

A Practitioner's Response to 'Probation and Mental Health: Do We Really Need Equivalence?'

Laura Cotter and Kim McDonnell*

Summary: This paper is a practitioner's response to 'Probation and mental health: Do we really need equivalence?', written by Charlie Brooker and published in *Irish Probation Journal*, 2021. Brooker's article provides robust data that highlight the need to ensure that mental health no longer remains the 'poor relation' in probation practice. This response focuses on the significance of research; the prevalence of mental health problems amongst those subject to probation supervision; the high incidence of comorbidity; levels of unmet need arising from difficulties with access to appropriate services; and the challenges of working with suicide ideation. The paper explores how the findings from Brooker's research are reflected in an Irish context, drawing from the authors' lengthy and direct experience of working with clients with mental health difficulties. Both practitioner authors are members of the Probation Service Mental Health Working Group, established in 2018.

Keywords: Mental health, probation, probation practice, prevalence, dual diagnosis, suicide, equivalence, research.

Introduction

Brooker opens his article with the term, 'Zeitgeist', possibly not a familiar term to some, described as 'the defining spirit or mood of a particular period of history as shown by the ideas and beliefs of the time'. He maintains that this is applicable to what is currently happening with the issue of mental health, for too long a neglected area within probation practice. It is encouraging that this 'spirit' is also visible in the Irish Probation Service, and Brooker's article prompted reflection by the authors on some initiatives that have shaped and informed a changing approach.

Griffin (2008) conducted one of the first probation practitioner studies, which explored experiences of mental ill-health, trauma and bereavement,

* Laura Cotter is a Probation Officer based in Dundalk (email: ldcotter@probation.ie). Kim McDonnell is a Senior Probation Officer based in Limerick (email: kxmcdonnell@probation.ie).

based on a review of 112 community supervision cases. Of the people reviewed, 39 per cent were identified as having a mental health problem over the course of their lives. Cotter (2015) examined whether the needs of offenders with mental health difficulties were addressed in prison and on probation supervision in the community. This was the first study to suggest that the prevalence of mental illness among offenders on probation across Ireland was high. The following year, Foley (2016) examined the prevalence and nature of mental health issues amongst those on supervision in one region of the Probation Service. The findings focused on the prevalence of a range of mental health difficulties, as well as highlighting high levels of dual diagnosis. These practitioner studies combined to shine a light on this neglected area, informing a shift in Probation Service focus and commitment.

The Probation Service *Annual Report, 2017* (p. 11) highlighted that ‘the consideration of mental health issues is an on-going concern for Probation Officers’. The Service expressed its commitment to increasing awareness in relation to mental illness, personality disorder and indicators of self-harm/suicide amongst staff. In 2018, delivering on that commitment, a Mental Health Working Group was established, and a senior psychologist was appointed. The ongoing work of the Mental Health Working Group, and the ground-breaking research conducted by Dr Christina Power, published in 2021 (frequently referenced in last year’s paper), has informed and expedited the setting-up of a high-level cross-departmental task force with members from the Probation Service, Mental Health and generic Health Service, the Irish Prison Service, An Garda Síochána and the Judiciary. When one considers the combined work of the high-level task force and the imminent publication of the *Probation Service Mental Health Action Plan*, based on Power’s research recommendations, it is fair to say that we too are experiencing our own ‘Zeitgeist’ in the Probation Service.

The prevalence of mental health problems in probation practice

Brooker’s paper is rich in statistical data drawn from studies across the UK and internationally, with a particular focus on the study undertaken with probationers in Lincolnshire. He comments on the dearth of research on probation and mental health in Ireland, noting that his trawl of previous Martin Tansey Memorial lectures revealed little or no reference to the issue. Conducting research in 2013, Cotter attempted to bridge this gap by drawing from data contained in the Level of Service Inventory-Revised (LSI-R)¹ risk

¹ The LSI-R is the approved actuarial risk assessment used by the Probation Service to classify risk of reoffending and to identify criminogenic needs.

assessments conducted in 2012. Analysis of the responses to five questions specifically targeting psychological or psychiatric functioning revealed that a high proportion of those on supervision had mental health needs, with Probation Officers identifying a significant percentage as requiring psychological assessment. As the research pointed out at the time, the 'scoring' of questions ranging across the categories of 'moderate interference', 'severe interference', 'active psychosis' and 'psychological assessment indicated' were at the discretion of the interviewer. The question raised then, and one that Brooker also highlights, is the issue of appropriate and targeted mental health training for Probation Officers. We will return to this later in the paper.

While progress has been slow at certain points, it is ongoing and, albeit seven years on, it is invaluable that a national study has now taken place. Power (2021) conducted three internal and incremental studies in the Irish Probation Service in 2019, exploring mental health among persons subject to probation supervision. Brooker (2021) discusses Power's key findings where over 40 per cent on a Probation Supervision Order compared to 18.5 per cent of the general population present with symptoms indicative of at least one mental health problem. Women present with higher rates of contact with services currently and in the past for mental health problems. Brooker also focuses on Power's finding that 50 per cent of those supervised by the Probation Service in the community who present with mental health problems also present with at least one or more of the following issues – alcohol and drug misuse; difficult family relationships; and accommodation instability (Power, 2021).

Just how vulnerable are those on probation to formal mental health problems?

Examination of the various data tables from Brooker's research clearly identifies the vulnerability of probationers to mental health difficulties. Both physical and mental health components are scored and benchmarked against the general population. Brooker (2021 p. 10) concludes: 'it is not only that health status is so poor, but death itself is far more likely especially for those at the point of leaving prison'. He compares the needs of probationers with those difficulties to probationers with no mental health difficulties, revealing a much higher level of unmet need and dissatisfaction in the first group. These findings will certainly resonate with practitioners as they did with the authors

of this paper. Attempting to address the needs of clients with a major mental health disorder can sometimes be a particularly daunting and lonely place in which to find yourself. There is a fear that you may not say or do the right thing when faced with a client who is severely mentally unwell, especially when they are not engaged with a mental health service. While it is possible to refer a client back to their doctor and support them with a referral to the Mental Health Service, the absence of a more direct and immediate referral pathway is a concern and a recurring frustration for Probation Officers.

Comorbidity

The challenge of working safely and effectively with mental health problems is even more complex when the mental health issue is comorbid with both drug and alcohol use. Brooker's findings from the Lincolnshire research on the prevalence of mental health disorders and co-occurring substance use (Table 3) are both interesting and important but will not be a source of surprise to most practitioners. The findings report on the co-existence of drug and alcohol use across a range of disorders, including mood, anxiety, psychotic and eating disorders, with scores ranging between 70 and 80 per cent.

Reflecting on one particular case of a homeless client who had a 'dual diagnosis' of schizophrenia and heroin dependency, it is acknowledged that there are real difficulties in establishing a relationship and engaging effectively when the community context is very chaotic. However, the absence of any protocol that could inform a collaborative case-management approach across the appropriate services, despite the well-intentioned efforts of individual professionals, compounded those difficulties even more. This man became increasingly unwell and eventually he was remanded in custody for an immediate psychiatric review by the prison In-Reach Psychiatric Team. The In-Reach service is only available in this dedicated remand prison, which processes approximately half of all remand cases in the State. The collaborative approach was very much in evidence within this setting. His mental health and drug use were stabilised, and, through case conferencing and effective liaison, a structured post-release supervision plan was put in place with a successful outcome. This process required the commitment of the Mental Health Service, the Addiction Services and the Probation Service within the prison and the community. It involved the housing support and Resettlement Officer in the prison, a referral to 'Housing First',² the local

² Housing First is a government initiative that provides participants with supported housing that involves intensive case management and assertive community treatment

Council authority, the social inclusion service, staff members from the homeless hostel where the man had previously resided, his family members and, most importantly, the client himself.

While this particular case resulted in an improved outcome for the client, it is important that custody should not be used as the vehicle to access mental health services. The detrimental impact of custody on mental health with specific regard to overcrowding and the use of isolation is well documented across a range of reports. 'Forced integration of mentally ill offenders with regular offenders as a result of overcrowding may be a contributing factor to the increased rates of mental ill-health, suicide and violence within the prison system' (European Committee for the Prevention of Torture [CPT] 2011, p. 21). Brooker's proposal around a model of 'Assertive Outreach' could well have provided the range of skills, proactive engagement in the community and sustained support in the aforementioned case, thus eliminating the need for recourse to containment. That proposal also aligns with Power's view that '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' (2021, p. 55).

Suicide in a probation supervision context

Brooker highlights in his article that 'safety to self is a key issue in probation'. Statistics on suicide, collated by the Ministry of Justice in England, provide an overview of prevalence and trends in a criminal justice context. In Ireland, data on suicide are captured by the Central Statistics Office (CSO). Of concern, in the context of responding to Brooker's article, is the limited availability of data on the prevalence, patterns and trends of deaths by suicide or suicide ideation amongst probationers or prisoners in Ireland.

The systematic reviews undertaken by Brooker and his colleagues illustrate the complexities of suicide ideation and the correlation with completed suicide. It is accepted that there is no single cause or risk factor that can sufficiently explain a suicidal act. What we do know from the work of the National Office for Suicide Prevention (NOSP) in Ireland is that one in four people will use a mental health service at some stage of their lives. The NOSP research also shows a strong link between mental health difficulties and death by suicide and that alcohol and other substance-use disorders are found in 25 to 50 per cent of all suicides. There is also a significant link between

economic factors – like social deprivation, homelessness and poverty – and suicidal behaviour. All of those issues are more prevalent in our client group, with increased vulnerability to self-harm and completed suicide. It should also be highlighted that people who engage in self-harm are at an increased risk of dying by suicide, compared to those who do not engage in self-harm.

The message from NSOP is that suicide prevention is everyone's concern. The national strategy – *Connecting for Life* – is all about connection. It stresses the importance of connection to family, to friends and to community, to mitigate against isolation. It suggests that if services are connected, then people can 'get the right help, at the right time, in the right place'. Yet frustratingly (as Brooker cites in his article), there is an assumption that offenders are 'dangerous'. As a consequence, many services may become or remain inaccessible to our clients – thus creating further isolation, discrimination and stigmatisation.

Brooker indicates that the rate of suicide amongst Probation clients between 2010/11 and 2015/16 was nine times higher than in the general population, higher than amongst the prison population, and, disturbingly, the risk of suicide is much higher in the first few weeks post release. Research in the Probation Service (Power, 2021) indicated that 10 per cent of clients reviewed contemplated death by suicide or made plans to die by suicide. It is encouraging that, despite the limitations with data collation, the organisation has become increasingly responsive to the devastating impact of suicide and self-harm on clients and their families and the related impact on the supervising practitioner. Four Probation staff are accredited as trainers of the Skills Training on Risk Management (STORM®) programme. This has facilitated a national roll-out of the training to all staff, to increase understanding and competence around strategies that increase awareness of suicide ideation and interventions to mitigate the risk of self-harm and completed suicide.

This training, combined with the work that is currently underway in relation to closer collaboration with mental health services, does meet some of the concerns expressed by Brooker in relation to strategic commitments by the National Probation Service (NPS) in England and Wales. He believes that 'there is a lack of clarity about the role Probation staff should undertake in relation to the assessment and recognition of mental health disorders and suicidality' within the approach of the NPS. Those who completed the STORM® training say that it helped them to acknowledge the clients' distress and respond appropriately. Probation Officers were encouraged by the fact that the

assessment of suicide intent has changed to reflect a person-centred approach and said that it helped them in meeting a 'duty of care' to clients who express thoughts of self-harm or wanting to die by suicide. However, we recognise that internal agency training is not of itself sufficient because, as Brooker states, 'people on probation are a very high-risk group for completed suicide' and so organisational upskilling must be complemented by high-quality interagency collaboration between justice agencies and mental health services, to reduce the likelihood of death by suicide amongst this group of people.

Concluding reflections

Brooker's paper and related research provide a very valuable resource that challenges our thinking and informs our continuing work in this area. As practitioners, we recognise that we have some way to go to reach the point where we are comparing types of disorders and the needs of probationers with these disorders, and ascertaining their satisfaction with the level of help received, as described through Brooker's research in the United Kingdom. We are very much at the stage of identifying the challenges for practitioners and the barriers to services for this client group. However, as the enormity of the situation has been confirmed through Power's work, and with the imminent publication of the related Action Plan, we are hopeful that the road ahead does not appear as bleak. With a focus on training and improved skill level within this area, we feel that there is a move in the right direction towards removing the fear/anxiety that exists with regard to meeting the needs of clients with severe mental illness.

While greater progress is required in relation to high-level multi-agency collaboration, we must also question what we as practitioners can do to improve practice and service delivery. What is our vision for the future? Is there another way? Returning to Brooker's original question, 'Probation and mental health: Do we really need equivalence?', he comments that originally it was thought that equivalent mental health services were what was needed. What Brooker now concludes is that due to the complexity of needs among probation clients, the reality unfortunately is that these equivalent services do not exist, and he proposes a model that is based on the principles of Assertive Outreach.

As part of Assertive Outreach (a model used widely here in addiction and homeless services), teams of practitioners focus on engagement and addressing crucial needs, such as housing, education and employment, as

well as mental health, with hard-to-reach clients. This proposal merits further exploration, particularly as Probation Officers currently engage in elements of Assertive Outreach, a practice that could be further enhanced through the establishment of formal protocols and shared interdisciplinary training. Brooker (2021) also suggests that the role of the Probation Officer in mental health needs to be clarified, especially in relation to the assessment and recognition of mental health disorders and suicidality. Cotter (2015) discussed the idea of 'specialised mental health caseloads', involving smaller caseloads with intensive interventions managed by expert Probation Officers. It is also suggested that mental health clinicians should extend their notions of interdisciplinary teams to include Probation Officers. Power (2021) also suggests that there is a strong case for specialist mental health Probation Officers who hold specialised caseloads. A common thread weaving throughout this piece has been the need for clarity of role and transparent referral pathways to the mental health services. A model that combines an Assertive Outreach approach with specialised mental health Probation Officers could work towards addressing this gap. Improving outcomes for clients is the ultimate goal.

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