



Probation's Role in Offender Mental Health

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Probation's Role in Offender Mental Health

Purpose: To examine how the role in offender mental health for the probation service described in policy translates into practice through exploring staff and offenders' perceptions of this role in one Probation Trust. In particular, to examine barriers to staff performing their role and ways of overcoming them.

Design: Qualitative secondary analysis of data from semi-structured interviews with a purposive sample of 11 probation staff and 9 offenders using the constant comparative method.

Findings: Both staff and offenders defined probation's role as identifying and monitoring mental illness amongst offenders, facilitating access to and monitoring offenders' engagement with health services, and managing risk. Barriers to fulfilling this role included limited training, a lack of formal referral procedures/pathways between probation and health agencies, difficulties in obtaining and administering mental health treatment requirements, problems with inter-agency communication, and gaps in service provision for those with dual diagnosis and personality disorder. Strategies for improvement include improved training, developing a specialist role in probation and formalising partnership arrangements.

Research Limitations: Further research is required to explore the transferability of these findings, particularly in the light of the recent probation reforms.

Originality: This is the first paper to explore how staff and offenders perceive probation's role in offender mental health in comparison with the role set out in policy.

Keywords: probation service, mental health, qualitative secondary analysis, transforming rehabilitation, qualitative research, offender health

Paper type: research paper

Introduction

The limited research on the prevalence of mental illness amongst offenders on probation utilises a variety of methodological approaches, and often focuses on a sub-section of the population (e.g. those in probation approved premises). This makes comparison between studies problematic (Sirdifield, 2012). However, one can cautiously conclude from this literature that the prevalence of mental illness in probation populations around the world is high in comparison to the general population, and the prevalence of some disorders is higher in females than in males (see Sirdifield (2012) for more on this).

UK research undertaken in one probation Trust suggests that 38.7% of probationers have a current mental illness, and 48.6% have a past/lifetime disorder (Brooker et al., 2012). Moreover, there is a high rate of co-morbidity and dual diagnosis in this population, with over half of those with a current mental illness screening positive in more than one diagnostic group, and 72.3% also having a substance misuse problem (Brooker et al., 2012). This high prevalence and complexity of mental illness amongst probationers raises the question of what policy suggests probation's role in offender mental health should be, and how this translates into practice.

The probation service in England and Wales works with adult offenders on community orders, suspended sentences and on licence, including high-risk offenders. Its role includes providing advice to the courts to inform sentencing decisions, enforcing sentences, public protection, and offender rehabilitation. There is a tension between 'care' and 'control' in probation practice. Like many probation services in Europe it was founded in philanthropic principles. It then adopted a largely rehabilitative/'treatment' orientated approach to working with offenders (McWilliams, 1985, Vanstone, 2004), and has since been subject to many reforms and changing messages about the extent of, and rationale for, any focus on offenders' welfare needs.

Briefly, the literature charts a shift in policy from the collapse of the rehabilitative-scientific ideal (Bottoms and McWilliams, 1979) to probation becoming an increasingly managerial and risk-orientated service (Newburn, 2003, Whitehead and Statham, 2006). Concerns have been expressed that the balance between 'care' and 'control' could tip so far that traditional values would be lost (Whitehead and Statham, 2006). However, studies of the overall role of probation staff report that despite pressure to adopt an increasingly 'target-orientated' approach, staff remain motivated by 'people-centred' factors, and focused on providing welfare to offenders (Annison et al., 2008, Farrow, 2004, Willis, 1986).

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3 There have recently been major changes to the criminal justice landscape. When the data for the
4 research presented here were collected, probation consisted of Probation Trusts. Following
5 *Transforming Rehabilitation* (Ministry of Justice, 2013) probation has been restructured into a public
6 sector National Probation Service (NPS), and 21 Community Rehabilitation Companies (CRCs)
7 consisting of private and voluntary sector organisations. The impact these changes on probation's
8 role in offender mental health remains to be seen.
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13 Several policy documents and reports outline a role for the probation service in offender mental
14 health (Table 1).
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17 [Table 1 here]
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20 Firstly, this involves working in partnership with health and social care agencies. The precise role
21 expected of individual agencies within such partnerships is somewhat unclear in the literature, but
22 ultimately they aim to ensure that offenders' mental health needs are identified and inform
23 healthcare commissioning, and offenders are supported to access to services.
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27 Secondly, probation's role centres on providing information to the courts to inform sentencing and
28 bail decisions, including diverting offenders away from custody when appropriate (Home Office,
29 1990, HMI Probation et al., 2009). Staff advise on the use of 'mental health treatment requirements'
30 (MHTRs) for offenders with a mental illness that does not require treatment in a secure in-patient
31 setting. To be able to consider mental health needs when advising the courts, probation staff need
32 knowledge of the signs and symptoms of mental illness, and local healthcare provision, although
33 increasingly support is provided by court liaison and diversion services.
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40 Despite some lack of clarity in the literature on the nature of the relationship between mental illness
41 and re-offending (Peay, 2011), identifying and addressing mental health needs has been cited as a
42 pathway out of re-offending (Home Office, 2004, Social Exclusion Unit, 2002). Research suggests that
43 new ways of working (e.g. specialty caseloads) may contribute to improving compliance with
44 community orders and reducing re-offending (Heilbrun et al., 2012, Skeem and Eno Loudon, 2006,
45 Ministry of Justice, 2014). Thus there is increasing focus on addressing offenders' welfare needs as a
46 means of reducing re-offending rather than simply as an end in itself.
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52 In summary, the role expected of probation involves advising the courts on alternatives to prison
53 such as the use of MHTRs; working in partnership to ensure that offenders' health and social care
54 needs are met, and (potentially) contributing to improving compliance and reducing re-offending
55 through focusing on mental health.
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3 It is important to understand how this role translates into practice. However, to our knowledge, no
4 research in the UK has directly focused on this area. This paper explores how staff and offenders in
5 one Probation Trust perceived the role of probation in offender mental health prior to the recent
6 reforms. It highlights barriers that need to be overcome to aid staff in performing their role, and
7 considers the implications of these findings in relation to the latest reforms.
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11 12 13 14 **Methods**

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16 Qualitative secondary analysis was conducted with data from semi-structured interviews with 11
17 probation staff and nine offenders. Interviews were conducted by a Research Assistant previously
18 employed by probation, a Clinical Studies Officer (CSO), and two service user representatives. For
19 safety reasons, and to enable note-taking in case of recording failure, the Research Assistant and
20 CSO worked as a pair and the service user representatives worked as a pair. A purposive sample of
21 24 offenders and 20 probation staff was selected based on 'appropriateness' and 'adequacy' (Morse
22 and Field, 1996). Consequently it comprised offenders with a current mental illness and experience
23 of accessing mental health services, and staff performing offender management roles.
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30 Ethical approval was provided by the Local Research Ethics Committee in March 2009
31 (08/H0403/151). Participants received literacy-screened information sheets and consent forms and
32 gave informed consent to the interviewer. They received a £10 store voucher for their time. Nine
33 offenders were contactable and consented to participate. The remainder were either unreachable or
34 they declined participation. After 11 staff were interviewed all of the offices across the county had
35 been represented, and data saturation was reached. Participants were a mix of males and females,
36 although (like the wider caseload) most offenders were male.
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42 Secondary analysis is "the use of an existing data set to find answers to a research question that
43 differs from the question asked in the original or primary study" (Hinds et al., 1997). This approach
44 enables researchers to make maximum use of existing data rather than unnecessarily involving
45 participants in further primary research. Several issues should be considered before conducting such
46 analyses. Firstly, "the extent to which the research purpose of the secondary analysis can differ from
47 that of the primary study" (Heaton, 2008, Hinds et al., 1997, Long-Sutehall et al., 2010), secondly,
48 "the degree to which the data generated by individual qualitative methods are amenable to a
49 secondary analysis" (Hinds et al., 1997, Long-Sutehall et al., 2010), and thirdly, how familiar the
50 researchers are with the context of the primary study and the original recordings (Heaton, 1998,
51 Hinds et al., 1997, Szabo and Strang, 1997).
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3 The first question is important for considering whether re-use of data would violate the original
4 ethical agreement (Heaton, 1998), and whether there are enough data of sufficient depth to answer
5 the new research question. The primary study drawn upon here asked 'what are probation staff and
6 offenders' experiences of trying to access (or facilitate access to) healthcare services' and 'what
7 barriers need to be removed to facilitate engaging this client group with appropriate services'? Many
8 of the interview questions were relevant to the secondary research (Table 2), which explored how
9 staff and offenders in one Trust perceived probation's role in offender mental health, what (if any)
10 barriers exist to staff performing their role, and how these could be overcome. Thus, we believed
11 there were sufficient data in which participants described the role of probation in offender mental
12 health and barriers that they encountered to justify the secondary analysis.
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20 [Table 2 here]

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22 The second question relates to the extent of missing data within the dataset. The purpose of the
23 primary study was 'data gathering' rather than theory generation. Therefore, all participants
24 answered the same questions, and there was no problem with missing data.
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28 Regarding the third question, CS was part of the team conducting the primary study. She was
29 familiar with interview context and had access to all of the digital recordings, allowing her to hear
30 participants' tone of voice and emphasis.
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33 Interviews were transcribed verbatim, imported into NVivo 8, and analysed using the constant
34 comparative method (Glaser and Strauss, 1999) (Figure 1). Initially, text was coded into 'free nodes'
35 based on the meaning of each segment, with care being taken to code sufficient text for each
36 segment to retain meaning when read out of context (Coffey and Atkinson, 1996, Tesch, 1990). Each
37 segment of text was considered in relation to text within existing codes. Through this iterative
38 process the boundaries of each code were established, and sub-codes were created. As participants
39 were drawn from a relatively small population, to preserve participants' anonymity individual
40 identifiers are not displayed in the analysis. However, staff responses can be differentiated from
41 offender responses, and the commentary indicates the proportion of participants expressing the
42 views described. Several techniques supported the trustworthiness of the analysis (Lincoln and
43 Guba, 1985) including an audit trail of decision-making, critical reflection, negative case analysis,
44 triangulation of sources, and presenting excerpts from the transcripts.
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53 [Figure 1 here]

Findings

This section presents the themes derived from the analysis and explores their relationships with each other. It details how participants described probation's role in offender mental health; and cross-cutting themes about factors affecting how this role is performed, barriers identified to staff performing their role, and strategies for overcoming them.

Participants' descriptions of probation's role in offender mental health

Both staff and offenders defined probation's role in offender mental health as involving a) identifying and monitoring mental illness amongst offenders, b) facilitating access to and monitoring offenders' engagement with health services, and c) managing risk. Staff placed a boundary on the first of these aspects, stating that whilst they may be expected to recognise potential signs and symptoms of mental illness amongst their caseload, they are *not* expected to diagnose or treat mental illness. This was reflected in one offender interview too.

Several cross-cutting themes were identified (Figure 2) around staff's ability to perform their role, and influencing how it was performed (see below).

[Figure 2 here]

Knowledge and understanding

Staff received very little formal mental health training. They relied on other sources of knowledge to identify and monitor mental illness amongst offenders. These included *a priori* knowledge from personal experience and/or previous work experience; learning 'on-the-job'; documents (e.g. psychiatric reports); and knowledge from social interactions with offenders, colleagues, and staff from other agencies. Consequently, staffs' approach to identifying and monitoring mental illness varied according to their prior experiences, work experience, and approaches to obtaining information from external sources. Whilst negative case analysis revealed that some staff felt that they had sufficient knowledge to perform this aspect of their role well, many desired more training, and many stated that they are not 'experts' in mental health. Staff particularly wanted to learn practical skills around working with people with mental illness:

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3 Staff: it's about...how to maybe engage someone with borderline personality
4 disorder...somebody with schizophrenia and maybe to be aware of...signs or indications that
5 it's deteriorating because I only know the basics
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9 *Care versus control*

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11 The broader tension between 'care' and 'control' in probation practice was also evident in
12 probation's role in offender mental health. Focus on offenders' mental health needs was often
13 viewed as voluntary, rather than a formal part of a community order (with the exception of cases
14 with a MHTR). Some staff believed that there should always be a focus on mental health:
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19 Staff: Something that's a key factor is looking at what needs they have as an individual that
20 could be met or supported through us...to get them the right support not only to address
21 their offending but to meet their needs
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24 For others, focusing on mental health was more of a priority if it appeared to be linked to offending
25 behaviour (i.e. was a criminogenic need):
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28 Staff: If someone has got mental health issues it's also looking at if it's a priority. For me if
29 it's linked to their offending...would be a key one
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32 Staff: Obviously we have some commitment to help them with their mental health, more so
33 if their mental health issues are related to risk to themselves or other people
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36 Whether or not mental health was viewed as a criminogenic need varied on a case-by-case basis:
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39 Staff: It depends on the individual you've got in front of you...it's an individual assessment.
40 Mental health is not necessarily an automatic factor...but clearly you know there are...in
41 some cases it's overwhelming it's a factor
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44 Moreover, the relationship between mental health and offending was perceived as being mediated
45 by substance misuse – people self-medicating for mental illness, or mental illness being believed to
46 be caused by drug misuse:
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49 Interviewer: how close do you think the connection is between offending and mental
50 health?
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52 Staff: In some cases I think they are very connected in others not so much...I've got one
53 guy...his is linked very very closely with mental health issues...now whether that's caused by
54 drug misuse or whatever else...
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57 Staff: It's an individual thing. I'm supervising somebody at the moment who I believe his
58 mental health affected his offending...he was very low in mood, depressed etcetera and I
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3 believe because of that he was drinking to counteract the way he was feeling...so for him I
4 don't believe he'd have committed the offence if his mental health had been average or
5 good or whatever
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9 Criminogenic and wider welfare needs were also viewed as interwoven, suggesting that staff should
10 focus on them not only as an end in itself, but as a means of reducing risk and improving compliance:
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13 Staff: The priority for us has got to be risk...so if for example...not having accommodation
14 increases their likelihood of alcohol misuse which then increases their risk then [we]...are
15 more likely to concentrate on accommodation. However I personally don't think that you
16 can support or change or...empower...without somebody being stable...you can use the
17 punitive elements like curfews...but there has to be the welfarist considerations as well
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19
20 Staff: Putting forward some sort of package to sort of support all their needs and specifically
21 as a probation officer criminogenic needs...However we do pick up...on...other areas that
22 help people's stability that might not be criminogenic but...it helps them... in terms of
23 compliance
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26 Most offenders expressed their appreciation for staff adopting a caring, understanding and flexible
27 approach, which included empathy, and discretion:
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30 Offender: They were actually better than the mental health service. Their support and their
31 compassion, their empathy...a lot more adaptive...There were times when I couldn't get here
32 because of a bout of anxiety...and she would come and visit me at my home and delay
33 appointments, work my appointments around appointments with my psychiatric nurse
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37 Indeed, a third of offenders described probation staff as providing a 'listening ear' or acting like a
38 'life coach':
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41 Offender: It's kind of like having a life coach more than anything else
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44 Offender: They were there as an information, as a support, not...somebody with a big stick
45 who's going to beat you every time you step out of line
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47 However, some participants felt that the amount of discretion staff have should be increased:
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49
50 Offender: I'm too worried about where I'm going to sleep tonight, where I'm going to wake
51 up tomorrow, what I'm going to eat rather than you've got to have your probation. If you
52 don't stick to your appointment you get breached and you're back in jail and...there's no give
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55 Staff: I'm having to breach this young man because he hasn't been in touch with me...and
56 I'm really loath to do it...However I'm going to have to
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3 The analysis indicated a relationship between two aspects of probation's role - facilitating access to
4 and monitoring offenders' engagement with health services, and managing risk. The type of action
5 that staff take to address offenders' mental health needs related to their assessment of risk, with
6 more emphasis being placed on monitoring mental health and ensuring that offenders engage with
7 external agencies in high risk cases:
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11 Staff: the level of monitoring differs with each case. I mean if I thought that someone was
12 deteriorating quickly and you know was a risk to themselves then certainly I would definitely
13 get another agency involved
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17 Thus both staff and offenders discussed probation's role in offender mental health in relation to
18 both 'care' and 'control'. Staff work flexibly to support those with mental health needs, but variation
19 was apparent in the circumstances in which they would do this.
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22 23 24 25 *Individualised referral networks and processes*

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27 Staff discussed barriers to facilitating access to and monitoring offenders' contact with health
28 services. Firstly, a lack of formal training, knowledge of mental health services and referral
29 procedures, and service level agreements. Staff did not take a uniform approach to this aspect of
30 their role. Instead, they had developed their own individualised referral networks and processes.
31 Staff and offenders stated that a first step to link someone known or suspected to be mentally ill
32 with appropriate services was a referral to a GP. One offender stressed that registering with a GP
33 can be problematic, particularly for those that are homeless.
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37 Starting with a GP could be seen as the 'best route' (particularly for those with a common mental
38 illness), or result from a belief that staff were unable to refer directly to mental health services. For
39 some this was an area of confusion:
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46 Staff: I don't think I mean I could be wrong, that I can make a referral to mental health
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49 Staff: I spoke to my manager about it and she wasn't sure whether we should be doing that
50 directly without going through the GP
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53 Other routes, included encouraging self-referral, direct referrals into mental health services, and
54 referring via a Health Support Service within the Trust (a multi-agency team focused on providing
55 health advice and brief interventions and improving offenders' access to mainstream health
56 services). Offenders discussed these routes, with one participant believing that probation could act
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3 as an advocate to reduce waiting times for service access. Conversely, one offender stated that
4 probation could not refer directly to mental health services.
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8 Just over a third of staff reported direct referrals to be rare. This may be due to the confusion
9 outlined above, or a lack of knowledge of mental health services. Some staff attributed this to
10 offenders having engaged with services prior to their community order:
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15 Staff: they're quite often in the system by the time they get to me anyway
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17 Interviewer: How often do you make referrals to mental health services?

18 Staff: Very rarely...they are either already engaged with the service... or they've been
19 referred by the time they come to me...and are waiting for an assessment
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22 This was supported by data from a third of the offender interviews:
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25 Offender: ...all the help was offered but I was already in the mental health system and I'd
26 already been assigned a psychiatric nurse ...so there wasn't really anything that they could
27 do for me that I hadn't already had done
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30 When staff did liaise directly with services, they had developed their own individual networks in
31 terms of which services they worked with and how, which also varied according to their perception
32 of offenders' needs, and the extent of an offender's prior engagement with services:
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36 Staff: I tend to work a lot with the Assertive Outreach Team in [place]...and I work quite a lot
37 with them in [place] which is quite unusual I think
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39 Staff: I'm a fan of working with a bloke called [name] from [service]...he's the kind of
40 specialist mental health homes type worker
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43 Some staff suggested that it would be beneficial to create a more formal referral procedure or
44 agreement with external agencies. Some participants also suggested creating a specialist worker
45 role:
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49 Staff: It would be nice if we had somebody within the service...who we could just...sort of
50 ring up and just bat something by really...I think it would give me more confidence in
51 thinking I've done the right thing
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56 *The importance of a trusting relationship*
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3 Staff and offenders stated that the quality of the relationship between staff and offenders affected
4 the likelihood of an offender being open and honest, and consequently of staff identifying that
5 someone was unwell and/or needing support. Two offenders illustrated this in detail:
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9 Offender: it depends on the person...I didn't trust them so I see them as a hindrance more
10 than a help...the one I've got at the moment's like the best one I've ever had in my life...we
11 got to a situation where she helped and like I kind of opened up to her. Rather as before I
12 could come and see the probation...they'd ask...[are you] alright and my life was
13 ****ed,...and I'd still lie to her and say "yeah everything's great"
14

15 Interviewer: but you feel that the probation service do recognise the mental health
16 problems that are

17 Offender: Yeah I do actually...If you're honest with them...because I have lied to them for
18 years like, but it's come to a stage where you think well it's about time I started telling the
19 truth really...they can't recognise it if you're not honest with them
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22 23 *Inter-agency communication*

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25 Another barrier to facilitating access to and monitoring offenders' engagement with health services
26 was problems with inter-agency communication and agencies' understanding of each other's remits,
27 even in cases with MHTRs. Indeed, MHTRs were described as hard to obtain. This was another area
28 in which participants said a specialist role could help:
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33 Staff: GPs or some of the mental health providers not being aware of what probation do and
34 the reasons for why we're calling...we don't really know their policies and procedures...that
35 sort of stuff
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37 Staff: probation would benefit from having a specialist mental health worker...that would
38 help with the communication aspect as well.....they do it over at the Youth Offending
39 Service and it works excellently...you're talking to somebody while you're making a cup of
40 tea and it...just stops those barriers
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43 Staff experienced difficulties in obtaining information from external agencies, and variation in what
44 information individuals would share:
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48 Staff: I mean there's conflicting legislation we have the Crime and Disorder Act 1998, which
49 sort of enforces that authorities must comply when it comes to offending or risk of harm yet
50 then we have the Data Protection legislation which says "ooh don't share information"...
51 sometimes you find yourself getting quite frustrated as when you're talking to ...a Social
52 Worker that's saying well "I can't share that information"
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56 57 *Gaps in service provision*

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3 Finally, participants pointed to a gap in service provision for those with dual diagnosis and/or a
4 personality disorder:
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7 Staff: The mental health side is saying well we can't do anything with them while they're
8 self-medicated, can't properly diagnose and obviously I have, perhaps have trouble getting
9 them to sort out their alcohol and drugs because obviously their mental health isn't stable
10 enough to keep up appointments so...it's like a chicken and egg situation
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14 Offender: OK you've got depression which is a mental illness, so they tend to put you on
15 anti-depressants and discharge you within a matter of days...and as for anything else i.e.
16 personality disorder, it costs too much money and too much time
17

18 19 Discussion

20 21 22 *Summary of Findings*

23
24 Policy outlines a role for probation in England and Wales in offender mental health involving advising
25 the courts on sentencing and working in partnership with other agencies to ensure that offenders'
26 health and social care needs are met. This role was broadly reflected in interview data from both
27 staff and offenders. However, staff encounter several gaps, limitations and barriers to performing
28 their role, and there is variation within and between staff in how they perform their role. Several
29 factors may explain this variation. Whilst some staff stated that probation should always focus on
30 offender mental health, in many cases the extent of this focus was determined by an offender's
31 perceived level of risk, whether they were subject to a MHTR, and whether mental health was
32 judged to be a criminogenic need. Some offenders praised staff's discretion and flexibility in relation
33 to enforcing the conditions of their order because of difficulties with attendance resulting from poor
34 mental health. However, both offenders and staff believed increasing staff's powers of discretion
35 would be helpful.
36

37
38 Limited formal training and a lack of service-level agreements resulted in variation in staff's
39 confidence in identifying mental illness, and the referral routes they used. Clarification was needed
40 on whether direct referrals into mental health services could and should be made, or whether access
41 should be via primary care.
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45 The analysis also highlighted the importance of staff developing a trusting relationship with
46 offenders to encourage an open and honest dialogue about their mental health. Finally, there were
47 problems with inter-agency communication, obtaining MHTRs, and gaps in service provision.
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Strengths and Limitations

To our knowledge, this is the first study to specifically investigate probation's role in offender mental health. The role was investigated from both offender (n=9) and staff (n=11) perspectives. The study was a secondary analysis of a small-scale study in one Probation Trust. There were practical constraints on the number of offender interviews that we were able to conduct, but we feel that the depth of data contained in the interviews was sufficient for this to be an adequate sample. Staff were interviewed from all probation offices within the Trust, but as participation was voluntary, they may have had an above average interest in mental health. Staff also acted as gatekeepers to the offender participants. Analysis was restricted to an existing dataset so it was not possible to generate new data based on emerging themes or to pursue emerging questions such as the potential influence of length of service on practice and/or perceptions, or the influence of offending history on offenders' perceptions (Szabo and Strang, 1997).

Numerous steps were taken to ensure the trustworthiness of the findings (Lincoln and Guba, 1985). Credibility was enhanced through the approach taken to sampling and the triangulation of data within and between staff and offender interviews. Moreover, the interviewers' backgrounds were varied, reducing the risk of bias resulting from the influence of a single interviewer. Using the constant comparative method improved credibility by encouraging constant questioning of coding, and negative case analysis was used throughout (Lincoln and Guba, 1985, Patton, 1990). Dependability and confirmability were enhanced by keeping an audit trail, and transparent presentation of data excerpts. Transferability is considered below.

We know from the limited literature available that the prevalence of mental health disorders amongst offenders on probation is high in many countries (Sirdifield, 2012), and that probation has a role supervising people with mental illness in many countries (van Kalmthout and Durnescu, 2008). Thus, our findings may broadly be of interest to practitioners in a variety of settings. However, the extent to which findings are transferable to another probation setting requires further research. Many of our themes are supported by the wider literature, and may resonate with contemporary probation practitioners in a range of settings in England and Wales. They highlight factors that support probation in performing a role in offender mental health (e.g. good offender-staff relationships), and raise issues, and potential solutions to these issues, that all providers could

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3 consider. However, this is was a small-scale study in one Probation Trust, which investigated
4 probation's role in offender mental health within a particular geographical area. There are potential
5 differences between settings both within and between countries. Moreover, as stated earlier,
6 probation in England and Wales has been subject to reforms since the study was conducted in 2009
7 (i.e. the policy landscape has considerably changed since the data were collected). Consequently,
8 further research is needed to explore potential similarities and differences between settings.
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17 *Implications for Policy and Practice*

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19 Within our study setting it appears that improving training and developing service-level agreements
20 would be beneficial. It may be inappropriate to expect probation staff to diagnose mental illness
21 (Canton, 2008) or provide treatment themselves, but enhanced training would improve their ability
22 to identify the signs and symptoms of mental illness. This is essential for advising the courts and
23 facilitating access to external services. It is particularly important that new providers are aware of
24 the role that staff are expected to perform in offender mental health and provide appropriate
25 training following concerns that the restructure may result in deskilling of the workforce (Burke,
26 2013). This could be supported by the new Probation Institute.
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33 Participants suggested creating a specialist role to address barriers related to inter-agency
34 communication and improve knowledge and understanding of mental illness and local service
35 provision. There is some evidence from the USA that specialist roles and programmes are effective in
36 supporting compliance (Lurigio, 2001). It may be beneficial to pilot such roles in the UK.
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40 Establishing service-level agreements between probation and health agencies would be beneficial in
41 our study setting to ensure a more systematic approach to referring those known or suspected to
42 have a mental illness to health services. If combined with cross-agency training or a specialist role,
43 this would improve staff's knowledge of local mental health services and referral procedures.
44 Probation's role has expanded following *Transforming Rehabilitation* to encompass supporting
45 continuity of care for those serving custodial sentences of less than 12 months, and the restructure
46 may be detrimental to existing local-level partnerships (Probation Chiefs Association and Probation
47 Association, 2013, Burke, 2013). Existing problems with inter-agency communication may be further
48 complicated by the NPS-CRC split. Moreover, recent research suggests that 20% of clinical
49 commissioning groups believe that "healthcare funding for probation is the responsibility of NHS
50 Area Teams" (Brooker et al., 2015). As Canton (2008) states, we should be clear about the
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3 circumstances in which a referral to a mental health agency should be made, how and by whom.
4 Canton recommended regular meetings between partners to create a clear understanding between
5 agencies of their responsibilities and how they will exchange information (Canton, 2008). Such
6 meetings need to include the NPS, CRCs and health agencies to prevent the existing difficulties with
7 inter-agency communication worsening as a result of the reforms.
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11 The quality of the relationship between probation staff and offenders is key. The importance of this
12 relationship for reducing re-offending has been discussed previously (see for example Rex, 1999,
13 Lewis, 2014). If the new probation providers are to perform their role in offender mental health well,
14 staff must demonstrate 'professionalism' – "the ability to understand and build a knowledge of, and
15 rapport with, the offender...to enable a meaningful exchange of information based on trust"
16 (Fitzgibbon, 2007).
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22 Staff found it difficult to obtain MHTRs and identified gaps in service provision for those with dual
23 diagnosis and personality disorder. The under-use of MHTRs (Khanom et al., 2009, Scott and
24 Moffatt, 2012), and earlier initiatives like psychiatric probation orders (Grünhut, 1963, Lewis, 1980,
25 Reed, 1992, H. M. Inspectorate of Probation, 1993) has been repeatedly lamented in the literature,
26 and as yet it is unclear what impact the introduction of new providers will have on this.
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31 Considering the transferability of our findings across England and Wales, training has been
32 repeatedly raised as an issue nationally (see for example Reed, 1992, H.M Inspectorate of Probation
33 (1993) and Bradley (2009)), suggesting this finding may be transferable. However, further research is
34 needed to fully explore the extent of the transferability due to changes in the policy landscape since
35 this study was conducted, and potential differences between probation areas. An operating model
36 has now been developed to ensure consistent provision of liaison and diversion services across
37 England. There have also been developments around working with offenders with personality
38 disorder (e.g. development of Psychologically Informed Physical Environments in prisons), which
39 include probation staff receiving Knowledge and Understanding Framework (KUF) training (Durcan
40 et al., 2014). However, Durcan et al., (2014) also highlight training as an area in need of further work.
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48 Probation-health partnerships exist in some areas (such as the Health Support Service the setting for
49 this research). Space does not permit a full review of these, but examples include Health
50 Trainers/Champions in probation settings (see for example Brooker and Sirdifield, 2007, Institute for
51 Criminal Policy Research, 2011a, Institute for Criminal Policy Research, 2011b, Dooris et al., 2013),
52 probation psychiatric services/clinics (Collins et al., 1993, Huckle et al., 1996, see for example Cohen
53 et al., 1999) and projects such as the Forensic Mental Health Practitioner Service (Senior and
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3 Kinsella, 2014). Here, probation staff are co-located with staff with more expertise in mental illness,
4 working in partnership with them. Such partnerships (some of which may have formal service-level
5 agreements) and training may directly or indirectly raise probation staff's level of mental health
6 awareness.
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10 11 12 **Conclusion**

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15 Staff and offenders in the Trust participating in this research perceived the role of the probation
16 service in offender mental health as: identifying and monitoring mental illness amongst offenders;
17 facilitating access to and monitoring offenders' engagement with health services; and managing risk.
18 Several barriers to performing this role were identified.
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22 Further research is required to explore the transferability of findings as the purpose and structure of
23 probation varies around the world, and within England and Wales services have been restructured
24 and improvements have occurred in some areas following the Bradley Report. However, many of the
25 findings are supported by the wider literature, and the question posed may be of interest to an
26 international audience.
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31 To ensure that staff can perform their role in offender mental health well current probation
32 providers may benefit from focusing on formalising partnership arrangements to ensure the
33 sustainability of local partnerships and achieve a more systematic approach to identifying, managing
34 and supporting offenders with mental illness; ensuring provision of adequate training; and trialling a
35 specialist role.
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42 **References**

- 43
44
45 Annison, J., Eadie, T. and Knight, C. (2008), "People First: Probation Officer Perspectives on Probation
46 Work", *Probation Journal*, Vol. 55 No. 3, pp. 259-271.
47
48 Bottoms, A. E. and McWilliams, W. (1979), "A non-treatment paradigm for probation practice",
49 *British Journal of Social Work*, Vol. 9 No. 2, pp. 159-202.
50
51 Bradley, K. (2009), "Review of People with Mental Health Problems or Learning Disabilities in the
52 Criminal Justice System", Department of Health, London.
53
54 Brooker, C. and Sirdifield, C. (2007), "New Futures Health Trainers: An Impact Assessment",
55 University of Lincoln, Lincoln.
56
57
58
59
60

- 1
2
3 Brooker, C., Sirdifield, C., Blizard, R., Denney, D. and Pluck, G. (2012), "Probation and mental illness",
4 *Journal of Forensic Psychiatry and Psychology*, Vol. 23 No. 4, pp. 522-537.
- 5
6 Brooker, C., Sirdifield, C., Ramsbotham, D. and Denney, D. (2015), "NHS commissioning in probation
7 in England – on a wing and a prayer", *Health and Social Care in the community*.
- 8
9 Burke, L. (2013), "Grayling's hubris", *Probation Journal*, Vol. 60, pp. 377-382.
- 10
11 Canton, R. (2008), "Working with mentally disordered offenders", in Green, S., Lancaster, E. and
12 Feasey, S. (Eds.) *Addressing offending behaviour: context, practice and values*, Cullompton,
13 Willan.
- 14
15 Coffey, A. and Atkinson, P. (1996), *Making Sense of Qualitative Data: Complementary Research
16 Strategies*, Sage, London.
- 17
18 Cohen, A., Bishop, N. and Hegarty, M. (1999), "Working in partnership with probation: the first two
19 years of a mental health worker scheme in a probation service in Wandsworth", *Psychiatric
20 Bulletin*, Vol. 23 No. 7, pp. 405-408.
- 21
22 Collins, P., Ball, H. and Costello, A. (1993), "The psychiatric probation clinic", *Psychiatric Bulletin*, Vol.
23 17, pp. 145-146.
- 24
25 Dooris, M., McArt, D., Hurley, M. A. and Baybutt, M. (2013), "Probation as a setting for building well-
26 being through integrated service provision: evaluating an Offender Health Trainer service.",
27 *Perspectives In Public Health*, Vol. 133 No. 4, pp. 199-206.
- 28
29 Durcan, G., Saunders, A., Gadsby, B. and Hazard, A. (2014), "The Bradley Report five years on. An
30 independent review of progress to date and priorities for further development", Centre for
31 Mental Health, London.
- 32
33 Farrow, K. (2004), "Still Committed After All These Years? Morale in the Modern-Day Probation
34 Service", *Probation Journal*, Vol. 51 No. 3, pp. 206-220.
- 35
36 Fitzgibbon, D. W. M. (2007), "Risk Analysis and The New Practitioner. Myth or Reality?", *Punishment
37 and Society*, Vol. 9 No. 1, pp. 87-97.
- 38
39 Glaser, B. G. and Strauss, A. L. (1999), *The Discovery of Grounded Theory: Strategies for Qualitative
40 Research*, Aldine De Gruyter, New York.
- 41
42 Grünhut, M. (1963), *Probation and Mental Treatment*, Tavistock Publications.
- 43
44 H. M. Government (2009), "Improving Health, Supporting Justice: The National Delivery Plan of the
45 Health and Criminal Justice Programme Board", Department of Health, London.
- 46
47 H. M. Inspectorate of Probation (1993), *Probation Orders with Requirements for Psychiatric
48 Treatment: Report of A Thematic Inspection*, Home Office, London.
- 49
50 Heaton, J. (1998), "Secondary Analysis of Qualitative Data, Social Research Update, 22: Autumn
51 1998", <http://sru.soc.surrey.ac.uk/SRU22.html>, University of Surrey.
- 52
53
54
55
56
57
58
59
60

- 1
2
3 Heaton, J. (2008), "Secondary Analysis of Qualitative Data: An Overview", *Historical Social Research*,
4 Vol. 33 No. 3, pp. 33-45.
- 5
6 Heilbrun, K., DeMatteo, D., Yasuhara, K., Brooks-Holliday, S., Shah, S., King, C., Dicarolo, A. B.,
7 Hamilton, D. and Laduke, C. (2012), "Community-Based Alternatives for Justice-Involved
8 Individuals with Severe Mental Illness: Review of the Relevant Research", *Criminal Justice
9 and Behavior*, Vol. 39 No. 4, pp. 351-419.
- 10
11
12 Hinds, P. S., Vogel, R. J. and Clarke-Steffen, L. (1997), "The Possibilities and Pitfalls of Doing a
13 Secondary Analysis of a Qualitative Data Set", *Qualitative Health Research*, Vol. 7 No. 3, pp.
14 408-424.
- 15
16
17 HMI Probation, HMI Court Administration, HMI Constabulary and HM Crown Prosecution Service
18 Inspectorate (2009), "A joint inspection on work prior to sentence with offenders with
19 mental disorders", HMP Probation, London.
- 20
21
22 Home Office (1990), "Provision for Mentally Disordered Offenders, Home Office Circular 66/90",
23 Home Office, London.
- 24
25
26 Home Office (2004), "Reducing Re-offending National Action Plan", Home Office Communication
27 Directorate, London.
- 28
29
30 Home Office and Department of Health (1995), "Mentally Disordered Offenders: Inter-Agency
31 Working", Home Office and Department of Health, London.
- 32
33
34 Huckle, P., Travier, T. and Scarf, S. (1996), "Psychiatric clinics in probation offices in South Wales",
35 *Psychiatric Bulletin*, Vol. 20, pp. 205-206.
- 36
37
38 Institute for Criminal Policy Research (2011a), "An assessment of the health needs of offenders in
39 West Sussex - Final report", Institute for Criminal Policy Research, London.
- 40
41
42 Institute for Criminal Policy Research (2011b), "Evaluation of the Leicestershire and Rutland
43 Probation Trust Health Trainer Service Final Report", Institute for Criminal Policy Research,
44 London.
- 45
46
47 Khanom, H., Samele, C. and Rutherford, M. (2009), "A Missed Opportunity? Community Sentences
48 and the Mental Health Treatment Requirement", Sainsbury's Centre for Mental Health,
49 London.
- 50
51
52 Lewis, P. (1980), *Psychiatric Probation Orders: Roles and Expectations of Probation Officers and
53 Psychiatrists*, University of Cambridge Institute of Criminology, Cambridge.
- 54
55
56 Lewis, S. (2014), "Learning from success and failure: Deconstructing the working relationship within
57 probation practice and exploring its impact on probationers, using a collaborative
58 approach", *Probation Journal*, Vol. 61 No. 2, pp. 161-175.
- 59
60
61 Lincoln, Y. S. and Guba, E. G. (1985), *Naturalistic Inquiry*, Sage, London.

- 1
2
3 Long-Sutehall, T., Sque, M. and Addington-Hall, J. (2010), "Secondary Analysis of Qualitative Data: A
4 Valuable Method for Exploring Sensitive Issues with an Elusive Population?", *Journal of*
5 *Research in Nursing*, Vol. 16 No. 4, pp. 335-344.
6
7
8 Lurigio, A. J. (2001), "Effective services for parolees with mental illnesses", *Crime and Delinquency*,
9 Vol. 47 No. 3, pp. 446-461.
10
11 McWilliams, W. (1985), "The Mission Transformed: Professionalisation of Probation Between The
12 Wars", *The Howard Journal of Criminal Justice*, Vol. 24 No. 4, pp. 257-254.
13
14 Ministry of Justice (2013), "Transforming Rehabilitation: A revolution in the way we manage
15 offenders", The Stationery Office, London.
16
17 Ministry of Justice (2014), "Transforming Rehabilitation: a summary of evidence on reducing
18 reoffending (second edition)", Ministry of Justice, London.
19
20 Morse, J. M. and Field, P. A. (1996), *Nursing Research: The Application of Qualitative Approaches*,
21 Chapman and Hall, London.
22
23
24 Newburn, T. (2003), *Crime and Criminal Justice Policy*, Pearson Education Ltd.
25
26 Patton, M. Q. (1990), *Qualitative Evaluation and Research Methods*, Sage, London.
27
28 Peay, J. (2011), *Mental Health and Crime*, Routledge, Oxon.
29
30 Probation Chiefs Association and Probation Association (2013), "Transforming Rehabilitation. A
31 Revolution in the Way We Manage Offenders. Consultation Paper CP1/2013. A Joint
32 Response from the Probation Chiefs Association and the Probation Association", Probation
33 Chiefs Association and Probation Association, London.
34
35
36 Reed, J. (1992), "Review of Health and Social Services for Mentally Disordered Offenders and Others
37 Requiring Similar Services", The Stationery Office, London.
38
39 Rex, S. (1999), "Desistance from Offending: Experiences of Probation", *The Howard Journal*, Vol. 38
40 No. 4, pp. 366-383.
41
42 Scott, G. and Moffatt, S. (2012), "The Mental Health Treatment Requirement: Realising a Better
43 Future", Centre for Mental Health, London.
44
45 Senior, P. and Kinsella, R. (2014), "A working partnership: an analysis of the relationship between
46 probation in London and Together for Mental Wellbeing", Hallam Centre for Community
47 Justice, Sheffield Hallam University, Sheffield.
48
49
50 Sirdifield, C. (2012), "The Prevalence of Mental Health Disorders amongst Offenders on Probation: A
51 Literature Review", *Journal of Mental Health*, Vol. 21 No. 5, pp. 485-498.
52
53 Skeem, J. L. and Eno Loudon, J. (2006), "Toward Evidence-Based Practice for Probationers and
54 Parolees Mandated to Mental Health Treatment", *Psychiatric Services*, Vol. 57, pp. 333-342.
55
56
57
58
59
60

- 1
2
3 Social Exclusion Unit (2002), "Reducing re-offending by ex-prisoners - Report by the Social Exclusion
4 Unit", Office of the Deputy Prime Minister, London.
5
6 Szabo, V. and Strang, V. R. (1997), "Secondary Analysis of Qualitative Data", *Advances in Nursing*
7 *Science*, Vol. 20 No. 2, pp. 66-74.
8
9 Tesch, R. (1990), *Qualitative Research: Analysis Types and Software Tools*, Routledge-Falmer,
10 London.
11
12 Van Kalmthout, A.M. and Durnescu, I. (2008), "European Probation Service Systems; A Comparative
13 Overview", in Van Kalmthout, A.M. and Durnescu, I. (Eds.) *Probation in Europe*, aolf Legal
14 Publishers, Nijmegen, pp. 1-42.
15
16 Vanstone, M. (2004), *Supervising Offenders in the Community: A History of Probation Theory and*
17 *Practice*, Ashgate, Aldershot.
18
19 Whitehead, P. and Statham, R. (2006), *The History of Probation: Politics, Power and Cultural Change*
20 *1976-2005*, Shaw and Sons.
21
22 Willis, A. (1986), "Help and Control in Probation: An Empirical Assessment of Probation Practice", in
23 Pointing, J. (Ed.) *Alternatives to Custody*, Blackwell, Oxford, pp. 162-182.
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Table 1 Overview of Literature on Probation's Role in Offender Mental Health

Document	Statements about probation's role in offender mental health
Home Office Circular 66/90 (Home Office, 1990)	<ul style="list-style-type: none"> Stated that "the probation service should act as part of a network of agencies...providing accommodation, care and treatment in the community for mentally disordered offenders" (Home Office, 1990: 78)
Reed Review (Reed, 1992)	<ul style="list-style-type: none"> Stressed the need for a multi-agency approach to identifying and meeting the needs of offenders with mental illness Stated that probation officers should work as part of a multi-professional care team to support offenders with mental illness
<i>Mentally Disordered Offenders Inter-Agency Working</i> (Home Office and Department of Health, 1995)	<ul style="list-style-type: none"> Stated that probation has a role in "fostering the development of close co-operation at a local level between the criminal justice system and health and social services" (Home Office and Department of Health, 1995: 18)
Bradley Report (Bradley, 2009)	<ul style="list-style-type: none"> Added impetus to the agenda around considering offenders' mental health needs, in particular diverting people into care when appropriate Stressed that real improvement in provision of care for offenders with mental illness can only be achieved through partnership working Recommended mental health and learning disability training for probation staff Emphasised the value of support from court liaison and diversion services that can provide probation staff with information about a defendant's mental health
<i>Improving Health, Supporting Justice</i>	<ul style="list-style-type: none"> Published in response to the Bradley Report and discusses the role of probation in contributing to Joint Strategic Needs

(H.M. Government, 2009)	Assessments, identifying the needs of those in contact with the criminal justice system to inform healthcare commissioning
<i>Transforming Rehabilitation</i> (Ministry of Justice, 2013)	<ul style="list-style-type: none">Restructured the probation service, making assistance to the courts an NPS role

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Table 2 Interview Questions Relevant to the Qualitative Secondary Analysis

Questions for Staff	Questions for Offenders
How would you describe the purpose of probation?	How would you describe the purpose of probation?
To what extent do you feel that it is your role to monitor offenders' mental health?	To what extent do you feel that mental health problems are recognised by the probation service?
When an offender presents with multiple needs, how do you decide which ones to work on with them?	Would you say that you had several needs whilst you were on probation? If so, how did you decide which ones probation could help you with?
To what extent do you think offending behaviour is linked to mental health problems?	To what extent do you think your offending is linked to your mental health?
To what extent do you feel that it is your role to refer offenders to appropriate mental health services?	To what extent has the probation service helped you to access health services?

Figure 1 Analysis Process

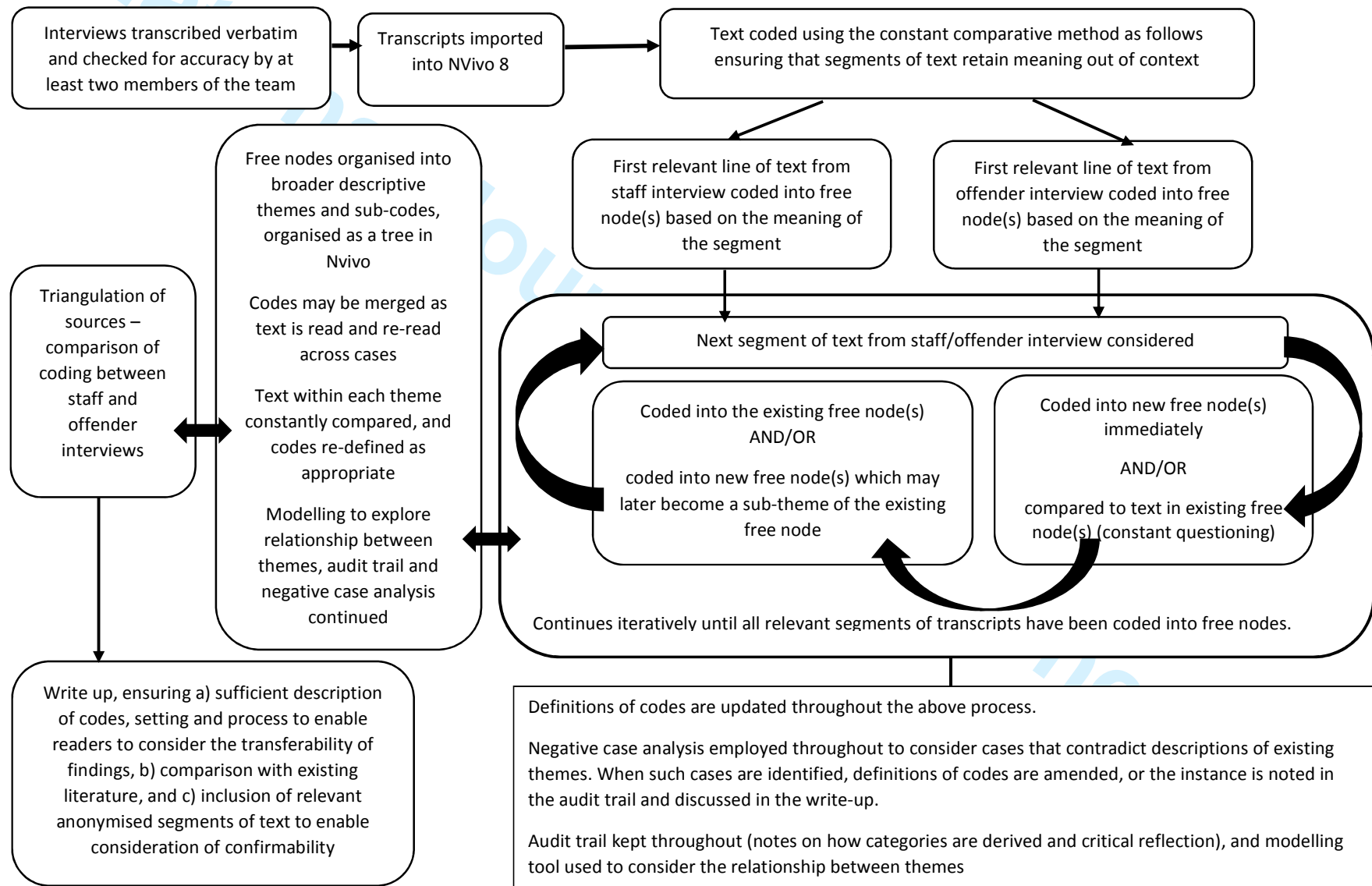
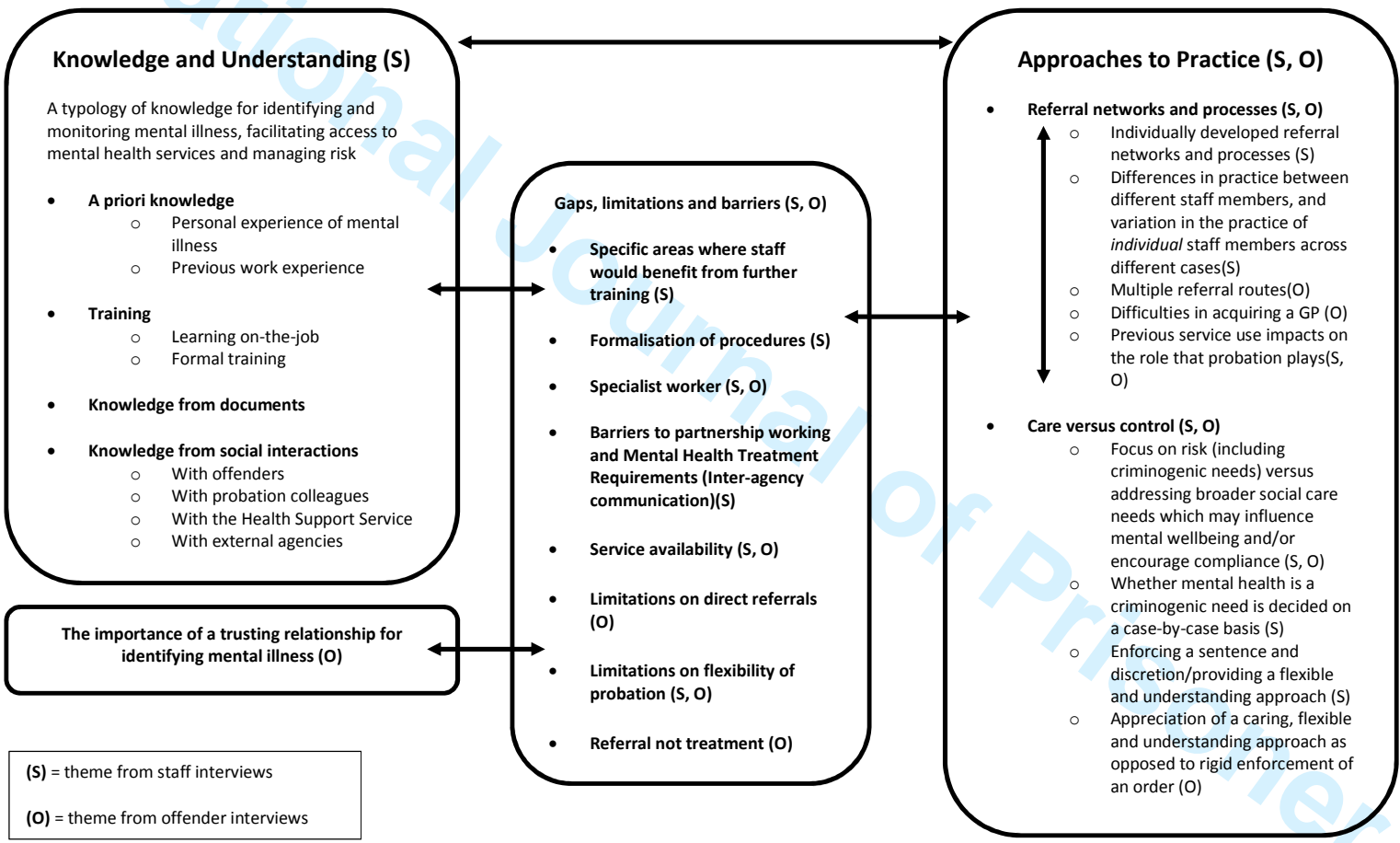


Figure 2: Model of Cross-Cutting Themes



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