2.5	40	41.7	614	23.7	349	14.0	222

Table 3: LSI-R data by region

Figures vary slightly across regions, yet a similar pattern is evident, there is a gap between the number of clients identified as experiencing mental health problems which impact moderately and/or severely on their lives and those engaged with a service for mental health support. Dublin South and Wicklow

reported the highest rates of moderate and severe interference (45.4%; 4%) and psychological assessment indicated, however, the region had the lowest number of men and women, receiving some form of mental health treatment at the time of the assessment (15%).

Comparison of the LSI-R 'Emotional/Personal' data from 2012-2013 and 2017-2018

Data from the current study exploring LSI-R 'Emotional/Personal' subcomponent questions and the LSI-R study (Cotter, 2015) is shown. Data follows a similar trend with comparable figures.

Figure 3 Percentages for 'Emotional/Personal' LSI-R data in 2012-2013 and 2017-2018

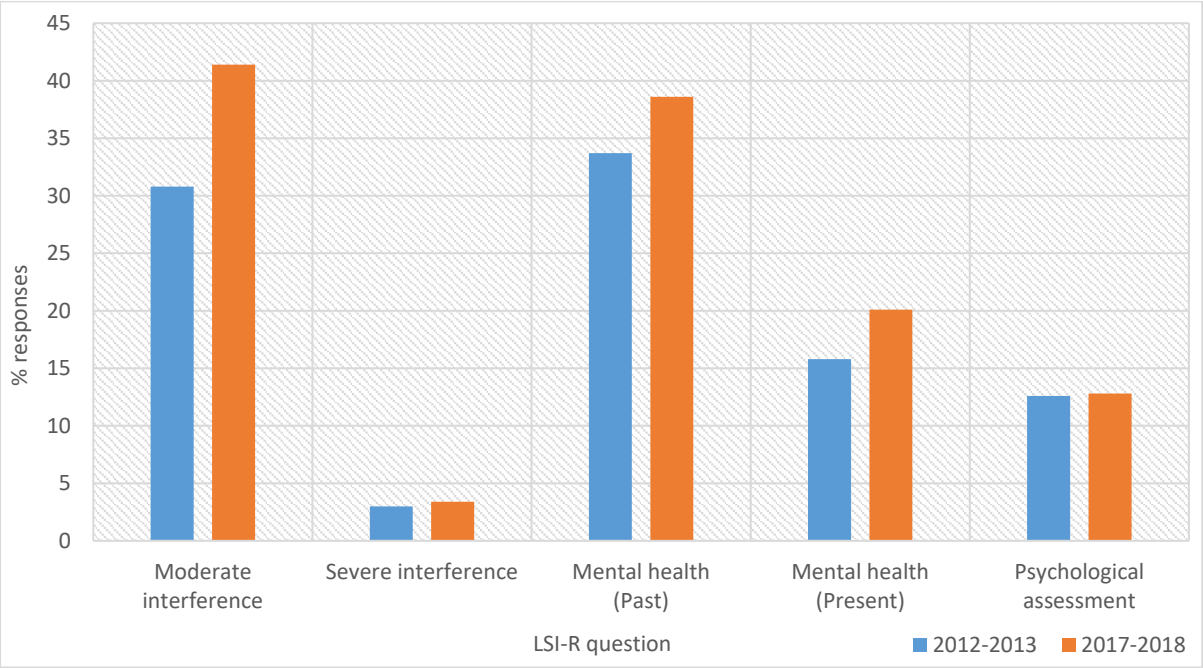

Figure 3: LSI-R data 2012-2013 and 2017-2018

The rate at which clients are experiencing mental health problems which impact moderately and severely on their lives is consistent with the previous study; although moderate interference is slightly higher in the 2017-2018 data. Both studies identify approximately a third of clients are reported as experiencing moderate interference and 3 per cent were experiencing severe interference and less than a fifth were accessing mental health assessment or treatment at the time of assessment. Similarly, a third have accessed a service for mental health problems in the past and psychological assessment indicated was identified in 12 per cent of cases.

Summary

Over half of women and over a third of men, in respect of whom an LSI-R assessment was completed in 2017-2018, were reported as experiencing mental health problems that moderately interfered with their lives. Just over 30 per cent of women and less than 18 per cent of men were receiving treatment at the time of the assessment. The findings are higher than those in the previous study (Cotter, 2015).

The current study found significant levels of missing data across each question amounting to approximately 10 per cent across each LSI-R question. This is a matter of concern for the Probation Service and requires further investigation to examine whether missing data is representative generally of LSI-R completion or is specific to the mental health questions. If largely related to non-completion

of the mental health questions, it may reflect lack of information, confidence, skill or competence in addressing the issues. This may require assessment of training needs, skills development and multi-agency working.

This preliminary study is subject to significant limitations. The scoring of the questions was at the discretion of the interviewer and although specialist training was provided on the risk assessment tool, there is little mental health training provided to Probation Officers. As such, it may be that the incidence of mental health problems is an underestimate. Furthermore, this study does not address co-occurrence of addiction issues. Nevertheless, this exploratory review shows a need for further investigation into the mental health needs of those engaged with the Probation Service in a more comprehensive study.

Study 2: Pilot study of Mental Health among persons subject to Probation Service supervision in Ireland

Introduction

The second study, conducted in 2019, expanded on the previous review of LSI-R data and explored mental health problems among persons subject to Probation Service supervision in more detail from the perspective of Probation Service staff. The study used a service evaluation questionnaire, Mental Health Service Evaluation (MHSE) developed by the author (Power, 2019). The questionnaire focussed on symptoms indicative of mental health problems, mental health diagnosis, past and current access to Mental Health Services, potential barriers to accessing and engaging with Mental Health Services and key life issues which may contribute to a client's current mental health.

The Global Assessment of Functioning (GAF) (American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, 1994) was also used in this study. The GAF is a single-item standard mental health status measure aimed at identifying a person presenting with mental illness or someone who has difficulty coping in their life. The GAF was used in the current study as a brief screening tool in addition to the service evaluation questionnaire.

Research design and methodological approach

Methodological approach

A quantitative approach and survey methodology were used to explore mental health problems among persons subject to probation supervision within the Probation Service. A semi-structured questionnaire was designed for the purpose of the evaluation in the absence of an available specific measure. The Mental Health Service Evaluation (MHSE) was developed in consultation with the Probation Mental Health Working Group. A small pilot of the questionnaire was undertaken by two Probation Officers and rated for clarity. The feedback from the pilot review was integrated into the questionnaire used in the study.

Participants

One urban Probation Service team participated in the study comprising Probation Officers and a Senior Probation Officer. Participants were asked to complete the following measures for each client on their caseload within the period of June to July 2019.

Measures

Participants were asked to complete the following measures:

Mental Health Service Evaluation (MHSE): Power (2019). Contains fourteen questions focussed on descriptive information (gender, age and ethnicity) and symptoms indicative of mental health problems, mental health diagnosis, past and current access to Mental Health Services, potential barriers to accessing and engaging with Mental Health Services and key life issues which may contribute to a client's current mental health. Categorical questions were rated as 'Yes 'or 'No'.

- *Global Assessment of Functioning (GAF)*: *American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders (1994).* The participant is asked to subjectively rate the

social, occupational, and psychological functioning of an individual, e.g., how well one is meeting various problems-in-living. Scores range from extremely high functioning [100-91] to severely impaired [10-1].

Administration of the measures

Participants completed paper questionnaires based on their experience and observations of working with the individual client and any collateral information available to them at the time of the completion. No interviews with clients were required. It was emphasised to participants that all questionnaires were anonymous and no client or Probation Service staff names were required. Completed questionnaires were returned anonymously to the researcher in an unmarked envelope and data was held in a secure cabinet in the Probation Service Headquarters.

Ethical considerations

Ethical issues were taken into account, including gaining informed consent from participants and ensuring confidentiality and anonymity. The researcher met with the Probation Service team, provided an outline of the research and asked for written consent from the Probation Officers prior to completion of the questionnaires. All data was kept strictly confidential. The name of the team has not been published to ensure team, client and data anonymity. The study had ethical approval from the Probation Service Research Review Committee.

Data analysis

The Statistical Package for the Social Sciences (SPSS) was used in the analysis of the quantitative data. The data was analysed using descriptive and frequency analysis. Comparison of means data (t-tests, ANOVA) were used on scale data including age, Global Assessment of Functioning scale and level of concern reported by Probation Officers. Chi-square tests were used to examine the relationship between known formal diagnosis, past and current involvement with services for mental health, symptoms indicative of mental health problems, key issues and barriers to access services and categorical demographic variables including gender and age.

Results

Descriptive results

A total of ninety-eight questionnaires were returned; 74 per cent of the total caseload. Of those, 91 per cent related to men (*n* = 89) and 9 per cent to women (*n* = 9). The mean age was 37 years of age (*n* = 95; *SD* = 10.1); 37 years for men (*n* = 86; *SD* = 11.1) and 32 years for women (*n* = 9; *SD* = 6.2).

Thirty-nine per cent of the total sample were aged 35 to 49 years of age (39%; *n* = 37), 35 per cent (*n* = 33) were 25 to 34 years, 12 per cent aged 50-59 years (*n* = 12), 11 per cent (*n* = 11) 18-24 years, and two per cent were aged 60 years or above (*n* = 2). Of those, 92 per cent were reported as White Irish (*n* = 90), 3 per cent Irish Traveller (*n* = 3), and 5 per cent (*n* = 5) African, Asian or Romanian.

Forty one per cent of the population (41%; *n* = 39) were unemployed, 24 per cent (*n* = 39) were engaged in drug and/or alcohol rehabilitation programmes, 25 per cent (*n* = 24) were in full time or part time employment; two clients were enrolled on training programmes and five were identified as full time parent, retired, or disabled.

The primary offence type recorded was acquisitive offences (33%; *n* = 32), followed by drug related offences (26%; *n* = 25), violence (against the person) (11%; *n* = 11), sexual offending (9%; *n* = 9), public order offences (8%; *n* = 8), driving offences (6%; *n* = 6), and property crime and 'other' (4%; *n* = 4).

Mental Health Service Evaluation (MHSE)

Probation Officers identified 42 per cent of their clients as presenting with active symptoms indicative of mental health problems (men 40.4%, *n* = 36; women, 55.6%, *n* = 5) and 21 per cent were engaged with a Service for some form of support for mental health (assessment and/or intervention) at the time of completion (men 21%, *n* = 19; women 22%, *n* = 2).

A third of clients were identified as having a known formal mental health diagnosis provided by a qualified clinician (men 27%, *n* = 24; women 67%, *n* = 6) and 40 per cent had received some form of support for mental health problems in the past (men 36%, *n* = 32; women 78%, *n* = 7).

Figure 4 Percentages on the questions included in the Mental Health Service Evaluation overall and for men and women

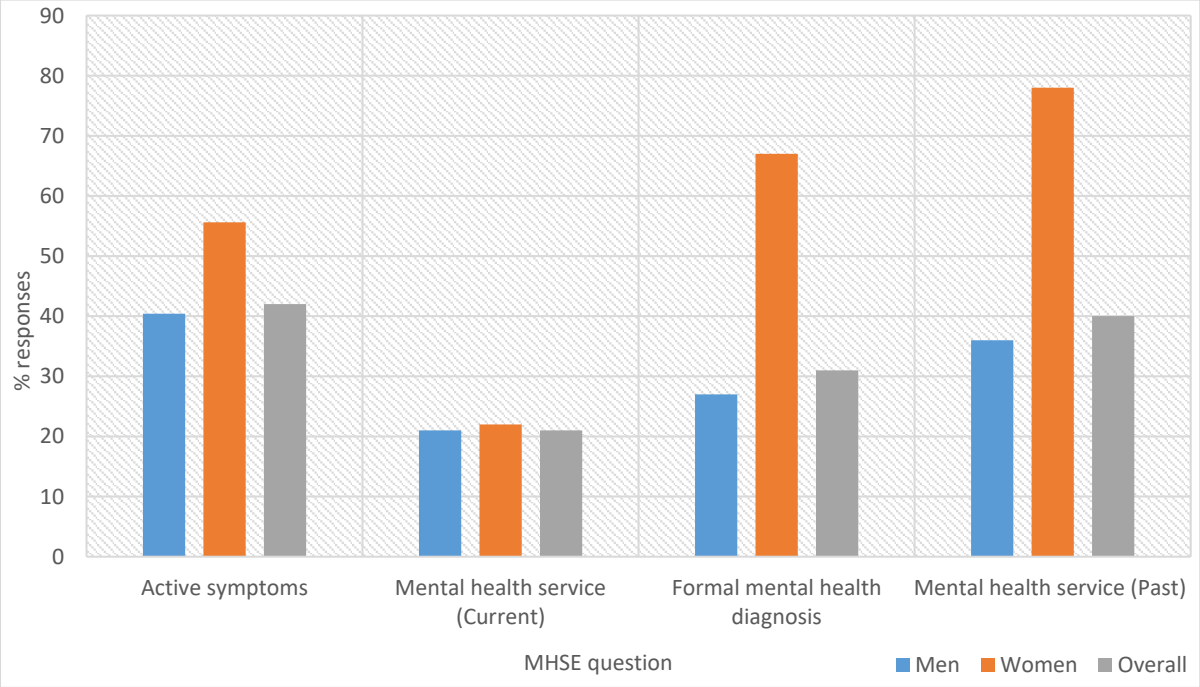

Figure 4: Percentages across service evaluation questions overall and for men and women

Active symptoms indicative of mental health problem(s)

The most frequently reported symptoms indicative of mental health problems identified by Probation Officers among their clients were sadness and low mood (26%), and anxiety-related symptoms (e.g. excessive worry, generalised anxiety) (18%). Withdrawal and social isolation was reported in 9 per cent of cases, self-harm (3%) and delusions, paranoia or hallucinations (3%); these were only identified in men. Active suicidal ideation was reported in 5% of cases, which included four men and one woman.

Current engagement with services for mental health problem(s)

Concerning current engagement with some form of service for mental health, 14 per cent of persons subject to Probation supervision were being treated with medication by their GP and 4 per cent were engaged with a Community Mental Health Teams (CMHT) and/or Psychiatry, only identified in men.

Of those clients engaged with a Service for mental health problems, Probation Officers reported they had mostly had 'none' or 'not enough' contact with their client's clinician. Probation Officers rated how concerned they were for their client based on their current mental health: 7.3 per cent were 'concerned' or 'highly' concerned, 8.3 per cent were 'slightly' concerned, 32 per cent 'perhaps' concerned or 'not sure' and 50 per cent reported 'no' concern.

Mental health diagnosis and past contact with services for mental health problem(s)

Anxiety disorders were reported in 13 per cent of cases, followed by mood disorders (9%) and stress disorders (7%). Personality disorders and related traits were reported in five cases and schizophrenia or other primary psychotic disorder in four cases; both were only reported in men.

Concerning some form of assessment or intervention for mental health problems in the past, 16 per cent of clients were reported as having received treatment from their GP with medication, 12 per cent had had contact with in-patient psychiatric services, and 10 per cent had previously had contact with a Community Mental Health Team (CMHT).

Access to services for mental health assessment/intervention

Along with reported limited access to mainstream Service for mental health, Probation Officers reported client lack of insight into their mental health as a barrier to accessing appropriate Services for mental health (15%). Furthermore, three clients did not have an allocated GP, and two clients were reported as having declined to engage with Mental Health Services following GP referral. One client was deemed unsuitable by their GP for onwards referral and a lack of appropriate Service was identified for one other individual.

Key factors identified as contributing to current mental health problem(s)

Probation Officers identified several key issues as likely to be contributing to their clients' mental health problem.

Figure 5 Percentages of key issues identified as possibly contributing to mental health problems overall and for men and women

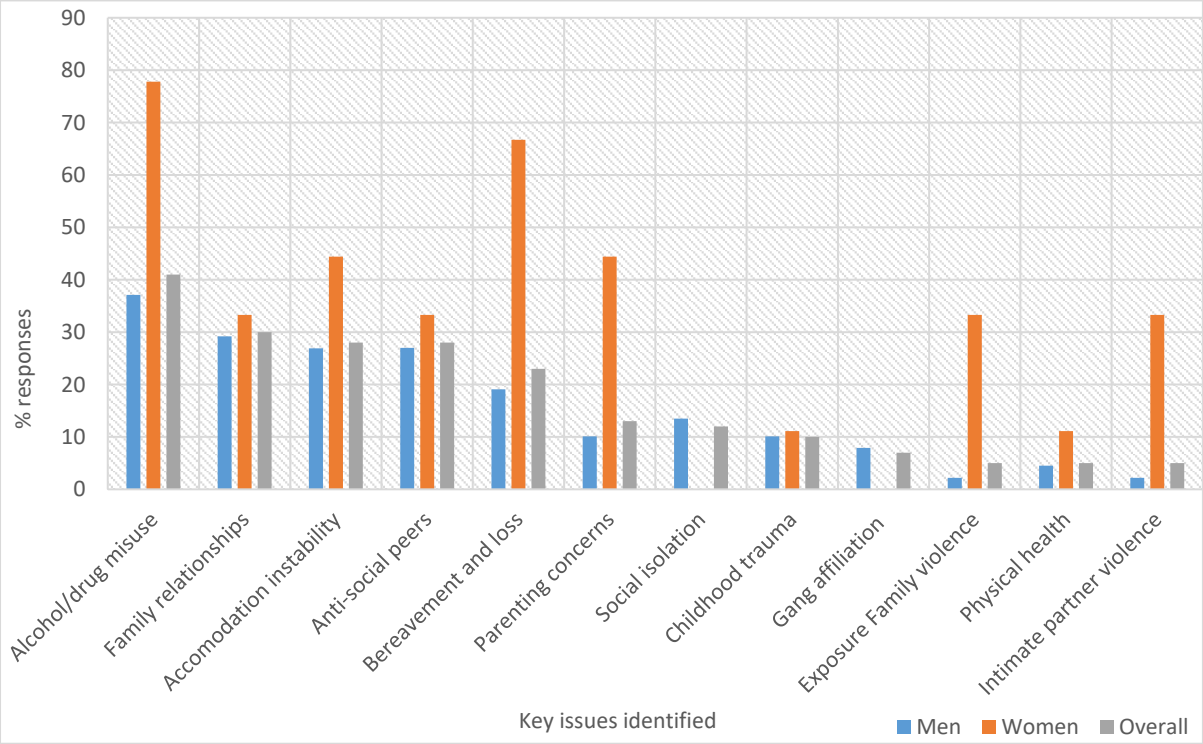

Figure 5: Key issues for clients overall and for men and women

Overall and for men, chronic misuse of alcohol and/or drugs was most frequently identified followed by current difficult family relationships and accommodation instability. For women, bereavement, loss, and parenting concerns were also identified as important factors. Social isolation was identified in 12 per cent of cases overall and gang affiliation was identified in 7 per cent of cases, both of which were only identified in men.

Childhood trauma was identified in 10 per cent of cases, similar for men and women. Chronic misuse of non-prescribed drugs in 34 per cent of cases, alcohol misuse in 22 per cent, and prescribed drug misuse in 16 per cent of cases were also reported. Exposure to family violence was reported in 5 per cent of cases, but higher for women than men (2.2% men; 33.3 women). This would indicate trauma is likely to be higher than 10 per cent reported.

Global Assessment of Functioning (GAF)

Table 4 The number and percentages across each GAF category

GAF scores	Global Assessment of Functioning Description	Overall	
		%	n
100-91	Superior functioning with no symptoms which impair functioning.	4.0	4
90-81	Absent minimal symptoms; Good functioning in all areas and no more than everyday problems or concerns (e.g. anxiety before an exam).	15.2	14
80-71	Slight impairment in work or home with occasional symptoms that are transient that are expected reactions to psychosocial stressors.	17.4	16
70-61	Mild symptoms such as mild insomnia or depressed mood or some difficulty in social, occupational or home situations.	24.5	24
60-51	Moderate symptoms such as occasional panic attacks or some difficulty building meaningful social relationships.	17.4	16
50-41	Serious symptoms such as suicidal thought or severe obsessive rituals. The person could have serious impairment in social or occupational functioning (no friends, can't keep a job).	4.3	4
40-31	Some impairment in communication, psychosis (loss of touch with reality) or both or major impairment in work, family life, judgement, thinking or mood).	4.3	4
30-21	A person experiences frequent delusions or hallucinations or features severely impaired communication or judgement. Inability to function in most areas (staying in bed, no meaningful relationships).	1	1
20-11	Major impairment. A person is in danger of hurting themselves or others. They may have made suicidal attempts, display frequent violent behaviours or have major impairment in communication (e.g. speaking incoherently)	1	1
10-1	A person is in persistent danger of hurting themselves or others or and had made a serious suicidal act with clear expectation of death or both	-	-
0 –ins.	Inadequate information to assess the person	8.7	8

Table 4: GAF scores overall

Clients were most often identified as presenting with 'slight impairment', and 'mild' and 'moderate' symptoms on the GAF scale such as depressed mood and mild insomnia, possible flat affect or occasional panic attacks and some difficulty with social and/or occupational functioning for those experiencing moderate symptoms.

Figure 6 Percentages of GAF scores overall and for men and women

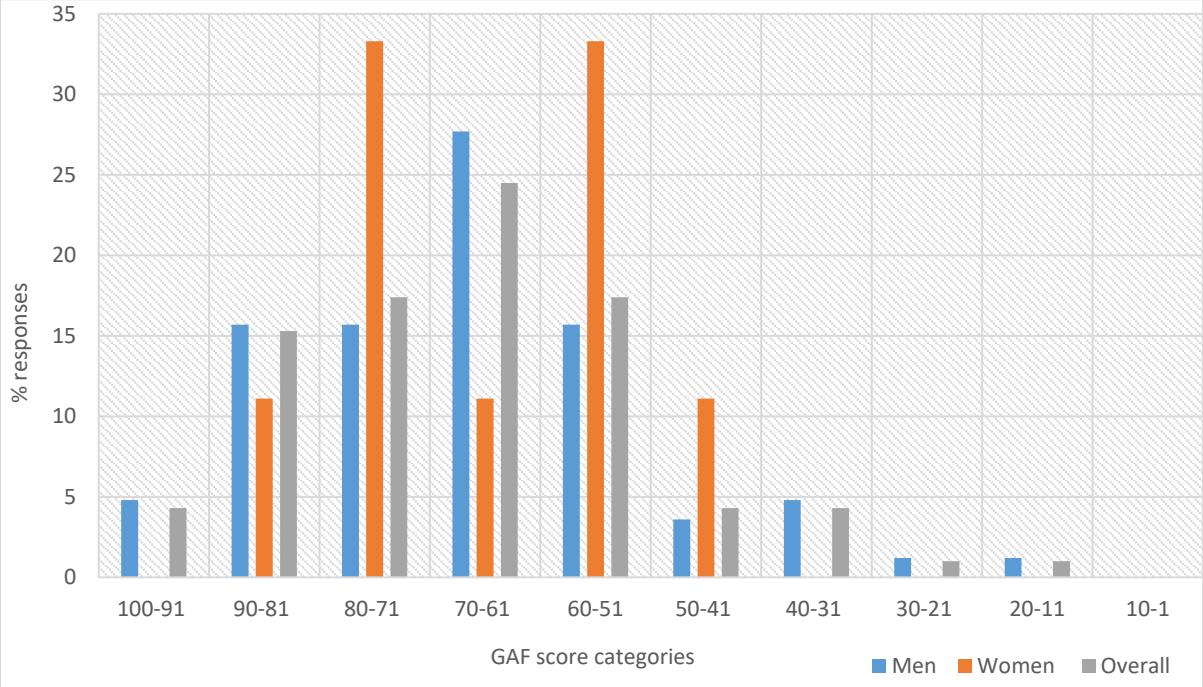

Figure 6: GAF scores overall and for men and women

Summary of findings

The findings from this exploratory pilot study point towards a significant level of psychological distress among Probation Service clients. Probation Officers indicate that a third of their clients have a known formal mental health diagnosis and forty per cent have previously accessed a Service for mental health problems in the past. Forty-two per cent of clients were identified as presenting with active symptoms of mental health problems, most often identified as low mood and sadness (26%) and anxiety-related symptoms (18%), and twenty-one per cent are receiving some form of support for mental health problems from services currently.

Inspection of the GAF ratings, show clients most often present with mental health problems which fall within the slight impairment and mild and moderate symptoms ranges, such as mild insomnia or depressed mood or some difficulty in social, occupational and home situations and occasional panic attacks and some difficulty developing social relationships. Approximately ten per cent of the GAF scores fell between the serious symptoms and major impairment. All ten per cent were men.

Taking into consideration the preliminary findings, namely, a high incidence of mental health problems among Probation clients and the learning from this pilot study, a third, larger scale study was conducted with five rural and urban general supervision teams and specialist teams across the Probation Service nationally. The third study aimed to explore whether the current findings were representative across Probation Service teams nationally.

Study 3: Mental health needs among persons subject to Probation Service supervision across five regional teams in Ireland

Introduction

The previous studies revealed key issues for the Probation Service, including significant unmet mental health need among clients subject to Probation Service supervision and potential gaps in knowledge and training in the area of mental health problems among Probation staff. Both studies were limited in scale, scope and methodology but were consistent with each other in identifying high prevalence and matters of concern and care issues.

A further examination of the issues and validation of the measures and processes with a larger representative sample was undertaken in Study 3 in August 2019. Based on the learning from the previous studies, Study 3 was conducted using the Mental Health Service Evaluation (MHSE) and the Global Assessment of Functioning (GAF) with five community supervision teams across the country and Probation Service regions.

Research design and methodological approach

Methodological approach

Study 3 used similar survey methodology, measures and administration method as in the second study. The principal measures were the Mental Health Service Evaluation (MHSE) and the Global Assessment of Functioning (GAF).

Participants

Five Probation teams, including Probation Officers and Senior Probation Officers, participated in the study. The five teams, from the five Probation Service community supervision regions nationally, included two specialist urban teams, two rural teams and one general urban team. Identifier details are not published in the study and findings to ensure team, client and data anonymity. The study received ethical approval from the Probation Service Research Review Committee. A similar methodology in engaging with the participants as in the previous study was applied.

Measures

- *Mental Health Service Evaluation (MHSE): Power (2019).* Contains fourteen questions focussed on descriptive information (gender, age and ethnicity) and symptoms indicative of mental health problems, mental health diagnosis, past and current access to Mental Health Services, potential barriers to accessing and engaging with Mental Health Services and key life issues which may contribute to a client's current mental health. Categorical questions were rated as 'Yes' or 'No'.
- *Global Assessment of Functioning (GAF)*: *American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders (1994).* The participant is asked to subjectively rate the social, occupational, and psychological functioning of an individual, e.g., how well one is meeting various problems-in-living. Scores range from extremely high functioning [100-91] to severely impaired [10-1].

Administration of the measures

Participants were asked to complete anonymous paper questionnaires based on their experience and observations of working with each client on their caseload on the specified study date and any collateral information available to them at the time of the completion of the questionnaire. No interviews with clients were required for the study. It was emphasised to participants that all questionnaires were anonymous and no client or Probation Service staff names or identifiers would be required or gathered in the study. Completed questionnaires were returned anonymously to the researcher in an unmarked envelope and data was held in a secure cabinet in the Probation Service Headquarters.

Data analysis

Statistical Package for the Social Sciences (SPSS) was used for analysis of quantitative data, descriptive and frequency analysis. Chi-square tests were used to explore the relationship between variables: mental health diagnosis, past and current involvement with a service for mental health problems, symptoms indicative of mental health, key issues contributing to mental health problems and barriers to access and engagement with Services, and categorical variables including gender, team and age.

Results

Descriptive results

Five hundred completed questionnaires were returned, eight per cent of the total population of persons subject to a Probation Service Supervision Order in Ireland as of 1 February 2019[20]. Table 6 shows the descriptive data from Study 1 analysis of LSI-R data is comparable with data in study 3.

Table 6 Number and percentages of age and gender in study 1 and Study 3

Study	**Gender**				**Mean age (yrs.)**					
	Men		Women		Men		Women		Overall	
	%	n	%	n	yrs. (*n*)	*SD*	yrs. *(n)*	*SD*	yrs. *(n)*	*SD*
LSI-R (*n*=9,534)	82.6	7,873	17.4	1,661	30 *7,870*	10.4	32 *1,659*	10.4	30.4 *9,529*	10.4
Study 3 (*n*=500)	82.3	408	17.7	88	33 *387*	10.3	33 *85*	7.8	*33 476*	9.9

Table 6: Descriptive data in study 1 and study 3

In study 3, 17 per cent were aged 18 to 24 years (17.2%; *n* = 82), 46 per cent 25 to 34 years (*n* = 219), 29 per cent 35 to 49 years (*n* = 138), 6.1 per cent were aged 50 – 59 years (*n* = 29) and 1.7 per cent (*n* = 8) were 60 years and over.

85.3 per cent were identified as white Irish *(n* = 419), 7.5 per cent as white Irish traveller (*n* = 37), 6.3 per cent other white background (*n* = 30), 0.6 Black African (*n* = 3), 0.2 per cent mixed ethic group (*n* = 1).

[20] Probation Service Monthly Offender Population Report 01/02/2019: Total caseload in the Community 8,536 (excluding community service and under 18's).

58.2 per cent (*n* = 278) were unemployed, 17.6 per cent in full time employment (*n* = 84), 5.4 per cent (*n* = 26) were in drug and/or alcohol rehabilitation, 4.8 per cent were enrolled in vocational/apprentice training (*n* = 23), 4.8 per cent in full/part time education. Ten individuals were identified as full time parents, two full time carers and 6.7 per cent were identified as 'other' (*n* = 32).

The primary offence types recorded included 'violence' (against the person) (31%; *n* = 146), acquisitive offences (23.1%; *n* = 109), drug related offences (16.6%; *n* = 78), public order offences (11.9%; *n* = 56), property crime (7%; *n* = 33), sexual offending (4.2%; *n* = 20), driving offences (3.2%; *n* = 15) and 'other' (3%; *n* = 14).

Two specialist urban teams were included: Team A (30%; *n* = 150) and Team D (8%; *n* = 42); two rural teams, Team B (9.4%; *n* = 47) and Team C (30%; *n* = 147) and one general urban supervision team, Team E (23%; *n* = 114). All of the clients in each team were mixed gender with the exception of Team B, which is a men only service.

Mental Health Service Evaluation (MHSE)

Mental health diagnosis

Overall, 41 per cent of clients (41%; *n* = 206) were formally identified as having a known mental diagnosis provided by a qualified clinician (men 38.5%, *n* = 157; women 52.3, *n* = 46). Anxiety disorders and mood disorders were most often reported, which was consistent for men and women.

Figure 7 Percentages of known mental health diagnoses identified overall and for men and women

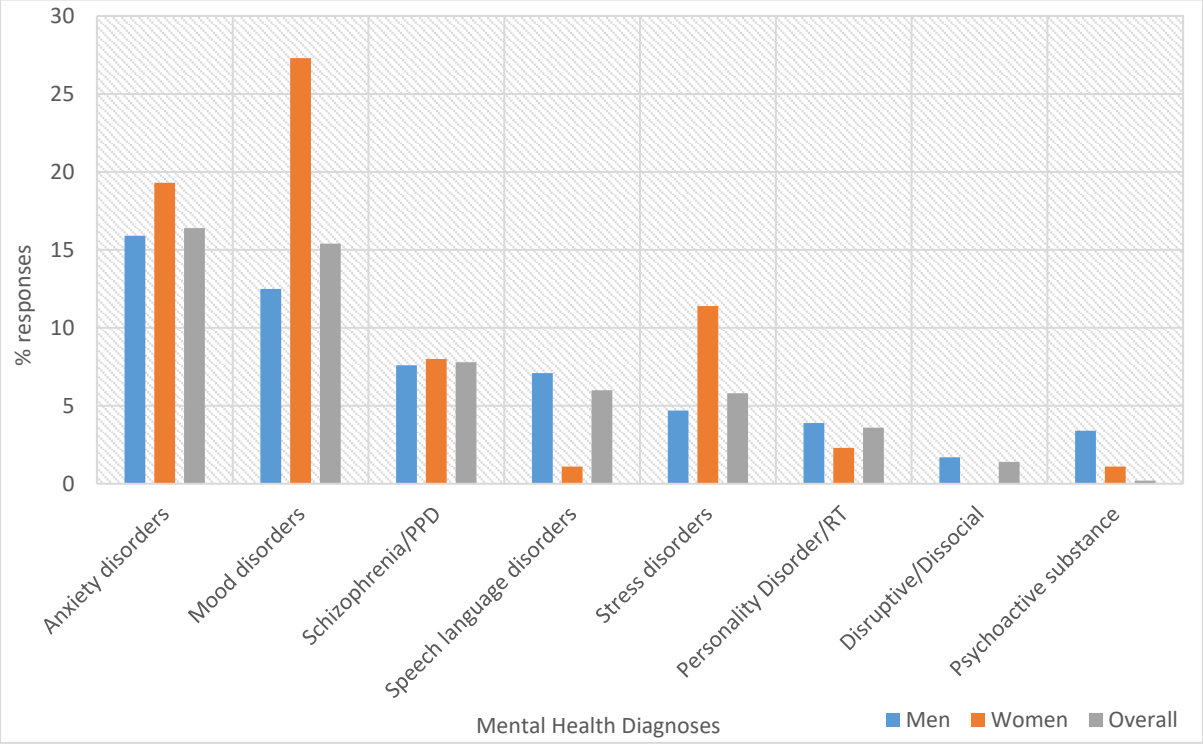

Figure 7: Diagnoses overall and for men and women

Women were reported as presenting with a higher rate of formal mental health diagnosis than men, and were more often diagnosed with mood disorder (12% men; 27% women) and stress disorder (5% men; 11% women). Personality disorder was reported in 3.6 per cent of cases (3.9% men; 2.3%

women). A speech and language disorder was identified more in men and disruptive behaviour or dissocial disorders was only identified in men (2%).

Past contact with Services for mental health problem(s)

Overall, 56 per cent (*n* = 280) of clients were reported as having received some form of assessment and/or intervention for mental health problems in the past (men 52.5%; women 70.5%); most often through a GP with medication followed by contact with a Community Mental Health Team (CMHT).

Figure 8 Percentage of contact with Services for mental health problems overall and for men and women

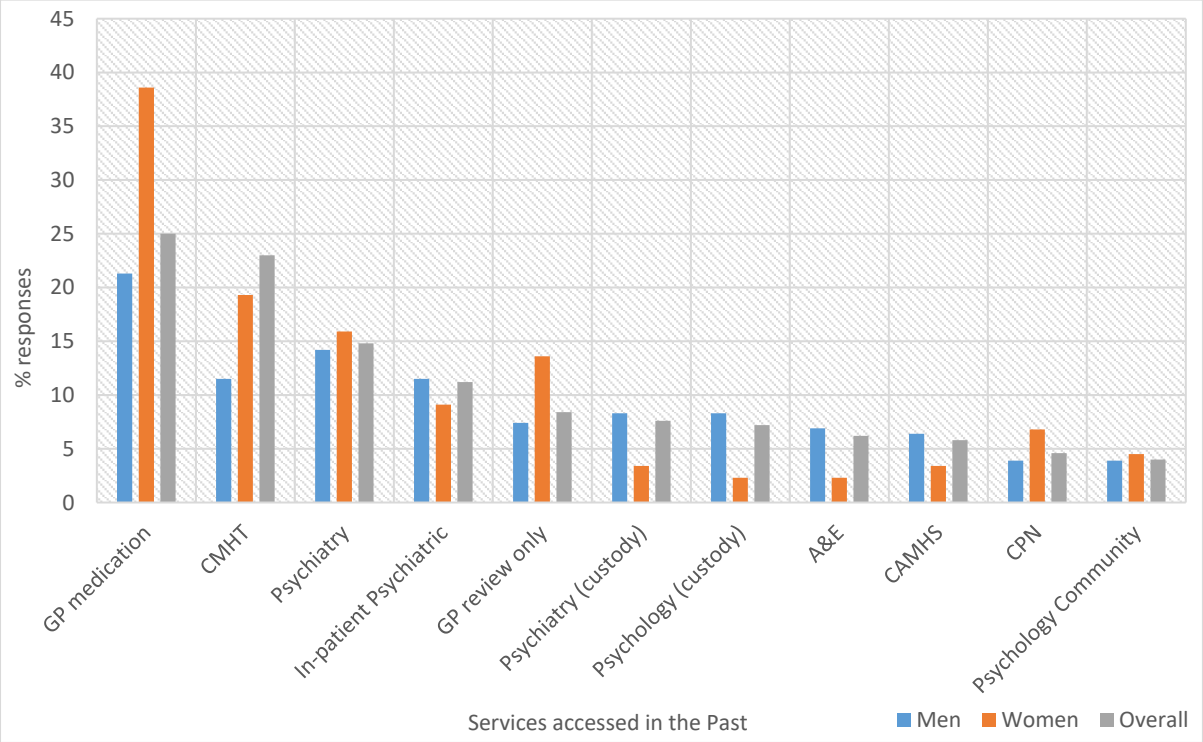

Figure 8: Services providing mental health support in the past

More women than men were identified as having had past mental health assessment or intervention, or both (community and/or custody) and higher rates of contact with Services, such as: GP and medication (21% men; 39% women), Community Mental Health Team (CMHT) (11% men; 19% women). However, more men than women were reported as having been seen by Psychology, Psychiatry, Addiction Services and Healthcare Services while serving a custodial sentence.

Active symptoms indicative of mental health problem(s)

Probation Officers identified 43 per cent (*n* = 216) of persons subjects to Probation supervision on their caseloads as experiencing active symptoms indicative of mental health problems (men 40.2%; women 56.8%). Low mood and sadness, low self-esteem, and anxiety related symptoms were identified most often. Suicidal ideation/plans was identified by Probation Officers in 10 per cent of persons (*n* = 51) (men 8%; women 16%).

Figure 9 Percentage of symptoms indicative of mental health problems overall and for men and women

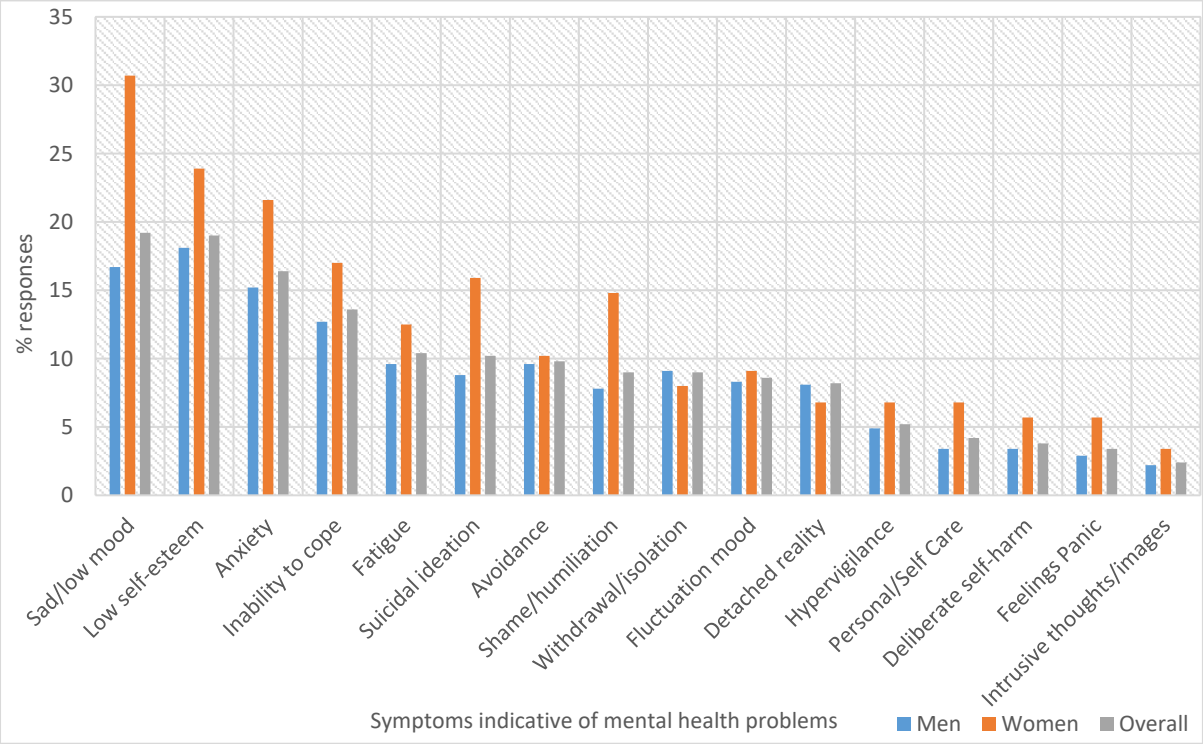

Figure 9: Symptoms indicative of mental health problems

More women than men were reported as presenting with active symptoms indicative of mental health problems. Women were identified as having higher or at least similar rates to men on all indicators of mental health problems with the exception of withdrawal and isolation and intrusive thoughts/images.

Of those persons identified as experiencing active symptoms indicative of mental health problems, 61 per cent were reported as having a known formal mental health diagnosis and 73 per cent have received a service of mental health problems in the past; 57 per cent were reported as currently receiving assessment and/or intervention for mental health problems, mostly in the form of medication through the GP (35%). In that group, difficult family relationships (69%), chronic alcohol/drug misuse (64%), accommodation instability (50%), childhood trauma (29%), bereavement (27%) and social isolation (21%) were the most frequently identified key issues identified by Probation Officers as likely contributing to mental health problems.

Current engagement with services for mental health problem(s)

Thirty per cent (*n* = 159) of clients were reported as currently engaged with services for mental health problems (men 28%, *n* = 114; women 48.9%, *n* = 43), most often through their GP with medication (20%), similar for men and women.

Figure 10 Percentage of clients currently engaged with Services for mental health problems overall and for men and women

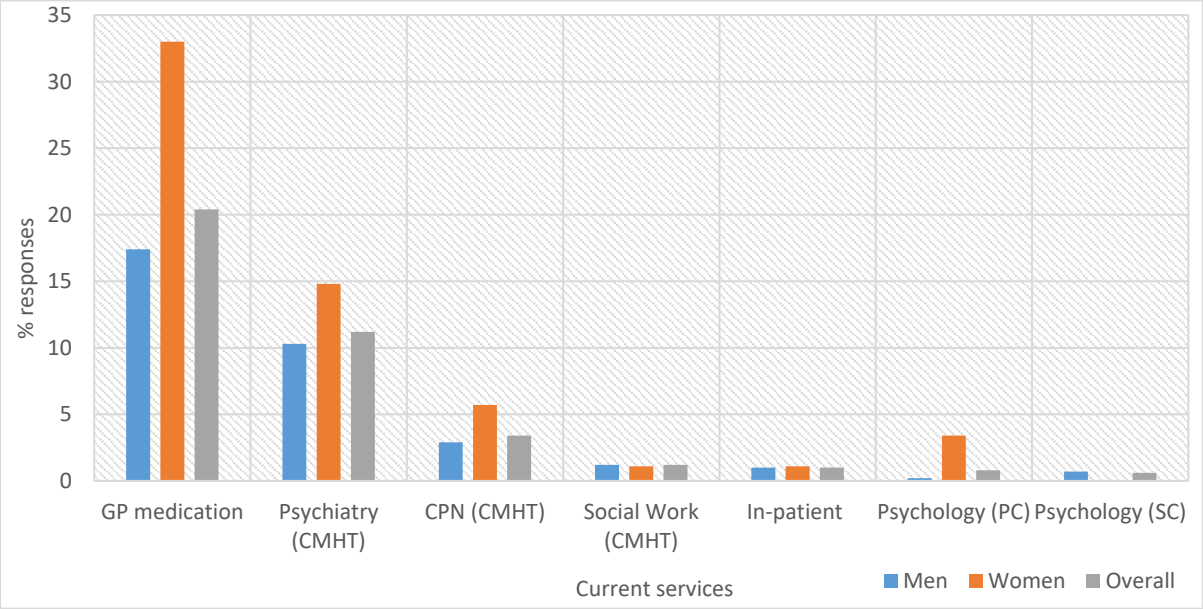

Figure 10: Current contact with services overall and for men and women

More women than men were reported as currently engaged with Services for mental health problems, including GP and medication (17% men; 33% women), Psychiatry-Community Mental Health Team (CMHT) (10% men; 15% women), Primary Care Psychology (1% men; 3% women). More men than women were identified as experiencing mental health problems but fewer were accessing Services (21% men; 15% women).

<u>Key factors identified as contributing to current mental health problem(s)</u>

Probation Officers identified several key issues as likely to be contributing to their clients' mental health problem.

Chronic misuse of drugs or alcohol or both, were indicated most often (51%) followed by difficult family relationships (49%) and accommodation instability (47%); this was consistent for men and for women. These were followed by past experience of trauma in childhood (20%) and bereavement/unresolved grief (18%). Social isolation and withdrawal (12%) and Living alone with poor social support were also identified (11%). Parenting concerns and access to children (11%) and intimate partner violence were key issues identified more often for women than for men. This is shown in Figure 11.

Figure 11 Percentages of key issues identified presented overall and for men and women

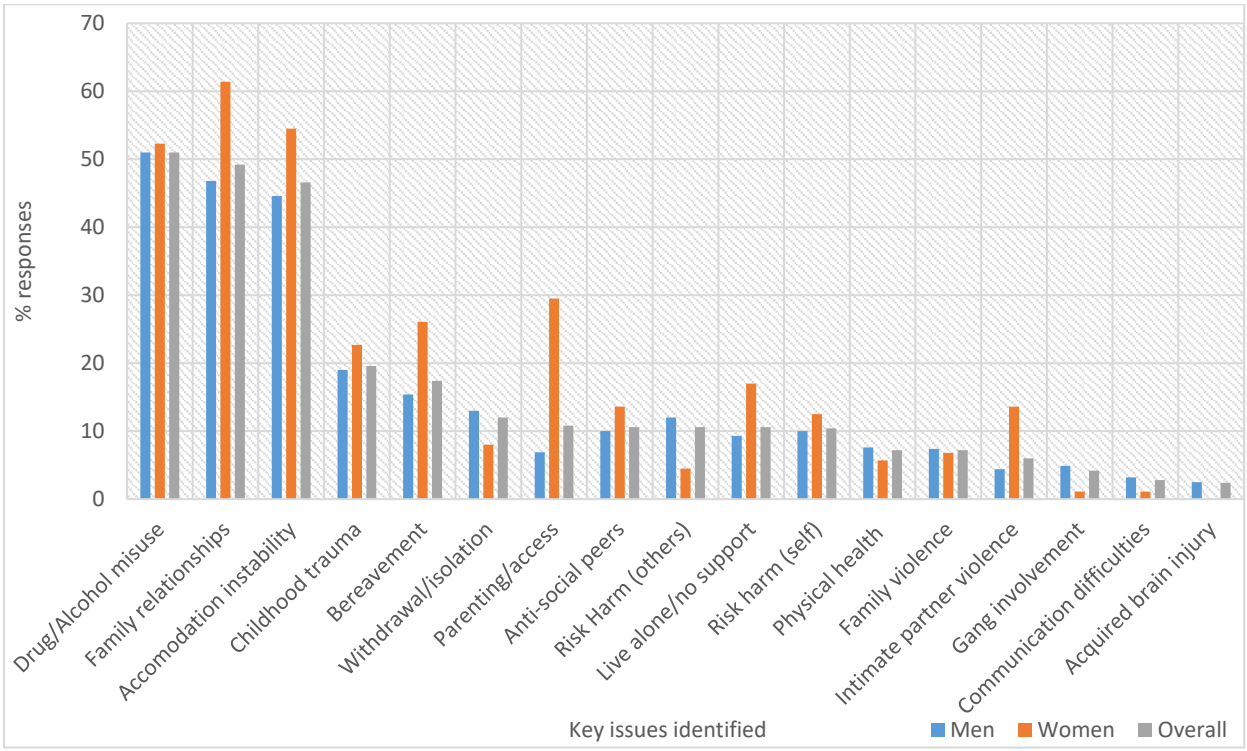

Figure 11 Key issues impacting on mental health overall and for men and women

Global Assessment of Functioning (GAF)

Figure 12 Percentages of GAF ratings presented overall and for men and women

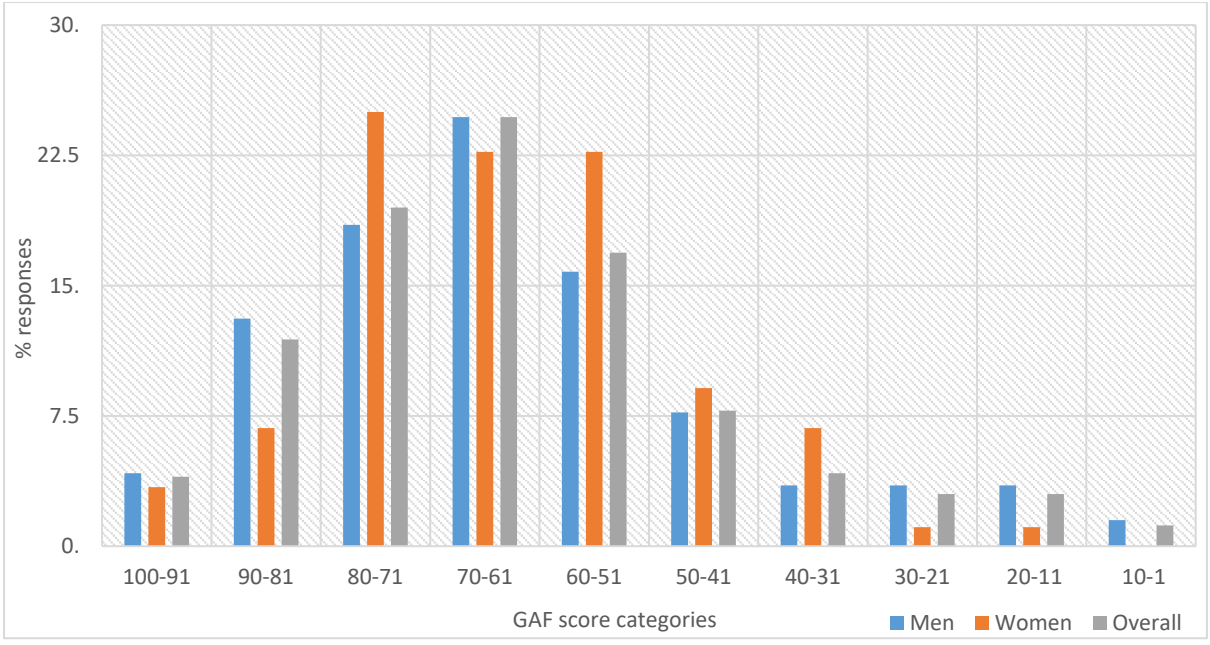

Figure 12: GAF scores overall and for men and women

Over half of clients (61%) were rated as having Global Assessment of Functioning (GAF) scores in the

'slight impairment', 'mild symptoms' and 'moderate symptoms' range; 19% were rated as presenting with serious and severe mental health. Those clients identified as having a known formal mental health diagnosis generally had lower scores on the Global Assessment Functioning (GAF), highlighting more serious symptomatology indicative of mental health problems and mental illness, than those without a formal mental health diagnosis.

Half of men and 70 per cent of women had GAF scores in the 'slight impairment', 'mild symptoms', and 'moderate symptoms' range. It is notable that 10.5 per cent (*n* = 42) of men's and 9 per cent of women's GAF scores (*n* = 8) fell in the serious or severe range (GAF: 40-31; 30-22; 20-11); and 1.5 per cent of men's scores fell in the 10-1 GAF range, that is, six men were identified in almost constant danger of hurting themselves or others, across the teams. Five individuals had a known formal mental health diagnosis of schizophrenia or other primary psychotic disorder and five clients had received support for mental health in the past, including four clients who were involved with a Community Mental Health Team (CMHT), three had received in-patient psychiatric care, and three were seen by psychiatry whilst in custody.

Of those identified with GAF scores in ranges [40-31; 30-21; 20-11], 77 per cent were identified as having a previous known formal mental health diagnosis; 87 per cent were reported as having previous contact with a service for mental health problems. Fifteen individuals were identified as currently presenting with serious active symptoms of mental health problems/mental illness and are not engaged with any Service for their serious mental health problem.

Mental Health Service Evaluation (MHSE) data presented by team

Teams were classified by type of supervision team including specialist or general supervision team and rural and urban settings.

Table 7 Number and percentages of service evaluation questions presented overall and across team

Team	**Formal mental health diagnosis**		**Mental health service (Past)**		**Active symptoms**		**Mental health service (Current)**	
	%	n	%	n	%	n	%	n
Team A Specialist	41	61	49	74	50	74	32	48
Team B Rural	38	18	66	31	32	15	36	17
Team C Rural	43	64	57	84	46	67	35	51
Team D Specialist	28	12	55	23	43	18	19	8
Team E Urban	45	51	60	68	36	41	31	35
Overall	41	206	56	280	43	216	32	159

Table 7: Figures service evaluation questions by team

Mental health diagnosis

Reported rates of known formal diagnoses ranged between 28 and 45 per cent across teams. The most frequently reported diagnoses were anxiety disorders across the teams (9-25%) and mood disorders (7-19%).

Figure 13 Percentages of mental health diagnoses identified overall and for men and women

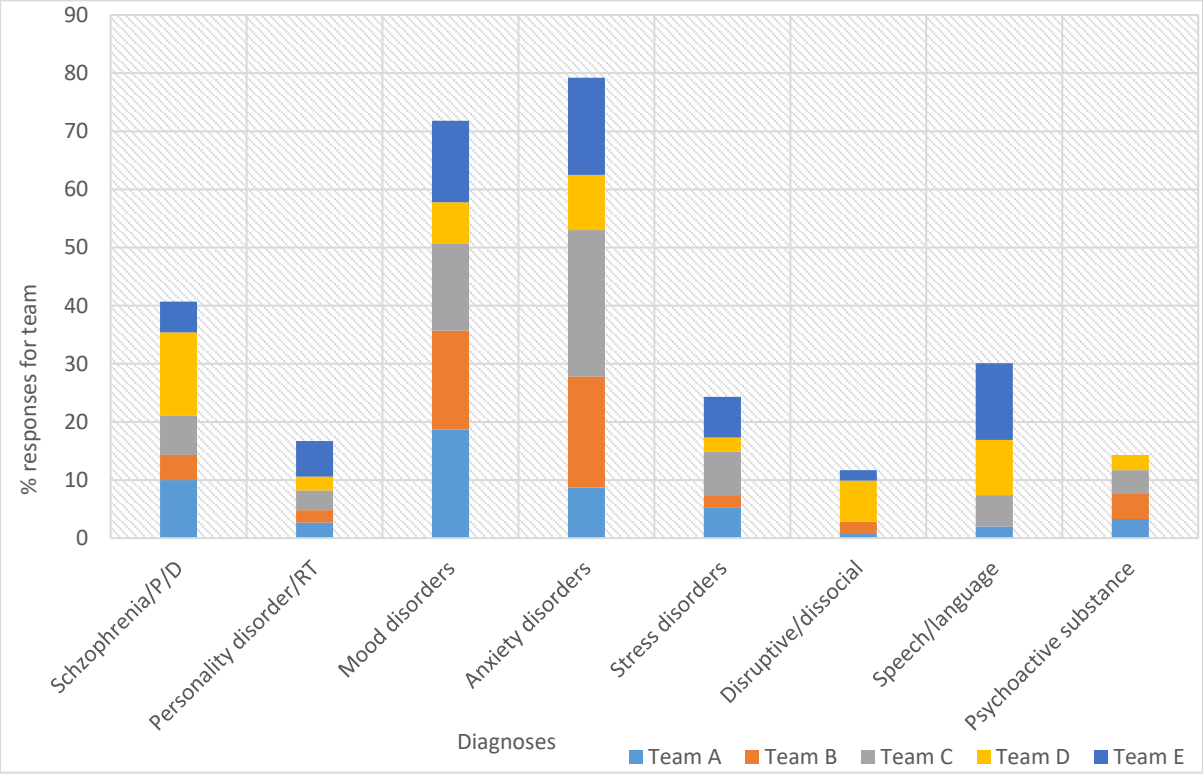

Figure 13 Diagnoses identified across for team

Team D reported the lowest rate for formal diagnoses compared to the average figure, the highest rate of schizophrenia (14%) and disruptive behaviour or dissocial disorders (7%). Team E reported the highest rate of formal mental health diagnosis (45%) and personality disorder, and Team E was the only team that reported personality disorder in women, and at a slightly higher rate than identified for men (5.7% men; 7.7% women). Specialist Team A reported the highest rate of mood disorders (18.7%), and the lowest rate of anxiety disorders (9%).

Past contact with services for mental health problem(s)

Overall, 56 per cent of clients were reported as having received some form of service for mental health problems in the past, ranging between 49 and 66 per cent across the teams.

Figure 14 Percentage of contact with Services for mental health support by team

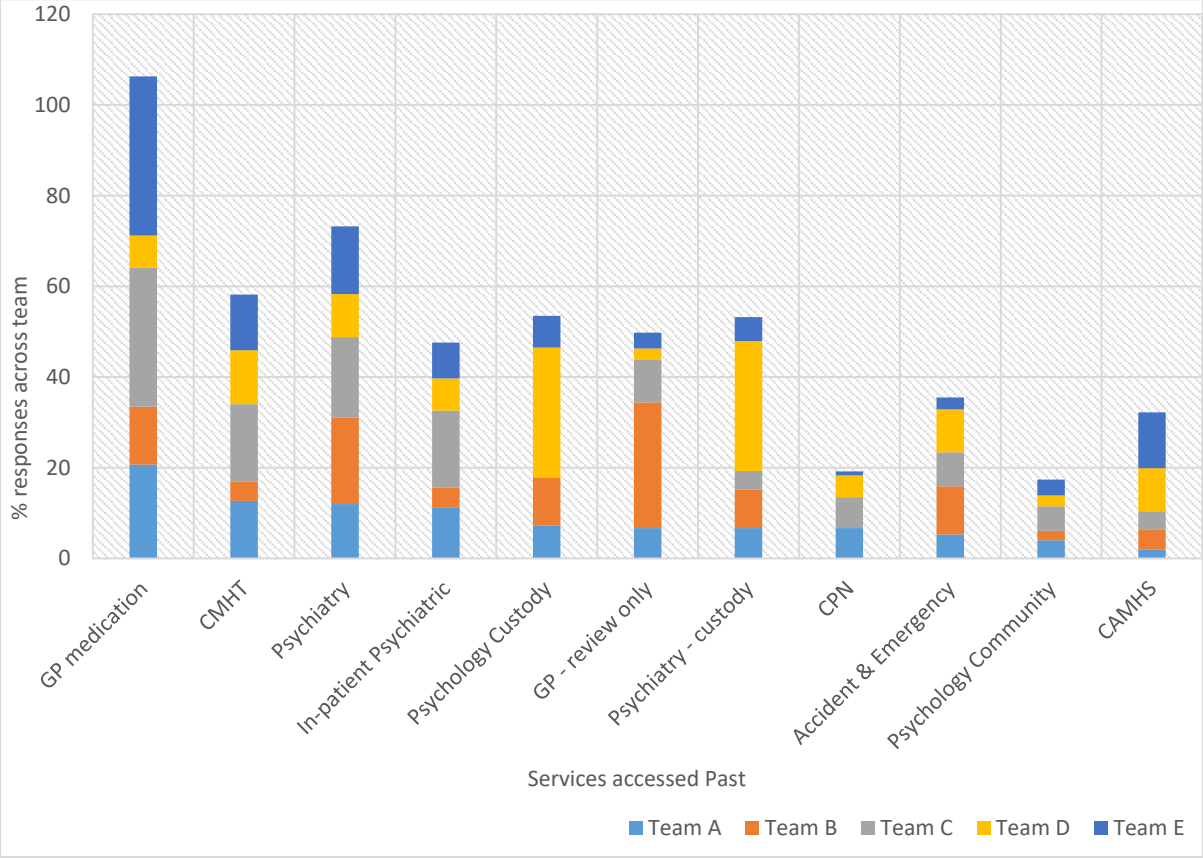

Figure 14 Services providing mental health support by team

Contact with GP and medication was the most frequent form of contact with a Service reported across teams, with figures ranging between 7 to 35 per cent. Past contact with in-patient Psychiatric Services, ranged between 4 and 17 per cent, with Team B, reporting the lowest number of cases and Team C, the highest (17%).

Team D reported the highest rate of contact with Child and Adolescent Mental Health Services (CAMHS) in childhood and more contact with Psychiatry and Psychology Services while in custody than clients in other teams. Previous contact with Psychological Services in the community was reported as ranging between 2 and 5 per cent across teams.

<u>Active symptoms indicative of mental health problem(s)</u>

Team A reported the highest rate of active mental health symptomatology and the highest rate of past and current contact with services for mental health problems. Team B reported the lowest rate of active symptoms indicative of a mental health problem.

Figure 15 Percentage of symptoms identified as indicative of a mental health problem presented by team

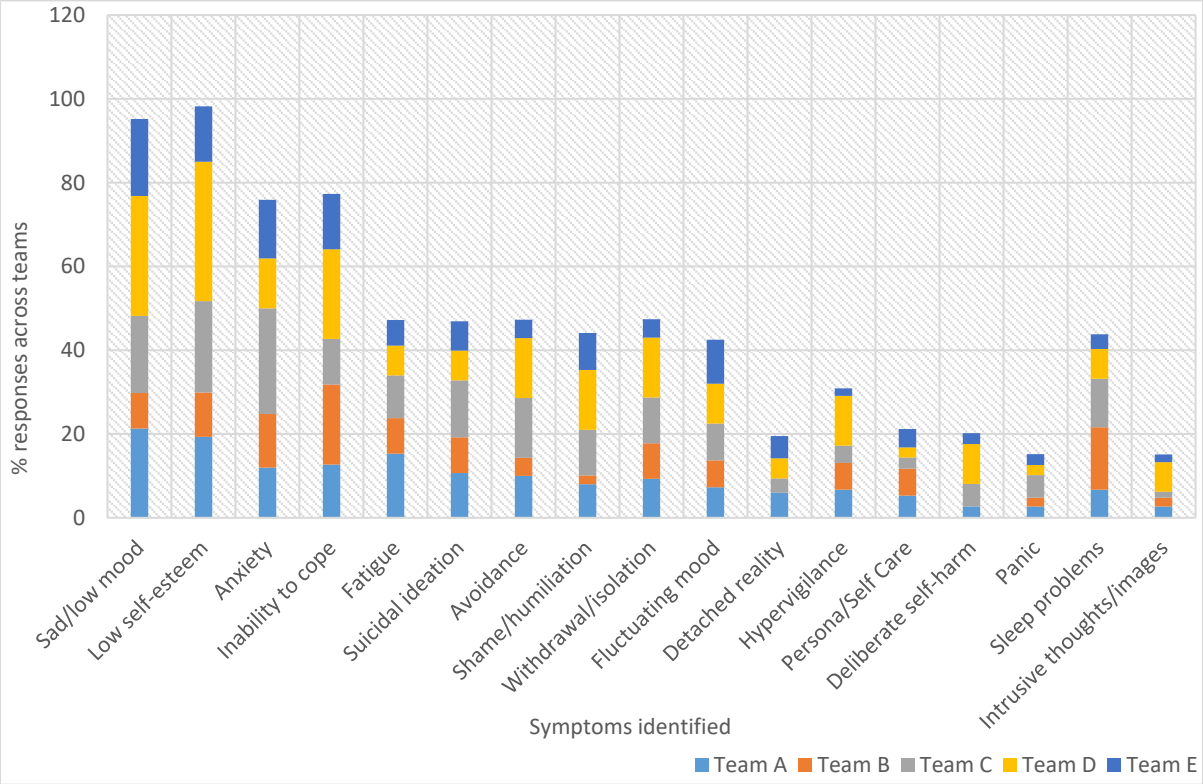

Figure 15: Symptoms identified by team

Reported rates of sadness and low mood (8-29%), low self-esteem (11-33%), withdrawal and isolation (4-14%), anxiety-related symptoms (12-25%) varied considerably across teams.

The rates for suicidal ideation ranged between 7 and 14 per cent, with Team C reporting the highest figure and Team E and D, the lowest (7%). Reports of deliberate self-harm behaviour ranged between 0 to 9.5 per cent across teams; Team B reported no incidence and Team D identified 9.5 per cent of clients were engaging in deliberate acts of self-harming behaviour.

Current engagement with Services for mental health problem(s)

Figure 16 Percentage of Probation Service clients currently engaged with services for a mental health problem by team

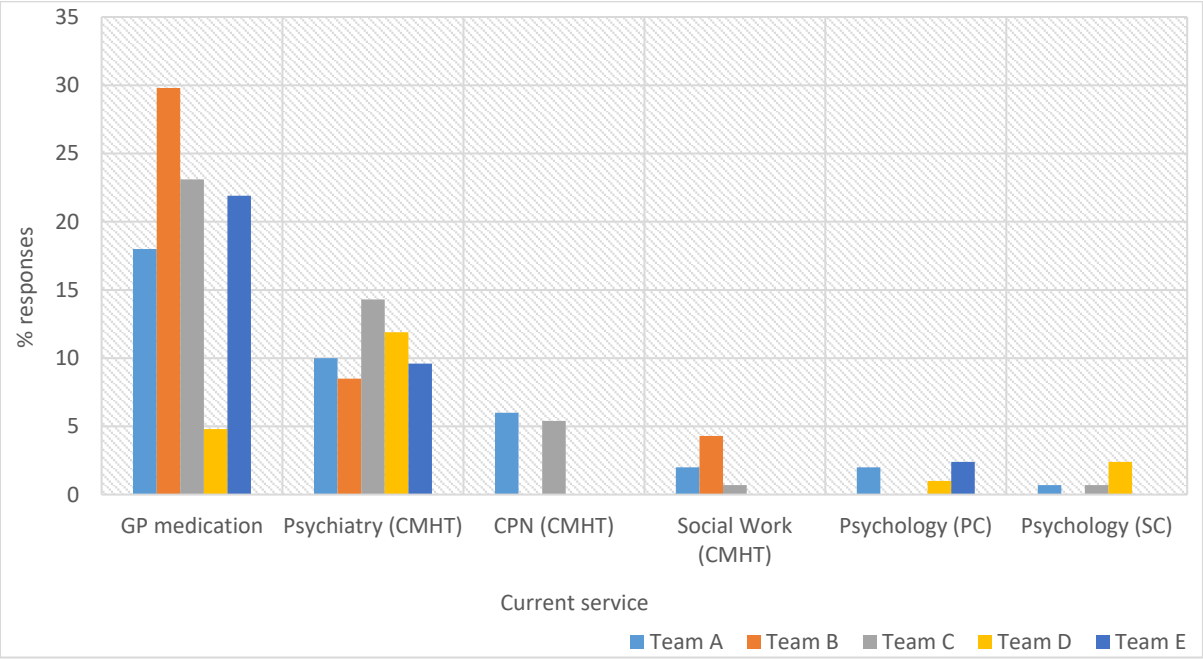

Figure 16: Current contact with services by team

Team D reported the lowest rate of clients currently engaged with Services for mental health problems (19%), the lowest rate of engagement with a GP and a higher rate of withdrawal and social isolation than in other teams.

The reported figures for those engaged with a Community Mental Health Team (CMHT) ranged between 8 and 14 per cent across teams. Three clients were reported as engaged with Secondary Care Psychology (Team A, C, D) and three clients from Team A were identified as currently engaged with Primary Care Psychology.

Barriers to accessing and engaging with services for mental health problems

The main barriers identified were that the client declined to engage with services, had limited insight into the severity of their symptoms or was deemed unsuitable for mainstream Mental Health Services by their GP. More men than women were identified as declining to engage with services for mental health support when needed, in all teams.

Rural Team C indicated that five clients were deemed unsuitable by a GP for onwards referral for mental health support (four men and one woman); two clients had physical difficulty accessing service and a lack of Mental Health Services was an issue for three clients. Urban Specialist Team A identified that three clients had no GP and three clients did not have a medical card.

Key factors identified as contributing to mental health problem(s)

Figure 17 Percentages of key issues identified by Probation Officers presented by team.

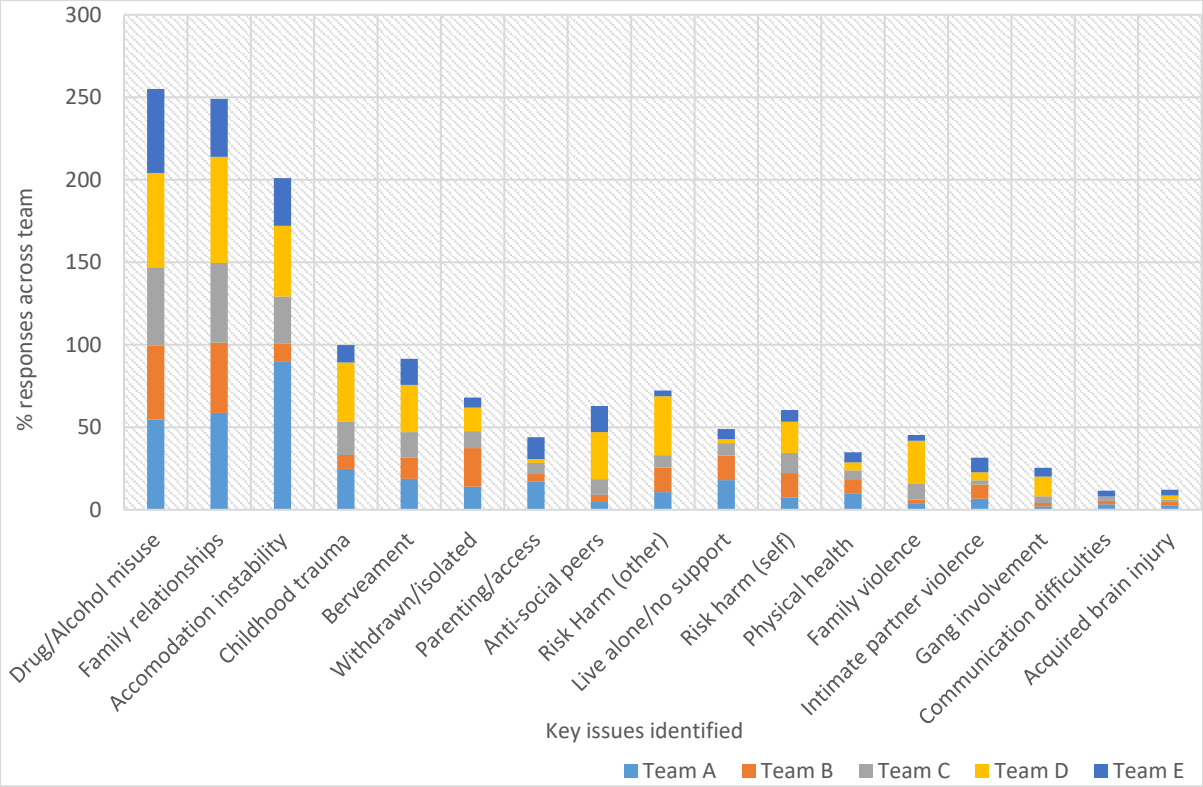

Figure 17 Key issues impacting mental health by team

For Specialist Team A, accommodation instability was the most frequently reported key issue considered likely to be contributing to mental health problems. This was closely followed by difficult family relationships, and drug and alcohol misuse, which were both identified in over half of cases. Team A also had the highest rate of living alone and poor social support (18%), poor physical health and parenting concerns (17%); a fifth of clients were identified as having a history of childhood trauma. This pattern appears to fit with the specialist nature of the team.

Rural Team B reported the lowest rates of accommodation instability, exposure to family violence, trauma in childhood and speech and language difficulties among the teams. It also reported the highest rate of social isolation and withdrawal (23%) of all teams, which may reflect the large geographical area the region, covers.

Nearly half of cases in Team C were identified as having difficult family relationships and issues with alcohol and/or drug misuse, followed by accommodation instability, which may contribute, to mental health problems. Childhood trauma was identified in a fifth of cases and approximately 15 per cent were experiencing bereavement/grief and loss and exposure to family violence (10%) and risk of harm to self (12%). Team C also reported 13.6% of person subject to a supervision order were experiencing suicidal ideation/plans (12.5% men; 16.7% women); and, 11% of women and 5% of men were identified as engaging in deliberate acts of self-harming behaviour.

Over half of all cases in Specialist Team D were identified as experiencing difficult family relationships (64%) and drug and alcohol misuse, higher than in other teams. Highest rates of risk of harm to others

(35%), involvement with an anti-social peer group (29%), bereavement and grief (29%), gang affiliation (12%) and childhood trauma (35.7%) were also reported.

In Urban Team E, half of clients were identified with drug and or alcohol misuse, a third with difficult family relationships and over a quarter with accommodation instability. Approximately 10 per cent were identified as having experienced childhood trauma, 15 per cent with bereavement/grief and anti-social peer group, factors which may contribute to poor mental health.

Global Assessment of Functioning (GAF)

Figure 18 Percentages of GAF ratings distribution across teams

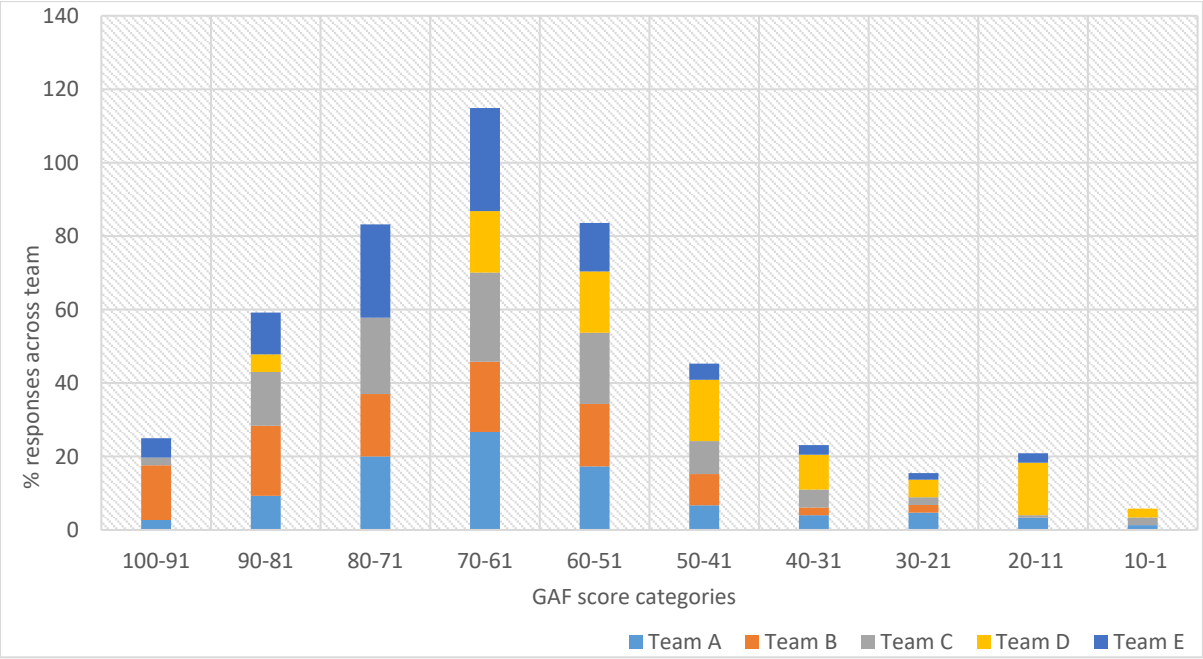

Figure 18 GAF score across team

The GAF scores were generally comparable across the teams, in that scores were highest within the 'mild' and 'moderate' ranges with fewer scores towards the lower end of the scale indicating severe and enduring mental health symptoms. However, there were some notable differences. The distribution of GAF scores in Team D indicate more complex mental health problems as the scores were skewed towards the middle and lower end of the GAF ranges indicating more serious and severe and enduring mental health problems. It is notable that nearly a third of clients in Team D were reported as having had contact with Psychology and/or Psychiatry Services while in custody and 14 per cent were identified as having a diagnosis of Schizophrenia or other primary psychotic disorder.

Team D Probation Officers reported higher levels of concern regarding their clients' mental health. When percentages between 'active symptoms' and current intervention were compared, the range for all five teams is 4-24 per cent, with Team D presenting the biggest gap of 24 per cent.

Summary of Findings

Over 50% of women and 40% of men, were identified as experiencing active symptoms indicative of at least one mental health problem; the most often reported symptoms were depressive and anxiety related symptomatology. Suicidal ideation and self-harming behaviour were identified, and is a matter is of particular concern for the Probation Service and the wider Health Services. The finding highlights the importance of raising awareness, and providing education and training in line with the National Office for Suicide Prevention National and Regional policies.

Overall 40 per cent of clients were identified as having a known formal mental health diagnosis and the most frequently reported diagnoses included anxiety and mood disorders. Over fifty per cent of clients were reported as having received some form of assessment and/or intervention for mental health problems in the past, most often receiving medication from a GP; 11 per cent were identified as having had contact with in-patient Psychiatric Services in the past.

Poor client insight into their mental health problems and lack of willingness to engage with Services for mental health were identified as barriers preventing access to and engagement with Mental Health Services, along with clients being deemed unsuitable for mainstream Mental Health Services or no service being available. Probation Officers rated their engagement with their clients' current Service provider as 'none' or 'insufficient' in 17% of cases.

Over 50% half of clients, were rated as having Global Assessment of Functioning (GAF) scores in the 'slight impairment', 'mild symptoms', and 'moderate symptoms' range; and ten per cent were rated as presenting with serious and severe mental health symptoms, and 1.5 per cent of men's scores fell in the 10-1 GAF range. There appears to be some difference between the types and frequency of symptoms possibly indicative of mental health problems and the GAF ratings provided by Probation Officers. This suggests possible gaps in understanding~~,~~ confidence and knowledge in basic assessment of mental health problems and the need for further training and skills development in recognition of symptoms and mental health problems.

Furthermore, it highlights that mild and moderate mental health problems are prevalent across teams yet there is very little, if any, engagement with Primary Psychology Services in the teams across regions, services that may be best placed to work with to address mild and moderate symptoms.

CHAPTER 4: DISCUSSION

The three studies have explored mental health among clients engaged with the Probation Service from the perspective of Probation Officers. The findings provide the Probation Service, as well as the Department of Justice and the Department of Health, with empirical evidence of the need for appropriate Mental Health Services and for cross-agency and interdisciplinary working with clients presenting with a range of mild and moderate and severe and enduring mental health problems within the Criminal Justice System.

Before going on to address the main points emerging from the studies, it is important to acknowledge the methodological shortcomings of these exploratory studies. Firstly, the scoring of the questions is subjective, at the discretion of the individual Probation Officer, and there is limited mental health training provided to Probation Officers. As such, it may be much more likely that the incidence of mental health problems reported is an underestimate. It is also clear that some questions required a more nuanced understanding and identification of specific symptoms indicative of mental health problems and did not appear to be well answered. In particular, there were gaps in the data collected and a discrepancy with other questions relative to the Global Assessment of Functioning (GAF) scores provided. Therefore, it is important to acknowledge concerns regarding the validity of the probation staff-rated GAF scores, particularly as Probation Officers receive very little specific training on mental health.

The Mental Health Service Evaluation (MHSE) questionnaire (Power, 2019) was developed for the purpose of this exploratory review in the absence of any other appropriate measure, and therefore, not validated in another setting. Although it was piloted in one team prior to the third study and revised based on feedback from Probation Officers, it lacks sensitivity and attention to other co-occurring difficulties such substance misuse and personality disorder. The GAF measure is also subject to limitation. As a one-item rating scale it does not take into account the complexities of mental health problems and scores can fluctuate daily. As such it cannot measure meaningful clinical change/real change. However, assessing outcomes and clinical change was not the focus of these studies and the GAF measure is useful in a generic group in this context and population. The GAF is also still used in Mental Health Services in Ireland.

The overall sample of 500 included in the third study is based on five Probation Service community supervision teams representing approximately 8 per cent of the population over 18 years of age and subject to supervision at the time of the study. Community Service and Young Persons Probation (YPP) teams were not included. The information collected was completed from the perspective of individual Probation Officers, and based on their knowledge and experience of their clients. This could be limited if the client is new to the Service or not engaging with their Probation Officer. Furthermore, there is a need to bring multiple perspectives together including those of the service user and other service providers including health care professionals, community mental health teams and the Irish Prison Service. The aim being to develop a person centred approach and to gain a greater understanding of the challenges for all stakeholders.

Incidence of Mental Health Problems

A significant incidence of mental health problems was identified in all studies. Over 40 per cent of clients were identified as presenting with active symptoms of mental health problems in the pilot study, similar to 43 per cent identified in the third study. These figures were consistent with Brooker et al., 2012) who estimated that approximately 39 per cent of individuals in a UK Probation population were suffering from mental health problems. This figure is also consistent with the prison population and the World Health Organisation (WHO)[21], which estimates that up to 40% of the global prison population were persons with mental health problems.

The findings from the studies also indicate a higher prevalence of mental health problems than those reported in the general population in Ireland. According to the Health at a Glance Report[22], Ireland has one of the highest rates of mental health problems in Europe, joint third of thirty-six countries, with 18.5 per cent of the Irish population reported as having a mental health problem such anxiety, bipolar disorder, depression or alcohol/drug use in 2016[23] (Mental Health Ireland). Furthermore, a survey completed by Healthy Ireland identified that nearly 10 per cent of the Irish population has a 'probable mental health problem' (Mental Health Reform 2020).

Mental Health Diagnoses

The most frequently reported formal diagnoses were anxiety disorders and mood disorders. More than 40 per cent of clients in study three and 31 per cent in study two had a known formal mental health diagnosis. The most frequently reported formal diagnoses were anxiety disorders and mood disorders, similar for men and women and consistent with previous research (Brooker et al., 2012) exploring mental health problems among probation supervision clients elsewhere.

Diagnosis of personality disorder and related traits was similar in both studies (5% and 4%) but low compared to studies in other jurisdictions (e.g. 47.4% Brooker et al., 2012). This difference may reflect underassessment due to mental health legislation, policy and practice in Ireland, paucity of specialist assessment and intervention services or non-identification. The Offender Personality Disorder Pathway programme[24] in England and Wales is a jointly commissioned initiative between NHS England and Her Majesty's Prison and Probation Service (HMPPS), to provide a pathway of psychologically informed services for offenders who are likely to be diagnosed with personality disorder in the UK. The service[25] offers specialist assessment and intervention and provides consultation and training to staff, particularly focussed on formulation and management of clients presenting with such complex interpersonal difficulties. The existence of the service may help to explain the difference in identification of personality disorder in Probation Services across the two jurisdictions.

Low rates of other types of mental health diagnoses were identified including, learning disability, communication difficulties including speech and language disorders and acquired brain injury. This is surprising given that prisoners with psychosocial and intellectual disabilities are disproportionately overrepresented in the global prison population (Irish Penal Reform Trust pg. 11). This may indicate further under-assessment or non-identification issues. The findings from the current studies may,

[21] World Health Organisation Europe Health in Prison Factsheet (WHO Regional Office for Europe), p. 1
[22] https://ec.europa.eu/health/sites/health/files/state/docs/2018_healthatglance_rep_en.pdf
[23] https://www.mentalhealthireland.ie/statistics.
[24] https://cpb-eu-w2.wpmucdn.com/blogs.lincoln.ac.uk/dist/9/8124/files/2019/07/OPD-Pathway.pdf
[25] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/869843/6.5151_HMPPS_Working_with_Offenders_with_Personality_Disorder_v17_WEB.pdf

therefore, also be an underestimate of other issues co-occurring with mental health problems among clients engaged with the Probation Service. However, the focus of the current studies is solely mental health.

Active Symptoms Indicative of Mental Health Problems identified by Probation Officers

Probation Officers most often identified symptoms of low mood and anxiety, as found in previous studies (e.g. Brooker et al., 2012). The most commonly identified symptoms of anxiety and low mood are also consistent with the findings from the GAF measure where over half of clients in both studies were identified in the 'slight impairment', 'mild' or 'moderate' range on the Global Assessment of Functioning (GAF).

Providing Probation Officers with training in mental disorders, particularly those most commonly identified, such as mood disorders and anxiety disorders, would likely increase understanding and recognition of the types of symptoms, and some insight into the evidence-based interventions which may be open to clients. This may help Probation Officers to support their clients to access and engage with the most appropriate services. This may also assist Probation Officers to undertake low level intensity work such as psychoeducation for anxiety and grounding techniques where necessary, however, only following specific training and support. It is also important to recognise that engagement with services may be particularly anxiety provoking for Probation clients. The Probation Officer may be the only person aware of their clients' mental health problems. Competent assessment, knowledge of available local and national Services and referral pathways are essential.

Based on the differences in reporting both within teams and across teams, it appears that some individual Probation Officers have a high level of knowledge and experience of mental health. Some Probation Officers identify symptoms of mental health problems more often and appear more confident making referrals and linking directly with local Services. Having Probation Officers with this level of experience and interest in the area of mental health is a significant strength for the Probation Service that should be developed further. There may be a strong case for specialist mental health Probation Officers, who hold 'speciality caseloads' (Skeem and Louden, 2006). Such specialist staff work with reduced mental health caseloads, receive training and on-going supervision in mental health and are also trained to use problem solving strategies. Duties also include developing relationships with local Mental Health Services, joint-working and accurate collecting of Service data.

Complex Mental Health Problems and Past In-Patient Psychiatric Care

Both team studies identify approximately 10 per cent of clients with complex mental health problems and past in-patient psychiatric care. Of those identified as experiencing active symptoms of mental health problems, fifty clients were identified with GAF scores within the serious and severe range, similar for men and women. Six clients were rated as 'in almost constant danger of self-harm or harm to others', all of whom were men. Both studies identified approximately 10 per cent of clients as having had previous contact with in-patient Psychiatric Services. Notably this figure varied across teams and one team identified 17 per cent of cases as having had received in-patient psychiatric care in the past.

Although it is not possible to make any direct comparisons, the figures reported in these studies are considerably higher than those for the general population. The Health Research Board (HRB) Irish

Psychiatric Units and Hospitals Census (2019)[26] reported a hospitalisation rate of 48.5 per 100,000 population based on 2,308 patients resident in Irish Psychiatric Hospital units on 31 March 2019.

One of the five Probation Service teams in the third study identified more clients with complex needs and more serious symptomatology than the other teams indicative of mental health problems and fewer clients were linked in with any service for mental health problems. This indicates the necessity to identify the specific needs of each team and to respond and adopt according the specific needs identified. In this instance, this particular team appears to require specialist support and a dedicated strategic input to address the identified needs. This will include closer working with the Senior Probation Officer as manager and possible additional support for Probation Officers with a focus on reflective practice skills, specialist training and development of closer links with community and forensic mental health services.

Suicidal Ideation and Self-Harming Behaviour

Suicidal ideation and self-harming behaviour is reported similarly in the studies and is of significant concern for the Probation Service and the wider Health Services. These findings are consistent with Philips et al., (2018) who found the suicide rate among people under probation supervision, including those serving a community order, suspended sentence order or on licence/post-release supervision, is significantly higher than the general population and also higher than in prison.

This is a particularly important finding and should not be underestimated in the current context of the current Covid-19 global pandemic. The authors of the International COVID-19 Suicide Prevention Research Collaboration (2020) argue that "An increase in suicide is not inevitable, if preventive action is taken imminently". They argue these actions may include developing clear pathways to care, staff training to support new ways of working and dissemination of evidence-based online interventions. The authors also identify vulnerable groups and risk-related factors such as social isolation and loneliness that may increase the risk of suicide. Many of these factors are identified in the present studies detailed in this report. According to Skinner and Farrington (2020) *"Shared responsibility lies with the prison, probation, health and social services to develop more collaborative practices in providing services for this high-risk group."* (pg. 6).

Based on these findings and in line with national guidelines, raising awareness and providing education and training to Probation Service staff on the Irish Connecting for Life National Strategy[27] to reduce suicide should be a priority. The aim of the Strategy is to reduce suicide rate and presentations of self-harm in the whole population and among specified priority groups. The role of the National Office for Suicide Prevention is to support, inform, monitor and co-ordinate the implementation of Connecting for Life.

To address this risk would necessitate a coordinated approach in partnership with National and Regional Suicide Resources Officers for Suicide Prevention. Ongoing support and encouragement by Probation Service management will be essential to ensure staff participation in Skills Training on risk management and self-harm training (STORM) to develop and enhance skills and confidence in assessment and management of self-harm. The consistent and comprehensive collection of national

[26] The Health Research Board (HRB) (2019). Irish Psychiatric Units and Hospitals Census 2019. https://www.hrb.ie/publications/publication/irish-psychiatric-units-and-hospitals-census-2019-main-findings/

[27] https://www.hse.ie/eng/services/list/4/mental-health-services/connecting-for-life/ https://www.hse.ie/eng/services/list/4/mental-health-services/nosp/preventionstrategy/

data on suicide attempts, suicides and deaths among persons supervised by or otherwise engaged with the Probation Service will be important in informing policy and practice developments and in monitoring intervention outcomes. This data will enable the Probation Service to better identify risk factors to intervene earlier and coordinate more closely with health colleagues where necessary.

Access to and Engagement with Community and Forensic Services for Mental Health Problems

A considerable number of clients in each of the studies were identified as experiencing serious mental health problems but not accessing any Service for assessment or intervention. This finding is consistent across the three studies. Understanding the reasons for this and the challenges service users experience in accessing and engaging with Services for mental health support is complex. In these studies, along with difficulties accessing and engaging with mainstream Mental Health Services, client motivation to engage with Services was a significant barrier identified by Probation Officers along with other issues such as client lack of insight. In this regard, there is a role for Probation staff motivating and supporting all clients to seek appropriate mental health support and advocate on behalf of clients for access to Services, where necessary. This includes recognising symptoms, having good knowledge of the Services available and of the formal referral pathways and confidence in initiating the referral, which can be a challenge without training and support.

Offering access to Services for mental health alone may not be sufficient to engage clients. Probation clients face multiple social, economic and psychological challenges and obstacles, internal and external. Engaging with Services for mental health support can be incredibly challenging for Probation Service clients, particularly where there is considerable instability and unmet basic physical and safety needs. The current studies highlighted some significant challenges, which may pose as additional barriers to accessing services. For example, rural Probation teams tend to cover wide geographical areas where access to general and specialist statutory and non-statutory services is limited. Probation Officers report that this poses significant challenges for isolated and marginalised clients who have to travel long distances on public transport or other means that may not always be available or reliable to access services.

A further challenge for Probation Service clients identified in the present studies is continuity of care particularly from custodial settings into the community. As highlighted in the data, many Probation Service clients have been supported for serious mental health problems by psychiatry and psychology and other Healthcare Services whilst in custody. Clients who transition from custody where they were receiving treatment or psychological intervention for mental health problems may have difficulty accessing and sustaining an equivalent level of care and support in mainstream community and forensic Mental Health Services. Negotiating care and continuing treatment pathways may be problematic for individuals and Services for multiple reasons that require joint interagency negotiation on access and to sustain client engagement with forensic or mainstream community mental health services. This is further complicated where there are multiple needs such as co-occurring substance misuse and/or lack of accommodation.

Similar to Fowler et al., (2019) another key consideration in both present studies is insecure accommodation and housing instability. Nearly half of all clients in the third study were identified as having accommodation instability. It is understandable that clients may not prioritise their mental health needs in the absence of basic physiological and safety needs such as housing, food and sleep; motivation decreases when these needs are not met (e.g. Maslow, 1943). Not having these basics in

place should not be an exclusion criterion in having access to the appropriate Mental Health Services at the appropriate time.

Two thirds of clients in the third study rated with more serious mental health symptomatology on the GAF were also reported as having insecure accommodation. This is important as clients may lose contact with referred Services and existing health care providers if they move out of a defined catchment area. Some clients may be of no fixed abode and not be engaged with a GP. This need for accommodation security may be particularly stressful and threatening especially where there are other aggravating difficulties such as mental health problems, speech and language and other communication difficulties that make it much harder to seek help when needed. This can impact on the development of trusting relationships with professionals across multiple Services and perpetuate feelings of social isolation, uncertainty and psychological distress. There is a need for closer relationships and more collaborative working with accommodation providers in order to help clients achieve basic needs such as accommodation stability. This could be facilitated in some ways by The Probation Service taking a more active engagement with national housing projects such as the Housing First programme and policy makers.

The Medical Model approach to addressing Mental Health Problems

Clients identified as engaged with a Service for mental health problems are most often receiving medication from a GP. This finding is consistent across both team studies. There is seemingly very limited engagement with psychological interventions, in both primary and secondary care Health Services. The most frequently reported symptoms appear indicative of the most common mental health disorders such as depression, generalised anxiety disorder and panic disorder and are treated with medication. There appears to be less engagement with psychological interventions, which are included within the evidence-based recommendations for mental health care (NICE guidelines[28]) for treatment of a wide range of psychological disorders. Treatment in the form of medication is often recommended alongside psychological therapies to improve mental health in the longer term for the individual depending on the specific mental disorder. Psychological or talking therapy approaches and interventions appear particularly underused almost everywhere.

Factors Contributing to Mental Health Problems

Alcohol and drug misuse, difficult family relationships and accommodation instability are the key issues identified as contributing to mental health problems. Alcohol/drug misuse was rated highest, however, the figures are comparably lower than in other studies (e.g. 60% Brooker et al., 2012). That may indicate an under-reporting. Approximately 50 per cent of clients were identified with co-occurring mental health problems and addiction. Substance misuse is often reported as a barrier to accessing and sustaining engagement with services for mental health problems. It is clear that there is an urgent need for improved access to specialist services offering care through multi-disciplinary assessment and intervention for those presenting with co-occurring mental health and addiction.

Similarly, the rate of gambling was also very low which would suggest an under-reporting and requires further examination. Difficult family relationships and accommodation instability were also rated highly problematic and this was similar overall in both studies and across separate teams.

[28] National Institute for Health and Clinical Excellence (NICE)

Childhood trauma which was identified in 20 per cent of cases overall in the third study. This figure was higher in the specialist teams (35.7% and 24.7%) compared to 8 per cent identified in a rural team. This figure appears particularly low in comparison to the other teams, and also when compared to data contained in a report produced by the Centre for Effective Services addressing Childhood Adversity (CES 2016) in Ireland. This low rate may reflect some degree of underreporting and may, at least in part, be due to the focus of the study being on mental health problems. Childhood trauma was not referenced or defined in the study. It does, however, prompt a question about how confident and skilled Probation Officers are in discussing early childhood experiences and the possible impact on mental health as an adult.

Both the Moore and Tatman and Fowler et al., (2019) studies highlight the value of mental health screening at an early stage in probation assessment and supervision. Their observations have particular relevance in the context of the current findings from the three studies. In the third study, of those identified with active symptoms indicative of mental health problems, 61 per cent were reported as having a known formal mental health diagnosis and 73 per cent have received mental health support in the past. There is a need for the Probation Service to complete mental health history taking at assessment and identify current mental health problems early in the process. However, for this type of early intervention to be effective, Probation Officers do need skills-based training in mental health along with greater coordination and communication with community and forensic mental health services and knowledge of formal pathways for accessing services. There is a need for similar communication with other services such as local authority housing services, early intervention and family services and co-occurring substance misuse.

A Trauma Informed Approach to Addressing Mental Health Problems in the Probation Service

In view of the findings and themes identified in these exploratory studies, including incidence of mental health problems, suicidal ideation and self-harm, interpersonal violence, difficult family relationships, early adverse childhood experiences and chronic misuse of drugs and alcohol, there is a clear need to develop a trauma-informed approach in Probation Service practice.

The findings from the present studies are consistent with the view of McCartan (2020) who advocates for the trauma informed approach in probation practice. This approach to mental health fits with and complements the overarching aim of many organisations striving to become trauma informed. This can begin immediately with policy development to inform practice. As a starting point, this would involve proofing policy documents in relation to their impact on a client's mental health. Possible review of how PSRs are structured to collate/ signal possible mental health problems. At present there are no formal guidelines on how Probation Officers address the issue of mental health problems within PSRs. Such guidelines would be beneficial.

Summary of findings

The findings from the three studies raise awareness of the issues and do identify mental health as a priority area for attention for the Probation Service. To do this, a tailored approach to mental health among Probation Service clients is required. That will include a staff training strategy. It will include working with individual teams to develop an engagement strategy, particularly for those clients presenting with active symptoms of mental health problems but not currently engaged with Services.

There is a clear need to develop a systematic collection of mental health information across the Service to explore national and local trends, identify areas for development and enable Probation Service management to open a dialogue on specific areas for co-operation development with other Services.

Going forward, there is a clear need for joint coordinated approach to address the mental health needs of individuals within the criminal justice system. It is essential to conduct further and in-depth studies from multiple perspectives including Probation Service clients, Mental Health Service professionals from Forensic and Community Mental Health Services and GP's. Having multiple perspectives will allow us to get a better understanding of the individual, service level and system challenges, and collaboratively agree and implement an integrated and co-ordinated approach and pathway to addressing those challenges.

CONCLUSION

Overall, mental health is an important criminogenic factor to be taken into account in assessment and supervision. In particular, it impacts directly on a person's capacity and ability to benefit from supervision and interventions especially when a mental health problem is a comorbid presentation with a drug and/or alcohol problem and/or emotional dysregulation. The findings here, drawn from practice research, provide valuable information to support initiatives across a number of areas of work in the Probation Service. The work plan of the Probation Service Mental Health Group is an important starting point to contribute to strategic developments. The Probation Service Mental Health Group can help inform development of a practice guidance framework, interagency negotiation and collaboration and help, with the aid of further research and evaluation, provide an evidence base to inform future practitioner training. That training and skills development will enhance confidence and capacity to engage with the issues that have often risk of being consigned to the margins because of their complexity and difficulty. Further research in this area is required in the future but the current findings do enable some immediate conclusions and broad recommendations.

To conclude, the '*A Vision for Change*' (2006) expert group recommended that Probation clients are entitled to equivalence of care. Probation Service clients should have the right to be treated in non-forensic Mental Health Services unless there are "cogent and legal reasons why this should not be done" and *"it is essential that there are linkages between the Probation Service and the relevant generic Mental Health Services and, where appropriate, Forensic Mental Health Services to ensure a linked approach and, particularly, continuity of care".* However, to date, there is little evidence to demonstrate that this worthy ambition is working in practice despite a growing number of clients who are experiencing mental health problems along with other co-occurring difficulties. Addressing these challenges requires a clear evidence-based strategy accompanied by an agreed action plan and a strong commitment to implement the recommendations and evaluate progress and disseminate information accordingly.

CHAPTER 5: RECOMMENDATIONS

1. **Development of a Probation Service Mental Health Engagement and Support Strategy that will build on the current findings and can be implemented nationally and locally**. This will require a co-ordinated approach and joint working with the Mental Health Working Group and the Learning and Development Team.

2. **There is a need for stronger links in supporting clients' engagement with Services and in developing multi-disciplinary partnerships and active working with Mental Health professionals** to maximise benefits of supervision and to reduce offending behaviour. This will ultimately require a proactive approach, making those links locally and nationally through senior management and the Mental Health Working Group actions.

3. **Mental Health skills training for Probation Officers focusing initially on identification of mild to moderate mental health problems including mood disorders (e.g. depressive disorders) and anxiety disorders (e.g. social anxiety, health anxiety and generalised anxiety, OCD)**. Recognition of symptoms will inform assessment and supervision plans and inform onwards referral for a specialist Mental Health Service. Furthermore, training to include knowledge of formal pathways and the services available.

4. **A tailored approach, with guidance, to addressing the mental health needs of clients engaged with the Probation Service is required**. This will involve working with individual teams to develop an engagement strategy, particularly for those clients presenting with active symptoms but not currently engaged with services. This should be offered alongside additional training and psychoeducation beginning with mental health problems such as depression and anxiety disorders.

5. **Provide support in the form of evidence based interventions, including reflective practice facilitated through a psychologist or appropriate supervision, to support staff who are managing complex and challenging cases where mental health is of significant concern.** Advice, guidance and support on complex case assessment, appropriate referral pathways and ongoing multi-agency support should be facilitated through direct consultation with a psychologist.

6. **Review and if appropriate, revise current systems for recording deaths of persons on Probation Service supervision to ensure relevant data is captured accurately.** The Probation Service should continue to deliver the STORM skills-based training for Probation Officers in light of the increasing concern regarding suicide among Probation clients. Closer working and greater communication, co-ordination and training with local and national HSE Suicide Resource Officers locally and nationally.

7. **There is a need for further research and focus on areas of development. In addition, a further study with a representative cohort of persons supervised by the Service should be undertaken to explore mental health needs from a client perspective**. This should include inviting feedback from other services including the Psychology Service in the Irish Prison Service, and specialist community based Forensic and Community Mental Health Teams. Further examination of the missing data identified in the first study of LSI-R should be pursued. Also, there should be research on effective mental health intervention for probation clients and development of formal pathways for them.

8. **Support The Probation Service to work towards becoming a trauma informed organisation.** D**e**liver training that focuses on trauma and its close links with offending behaviour and mental health. Also, the Service should continue to work closely with other linked services and projects which are currently developing, implementing and evaluating their trauma informed practice. This is consistent with the Service Delivery Principles identified in *'Sharing the Vision'.* The Principles require co-ordination and effective communication between services and organisations.

9. **Substance misuse and co-occurring mental health problems are highly prevalent and problematic among Probation Service clients.** Substance misuse is often reported as a barrier to accessing and sustaining engagement with services for mental health problems. More collaborative and joint working with services that are multi-disciplinary and offer out-reach services is required to address the co-occurring conditions. There is an urgent need for improved access to specialist services offering care through multi-disciplinary assessment and intervention for those presenting with co-occurring mental health and addiction issues. These issues cannot be addressed in isolation where there are complex overlapping needs.

10. **Personality Disorder is not recognised in the Irish Mental Health Act 2001[29], which may, at least in part, explain why Personality Disorder as a formal diagnosis was reported as low**. This may indicate that personality disorders are largely unaddressed and under diagnosed when compared with other jurisdictions. This can contribute to difficulties in assessment, management and intervention and requires further attention. There is a need for a shared understanding and recognition of personality disorder as an issue. There is also a need for a multi-dimensional focus to include the full range of psychiatric/ psycho-social/ neurological issues. A psychosocial multi-disciplinary approach would enhance outcome benefits in working with individuals across the Probation Service presenting with complex mental health problems and co-occurring difficulties such as dual diagnosis, addiction, personality disorder and neurodiversity issues.

[29] http://www.irishstatutebook.ie/eli/2001/act/25/enacted/en/html

REFERENCES

Afifi, T. O., Enns, M. W., Cox, B. J., Asmundson, G. J., Stein, M. B., & Sareen, J. (2008). Population attributable fractions of psychiatric disorders and suicide ideation and attempts associated with adverse childhood experiences. *American Journal of Public Health*, *98*(5), 946–952.

Ali, A., & Ghosh, S., Strydom, A. & Hassiotis, A. (2016). Prisoners with intellectual disabilities and detention status. Findings from a UK cross sectional study of prisons. *Research in developmental disabilities*, 53-54, 189-197. https://www.sciencedirect.com/science/article/pii/S0891422216300245

American Psychiatric Association (APA) (2000). *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text revision) (DSM-IV-TR). Washington, DC: American Psychiatric Association.

Andrews, D. & Bonta, J. (2004). *LSI-R: The Level of Service Inventory-Revised*. Toronto: Multi-Health Systems Inc.

Andrews, D. A., & Bonta, J. (1995). *LSI-R: The level of service inventory-revised user's manual*. Toronto: Multi-Health Systems Inc.

Andrews, D. A., & Dowden, C. (2006). Risk principle of case classification in correctional treatment: A meta-analytic investigation. *International Journal of Offender Therapy and Comparative Criminology*, *50*, 88-100. https://doi.org/10.1177/0306624X05282556

Bowles, M. A., DeHart, D., & Webb, J. R. (2012). Family influences on female offenders' substance use: The role of adverse childhood events among incarcerated women. *Journal of Family Violence*, *27*(7), 681-686. https://doi.org/10.1007/s10896-012-9450-4

Brooker, C., Sirdifield, C., Blizard, R., Denney, D. & Pluck, G. (2012). Probation and Mental illness. *Journal of Forensic Psychiatry and Psychology*, *23*(4), 522–537. https://doi.org/10.1080/14789949.2012.704640

Brooker, C., Sirdifield, C., Ramsbotham, D. & Denney, D. (2017). NHS commissioning in probation in England — on a wing and a prayer. *Health and Social Care in the Community*, *25*(1), 137–144. https://doi.org/10.1111/hsc.12283

Brooker, C. & Ramsbotham, D. (2014). Probation and mental health: Who cares? *British Journal of General Practice*, *64*(621), 170–171. https://doi.org/10.3399/bjgp14X677743.

Brooker, C., Sirdifield, C. & Marples, R. (2020). Mental health and Probation: A Systematic review of the literature. Forensic Science International: Mind and Law, 1, 100003. https://doi.org/10.1016/j.fsiml.2019.100003

CES (2016). *Addressing Childhood Adversity in Ireland*. Centre for Effective Services. Dublin https://www.effectiveservices.org/assets/Final_Adversity_Lit_Review_September_2016.pdf

Chapman, D. P., Whitfield, C. L., Felitti, V. J., Dube, S. R., Edwards, V. J., & Anda, R. F. (2004). Adverse childhood experiences and the risk of depressive disorders in adulthood. *Journal of Affective Disorders, 82*(2), 217–225.

Clayton, A., O'Connell, M. J., Bellamy, C., Benedict, P., & Rowe, M. (2013). The citizenship project part II: Impact of a citizenship intervention on clinical and community outcomes for persons with mental illness and criminal justice involvement. *American Journal of Community Psychology*, *51*(1-2), 114-122. https://doi.org/10.1007/s10464-012-9549-z

Cotter, L. (2015). 'Are the needs of adult offenders with mental health difficulties being met in prisons and on probation?' *Irish Probation Journal*, *12*, 57–78. http://www.probation.ie/EN/PB/0/068C17157F5F892C8025802E00485264/$File/IPJ2015pages57to78.pdf.

Crane, C. A., & Eckhardt, C. I. (2013). Evaluation of a single-session brief motivational enhancement intervention for partner abusive men. *Journal of Counseling Psychology, 60*, 180–187. https://doi.org/10.1037/a0032178.

Department of Health and Children (2006). *'A Vision for Change': Report of the Expert Group on Mental Health Policy*. https://www.hse.ie/eng/services/publications/mentalhealth/mental-health---a-vision-for-change.pdf.

Department of Health (2014). *Report of the Expert Group on the Review of the Mental Health Act 2001.* https://www.gov.ie/en/publication/637ccf-report-of-the-expert-group-review-of-the-mental-health-act-2001/

Department of Health (2016). *Connecting for Life: Irelands National Strategy to Reduce Suicide 2015-2020*. https://www.hse.ie/eng/services/list/4/mental-health-services/connecting-for-life/

De Ravello, L., Abeita, J., & Brown, P. (2008). Breaking the cycle/mending the hoop: Adverse childhood experiences among incarcerated American Indian/Alaska Native women in New Mexico. *Health care for women international*, *29*(3), 300-315. https://doi.org/10.1080/07399330701738366

Felitti, V. J., Anda R. F., Nordenberg D., Williamson D.F., Spitz A.M., Edwards V., Koss M.P, & Marks, J.S. (1998). The relationship of adult health status to childhood abuse and household dysfunction. *American Journal of Preventive Medicine*, *14*, 245-258. http://www.ajpmonline.org/article/S0749-3797(98)00017-8/pdf

Foley, T. (2016). 'Mental health survey of the Dublin South and Wicklow Region'. Unpublished

Fowler, J. C., Price, R. C., Burger, K., Mattei, A. J., McCarthy, A. M., Lowe, F. & Sathiyaseelan, T. (2019). "Embedding third sector psychology services within the probation environment: an alternative to MHTRs". *Journal of Criminal Psychology*, *10*(1), 16-29. https://doi.org/10.1108/JCP-04-2019-0013

Geelan, S., Griffin, N., Briscoe, J., & Haque, M.S. (2000). A bail and probation hostel for mentally disordered defendants. *Journal of Forensic Psychiatry*, *11*(1), 93–104. https://doi.org/10.1080/095851800362382

Griffin, M. (2008). Mental health, trauma and bereavement on Limerick caseload in 2008. Unpublished.

Gunnel D, Appleby L, Arensman E, et al. (April 21, 2020). Suicide risk and prevention during the COVID-19 pandemic. *Lancet Psychiatry*, 4/21/20 https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(20)30171-1/ fulltext

Herinckx H. A., Swart S. C., Ama, S. M., Dolezal, C. D., & King, S. (2005). Rearrest and linkage to mental health services among clients of the Clark County mental health court program. *Psychiatric Services*, *56*(7), 853–857. https://doi.org/10.1176/appi.ps.56.7.853

Irish Penal Reform Trust (2019). *Progress in the Penal System (PIPS): A framework for penal reform*. https://www.iprt.ie/site/assets/files/6470/pips2018.pdf

Irish Penal Reform Trust (2020). *Making Rights Real for People with Disabilities in Prison*. https://www.iprt.ie/site/assets/files/6611/people_with_disabilities_in_prison.pdf

Kolla, N. J., Malcolm, C., Attard, S., Arenovich, T., Blackwood, N., & Hodgins, S. (2013) Childhood maltreatment and aggressive behaviour in violent offenders with psychopathy. *Canadian Journal of Psychiatry*, *58*, 487–494. https://doi.org/10.1177/070674371305800808

Lansdell, G., Saunders, B., Eriksson, A., Bunn, R. & Baidawi, S. (2018). 'I am not drunk, I have an ABI': findings from a qualitative study into systematic challenges in responding to people with acquired brain injuries in the justice system. *Psychiatry, Psychology and Law*, *25*(5), 737-758. https://doi.org/10.1080/13218719.2018.1474818

Li, M., D'Arcy, C., & Meng, X. (2016). Maltreatment in childhood substantially increases the risk of adult depression and anxiety in prospective cohort studies: systematic review, meta-analysis, and proportional attributable fractions. *Psychological Medicine, 46*(4), 717–730. https://doi.org/10.1017/s0033291715002743.

Lu, W., Mueser, K. T., Rosenberg, S. D., & Jankowski, M. K. (2008). Correlates of adverse childhood experiences among adults with severe mood disorders. *Psychiatric Services, 59*(9), 1018–1026.

Manchak, S. M., Skeem, J. L., & Douglas, K. S. (2008). Utility of the Revised Level of Service Inventory (LSI-R) in predicting recidivism after long-term incarceration. *Law and human behavior*, *32*(6), 477-488. https://doi.org/10.1007/s10979-007-9118-4

Maslow, A. H. (1943). A theory of human motivation. *Psychological Review, 50*(4), 370-96. http://psychclassics.yorku.ca/Maslow/motivation.htm

Mitton, C., Simpson, L., Gardner, L., Barnes, F., & McDougall, G. (2007). Calgary Diversion Program: A Community-based Alternative to Incarceration for Mentally Ill Offenders. *The Journal of Mental Health Policy and Economics, 10*(3), 145-151.

McCartan, K. (2020). *Trauma-informed Practice*. HM Inspectorate of Probation: Academic Insights 2020/05. https://www.justiceinspectorates.gov.uk/hmiprobation/wp-content/uploads/sites/5/2020/07/Academic-Insights-McCartan.pdf

Moore, M. & Tatman, A. (2016). Adverse Childhood Experiences and Offender Risk to Re-offend in the United States: A Quantitative Examination. *International Journal of Criminal Justice Sciences*, *11*, 148-158. http://www.sascv.org/ijcjs/pdfs/moore&tatmanijcjs2016vol11issu2.pdf.

Phillips, J., Padfield, N. & Gelsthorpe, L. (2018). Suicide and community justice. *Health Justice*, *6*, 14. https://doi.org/10.1186/s40352-018-0072-7.

Porporino, F. (2015). New Connections: Embedding Psychology Services and Practice in the Irish Prison Service. http://www.irishprisons.ie/wpcontent/uploads/documents_pdf/porporino_report.pdf

Pournaghash-Tehrani, S., & Feizabadi, Z. (2009). Predictability of physical and psychological violence by early adverse childhood experiences. *Journal of Family Violence*, *24*, 417-422. https://doi.org/10.1007/s10896-009-9245-4

Revolving Doors Agency (2017). *Rebalancing Act. A Resource for Directors of Public Health, Police and Crime Commissioners, the Police Service and Other Health and Justice Commissioners, Service Providers and Users.* London: Revolving Doors Agency.

Sheffler, J. L., Stanley, I. and Sachs-Ericsson (2020). Chapter 4: ACEs and mental health outcomes 'in' *Adverse Childhood Experiences: Using Evidence to Advance Research, Practice, Policy, and Prevention*. Edited by Asmundson, G. J. G. and Afifi, T, O. (2020). Elsevier Inc. Amsterdam.

Sirdifield, C. (2012). The Prevalence of Mental health Disorders amongst Offenders on Probation: A literature review. *Journal of Mental Health*, *21*(5), 485–498. doi.org/10.3109/09638237.2012.664305

Skeem, J. L., Emke-Francis, P., & Louden, J. E. (2006). Probation, Mental Health, and Mandated Treatment: A National Survey. *Criminal Justice and Behavior*, *33*(2), 158–184. https://doi.org/10.1177/0093854805284420

Skinner, G. C. M. & Farrington, D. P. (2020). A systematic review and meta-analysis of offending versus suicide in community (non-psychiatric and non-prison) samples. *Aggression and Violent Behavior* (in press). http://doi.org/10.1016/j.avb.2020.101421.

Treisman, K. (2020). *A Treasure box for Creating Trauma-informed organizations: A ready to use resource for trauma, adversity, and culturally informed, infused, and responsive systems*. Jessica Kingsley Publishers. London.

Young, S., Gudjonsson, G., Chitsabesan, P. *et al.* (2018). Identification and treatment of offenders with attention-deficit/hyperactivity disorder in the prison population: a practical approach based upon expert consensus. *BMC Psychiatry 18***,** 281. https://doi.org/10.1186/s12888-018-1858-9

Weisman, R., Lamberti, J. & Price, N. (2004). Integrating Criminal Justice, Community Healthcare, and Support Services for Adults with Severe Mental Disorders. Psychiatry Quarterly, *75*, 71–85. https://doi.org/10.1023/B:PSAQ.0000007562.37428.52

Whitfield, C. L., Anda, R. F., Dube, S. R., & Felitti, V. J. (2003). Violent childhood experiences and the risk of intimate partner violence in adults: Assessments in a large health maintenance organization. *Journal of Interpersonal Violence, 18*(2), 166-185. https://doi.org/10.1177/0886260502238733